Universal Health Insurance - Labour's health policy

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Universal Health Insurance - Labour's commitment

Labour will introduce Universal Health Insurance.

Labour in Government will introduce Universal Health Insurance. From Day One in office, Labour will begin the phased introduction of a universal health insurance system. Each phase will improve access to health care.

This document sets out the steps on the path to a universal system of health care insurance, which will guarantee access to care in need, without discrimination on the basis of income. This is a realistic, costed and achievable programme of reform.

At a time of economic crisis, we need social solidarity more than ever.

Reform is no longer just an aspiration for Irish health care - it is now an essential. Labour has always believed and argued that access to health care should not be dependent on your means. It has always been a scandal that in Ireland, more money means better care and not enough money can mean no care at all. Now in this economic crisis, many people feel insecure about their jobs, their incomes and their families' future. No one should feel insecure about their access to health care when they need it.

Labour will introduce universal access to health care - for everyone who needs care when they need it. Of course we have to pay for this system of care. We already pay for care in an unreformed system. Now we pay through taxes, charges and insurance without any guarantee that we will get care when we need it or that a change in our circumstances won't make care unaffordable. Under universal health insurance, we will pay on the basis of our ability to pay and we will receive care on the basis of our need for care. We will get much better care and value than we get in today's unreformed health care system.

Under universal health insurance, when you are in work and earning a good income, you will contribute to the system. If you are out of work or on a low income, if you are ill and cannot work, even though you cannot contribute to the system, you and your children will have the same access as everyone else. This is social solidarity. It is the basis of the systems of health care in most European countries. Now at a time of economic crisis, we need social solidarity more than ever.

We cannot afford *not* to reform the Irish health system.

We now spend 12% of our national income on health care.[1] We spend as much on health care as many countries that have long achieved universal access to good quality care. It is clear we spend badly.

After 13 years of a Fianna Fail/Progressive Democrat Government the only health care reform has been the creation of the HSE - and this has been a disaster. The HSE is too big, does not answer to democratic control, does not know how our health care budget is being spent, and has cut hospital care while increasing layer after layer of highly paid bureaucracy. The rushed redundancy programme introduced in the last days of this Government is as chaotic and disorganised as every aspect of health administration under this Government.

The Minister for Health has been invisible - except when there has been a private, for-profit hospital or clinic to be opened. In the boom years the Government used our money to build a network of private, for-profit hospitals. These hospitals are funded by tax breaks for the wealthy, a way of taking money out of your pocket and putting it into theirs.

Now the Government is cutting public hospital and community services. Waiting lists for hospital treatment are climbing. Our two-tier system of public and private hospital care remains unreformed. This Government's new hospital consultants' contract does not give equal access to care in public hospitals, never mind in the private hospitals that we have all funded.

The majority of the population has to pay for visits to family doctors. Illness remains undetected until too late because people put off going to the doctor. We have no national system of preventive care and health checks. Families struggle to care at home for ill, older relatives, without the community services and support that they need.

Labour is committed to reforming this system: how we fund care, how we access care and how we deliver it. Throwing money at the system has been tried and failed. Now it is no longer an option. We cannot afford waste, big bureaucracy and spending health care budgets on profits for the wealthy. We cannot afford not to reform Irish health care.

A new policy for a new decade

In 2000 Labour published a discussion document on Universal Health Insurance and in 2001 Labour published "Our Good Health", a far-seeing policy with a commitment to delivering a system of Universal Health Insurance. Nearly ten years later, many others have joined Labour in supporting a universal insurance system. Other political parties, the health professions and health policy researchers have proposed different variants of universal health insurance. This document is an updated Labour policy for a new decade, a policy adapted to developments in Irish health care, taking into account our changed economic circumstances and drawing on the substantial Irish research that is now available on models of universal health insurance and options for reform.

Our policy

Primary care reform

Labour will introduce a system of Universal Primary Care Insurance, which will give everyone entitlement to GP care without paying fees.

This is a quick, affordable reform in which the Irish State will guarantee access to care. Labour believes that the public protests over the removal of automatic entitlement to medical cards for over-70s demonstrate that Irish people understand the value of a state-guaranteed system of access to primary care. Phased in over four years, this reform will start from Labour's first year in Government with the extension of access to GP care without fees to people with long-term illnesses.

Hospital care reform

Labour will introduce a system of Universal Hospital Care Insurance. Phased in over six years, this system will give everyone the benefits enjoyed now by people with private health insurance. Everyone will be insured for hospital care by either a private or public insurer. Everyone will have equal access to care in public and private hospitals. Hospitals, public and private, will have the independence and freedom that will allow them to supply care to the insurance system and to be paid according to the level of care they deliver. The National Treatment Purchase Fund (NTPF) and the purchasing arm of the HSE will come together to provide a new public insurer. Reform in the management of hospitals, establishment of the new public insurer and development of systems of regulation and financing will take time, which is why introducing this system will take the life of one government. But its introduction will start from year one with an expansion of the role of the NTPF to purchase diagnostic tests for people who do not have insurance.

Who is responsible?

The Minister for Health will be clearly in charge of the health care system and answerable to the Government and Dáil Eireann. The development of the system of Universal Health Insurance will completely reform the role of the HSE. The Minister will introduce legislation to enact Universal Primary Care Insurance and Universal Hospital Care Insurance.

Labour in Government will deliver this reform

Labour believes that the right time to create a Universal Health Insurance system for Ireland is now. This document explains how Labour will fund this reform by a combination of reducing costs and re-allocating health care budgets. This will be an Irish system designed for Irish circumstances, within the obligations of EU membership, and in harmony with the principle of social solidarity. This reform will ensure that no one in Ireland - young or old, in or out of work - will fear being denied health care when they need it.

The reasons why we need to reform Irish health care

Irish health care is never out of the news because our health care system is a failure. While no country claims to have a perfect health care system, for a developed and relatively rich country, Ireland's health service does particularly badly. Care is not good enough. Access to care is unfair. There is much waste and little or no cost control. Many aspects of the system are complex and work against delivering best care. The administrative system is disastrously bad.

Reasons for reform 1: Inadequate care in the community

Ireland has a severe shortage of family doctors. The cost of going to the doctor is so high that many people do not go even when they or their children are sick.

A severe shortage of family doctors

We have only 55 GPs per 100,000 people compared to 65 in Northern Ireland, 76 in the UK overall, 75 in Spain and 163 in France.[2] Some counties in Ireland have as few as 45 GPs per 100,000 people. Counties with rapid population growth - such as Monaghan and Kildare - have even fewer.[3] Despite recent increases in GP training places, Ireland is still training only 158 GPs each year when we need to train 250 to reach the EU average.[4]

In 2001 the Government announced a strategy of developing primary care teams which would bring together GPs, practice nurses, public health nurses and community care professionals to offer patients integrated care in one location. International health care experts agree that most health care needs should be met by such primary care teams. The plan was to have 400-600 teams in place by 2011.

Nine years after the strategy's publication, in March 2010, only 11 teams were fully operational, with GPs and HSE staff located in one building. [5] Although the HSE talks

of hundreds of teams, many of these are virtual according to the Irish Medical Organisation.

Reasons for reform 2: Cost stops sick people from going to the doctor

A North-South study found that cost prevented 19% of patients in the Republic from consulting a doctor when they were sick compared to under 2% in Northern Ireland.[6] Only 38% of people in the Republic have medical cards or GP-visit cards and access to GPs without charge; in Northern Ireland access is free for all.

Ireland's primary care system operates as a free market, in which GPs set up where they wish and set fees as they wish. The majority of the population, who do not have medical cards, have no guarantee that they will be able to find or afford general practitioner care in need. Yet without a GP referral, anyone who attempts to access hospital accident and emergency care must pay a fee of €100.

Experts appointed by the Minister for Health were highly critical of Ireland's system of fees for GP care in their July 2010 report:

"The requirement for the majority of the population to pay out-of-pocket for GP care is unique to Ireland compared to other developed countries..."

"High pay-as-you-go GP charges are known to deter use of care, increasing the risk of later detection of medical problems, with the likelihood of higher costs in terms of health care in the longer term."

"Payment for health care at the point of use conflicts with the goal of developing continuity of care which is particularly important for effective chronic disease management."[7]

Report and Evidence Volumes of the Expert Group on Resource Allocation and Financing in the Health Sector, published July 2010

When in 2008 this Government announced the re-introduction of means-testing for medical cards for people aged 70 and over, there was massive public outcry. Older people's doctors joined this outcry. Older people and their doctors know the value of a health care system that everyone can access on equal terms without fear of cost. Many of us develop disabling conditions or chronic illnesses as we age. With good medical care and community support, we can still live full lives. Medical cards open access not only to GP care but also to community services, provided by professionals like public health nurses, physiotherapists, occupational therapists and home helps. These community services are vital to keeping older people at home and out of long-term residential care.

Letter to The Irish Times from a Geriatrician, October 2008

Cutting costs in the health service

Madam, - The introduction in 2001 of the scheme entitling all over-70s to a medical card was a very important healthcare development.

It guarantees ready and immediate access to a general practitioner should an elderly person suddenly become unwell. It also ensures that the services of public health nursing and community care are readily available.

It allows for a more streamlined and integrated discharge plan for elderly patients from hospital back into the community - a core objective of the scheme.

The cost of providing medical cards for the over-70s is by now well factored into revenue and the only additional cost is the provision of extra cards for those who reach their 70th birthdays. From this sum can be subtracted the cost of paying for the cards of elderly people who pass away. The increased revenue costs each year are therefore minimal.

The over-70s medical card provision was an inspired advance in the care of elderly people and it is imperative that this progressive step is not undermined. - Yours, etc,

J. BERNARD WALSH,

Consultant Geriatrician and Clinical Professor

Under this Government the HSE has been cutting hospital care and arguing for re-configuration of care to the community. Yet community care has not developed as it should, leading to great hardship for families who must care for their loved ones at home with little help.

"The whole purpose of health service reform is to take resources from the acute hospital sector and spend more resources in the community sector."

– Taoiseach, Brian Cowen, Dáil Debates, Leaders' Questions, May 21st 2008.

Number needing help up one-third

ALZHEIMER SOCIETY: ALZHEIMER CARERS are facing a crisis with the number of people with dementia awaiting access to community services up by one-third in the last year, the Alzheimer Society of Ireland said.

The society said more than 1,000 people across the country were now unable to access home care, day care and residential care services, and that it expects this number to increase over the coming years.

The Irish Times - October 8th, 2010

Reasons for reform 3: Inadequate care in hospitals

Public cutbacks, private profit

In the 2007 Programme for Government, this Government promised to increase public hospital beds by 1,500.[8] It has not done that. It has done the opposite. The HSE has cut public hospital beds. The Minister for Health has been promoting and opening private hospitals.

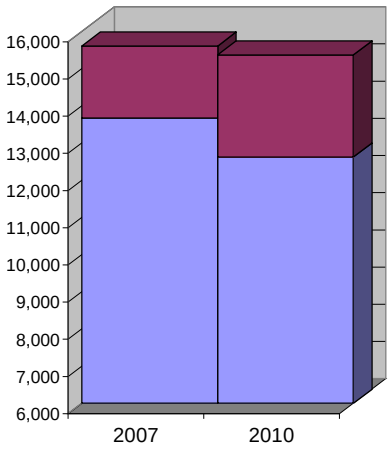
The HSE on its own admission shut down over 1,000 beds in public hospitals coming into the winter of 2010. Closures ran at 1,044 in August, 1,147 in September and 1,045 in October, according to the latest figures published by the HSE at the end of the year. [9] Meanwhile, between 2007 and 2010, private hospitals added over 800 beds.[10]

When winter illnesses increased numbers of patients presenting at hospitals at the beginning of January 2011, there was immediate crisis in Emergency departments with record numbers of patients sleeping on trolleys and in waiting room chairs. Members of the Irish Nurses and Midwives Organisation (INMO) counted 1,660 public beds closed on January 7th 2011. More than 1,100 of these closed beds were in public acute hospitals and over 500 were in district hospitals and community nursing units which care for older people (Appendix 1 lists the closures).

Under this Government, information on the number of beds available and open in public hospitals is not published until it is so out of date that it is useless. The Department of Health used to supply this information monthly. The HSE does not publish this information and supplies it to the Department years out of date. As late as January 2011, the most recent figure for available public hospital beds that the Department published was for the end of 2008! If the 2010 cuts are subtracted from peak public hospital bed numbers for the decade in 2007 to estimate available beds in public hospitals in 2010, it appears that over the three-year life span of this

Government, beds in private hospitals have increased to account for 18% of overall available hospital beds compared to 12% in 2007 (Figure 1).

Figure 1 Public hospital bed closures and private hospital bed growth



	2007	2010
Beds in public hospitals	**13,668**	**12,623**
Beds in private hospitals	**1,934**	**2,744**

Source: Private hospital beds from Report of the Expert Group on Resource Allocation and Financing in the Health Sector, Evidence Volume 1 Table 7.6; Average public hospital beds available for 2007, published by Department of Health and Children on its website[11]; Public hospital beds for 2010 subtracts closures announced by HSE for October 2010 from 2007 total, peak public hospital beds in the decade. Includes day beds.

Unsafe occupancy levels

Irish public hospitals are bursting at the seams. The number of inpatients treated each year in public hospitals has been falling since 2007.[12] The occupancy rate recorded for our public hospitals in the HSE's monthly reports has been at 90% and over in 2010.[13] This means that there are insufficient beds available to offer safe, hygienic care with proper infection control. Ireland's public hospitals have the highest rate of bed occupancy in the EU.[14] The EU average is generally between 75 to 80% and international experts recommend that occupancy should not exceed 85%. Occupancy rates are "unsustainably high" according to Harney's expert group. [15]

HSE plans for radical cuts

Although the Programme for Government agreed between Fianna Fail, the Greens and the Progressive Democrats in 2007 supported increasing public bed capacity, the HSE has been pursuing a policy of cutting back acute hospitals. A study commissioned by the HSE recommended cutting back Irish hospital beds to a lower level than in any other OECD country. PA Consulting Group recommended that the number of inpatient beds in Irish public *and* private hospitals should be cut from 13,380 in 2007 to 7,777 in 2020. There has been every appearance that the HSE supports this policy. If the HSE were to stay on this course, by 2020 Ireland will have only 1.5 inpatient beds for every 1,000 people and only 10.8 beds for every 1,000 people aged 65 and over. This would be fewer beds by far than in any OECD country (Appendix 2 Figures 1 and 2).[16]

Commenting on this policy, an ESRI report has warned that "the capacity of other health care sectors and primary care and long-stay care to absorb a reorientation of care away from acute hospitals is extremely limited at present and over the period to 2020 without substantial and sustained investment." [17]

GOVERNMENT PROMOTES HYGIENIC HOSPITAL CONDITIONS …..FOR THE PAYING CUSTOMER…

Minister for Health opens private hospital extension

In September 2010 Minister for Health Mary Harney opened a €100m expansion of Dublin's Blackrock Clinic, which added three new floors to the private hospital. The expansion increased beds at the hospital by 42%, bringing the total to 170.

"Blackrock Clinic will be the first major acute hospital in Ireland to accommodate all in-patients in single rooms, providing improved comfort and privacy as well as reducing the chance of infection, said a spokeswoman." (Irish Medical Times report, September 28th 2010)

…WHILE PATIENTS IN DIRE NEED RISK THEIR LIVES

Meanwhile down the road at the public St Vincent's Hospital, cystic fibrosis patients still waited for the single hospital rooms that would allow them to have essential hospital treatment without running the risk of contracting life-threatening infections on hospital wards. With talk of a general election as a spur to the Minister, a contract was signed in October 2010 for construction of a 30-35 bed unit - which would not be complete until 2012.

Experts appointed by the Minister for Health have pointed out that the state funded the private hospitals and needs to get better use from them:

"There is a shortage of certain types of public acute hospital capacity in Ireland, resulting in unsustainably high occupancy rates... "

"In contrast to the public sector, there is a surplus of some types of private hospital space that has developed on foot of subsidies for these investments via the tax system. Unfortunately, despite the tax incentives given, these developments took place in the absence of any integrated health planning structure. Consequently, there is a major challenge ahead to explore how these facilities can be used optimally in the future in light of the very significant state investment in them via tax reliefs."

"The one part of the private hospital development that was part of the overall health planning system...were the co-located hospitals. In the present economic climate, these may not come on stream."

"Since there is currently a shortage of certain types of acute hospital space (with unsustainably high occupancy rates) and pressure from a larger population, and since there is a surplus of private hospital space (which may be in some cases suitable for elective treatment services) it may be possible to address these shortages by allowing public hospitals to rent space in private hospital in their areas."[18]

Report of the Expert Group on Resource Allocation and Financing in the Health Sector, published July 2010

Reasons for Reform 4: Unequal access to hospital care

This Government has made the two-tier divide worse

There has always been a problem of two-tier access to care in Ireland's publicly funded hospital service. Patients who pay for private health insurance are able to access care faster than patients without insurance. Fear of being unable to access hospital care is the main reason why so many people pay for private health insurance, even when they are very hard pressed to find the money to do so.

Despite lengthy negotiations on a new and more expensive contract for public hospital consultants, it remains the case that public hospitals and doctors are paid differently for public and private patients, which gives both perverse incentives to discriminate between patients. Public care paid for by the Exchequer is rationed. Private care paid for by private fees and insurance is incentivised. Doctors on public salaries may still increase them by earning private insurance payments. Hospitals trying to get by on constrained public budgets, earn more income by treating more private patients. This is the conflict at the heart of the two-tier system, which Labour will remove by treating all patients equally and paying doctors and hospitals in the same way for all patients, central principles of Universal Health Insurance

Fianna Fail/Progressive Democrat governments have made the two-tier divide worse. In the boom years the Government used our money to build a network of private, for-profit hospitals. These hospitals are funded by tax breaks for the wealthy, a way of taking money out of your pocket and putting it into theirs. Fianna Fáil Minister for Finance, Charlie McCreevy, introduced these tax breaks in 2001 and extended them in 2002 when he was lobbied by private hospital owners and other entrepreneurs.[19] The cost of these tax breaks has been considerable. Access to these hospitals is entirely determined by money. To receive care in these privately owned hospitals, you must either pay for care out of pocket; or through your private health insurance.

If you have neither ready money nor private health insurance, the only way that you will receive care in these private hospitals, which you funded from your taxes, is by

waiting for care in a public hospital, possibly for a very long time. If you have waited a long time, the National Treatment Purchase Fund will buy you private hospital care, channelling more public money into these private, for-profit hospitals. Your wait can be long because waiting starts with the wait for a specialist appointment followed by a wait for diagnostic tests, followed by waiting for treatment in a public hospital. Your wait is now getting longer because of Government cutbacks of public hospital services.

During her tenure as Minister for Health, Mary Harney said that this Government believes in equity. "Our policy is equity of access to publicly funded health services", she has said.[20] Her actions did not support this claim. If the Minister truly supported equity of access to publicly funded health services, public hospitals should no longer discriminate between patients based on their insurance status. And the Minister should have ensured that private hospitals, which are also significant beneficiaries of public funds, should be open to public patients on an equal footing with private patients. Instead the Minister promoted and presided over the growth of a private, for-profit hospital industry, to which the non-insured have no claim.

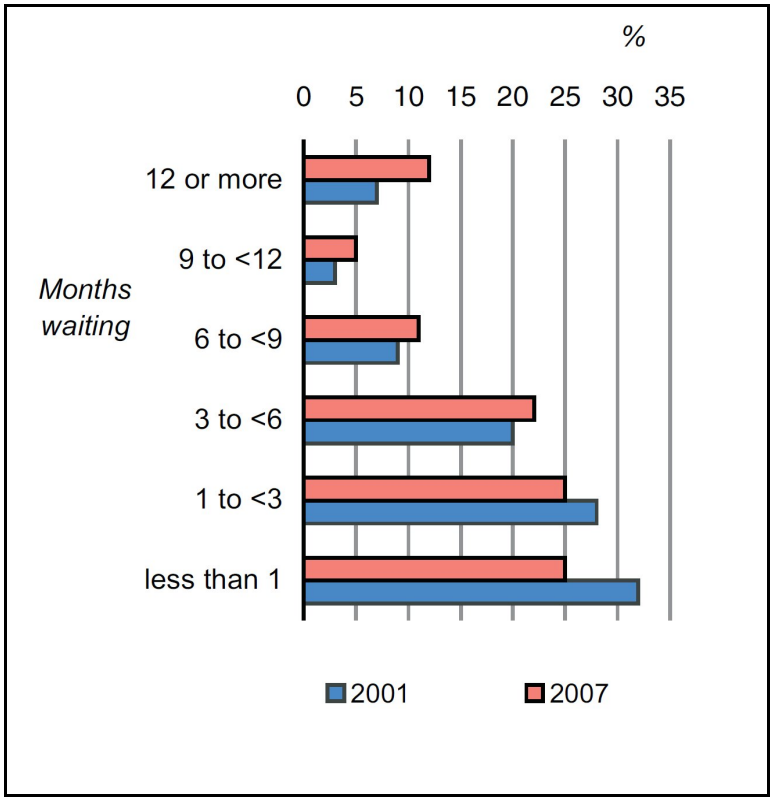
Public waiting lists are rising

This Government has also presided over a surge in public hospital waiting lists. In October 2010 over 20,000 public patients had waited for longer than three months for hospital treatment, an 11% increase compared to October 2009. In some hospitals the waiting lists for treatment are particularly bad. In Beaumont on Dublin's Northside over 1,600 public patients had waited longer than three months for treatment in October 2010, which was more than double the number a year earlier. In Cork University Hospital there was a 36% increase and in Galway University Hospital there was a 50% increase in patients waiting over 3 months for treatment (Appendix 3 for more detailed waiting list figures).

Although the National Treatment Purchase Fund has secured treatments for long waiters, it has not changed a picture of serious waits for diagnosis and treatment for public patients. Such waits damage patients' health and may threaten their lives.

Before the recent cutbacks made waiting lists worse, a survey found that the percentage of the population waiting for care was as bad in 2007 as it was in 2001, when the NTPF was established. The Central Statistics Office found in 2007 that 3% of adults were on out-patient waiting lists, 1% were on inpatient waiting lists and 1% were on day patient waiting lists. 12% of those on an outpatient list had been waiting at least 12 months, up from 7% in 2001 (Figure 2). In 2007 as in 2001, older people were more likely to wait for care: 6% of people aged 70 and over were on outpatient waiting lists.[21] When in a pilot scheme the NTPF arranged outpatient appointments for 3,200 people who had been waiting for them, the Comptroller and Auditor General reported that they had been waiting *on average* 554 days! This was a wait of effectively 18 months for this first appointment to see a hospital specialist following GP referral.[22]

Figure 2 Length of time on outpatient waiting lists, 2001 and 2007



Source: Quarterly National Household Survey, Module on health status and health service utilisation, quarter 3 2007. www.cso.ie

Reasons for reform 5: How we spend on health care

Other countries achieve better value for money in health spending

Irish health spending increased rapidly over the last decade until recent cutbacks. Ireland needed to catch up to recover from the severe cuts to the health budget in the last fiscal crisis in the late 1980s and because of population growth and ageing. Health spending in Ireland is not out of line with other countries and the process of catch up is not over. But what we get in return for this big investment is not good enough. Other countries have done much better in achieving value for money in health spending.

Labour does not believe that we spend excessively on health care

Compared to neighbouring countries, Ireland's public spend on health care was about average in 2007, the latest year for which international figures are available. In Ireland we spent approximately €2,400 per person on public health services in 2007. This was almost exactly the average spend per person in the pre-enlargement EU countries.[23] In 2007 we spent about 9% of our national income on health care, public and private. Relative to national income, this ranked Ireland as a relatively low spender on health among comparable countries (See Appendix 4 for more detail).[24]

The recession and crisis in the public finances has changed this picture in a number of ways in recent years. Reduced pay rates in the public service have cut the cost of Irish public health services. Rising unemployment has meant that more people are now covered by the medical card scheme and qualify for free GP visits and drugs. This essential extension of care to people whose incomes have dropped has been a pressure on a constrained public health budget, making pressures on services worse in other areas.

Since national income has declined sharply due to the property collapse, the banking crisis and the recession, Ireland's health spend may now be as high as 12% of national

income, which is not an increase in terms of services delivered but a larger slice of a much reduced pie. If social services like disability services and care of older people which we fund from our health care budget are counted too, we in Ireland spend approximately 15% of national income on health and social care services.[25] There are no international figures to compare health and social spending combined.

Labour does not believe that we spend excessively on health care. But Labour is convinced that we could spend better and achieve much better access to care and outcomes from care, if we reform our system. Spending better is essential during this time when spending more is not an option. Ireland will recover from the recession and the recent catastrophic collapse in national income. Labour is determined to ensure that even in the recession, we protect and improve our health care system, so that when we emerge from recession, Irish health care will be one of our strengths, one of the reasons why it will be attractive to live, work and raise children in Ireland. Labour will ensure that we do not emerge from the recession with a legacy of untreated illness and neglected needs, and a decimated and demoralised health service, as we did after the cutbacks of the 1980s.

Spending better is essential at this time when spending more is not an option

It is not difficult to find instances of poor spending in Irish health care. Areas with immediately quantifiable potential for savings within *public* health spending are: the drugs budget; how hospitals operate and where care is delivered; and the cost of administration. But there is also great scope for savings in *private* health spending - which is equally a cost born by Irish people and the Irish economy. The uncontrolled development of private, for-profit medicine and hospitals under Fianna Fail/Progressive Democrat Governments has created cost escalation. The deepening two-tier delivery of care causes duplication, poor cost control and perverse incentives. Labour's reform of this system into a State guaranteed and regulated universal insurance system will reduce the cost of health care delivery in Ireland without sacrificing quality of care.

How to cut costs in Irish health care

1. **Reduce drug costs**: Researchers in the ESRI have highlighted the potential for cost savings in the area of the state's large drug budget. Other countries have significantly reduced their spend on drugs by much greater use of generic versions of drugs or by setting the price of state subsidised drugs at the price level of the cheapest alternative (reference pricing). These measures substitute cheaper equally effective drugs for the more expensive, branded versions and are widely used internationally.

There is great scope for reducing Irish drug costs. Ireland came 20th in a comparison of 22 OECD countries with generics accounting for only 13% of drugs in 2004 compared to 49% in the UK in 2004 and nearly 60% in the UK in 2007. Introduction of reference pricing in Germany saved 9% of total drugs spending annually. This measure alone would equate to an annual saving of €225 million on Ireland's €2,500 million drugs spend.[26]

2. **Make better use of hospitals**: Ireland's hospitals are not as efficient as one another or as hospitals in other countries. Efficiency in this context means better use of expensive hospital care without sacrificing the quality of care received by patients. Examples of less than efficient use of care are when:

- Patients continue to attend hospitals for treatment when they would receive more appropriate care closer to home in a primary care setting.
- Patients stay longer in some hospitals than others after the same procedure and with the same need, reflecting differences in how hospitals manage their beds.
- Some patients might have avoided admission altogether or remained in hospital for a much shorter period had their assessment, diagnosis and treatment taken place in a Medical Assessment Unit.

ESRI researchers have estimated that if all Irish acute public hospitals were operating at the level of the most efficient, the potential savings annually would be 6% of the public hospital budget, approximately €300 million when calculated based on the 2007 budget. If all Irish acute public hospitals were operating at the level of the most

efficient internationally, the potential savings would increase to approximately €911 million on the 2007 budget or 18.2%. [27] This means that for the same spend, better use of hospitals could *increase services to patients* by 18% too. This is a key objective of Labour's reform of Irish health care.

3. **Reduce the cost of administration:** It is an open secret that when the HSE was established by amalgamating the old health boards, a great opportunity was lost because of Government mismanagement. A major part of the logic of this reform was to reduce administrative costs by removing duplication. To do so required a redundancy programme. The Government was not willing to fund this until late 2010, six years after the establishment of the HSE, seeking redundancies in a rushed and unplanned way because of the fiscal crisis.

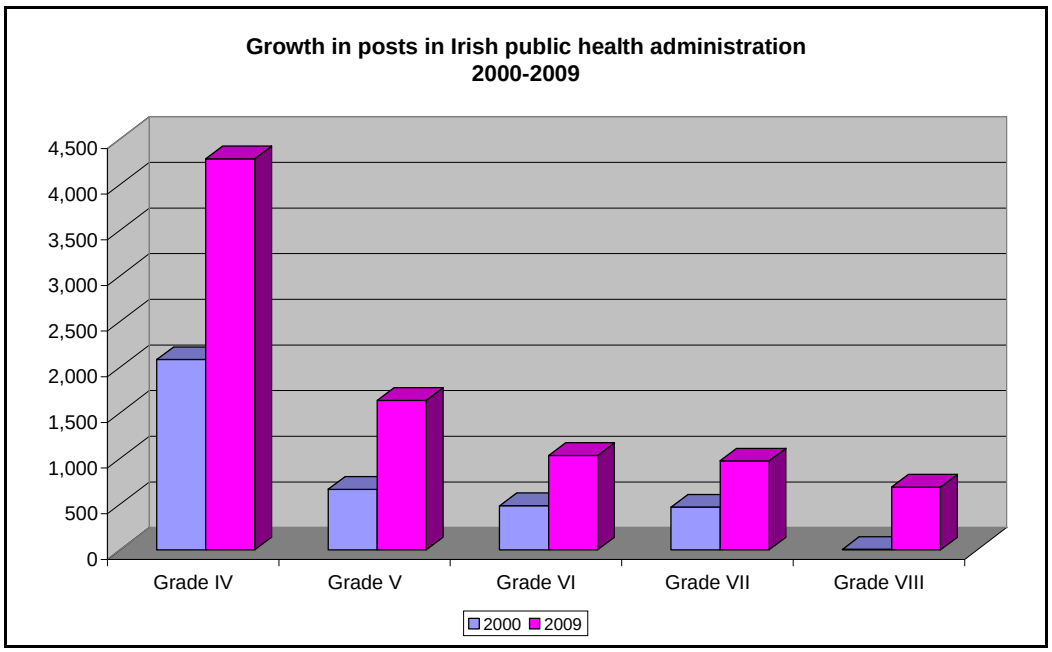
The consequence of the Government's unwillingness or inability to manage this transformation properly has been a proliferation of senior managers with too little to do. This has cost Irish health care and the Irish state dearly. We have continued to pay many more administrators than we need. And the HSE has become an inefficient, unaccountable, top-heavy organisation, in which staff repeatedly say they do not know to whom they report or where responsibility for decisions lies.

Between 2006 and 2009 when the hospitals budget went up by 13% and the budget for primary care, care in the community and long-term care went up by 16%, the budget for "corporate and shared services" went up by 46%! [28] Although overall numbers of people employed in clerical grades reduced after 2007, numbers in some clerical grades continued to increase.

In 2000 the health boards had 6,700 junior clerical staff; in 2009 there were 7,700. On the rungs of the ladder above them at Grades 4 to 8 there were 3,700 staff in 2000; in 2009 there were 8,600 (Figure 3).[29] At the top, in addition to its chief executive, the HSE has 11 national directors or equivalent on salaries of from €140,000 to €180,000 in 2010.[30] The Government's rushed package aimed to save €200 million annually. The evidence emerging of lack of oversight and accountability for spending in the

HSE suggests that there is potential for considerably more savings with reform and properly planned reductions in staff numbers.

Figure 3



Source: Chart generated using figures from Table 13.2 page 380, Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2

4. No longer provide tax incentives for private hospitals - and achieve universal access to existing private hospitals: Tax incentives for private hospitals have cost the Exchequer and all of us. Yet these hospitals were unplanned, remain under-utilised, and are inaccessible to a large proportion of the population. Labour in Government will not develop hospitals by means of expensive tax incentives for the wealthy but will only license hospital developments that are accessible to all and fit in with overall health policy. Under Universal Health Insurance, the existing private hospitals will have the opportunity to tender to provide care for the entire population, provided that care is offered at competitive rates.

5. Reform the National Treatment Purchase Fund: The NTPF buys care for public patients primarily in private hospitals, a rescue for public patients after their long waits but in an expensive and perverse form. Its operation is a sticking plaster solution

for a system in which private patients may purchase faster access to care in public hospitals. The State already funds the public hospitals but because of long public hospital waiting lists for public patients, through the NTPF the State pays on the double for their care in private hospitals or even in the public hospital where they are on a list! This Fund has been a boon for private hospitals at the expense of funds for public hospitals, where it may only spend 10% of its budget. In public hospitals the NTPF has even paid consultants additional fees for patients who have languished on their own or their colleague's waiting list, creating an incentive to maintain waiting lists.

Labour in Government will not force public patients to wait before they gain access to care in private hospitals. Labour will use the principle of the National Treatment Purchase Fund - a purchaser of care for patients that is separate from the providers of care - to ensure that public patients gain access to care in public and private hospitals without having waits that are damaging to health. Under Labour the NTPF will become subsumed into a new public hospital care insurer. The circular and perverse payment on the double for care in the current system will end. But the guarantee of access to care after waiting which the NTPF offers will be replaced by a guarantee of access to care for everyone in the same period as a private patient.

6. Reform the two-tier system: Having two systems that operate concurrently with two systems of accessing care - for public patients and the privately insured - is expensive to administer and creates many perverse incentives. Critics of Universal Health Insurance argue that it will add to administration costs. They ignore the fact that in Ireland we *already* have a system of competing private insurers, an insurance authority, and systems of community rating and risk equalisation. We are carrying many of those costs already. But in Ireland we *also* have all the costs of running a bureaucratic public health care system, to which we perversely give patients with private insurance faster access. The costs of this two tier system include: the costs of maintaining two waiting lists for public and private patients; the costs of repeated visits to outpatients for patients who are waiting; and the costs of medication for untreated illness among long waiters.

7. Control hospital consultants' remuneration: We pay our public hospital consultants handsome salaries with all the added benefits of being some of the most highly paid public sector employees, such as large pensions, paid holidays and professional indemnity insurance. The starting salary of a hospital consultant in Ireland who commits to doing only public work has been calculated to be 76% higher than the equivalent in the UK.[31] The starting public salary for a consultant in Ireland on a contract which permits him to earn private fees in addition is only marginally lower than for a consultant who does public-only work. [32] With private fees, this consultant's remuneration is at least double that of the equivalent consultant in the UK. An Irish consultant's core weekly hours are shorter than those of his UK counterpart.

The shortage of fully trained hospital specialists in Ireland, with much of public hospital work still performed by junior doctors in training, has made private health care a suppliers' market in our two-tier system. Some hospital consultants' private earnings have been very high indeed.[33] Although these have not been costs to the Exchequer except when paid by the NTPF, they are costs to us all through out of pocket payments (for visits to consultants' rooms) or through private health insurance. This is one of the ways in which health care consumes too high a proportion of our national income for too poor a return.

Labour in Government will increase numbers of hospital consultants but control their remuneration rates within the Universal Hospital Insurance System. The EU and national competition law requirements that have impeded control of consultants' remuneration in our private, for-profit insurance system have limited application to a statutory, compulsory social insurance system, provided it is organised according to principles of social solidarity, and designed with care.[34]

Reasons for reform 6: The HSE disaster

There has been a collapse of responsibility and accountability... The Minister has hidden behind the HSE

When the HSE was established in 2005, the rationale for its establishment was to be clarity of roles and responsibilities. "The people will have clarity now about who is in charge of policy and who is in charge of the management of health services," the Minister for Health, Mary Harney, promised.[35] Neither the HSE nor the Minister lived up to this promise.

There has been a collapse of responsibility and accountability in the making of policy for Irish health care and in its implementation. The Minister has hidden behind the HSE and has failed to make sensible, coherent policy. The HSE's management of the health services has been unaccountable even to elected representatives in Dáil Eireann. Top-heavy, bureaucratic management has become a feature of the HSE's operation from the outset.

After the costly mistakes in how this Government and the Minister set up the HSE, Labour will change the role of the HSE in the transition to Universal Health Insurance. This will not be an overnight restructuring, which would be a disruptive exercise in change for change's sake. All Labour's reforms of health administration are designed to deliver gains in access to health care, the true measure of any reform. Layers of HSE management will go from the outset to deliver cost savings. This will give the added gain of simplifying the HSE's structure.

To ensure greater accountability and democratic control, Labour in Government will restore primary responsibility for health policy and spending to the Minister for Health, who is clearly answerable to the Government of the day and to Dáil Eireann. The Department of Health will take back from the HSE statutory accountability for the Health Vote - the money that we collectively spend on public health and social care. The process of establishment of a Universal Health Insurance System will lead

to the progressive devolution of the powers that are currently concentrated within the monolith that is the HSE.

6 Essential reasons for Labour's reform

1: Inadequate care in the community - too few GPs and other community carers

2: Cost stops sick people from going to the doctor - fees are a deterrent to GP visits

3: Inadequate care in hospitals - public hospital cuts are reducing services for patients

4: Unequal access to hospital care - mounting public waiting lists

5: How we spend on health care - better spending would deliver more care

6: The HSE disaster - unaccountable and incoherent

Labour's commitment to reform - the principles

Access to care in need

Access to care in need is the central objective of Labour's reform. A reform that does not advance access to care is a waste of time, energies and money. This country cannot afford another HSE. Labour's reform is designed to ensure that we receive care when we need it, in the most appropriate place and from the most appropriate carer. Each step of Labour's reform will increase access to care.

Security about your health care, payment according to ability to pay

We cannot protect ourselves entirely from ill-health. But as a society, we can protect ourselves from fear about our ability to access health care. Labour's reform is in essence a social pact that no one should fear being denied access to care in need. Many of our European neighbours have achieved such security for their people. The principle at the heart of health care systems that guarantee security about access to health care is social solidarity. Access to care is according to need and payment for care is according to ability to pay.

Universal health insurance is, in some respects, like other forms of insurance. We insure our houses so we can re-build if there's a fire. If we were not insured, the cost of re-building would be impossible for most people. But by all insuring even though many of us never need to claim, we generate sufficient funds to give us all the security of knowing that we are covered against catastrophic events.

Universal health insurance is collective insurance for health care. We all pay to create a fund to ensure that, even if this year or this decade, you may not have need, when and if you need care you will be covered by the collective fund.

Universal insurance in place of fees and charges

Labour will replace fees and charges for care with universal health insurance. We currently pre-pay for care through our taxes and private health insurance. But private health insurance lapses if you cannot pay your premium. And two-thirds of the population must pay fees for every GP visit. We pay hospital charges which vary according to our circumstances. All these fees and charges are barriers to accessing care in need. This is bad for health, bad for health care and it is unjust.

In this economic crisis, hard-working people who for decades have paid taxes and paid for private health insurance may find themselves unable to access care because of drops in their income. If they are not eligible for a medical card and have not the cash in hand, they cannot pay for GP visits for their families. If they have had to let their private health insurance lapse because they can no longer afford it, despite years of contributing to the insurance company's collective funds, they will lose the security about access to hospital care that private health insurance gives. Such barriers to care have always faced many people in Ireland. In this economic crisis, any of us might face them.

Labour's reform will end fees for GP care and will guarantee access to public and private hospitals on the same basis for all. Each of us will be insured under Universal Health Insurance. Unlike under private health insurance, a fall in our incomes that means we can no longer contribute to the insurance fund or contribute as much as before will not change our access.

Universal access

Under Universal Health Insurance, we will all access care equally. None of us will pay fees. Labour believes in universalism. This means that wealthy people will not pay fees either. But wealthy people will contribute more to the system, through their taxes. This is just and equitable.

In a system with fees wealthy people can purchase better access and people who cannot afford the fees are denied access. In means-tested systems, like the old university grant systems or the medical card system, there is always a denial of access to people who are above the threshold for state support and not rich enough to pay fees. Universal systems remove fees and means testing. No one need fear denial of access. The consequence that rich people too gain access without payment is set right by having a system of funding through progressive taxes and universal insurance, which charges them according to their ability to pay.

Universalism is not new to Ireland. National school education is available to all on the same basis and paid for all by taxation. The wealthy may and do avail of it equally. We all gain from a system which we all collectively fund.

A compulsory system

Labour will make universal health insurance compulsory. In our current system we are required by law to educate our children yet we are not obliged to bring them to the doctor when they are ill. The State pursues us if our children are missing from school, but charges us €100 if we bring them to a hospital without first paying €50 to €60 to visit a doctor, whether or not we can afford to pay. In Labour's reform, registration with a family doctor and participation in the Universal Hospital Care Insurance system will be compulsory.

Cost control to deliver more care

Labour will reduce the cost of health care in Ireland so that more care can be delivered from the health care budget. The depth of the economic crisis makes reform in health spending essential. We cannot afford to continue each year spending so much of our national income on health care for very poor returns. We cannot afford to continue paying out of pocket and through private insurance for uncontrolled for-profit health care. We cannot afford funding from Exchequer spending a public health care system that has a top-heavy administration, excessive drug costs and inefficiencies in how hospitals deliver care. We cannot afford to continue with under-

developed primary care and too much care taking place in the expensive, hospital setting. We cannot afford the illogicality and duplication of running two systems of health care on one small island: a rationed public system and a competing, heavily state-subsidised private system. Without reform, we all lose. We will all gain from reform.

Increasing care to meet unmet need

Labour's reform is designed to ensure that people who have been unable to access timely and appropriate care will do so. This means that Labour's reform will increase the amount of care delivered, in the form of visits to GPs and other community care professionals, care at home and in hospital. Some of the resources to meet this unmet need will come from cutting the costs of delivering care and some will come from increasing efficiency in the delivery of care.

Health is wealth

The health of a nation is part of the wealth of a nation. Labour does not believe that health care is an add-on, a luxury, something you resource in the good times and savagely reduce in the bad times. This has been the pattern in Irish health care since the 1970s. It has made planning of services impossible, has built up a legacy of neglected health care needs and has given us an incoherent health service, which is an anachronism in a modern European state. In Ireland we have accepted the argument that good roads help development and that good schools are essential to development. Strangely we have not accepted that good health is essential to development. Labour believes that a good health care system and universal access to good quality care will be key stepping stones to national recovery.

Principles underlying Labour's Reform

Access to care in need

Security about your health care

Payment according to ability to pay

Universal insurance in place of fees and charges

Universal access

A compulsory system

Cost control to deliver more care

Increasing care to meet unmet need

Health is wealth

The next sections of this document will explain in sequence what Labour will achieve by this reform, how Labour will achieve it and how Labour will ensure we can pay for it.

How Labour will reform Irish health care

In any reform it is critical to know your destination and the steps that will take you there. The destination of Labour's reform is a Universal Health Insurance system, which is designed for Ireland, building from the system we have now.

The reform has two parts: a primary care reform; and an acute hospital care reform. The full primary care reform will take four years. The full acute hospital reform will take six years. Each reform will take place in a phased way. Each reform will start from Day One in Government. Labour will achieve this reform of Irish health care in a logical, phased and affordable way.

Universal Health Insurance: Irish-style

When Labour's reform is complete, these will be the key elements of the system:

1. Universal access to primary and hospital care, free at the point of delivery, funded by a combination of insurance and tax

2. Universal primary care insurance instead of the medical card system and payment out of pocket

3. Universal hospital care insurance instead of the two-tier system of private and public patients

4. Public and private hospital care insurers who purchase hospital care for you from competing public and private hospitals and clinics

5. A new public insurer created by combining the National Treatment Purchasing Fund and the purchasing arm of the HSE, both of which currently fund public patient care

6. The right to change insurer

Labour's reform of primary care

Why reform should start with primary care

Reform of primary care is long over due in Ireland. Primary care is best delivered by teams of health and social care professionals including GPs, practice nurses, public health nurses, physiotherapists, and others. There are sound health policy and economic reasons why primary care reform should come first.

Health experts agree that most illnesses should be treated and most care should take place in the primary care setting. Primary care is where most management of chronic disease should take place. Chronic diseases such as diabetes are the major challenges faced by health care systems in developed countries. Primary care is also where preventive care should take place, which will improve the overall health of the population at relatively low cost. Making primary care accessible will improve our health and lives.

Only with a reformed and properly resourced primary care system can the acute hospital care system operate as it should. Today in Ireland it can be less difficult for a patient to access hospital care than primary care. Return visits to outpatients are free, whereas for the majority of the population GP visits are not. Making primary care accessible will deliver cost savings across Irish health care by moving care to the less costly setting, which even more importantly is the more appropriate setting.

By starting with reform of primary care Labour will ensure that hospital care reform can be implemented more effectively and at lower cost.

Labour's primary care reform

Labour will introduce a system of Universal Primary Care Insurance, so that no one will be denied access to a family doctor because they cannot afford to pay fees. Phased in over four years, this system will give everyone entitlement to GP care, without paying fees. Since primary care will be delivered by teams of professionals, it

will also give everyone entitlement to the care of primary care professionals such as practice nurses or public health nurses without paying fees.

This is a quick, affordable reform in which the Irish state will guarantee access to care through a new Primary Care Insurance Fund. Labour believes that the public protests over the removal of automatic entitlement to medical cards for over-70s demonstrate that Irish people understand the value of a state-guaranteed system of access to primary care. This reform will start from Labour's first year in Government with the extension of access to GP and other primary care without fees to people who receive free prescription medicines under the long-term illness scheme. Over four years Labour will progressively extend entitlement to primary care without paying fees until the entire population is covered by primary care insurance.

In primary care, Labour's reform introduces insurance principles without insurance companies. Private insurance companies have made little inroad into primary care insurance. This has been an instance of clear market failure. The State has effectively been the major insurer of care for those who qualify for medical cards but the rest of the population has been left to the vagaries of a free market in care. Labour's reform is compulsory social insurance for primary health care. This will be a statutory system of social health insurance organised according to principles of social solidarity. The EU does not require such a system to operate under competition law with competing insurers.

The reasoning behind phasing in Labour's primary care reform

Labour will phase the introduction of this system because increasing the supply of care and changing how we finance care cannot happen overnight. Since the system will make it easier to access GP and other primary care, there will be additional demand for care from people, who under our current system have illnesses and conditions that have gone untreated because they cannot afford care. Meeting such unmet need will require an increase in the supply of GPs and other carers. Building up this supply of carers requires phasing.

Moving to universal primary care insurance will also require changing our system of financing primary care. The Government will transfer tax funding for primary care into the Primary Care Insurance Fund. This will include the tax funding that currently goes into the medical card scheme to fund medical cards and GP-visit cards. Under universal primary care insurance, everyone will have access to GP care without paying fees. The additional funding required to extend free GP care to the entire population will also go into the Primary Care Insurance Fund. (See 'Meeting the costs of Labour's Primary Care Reform' below for detail.) This will be a transparent system of funding primary care.

Moving to this new system will require new legislation, a new system of paying GPs and rapid build up of primary care teams. This build up will have to be planned and systematic to ensure adequate supply of care, especially in areas of the country where there is currently a particular under-supply. Under-supply of GPs chiefly occurs in areas where there are many people on low incomes who cannot afford care under our current market system, which has made it unattractive for GPs to locate there; or in areas where rapid population growth due to new housing development has outstripped the supply of GPs.

How GPs will be paid under universal primary care insurance

Under universal primary care insurance, GPs will be paid as they are currently paid under the medical card system. This means that they will be paid by capitation, a fixed amount for each person on their register in a given year. They will also be able to earn additional fees, as they currently do, for particular services such as vaccination that are public health priorities. Capitation payments will prevent the internationally-recognised problem of supplier-induced demand. This can happen when suppliers of health care are paid by fees for each visit, which incentivises doctors to encourage unnecessary visits. Health system experts recognise that this is a particular risk when there is fee payment in a universal system, where doctors receive fees for each visit which are paid by an insurer or the state, without representing an immediate, additional cost to the patient.

Capitation payments along with universal registration of patients with primary care teams will give GPs a secure income. In return for that income and security, there will be a new GP contract, which requires much more active patient management by doctors and the integration of GPs with the rest of the primary care team. Where aspects of care can be safely and appropriately delivered by a practice nurse or other primary care team member, the patient will receive care from such other team members rather than the GP. This will make much better use of the skills that already exist in primary and community care. This also offers a realistic pathway to build up the supply of care despite the current shortage of GPs in Ireland.

This will not be a compulsory system for GPs. If GPs choose to stay outside the system and continue to charge private fees, they may do so. But the entire population will be compulsorily insured under universal primary care insurance; and will be required to register with GPs within the system. GPs within the system will not be allowed to charge fees outside it.

Phases in Labour's primary care reform

WHEN	ACTION
YEAR ONE	• **Extend medical card coverage to people who receive free drugs under the long-term illness scheme** • **Publish Primary Care Insurance Bill with:** ➢ **Statement of entitlements** ➢ **Statement of terms for GPs who contract into primary care insurance system** ➢ **Provision for establishment of the Primary Care Insurance Fund** • **State intent to EU to introduce new statutory social health insurance system for primary care, outside scope of competition law**
YEAR TWO	• **Extend medical card coverage to people who receive free drugs under the high-tech drugs scheme (undergoing treatments like chemotherapy)** • **Primary Care Insurance Act becomes law with start date in Year 3**
YEAR THREE	• **First phase of universal system: subsidies reduce cost of GP visit for all** • **Establishment of Primary Care Insurance Fund**
YEAR FOUR	• **System now universal: 100% fully covered for GP and other primary care** • **Patients no longer pay fees to GPs**

Meeting the costs of Labour's primary care reform

The introduction of Universal Primary Care Insurance is a costed programme of reform. Labour's costings are based on the Report of the Expert Group on Resource Allocation and Financing in the Health Sector published in July 2010.[36] The Expert Group in its report and two detailed evidence volumes costed the introduction of a system of subsidised access to GP care. Labour's policy has taken those costings and applied them to access free at the point of delivery to GP care. Instead of paying GPs when we are in need of care, we will collectively fund our care through the tax system.

Cost of GP care free at the point of delivery

Already 38% of the population has access to GP care free at the point of delivery. These are the approximately 1.7 million people who are covered by medical cards or GP-visit cards.[37] The cost of their GP care is already part of the Health Budget and is funded from overall tax revenue. The state will transfer this funding into the Primary Care Insurance Fund. Medical card holders qualified for free drugs until this Government introduced a 50 cent per item prescription charge in 2010. Labour in Government will remove this charge. Medical card holders' free drugs cover will remain funded by the state from overall tax revenue. The state will also transfer this funding into the Primary Care Insurance Fund.

Labour's reform will extend GP care free at the point of delivery to the remaining 2.8 million people, who currently pay fees. The Expert Group in its costing of subsidised care based its costs on information about the frequency of GP visits by people in Ireland at different ages and of different genders. Research has shown that medical card holders visit GPs more frequently not just because they do not have to pay fees but primarily because they are on average older and poorer than the population as a whole and have more ill-health and greater need for care for those reasons.

The Expert Group considered it reasonable to assume that when offered access to GPs without fees, people with chronic diseases would increase the frequency with which they would visit GPs to the same frequency as medical card holders (5.3 visits on average p.a.). There are estimated to be just under 650,000 people with such conditions. They include: people who receive free medicines under the long-term illness (LTI) scheme with conditions such as Parkinsonism, diabetes, epilepsy and multiple sclerosis; and people who require high-tech, particularly expensive drugs like those used as part of chemotherapy treatment. People who qualify for either the LTI or High-Tech drug schemes currently receive free drugs but must pay for GP visits. Other people with chronic conditions include those who have suffered angina, heart attack, stroke or hypertension. [38] The Expert Group also assumed that people who were in relatively good health, when offered subsidised access to care, would continue to visit GPs at the average rate of the population without medical cards (2.1 visits p.a.).[39]

Based on these visiting rates and with a fee cap for GPs of €45, the Expert Group put the cost of GP care for people without medical cards or GP-visit cards at €388.9 million per annum in 2009 prices.[40] In Labour's reform this additional sum of €388.9 million required to extend coverage to the entire population will be paid to GPs by capitation rather than fees. The overall system of capitation will be reformed to ensure that GPs' payments do not differentiate between patients on the basis of their income. Capitation rates for patients will only differ to reflect probable differences in their need for care, based on factors like age and chronic conditions.

How Labour will fund the cost of GP care free at the point of delivery

Labour will fund the cost of extending GP care free at the point of delivery to the entire population from savings elsewhere in the healthcare budget. Labour in Government will achieve these savings without reducing the supply of care in other settings. The €389 million cost of extending free GP care will be met by: ending tax relief for GP fees, which is no longer needed under Labour's reform; savings on the state's drugs budget; further reducing numbers employed in HSE administration; and reducing hospital consultants' remuneration rates (Table 1). These savings will also

fund the reversal of this Government's introduction of charges on prescribed medicines for medical card-holders and an expansion of community and long-term care services (discussed on pages 46 and 69).

Table 1 Meeting the cost of Labour's full primary care reform in 2014

	Costs & Savings 2014 €'m
Costs of Labour's reform:	
Free GP care for all	389
Removing prescription charge for medical cardholders	25
Expanding community and long-term care	75
Total cost	489
Savings to fund Labour's reform:	
Savings on State's drugs budget [1]	100
Ending tax relief on GPs' fees (no longer necessary) [2]	40
Re-allocation from HSE payroll savings	175
Saving on hospital consultants' pay [3]	75
Savings on HSE procurement [4]	100
Total savings	490

Notes:

1. ESRI research suggests considerable potential for savings on the state's drugs budget (discussed on page 21). The Government's 2011 Health Estimates anticipate €200 million will be saved on the state's drugs budget in 2011.[41] There is scope to achieve additional savings, conservatively estimated at €100 million here.

2. The value of tax relief claimed by individuals on their GP fees has been estimated at €40-€45 million. [42]

3. Irish hospital consultants' rates of pay considerably exceed rates in the UK and their reduction is essential to controlling costs in Irish health care. Irish public-only hospital consultants have a starting salary which is 76% higher than the starting salary in the UK's NHS. Even with merit payments under the UK's Clinical Excellence Awards Scheme, the majority of hospital consultants in Northern Ireland earn significantly less than consultants in the Republic.[43] This €75 million saving represents less than 20% of public hospital consultants' estimated payroll costs.[44]

4. The Government's 2011 Health Estimates forecast a saving of €200 million from a 5% reduction in non-pay procurement and non-core pay expenditure. This represents a further 3% saving on HSE procurement.

In the first two years of Labour's reform free GP care will be extended to people who currently receive free medicines under the long-term illness scheme and the high-tech drug scheme (Table 2). In the third year, GP care will be subsidised for the entire population and in the fourth year, fees for GP care will end. This phased introduction is designed to provide funds to employ more GPs and practice nurses at a pace that matches the build-up of supply of additional doctors and nurses and additional demand for their care (Table 3).

Table 2 Phased costs of Labour's four-year primary care reform

Year of reform	Phases in extension of free GP care	Cumulative additional annual cost €'m
2011	Extension free GP care to approx. 64,500 claimants under long-term illness (LTI) scheme	17.3
2012	Plus extension free GP care to approx. 54,500 claimants under high-tech drug (HTD) scheme (€14.6m)	31.9
2013	Plus subsidised GP care for remainder of population	194.5
2014	GP care without fees for total population	389

Note: In the first two years, the extension is costed at the average cost of GP care under the medical card scheme (average capitation, fee and allowance payments to GPs per medical cardholder), since these are groups with relatively high needs. In the subsequent years, the costing is based on the work of the Expert Group (explained in text). This costing is based on 2009 population and medical card eligibility. In 2010, falls in incomes increased numbers of people eligible for medical cards and GP-visit cards by 136,000 while population increased by only 11,400. Since this extension of free care is already funded, these costings overstate the cost of extending free care to the entire population, leaving an additional margin of funding to increase GP training places and meet potential demand for care which exceeds the rate anticipated by the Expert Group (at the level discussed in the box on the example of Northern Ireland below and incorporated in Table 3).

How Labour's reform will fund and supply more primary care

This reform achieves two very important objectives: it gives each of us security about our access to primary care and it will generate additional and predictable resources to develop primary care. By adopting the costings of the Expert Group, Labour intends

that the new GP contract will pay GPs through capitation at rates equivalent to €45 per visit, which is lower than the rate charged by many GPs today. Labour believes that this saving on paying GPs is justified because GPs will be working in a different way in primary care teams in a universal primary care system. They will have more patients registered with them. Their income will be secure. They will be working with other professionals, to whom they will delegate care where appropriate.

Since this reform provides funds for an anticipated increase in demand for care from primary care professionals, it is important to plan for that demand to be supplied. The additional demand for care from people with chronic conditions will potentially increase visits to GPs by 14.5% (See Appendix 5 for calculations). With an estimated 2,500 GPs currently working in Ireland, this suggests a need for an additional 360 to 370 GPs. Recruiting so many GPs is, however, not feasible in such a short time frame. It is also neither desirable nor necessary.

Labour's reform will accelerate the development of primary care teams in which more care is supplied by practice nurses. Only 70% of Irish GP practices employ full or part-time practice nurses, which means that there is considerable scope to increase the input of nurses to primary care.[45] Research has shown that patients with cardio-vascular disease were much more likely to be seen by a practice nurse and used hospital care to a lesser degree in Northern Ireland than in the Republic.[46] It has been estimated that up to 50% of the workload of a GP could be taken on by a practice nurse.[47] In a reformed system in which GPs are paid by capitation, there will be no incentive for GPs to treat patients directly if their care could be equally well or better supplied by a practice nurse, paid from the capitation payment for that patient. Labour's reform will act as a powerful lever to encourage such inter-disciplinary working in primary care.

In the short-term, the supply of GPs can be increased by recruiting doctors from abroad and by encouraging deferred retirement of existing GPs. Combined with recruitment of practice nurses, the additional demand for care resulting from Labour's reform can be supplied within the four year time frame (Table 3). Increases in the numbers of GPs being trained will also be required to meet anticipated growth in

demand for primary care due to population growth and ageing. Increased training places over and above current numbers will significantly increase supply of care in the medium to longer term. All these measures have been suggested already by researchers concerned by GP shortages in Ireland.[48]

Table 3 Meeting need for increased supply of GPs and practice nurses

	Increase in supply over 4 years			
	2011	2012	2013	2014
100 additional practice nurses p.a. (1 nurse equivalent to 0.5 GPs)	50	100	150	200
Retirement deferred by 2 years (50% uptake)[49]	39	83	87	87
Recruitment from abroad at rate 35 GPs p.a.	35	70	105	140
Total additional supply GPs/practice nurses	124	253	342	427
Percentage increase in supply	5%	10%	14%	17%

Recruiting an additional 35 GPs annually from abroad to a reformed Irish primary care system is not unrealistic. Ireland is, by a very large margin, the European country with the highest percentage of doctors practising abroad. A number of studies have estimated that there are over 6,000 Irish-trained doctors practising in other countries, which compares with approximately 9,400 doctors working in Ireland: some 2,500 general practitioners, another 2,000 - 2,400 hospital consultants and approximately 4,500 non-consultant hospital doctors.[50] The majority of Irish emigrant doctors work in universal health care systems - in the UK and Canada, principally.[51] These highly-skilled, Irish-trained doctors have been a great loss to Ireland. Working in a universal health care system with lower rates of remuneration has not deterred Irish medical graduates from making their careers in the UK's NHS. A sustained recruiting drive for GPs to work in Ireland should be targeted initially at these doctors but should also invite doctors trained in other countries.

With anticipated unemployment and emigration among Irish graduate nurses and with reforms to transfer care from the acute to the primary setting where this is more appropriate, increasing the current estimated practice nurse workforce of 1,050 by

employing an additional 100 nurses per annum is also realistic. Incentives to existing GPs to defer retirement by two years could retain over 80 GPs in the system in the years from 2012 to 2017, giving a window of time in which increases in GP training places could produce greater numbers of newly trained GPs to meet the needs of universal primary care and population growth. Table 3 shows how the demand for additional GPs and practice nurses could be supplied over the period of Labour's reform, assuming a 50% uptake of deferred retirement by existing GPs.

Under Universal Primary Care Insurance, primary care teams will develop at a much faster rate than they have done over the years since the 2001 Primary Care Strategy was published. Universal patient registration and new funds employing more doctors and nurses in primary care will finally breathe life into the development of primary care. Primary care teams should be, to a much greater degree, housed under the same roof. Under Labour, the Minister for Health will work to ensure that there is a primary care team operating on every acute, district and community hospital site. Renting premises from existing public health facilities or building premises on land owned by the state will reduce the capital cost of housing primary care teams.

How feasible is Labour's primary care reform? The example of Northern Ireland

Northern Ireland has free access to GPs. A study showed that the average per person GP visiting rate across the population in Northern Ireland in 2001 was 3.8 visits compared to 3.2 visits in the Republic.[52] Therefore Northern Ireland had on average 18.75% more visits per person than in the Republic. Northern Ireland also has 18% more GPs with 6.5 GPs for 10,000 people compared to 5.5 in the Republic in 2009. Labour's reform is based on the work of the Expert Group and assumes a 14.5% increase in visits (Appendix 5). Since the Expert Group looked at subsidised care and Labour is planning for free care, is this anticipated increase in visits realistic given experience in Northern Ireland?

Northern Ireland would be expected to have a higher GP visiting rate than the Republic because Northern Ireland has a much older population with 14.2% of the population aged 65 and over compared to 11.4% in the Republic.[53] This would suggest that while removing fees in the Republic could increase visiting by more than 14.5%, the increase would not be as high as 18.75%. For this reason, Labour's policy for increasing the supply of GPs provides for a potential increase in visiting in the middle of that range at 16% (Table 3). This is why Labour will introduce this reform over four years and why Labour's reform will significantly increase numbers of practice nurses. The reform requires and will incentivise changes in how care is delivered with GPs working in teams with practice nurses and other professionals.

The evidence from Northern Ireland supports this approach. A study comparing cardio-vascular risk management North and South showed better blood pressure and cholesterol control in Northern Ireland with patients having 21% fewer GP visits, 31% more practice nurse visits, and 10% fewer visits overall.[54] This suggests that there is potential to deliver much more care from the existing GP workforce in a better planned, universal system with capitation payments for GPs and much greater use of practice nurses. If the Republic were to move to the ratio of nurse visits to GP visits shown in this study, there would be scope for a 15% increase in the supply of primary care by increasing nurse numbers alone, while retaining the existing GP workforce.

The cost of prescription drugs

The Labour Party recognises that the necessity to pay for prescription drugs out of pocket can stop people buying medicines that they need. Under Labour's primary care reform medical card holders will have their eligibility for free prescription medicines restored. Labour in Government will remove the 50 cent charge for each prescription item for medical card holders introduced by this Government in 2010, the approximately €25 million full-year cost of which will be met by savings on the state's drugs budget.[55]

Currently individuals and families who are not eligible for medical cards or for free medications under the Long-Term Illness or High-Tech Drug schemes must pay the first €120 of their drug costs each month before they qualify for free drugs under the Drug Payment Scheme (DPS). Labour believes that we should move to a system in which universal health insurance covers us all for the cost of prescription drugs. However, because of the fiscal crisis, Labour sees this as a reform to be introduced as resources improve with resumed growth, with progressive extension of eligibility for free drugs based on people's incomes and health care needs.

Labour in Government will reduce the cost of drugs for the state and individuals by adopting the approach to reference pricing and generics, applied in Germany. This approach will reduce the overall cost to the Exchequer of the health budget and also reduce the cost to individuals of the prescriptions that they must pay out of pocket.

What Labour's Universal Primary Care Insurance will mean for you

- ***You and your family will no longer pay fees to GPs.***

- ***You will not have to worry about being unable to go to the doctor because you have no medical card and no money to pay the doctor.***

- ***No matter how your working situation changes, this will not affect your relationship with your doctor.***

- ***There will be more doctors and primary care professionals such as practice nurses and public health nurses working in teams, available in all areas.***

- ***You will have to register with a primary care team. In return you will know that this team is responsible for your access to health care when you need it.***

Labour's reform of hospital care

Hand in hand with reform of primary care, Labour will reform hospital care. This reform will ensure that everyone can access care in public and private hospitals on the same basis that privately-insured patients access care now.

Under Universal Hospital Care Insurance, we will contribute to the funding of our care when we have the income and ability to do so. Unlike under private health insurance, we will keep our access to care, even when we do not have the income to contribute to the system.

Labour will reform how hospitals and their doctors work, so that all of us get better value from what we pay for hospital care and to hospital consultants. Labour will reform how we purchase drugs nationally so that we will get better value from what we pay for drugs.

Labour will end the incoherent, irrational hospital policy of this Government, which cuts public beds and rewards the wealthy for developing private, for-profit hospitals for private payers. Public and private hospitals will offer care equally to all under Universal Hospital Care Insurance at rates that do not allow profiteering from Irish health care.

This reform cannot happen overnight because to work properly, it requires change in how hospitals are managed, how hospital care is purchased on our behalf and how we contribute to the cost of our care. The introduction of Universal Hospital Care Insurance will be a phased programme over six years. In each phase access to care will improve because Labour believes that the test of any reform is improved access.

Universal Hospital Care Insurance - the key elements

A compulsory system with public and private insurers

In the sixth year, in the full system of Universal Hospital Care Insurance we will all be insured by a public or private insurer in a compulsory insurance system. We will all have equal access to public and private hospital care. We will have a choice of insurer. We will pay for our insurance according to our ability to pay.

Payment according to ability to pay

Today we fund our hospital care by a mixture of tax, private insurance and charges. Most of the funding comes from tax, paid for by us all. Private health insurance contributes less than 10% of our overall health spending and 20% of our spending on hospitals, public and private.[56]

Under Universal Hospital Care Insurance our hospital care system will still be funded by a mixture of taxation and insurance but now health insurance will be compulsory. Our insurance payments will be related to our ability to pay, with the state paying for insurance for those on the lowest incomes and subsidising payments for those on middle incomes. Universal Hospital Care Insurance will cover all our hospital care costs. We will no longer pay out of pocket for hospital charges or for seeing hospital consultants in their private rooms.

The Hospital Insurance Fund

The state will pay the money we contribute for hospital care through taxation into a separate Hospital Insurance Fund. The Hospital Insurance Fund will determine how this money is allocated. We will choose our insurer. Depending on our income, we will either pay a premium directly to this insurer or the Hospital Insurance Fund will pay the insurer for us or subsidise our payment.

In addition to subsidising our premia according to our income, the Hospital Insurance Fund will be responsible for risk equalisation between insurers. In a reformed, effective risk equalisation system, the Fund will adjust insurers' premium income by levying a contribution from all insurance to fund top-up payments for insurers with memberships, who are at relatively high risk of needing care because of their age or for other reasons.

It will remain the case that a sizeable proportion of our hospital care will be funded from taxation. Today, the privately insured do not pay for the full costs of their care in public hospitals. When we are all insured, the insurance system will continue to fund some but not all of the costs of our hospital care. Under Universal Hospital Care Insurance, insurers will contribute approximately half of the cost of care, with the Hospital Insurance Fund directly funding hospitals for the remainder. Such payments from the fund will cover aspects of hospital care that insurers do not cover such as ambulance services and Accident and Emergency services. The Hospital Insurance Fund will also fund hospitals directly for teaching health professionals in training or providing particularly expensive care such as liver or heart transplants for small numbers of people.

In addition, the Hospital Insurance Fund will fund 30% to 50% of the cost of treatments purchased on our behalf by insurers, just as today the state contributes a proportion of the cost of care for the privately insured. Such matching payments will reduce the potentially de-stabilising effect of a very large proportion of tax-funded health spending being transferred to the insurance market, with consequent requirements for the build up of large reserves (Appendix 6 elaborates on this issue). As the compulsory insurance system beds down and becomes established over time, this element of matching payments from the Fund could be reduced.

The Universal Hospital Care Insurance guarantee

A guarantee of access to care for all will be central to Universal Hospital Care Insurance. Insurers will be obliged to offer the same Universal Hospital Care package to all under the statutory system of health insurance. The Minister for Health, answerable to the Government and Dáil Eireann, will determine in consultation with the Hospital Insurance Fund and medical experts the treatments included in the guaranteed Universal Hospital Care package.

The treatments covered in the Universal Hospital Care package will be based on national protocols for care, developed by national clinical directors for differing groups of conditions.[57] As in other Universal Health Insurance systems internationally and in private health insurance, the package of care guaranteed by universal insurance will change as new treatments become available. The process of determining and reviewing the package will be established in new legislation, the Universal Hospital Care Insurance Act.

The Hospital Insurance Fund will consult with the insurers and employ its own actuaries to calculate the cost of this guaranteed package and the appropriate premia to cover it. Such calculations are central to how private insurers operate today. The Hospital Insurance Fund will determine that premia for this statutory system of hospital care insurance should be at a level which does not provide for excessive profits from Irish health care. When the Minister and the Fund agree on the contents of the package and the appropriate premia, the level of taxation required to subsidise hospital care will be adjusted accordingly.

This system will be transparent. We will see how much goes into hospital care and what it buys. When care costs too much because of escalation in hospital costs or administration costs in insurance companies, that will be apparent. As a society, we will be able to judge much more clearly what we want to spend on hospital care. Through the Hospital Insurance Fund we will be able to take action to achieve a price for care that we consider reasonable.

A statutory system embodying principle of social solidarity

This will be a statutory system of universal hospital insurance organised according to principles of social solidarity. EU and national competition law requirements have limited application to a statutory, compulsory social insurance system, provided it is organised according to principles of social solidarity, and designed with care.[58]

This system of Universal Hospital Care Insurance will therefore be different from our existing private health insurance market. In a statutory system organised according to ability to pay, the state has much greater scope to determine how the system is run than in a private market system, which is subject to EU and national competition law. This is very important for achieving cost control within the system.

Achieving cost control in a compulsory insurance system

Competing private, for-profit insurers can drive up costs. Under Universal Hospital Care Insurance, this will not be allowed to happen because the Hospital Insurance Fund in consultation with the insurers will be able to determine appropriate rates of payment for procedures, including the fees or salaries for professionals performing those procedures. The Universal Hospital Care Insurance Act will provide a statutory basis for the respective roles of the Fund and the insurers in this process. The Fund will also be able to use its power as a single buyer to achieve better value for our national hospital spend on inputs to our care such as drugs and medical equipment.

This model of combining a number of insurers with centralised determination of rates of payment and funding will not be a new departure in European health care. In Germany, for instance, although there are many sickness funds providing compulsory health insurance, fees and funding are agreed centrally by the association of funds.[59]

The role of insurers

The role of insurers under Universal Hospital Insurance will be similar to the role played by private health insurers today. Insurers will be obliged to offer open

enrolment to all. There will be a system of risk equalisation to ensure that insurers with more, older members with greater health care needs will be compensated for the additional costs they bear.

Insurers will purchase our care from hospitals, public and private. They will not take over the running of hospitals, which will be independent providers of care, separate from insurers as purchasers of care. Aspects of hospital care that insurers do not cover such as ambulance services and Accident and Emergency services will be directly funded by the Hospital Insurance Fund. The Hospital Insurance Fund will also fund hospitals directly for teaching health professionals in training or providing particularly expensive care such as liver or heart transplants for small numbers of people.

Insurers will still be allowed to sell additional health insurance in a private market for those who want benefits that are not required for medical reasons, and so not covered by the Universal Hospital Care package. Such benefits might include private rooms, for instance, if the Universal Hospital Care package only covers semi-private accommodation; travel insurance; or insurance for cosmetic surgery that is not required for medical reasons. This would be a separate market for insurance, to which EU and national competition law would apply.

Insurers who choose to participate in the Universal Hospital Care system will not be allowed to sell additional insurance giving faster access to procedures covered by the Universal Hospital Care package. Hospitals and clinics which participate in supplying care to the Universal Hospital Care Insurance system will not be allowed to sell faster access to procedures covered by the Universal Hospital Care package.

If private insurers and hospitals wish to operate outside the Universal Hospital Care Insurance system, they may do so but they will receive no funds or subsidy from the Hospital Insurance Fund. Individuals, who choose to buy such additional insurance, if such a market were to develop, would do so in addition to their compulsory contributions to the Universal Hospital Care Insurance system.

A new public insurer of hospital care

This new system of Universal Hospital Care Insurance is designed to grow from the system of accessing and financing hospital care that we now have in Ireland. It is not a transplant from another country or culture. Labour does not believe that transplanting wholesale a system designed for another country will work in Ireland. This is a feasible reform because its roots are in the system we now have. There are a feasible series of steps to get to it. A key element of the path from today's system to Universal Hospital Care Insurance will be the development of a new public insurer of hospital care from our current system of financing care for uninsured patients.

Today we all have the right to public hospital care, largely paid for by the state through the vehicle of HSE funding of public hospitals from our taxation. Approximately half of us also buy private health insurance to purchase private hospital care and faster access to public hospital care. The state also pays for access to private hospitals for those of us who do not have insurance through the vehicle of the National Treatment Purchase Fund, also paid for by our taxation. So today those of us who do not have insurance receive care in both public and private hospitals paid for by taxation and purchased by either the HSE or the NTPF. If we are uninsured, we receive care later and we have no security about access to care in need. This dual system channels a lot of tax income into hospitals for public patient care but does little to ensure that that care is delivered in a timely and efficient way.

The new system of Universal Hospital Care Insurance will change how our taxation purchases care. A new public insurer will be created by combining the National Treatment Purchase Fund and the part of the HSE that currently funds public hospitals. The new Hospital Care Purchase Agency will start developing in the first year of Labour in Government. Initially it will not form part of a compulsory insurance system but it will change how care is purchased for public patients under our existing system as a necessary transition phase to Universal Hospital Care Insurance.

How the new public insurer will buy hospital care for the uninsured

The Hospital Care Purchase Agency will buy care for uninsured patients in the same way that insurers buy care for private patients. It will buy care from wherever care can be delivered safely, cost effectively and without delay. This means that the uninsured will not have to wait before they are offered care in private hospitals. It means that the Hospital Care Purchase Agency will not face limitations in the proportion of its budget that should go to public hospitals, as the National Treatment Purchase Fund does. Over time and in planned phases, the Hospital Care Purchase Agency will take over all purchasing of hospital care for uninsured patients from the HSE and the NTPF.

Instead of giving block grants to hospitals for public patient care, this new body will pay hospitals according to the number of patients they treat and the kind of treatments patients receive. Money will follow the patient for uninsured patients in the same way as it does for the privately insured. This will be a very powerful lever to change how public hospitals perform. They will be rewarded not penalised for treating more patients. Hospitals will have an incentive to become more efficient in how they supply care. This is a change which is already happening in Irish public hospital funding through the Casemix system and is common internationally.[60] This reform will very much speed up the changeover of Irish hospital funding to Casemix.

The Hospital Care Purchase Agency will purchase care from public and private hospitals as private insurers now do, with hospitals competing to offer that care. To ensure that hospitals compete on an equal footing, public hospitals will be compensated for costs they bear that private hospitals do not, such as the costs of Accident and Emergency departments and of training health care professionals. Until the establishment of the Hospital Insurance Fund, such funding to hospitals will continue to be allocated from taxation through the HSE.

Phases in the development of the new public insurer of hospital care

The changeover to the Hospital Care Purchase Agency will begin from Labour's first year in Government. In the first year, a pilot scheme will move funding for selected diagnostic procedures for uninsured patients from the HSE to the NTPF. This will be the beginning of a progressive move of eventually large amounts of funds, so there will also be provision for staff to move with the funds and for the evolution of the former NTPF into the new Hospital Care Purchase Agency.

The Hospital Care Purchase Agency will differ from the NTPF. The difference can be explained by the example of colonoscopies, tests to identify the presence or risk of bowel cancer. Although today the NTPF pays for colonoscopies for long waiters, a development that followed the scandal of Susie Long's death after her wait for diagnosis, there remains a long wait for colonoscopies.[61] The new Hospital Care Purchase Agency will take over from the HSE allocation of *all* funds for the purchase of colonoscopies for the uninsured, not just funds to purchase this procedure for long waiters. This means that any hospital that performs colonoscopies will be paid by the Hospital Care Purchase Agency. Hospitals that run up long waiting lists and are slow to supply the procedure may lose this funding to more efficient hospitals that are within reasonable reach for patients. By changing how care is purchased, a new set of incentives will be created which will change how hospitals behave. In place of the guarantee of care after waiting under the NTPF, the uninsured will have the same guarantee that the insured have - no waits that endanger health.

Following a pilot scheme in the first year of Labour in Government in which some diagnostic procedures will be purchased in this way, the Hospital Care Purchase Agency will progressively take over responsibility for purchase of all diagnostic procedures for the uninsured followed by all hospital treatments for the uninsured until it is the full purchaser of care for the uninsured. It will then be ready for establishment on a statutory basis as the new public insurer as part of the changeover to Universal Hospital Care Insurance.

Once the Hospital Care Purchase Agency is established as an independent, public body in a compulsory insurance system, it will be able to offer membership to anyone who wishes to move to it from a private insurer. Since those of us who were formerly uninsured will have insurance cover under the universal system, we will also have the option of choosing to move from this new public insurer to the VHI or a private insurer. As in the case of private insurers, the flow of funds into the public insurer will be determined by the size of its membership. Having two public bodies (the Hospital Care Purchase Agency and the VHI) competing to supply services in the same sector will not be a new departure for Ireland: Bord Gais and the ESB currently compete to sell electricity. Labour in Government will not privatise the VHI because Labour does not believe that the Universal Hospital Care Insurance system should be given over to for-profit insurers.

The role of hospitals

Under Universal Hospital Care Insurance, public hospitals will be given much more independence. They will no longer be managed by the HSE. They will operate as independent, not-for-profit foundations or trusts, with managers accountable to their boards. Boards will include representatives of local communities. For some smaller hospitals it will make sense for them to combine in a local hospital network, with a shared management and board.[62] Hospitals and hospital groups will be able to compete to supply care to private or public insurers. They will be paid according to the care they deliver. In this system, the money will follow the patient.

This freeing of public hospitals will not, however, be a free market in care. A free market is not compatible with social solidarity and good planning for community health care needs. An unregulated market would jeopardise the survival of smaller hospitals in areas of dispersed population. It would run counter to the development of centres of excellence for certain kinds of care. This Government has given tax subsidies to develop a free market in private hospitals, which attempt to cherry pick the most profitable procedures from the public hospital sector and which are too small to offer complex care of the kinds needed by a population with growing numbers of

older people. Labour's hospital reforms will be quite different from this Government's free market in hospital care.

Under Universal Hospital Care Insurance, the Minister for Health answering to the Government and Dáil Eireann will be responsible for health policy, including hospitals policy. Where a hospital plays an important role in supplying care in an area, it will not be allowed to close. If under the system of Universal Hospital Care Insurance, its income is insufficient to ensure its viability, it will be protected. If it is failing due to inefficiency, its management will be replaced. If it is failing because it needs to offer a differing package of care, it will be assisted by the Hospital Insurance Fund in achieving that change. Where a hospital plays an important role in a local community but does not have a sufficient throughput of patients to remain viable based on Casemix payments alone, the Hospital Insurance Fund will provide funds for this function of standing in readiness.

There will be a national licensing system for hospitals, developed by HIQA in consultation with the national clinical directors. This system will determine the required standards of care for any hospital, public or private, which wishes to supply care to the Universal Hospital Care Insurance System. For complex care suited to centres of excellence, only hospitals which can offer the appropriate standard of care will be licensed to supply it.

The role of doctors and how they are paid

Many strong advocates for an end to the two-tier system are Irish hospital doctors. Labour is convinced that Irish hospital doctors will welcome working in a reformed universal health care system, where they are not confronted by the moral dilemmas of two-tier access to care, a system imposed on them and not of their making. The Irish doctors working in Ireland are no different from the thousands of Irish medical graduates who have made distinguished careers in the UK's NHS for lower remuneration in a universal system.

Highly trained, skilled and motivated hospital specialist doctors are central to the functioning of a modern, high quality health care system. Ireland has traditionally exported many of our medical graduates to perform this role in other countries, while relatively few graduates become consultants in Ireland. There is consensus that we still need many more consultants working in teams, in place of a system that is too heavily reliant on junior doctors in training. Labour in Government will increase numbers of hospital consultants and control their pay rates within the Universal Hospital Insurance System. Under Universal Hospital Care Insurance, consultants will be leaders in their hospitals and hospital networks with the opportunities to become clinical directors or chief executives and to increase their incomes not by private practice but according to the excellence of their contributions to care.

Hospital consultants will no longer operate in a two-tier system, in which they are paid differently for different groups of patients: fees for private patients and salaries for public patient care. Since all patients will be insured under compulsory health insurance, doctors will receive the same form of payment for all patients. This will end discrimination between patients based on income and insurance status that is at the heart of two-tier access to care.

Those consultants, who have been earning very high private fee income, will be unable to continue doing so under the Universal Hospital Care Insurance system. The emphasis on cost control within the system and the setting of rates of payment for the Universal Hospital Care package centrally by the Hospital Insurance Fund will establish the rates at which hospital consultants are paid. This system will control the costs of hospital care, whether supplied by private or public hospitals. Hospital specialists will be able to choose whether they work for private or public hospitals but they will have to work exclusively for one hospital or hospital group. Within their hospital they will be paid in the same way for all patients' care. This could be by a combination of salary and fee income, depending on the specialty or type of care. The important changes in this system of payment from the payment system today is that there will be no difference in how hospital doctors are paid for different groups of patients for the same procedures and there will be cost control within the system.

Hospital doctors will work in teams, paid in the same way for all patients, in hospitals which are highly motivated to deliver more care under the Universal Hospital Care Insurance system. In place of augmenting their salaries by private practice, hospital consultants will have opportunities to augment their salaries by becoming leaders of and managers in their hospitals. As in the UK's system of Clinical Excellence Awards, doctors will be rewarded additional payments for work, including research and academic work, that is recognised by their peers as making particular contributions to patient care and the development of hospital services. [63]

Phases in Labour's hospital care reform

WHEN	ACTION
DAY ONE	➢ **Announcement: Universal Hospital Care Insurance to replace two-tier system and public-private mix.** ➢ **Phased introduction.**
YEAR ONE	➢ **National Treatment Purchase Fund to become purchaser of diagnostics: pilot programme to clear waiting for colonoscopies and other selected diagnostic procedures** ➢ **Public and private hospitals tender for supply of such procedures.** ➢ **HSE payments for these procedures diverted through NTPF.** ➢ **Transparent pricing at Casemix rate.** ➢ **Publication of: hospitals that win tenders to supply procedures, hospitals' delivery of care. Annual re-tendering.** ➢ **First phase in preparing public and private hospitals for competition in universal hospital care insurance system.** ➢ **First phase in development of new public insurer.**
	➢ **Department of Health prepares report on cost-effective pricing and funding mechanisms for care and care to be covered under Universal Hospital Care Insurance.** ➢ **Report to be published as White Paper on Financing Universal Hospital Care.**
YEAR TWO	➢ **NTPF purchaser of all diagnostics for uninsured.** ➢ **Public hospitals/hospital networks prepare to become independent care providers, autonomous from HSE.** ➢ **Department of Health drafts Universal Hospital Care Insurance Bill.**

YEAR THREE	➢ **NTPF merges with purchasing arm of HSE to become public purchaser of diagnostics and treatment.** ➢ **Publication Universal Hospital Care Insurance Bill, contains:** o **Universal Hospital Care Insurance guarantee** o **Establishment of responsibilities and roles of: Minister; Hospital Insurance Fund; insurers including new public insurer; providers of care;** o **Provides for financing mechanisms** o **Provides for establishment of Hospital Insurance Fund** o **Provides for establishment of new public insurer** o **Provides for foundation status for public hospitals**
YEAR FOUR	➢ **Passage Universal Hospital Care Insurance Act** ➢ **Date set for establishment of system** ➢ **Public purchaser of care separates from HSE, now separate agency - Hospital Care Purchase Agency** ➢ **Hospitals/hospital networks given foundation status** ➢ **Pilot year for full new purchaser-provider system** ➢ **Foundation hospitals compete to supply care to Hospital Care Purchase Agency and private insurers**
YEAR FIVE	➢ **New purchaser-provider system now stable** ➢ **Establishment Hospital Insurance Fund**
YEAR SIX	➢ **Universal Hospital Care Insurance now effective.** ➢ **Hospital Insurance Fund receives state funding from taxation** ➢ **All covered by compulsory hospital care insurance** ➢ **Hospital Insurance Fund pays premia for lower income households, subsidises premia above threshold. All have choice of insurer.**

Universal Hospital Care Insurance - the cost

The introduction of Universal Hospital Care Insurance is a feasible, costed and affordable reform. The reform is primarily about spending better not spending more. Labour's costings are based on a series of reports produced by a team of researchers at Trinity College Dublin for the Adelaide Hospital Society and published in 2006, 2008 and 2010. These reports costed the introduction of Universal Health Insurance to Ireland for a range of models covering differing packages of care. [64]

The final of these TCD/Adelaide reports concluded that it was possible for the running costs of a universal health insurance system to be entirely covered by a 19% increase in efficiencies in the delivery of care.[65] The Expert Group who reported to the Minister for Health in July 2010 separately calculated that there could be an 18% saving from bringing efficiency levels in Irish hospitals to the level of the best hospitals internationally.[66] There is great scope for increased efficiency and cost effectiveness in how we supply hospital care in Ireland. Neither our public nor our private hospitals make the best use of their resources by international standards. Evidence of under-used capacity and cost escalation in the delivery of private hospital care suggests that it is valid to anticipate that private hospitals as much as public hospitals could deliver much more care than they do at present for the same spend, if fully utilized with controlled costs in a universal system. [67]

Efficiency can mean reducing inputs - staff and beds - and producing the same amount of care. Or efficiency can mean maintaining inputs - staff and beds - and producing more care. That is how the Labour reform will put efficiency to work to achieve Universal Hospital Care Insurance. This reform will achieve the delivery of much more care so that people who cannot now afford private insurance will access care as readily as private patients do today. Under Universal Hospital Care Insurance, a reformed hospital care system, incentivised to deliver more care, will supply the unmet needs for care, which are reflected in public hospital waiting lists. In Labour's reform, efficiency savings will go to addressing unmet need.

While this is ambitious, Labour's primary care reforms are designed to ensure that hospital care reform is realisable. This is one of the chief reasons why Labour believes we should begin with reform in how we access and resource primary care. Only by having an efficiently functioning primary care system, meeting the great bulk of people's health care needs, can hospitals be freed to deliver more and better care. The presence of more carers in the community will facilitate shorter lengths of stay in hospitals. To ensure that hospitals can perform to maximum efficiency, Labour will also invest in and develop our community services, a much less costly way of delivering care.

Labour's Universal Hospital Care Insurance scheme is the equivalent of the TCD/Adelaide researchers' costed model of access to hospital care, which would give to us all the hospital care currently received by the privately insured. Costs included are: semi-private accommodation and consultant-provided care. Essentially these costings add the cost of extending private insurance for the uninsured to the existing national spend on hospital care which we already fund through taxation and private insurance. Since the uninsured are on average on lower incomes and older than the privately insured, the researchers adjusted their costings upwards to reflect the uninsured population's poorer health and greater need for care.[68]

When applied to our national spending on hospitals in 2009 the cost of Universal Hospital Care Insurance would represent a 28% increase on existing public and private spending on hospitals of €7.4 billion (Table 4). By meeting most of this cost through efficiency savings, the actual increase in national spending on hospitals will be 5% or €371m in 2009 prices under Universal Hospital Care Insurance. In real terms this cost can be reduced further if the price of delivering hospital care is reduced.

This cost is for day-to-day or current spending not capital costs or the cost of building more facilities. In health care, current spending which primarily pays staff is always many multiples of capital spending, which has been running at under 3% of our national spend on care. Capital spending is discussed below.

Table 4 Hospital Costs now plus the Cost of Universal Hospital Care Insurance

	€'m
Public hospital costs	5,475
Private health insurance (incl. 20% tax relief)	1,850
National Treatment Purchase Fund	90
Total current hospital costs	7,415
Additional cost of extending insurance to uninsured[1]	28%
Saving if existing and additional public and private hospital spend at 100% efficiency[2]	23%
Outstanding cost of moving to Universal Hospital Care Insurance if 100% hospital efficiency	5% = €371

Note: This table updates to 2009 the cost estimates for Social Health Insurance in hospital care of *Social Health Insurance: Further Options for Ireland*, Thomas et al (2008) Page 7 Table 1. The update applies this methodology to the 2009 National Hospitals Office budget and private insurance premia supplied by the Health Insurance Authority. More details on this methodology in *Social Health Insurance: Options for Irelan*d, Thomas et al (2006) especially Page 26, Table 4.1. These calculations are based on 2009 spending because national spending on private health insurance has not yet been published for 2010.

1. This is the increase in existing overall hospital spend if existing insurance cost applied to uninsured, taking their relatively poor health status into account. This estimate applies the ratio of cost of insured to uninsured applied in Thomas et al (2006). The NTPF budget is deducted from the cost of extending insurance to the uninsured since it would be subsumed into the new public insurer. The cost of extending insurance to the uninsured includes a cost estimate for introducing consultant-provided care.

2. This is an 18.2% saving on existing and additional spending expressed as a proportion of the existing budget. This is the potential saving which the Expert Group calculated could be achieved by bringing efficiency levels in Irish hospitals to the levels of the best hospitals internationally. In Labour's reform, this efficiency gain will be employed to deliver more care for the same inputs, i.e. to deliver increased care to meet unmet need by optimally employing the resources of both public and private hospitals.

How Labour will fund the cost of Universal Hospital Care Insurance

It is clear that the key to an affordable reform is achieving efficiencies. Delivering on this achievement requires beginning with Labour's primary care reform and progressing to Labour's hospital care reform in realistic steps. That is why the hospital care reform is designed to take six years. The additional 5% cost of Universal

Hospital Care Insurance will potentially arise in the sixth year. The real value of that cost will depend on the overall value of the hospital's budget at that point. Labour will address costs in the delivery of health care as part of its programme to put Ireland's finances on a more stable path. Measures such as the introduction of reference pricing and greater use of generics for the national drugs budget, greater control over hospital consultants' remuneration and professional fees generally, more cost-efficient purchase of care by the NTPF and reduction in numbers of managers and administrators will reduce the cost of delivering care.

The full introduction of Universal Hospital Care Insurance will build on this base of a lower-cost delivery of health care in Ireland. The additional 5% cost for the full Universal Hospital Care Insurance system will be 5% of a lower-cost hospital care budget. The potential for efficiencies in the delivery of hospital care is distinct from such measures to reduce the cost at which care is delivered. Efficiencies are achieved by delivering more hospital care with the same essential inputs, i.e. beds and hospital staff. Labour's path to delivering these efficiencies is also the path to developing Universal Hospital Care Insurance. It requires changes in how care is purchased and delivered; reform and better resourcing of primary care; and better development of community and long-term care.

If costs are reduced sufficiently in the delivery of hospital care, the 5% additional payment will not be required. To put this discussion in perspective, even if the full 5% additional cost were to arise, at €371 million in 2009 prices, this is effectively the same as the value of 20% tax relief on private health insurance premia at €370 million. Overall, if the full additional cost were to arise, we would collectively pay only 5% more for a reformed, equitable hospital system, in which we will have security about access, whatever our life circumstances. Depending on the achievement of reduced costs in the delivery of care, this 5% additional payment will be reduced in real terms. In six years time economic recovery will mean that more people are in work, on higher incomes and able to contribute to the system, so that if there is a 5% or lower additional cost, this will be funded without any additional cost to the people who are currently contributing to the system.

This reform will generate additional resources for hospital care. This will be achieved primarily by cost control and making better use of private hospitals and by operating public hospitals more efficiently. All hospitals, whether public or private, will be incentivised to supply more care under the Universal Hospital Care Insurance system. Better resourcing and development of primary, community and long-term care will reduce the problem of delayed discharge from hospital care of people who no longer require it. Labour will also invest in new, modern hospitals, including the National Children's Hospital and a new hospital for the North-East. More efficient care will reduce occupancy rates and achieve better infection control.

What Labour's Universal Hospital Care Insurance will mean for you

- ***You and your family will be insured for care in public and private hospitals.***
- ***Universal hospital insurance will give you guaranteed access to care just like private health insurance.***
- ***You and your family will not have to worry about being denied hospital care if you cannot afford private health insurance***
- ***You will not have to pay extra charges for hospital care.***
- ***No matter how your working situation changes, this will not affect how the most senior hospital doctors treat you.***
- ***You will be obliged to have compulsory hospital insurance. You will choose your insurer.***
- ***If your income is high, you will pay a premium without subsidy from the state. If your income is low, the state will buy your insurance for you. The state will subsidise insurance for people on middle incomes.***
- ***The path to the system of Universal Hospital Care Insurance will take 6 years. During those years, access to hospital care will improve for uninsured patients with much greater use of private facilities for your care and progressive freeing of public hospitals to tender to supply your care.***
- ***The cost of hospital care will reduce enabling more care to be delivered for the same spend.***

The relationship between primary, acute and community care

Although this reform will take place in separate phases for primary and hospital care, Labour in Government will also address the relationships between primary care, acute hospital care, and community and long-term care. Improving these relationships will be a central focus of Labour's reform. Discontinuity of care between different settings is one of the major problems of our present dysfunctional system. Labour's reform will ensure integration of care in different settings.

Consequently, Labour will also invest in and reform care of older people in the community and residential settings, which is closely inter-linked with primary and hospital care. Labour in Government will provide additional funding for community and long-term care: €50 million in 2012 and €75 million thereafter. Labour will review the operation of the Fair Deal system of financing nursing home care with a view to developing a secure and equitable system of access to and financing of community and long-term care which supports older people to remain in their own homes.

At present community and long-term care is administered by the HSE. As the HSE evolves under Universal Health Insurance, its sections with responsibility for primary and hospital care will be subsumed into the new structures of the Universal Health Insurance system. As a parallel evolution of the HSE, its sections that currently administer community and long-term care services will also take on a new identity. Re-named and organised as a number of Regional Care Agencies, they will continue to have responsibility for administering and funding community and long-term care. They will be accountable to the Minister for Health and will work closely with the Primary Care Insurance Fund and primary care teams. When the Universal Health Insurance system is fully operational, the relationship between the Primary Care Insurance Fund, the Hospital Care Insurance Fund and the Regional Care Agencies will be overseen by a central Integrated Care Agency within the Department of Health and answerable to the Minister for Health.

This central agency will not be a large bureaucracy. Its responsibilities will be to oversee the flows of centrally tax-funded resources between the different arms of the system, so that there are incentives for care to occur in the best setting. Under such a system, for instance, the Minister could direct the Integrated Care Agency to decide that some of the fund for hospital diagnostics should instead go to funding the development of diagnostic facilities in the primary care setting; or that Regional Care Agencies should be obliged to fund hospitals for the care of patients who cannot find care in the community when they are ready for discharge, a system employed in other countries to incentivise the provision of care outside the hospital setting. The Integrated Care Agency will provide the mechanism to ensure integrated provision of care.

Funding the capital costs of new facilities

The annual capital budget for health is a relatively small proportion of public health spending (3% in 2010) and of the state's overall capital spending (under 8% in 2010). This sum provides new public facilities such as primary care centres, community nursing units and hospital developments. Under this government, there has been further hidden and significant state capital investment in private health care in the form of tax reliefs for private hospital developments. Labour will no longer incentivise such developments.

Labour's phased Universal Hospital Insurance reform is designed to get the best possible use from all our existing hospital capacity, whether public or private. If all our inpatient beds in public or private hospitals were fully used, we would have approximately 3.2 beds for every 1,000 people, which would be in the middle of the international spectrum.[69] Given bed closures and the two-tier system, however, our ratio of public hospital beds available to the entire population is close to the bottom of the international spectrum. Since nearly a fifth of overall beds are in private hospitals, there is a pressing need to open up their use to the entire population. Opening up the use of all hospital beds to efficient, cost-effective care will reduce the immediate need for investment in new hospitals. But even when private hospital beds are integrated in

a universal system, additional bed capacity will be needed in the medium term as our population grows and ages. It can be more expensive to try to run a hospital system with too few beds: elective procedures are cancelled because of competing admissions through A &E; infection control is very difficult. Since by far the more significant costs in health are current operating costs not capital costs, it makes sense to invest in sufficient capacity so that staff are employed optimally. In our over-occupied system, staff time is wasted when procedures are cancelled. Therefore there remains a case for well-judged and planned increases in bed capacity.

In the present fiscal crisis, Labour in Government will prioritise capital spending in health. The health care system has needs for investment whether there is reform in how we access and fund care or not. If we optimise use of existing acute hospital capacity, the most pressing immediate need for investment is in stepdown and long-term care, primary care and community care facilities such as day care centres for older people. There is need to modernise hospitals, substituting better facilities for some of the essentially sub-acute capacity in the hospital network and using some sub-acute hospital sites to develop long-term/stepdown facilities.

Labour will invest in new, modern hospitals, including the National Children's Hospital, and a new hospital for the North-East, and we support the policy objective of relocating maternity hospitals to acute hospital campuses in Limerick and Dublin. Labour in Government will explore the scope for providing health care facilities through non-traditional financing via the Strategic Investment Bank.

Administration of the Health Care System

Labour will change the role of the HSE in the transition to Universal Health Insurance. This will not be an overnight restructuring, which would be a disruptive exercise in change for change's sake. All Labour's reforms of health administration are designed to deliver gains in access to health care, the true measure of any reform. Layers of HSE management will go from the outset to deliver cost savings and give the added gain of simplifying the HSE's structure.

To ensure greater accountability and democratic control, Labour in Government will restore primary responsibility for health policy and spending to the Minister for Health, who is clearly answerable to the Government of the day and to Dáil Eireann. The Department of Health will take back from the HSE statutory accountability for the Health Vote - the money that we collectively spend on public health and social care. The process of establishment of a Universal Health Insurance System will lead to the progressive devolution of the powers that are currently concentrated within the monolith that is the HSE.

What we expect from the Minister

The Minister for Health and the Department of Health will be responsible for policy and spending. In this period of reform, the Minister for Health with the support of the Government will be an energetic, visible leader of the transition to Universal Primary and Hospital Care Insurance.

The Minister with the assistance of the Department will:

- Prepare and introduce the Universal Primary Care Insurance Bill
- Drive a transparent and accelerated process of primary care development
- Introduce changes to the GP contract to prepare for Universal Primary Care Insurance
- Prepare the White Paper on Financing Universal Hospital Care

- Prepare and introduce the Universal Hospital Care Insurance Bill
- Direct the changes in the HSE which will prepare it for the evolution to Universal Hospital Care Insurance
- Direct the changes in the role of public hospitals which will prepare them for the evolution to Universal Hospital Care Insurance
- Oversee the transition to Universal Health Insurance, with funds collected for primary care going into the Primary Care Insurance Fund and funds for hospital care going into the Hospital Care Insurance Fund
- Establish and provide policy direction to the Integrated Care Agency which will ensure integration of care between primary, hospital, community and long-term care providers

What we expect from the HSE

Without disruptive overnight reform, by the end of the transition to Universal Primary and Hospital Care Insurance, the HSE will have changed from a confused and confusing monolith into a number of devolved bodies with clear areas of responsibility. Hospitals will gain in independence as will local providers of community and primary care. The purchasing and commissioning of care will be taken over by the health insurance system, including the new public insurer.

Key changes in the evolution of the HSE will be:

- Responsibility for overall state spending will return to the Department of Health
- A planned programme will reduce administrative layers in the HSE.
- The HSE hospital purchasing arm will merge with the NTPF to become the new public insurer
- HSE hospitals will become autonomous providers of care to the insurance system
- HSE clinical directors will answer to the Minister and work closely with HIQA

- HSE administration of community and continuing care will devolve to Regional Care Agencies, working closely with primary care teams.

Mental health services

Mental health services are currently funded from the public health budget and private insurance and are delivered in community and hospital settings, largely administered by the HSE. Mental health services will be supplied within the Universal Health Insurance System in primary care and in hospitals. Labour in Government will commission a study in consultation with mental health professionals to determine how best to integrate mental health services into the Universal Health Insurance system. The eventual integration of mental health services should lead to more transparent funding and better resourcing of mental health services.

Health and social care for children and for people with disabilities

Care services for children and families and for people with disabilities are funded by the public health budget and administered by the HSE. As the HSE evolves into separate organisations, programmes for children and families and for people with disabilities should be funded and administered separately and transparently. Some if not most programmes in these areas should probably be within the remit of the Regional Care Agencies. Labour in Government will undertake a consultative process with interests in these areas to determine what administrative structures would best serve the future development of these services.

Appendix 1

Table A1

Irish Nurses and Midwives Organisation - Bed closures as of January 7th 2011

Hospital	Closed beds
Aras Mahair Pol CNU, Castlerea	10 - long stay beds for elderly closed due to non replacement of staff
Ard Aoibhinn, Cardonagh	4- Alzheimer's beds closed
Bantry General Hospital	14 - surgical ward beds closed
Beaumont Hospital	62 - beds closed
Belmullet District Hospital	10 - care of the elderly beds closed
Bethany House (Care of the Elderly) Carlow	38 - beds closed
Clonakilty Community Hospital	16 - beds closed
Connolly Hospital	2 - (1 ICU & 1 CCU beds closed)
	30 - beds closed
Cork University Hospital	62 - beds closed
Elective Orthopaedic Hospital, Croom	9 - beds closed
Ennis General Hospital	25 - surgical beds closed
John Sullivan Memorial Home, Cavan	14 - beds closed
Kerry General Hospital	29 - surgical beds closed
Kilcreen Hospital, Kilkenny	20 - beds closed
Letterkenny General	28 - beds closed
Lifford Hospital	10 - beds closed
Lisdarn Hospital, Cavan	15 - beds closed
Loughloe House	26 - beds closed
Louth County Hospital	97 - beds closed
Mayo General Hospital	16 - male surgical beds closed
Mercy University Hospital, Cork	31 - surgical ward beds closed
	6 - Male surgical beds (St Patrick's Ward)
	6 - Paediatric beds (St Anne's Ward)
Merlin Park, Galway	34 - medical ward beds closed
	9 - Orthopaedic Day Ward
	27 - beds closed
Monaghan General	56 - beds and a high care unit
Midlands Regional Hospital Mullingar	41 - beds closed
Midlands Regional Hospital, Tullamore	86 - beds closed
Midlands Regional Hospital, Limerick	6 - paediatric beds closed
Naas	24 - beds closed
Nenagh General	25 - beds closed
Ofalia House, Edenderry (Care of the elderly services)	12 - beds closed
Our Lady's Hospital for Sick Children, Crumlin	25 - orthopaedic ward beds closed.
	Equivalent of One Theatre - reduced capacity and outpatients reduced by

	15%.
Our Lady's Hospital, Navan	18 - medical beds closed
	15 - medical beds: To be closed 18/10/10
	13 - surgical beds: To be closed 18/10/10
Pathways (Care of the Elderly) Cavan	6 - beds closed
Plunkett CNU, Boyle	9 - beds closed
Portiuncula Hospital	13 - beds closed (St John's Ward)
Ramelton N.U., Donegal	8 - beds closed
Royal Victoria Eye and Ear Hospital	10 - recovery beds closed
Sacred Heart, Castlebar	36 - beds closed
Sligo General Hospital	66 - beds closed
South Tipperary General	20 - beds closed
	1 - ICU bed closed
South Infirmary Victoria University Hospital, Cork	27 - beds (female medical ward)
St. Anne's, Clifden	10 - beds closed
St Brendan's Home, Loughrea	12 - beds closed
St Colmcille's, Loughlinstown	23 - beds closed (medical ward)
	11 - beds closed (children's ward)
St. Columbanus Home, Killarney	19 - care of the elderly beds closed
St. Francis CNU, Galway	8 - beds closed
St Vincent's, Athlone/ St Mary's, Mullingar/ St Joseph's, Longford (Care of Elderly Facilities)	40 - beds closed
St John's, Enniscorthy	7 - beds closed
St. John's, Limerick	25 - beds closed
St Joseph's Hospital, Dungarvan	2 - beds closed (St Michaels ward)
St Joseph's, Ennis	20 - beds closed
St Joseph's, Stranolar	19 - beds closed
St Luke's General Hospital, Kilkenny	26 - pre-discharge beds closed
	9 - in-patient beds closed
	14 - gynae beds closed
	2 - medical beds closed
St Mary's Orthopaedic Hospital	25 - beds closed
St Patrick's Hospital, Waterford	19 - long stay beds closed
St Vincent's Hospital, Athy	26 - bedded care of the elderly ward
St Vincent's Hospital Mountmellick	12 - beds closed
Tallaght Hospital	10 - paediatric beds closed
	31 - beds closed (Burkett Ward)
University College Hospital, Galway	8 - Paediatric beds closed
	8 - beds (St Mary's Ward)
	15 - beds closed (St Monica's Ward)
	2 - ICU beds closed
	1 - ICU bed closed (cardiac/ thoracic)
	28 - Beds closed (St Michael's Ward)
Virginia Health Centre, Cavan	4 - beds closed

Waterford Regional Hospital	6 - in-patient beds closed
Wexford General Hospital	14 - gynae beds closed 25 - bedded ward closed
Total	1,660

Source: INMO website. Link: http://www.stophealthcuts.ie/INOPage_5_311.aspx

Appendix 2

How HSE-commissioned report advised cutting Irish hospital beds by 2020

Figure A.1

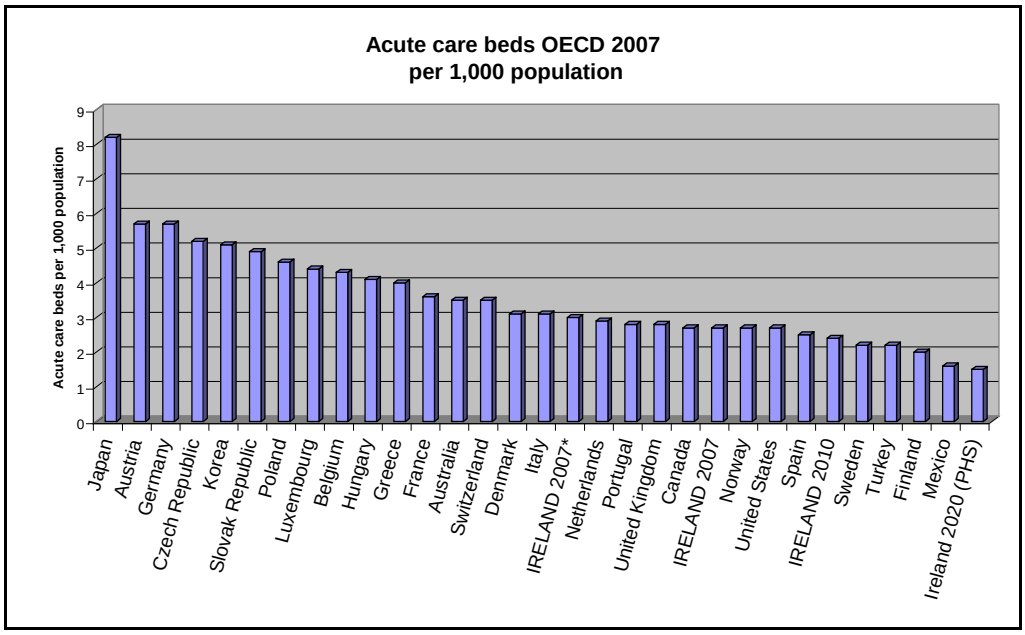
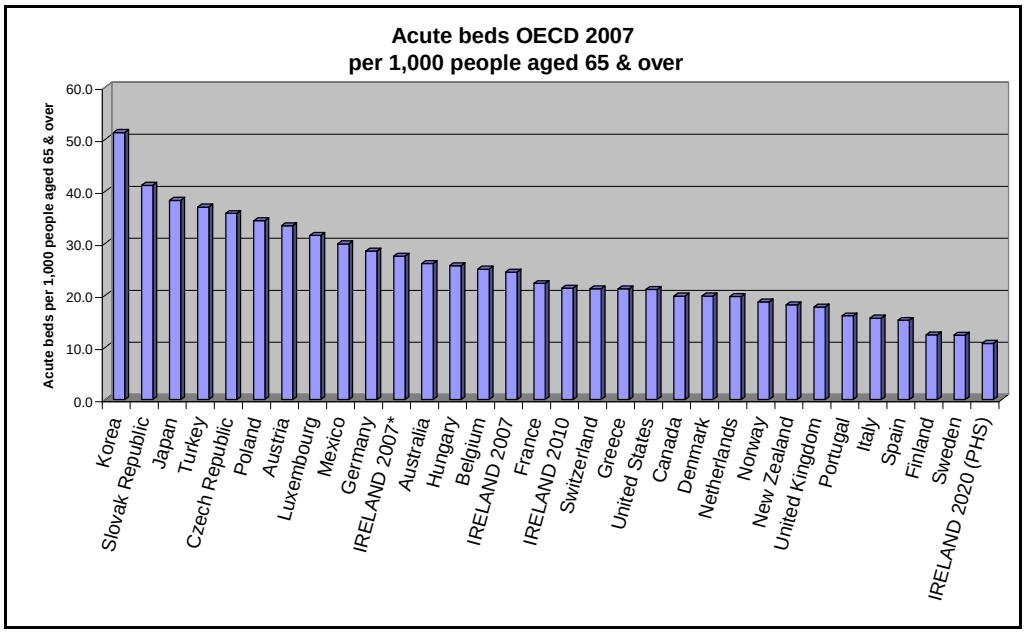


Figure A.2



See discussion page 13. Source: OECD Health Data 2010 for international data. Irish 2020 figures for PA's Preferred Health System (PHS) from Layte et al (2009) Projecting the impact of demographic change on the demand for and delivery of health care in Ireland, Research Series No 13, ESRI (2009). Ireland 2007* and Ireland 2020(PHS) includes private hospital beds. Ireland 2010 applies October 2010 bed cuts published by HSE to 2007 total.

Appendix 3

Table A2. Numbers of public patients waiting for treatment, October 2010 and October 2009

	Inpatient		Day Case		Total		
	Children	Adults	Children	Adults	Children	Adults	Children + Adults
0-3 months							
2009	839	6,400	1,066	13,975	1,905	20,375	22,280
2010	868	6,229	1,327	17,919	2,195	24,148	26,343
Change 2009-2010	29	-171	261	3,944	290	3,773	4,063
% change	3%	-3%	24%	28%	15%	19%	18%
over 3 months							
2009	1,275	6,394	1,835	8,684	3,110	15,078	18,188
2010	1,132	6,815	1,536	10,640	2,668	17,455	20,123
Change 2009-2010	-143	421	-299	1,956	-442	2,377	1,935
% change	-11%	7%	-16%	23%	-14%	16%	11%
Total waiting							
2009	2,114	12,794	2,901	22,659	5,015	35,453	40,468
2010	2,000	13,044	2,863	28,559	4,863	41,603	46,466
Change 2009-2010	-114	250	-38	5,900	-152	6,150	5,998
% change	-5%	2%	-1%	26%	-3%	17%	15%

Sources: HSE Performance monitoring reports, October 2009 and October 2010, supplementary volumes.
http://www.hse.ie/eng/services/Publications/corporate/HSE_Monthly_Performance_Reports_.html

Table A3. Numbers of public patients waiting for treatment, October 2010 and October 2009, selected hospitals

	Inpatient		Day Case		Total		
	0-3 months	3+ months	0-3 months	3+ months	0-3 months	3+ months	All
Beaumont							
2009	545	442	694	311	1,239	753	1,992
2010	527	705	1,827	917	2,354	1,622	3,976
Change 2009-2010	-18	263	1,133	606	1,115	869	1,984
% change	-3%	60%	163%	195%	90%	115%	100%
Cork University Hospital							
2009	473	408	379	294	852	702	1,554
2010	455	548	499	405	954	953	1,907
Change 2009-2010	-18	140	120	111	102	251	353
% change	-4%	34%	32%	38%	12%	36%	23%
Galway University Hospital							
2009	662	995	1,559	1,488	2,221	2,483	4,704
2010	496	1,180	1,777	2,540	2,273	3,720	5,993
Change 2009-2010	-166	185	218	1,052	52	1,237	1,289
% change	-25%	19%	14%	71%	2%	50%	27%

Sources: HSE Performance monitoring reports, October 2009 and October 2010, supplementary volumes.
http://www.hse.ie/eng/services/Publications/corporate/HSE_Monthly_Performance_Reports_.html

Appendix 4

Figure A.3 Irish public day-to-day health spending compared to spending in other countries

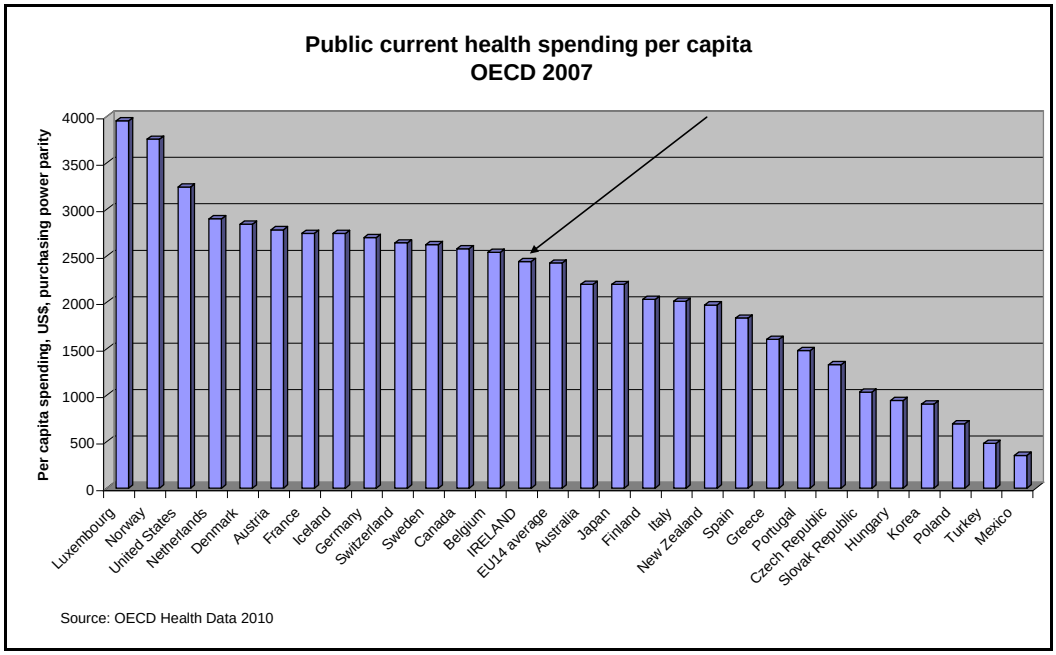


Figure A.4 Total health spending as a percentage of gross national income

Total Health Expenditure as a % of GNI, 2000 and 2007

Country	2000	2007
Australia	9.0	9.1[a]
Canada	9.1	10.5
Germany	10.4	10.4
Ireland[b]	7.3	9.0
Netherlands	7.8	9.8
New Zealand	8.9	9.9
Sweden	8.4	9.2
UK	7.2	8.4
US	13.2	17.3
EU-15[c]	**8.7**	**9.6**

Source: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Page 330 Table 11.1

Appendix 5

Table A4 Effect of Labour's reform on GP visits

Patient categories by eligibility/ health status	Numbers of people (millions)	Average GP visits per person p.a.	Total annual visits to GPs
Medical card holders and GP-Visit card holders	1.56	5.3	8,268,000
Fee-paying patients	2.90	2.1	6,090,000
Total population	4.46		14,358,000
Labour's reform and extra demand for care		Additional visits p.a.	
People with chronic illnesses	0.65	3.2	2,080,000
Percentage increase in total annual visits to GPs			14.5%

Appendix 6

A note on insurers' requirement for reserves

Currently, health insurers in Ireland have a regulatory requirement from the Central Bank that they should hold reserves at 40% of their premium income.[70] By European standards, this is a relatively high reserve requirement. The minimum European standard is the higher of the reserves calculated under a premium or claims related basis.[71] This equates to approximately 21% of gross written premium income in the financial year 2009. It is expected that this requirement will be reduced further in 2013 under the Solvency II proposals currently being introduced by the European Commission. Under Universal Hospital Care Insurance, the regulatory requirement for reserves in the Irish system would be at the European standard.

When the full Universal Hospital Care Insurance system becomes operational and the new public insurer is established, it will be required to have reserves, which the state will have to invest as a once-off establishment cost. This insurer will potentially begin its independent life with a membership comprising the 50% of the population that is currently uninsured. It will therefore potentially have a premium income which is 50% of the total premium income in the system. Since the Hospital Insurance Fund will be meeting half of the overall costs of hospital care, the public insurer's premium income will represent one quarter of the overall cost of the system. The new insurer will have to begin life with a maximum once-off injection of reserves of 21% of that amount, which would be €410 million, based on the implementation of Universal Hospital Care Insurance at 2009 prices (Table A5).

Table A5 Reserve requirement for new public insurer

Universal Hospital Insurance Funding (2009 prices)	€'m
Overall hospitals funding	7,800
Of which:	
From Hospital Insurance Fund (not subject to reserve requirements)	3,900
From insurers' premium income	3,900
Of which:	
New public insurer's premium income (50% total)	1,950
Reserves at 21% of premium income	410

[1] See Note 25 below.

[2] OECD Health Data 2010 Figures for 2008. Northern Ireland figure from Northern Ireland Family Practitioner Services Statistical Report 2007/2008 www.hscbusiness.hscni.net

[3] Layte et al (2009) Projecting the impact of demographic change on the demand for and delivery of health care in Ireland, Research Series No 13, Chapter 3, ESRI (2009).

[4] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 1, Chapter 8

[5] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 1, Chapter 8

[6] O'Reilly et al (2007) Consultation charges in Ireland deter a large proportion of patients from seeing the GP: results of a cross-sectional survey. European Journal of General Practice 13(4)

[7] Report of the Expert Group on Resource Allocation and Financing in the Health Sector, Chapter 3; and Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 10.

[8] Programme for Government, 2007-2012, page 37.

[9] HSE Performance Monitoring Reports August to October 2010 http://www.hse.ie/eng/services/Publications/corporate/HSE_Monthly_Performance_Reports_.html

[10] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 1, Chapter 7, Table 7.6

[11] http://www.dohc.ie/statistics/key_trends/hospital_care/table_3-1.html

[12] http://www.dohc.ie/statistics/key_trends/hospital_care/table_3-1.html

[13] HSE Performance Monitoring Reports http://www.hse.ie/eng/services/Publications/corporate/HSE_Monthly_Performance_Reports_.html

[14] OECD Health Data 2010

[15] Report of the Expert Group on Resource Allocation and Financing in the Health Sector, Chapter 3 pages 50

[16] Layte et al (2009) Projecting the impact of demographic change on the demand for and delivery of health care in Ireland, Research Series No 13, p. 118, ESRI (2009).

[17] Layte et al (2009) Projecting the impact of demographic change on the demand for and delivery of health care in Ireland, Research Series No 13, p. 149, ESRI (2009).

[18] Report of the Expert Group on Resource Allocation and Financing in the Health Sector, Chapter 3 pages 50-51

[19] Wren M.A. (2003) Unhealthy State, Chapter 14

[20] 'No simple solutions on health equity and funding', The Irish Times, April 28th 2010.

[21] Quarterly National Household Survey, Module on health status and health service utilisation, quarter 3 2007 www.cso.ie

[22] Report of the Comptroller and Auditor General, Accounts of the Public Services 2009, Vote Management, Volume 2, page 486, September 2010

[23] OECD Health Data 2010 The average is calculated for 14 pre-enlargement EU countries, UK not available, using spending expressed in US dollars, adjusted for purchasing power parities. Luxembourg's 2006 spend is updated for 2007, employing its trend spending growth rate.

[24] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Page 330 Table 11.1; and Section 11.4

[25] Total Irish health expenditure is estimated at 12.1% of Gross National Income (GNI) and total health and social care expenditure is estimated at 15.2% of GNI in 2009. Source: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Page 330 Table 11.1 footnote; and Section 11.4. Latest estimates published by the Department of Health and Children for 2008, http://www.dohc.ie/statistics/key_trends/health_service_expenditure

[26] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 12

[27] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 14

[28] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 1, Page 19, Table 1.2

[29] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 13, Table 13.2

[30] HSE Consolidated Salary Scales, January 2010, www.hseea.ie

[31] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 13, pp 401-404. This calculation takes purchasing power parities in the two countries into account.

[32] A Type A public hospital consultant starts in 2010 on €184,455; a Type B consultant with the right to 20% private practice starts on €173,620. Source: HSE Consolidated Salary Scales, January 2010, www.hseea.ie

[33] Wren M.A. (2003), Unhealthy State, pp 167-169; Wren M.A (2004), 'Health Spending and the Black Hole' in Quarterly Economic Commentary, ESRI, Autumn 2004 pp 60-62

[34] Ruling of the European Court of Justice in AOK Bundesverband v. Ichthyol-Gesellschaft Cordes (2004) ECR I-2493 cited in Mossialos E. et al (2010), Health Systems Governance in Europe - the role of European Union law and policy, European Observatory on Health Systems and Policies, Cambridge University Press (2010)

[35] Statement from the Tánaiste, November 19th 2004

[36] The Expert Group's costings are based on 2009 data for medical cardholders and population. The Central Statistics Office estimates a small rise in population in 2010, which would suggest there should be provision for costing care to more people. However, this has been more than overtaken by a large rise in numbers on medical cards due to falling incomes (see next note). This policy is therefore over-providing for the extension of care by using the Expert Group's figures for 2009.

[37] An additional 136,000 people qualified for medical cards or GP-visit cards between the end of 2009 and October 2010 bringing total cardholders in that month to 1.71 million out of an estimated population of 4.47 million. The CSO has estimated that population grew by only 11,400 in 2010 due to outward migration. HSE Performance Monitoring Report October 2010 at http://www.hse.ie/eng/services/Publications/corporate/HSE_Monthly_Performance_Reports_.html and Central Statistics Office Population and Migration Estimates April 2010, published September 21st 2010, www.cso.ie

[38] Report of the Expert Group on Resource Allocation and Financing in the Health Sector, Chapter 3; and Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 15, p. 485 Table 15.4 for estimated numbers with chronic conditions.

[39] Report of the Expert Group on Resource Allocation and Financing in the Health Sector, Chapter 3; and Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 15, p. 487 for visiting rates and assumptions about changes in rates.

[40] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 15, p. 490 Table 15.6 While the Expert Group recommended a system of subsidised GP fees, it also calculated the total cost of GP care under varying assumptions about GP payment levels.

[41] Announcement by Minister Harney for Estimates for Health 2011, http://healthupdate.gov.ie/on-the-record/announcement-by-minister-harney-for-estimates-for-health-2011.html

[42] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 15, p. 475

[43] Consultants' salaries, numbers, scales and comparisons with UK rates from Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 13 and Appendix 6, Table A6.10.

[44] This estimated saving is based on a total of 2,025 public hospital consultants and an average starting salary of €175,000, giving a minimum estimated payroll of €354m. Since this is based on starting salary and excludes additional allowances, total payroll plus allowances is estimated to be close to €400 million of which €75 million would represent 18.7%.

[45] Layte et al (2009) Projecting the impact of demographic change on the demand for and delivery of health care in Ireland, Research Series No 13, Chapter 3 page 46, ESRI (2009).

[46] Cupples M E, M C Byrne, S M Smith, et al. (2008) Secondary prevention of cardiovascular disease in different primary healthcare systems with and without pay-for-performance. Heart 2008 94: 1594-1600

[47] Teljeur C., S. Thomas, F. O'Kelly et al. (2010) General practitioner workforce planning: assessment of four policy directions. BMC Health Services Research 2010, 10: 148

[48] Ibid.

[49] Methodology as in Teljeur et al. (2010) General practitioner workforce planning: assessment of four policy directions. BMC Health Services Research 2010: 10

[50] Teljeur C., S. Thomas, F. O'Kelly et al. (2010) General practitioner workforce planning: assessment of four policy directions. BMC Health Services Research 2010, 10: 148 for GP numbers;
Dáil Debates, October 5th 2010, Minister for Health priority questions, for hospital doctor numbers.

[51] García-Pérez, M.A. et al (2007) Physicians' migration in Europe: an overview of the current situation. BMC Health Services Research 2007, 7:201;
Mullan F (2005) The Metrics of the Physician Brain Drain. The New England Journal of Medicine, Boston: Oct 27, 2005. Vol. 353 17; p. 1810

[52] Patrick McGregor, Anne Nolan, Brian Nolan and Ciaran O'Neill, A comparison of GP visiting in Northern Ireland and the Republic of Ireland, ESRI Working Paper No 22, data for 2001.

[53] The GP visiting figures derive from data for 2001 when NI had 13.3% of population aged 65 and over compared to 11% in the Republic

[54] Cupples M E, M C Byrne, S M Smith, et al. (2008) Secondary prevention of cardiovascular disease in different primary healthcare systems with and without pay-for-performance. Heart 2008 94: 1594-1600

[55] The 50 cent charge is levied on each prescription item. In 2009 51 million items were prescribed for medical cardholders. In the year to October 2010, there was a 7% increase in the number of prescriptions reimbursed for medical card holders compared to the same period in 2009, which pro rata would suggest that 54.5 million items may have been prescribed during 2010. This would suggest potential revenue from the 50 cent charge of €27m. However, no family should be levied more than €10 per month under this charge, which means that the revenue would be lower than €27m. Sources: Primary Care Reimbursement Service Statistical Analysis of Claims and Payments 2009; HSE Performance Monitoring Report October 2010; HSE information on 50 cent charge at http://www.hse.ie/go/50c/

[56] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 1, Chapter 1; and Volume 2, Chapter 10 for health insurance as proportion of the overall health spend; Calculation of health insurance as proportion hospital spending is as follows: In 2009, the budget of the National Hospitals Office was €5,475 m; the budget of the National Treatment Purchase Fund was €90m; and total national health insurance premia came to €1850 m, of which tax relief constituted 20%. Private health insurance paid by individuals and companies on their behalf represents 20% of these sums combined but not all of it was devoted to hospital spending.

[57] The network of clinical directors already exists. Following the recent establishment of the HSE Directorate of Quality and Clinical Care, 50 Clinical Directors were appointed to develop and strengthen clinical management within hospital services and to develop care protocols in different areas.

[58] Ruling of the European Court of Justice in AOK Bundesverband v. Ichthyol-Gesellschaft Cordes (2004) ECR I-2493 cited in Mossialos E. et al (2010), Health Systems Governance in Europe - the role of European Union law and policy, European Observatory on Health Systems and Policies, Cambridge University Press (2010)

[59] Thomas et al (2010) Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland Chapter 8, TCD/The Adelaide Hospital Society, 2010 www.adelaide.ie

[60] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 1, Chapter 7

[61] "Over 1,000 wait for colonoscopy", The Irish Times, August 10th 2010

[62] The concept of "strong, autonomous hospital groups" is developed in Tussing D. and M. A. Wren (2006) How Ireland Cares, Chapter 10, New Island (2006)

[63] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 13

[64] The three reports are Thomas et al (2006) Social Health Insurance: Options for Ireland; Thomas et al (2008) Social Health Insurance: Further Options for Ireland; and Thomas et al (2010) Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland, all published by The Adelaide Hospital Society, www.adelaide.ie

[65] Thomas et al (2010) page 29

[66] Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 2, Chapter 14

[67] According to the Comptroller and Auditor General Accounts of the Public Services 2008 the National Treatment Purchase Fund paid private hospitals over seven sample procedures an average contracted price 5% below Casemix but the contracted price for public hospitals was at least 23%

below adjusted Casemix for all procedures, and averaged 31% below. The Department of Health and Children pointed out that the prices paid by NTPF for work in public hospitals did not contain a remuneration element for the treating consultant, because they were in receipt of a public salary. However, most private hospital consultants are also in receipt of a public salary.

[68] Thomas et al (2006) page 26 explains the TCD researchers' initial costing methodology. The "Rolls-Royce, Low" option is the model applied here. Thomas et al (2008) Table 1 Page 7 updates these cost estimates.

[69] OECD Health Data 2010 for international figures. A ratio of 3.2 inpatient beds to 1,000 people in 2010 assumes 12,120 public inpatient beds (beds available in 2007) and 2,174 private inpatient beds. Sources: Department of Health and Children Statistics and Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, Volume 1, Page 227, Table 7.6

[70] Vhi Healthcare currently has a derogation from these provisions

[71] Solvency requirements are outlined in the insurance directives of the European Union and transposed into Irish regulations by means of Statutory Instruments. See Directive 2002/13/EC of the European Parliament and of the Council of 5 March 2002 amending Council Directive 73/239/EEC for the solvency margin requirements for non-life insurance undertakings

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