

# **SPEECH BY EAMON GILMORE TD**

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## **BROAD CONSENSUS NOW GATHERING BEHIND UNIVERSAL HEALTH INSURANCE**

I would like to thank you for the invitation to speak here today, and to congratulate you on the publication of your report on the financing options for universal health insurance. It makes for very interesting reading and, with my colleague and health spokesperson Jan O'Sullivan, I look forward to examining the implications of your findings in greater detail.

What this report makes clear is that the introduction of universal health insurance in Ireland is both feasible and affordable. The argument is sound. The political challenge lies in winning it, which is what I would like to discuss here today.

The Labour Party has been making the case for universal health insurance for almost a decade. Our health policy is a product of our core principle: that something as vital to human life, and human dignity, as healthcare, should be equally available to each member of our community on the basis of medical need, not income.

However, not only was our 2001 policy a response to the fundamental unfairness of the existing system; it was also proposed as a solution to its inefficiency. Put simply, fairness – or every person being treated equally – is more efficient. Today's report confirms that.

The Labour Party's approach to healthcare is informed by the values which have shaped our movement. It was our fellow social democratic parties across Europe and beyond, who forged many of the universal healthcare systems that became an emblem for progress, for solidarity, and for equal citizenship.

It is not a coincidence that Ireland's costly two-tier system and high thresholds for access to primary care, are something of an anomaly in Europe. After all, values, and politics, determine how we distribute care, and how we pay for it.

On the one side, are those of us who believe that access to healthcare should be equal and universal. On the other side, are those who do not. And those who do not, have been in power for most of Ireland's independence.

It is extremely heartening for those of us who have long-argued for a more equitable health system, to finally see a consensus gathering around universal health insurance. Just last week, the IMO was the latest organisation to come out in favour of universal health coverage, which was very welcome.

This is what change looks like. This is how progress is made. But it is absolutely critical that, in our common journey towards universal health insurance, we do not lose sight of the principles that are guiding us: fairness, and efficiency.

The battle for a universal health insurance system will be won and lost on the doorsteps, in living rooms and in office canteens.

And what will be discussed will not be technical merits or otherwise of different models of universal health insurance. It will be: does this make sense for me and my family? Is it better than what is on offer already? Can the country afford it?

Don't get me wrong: of course the model of universal health insurance matters a great deal – it matters in relation to equity, transparency and cost. But the ultimate goal of equitable and affordable healthcare for every citizen matters most.

We can solve the technical questions. It is not beyond our ingenuity as a people – or our solidarity with our fellow men and women – to reform the healthcare system so that it treats everyone equally and excellently.

The bigger challenge lies, first, in having people understand what social or universal health insurance actually is. And secondly, in convincing people that it will offer them better healthcare, and better value for money, than they have at present.

That is the political prerequisite for success. Without these two steps, we will not succeed. The agenda of vested interests flows into the vacuum left by poor communication, and turning a blind eye to people's fears.

Just look to President Obama's recent experience in the United States. When the process of reform gets more attention than the purpose of the reform, then you have a recipe for trouble.

Access to healthcare is an extremely sensitive issue, even when the goal of reforms is to make that access universal. We would do well to remember Bill Clinton's remarks of his own failed attempt at healthcare reform: everyone is in favour of change in general, but not in particular.

And, as the Democratic Party learnt the hard way 15 years later, the aim of levelling up can easily be manipulated to exploit people's fear of levelling down. Ultimately, that fear hobbled the Obama administration's ambitions, and the public plan option was lost along the way. Ironically, this public option would have been good for competition – both on quality and price – and would have kept costs lower.

Here in Ireland, we need to acknowledge that the existing state of our public health service could be one of the biggest obstacles to convincing people that more access to it can be better.

That is why a key step towards universal health insurance, is tackling some of the fundamental problems in our health system. Problems which, if we are frank, fifty per cent of the population seek to insure themselves against.

Firstly, our health service does not have the capacity to meet demand. At just under 3 beds per 1,000 people, Ireland has one of the lowest numbers of acute inpatient hospital beds in the OECD, and one of the highest levels of bed occupancy. We have one third the number of GPs per capita as France or Austria, and half that of Germany. And we employ fewer specialists than the EU15 average.

Ours is a system where care can, on occasion, be rationed to the point of scarcity. Yet ours is not a lean health system: it is at once starving, and bloated.

This brings me to the second reason why our health system is not working: quite simply, we feed it badly, and with all the wrong incentives.

At the heart of this, is the two-tier system, with separate queues for public and private patients, for services that are, for the most part, publicly-funded. As long as hospitals and consultants are paid differently for public and private patients, the incentive will always be to prioritise revenue-raising private patients.

Not only does this lead to indefensible and immoral inequities in our health system, where those who can afford it can get treated earlier than those who cannot, but also to a poor use of resources, including the unnecessary duplication of services.

The structure of our health service is dictated by this public-private divide yet private health insurers contribute less than 10 per cent of the cost of running the health service. I would challenge anyone to make the case for allowing less than 10 per cent of funding to wag the other 90 per cent. It simply doesn't make sense.

A further perverse incentive is how hospitals are paid. Global hospital budgets are awarded largely on the previous year's output, essentially rewarding them for stasis, not for productivity. If a hospital's budget is running out, it makes sense for managers to leave patients on a waiting list – where they are not costing any money – or to close wards. But that does not make sense for patients, or for the taxpayer, who is not getting the maximum use of the resources we pay for.

Ireland has a very costly model of delivering healthcare. This is due in part to the inefficiencies outlined above, but also to our over-reliance on inpatient hospital services to respond to the health needs of our population.

It is not inconsistent to state that we do not have enough acute inpatient capacity, and to say that we are over-reliant on it. Both statements are true, and are the reason why the coming decade will be a critical one for our health service.

We are going to need to invest further in our health system, just to keep up with demographic change. At a minimum, the ESRI estimates the number of people over 65, who are the most intensive users of health services, to increase by almost 70 per cent by 2020.

Whatever reform option is adopted, it must facilitate a shift to a far greater emphasis on primary care.

In this respect, the professed desire of the HSE to shift the majority of care to the primary system is to be welcomed. However, without tackling the crippling effect of the public-private divide; the way we pay healthcare providers for their services; and the issue of under-capacity, the problems that have dogged our health service for the past few decades will continue to get worse. Not only that, but paying for them will get more expensive.

The fundamental insight of universal health insurance is that how we pay for healthcare has a profound effect on how our health service works, how efficient it is, and how fair it is.

The key driver of both efficiency and fairness, is that money follows the patient, bringing demand and supply closer together.

In the longer run, UHI also provides a rational basis for extending capacity. If a hospital manager can demonstrate that they could do even more, for example, with another ward, or another operating theatre, then why not let them take out a loan and build it themselves? A Strategic Investment Bank, which the Labour Party proposed last month, would be a new source of public and private credit for this kind of venture.

And if money follows the patient to a hospital, it can also follow her to the community – to GP services, physiotherapists and nurses that can provide appropriate care more cheaply and more conveniently.

These are the principles that make universal health insurance work: that equity is more efficient; that money follows the patient; and that by taking away the barriers to primary care, we can provide a better, and better value, health service.

To that I would add one more: that the profit motive is taken out of life and death decisions. For the Labour Party, access to essential healthcare should not be beholden to shareholders or vulnerable to speculators.

In the period since the Labour Party first proposed its universal health insurance policy, health spending increased by some ten billion euro.

The health insurance market was opened up to competition.

And the HSE was established.

Yet we are no closer to universal primary care; no closer to patients being treated equally, according to medical need; and we are no closer to matching supply of care to demand, because we are still funding our system in a way that perpetuates all of its flaws.

As we have heard, there are a number of ways to harness the efficiency of UHI: The single-payer model, whether funded directly by a 'pure' health insurance contribution; subsidised through tax; or a mix of income tax, social insurance and other kinds of taxes, as in France, has the major benefit of not needing a complex regulatory structure. Focus would shift to regulating the quality of healthcare providers, not keeping insurers within the rules.

The model of compulsory private insurance – adopted in the Netherlands – has the benefit of looking more familiar to Irish people, while still delivering equal, universal access to essential care.

But the jury is still out on whether it will actually reduce the cost of providing healthcare, and compulsory premiums are on the rise. One argument is that it trims administration costs, but what the insurance companies could shed, was offset in part by the 500 extra staff the Dutch tax department had to hire, to administer complex subsidies to the less well off – in this case, 40 per cent of the population.

Then there is a mixed model, still with competing private insurers, but with at least one public insurer – along the lines of Obamacare. Medical card benefits would be available to all current medical card holders, except now delivered through their health insurance card. This public option would also cover the 16 per cent or so who have no insurance and no medical card, and would be available to anyone who wanted to opt in.

The benefits of having a strong public insurer in a mixed insurance model, is its ability to be an aggressive purchaser of services, lowering the cost of providing treatment. One thing is certain, whatever path we choose, we will end up with a distinctly Irish model, which takes account of our specific circumstances.

And we will still have to answer those questions raised at the beginning: does it make sense for families? Does it make the health service better? And will it be economically sustainable?

It is how we answer those questions, that will win the hearts and minds of a population made anxious by scarcity, and sceptical of reforms that have not delivered tangible benefits.

The coming years will be extremely challenging. No one is under any illusion that growing employment, and fixing the public finances, will be easy. But what is equally clear is that a government too focused on the short-term, will ignore longer term risk.

Today's report is an extremely valuable and important contribution to the debate, and will be informing our updated universal health insurance policy in advance of the next general election.

If, after that election, the Labour Party is in government, central to our mission will be the implementation of health reforms, and improvement in capacity, so that we can implement universal health insurance.