



THE IRISH HEALTHCARE SYSTEM

An Historical and Comparative Review

A report commissioned by the Health Insurance Authority

September, 2018

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Introduction

The effectiveness of the Irish healthcare system, whether public or private, is of immense importance to all members of the public and of all ages. The current Irish system is primarily a tax-financed public system but with significant out-of-pocket spending, mainly in primary care, and with supplementary health insurance for private hospital cover, with a 45% rate of public participation.

One of the principal functions of the Health Insurance Authority (HIA), as an independent regulator for private health insurance, is to increase awareness of members of the public of their rights as consumers of health insurance and health insurance services available to them.

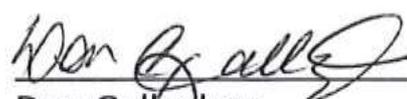
In this context the HIA believes, in the first instance, that the current healthcare system and structure could best be understood, and appreciated, by consumers against an historical backdrop covering social, religious, political and economic influences impacting the evolution of healthcare in Ireland since medical charities first appeared in the early 18th century. To this end the HIA was pleased to commission Dr Laurence Geary of UCC to write a brief history of Irish healthcare up to the mid-twentieth century. Brendan Lynch, HIA's Head of Research, then added a summary of healthcare developments from then up to the present day, with an emphasis on the health insurance system.

The HIA also believes that benchmarking the Irish healthcare system against the corresponding systems in other developed countries would be constructive and informative from a consumer perspective. This can be achieved by, firstly, establishing how we currently rank by various performance measures and, secondly, how Ireland might be able to learn from some of the success stories (or failures) from these other healthcare systems. The HIA was pleased to commission Dr Brian Turner from UCC to carry out an international benchmarking comparison with four other healthcare systems, namely, the UK, Australia, Germany and Belgium.

The 2017 Sláintecare report specifically proposes the phased elimination of private care from public hospitals. Given the significant impact of this proposal on consumers' health insurance coverage the HIA's commissioned research should also make a direct and meaningful contribution in helping the public, as well as healthcare policymakers, providers and insurers, become as informed as possible when evaluating the current and proposed Irish healthcare systems.



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Part I

From Medical Charities to a National Healthcare System

A Chronology of Key Milestones in the Evolution of Irish Healthcare Services

From Voluntary Hospitals to Voluntary Health Insurance A History of Irish Healthcare from the Early-Eighteenth to the Mid-Twentieth Century

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This essay surveys the evolution of medical facilities for the treatment of the physically ill in Ireland, from the inception of the first voluntary hospital in Dublin in 1718 to the creation of the Voluntary Health Insurance Board in 1957, which was intended to fill eligibility gaps in public hospital cover for the more affluent sectors of Irish society.

Medical Charities

Voluntary Hospitals

Ireland's earliest institutions for the reception and care of travellers, the poor and the sick pre-dated the arrival of Christianity in the fifth century, and were attached to the royal residences at Tara and Emain Macha. In later centuries, facilities for the relief of the sick and the poor were located in abbeys and monasteries until King Henry VIII of England suppressed these foundations in the 1530s. The wars of conquest and settlement in the sixteenth and seventeenth centuries led to the establishment of military hospitals in many parts of the country, but there was no hospital provision for the civil population of Ireland from the time of the Reformation until the beginning of the eighteenth century, when a compound of ideological, demographic and social forces resulted in the establishment of voluntary hospitals in Dublin and in several Irish provincial centres to provide free medical aid to the sick poor.

The motives for founding and funding voluntary hospitals and other charitable institutions in Ireland, England and elsewhere were more complex than the biblical injunction to heal the sick or the title medical charity might suggest. In an essay published in 1733, Jonathan Swift claimed that there was nothing that redounded more to individual reputations or national honour than the establishment and support of institutions for the relief of different types of distress. According to Swift, 'the diseased and unfortunate are thereby delivered from the misery of wanting assistance; and others are delivered from the misery of beholding them'.¹ The suggestion that there was an element of social calculation in any such initiative contains

¹ Jonathan Swift, *A serious and useful scheme, to make an hospital for incurables, of universal benefit to all his majesty's subjects.*

more than a grain of truth. The voluntary hospital movement was inspired by a combination of philanthropy and utilitarianism, forces that fused in eighteenth-century Enlightenment thinking. A belief in social progress and the attainment of happiness and fulfilment were matched by the needs of a mercantile and industrial age that required an increased and healthy population, both as producers and consumers. Medicine became increasingly democratic. Professional healthcare was no longer the prerogative of the rich, but shifted to accommodate, if not openly embrace, those at the lower end of the socio-economic scale. This democratic impulse was most clearly seen in the establishment of hospitals and dispensaries, where the focus was on institutional rather than on individual treatment of the sick.

The first voluntary hospital, the Charitable Infirmary, opened in a small house in Cook Street, Dublin, in August 1718, two years before England's first voluntary hospital, the Westminster, was established in London, and this was followed by others in the capital and in Cork, Belfast, Limerick and Waterford.² The earliest voluntary hospitals were of a general nature, and admission was usually restricted to curable cases, mainly accidents and minor medical complaints. The exclusion of children, women in childbirth, the infectious, the venereal, the insane, and incurables led to the establishment of specialist institutions for their needs. The first, for incurables, was in 1744, when the Charitable Musical Society in Dublin rented a small premises in Fleet Street, to accommodate 'those wretched objects of incurable suffering whose hopeless diseases, deformities and loss of limbs deprive them of the means of earning their own subsistence'. As a result of being debarred or discharged from all other hospitals, these individuals were driven 'to exhibit their loathsome appearances in the public streets to excite commiseration'.

As their name implies, voluntary hospitals were dependent on philanthropy or voluntary financial support for their existence. They were built, equipped and maintained by private endowment and public subscriptions, although some, because of their perceived utility, received state grants from the 1750s onwards.³

County Infirmaries

The voluntary hospitals that evolved in eighteenth-century Ireland were limited to the five largest urban centres. The remainder of the country was bereft of hospital provision until 1765, when an Act of the Irish parliament provided for the establishment of an infirmary or hospital in each Irish county. As with the voluntary hospitals, the inspiration was not entirely charitable or altruistic. Late eighteenth-century utilitarianism was classically captured in the preamble to the legislation, which stated that these institutions would be a means of restoring the health and prolonging the lives of many Irish people, and they would promote labour and industry and increase productivity in the country.

² For a list of pre-Famine voluntary hospitals see Laurence M. Geary, *Medicine and charity in Ireland, 1718- 1851* (Dublin: University College Press, 2004), pp. 18-20.

³ The foregoing material derives from *Ibid.*, chapter 1, voluntary hospitals, pp.13-39

County infirmaries were funded by a combination of parliamentary grants, county taxation, subscriptions to qualify as annual or life governors, and donations. Theoretically, admission was restricted to poor persons suffering from non-infectious diseases and to those requiring surgery. Less serious cases were attended in out-patient clinics. Individuals who could afford to pay for medical care, and incurables, irrespective of their financial standing, were debarred from these institutions.⁴

Fever Hospitals

In the eighteenth and early nineteenth centuries, the great despoiling infections that threatened public health in Ireland were tuberculosis, smallpox, and fever, a generic term that embraced typhus fever, relapsing fever, and typhoid fever. Fever had been endemic in the country for generations, and had killed and terrified countless thousands. The agency of the disease was not discovered until early in the twentieth century, but it was generally conceded from a much earlier period that hunger, poverty, and insanitary living conditions were predisposing causes. Irish people had an unrivalled knowledge of fever, its symptoms, and consequences. They were empirically aware that the disease was contagious, and fear of infection drove them to quarantine those who contracted the illness. Fever hospitals, for the more effective isolation of the infected, were established in Dublin, Cork, Waterford, Kilkenny, Belfast, and Limerick under special acts of parliament in the late eighteenth and early nineteenth centuries. These institutions in the main urban centres were complemented by three distinct types of publicly-funded fever hospitals that were set up following legislation in 1807, 1818, and 1843. The most extensive were the district fever hospitals that were instituted following the great fever epidemic of 1816-1818. They were funded by public subscriptions and local taxation, which had to be raised on an annual basis. Fever's ability to leap class and social barriers was a powerful motivating factor in establishing institutions where the infected could be isolated and treated. According to one early nineteenth-century Dublin philanthropist, fever hospitals were established when society realised that the health of the poor was the security of the rich.⁵

Dispensaries

In practical terms, hospitals were restricted to those who lived within a reasonable distance of them. Individuals who resided in remoter areas were effectively excluded because of an inadequate and expensive road and transport network. This fact was acknowledged in an 1805 Act of the United Kingdom parliament which provided for the establishment of dispensaries throughout Ireland. Dispensaries were intended to complement the county infirmaries, to provide medical and surgical relief to the poor of the neighbourhood in which they were established. These institutions differed from voluntary hospitals and county infirmaries in that they had no wards or in-patient facilities. Dispensary doctors provided

⁴ Ibid., chapter 2, county infirmaries, pp. 40-53.

⁵ Ibid., chapter 4, fever hospitals, pp. 70-92.

professional advice and medicines on an out-patient basis, and visited the sick in their homes as part of the service. There was no standard principle on which dispensaries were established. The location of county infirmaries was specified by law, but dispensaries could be opened anywhere, irrespective of need or demand. Once subscriptions were raised in a locality, the county grand jury, which was the local taxing authority, was obliged to sanction a similar amount.

The combined sum was placed at the disposal of a committee elected by the subscribers to use at their discretion to provide medical relief to the sick poor. These institutions were mainly concentrated in towns and in the wealthier areas where subscriptions could more readily be raised. They were scarce in the poorer and remoter rural districts where their need was greatest.⁶

Medical Charities: Governors and Patients

The four types of public medical institutions outlined above were collectively known as medical charities. They were not designed for the destitute but for the deserving or working poor, individuals who could support themselves and their families, however marginally, through their own labour and productivity but who would have been reduced to penury if prevented by serious illness from working for any length of time. The pauperising effects of illness were widely recognised and it became customary to treat small farmers, cottiers, agricultural labourers, artisans, and domestic servants who might be reduced to this condition without gratuitous medical relief.

The founders and supporters of medical charities argued that these institutions conferred moral, as well as practical, benefits on the sick poor. If medical intervention prevented individuals and their families from sinking into pauperism, such assistance strengthened and promoted the legitimate and desirable concepts of independence, pride, and respectability among the poor. In practical terms hospitals provided rest, care and superior diet to their inmates, factors that contributed to recovery and convalescence in those who gained admission.

The advantages offered to the middle and upper classes by these institutions were less tangible, but no less real. The enabling of hospital relief to the poor discharged charitable obligations and helped to protect the persons, families and general interests of the higher social classes. Beneficence raised the donor's public and philanthropic profile, and conferred the right to recommend patients for admission, which, again, had implications for social status and relationships. Such philanthropy, by subordinating the poor to the benevolence of the middle and upper classes, constituted an exercise in social control.

Hospital and dispensary patients were expected to show deference and gratitude to their benefactors, a social submissiveness that was captured in the patronising, almost penal, rules

⁶ Ibid., chapter 3, dispensaries, pp. 54-69.

and regulations that applied to these institutions. The rules governing hospital admission and conduct were strict and there were several offences for which patients could be summarily discharged, including the consumption of alcohol, smoking, gambling, swearing, blasphemy, lewd conversation, defacing or dirtying the premises, and disobedience or impudence to the medical and ancillary staff. Such rules and regulations featured in all Irish hospitals and in similar institutions elsewhere, including England and America. Paternalistic and oppressive hospital bye-laws were devised and enforced by the governors who managed these institutions, individuals who were exercising their authority over perceived social inferiors.

The medical charities that were established in Ireland in the eighteenth and early nineteenth centuries were marred by abuses, inequities and deficiencies, and these features generated heated controversy and debate. There were several areas of concern, but the most pressing related to the finances and management of these institutions. Medical charities' funding, particularly that of dispensaries and district fever hospitals, was the feature that drew the most vocal criticism. The income of these institutions was dictated by voluntary subscriptions, which had to be raised before local taxation – in the form of grand jury presentments – could be obtained. The result was that charitable funding was irregular, insecure and generally inadequate, which meant that the future of these institutions was uncertain. The question of control and management, at local and national level, was equally problematic. Each charity was independently managed, and there was no overall, regulatory agency. The absence of such a controlling body ensured that management was both arbitrary and inconsistent.⁷

The Poor Law, 1838

The structural defects that were inherent in the Irish medical charities network were exposed and compounded by the poverty, disease and famine that were features of the country in the eighteenth and nineteenth centuries. Following a disastrous famine in 1740-1, the Irish population grew rapidly, rising from between 2,000,000 and 2,500,000 in the mid-eighteenth century to about 4,000,000 in 1790, and 5,000,000 in 1800. The first successful Irish census, in 1821, recorded a population of almost 7,000,000. By the time the Great Famine began in the mid-1840s, the population was approaching 8,500,000.⁸

Pre-Famine Ireland was a rural society, one that was largely unaffected by the industrial revolution that transformed Great Britain and much of continental Europe. Eighty-five per cent of the rapidly-growing Irish population lived in the countryside, many in cramped, sub-standard homes, where domestic and personal hygiene were problematic. They survived largely on potatoes and buttermilk, a healthy and wholesome, if monotonous, diet. Potatoes offered many advantages as a primary food source, but in Ireland they were often insufficient

⁷ Ibid., chapter 5, governors and patients, pp. 95-122.

⁸ Liam Kennedy and Leslie A. Clarkson, 'Birth, death and exile: Irish population history, 1700-1921', in B.J. Graham and L.J. Proudfoot (eds), *A historical geography of Ireland* (London: Academic Press, 1993), pp. 158- 64.

in quantity, deficient in quality, and prone to failure. Food shortages contributed to dietetic disorders, and had a strong influence on epidemic infections, notably fevers and diarrhoeal diseases.

In the first half of the nineteenth century, Ireland was not overly impoverished by contemporary standards, but the country was characterised by a highly unequal distribution of income and resources. The pre-Famine period witnessed a widening of the social divide, a sharpening of income inequality. The living standards of the middle- and upper-classes improved, but the circumstances of the Irish poor deteriorated significantly. In this respect, the ending of the Napoleonic wars in 1815 was a critical turning point. The thirty years between 1815 and the commencement of the Great Famine in 1845 were marked by a severe downturn in economic activity, increased unemployment, subsistence crises, minor famines, and recurring outbreaks of disease. Deteriorating economic and social conditions manifested themselves in several ways, including a massive increase in begging, vagrancy, and emigration. However, the most telling indicator of the post-Napoleonic poverty crisis was the report in the mid-1830s of the so-called Poor Inquiry, an investigative committee appointed by parliament and chaired by Dr Richard Whately, the Anglican Archbishop of Dublin, which concluded that some 2,385,000 individuals, almost one-third of the Irish population, were without work and in need of assistance for more than half of every year. The committee submitted a comprehensive, if extremely bleak, report on Irish social conditions, arguing that they could only be redressed by innovative and unconventional methods. Whately and his colleagues recommended that the government should develop the Irish economy by promoting public works, including land reclamation and the development of the fishing industry. They also proposed large scale emigration to the colonies as a means of reducing the country's excessive population. These initiatives should be financed by state loans and local taxes.⁹

The government rejected the Whately committee's proposals as too radical, at odds with the non-interventionist economic orthodoxy of the time, the doctrine or philosophy of political economy, more commonly known as *laissez-faire*. The government instigated another investigation into Irish poverty and living conditions, this time by George Nicholls, an English poor law commissioner, who, after a short and geographically-limited visit to the country, recommended a system of indoor relief based in workhouses, similar to that recently instituted in England, but one that the Poor Inquiry had already rejected as unsuitable for Ireland. Nicholls insisted that the function of the poor law was to relieve destitution rather than poverty, and he estimated that about one per cent of the Irish population fell into the pauper category.

A poor law act, based on Nicholls' recommendations, came into force in Ireland in July 1838.¹⁰ Under the terms of the legislation, the country was divided into 130 administrative units known as poor law unions, each with a single workhouse, centrally situated close to a

⁹ *Poor inquiry (Ireland). Third report of commissioners for inquiring into the condition of the poorer classes in Ireland.* BPP 1836 [35] xxx, pp. 25-26.

¹⁰ 1 & 2 Vict., c. 56, 'An act for the more effectual relief of the destitute poor in Ireland', 31 July 1838.

market town. The system was funded by a compulsory property tax, the poor rate, which was based on a nationwide valuation, known as the poor law or Griffith's valuation. The administration of each union was entrusted to a board of guardians, which was composed of two elements, individuals elected by the ratepayers, and justices of the peace resident in the union. The English Poor Law Commission was given overall administrative responsibility, and this body delegated Nicholls to act on its behalf in Ireland.¹¹

The Relief of the Poor (Ireland) Act, 1838 did not provide the Irish poor with a legal entitlement to assistance. Relief was discretionary and dependent on the availability of workhouse places. The refusal to provide outdoor relief meant that public assistance to the poor was limited to the number of inmates the workhouses could contain, approximately 100,000. Relief was also financially restricted, circumscribed by the funds that could be raised locally from the poor rate. Most significantly, in an Irish context, the poor law was incapable of dealing with a major crisis like famine.

The poor law was an alien concept to the Irish, one that was imposed from without, and administered by outsiders. The workhouses were constructed and managed in such a way as to deter all but the truly destitute from seeking admission, and to stigmatise those who did. The overriding concern was to offer no incentive to idleness. The labouring poor should be discouraged from lapsing into destitution by making the prospect unattractive. The standard of food, clothing and accommodation that was provided to workhouse inmates at public expense was intended to be inferior to that which was available to any self-supporting labourer, irrespective of the nature or lowliness of his occupation. The buildings were uniform, cheap and unattractive. The way they were run was equally grim and forbidding, with the emphasis on regimentation and discipline. Work was compulsory, tedious and often pointless. Paupers were not allowed alcohol or tobacco. They had to enter the workhouses as whole family units, but once inside families and the sexes were segregated. The ethos underpinning poor relief, its very philosophy, was punitive and degrading. It was intended to deter all but the desperate and the utterly destitute. This was the so-called workhouse test or principle of less eligibility. Those who were prepared to have their lives regulated by officialdom, to forgo their independence, liberty and status had proved their destitution; they had passed the workhouse test.¹²

The 1838 poor law legislation was circumscribed by the political and economic philosophies of the day and was flawed both in its thinking and execution. The Act was grudging and demeaning, intended to degrade and deter, and those whom it was meant to relieve hated it unreservedly. It was also hopelessly inadequate, designed to accommodate no more than 100,000 individuals in a society where some 2.5 million were regularly at risk.

The poor law consisted of two components, the civil and the medical, which addressed pauperism and illness respectively. In addition to its poor relief provisions, the 1838 Act

¹¹ R.B. McDowell, *The Irish administration, 1801-1914* (London and Toronto: Routledge & Kegan Paul, 1964), pp. 175-76; Christine Kinealy, *This great calamity: the Irish Famine, 1845-1852* (Dublin: Gill & Macmillan, 1994), pp. 6-30.

¹² Kinealy, *This great calamity*, pp. 6-30.

enjoined the Poor Law Commission to investigate the existing medical charities, to recommend any additional hospitals or dispensaries that might be required for the sick and convalescent poor in the different poor law unions, and to suggest and implement changes to improve the management of these institutions. In the wake of this inquiry, George Nicholls recommended extensive changes in the funding and management of dispensaries and fever hospitals, and the appointment of a central regulatory authority to ensure the efficient and economic management of these charities. The whole thrust of Nicholls's report and of his remedial suggestions was that the supervisory role should be entrusted to the Poor Law Commission, and that the medical charities should be made part of the Irish poor law system.

Nicholls's report and the proposed relationship between the Poor Law Commission and the medical charities divided public opinion in Ireland. Some agreed with his argument that illness among the poor was probably the single most significant factor in pauperising individuals and entire families, and as such the commission had a key role to play in the administration of medical and pauper relief. Others, including a substantial segment of the medical profession, were thoroughly alarmed at the prospect of the medical charities coming under the control or influence of the Poor Law Commission. These doctors were inherently opposed to any change that threatened their interests and monopolies, and they also regarded any association with the poor law system as socially and professionally degrading. Over the next few years, Irish medical practitioners mounted an impressive, and successful, defensive action against any encroachment by the Poor Law Commission onto Irish medical territory, and in the process thwarted all attempts to reform the medical charities. Their opposition was eventually undone by an occurrence entirely beyond their control – catastrophic famine.¹³

The Great Famine, 1845-52¹⁴

General starvation and famine-related diseases were responsible for more than 1,000,000 excess deaths in Ireland between 1845 and 1852, and at least another 1,000,000 people emigrated. By the time of the first potato failure in the early autumn of 1845, 118 of the projected 130 workhouses were operational, some with fever hospitals attached, and the country possessed more than 800 medical charities. These figures suggest that a comprehensive poor relief and medical service existed at the commencement of the Famine, but the institutions were defective in many respects and were to prove totally inadequate in meeting the crisis.

The starving, the sick and the destitute descended upon dispensaries, hospitals and workhouses in search of food and medical assistance. Those who were too ill or too weak to crawl, or who were unable to procure transport of their own were carried by their friends or relatives and abandoned outside the nearest institutional wall if they were not admitted. Such

¹³ Geary, *Medicine and charity in Ireland*, pp. 159-60.

¹⁴ For the impact of the Great Famine on the medical charities, and for the medical response to the Famine, see *Ibid.*, chapter 8, medical relief during the Great Famine, pp. 181-209.

an act of despair and finality was indicative of the plight of the starving poor, but it also reflected the enormous pressures that were brought to bear on the country's relief and medical institutions. The catastrophic levels of destitution, morbidity, and mortality that occurred simply overwhelmed these agencies. Neither the poor law nor the country's medical services was designed to cope with a cataclysm on the scale that occurred, and by the late 1840s it was clear that the medical charities' network was in considerable disarray and that government intervention was urgently required to prevent the system from imploding. The response was a medical charities act that came into effect on 1 October 1851.¹⁵

The Poor Law Medical Service¹⁶

The legislation applied only to dispensaries; it did not address the broader medical charities network. Under the terms of the Act, the country's poor law unions, which had expanded from the original 130 to 163 during the Great Famine, were divided into 723 dispensary districts. Each district had a single dispensary and some of the larger ones had branch or outlying dispensary stations to facilitate patient access.

The Organisation of the Dispensary Service under the 1851 Medical Charities Act

	Poor Law Unions	Dispensary Districts	Dispensaries/Dispensary Stations	Doctors	Apothecaries/Compounders Of Medicine	Midwives
Leinster	40	208	308	230	10	3
Ulster	44	215	260	222	2	4
Connacht	29	95	108	103	6	0
Munster	50	205	284	221	11	0
Ireland	163	723	960	776	29	7

Source: *Medical charities, Ireland. First annual report of the commissioners for administering the laws for the relief of the poor in Ireland, under the Medical Charities Act, 14 & 15 Vic. C. 68, HC 1852-3 [1609] l.325, p. 133.*

The 1851 Medical Charities Act directed the Poor Law Commission to frame rules and regulations for the administration and supervision of the reorganised dispensary service. The poor law guardians of the different unions provided the dispensary premises, medicines and appliances, and the service was funded by a local property tax known as the poor rate. Each dispensary was

¹⁵ 14 & 15 Vict., c.68, 'An act to provide for the better distribution, support and management of medical charities in Ireland; and to amend an act of the eleventh year of her majesty, to provide for the execution of the laws for the relief of the poor in Ireland', 7 August 1851.

¹⁶ This section derives from Laurence M. Geary, 'The medical profession, healthcare and the poor law in nineteenth-century Ireland', in Virginia Crossman and Peter Gray (eds), *Poverty and welfare in Ireland, 1838- 1948* (Dublin: Irish Academic Press, 2011), pp. 189-206.

managed by a committee that was elected annually from the poor law guardians and wealthier property holders in the district. The Act entitled 'any poor person' who resided in the dispensary district to free medical advice and medicine on presentation of a ticket that could be widely obtained. There were two, colour-coded, ticket classifications: black, which obliged patients to attend the dispensary, and red, which entitled the holder to free medical treatment at home. The post-Famine dispensary service was open to abuse and many individuals who could afford to pay for private medical treatment availed of it. The problem arose from a lack of definition in the hastily devised 1851 Medical Charities Act, which simply stated that poor persons were entitled to free medical advice and medicine through the dispensary service. There was no official attempt to define a poor person. The term was entirely relative, and was sufficiently elastic to embrace just about everybody in the community – farmers, shopkeepers and tradesmen, as well as the socially and economically disadvantaged.

The red and black ticketing system facilitated corruption as well as open access to dispensary relief by all social classes. Members of dispensary committees, relieving officers and wardens were authorised to issue tickets. Local boards of guardians appointed these individuals and nominations to these semi-official positions were often influenced by religious and political sentiment. Publicans, shopkeepers and clergymen generally acted as wardens, and, while they were unpaid, each had an obvious vested interest in the wholesale disbursement of dispensary tickets. The latter were issued to all-comers, irrespective of financial status, legitimately, to relieve illness, but also to attract custom or to reward religious and political allegiances. Red, or visiting, tickets, which obliged dispensary doctors to attend patients in their homes, were particularly problematic. These tickets were known as 'scarlet runners', a designation that encapsulated their imposition on medical practitioners. The medical profession contended that all who were involved in administering the dispensary system both locally and nationally were aware of these abuses but ignored them.

The 1851 Medical Charities Act, which was a direct consequence of the Great Famine, removed the vestiges of paternalism and philanthropy that had been associated with the dispensary network for more than half a century and made these institutions an integral part of the poor law system. The Relief of the Poor (Ireland) Act, 1838, amendments in 1843 and 1847, and the 1851 Medical Charities Act were an acknowledgement of the inadequacy of philanthropy and private initiatives to deal with sickness and poverty in Ireland. They marked both the passing of an old order and the failure of government laissez-faire policies. The 1838 and 1851 legislation established nationwide workhouse and dispensary systems that were funded from the poor rates and administered by the Poor Law Commission. These Acts represented an inexorable tendency towards greater state involvement and increased centralisation.

Dispensaries provided an out-patient service only. The sick poor who required hospital treatment were accommodated in the workhouse infirmaries and fever hospitals, and these institutions constituted the second branch of the Irish poor law medical service. In the workhouse infirmaries, individuals suffering from dangerous infectious diseases were segregated from general patients, either in separate wards or in detached buildings. As with

dispensaries, the Great Famine had a significant impact on fever hospital arrangements, transforming a medical charities network into one that operated under the poor law. Between 1845 and 1852, the number of fever hospitals that were supported by public subscriptions and local taxation declined from 101 to 40, while those that were located in workhouses and funded by poor rates increased from 20 to 147.

The incidence of fever and other dangerous infectious diseases declined dramatically in the post-Famine years and so did the number of deaths from these diseases. These trends were facilitated by a significant reduction in the Irish population, improved living and social conditions for all classes, advances in public health, scientific developments in medicine generally, and by the presence of an extensive fever hospital network. In many Irish poor law unions in the second half of the nineteenth century, the capacity to treat infectious cases exceeded requirements, isolation facilities having been largely established to meet the Famine fever crisis. By the close of the century, the fever wards and hospitals that survived the Great Famine were either empty or contained a mere handful of patients suffering from infections such as measles, diphtheria, scarlet fever, and typhoid or enteric fever.

The workhouse infirmaries and fever hospitals were originally intended for the sick in the workhouses but, following legislation in 1862, they were converted into general hospitals for the sick of each poor law union.¹⁷ Despite the broadening of their remit, the poor were reluctant to avail of these hospitals' services because of their association with the workhouses, pauperism, and social degradation. Hospital inmates had to endure the same conditions as paupers in the workhouse; they wore the same clothing, lived in the same unattractive buildings, and were governed by the same restrictive rules and regulations.

In the post-Famine period, emigration, improved employment opportunities and the enforcement of laws against mendicancy had reduced the number of able-bodied inmates in the workhouses, and the vacuum was filled by the elderly and the infirm, the feeble-minded and the insane, children and the sick. Furthermore, it was the chronically, rather than the acutely, ill who were largely treated in the workhouse infirmaries. Those suffering from serious illness and those requiring advanced surgery were often transferred to the county infirmaries or to voluntary hospitals in the cities, particularly in poor law unions where these institutions were contiguous to the workhouse. By the close of the nineteenth century, the workhouse buildings and infirmaries were unsuitable for treating the sick and sheltering the elderly, and the rules and regulations governing these types of inmates were inappropriate. There were concerns over neglect and mismanagement in the workhouse infirmaries generally, and over nursing irregularities in some of these hospitals, frequently because responsibility for nursing was entrusted to different orders of nuns, women who had no professional training, tended female patients only, and did not perform night duties. Nuns were widely praised for their commitment and humanity, and for the order and cleanliness they introduced to the workhouse infirmaries under their charge, but they were criticised

¹⁷ 25 & 26 Vict., c. 83, 'An act to amend the laws in force for the relief of the destitute poor in Ireland, and to continue the powers of the commissioners', 7 August 1862

for their lack of professional training as nurses. In September 1897, the Irish Local Government Board, which had replaced the Poor Law Commission twenty-five years earlier, terminated pauper nursing in the workhouse infirmaries and recommended the appointment of trained nurses, individuals who had spent at least two years in a clinical or other hospital recognised by the board, and who had been examined and certified as proficient in nursing by the hospital.

By the beginning of the twentieth century the nature, philosophy and purpose of the poor law had altered fundamentally and so had attitudes to poverty and the poor. The early and mid-Victorian emphasis on individualism and self-help had changed, and social reformers were increasingly willing to accept a more positive role for the State in the formulation and implementation of social policy. There was an increased awareness of poverty as distinct from pauperism or destitution, and a growing demand for a remedy to the latter. This led to increased efforts to prevent pauperism and to make more adequate provision for the vulnerable. The early 1900s were marked by an intense debate on the poor law and a growing demand for reform in both Britain and Ireland. Two major reviews were undertaken, by the vice-regal commission on poor law reform in Ireland, which reported in 1906, and by a royal commission on the poor law in the United Kingdom. The former recommended the separation of the workhouse infirmaries from the poor law system and the creation of a state medical service, comprising the newly-independent workhouse hospitals, county infirmaries and dispensaries, which would be entirely funded by the exchequer. The state would pay the salaries and pensions of the medical personnel, who would be recruited by means of a competitive state examination.¹⁸

The Liberal government failed to act on these proposals, and it also ignored the report of the royal commission which was issued in May 1909. Instead, it embarked on a new direction, disregarding the question of poor law reform, and launching a number of welfare initiatives that were independent of the poor law. The most revolutionary were the Old Age Pensions Act, 1908 and the National Insurance Act, 1911, which aimed to protect the working classes against poverty, to help them maintain their independence during sickness, unemployment, and in old age. The dramatic events of the following decade – World War I, and the Irish revolution – ensured that the problems confronting the country's poor law medical service remained unaddressed. In May 1920, the Irish Public Health Council, which had been appointed in the previous September to advise and assist the government in promoting health policies generally, informed the Chief Secretary for Ireland that the country's medical and health services required urgent reform. According to the council, the voluntary hospitals were in financial difficulties, the public hospital system was 'disjointed and unsatisfactory', and the dispensary service was in need of complete reorganisation and modernisation. The council submitted a plan for a state medical and public health service which was independent of the poor law and which, given the unfolding political situation in Ireland, could be applied

¹⁸ Ruth Barrington, *Health, medicine & politics in Ireland 1900-1970* (Dublin: Institute of Public Administration, 1987), pp. 24-34.

to any constituent part of the country in the event of partition.¹⁹

In the seventy years 1851 to 1921, the Irish poor law provided both an inpatient and outpatient service to the sick poor. Those who required hospital treatment were accommodated in workhouse infirmaries and fever hospitals; those whose complaints were less serious were treated in dispensaries where they received professional advice, medicine and treatment free of charge. The dispensary system did not alter fundamentally during this period. The service was delivered to the poor either in their own homes or in independent facilities scattered throughout the country and, consequently, the dispensaries were largely free of the odium that attached to inpatient treatment under the poor law. Ideologically, structurally, and in their professional organisation, inpatient facilities – the workhouse or union infirmaries and fever hospitals – were largely obsolete by the beginning of the twentieth century, but the desired separation of these institutions from the poor law system, and the creation of a state medical service were not realised prior to the establishment of the Irish Free State.

The workhouse and its ancillary institutions represented a loss of independence and respectability for those availing of its services. The working and lower middle classes, comprising small farmers, small shopkeepers and traders, artisans, servants, labourers, and other self-supporting individuals, shunned any association with the poor law and its hospitals, and sought medical and surgical relief, when required, in the county infirmaries – the country's provincial hospitals – and in the voluntary hospitals in the main cities. According to one medical practitioner, writing in the mid-1880s, 'the rooted repugnance which exists to entering a workhouse hospital' did not obtain in the county infirmaries.²⁰

These institutions, dating from 1765 and independently managed by their own boards of governors, derived their support from taxation – county cess (tax) or the poor rate – which accounted for about seventy per cent of gross income, subscriptions to qualify as governors, and bequests or donations.²¹ Under the Local Government (Ireland) Act, 1898, county councils became the taxing authority for the infirmaries, and their management, including the admission of patients, was vested in committees appointed triennially, consisting of representatives of the boards of governors and the county councils.²²

The voluntary hospitals in Dublin and other Irish cities derived their patients essentially from the same social base as the county infirmaries – the respectable and self-supporting poor from the labouring and lower middle classes. As we have seen, the Irish Public Health Council informed the government in May 1920 of these institutions' financial difficulties, which were

¹⁹ *Ministry of Health Act, 1919. Report of the Irish Public Health Council on the public health and medical services in Ireland*, HC 1920 [Cd.761] xvii.1075, pp. 3, 5-6, 25.

²⁰ Hercules MacDonnell, 'Statistics of the county infirmaries, Ireland', *Journal of the Statistical and Social Inquiry Society of Ireland*, 56 (1884), pp. 541-43. For further commentary on the social differentiation between the union and county infirmaries, see Z. Johnson, 'The provincial hospitals of Ireland', *Dublin Journal of Medical Science*, 91(1891), pp. 217-26.

²¹ MacDonnell, 'Statistics of the county infirmaries, Ireland', p. 542.

²² 'An act for amending the law relating to local government in Ireland, and for other purposes connected therewith', section 15, 12 August 1898.

caused or compounded by inflation during and after World War I, challenges to traditional philanthropy, reduced subscriptions, increased costs associated with scientific advances in medicine, and an ageing, deteriorating and increasingly unsuitable built environment. Additional revenue was generated from fee-paying patients, but it was insufficient to meet running costs and capital expenditure, and by the time of Irish independence many voluntary hospitals were in deep financial trouble.²³

Independent Ireland

In 1921, the playwright John Millington Synge observed that the workhouse was a refuge for ‘tramps and tinkers’ and was ‘looked on with supreme horror by the peasants’, adding that the latter dreaded it more than the madhouse or lunatic asylum.²⁴ Synge’s depiction of the union workhouse as a refuge for the underbelly of Irish society captured the repugnance that the poor felt for these institutions. The popular aversion to the workhouses and the other trappings of the poor law was reflected in the radical statement of intent on social matters, the ‘Democratic Programme’, which the first Dáil Éireann approved after convening on 21 January 1919.

The ‘Democratic Programme’ committed the fledgling Irish ‘Republic’ to abolishing ‘the present odious, degrading and foreign poor law system’ and replacing it with ‘a sympathetic native scheme for the care of the nation’s aged and infirm’. Similarly, it was the Republic’s duty to safeguard the health of the people and ensure the physical as well as the moral well-being of the nation.²⁵ For a host of reasons – political instability, economic recession and the necessity for fiscal prudence, and the compounded problems facing a government newly emergent from a period of revolution and civil war – the Democratic Programme’s commendable aspirations never translated fully into practice.

The Free State government began the task of dismantling the country’s hated eighty-five-year-old poor law, and overhauling the inherited cumbersome and outmoded healthcare system. The poor law unions were abolished in 1923 and the boards of guardians two years later. Their functions were transferred to boards of health and public assistance, in effect sub-committees of the county councils that had been established a quarter of a century earlier. A number of workhouses were destroyed during the struggle for independence, and the remainder were either amalgamated or abolished and replaced by poor relief and medical services administered on a county basis. The intention was that each county should have a central county home to accommodate the aged and infirm poor and a county hospital, with a number of auxiliary district hospitals, to cater for the acutely ill. The county infirmaries, which had come under the control of the county councils in 1898, were subsumed into this system. By the mid-1920s, county homes, county hospitals, district

²³ Marie Coleman, *The Irish sweep. A history of the Irish hospitals sweepstake, 1930-87* (Dublin: University College Dublin Press, 2009), pp. 4-22; Barrington, *Health, medicine & politics in Ireland*, pp. 108-10.

²⁴ John M. Synge, *In Wicklow and West Kerry* (Dublin and London: Maunsell & Roberts, 1921), p. 25. ²⁵ Dáil Éireann Debate, 21 January 1919, Vol. F, no. 1.

²⁵ Dáil Éireann Debate, 21 January 1919, Vol. F, no. 1.

hospitals, and fever hospitals had been, or were in the process of being, established throughout the twenty-six county state, many in former workhouses. These schemes initiated the process of separating the public medical services from the relief of the poor. Both services were administered locally by the county councils, and financed by a rate levied throughout the county.²⁶

The county and district hospitals provided medical treatment for the sick in their area, regardless of income, although they were primarily intended for the poor, broadly defined as individuals who were unable to provide by their own industry or other lawful means necessary medical or surgical treatment for themselves or their dependants. The publicly-funded local authority hospitals were legally obliged to give priority of admission to such people, and to treat them without charge.²⁷ Historically, voluntary hospitals accommodated and treated a similar constituency but their financial difficulties in the opening decades of the twentieth century, outlined above, made them increasingly dependent on fee-paying patients and by 1935 the proportion of patients treated without charge in the voluntary hospitals had fallen to 40 per cent,²⁸ an indication of the growing significance of fee income for this sector, and of potential healthcare costs for increasing numbers of individuals.

In the difficult economic climate of the 1920s and 1930s, with government expenditure cut wherever possible and a reluctance to add to the existing level of taxation, funding was the key issue for the reorganised public hospital system, as it was for the voluntary hospitals in Dublin, Cork and elsewhere. The latter institutions retained their prestige and autonomy into the twentieth century, but by the time of Irish independence depleted resources and financial uncertainties threatened their very existence. The National Maternity Hospital, Holles Street, Dublin, which was established in 1894, was the most exposed and vulnerable, but a uniquely Irish solution, the legalisation of sweepstakes on horse races to raise funds for this and other financially pressed hospitals, resolved the difficulty.²⁹

The Irish Hospitals Sweepstake began in 1930 and for the next half century proved to be the financial linchpin for the development of the country's local authority and voluntary hospital networks. The Public Hospitals Act, 1933 established a statutory body, the Hospitals Trust Board, to administer funds raised by sweepstakes on each year's principal horse races. The Act authorised the responsible government minister to apportion grants from the proceeds to local authority and voluntary hospitals alike. An additional body, the Hospitals Commission, advised the minister on the disbursement of funds, but he had considerable discretionary powers of his own.³⁰ The injection of sweepstake funds secured the future of the voluntary hospitals – although the consolidation and rationalisation of the sector proved elusive – and led to some improvements in the general hospital service, including the construction of an

²⁶ Barrington, *Health, medicine & politics in Ireland*, pp. 90-96, 111; Donnacha Seán Lucey, *The end of the Irish poor law? Welfare and healthcare reform in revolutionary and independent Ireland* (Manchester: Manchester University Press, 2015), pp. 152-61.

²⁷ Saorstát Éireann, *Report of the commission on the relief of the sick and destitute poor, including the insane poor* (Dublin: Stationery Office, 1927), pp. 13, 19; Public Assistance Act, 1939, 'An act to make further and better provision in relation to the relief of the poor and for that purpose to amend generally the law relating thereto, 8 August 1939, part 3, section 18(2).

²⁸ Barrington, *Health, medicine & politics in Ireland*, p. 119.

²⁹ Coleman, *The Irish sweep*, pp. 4-22; Barrington, *Health, medicine & politics in Ireland*, pp. 108-10.

³⁰ Coleman, *The Irish sweep*, pp. 52-63; Barrington, *Health, medicine & politics in Ireland*, pp. 117-18.

extensive network of county, district and fever hospitals throughout the country. Dispensaries were not included in the 1933 Act, and were thus debarred from sweepstake funding. These institutions were the Cinderella of the health services in the decades after independence, neglected, and in receipt of no more than the bare minimum in government funding to keep the system afloat.³¹

The sweepstake bonanza did little to assuage the prevailing dissatisfaction with the health services generally in the 1930s and early 1940s, especially among the middle classes whose needs and demands were not being met. The publication of the Beveridge report in Britain in late 1942, which proposed a radical plan for comprehensive social insurance and a universal health service³², and the subsequent British white paper *A National Health Service* stimulated public debate in Ireland, and prompted discussion among government officials, the medical profession, and the Catholic Church on improving the Irish healthcare system. The Catholic Church in Ireland claimed for itself a special competence and authoritative role in such matters as health, education and sexual morality, and assumed a right to dictate to government and to society generally on social and moral behaviour.

In October 1944, Dr John Dignan, Bishop of Clonfert, and chairman of the National Health Insurance Society, published a scathing critique of the state's social services, particularly those relating to health.³³ Dignan, whose approach was heavily influenced by Catholic social teaching and the Beveridge report, believed that access to medical care should be available to all by right, not by charity, and he advocated an insurance-based healthcare system under the aegis of the National Health Insurance Society as an alternative to the existing state-operated model. The bishop's radical proposals were both naïve and flawed, and the Fianna Fáil government rejected them unceremoniously.³⁴

In 1944 also, the medical profession put forward their own proposals, which, like Dignan's, contained a strong insurance element, but the plan was generally perceived as protecting professional interests rather than genuinely promoting those of their patients, and ameliorating the existing system.³⁵

In September 1944, the Department of Local Government and Public Health recruited Dr James Deeny, an energetic, idealistic and innovative general practitioner from County Tyrone, as its chief medical officer. Shortly after his appointment, Deeny chaired a departmental committee that was established to review the public medical services, to report on trends in other countries, to assess the plans put forward by Bishop Dignan and the medical profession, and to submit official proposals for reform. In their report, which was submitted in September

³¹ Barrington, *Health, medicine & politics in Ireland*, pp. 122-24, 134-36; Saorstát Éireann, *Report of the commission on the relief of the sick and destitute poor*, pp. 64-65.

³² William Beveridge, *Social insurance and allied services* (London, 1942).

³³ *Social security: outlines of a scheme of national health insurance* (Sligo: The Champion Publications, Ltd, 1945).

³⁴ J.H. Whyte, *Church and state in modern Ireland, 1923-1979* (Dublin: Gill and Macmillan, 1980), 2nd ed., pp. 101-06; Barrington, *Health, medicine & politics in Ireland*, pp. 143-52.

³⁵ Barrington, *Health, medicine & politics in Ireland*, pp. 152-55.

1945, the committee rejected Dignan's and the doctors' proposals as fundamentally and fatally flawed in practical terms, and offered a radical alternative, for which Deeny was responsible, in effect a free national health service for everyone who wished to use it. The committee proposed that the existing health services be integrated and extended and made universally available. The medical profession and the Catholic Church responded negatively to the scheme, but it was its scale and potential cost to the exchequer rather than the opposition of these interest groups that prompted the government eventually to reject it.³⁶

The committee's philosophy and influence were apparent in the government's white paper, *Outline of proposals for the improvement of the health services*, which was published in September 1947, and in the Health Act, 1947,³⁷ which provided, inter alia, a free medical service for mothers and children up to the age of sixteen, irrespective of income.³⁸ Five years later, in July 1952, Dr James Ryan, Minister for Health and Social Welfare in the minority Fianna Fáil government, proposed a major extension of entitlement to free hospital services. At the time, about two-thirds of hospital patients were obliged to pay their full treatment costs from their own resources. Hospital charges had risen rapidly in the years after World War II and many patients found it increasingly difficult to meet them. In these circumstances, Ryan proposed to extend eligibility to free or heavily subsidised hospital care to all but the top-earning 15 per cent of Irish society, on the principle that the state had a responsibility for those who could not afford to pay. Adroitly, the Minister for Health and the government dismissed the self-serving objections of the medical profession and the Catholic hierarchy, and their proposals became law in October 1953.³⁹

Previously, a person had to apply to the local authority for a ticket every time he or his dependants sought free medical care at a dispensary, a legacy and a reminder of the old poor law system. Under the Health Act, 1953, individuals who satisfied a means test, who could demonstrate their inability to pay for medical treatment, were registered by the local health authority and issued with a medical card, which had to be renewed annually, and which entitled the possessor to outpatient care by the district medical officer – formerly the dispensary doctor – to medicines and appliances, and to general hospital and specialist services, all without charge. About 30 per cent of the population were on the medical register. The 1953 Act extended entitlement to free or subsidised hospital care to non-medical card holders, to the middle income group who constituted about 55 per cent of the population, comprising individuals who were insured for social welfare, persons whose family income was less than £800 a year, farmers whose holdings did not exceed £50 rateable valuation, and anyone else for whom the provision of such services from their own resources would cause 'undue hardship'. The remainder of the population, the higher income group,

³⁶ Ibid., pp. 155-61; James Deeny, *To cure and to care. Memoirs of a chief medical officer* (DunLaoghaire: Glendale Press, 1989), pp. 104-14.

³⁷ 'An act to make further and better provision in relation to the health of the people and to provide for the making of regulations by virtue of which certain charges may be made', 13 August 1947.

³⁸ Barrington, *Health, medicine & politics in Ireland*, pp. 175-94.

³⁹ 'An act to amend and extend the Health Act, 1947, and certain other enactments', 29 October 1953; Barrington, *Health, medicine & politics in Ireland*, pp. 226-44.

remained personally responsible for their own health costs.⁴⁰

Private health insurance was historically an insignificant feature of the Irish healthcare system. Friendly or benefit societies and certain types of employment offered some coverage, but the numbers involved were relatively small, perhaps no more than 50,000 individuals at any given time.⁴¹ The exclusion of the affluent from the benefits of the 1953 Act resurrected the question of voluntary health insurance as a mechanism by which those who were ineligible for the free public services could meet the high and unforeseeable costs of ill-health. In January 1955, T.F. O’Higgins, Minister for Health, appointed a committee to investigate the feasibility of introducing a scheme whereby individuals could insure themselves and their dependants against the cost of hospital, specialist, maternity and dental care, medicines and appliances. The advisory body reported in May 1956 that such a scheme was practicable for the upper income group and for those on middle incomes who wished to opt for private care, and estimated a client base of 500,000. They recommended the establishment of a not-for-profit state-owned statutory organisation to operate the scheme. The essence of their report translated into law as the Voluntary Health Insurance Act, 1957.⁴²

From October 1957, the Voluntary Health Insurance Board (VHI) offered a number of schemes (‘plans’) that provided different levels of cover depending on premiums, with greater flexibility, choice, and range of services evolving gradually. The VHI was established on community rather than risk rating, the principle that all members paid the same annual subscription irrespective of age, and it offered lifetime cover. Membership grew rapidly, from 23,238 at the end of February 1958 to 645,165 twenty years later, and by the early 1990s about one-in-three Irish people were policy holders, mainly drawn from middle income groups.⁴³ In 2002 nearly half of the population was covered.⁴⁴ By then, the private health insurance market in Ireland was open to competition and the VHI had lost its near monopoly.⁴⁵ The imperative that prompted individuals to take out private cover was no longer a lack of entitlement to public hospital services – there had been universal eligibility since 1979 – but a desire for more choice over the timing and location of treatment, coupled with mounting concerns over the quality of the public system, especially in relation to waiting times.⁴⁶

⁴⁰ Government of Ireland, *The health services and their further development: laid by the government before each house of the Oireachtas* (Dublin: Stationery Office, 1966), pp. 12-15.

⁴¹ Houses of the Oireachtas. 1994. Houses of the Oireachtas seventh joint committee on commercial state sponsored bodies: first report: Voluntary Health Insurance Board. Dublin: Government of Ireland, <http://hdl.handle.net/10147/560484>, pp. 9-10.

⁴² Brendan Hensey, *The health services of Ireland* (Dublin: Institute of Public Administration, 1979), 3rd ed., pp. 107-109; Barrington, *Health, medicine & politics in Ireland*, pp. 246-47.

⁴³ Hensey, *The health services of Ireland*, p. 110; Houses of the Oireachtas seventh joint committee on commercial state sponsored bodies, pp. 2, 9-10, 14-15.

⁴⁴ Francesca Colombo and Nicole Tapay, ‘Private health insurance in Ireland: a case study’, OECD Health working paper number 10, p. 9, DELSA/ELSA/WD/HEA (2004) 1.

⁴⁵ Health Insurance Act, 1994 (30 June 1994).

⁴⁶ Houses of the Oireachtas seventh joint committee on commercial state sponsored bodies, pp. 17-19; Colombo and Tapay, ‘Private health insurance in Ireland’, pp. 9-10.

A 2004 OECD report on the private health insurance market in Ireland concluded:

Private health insurance plays a prominent role in Ireland. The health system is designed to offer comprehensive publicly funded health services to low-income groups, and universal public hospital coverage. Policies have encouraged the development of private health insurance, initially to finance hospital care for high-income groups, and, upon extension of public hospital coverage to the entire population, to provide all individuals with a private alternative to the public system, as well as a means of funding cost-sharing and services not covered by the public system. PHI has historically financed treatments of private patients within public hospitals, and, to a growing extent, in private hospitals.⁴⁷

The modernising health service that served the country in the late 1950s was infinitely superior to that of the preceding decades, and the main beneficiaries were the Irish people, for whom, according to medical historian Ruth Barrington, the extension of eligibility and the provision of publicly guaranteed insurance through the Voluntary Health Insurance Board had removed ‘the fear of crippling medical costs’, and ensured that the Irish people of the 1950s and later, unlike their predecessors, were unlikely to be pauperised as a result of serious illness. ‘It was an achievement about which politicians, health administrators, doctors, and even bishops, could be proud’, she concluded.⁴⁸

⁴⁷ Colombo and Tapay, ‘Private health insurance in Ireland’, p. 45.

⁴⁸ Barrington, *Health, medicine & politics in Ireland*, pp. 248-50.

Significant Developments in Irish Health Insurance and Healthcare since 1950

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In 1945, after considering the pros and cons, the Government made an active decision not to introduce a free national health service in contrast to the establishment of the NHS in the UK (Geary, Barrington).

The Health Amendment Act 1953 amended the 1947 Health Act and provided free or heavily subsidised hospital care to all but the top-earning 15% of the population. Before 1953, the majority of the population were obliged to pay most of the cost of their hospital treatment from their own resources. Nearly all hospitals received some level of Government subsidy, whether they were owned by Government bodies or private trusts, that is, “voluntary hospitals” (Geary, Barrington). There were a handful of smaller private hospitals that were not subsidised by the State in the 1950s, mainly run by the Bon Secours religious order of nuns.

Private health insurance was not generally available to the Irish population except for a small number of occupational based schemes, many of which only provided limited benefits. The ESB Medical Provident Fund was founded in 1955 and immediately became the most significant and comprehensive of such schemes, although it was restricted to ESB employees and their families.

The Voluntary Health Insurance Act 1957.

The new statutory body, the Voluntary Health Insurance Board, was intended to provide community rated health insurance for those on higher middle incomes who were obliged to pay for their care in public hospitals, and anyone else who wished to opt for private care in hospitals even if they were entitled to avail of free or greatly subsidised care. The health insurance could also be used in private hospitals that were not subsidised by the State. The estimated target client base was 500,000 (Geary, Barrington, Hensey). If it can be assumed that somewhat more than 50% take-up might eventually occur among the target client base, then the expected membership was approximately 10% of the then population of 2.9m.

It should be noted that the economic background was one of relative underdevelopment, weak economic growth and constrained public finances and this was reflected in the size of the Government budget for providing public healthcare and the subsidy for the provision of free and subsidised hospital treatment.

Effectively, the VHI was established as a state controlled statutory monopoly (except for a few small occupational funds) providing health insurance on a non-profit but unsubsidised basis. The state did not provide any cash grants to the VHI, although an initial loan was provided, which was later repaid. It was not legally an insurance company and was not required to provide any financial backing in its balance sheet for its insurance liabilities¹. Its legal requirement was to match its income with charges properly chargeable to its income taking one year with another. The Minister for Health could decide (if s/he wanted to) the benefits of health insurance schemes.

Subsequently, the State provided full income tax relief to subscribers on their VHI premiums.

1960s and 1970s economic growth

Due to economic reforms first introduced in 1958, economic growth improved in the 1960s and therefore average real disposable incomes. The number of people in the State that could be described as middle income increased significantly. (The global economic background was also very favourable). However, there was a continued high rate of emigration and the population barely grew despite a high birth rate and falling death rate.

Irish economic growth continued at a high rate in the 1970s relative to previous growth rates from 1922 to 1960, despite the global oil crisis of 1973. Accession to the EEC in 1973 led to a large increase in agricultural incomes due to the Common Agricultural Policy and this provided a very significant impetus to the economy because at the time approximately 16% of the workforce were employed in agriculture. Population growth occurred in the 1970s mainly because employment was growing and there was a lower rate of emigration than in the 1960s.

The number of insured people (subscribers plus family members on policies) grew rapidly. By 1970, VHI had 386,000 insured and by 1980, 843,000 insured. (White Paper) The population in 1980 was 3.4m.

By the mid-1970s, the VHI had three main hospital plans. Plan A provided cover for accommodation and consultant treatment for private patients in a bed in a “semi-private” ward in a public hospital (including voluntary public hospitals). Plan B provided cover for accommodation and consultant treatment for private patients in a bed in a private room in a public hospital and in a bed in a semi-private ward in a private hospital (whose operations were not funded by the State, e.g. Bon Secours). Plan C provided cover for accommodation in a private room in a private hospital. Other minor plans existed, for instance, Plan T.

¹ In 2015, the VHI established subsidiaries; one of which is VHI Insurance DAC and it is a regulated insurance company that underwrites VHI's health insurance policies.

The Health Act 1970 was a significant development in Irish healthcare. The most important provisions were;

- Eight regional health boards were established covering the whole State to administer and provide public healthcare, including regional and county hospitals. They replaced the arrangement under the Health Act 1947, where each local authority (city or county council) was also a health authority.
- The medical card system was simplified and expanded. Over one-quarter of the population became entitled to medical cards and this proportion increased significantly, especially during the early 1980s recession, to one-third.
- Legislative provisions were made for eligibility for public hospital services
- A two-tier framework of “eligibility” for public health services was introduced. “Full eligibility” entitled people to a medical card, of which the main benefits were free GP and prescription medications for the person and their dependants as well as treatment in public hospitals (including public voluntary hospitals). “Limited eligibility” only entitled people to free treatment in public hospitals, including maternity services and some public hospital outpatient services.
- “Full eligibility” was restricted to people (and their dependants) who were dependant on basic social welfare payments or whose incomes were not very much more than basic social welfare incomes. “Limited eligibility” was defined by reference to a definition of “insured persons” in the social welfare Act 1952, which meant employed people earning under a certain limit and unemployed people (and their dependants). Higher earners and most self-employed people and their families were excluded from the limited eligibility definition and were therefore only entitled to some minimal community health services.
- Comhairle na nOspidéal was established to rationalise and regulate the appointment of medical consultants and other medical staff to hospitals.

Public hospital developments

Given the relative underdevelopment of the country after independence and up to the 1970s, and also the decision in 1945 not to introduce a new comprehensive national health service, the necessary upgrading of the Irish public hospital system took place only gradually from the 1950s onwards but mostly from the 1970s through the 1990s. Outside of Dublin, major tertiary regional hospitals were established in the main west of Ireland cities, Limerick, Galway and Cork (new hospital opened in 1978) with bed capacities between 350 and 500. Elsewhere outside Dublin, approximately ten old County hospitals were upgraded and sometimes rebuilt as “General” Hospitals with a bed capacity of 150 to 200. In Dublin, there was a long drawn out process of closure and amalgamation of a plethora of old small out-dated hospitals. New hospitals were established in north Dublin (Beaumont, 1987), inner west Dublin (St James, early 1990s) and southwest Dublin (Tallaght 1998).

Universal entitlement to public hospital treatment came incrementally. In 1979, entitlement to public hospital accommodation became universal (including the top 15% of income earners). However, this did not include universal entitlement to consultant treatment in a public hospital. The VHI offered a relatively low cost Plan T that provided cover for private

consultant treatment in a public hospital but not cover for private accommodation in the same public hospital. (Such a Plan would not now be in compliance with the Health Insurance Acts.)

In 1991, entitlement to consultant treatment in public hospitals became universal. Treatment (including surgery) of patients can be delegated to junior doctors and registrars employed by the hospital at the discretion and under the supervision of the relevant consultant.

Private hospital developments

New private hospitals opened in the 1970s and 1980s, which did not provide free or subsidised hospital accommodation funded by the State. The first of these was St Vincent's Private Hospital in the 1970s, which was co-located with St. Vincent's (public) voluntary hospital in South Dublin city and where hospital consultants employed by the public hospital would provide private treatment to private patients in the exclusively private hospital. In 1975, the private maternity hospital, Mount Carmel, opened facilities that could provide orthopaedic surgery as well as its existing maternity services. (O'Morain).

Prior to the opening of St Vincent's Private, the main private hospitals in the State (that is, with no Government subsidy) were the five run by the Bon Secours religious order. While the separate maternity hospital in Cork is now closed, the remaining four are still operating in Cork, Galway, Kerry and north Dublin. Recently, the Group acquired the old Barrington's hospital in Limerick. The Cork hospital is Ireland's largest private hospital and also the location of the Group's headquarters. A major extension to that hospital is also under construction at present.

Substantial increases in total new private hospital capacity can have significant consequential effects on the health insurance market. Two major new private hospitals, the Blackrock Clinic and Mater Private² both opened in the mid-1980s. Both hospitals were publicised as having high-technology facilities and would provide a wide range of high level surgical treatments by well qualified consultants. The VHI agreed to pay higher amounts to these new hospitals compared to existing private hospitals for comparable periods of hospital stay and treatment and introduced two new more expensive plans, D and E, which offered full cover in those two private hospitals. None of their existing plans A, B, C provided full cover for these two new hospitals.

In 2002, a new tax relief was introduced specifically to encourage or aid the financing of new private hospitals and this led to a surge in new private hospital capacity between 2004 and 2009³, viz:

- The Galway Clinic, covered by private health insurance since 2004, 146 beds
- The Hermitage Medical Clinic, covered since 2007, 101 beds

² The Mater Private is close to but not co-located with the Mater public voluntary hospital; unlike St Vincent's private, which is physically and organisationally co-located with St Vincent's public voluntary hospital.

³ Sources: Insurance policy documents, www.galwayclinic.com, www.hermitageclinic.ie, www.waterfordchamber.com, www.beaconhospital.ie, www.sportsurgeryclinic.com

- The Whitfield Clinic, covered since 2007, 64 beds (inpatient and day patient)
- The Beacon Hospital, covered since 2008, “capacity for 214 beds”
- The Santry Sports Clinic, covered since 2008, 62 beds (inpatient and day patient)

From 2010, the total number of private hospital beds continued to increase⁴, viz;

- The Blackrock Clinic main extension opened in October 2010 increasing by 50 the inpatient bed capacity to 170 and providing for an expanded 30 bed day surgery unit, as well as a new A&E department.
- St Vincent’s Private Hospital moved to a new building, which opened in November 2010 with 236 in-patient beds (previously 164) and additionally, an expanded day case/day surgery facility with 54 beds (previously 36).
- Mater Private Cork opened in January 2013 with 75 beds with business from the old Shanakiel Private Hospital (44 beds) transferring to it.

Increased private hospital capacity can lead to increased utilisation of private hospital accommodation nationally by meeting previously unmet demand (including by providing services that were previously not available), meeting increasing demand (for example as a result of ageing) or through supplier led demand (a common feature of healthcare markets). It is likely that the substantial increase in private hospital capacity from 2004 to 2013 contributed to the significant rise in annual increases in total health insurance claims in the 2009 to 2012 period, which in turn led to significant increases in premiums. The rate of increase in total claims diminished noticeably in 2013.

Economic and public spending background since 1980

The changing economic and fiscal background is an important context for developments in the health service and for health insurance. After the 1970’s changes in eligibility for public hospital treatment, there was relatively little change in the formal structure and provision of public health services as regards the general public. However, there were substantial swings in the funding of the public healthcare system as a consequence of major shifts in the economy and in the public finances. There were two periods of relative cutbacks in the public health services; the first was in the mid to late 1980s and the second was during the economic and fiscal crisis of 2008 to 2013. There were substantial real increases in public healthcare spending from the late 1990s to 2007.

Apart from the short-term impact on public healthcare provision, there can be at least two longer lasting impacts from extended relative restrictions in public healthcare spending. Firstly, capital investment might be unduly constrained whether in buildings or expensive medical equipment. Secondly, waiting lists tend to rise substantially during these periods and remain elevated, even when the spending restrictions have ended, as has been the case in 2015 and 2016, for instance⁵.

⁴ Sources: www.svph.ie, www.blackrock-clinic.ie, www.materprivate.ie, www.irishexaminer.com

⁵ Turner, Brian “International Benchmarking of the Structure of Irish Healthcare”, HIA, 2018

The economy stagnated from 1980 to 1987 with practically no growth for various reasons including the second oil crisis in 1979. Unemployment rose sharply and net emigration also greatly increased. There was also a fiscal crisis with very high budget deficits, national debt and debt servicing costs. Until 1983, numbers with health insurance continued to rise partly because of the growth momentum from the late 1970s in the economy and society. Numbers then stagnated until 1987. The fiscal crisis led to cutbacks, or at least restrictions, on public healthcare spending during the 1983 to 1989 period.

The economic background improved substantially from the early 1990s onwards. The most useful measure of the economy is gross national disposable income in real terms. It grew by 10.6% per annum (p.a.) from 1995 to 2000 and 3.3% p.a. from 2000 to 2008. It fell sharply in 2009 and stagnated for the next few years before beginning to grow again in 2013.

The following table shows current public spending on healthcare according to the health accounts data series of the CSO.

	Current public spending Health €m	% Increase	Consumer Inflation
2000	4961		
2001	6122	23%	5%
2002	7168	17%	5%
2003	8035	12%	4%
2004	8903	11%	2%
2005	10265	15%	2%
2006	10817	5%	4%
2007	12191	13%	5%
2008	13557	11%	4%
2009	13748	1%	-4%
2010	13420	-2%	-1%
2011	13168	-2%	3%
2012	13425	2%	2%
2013	13096	-2%	1%
2014	13264	1%	0%
2015	13891	5%	0%
2016	14653	6%	0%

Government expenditure was allowed to grow significantly faster than inflation in the late 1990s and the rate of growth of spending accelerated further in the noughties up to the year of the major economic downturn in 2009 and the IMF/ECB bailout of the country in 2010. Public spending grew by 8.4% p.a. from 1995 to 2000 and by 11.2% p.a. from 2000 to 2008. Public spending in 2016 was still lower in nominal terms than it was in 2008 (ignoring the huge sums invested in Ireland's failed banks in 2010). The sharp economic downturn began in August 2008 but was not reflected in the correction in the public finances until 2009. Public spending on health was the biggest driver of government spending increases in the ten years before 2009. Similarly, public spending cutbacks in real terms from 2009 onwards were also

felt keenly in the health services (although by far the largest brunt of public spending cutbacks was borne by public servants in pay cuts, including all those employed in the public health services). There were also large reductions in payments to GPs (who are not public employees). The economy has been growing again since 2013 and public spending on health services has been rising again in real terms since 2015.

Capacity of the public hospital system

A particular feature of the 1980s and into the early 1990s was a significant incremental reduction in the number of beds in public hospitals, in contrast to the increase in private hospital beds in the 1980s and 2000s. In recent years, there has been little change in the number of public hospital beds. However, the growing and ageing population is leading to higher demand for acute hospital services.

The preferred healthcare policy choice in Ireland is to increase the provision of healthcare at primary care level and divert some portion of the possible future demand for acute hospital services towards primary care and outpatient care, ideally by earlier intervention to prevent acute illness developing in the first place. Another preferred policy choice that has been implemented to a great degree in the last fifteen years is to increase acute hospital admissions relative to the number of beds, mainly by a much greater use of day case procedures but also by reducing avoidably long lengths of stay in hospitals for patients.

In 2007, the HSE commissioned and subsequently published a report titled “Acute Hospital Bed Capacity Review”. It found that Ireland had 20% fewer acute hospital beds per capita relative to the OECD. However, the report also found that there was scope for improving the efficiency of Irish hospitals and much of the recommendations in the report have been implemented, including the preferred policy choices mentioned in the previous paragraph. It should also be noted that the average age of the Irish population in 2007 and today is younger than the OECD average, which would indicate that underlying demand for acute hospital services could be lower than the OECD average, all other things being equal.

Re-organisation of public hospitals in networks

In the last ten years, some rationalisation and re-organisation of public hospital activity between hospitals has been implemented. Early small scale examples were the Cavan/Monaghan area near the northern border and in southeast Dublin. Much more far-reaching re-organisations have been recently implemented in the South-west (especially Cork City and county) and the Mid-west. However, a few years ago, the Government failed to implement a proposed reorganisation in the South-east. Recently all the acute public hospitals in the country have been allocated to one of six hospital groups. A new National Childrens’ Hospital is under construction in Dublin to replace two old and outdated childrens’ hospitals.

Health Insurance Act 1994

The EU third non-life insurance directive of 1992 obliged Member States to make legal provision for the completion of the EU internal market in non-life insurance, including health insurance.

The 1994 Act formed part of Ireland's implementation of the Directive, although it went much further in health insurance than a minimal implementation. The Act opened the health insurance market in Ireland to competition but provided that competition was to be only on the basis of community rating and open enrolment. This was acceptable to the EU Commission and the EU Council of Ministers. VHI's premiums had always been community rated and were so at the time. Most of the existing small occupational health insurance schemes were immediately registered as "restricted membership undertakings" under the provisions of the Act. The Act provided for lifetime cover and Minimum Benefit Regulations. The Act also provided for a possible Risk Equalisation Scheme and for the establishment of a Health Insurance Authority. A definition of a "health insurance contract" was included for the purposes of the Act. There was a significant broadening of this definition in a 2001 amendment to the Act.

The 1994 Act has been amended many times. Since the introduction of risk equalisation payments in 2009, there have been annual amendments to the Act, partly because the fixed monetary credits payable to insurers for older people have needed to be changed each year.

Over time, the most significant changes to the Health Insurance Acts 1994 to 2017 have been the introduction of risk equalisation and lifetime community rating. The latter means that people who take out health insurance for the first time after the age of 35 might be charged an additional loading on their policy, depending on the circumstances. The risk equalisation system is discussed below.

The Act provided for the establishment of the Health Insurance Authority on 1 February 2001. It is a statutory body with responsibility to regulate the health insurance market under the Health Insurance Acts. The Principal Objective of the Act relates to supporting community rating. The Authority has a 5-person non-executive Board and a staff of 10. The Authority is funded entirely by a levy of 0.09% of health insurance premiums paid by the insurers. The Authority's functions include;

- enforcing compliance with the Health Insurance Acts,
- advising the Minister (and his officials) on health insurance matters and making annual recommendations to the Minister on risk equalisation credits and levy
- administering the risk equalisation scheme
- monitoring the operation of the Acts, the health insurance market and more generally health insurance issues
- increase awareness of the public of available health insurance services and their rights as consumers of health insurance.

Regulations (Statutory Instruments made by the Minister for Health under the provisions of the 1994 Act) were introduced under various sections of the 1994 Act, including;

- Open Enrolment Regulations that determined waiting periods
- Lifetime Cover Regulations
- Minimum Benefit Regulations

- A Regulation provided for a possible Risk Equalisation Scheme, but the Scheme was not introduced at the time.

In 1999, the Government published a White Paper on Private Health Insurance setting out the Government's policy objectives and proposals regarding the role of private health insurance in the overall healthcare system.

Developments in health insurance during the 1990s

In 1996, income tax relief on health insurance premiums was reduced from the marginal tax rate to the standard rate. (Today's income tax rates are 40% for the higher rate and 20% for the standard rate). In 2015, income tax relief on health insurance premiums was further restricted and was capped at €200 per annum. Therefore, insurers had to increase the net price to customers of policies above €800 per annum or suffer an effective reduction in revenue. For instance, on a policy with a net price of €1500 to the customer, the insurer would receive €175 less than before the tax relief change, unless it increased the price of the policy.

In 1997, BUPA, the UK mutual health insurer entered the Irish market. They introduced a suite of health insurance plans that broadly matched the VHI suite of plans but were sometimes cheaper. BUPA also competed strongly in the employee group scheme segment of the market. BUPA's market share rose steadily to 12% in 2001 and 20% in 2004. In late 2004, a start-up insurer, Vivas, entered the market. Against the background of a booming economy and a strongly rising total market, Vivas had a 6% market share by early 2008 and BUPA's successor in the market, Quinn Insurance, 22%.

Risk equalisation and the BUPA legal challenge

In 2003, the 1994 Act was amended to provide for a risk equalisation scheme. However, in both the years 2004 and 2005, the Minister decided to defer the introduction of risk equalisation payments.

The risk equalisation scheme was intended to partially offset the risk of relatively higher total claims that an insurer would probably experience if the total of adults that they insured were older than the market average, given that insurers are not allowed to vary their premiums according to the expected risk of claims from an insured individual (the rule of community rating of premiums). The scheme involved payments between health insurers depending on the age profile of their customers. Almost certainly, the state-owned VHI would have been a recipient of payments from the other insurers.

BUPA initiated a legal challenge to the introduction of risk equalisation payments and the High Court put a stay on the payment of risk equalisation payments pending its decision.

The Minister for Health and Children decided to introduce risk equalisation payments from January 2006. However, payments were suspended due to the on-going legal challenge. In November 2006, the High Court upheld the legality of the risk equalisation scheme.

In December 2006, BUPA announced that it was withdrawing from the Irish health insurance market citing the large payments that it would have to pay to the VHI under the risk equalisation scheme. It said that it would forthwith both refuse to accept new members or to renew existing members when annual policies expired. In 2007, Quinn Insurance Ltd, an Irish insurance company took over the Irish health insurance book of BUPA.

BUPA also appealed the High Court decision to the Supreme Court, which continued the suspension of risk equalisation payments. In August 2008, the Supreme Court overturned the High Court decision and decided that the risk equalisation scheme was illegal. Many legal issues were raised in the court proceedings. Ultimately, the Supreme Court ruled that the introduction of the RES was illegal because it was based on community rating across everyone with health insurance, which was not the more limited meaning of the definition of community rating in the Act. When the section concerning a risk equalisation scheme was inserted into the amended Act in 2003, the technical legal drafting of it was not properly aligned with the pre-existing sections of the Act and/or necessary changes were not made to those pre-existing sections. The Court did not make any rulings on the various other legal issues raised during the proceedings, including a number of important legal issues raised by BUPA.

In 2010, Quinn Insurance Ltd became insolvent after losing money in 2008 and 2009. A receiver to the company continued trading in the health insurance market.

In 2012, Laya healthcare, a startup Irish health insurance operation, took over the remaining book of Quinn Insurance Ltd (which was under public administration as an insolvent insurer). Laya's insurance underwriter is Elips Ltd, which is a subsidiary of Swiss Re. In 2017, Laya Healthcare Ltd was acquired by the large US insurance company AIG, although Elips Ltd continues to be the insurance underwriter for the health insurance policies. Laya Healthcare Ltd acts as a tied intermediary to Elips. The policies are branded "laya healthcare".

A de facto risk equalisation system introduced

In early 2009, a major amendment to the Health Insurance Acts was enacted that, *inter alia*, introduced an interim tax credit and levy scheme to function as a risk equalisation scheme with the following features;

- A special stamp duty on all health insurance policies
- The State would pay income tax credits directly to health insurers in respect of older customers
- The claims data received by the Health Insurance Authority (HIA) showed that health insurance claims were heavily weighted towards older customers, especially those over 65 years of age.
- The HIA would make annual recommendations to the Minister on the levels of credits and stamp duty.

The scheme differed in two significant legal respects from the previous risk equalisation scheme that was declared illegal by the Supreme Court. Firstly, payments were made to and

from the State rather than directly between health insurance companies. Secondly, the payments in both directions were effected on the basis to changes in tax law. Both of these differences made it more difficult to mount a successful legal challenge to the scheme compared to the previous scheme that the Supreme Court had determined illegal.

The Irish Government agreed with the EU Commission that the new scheme was a state aid under EU law but it was also accepted that it fulfilled the legal conditions as an allowable state aid because it was a “service of general economic interest” (SGEI) according to article 14 of the Treaty on the Functioning of the EU.

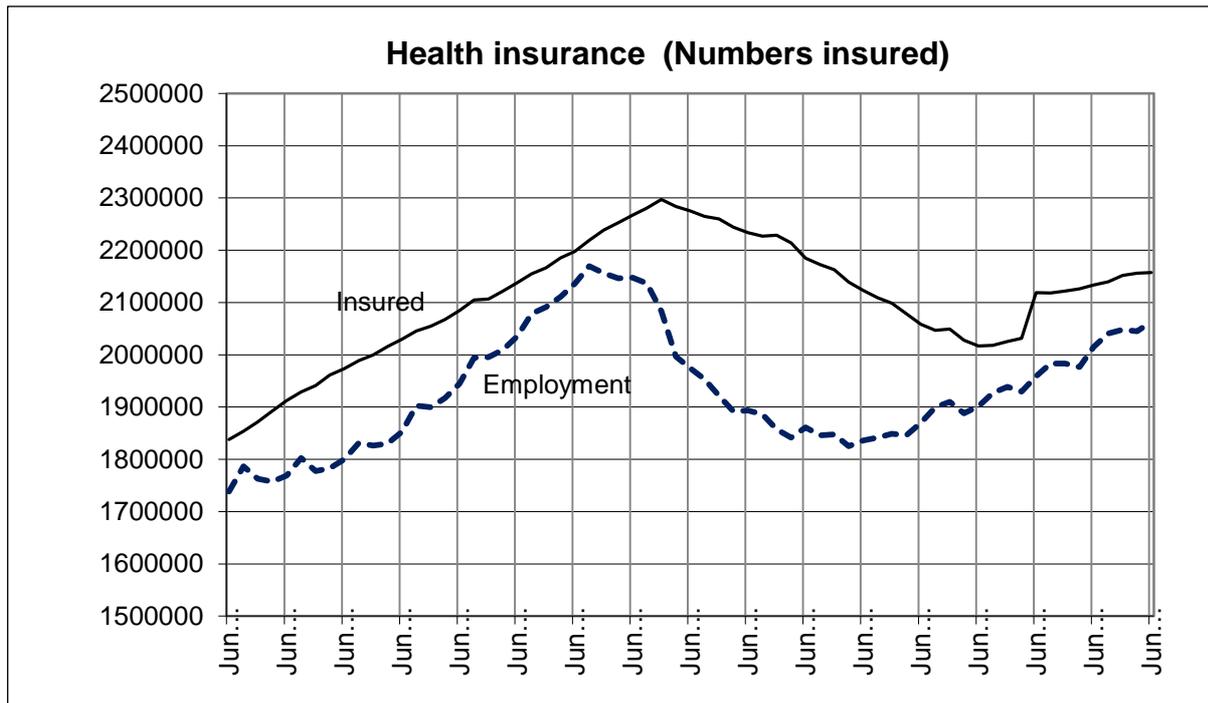
The scheme resulted in Quinn Insurance and Hibernian Insurance (an Aviva plc subsidiary that had acquired Vivas Health) receiving much less in total tax credits than they paid in levies on policies. Conversely, the Vhi received much more in tax credits than it paid in levies because the Vhi had a much larger proportion of older customers than its average market share. The EU Commission did not object to the scheme under the state aid rules.

In 2013, a revised risk equalisation scheme was introduced that continued the same structure of credits and payments as with the interim tax-based scheme. In EU Law, it is also a SGEI. A risk equalisation fund managed by the HIA was introduced, which is responsible for the payment of risk equalisation credits (which replaced the income tax credits of the interim scheme). In 2016, the EU Commission did not object to a new risk equalisation scheme with minor changes until the end of 2020.

The risk equalisation levy per insured person per year on all premiums (which funds the age and health status credits) was introduced in 2009 at a rate of €160. In 2017, it was €444 except for a reduced levy of €222 on 10% of insured persons who have relatively cheap policies classified as “non-advanced” with benefits confined mostly to private treatment in public hospitals. The levy on children’s policies is one-third of the adult levy.

Economic boom to bust to recovery – Numbers with health insurance

With the background of a rapidly growing economy, numbers with health insurance rose strongly and continuously every year from the mid-1990s to 2008. However, the economy went into deep recession in late 2008 and GNP fell by 10% in 2009. It continued falling until late 2012. Numbers with health insurance followed suit and began falling steeply early in 2009 and only returned to a rising trend in late 2014. Since then, numbers with health insurance have continued to rise steadily as a result of a growing economy and active marketing by the health insurers.



Health insurance plans

While there has been a significant degree of product innovation in the last ten years, the overwhelming proportion of claims by value continues to be for in-patient hospital treatment and accommodation. There has been a steady increase in the number of products, which got to well over three hundred by 2013. Two significant product developments in the last eight years are firstly, excesses and co-payments and, secondly, special high co-payments for knee and hip replacements and cataract removal. It is generally considered that the latter development is an attempt to dissuade older people from purchasing those particular products. Excesses are once-off payments of between €100 and €600 that an insured person has to pay when making a claim for private hospital treatment. Co-payments are part payments of the cost of the claim by the insured person, which can be structured as a percentage of the total or as a significant payment per private hospital claim. Excesses and co-payments are not allowed by law for private treatment in public hospitals.

In 2010, VHI introduced a major restructuring of its product portfolio, including a new product range, One Plan, that appeared to be targeted at younger adults. Many products are targeted at employee group schemes.

Recent developments

The composition of the health insurance market changed again in 2012 when a fourth open market competitor, GloHealth, entered the market as a new startup Irish health insurance operation. Irish Life had a large minority shareholding. The insurance underwriter was a subsidiary of Munich Re. Another change occurred in 2016 when Irish Life Assurance, a subsidiary of Canadian insurer, Great West, acquired Aviva Health Insurance (formerly Hibernian) and the balance of the shares in GloHealth and merged their operations with the approval of the Competition and Consumer Protection Commission. This left three main

health insurance companies in 2017 offering insurance to all Irish residents. There are also three main restricted membership undertakings who together account for 4% of the health insurance market.

In 2014, the Government restructured charges for private patients in public hospitals, which resulted in total additional claims costs for health insurers of between €100m and €200m. Previously, patients requesting treatment privately were only charged for a private bed (up to €1,000 per day) if they occupied a designated private bed. Under the new rules, any patient who requests private treatment is charged a private bed rate (usually €813), wherever in the hospital they are accommodated. They must also pay the supervising consultant privately if the consultant has a contract that entitles him or her to practise privately in the hospital. However, the charge in A&E is a one-time charge of €100.

In 2015, “Lifetime Community Rating” in Irish health insurance was introduced. People now have to pay proportionate additional loadings on their health insurance policies depending on how much older than 34 they are when they purchase health insurance for the first time, if they did not have health insurance in May 2015. There are various exceptions in the rules.

Further Information

The following is a link to the HIA website with a summary of the current risk equalisation scheme and developments regarding risk equalisation in the last ten years.

<https://www.hia.ie/sites/default/files/Health%20Insurance%20Levy-RE%20May%202017.pdf>

The following is a link on the HIA website outlining most of the primary and secondary elements of Irish health insurance legislation. See also www.irishstatutebook.ie. (There is no legal consolidation of the Health Insurance Acts 1994 to 2016, although privately compiled ones exist.)

<https://www.hia.ie/regulation/private-health-insurance-legislation>

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Part II

Irish Healthcare: A Comparative Analysis

International Benchmarking of the Structure of Irish Healthcare

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Foreword from the Author

The Irish healthcare system has developed over decades into the system that we know today, with a mixture of public and private funding and provision. While this is not unusual in an international context, what is unusual is the degree of overlap between the public and private elements of the system.

This mixed system has come into sharp focus with the publication in 2017 of the Sláintecare report by the Oireachtas Committee on the Future of Healthcare. One of the key recommendations contained in that report is a greater separation of the public and private elements of the system.

This benchmarking exercise is designed to put the Irish healthcare system in an international context, by comparing and contrasting it with four other healthcare systems – the UK, Australia, Germany and Belgium. The first two of these systems are, like Ireland's, primarily taxation-based, or Beveridge type systems, while the German and Belgian systems rely largely on social health insurance, the Bismarck model.

There are numerous differences and also similarities between the five systems, both in terms of the public elements of the system and also the private health insurance markets in the various countries, and their interactions with the statutory systems alongside which they operate and with which they interact.

The individual country sections are designed to give an overview of the health systems in each of the chosen countries, while the discussion section highlights some comparisons and contrasts, as well as placing some of these comparisons in the context of the Sláintecare report.

Brian Turner
September 2018

SECTION I – IRELAND

Healthcare Funding in Ireland

The funding of Ireland's health care system comes primarily from Government sources, with significant contributions from out-of-pocket payments and private health insurance. Figures for 2016 show that 72% of current healthcare spending came from Government Schemes, 13% from Household Out-of-Pocket Payments and 12% from Voluntary Health Insurance Schemes.¹ The remainder (3%) came from Other Voluntary Care Payment Schemes, which includes non-profit institutions and employer-provided healthcare (CSO, 2018).

The relative proportions of funding coming from these sources changed significantly during the recent economic crisis, with the proportion of funding coming from private (non-Government) sources rising from 21% in 2008 to 31% in 2014, which is one of the highest ratios of private funding in the EU-15². This has raised concerns over equity of funding, as private sources of funding tend to be regressive, while public sources tend to be progressive (Turner, 2016).

In an international context, current health expenditure in Ireland represented 7.8% of GDP in 2016, the lowest of the five countries being examined in this report. Of the other countries, Germany spent 11.3% of GDP in 2016, Belgium 10.4%, the UK 9.7% and Australia 9.6% (OECD, 2017a).

However, care should be taken in interpreting these findings, as a sharp increase in GDP in Ireland in 2015 led to a reduction in the health spending to GDP ratio.³ Furthermore, some have questioned the appropriateness of using GDP in an Irish context, suggesting instead that GNP or GNI should be used as the denominator.

Another alternative would be to use health spending per capita, adjusted for currency fluctuations and relative purchasing power. On this measure, current health expenditure in Ireland in 2016 was US\$5,528 on a Purchasing Power Parity (PPP) basis. This is lower than in Germany (\$5,551) but higher than in Belgium (\$4,840), Australia (\$4,708) and the UK (\$4,193) (OECD, 2017a).

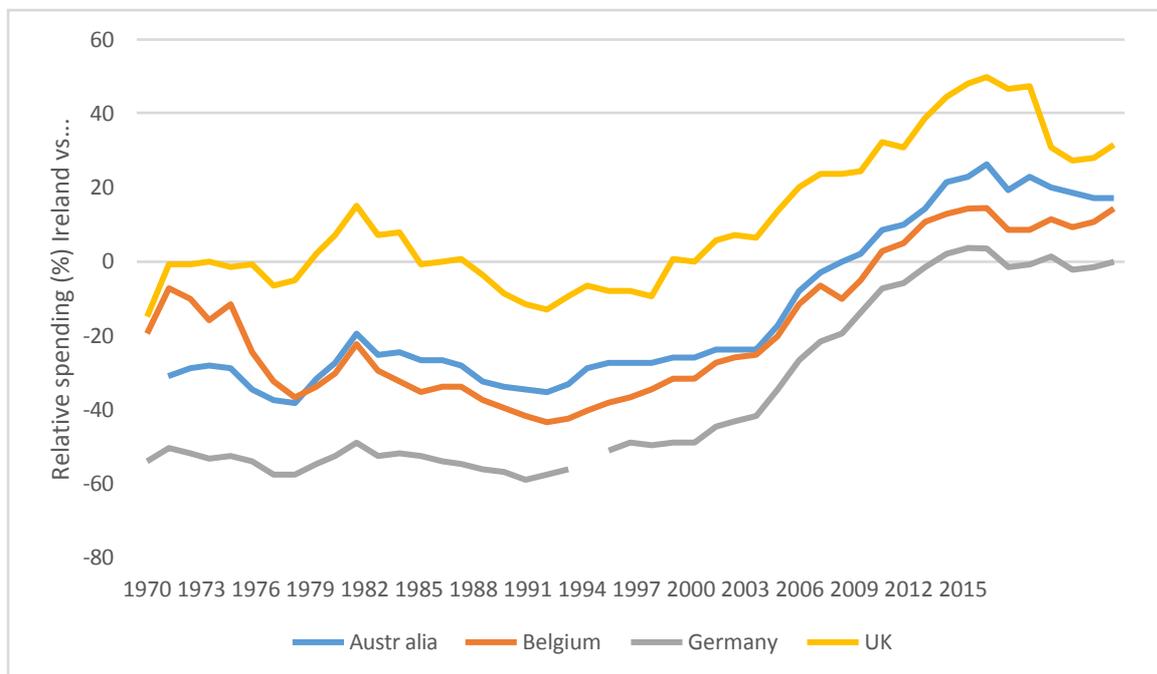
¹ Out-of-pocket payments include direct user charges (e.g. GP consultation charges) and cost-sharing (e.g. excess payments for voluntary health insurance, statutory bed charges in public hospitals). See CSO (2015a) for detailed definitions.

² Some of the newer EU member states have higher ratios of private spending as their public health systems are not as developed as those in many western European countries. The EU-15 consists of Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom. Of these countries, only Greece and Portugal had higher proportions of private health spending than Ireland in 2014, while Spain had a proportion that was only marginally lower than that in Ireland. The same pattern was seen in 2015.

³ The sharp rise in GDP (26% in 2015) was largely accounted for by relocations of entire corporate balance sheets to Ireland along with trade in aircraft by aircraft leasing companies based in Ireland.

However, these figures also need to be viewed in a historical context. Ireland’s health spending per capita compares well with these other countries in more recent years, but this follows relative under-spending for decades beforehand, particularly relative to Australia, Belgium and Germany (see Figure 1). Health expenditure per capita in Ireland only began to exceed the comparable figures in Australia and Belgium since the mid-2000s, while it has only been similar to that in Germany since the late-2000s. Ireland’s per capita spending followed a broadly similar pattern to that in the UK until the mid-1990s, since when Ireland has spent more on a per capita basis than the UK. However, the percentage of health expenditure coming from public sources is significantly higher in the UK – just under 80% in 2015 compared with just under 70% in Ireland in the same year (Eurostat, 2018).

Figure 1: Relative Health Spending per Capita (US\$ PPP), 1970-2016



Source: OECD, 2017a

However, one issue that should be taken into account is that Ireland has a relatively young population. In particular, a lower proportion of the Irish population is aged 65 and over compared with the other countries, while a higher proportion of the Irish population is aged under-15 than in the other countries (see Table 1). As age is a key determinant of medical expenses, Ireland’s relatively young population profile has implications for the relative spending versus countries with older population age profiles.

Table 1: Percentage of Population in Broad Age Categories by Country, 2016

Country	Under-15	15-64	65 and over
Australia	19.5	66.2	14.3
Belgium	17.0	64.8	18.2
Germany	13.2	65.7	21.1
Ireland	21.9	64.8	13.2
United Kingdom	17.7	64.3	17.9

Source: Eurostat (2017a), Australian Bureau of Statistics (2017)

In terms of healthcare resources, Ireland had 2.9 practising physicians per 1,000 population in 2015, compared with an OECD average of 3.5. The figures also show that 59% of doctors in Ireland were generalists, with 41% specialists. This compares with an OECD average of 30% generalists, 63% specialists and 7% not defined. However, it is noted by the OECD that in Ireland (and Portugal), most generalists are not GPs but rather non-specialist doctors working in hospitals or other settings. (OECD, 2017b)

The figures also show that Ireland had 11.9 practising nurses per 1,000 population in 2015, compared with an OECD average of 9.0. However, two factors are noted that increase the Irish figures. The first is that Ireland, along with a number of other countries, includes not just nurses providing direct care to patients but also those working in the health sector as managers, educators and researchers. The second is that, in Ireland (along with Australia and Spain), the figures include midwives. (OECD, 2017b)

In relation to hospital beds, the report shows that Ireland had 3.0 hospital beds per 1,000 population in 2015, compared with an OECD average of 4.7.⁴ It notes that the average number of beds per 1,000 population has fallen over the last decade and a half (from 5.6 in 2000 to 4.7 in 2015), partly as a result of advances in medical technology that has enabled the increased use of day care procedures, and partly due to public spending reductions in some countries. It also showed that Ireland had the highest bed occupancy rate for curative (acute) care beds of the 27 OECD countries for which that measure was reported, at 94.7%, compared with an average for the 27 countries of 75.7%. Israel and Canada were the only other countries with a rate above 90%. (OECD, 2017b)

Entitlements to Healthcare Services in Ireland

All residents of Ireland are effectively entitled to treatment in public hospitals, with those not in possession of a Medical Card (see below) required to pay a nominal daily charge up to a maximum of €800 in a continuous 12-month period. There is also a charge of €100 for treatment in an Accident & Emergency department for those without Medical Cards who are not referred by their GP.

⁴ This figure includes private hospital beds – see OECD (2018b) for definitions.

Entitlements to public healthcare services in Ireland are largely based on possession of a General Medical Services Card (commonly referred to as a GMS Card or a Medical Card). These are predominantly granted to those on low incomes. However, between 2001 and 2008, those aged 70 and over had automatic entitlements to Medical Cards irrespective of income, and since 2009 the income thresholds for this age group have been higher than for those aged under-70. A number of groups are exempt from means tests for Medical Cards, and in June 2017, children in receipt of the Domiciliary Care Allowance became eligible for them without means testing (Citizens Information, 2017).

Those who possess a Medical Card (Category I – approximately 36% of the population) receive free (at the point of use) inpatient, day case and outpatient care, and have a modest co-payment for prescription drugs (currently €2 per item up to a monthly limit of €20 per family).

Those who do not have a Medical Card (Category II – approximately 64% of the population) must pay out-of-pocket charges for medical services. These payments are a mixture of full charges (GP consultation fees), monthly deductibles (DPS threshold), and co-payments in the public hospital system (statutory bed charge, A&E charge without a GP referral). Some people in Category II are eligible for a GP Visit card (approximately 10% of the population), which confers them with free at the point of use GP visits, but not the other benefits of the Medical Card. The number of people with GP Visit cards has increased substantially in recent years as successive governments have expanded the entitlements to these cards. In 2014, these cards were given to those aged 70 and over who did not already possess a Medical Card, while in 2015, those aged under-6 who did not already have a Medical Card were given GP Visit cards.

One of the reasons for the increase in private funding, discussed above, is that the out-of-pocket payments have been increased in recent years, as detailed in Table 2. These increases stemmed from a contraction in Government spending on health, brought about by the economic crisis in Ireland, which led the Government to increase the reliance on cost-sharing for such services.

However, it should be noted that certain health expenses (see <http://www.revenue.ie/en/personal-tax-credits-reliefs-and-exemptions/health-and-age/health-expenses/index.aspx> for details) qualify for tax relief at the standard rate of income tax (currently 20%) and a limited range of dental and ophthalmic services are covered under the PRSI (Pay Related Social Insurance) scheme.

The Sláintecare report stated, “In Ireland, there are virtually no universal entitlements to healthcare, only ‘eligibility’ for some services as specified in the 1970 Health Act.” (Houses of the Oireachtas, 2017: 43). This is a relatively unusual situation internationally. The Maternity and Infant Care Scheme, under which maternity care and infant care for the first six weeks of life are free for all mothers and babies, is a rare exception, as are vaccinations and screening services (Houses of the Oireachtas, 2017).

Table 2: Out-of-pocket Payments for Healthcare Services in Ireland

Year ^a	Prescription Charges (per item) and monthly limit (per family)	DPS Threshold (per month)	A&E Charge (without GP referral)	Statutory Bed Charge (per night/day) ^b
2007	N/A	€85	€60	€60
2008	N/A	€90	€66	€66
2009	N/A	€100	€100	€75
2010	€0.50 (€10)	€120	€100	€75
2011	€0.50 (€10)	€120	€100	€75
2012	€0.50 (€10)	€132	€100	€75
2013	€1.50 (€19.50)	€144	€100	€75
2014	€2.50 (€25)	€144	€100	€75
2015	€2.50 (€25)	€144	€100	€75
2016	€2.50 (€25)	€144	€100	€75
2017	€2.50 (€25) Reduced for over-70s to €2.00 (€20)	€144	€100	€80
2018	€2.00 (€20)	€134	€100	€80

^a: Figures relate to year-end, except for 2018, which is current at time of writing

^b: Subject to a maximum of 10 x statutory charge in a continuous 12-month period

Healthcare services in Ireland are delivered by a mixture of public and private providers. The Health Service Executive (HSE) is the body responsible for the provision of public health services in hospitals and community settings. In addition, the HSE funds a number of voluntary hospitals, which are independently managed but provide public hospital treatment. There are also a number of private hospitals and clinics across the country.

Almost all GPs in Ireland are independent practitioners, either self-employed or part of a group practice. Most GPs treat a mixture of public (medical card holders and GP visit card holders) and private patients and are paid on a capitation basis for public patients but a fee-for-service basis for private patients.

Private Health Insurance in Ireland

Alongside the public healthcare system, Ireland has a voluntary private health insurance market. This is primarily supplementary in nature, with some complementary cover.⁵ The supplementary element of private health insurance in Ireland provides cover for hospital services, while the complementary element provides partial reimbursement of fees for day-

⁵ Private health insurance can be categorised as supplementary, complementary or substitutive. Supplementary health insurance typically confers faster access, superior accommodation and/or greater choice of providers. Complementary health insurance can cover services not covered by the statutory healthcare system or it may provide reimbursement for statutory user charges. Substitutive cover provides benefits for those who are not eligible for statutory healthcare or who opt out of statutory healthcare. For a more detailed discussion of this categorisation, see Mossialos & Thomson (2009).

to-day medical expenses including, *inter alia*, visits to GPs, physiotherapists, opticians, dentists and alternative practitioners, as well as A&E charges. The average premium paid per insured person in 2015 was €1,177 (HIA, 2017).

Claims for hospital treatment are usually settled directly between insurers and hospitals and consultants, with little balanced billing of those insured. The vast majority of consultants have fully-participating agreements with insurers, under which they accept the insurers' payments as full payments for their services, although a relatively small number do not have such agreements in place and can therefore balance bill. Increasingly, in recent years, more plans available in the market involve excesses for treatment in private hospitals (usually on a per-claim basis rather than a per-night basis), so there is an element of out-of-pocket payments for such episodes. For the day-to-day benefits, insured persons usually pay out-of-pocket for the services and then claim back the partial reimbursement afterwards.

The majority of claim payments by health insurers in Ireland are for hospital treatment. This is reflected in the SHA figures, which show that 78% of the funding coming from Voluntary Health Insurance Schemes is spent on Hospitals, while just under 5% is spent on Ambulatory Health Care Providers (which would include Medical and Dental Practices). This is in contrast to Government funding, which is spread more evenly, including 36% going to Hospitals, 20% to Long-Term Residential Facilities, a further 19% spent on Ambulatory Health Care Providers, and 14% to Retailers of Medical Goods (CSO, 2018).⁶

Looking at the expenditure on hospitals specifically, 71% of this came from Government funding in 2016, with 27% coming from voluntary health insurance providers. The remaining 3% came from out-of-pocket payments and charitable donations (CSO, 2018).

Related to this, figures from The Health Insurance Authority show that, in 2015, 32% of the benefits paid by insurers that feed into the risk equalisation scheme went to public hospitals, a further 47% was paid to private hospitals, with 20% being paid to consultants (HIA, 2016c).

The take-up rate of private health insurance in Ireland is currently just over 45% of the population (HIA, 2018). Although this is down from a peak of almost 51% at the end of 2008, it remains relatively high by international standards for supplementary health insurance. Among the key drivers of demand for private health insurance in Ireland are the perceived high costs of medical treatment and a lack of confidence in the standard of, and access to, public health services (HIA, 2016a).

The health insurance market in Ireland is heavily regulated, with premiums set on the basis of community rating, whereby premiums may not be varied by reference to the risk that a

⁶ The figures also show that around 1% of Government expenditure on health is spent on administration, compared with 13% of voluntary health insurance expenditure (CSO, 2018). However, the CSO notes that the Government figure only includes the direct costs of the CEO and National Directors' Offices of the HSE, along with the costs of the Department of Health, the Health Information and Quality Authority and the Health and Safety Authority). It does not include "any overhead expenses connected with the administration of functioning of health providers, including hospitals or other providers, which are to be included in the expenditures by service consumed." (CSO, 2015b)

consumer represents to an insurer, although exceptions are permitted for children (aged under-18), young adults (aged 18-25) and members of group schemes. Lifetime community rating was introduced on 1st May 2015 to replace the previous single-rate community rating system.

Other regulatory provisions include open enrolment (whereby insurers may not refuse to cover an applicant except in limited circumstances) and lifetime cover (whereby insurers may not refuse to renew cover except in limited circumstances). Maximum waiting periods are specified for initial post-application periods, pre-existing conditions and upgrades in cover. A prescribed set of minimum benefits must also be covered, although the regulations governing these have not been updated since 1996. A risk equalisation scheme has been in place since 2013 (following an interim scheme which was in place from 2009-2012), designed to “address differences in insurers’ claims costs that arise due to variations in the health status of their members.” (HIA, 2016b: 10)

Privately insured patients in Ireland may be treated in public or private hospitals. Up to 2013, a proportion (20%) of beds in public hospitals were designated private beds, which were mostly for use by private patients (however, private beds were sometimes used by public patients, such as in cases where private rooms were required for infection control). Bed charges for private beds were set by Regulations made by the Minister for Health, and these charges were increased substantially in recent years (Turner, 2015). Furthermore, many consultants working in the public hospital system in Ireland have contracts that permit them to treat private as well as public patients.

In 2009, a report from the Comptroller and Auditor General (C&AG, 2009) found that around half of private patients treated in public hospitals were accommodated in public or non-designated beds (such as in Intensive Care Units or Coronary Care Units). Therefore, while consultants were being paid for treating private patients, the hospitals were not receiving payment apart from the statutory bed charges.

A new charging structure for privately insured patients being accommodated in public hospitals came into effect on 1st January 2014. Since then, insurers are charged for the use of any bed in a public hospital by their members, with the charges differentiating between private rooms and multi-occupancy rooms, which would include semi-private rooms and wards (Turner, 2015).

As can be seen in Table 3, this led to a significant increase in the charges for what had previously been designated public or non-designated beds, although there were reductions in charges for private and semi-private rooms in the larger hospitals. Furthermore, there was a significant reduction in charges for insured patients accommodated on a day case basis in larger hospitals. This may have been an attempt to incentivise insurers to make greater use of this type of accommodation. Figures for 2016 show that, of private discharges from public hospitals, 55% were on a day case basis, compared with 64% of public patients (Healthcare Pricing Office, 2017).

Table 3: Bed Charges for Private Patients in Public Hospitals

Hospital Type	Private Room		Semi-Private Room*		Day Case		Public/Non-designated Bed	
	2013	2014	2013	2014	2013	2014	2013	2014
HSE Regional Hospitals and Voluntary and Joint Board Teaching Hospitals	1,046	1,000	933	813	753	407	75	813
HSE County Hospitals and Voluntary Non-Teaching Hospitals	819	800	730	659	586	329	75	659
HSE District Hospitals	260		222		193		75	

* Figures for 2014 refer to accommodation provided in a multi-occupancy room. In practice, this could be a semi-private room or a ward. *Source: Turner (2015)*

This new charging structure has led to a significant increase in the income accruing to public hospitals from private patient charges, from €239.187m in 2013 to €334,936 in 2016 – an increase of 40% increase over three years (HSE, 2015, 2017). It should be noted however that these figures do not include voluntary hospitals. If these hospitals are included the figures show an increase from €467m in 2013 to €626m in 2016, a 34% increase. Figures from The Health Insurance Authority show that insurers paid €594m to public hospitals (excluding consultant payments) in 2015, compared with €464m in 2014, an increase of 28%. Furthermore, in 2015, payments to public hospitals represented 32% of payment from insurers, compared with 28% in 2014 (HIA, 2015, 2016c). Interestingly however, this increase has more recently been reversed, with as yet unpublished data from The Health Insurance Authority showing that, in 2017, 29% of claim payments went to public hospitals.⁷

Another change relating to private health insurance was the capping of tax relief on premiums, which came into effect in October 2013 (Turner, 2015). Prior to this, insured persons were granted tax relief (at source since 2001) on their premiums, irrespective of the amount of premium paid. Relief was granted at the standard rate of income tax, having previously been available at the marginal rate until the mid-1990s. In 2013, the amount of premium on which tax relief was claimable was capped at €1,000 for an adult and €500 for a child. This had the effect of reducing the cost of this tax relief to the State, although the amount payable on this remains significantly higher than the cost of tax relief on medical expenses (to which all taxpayers are eligible).

Debate and Future Direction of the Irish Healthcare System

The Irish health system has been criticised for being a two-tier system, whereby private patients receive preferential treatment. However, the true picture is more nuanced than this,

⁷ By contrast, 50% of the claim payments in 2017 went to private hospitals, with the remaining 21% being paid to consultants (for treatment in public and private hospitals but excluding outpatient consultations).

with evidence of private patients receiving faster access to hospital treatment (CSO, 2002), but also evidence that those who must pay user charges to visit GPs (and could therefore be considered private patients for these services) put off visiting GPs on cost grounds (O'Reilly et al, 2007).

One of the key issues that leads to such criticism is the degree of overlap between the public and private funding and delivery of healthcare in Ireland. As Smith (2009) notes, some services are publicly funded and publicly delivered, some are publicly funded and privately delivered, some are privately funded and publicly delivered, and some are privately funded and privately delivered.

In 2016, the cross-party Oireachtas Committee on the Future of Healthcare was established, with a view to drawing up a 10-year plan for the Irish healthcare system to ensure universal healthcare based on need. The Committee published its report in May 2017 (Houses of the Oireachtas, 2017). Among the report's recommendations are the removal or reduction in a number of out-of-pocket charges for accessing healthcare services, the expansion of free-at-the-point-of-use GP care to all, and the removal of private practice from public hospitals.

As mentioned above, many privately insured patients are treated in public hospitals, and many public hospital consultants have contracts that permit them to undertake private practice. Figures from the Hospital Inpatient Enquiry (HIPE) system show that, in 2016, 19.5% of inpatient discharges and 14.6% of day patient discharges from participating public hospitals were of private patients (Healthcare Pricing Office, 2017).

The phasing out of private practice in public hospitals will therefore not be straightforward. The Oireachtas Committee on the Future of Healthcare estimates that the cost of this will be €649m per annum to replace the private income currently accruing to public hospitals (Houses of the Oireachtas, 2017). Furthermore, consultant contracts will need to be renegotiated for those public hospital consultants who currently have private practice rights in public hospitals under their existing contracts.

However, such negotiations may not be straightforward. Despite being able to choose public-only contracts, with higher salaries, a significant majority of consultants have opted for contracts that entitle them to private practice rights (in public hospitals and also off-site in some cases), which suggests that they perceive themselves to be better off on the latter contracts. Removing private practice from public hospitals will also force consultants to choose between public and private work, and the consequences of this are difficult to determine but have the potential to lead to significant movement of consultants.

If these recommendations are followed, then it will have the effect of restricting privately insured hospital treatment to private hospitals. This will reduce the choice of facilities that private health insurers can offer their customers, and will put additional pressure on the private hospital system, which currently treats only a proportion of private patients. For example, figures from 2010 show that 62% of adults with private health insurance who had

an inpatient stay in the previous 12 months were accommodated in public hospitals (CSO, 2011). However, if the public hospital system receives the investment that is proposed, this would likely lead to a reduction in the number of people with private health insurance as it would remove one of the main drivers of demand for such insurance.

Another possible impact of this proposed change could be a change in the waiting times for private patients. This would depend on the capacity of the private hospital system to deal with any increased demand resulting from the transfer of private patient treatment from public hospitals (notwithstanding any reduction in demand overall, as noted above). In this regard, it is worth noting that the Private Hospitals Association has repeatedly stated that it could provide significant assistance in reducing waiting lists for public patients if the State were to contract with its members (see, for example, <http://privatehospitals.ie/great-irish-waiting-list-paradox/>), which suggests that there is spare capacity in the private hospital sector at present.

Furthermore, if people with private health insurance are treated in public hospitals because the required services are not available in private hospitals (or if there is limited capacity within the private hospital system for such services), then their waiting times for these services may lengthen under the new proposals, as there would be a single waiting list for public hospital services. It is also unclear how the proposals will affect children and private maternity patients, as there are no private children's or maternity hospitals in Ireland.

The future of the private health insurance sector in Ireland is therefore somewhat uncertain. However, demand is likely to remain robust for a number of years, until such time as the implementation of the recommendations of the Oireachtas Committee becomes clearer.

SECTION II – UNITED KINGDOM

Healthcare Funding in the UK

The UK health system⁸ is a prime example of a primarily tax-funded model, the centre-piece of which is the National Health Service (NHS). The NHS was founded in 1948, following the recommendations of a 1942 report by economist William Beveridge, which has led to tax-funded health systems sometimes being referred to as Beveridge systems (for example, in Health Consumer Powerhouse, 2018).

The majority – 80% in 2015 – of funding comes from Government sources, with out-of-pocket payments accounting for 15% of funding and voluntary health insurance a further 3.4% (Eurostat, 2017b). The remaining 1.6% of healthcare expenditure was funded by non-profit institutions serving households (NPISH).

The UK government allocates money for healthcare in England directly, while it allocates block grants to Scotland, Wales and Northern Ireland, which decide their own policies for healthcare. While healthcare is provided by the NHS, social care is funded through local government and mostly privately provided (Cylus et al, 2015).

A purchaser-provider split was first introduced in 1990s and has been further refined since then. In England, NHS England, which receives funding from the Department of Health, distributes funding based on weighted capitation (based on age, input costs, social factors and measures of health status) to GP-led Clinical Commissioning Groups, as well as to specialist and primary care services (Cylus et al, 2015).

These CCGs commission hospital care (urgent and elective) as well as community health services, mental health services and other services, from public hospitals (run by NHS trusts and foundation trusts, which are semi-autonomous from the NHS and can earn up to 49% of their income from private sources) and community and mental health providers (including from the voluntary and private sectors). Most hospital care involves a payment-by-results system, which uses Diagnosis- Related Groups (DRGs) to determine payments based on national average costs. Pay for Performance links a small proportion of provider income to achieving targets (Cylus et al, 2015).

The NHS is seen as a national institution in the UK. However, like Ireland, the UK health system suffers from problems relating to accessibility, with the second lowest score – only Ireland scores lower – on this measure in the European Health Consumer Index 2017. However, it scores joint 8th out of 34 countries for Range and Reach of Services and joint

⁸ In recent years, there has been some divergence between the health systems of England, Wales, Scotland and Northern Ireland. However, for the purposes of this discussion, reference will be made to the UK system as a whole. Where relevant, specific differences within that will be highlighted.

second on Prevention (only Norway scores higher on this category). Overall, the UK is ranked 15th of the 34 countries in the index (Health Consumer Powerhouse, 2018).

Entitlements to Healthcare Services in the UK

There are broad entitlements to public health services in the UK, although these are not clearly defined (Foubister & Richardson, 2016). Some user charges are payable, such as for prescription medications (although these have been abolished in all but England in recent years), for which a co-payment of £8.20 per prescription is payable, although there are exemptions for children, those aged 65 and over, pregnant women, people with chronic illnesses and some lower-income groups (Foubister & Richardson, 2016). In 2015, almost 90% of prescription items were dispensed free of charge (Health and Social Care Information Centre, 2016).

User charges are also payable for ophthalmic care and most dental care. However, these charges still account for a relatively small proportion of the overall health budget, with the prescription and dental charges combined raising around £1.1bn, or less than 1% of the health service budget (King's Fund, 2014a). Patients' payments accounted for just 1.2% of NHS income in 2011 (King's Fund, 2014c).

In contrast to Ireland, GP visits in the UK do not incur fees at the point of use. However, waiting times for GP can be lengthy, with 2013 figures showing that only 52% of adults in the UK able to access a same day or next day appointment when sick (Mossialos et al, 2014). Concern has recently been expressed that increasing numbers of patients will be waiting a week or more to get an appointment with their GP, with the figure predicted to rise from 80 million occasions in 2016/17 to over 100 million occasions by 2022 (RCGP, 2017).

The NHS in England has set maximum waiting time targets for hospital treatment. For non-urgent, consultant-led treatment, the target is that 92% of patients should wait no more than 18 weeks from the date the appointment is booked, although this does not apply to maternity services or consultant-led mental health services. For urgent cancer referrals, the maximum waiting time target is two weeks (NHS Choices, 2017). However, this target has not been met since December 2015, although it has remained close to or above 90%. It has recently been relaxed for certain procedures in order to allow the NHS to focus on other priorities including A&E departments (Campbell, 2017).

Private and public healthcare have greater separation in the UK than in Ireland, although there remain some overlaps. For example, consultants working for the NHS provide most of the private consultant care, with approximately half of NHS consultants also carrying out private work (King's Fund, 2014b). However, NHS consultants carry out their private work in their own time.

There are relatively few consultants who work solely in private practice. Prior to 2003, consultants could only earn up to 10% of their NHS salary from private practice, however a

new contract signed in 2003 removed this cap (Cylus et al, 2015). NHS hospitals may offer private hospital services on NHS sites, and ‘amenity-beds’, whereby private patients may enjoy superior accommodation for which they pay an amount close to what they would pay in a private hospital, but the care they receive is still provided through the NHS (Cylus et al, 2015).

The overlaps also work in the opposite direction, with around a quarter of the income of private hospitals coming from the NHS, which purchases operations and procedures in private hospitals (King’s Fund, 2014b). This follows a more than quadrupling of spending on private facilities by NHS commissioners in England between 2002 and 2012 (Bíró & Hellowell, 2016), although the authors suggest that this use of private facilities has been facilitated by increases in public healthcare expenditure that are unlikely to be repeated in the future. Public patients are given a choice of which hospital they wish to be treated in, which may include private hospitals (Cylus et al, 2015).

Private Health Insurance in the UK

Private health insurance in the UK plays a primarily supplementary role, providing faster access, a choice of private provider (either in a private hospital or the private wing of an NHS hospital) and a specialist acting in a private capacity.

However, it also has some elements of complementary health insurance, sometimes covering benefits not covered under the NHS, such as complementary and alternative therapies. Restricted cover plans, which only cover specific conditions or specific types of care (such as high-cost cancer medicines or diagnostics) are also available. There is also a market for health insurance providing dental care, which has seen some growth in recent years as dental treatments available under the NHS have been scaled back (Foubister & Richardson, 2016).

In some respects, there are two sub-markets for private health insurance in the UK. The first is the corporate market, whereby health insurance is provided as a benefit by some employers, while the second is the individual market, where people voluntarily purchase health insurance themselves. The individual market only accounts for around a quarter of the total market (LaingBuisson, 2016). Corporate, self-insured schemes, known as Healthcare Trusts, are also included in market figures.

The overall take-up rate of private health insurance in the UK in 2015 was 10.6%, down from a peak of 12.4% prior to the recession. In total, there were just over 4 million policies in effect in 2015, covering 6.9 million people. Company paid policies accounted for 76.3% of the number insured, but just 61.6% of the premium paid (£2.903bn out of a total of £4.71bn). However, take-up rates differ geographically, with a higher take-up rate in England than in the other parts of the UK. The average premium paid per policy was £1,023 in the company-paid market and £1,909 in the individual market (LaingBuisson, 2016).

This partly reflects the older age profile of those insured in the individual market and the consequent higher risk that they represent to insurers. Figures from 2012/13 show that those in the individual market accounted for 18% of the number covered but nearly 40% of the claims paid to private hospitals and specialists (LaingBuisson, 2013, cited in King's Fund, 2014b). Premiums in the corporate market for private health insurance in the UK are primarily group rated, whereas premiums in the individual market tend to be risk-rated. Furthermore, full medical underwriting, whereby applicants are asked for details of their medical history, is common practice in the individual market (ABI, 2012).

Overall, the market is not heavily regulated, except from a prudential point of view. Tax relief on private health insurance premiums for the over-60s was introduced in 1990 in an effort to increase affordability for this age group and encourage them to take out private health insurance and ease the burden on the NHS (Foubister & Richardson, 2016). However, this tax relief was removed in 1997 and subsequent research suggested that the cost of the relief outweighed the benefits in terms of savings to the NHS, and that those who benefitted from the relief would likely have taken out private health insurance anyway (Emmerson et al, 2001).

In terms of benefits, private health insurance in the UK is less comprehensive than it is in Ireland. For example, few policies cover maternity or mental health benefits, while none provide cover for accidents and emergencies or GP services (Kings Fund, 2014b). Policies also have varying levels of co-payment and cover limits, while they may also vary in terms of restrictions on the choice of private hospitals in which members can be treated. Some policies only cover specific illnesses, such as cancer or cardiac care, while others only take effect when NHS waiting times exceed a particular length.

Pre-existing conditions are not covered, which is in contrast to Ireland where cover is available for such conditions after a (usually) five-year waiting period, while chronic conditions are usually not covered. Furthermore, in some cases, private health insurance may pay a cash benefit if an insured person opts to be treated under the NHS rather than having private treatment (ABI, 2012).

The health insurance market in the UK is quite highly concentrated, with the top four insurers between them accounting for 87% of the market. The largest two insurers, BUPA and AXA PPP Healthcare have 65% of the market between them, while the third and fourth largest insurers, Aviva Insurance and Vitality Health (formerly PruHealth) accounting for 11% and 10% of the market respectively. Of the top four, only BUPA is specifically a health insurer, while the remainder are divisions of insurers offering a wider range of insurance types (Foubister & Richardson, 2016).

Private health insurers in the UK pay service providers directly for services delivered, with set prices negotiated in advance. Policyholders may select a provider from the list of providers available under their plan. In some cases, consultants may balance bill patients, in cases

where their fees exceed the standard fees paid by the insurers. In some cases, pre-authorisation of care is necessary (Foubister & Richardson, 2016).

Debate and Future Direction of the UK Healthcare System

There has been some discussion in recent years about the sustainability of the NHS model. Some have suggested introducing charges for visiting a GP, on the basis that such charges would deter overuse of these services by those who do not have a genuine health need and that they would raise additional funds for the NHS.

However, the King's Fund cautions that, while charges might reduce the number of missed GP appointments (over 12 million per year) and deter other forms of overuse, it might also deter appropriate use, particularly from low-income groups. Furthermore, it argues that a £10 per visit charge would raise between £3.5bn and £4.5bn per annum, but that exemptions would need to be designed to ensure that those in low-income groups and those who are sicker would not face a financial barrier to accessing GP services, thereby reducing the amount, while administration costs of any such scheme would further reduce the net benefit (King's Fund, 2017).

Although the UK private health insurance market accounts for a considerably smaller proportion of UK healthcare expenditure than its Irish counterpart, similar debates and concerns have been expressed about the impact of private health insurance on the public health system. In particular, as some NHS doctors carry out private work, concern has been expressed that this private work detracts from their public work, leading to longer waiting times for public patients. Some research has suggested that longer waiting times lead to higher demand for private health insurance (Bíró & Hellowell, 2016), which may lead to self-reinforcing patterns.

Debate has also centred around equity issues, as those who can afford private health insurance are likely to be those on higher incomes and, if they receive faster access to care then this goes against the principles of the NHS (Foubister & Richardson, 2016). Concern has also been expressed about a potential future increase in demand for private health insurance if waiting lists lengthen as a result of constrained public healthcare budgets, and the potential for greater use of privately financed healthcare to erode support for the NHS and/or increase the political acceptability of alternatives, which may increase inequity in access to healthcare (Bíró & Hellowell, 2016).

However, it would appear that newer doctors are less likely to engage in private practice, with the British Medical Association reporting that fewer than 10% of new NHS consultants engage in private practice (King's Fund, 2014b). This finding has implications, not just for equity, but also for the future of the private health insurance market.

Another concern that has been expressed regards the change in the cap on the proportion of private income that NHS hospitals can earn. Under the Health and Social Care Act, 2012, this

was set at 49% of the total. Previously, the cap was set at the level the hospitals had reached in 2006, which averaged 2%, although some hospitals had higher rates. In the aftermath of the passing of this Act, private patient income increased sharply at a number of hospital trusts, although it remains relatively low at less than 1% across England (Watt, 2014).

SECTION III – AUSTRALIA

Healthcare Funding in Australia

The Australian health system is predominantly funded via taxation, but with significant contributions from private health insurance and out-of-pocket payments, much like the Irish system. Estimated figures suggest that, in 2016, 67.8% of funding came from public sources, with the remaining 32.2% coming from private sources. Further disaggregated data are only available for 2014, when the overall proportions coming from public and private sources were 67.4% and 32.6% respectively.

These figures show that, in 2014, 13.1% of funding came from voluntary health care payment schemes (with 9.6% coming from voluntary health insurance schemes – this is what would be considered private health insurance, with the corresponding figure in Ireland being 13%) and 19.6% from out-of-pocket payments (OECD, 2018a). This is similar to the Irish case, where a majority comes from public sources, with out-of-pocket payments accounting for a larger proportion of the private funding than private health insurance.

Of the public funding of healthcare in Australia, two-thirds comes from the federal government, with the remaining one-third coming from State, Territory and Local governments. The federal government has responsibility for setting national health policies and subsidising health services provided by State and Territory governments and the private sector. State and Territory governments deliver health services, provide community and public health services and regulate health professionals. Local governments provide environmental control (including health inspections) and provide home care and personal preventive services, such as breast cancer screening (Australian Government Department of Health, 2018).

In terms of healthcare resources, Australia has 3.5 practicing physicians per 1,000 population, close to the OECD average of 3.4 (and above the Irish figure of 2.9), and 11.5 practicing nurses per 1,000 population, above the OECD average of 9.0. It also has 3.8 hospital beds per 1,000 population, below the OECD average of 4.7 but above the Irish figure of 3.0 (OECD 2017b). It is estimated that primary care accounted for 38% of recurrent health spending in 2013-14, with hospital services accounting for a further 40%. The remaining 22% was spent on other services, which incorporate referred medical services, administration and research, and other health goods and services (AIHW, 2016).

In 2015-16, there were 1,331 hospitals in Australia, of which 701 were public and 630 were private. Public hospitals provided almost 61,000 beds, while private hospitals provided 33,100 beds. Around 91% of care in public hospitals and 33% of care in private hospitals was funded by governments.

Governments mainly fund emergency department and outpatient services, while inpatient services are often funded by a mixture of government and private sources. Half of hospitalisations were for public patients (this figure rose to 83% for public hospitals). Private health insurance was used to fund 42% of hospitalisations (this figure rose to 83% for private hospitals). Self-paying patients accounted for fewer than 1% of hospitalisations in public hospitals and 7% in private hospitals. Average lengths of stay were shorter in public hospitals than in private hospitals (AIHW, 2017).

Public hospitals are funded by a mixture of federal, State and Territory governments and managed by State and Territory governments, while private hospitals are owned and operated by the private sector but licensed and regulated by governments (AIHW, 2016).

Entitlements to Healthcare Services in Australia

Entitlements to healthcare services in Australia largely stem from Medicare, the universal public health insurance scheme established in 1984, which is funded through taxation (general taxation and a 2% Medicare levy) and which provides free or subsidised access to public hospital services and to treatment by health professionals. Medicare has three elements – hospital, medical and pharmaceutical. For hospital services, it provides free-at-the-point-of-use treatment as a public patient in a public hospital, but also covers 75% of the Medicare Benefits Schedule (MBS) fee for services and procedures for private patients in either public or private hospitals. MBS fees are set by the federal government, but practitioners may charge fees in excess of these fees, in which case patients must make up the shortfall (AIHW, 2016).

For non-hospital treatment, Medicare reimburses 100% of the MBS fee for a GP and 85% for a specialist, although again if the doctor charges more than the MBS fee, the patient must make up the gap. Medicare does not usually cover the costs of ambulance services, most dental examinations and treatment, most physiotherapy and allied health services, and glasses and contact lenses (AIHW, 2016).

Prescription drugs are largely subsidised under the Pharmaceutical Benefits Scheme (PBS). General patients pay a maximum of \$38.30, while those with a concession card pay a maximum of \$6.20. General patients have a maximum threshold of \$1,475 per annum, above which they pay the concessionary rate. Concession card patients face a maximum threshold of \$372, above which their drugs may be free for the remainder of the year. For drugs not listed on the PBS schedule, patients must pay the full cost, although these may in some cases be partly reimbursed by private health insurance (AIHW, 2016).

Public hospital doctors are salaried, although many services delivered in public hospitals are provided by doctors under fee-for-service arrangements. According to Cheng et al (2013), medical specialists in Australia can work in public practice only, private practice only or a mixture of both. If they combine both, in some cases their private work may be carried out in public hospitals and/or in private hospitals. However, they note that many public specialists

who have entitlements to treat private patients in public hospitals do not actually do so. Meanwhile, specialists working primarily in private practice (from their own consulting rooms or in private hospitals) may also work in public hospitals as Visiting Medical Officers on a contractual basis, usually reimbursed on a fee-for-service basis. In a sample of 2,246 specialists, they found that almost 33% work solely in the public sector, just over 19% work solely in the private sector, and 48% are in mixed public-private practice. Of those with mixed practice, 42% work mainly in public hospitals, 22% work mainly in private hospitals, and 36% work mainly in private consulting (non-hospital) practices (Cheng et al, 2013).

Australians are entitled to free hospital treatment as public patients, although even if they elect to be treated as private patients they are still heavily subsidised by the state, as highlighted above. Shmueli & Savage (2014) find that, while public and private patients treated in public hospitals do not have significant differences in outcomes of care, private patients tend to be treated more quickly. Furthermore, private patients, despite being healthier on average than public patients, tend to receive more procedures, which the authors speculate may be due to the fact that the hospitals and doctors earn more for treating additional private patients than additional public patients (Shmueli & Savage, 2014).

Private Health Insurance in Australia

Voluntary supplementary private health insurance (or duplicative insurance, as the OECD categorises it) is available to those in Australia, and can cover hospital treatment only, general treatment only (which provide benefits for ancillary services, such as physiotherapy, dental and optical treatment) or a combination of both. As at June 2017, 11.3 million people (46% of the population) were covered by hospital insurance (including those with combined cover), with a further 2.2 million covered by general treatment insurance only, bringing the overall penetration rate to 55% (APRA, 2017).

Hospital cover plans allow privately insured patients to choose to be treated in public or private hospitals, and they may also choose their doctor (unlike public patients, who do not get a choice of doctor). General treatment cover provides cover for services not covered under Medicare (and thus provides a complementary element of health insurance). Plans can also be purchased to cover prescription drugs not covered under the PBS, although these usually involve co-payments. In some cases, ambulance cover may also be available. Plans can be combined to provide cover for whatever benefits a policyholder wishes to cover.

Premiums for hospital based insurance are set on the basis of lifetime community rating (known as Lifetime Cover in Australia). The threshold age is 30, and a premium loading of 2% of the base premium is applied for each year above this that a person waits to take out private health insurance, subject to a maximum late entry loading of 70%. Premium loadings are only payable for 10 years, provided that continuous coverage is maintained. Policyholders may benefit from gaps in cover up to 1,094 days during their lifetime, to cover short gaps such as when they change insurer, suspension of membership (which must be agreed to by the insurer), and periods spent overseas (for at least one year). Migrants moving to Australia who are aged over 31 have one year from their date of Medicare registration to take out private health insurance without paying a late entry loading (Private Health Insurance Ombudsman, 2018).

For hospital plans, the government sets maximum waiting periods for cover, which are 12 months for pre-existing conditions and obstetrics, two months for psychiatric care, rehabilitation or palliative care (even for pre-existing conditions), and two months for all other care (Private Health Insurance Ombudsman, 2018).

Although there is a long history of health insurance in Australia, the establishment of Medibank in 1975 (renamed to Medicare in 1984), to provide universal healthcare had a major impact on the market for private health insurance. Take-up rates for private health insurance declined steadily during the 1990s, leading to concerns that the decline in private coverage would put undue strain on the public hospital system.

The then government reacted to these concerns by implementing a series of reforms designed to encourage take-up of private health insurance again. The first of these was the Private Health Insurance Incentives Scheme, whereby those on high incomes who did not take out private health insurance were subject to a levy, while a means-tested subsidy was available for low-income earners to purchase private health insurance. The second was a 30% rebate for all those who took out private health insurance, to replace the means-tested subsidy from the PHIIS. The third was the introduction of lifetime community rating (discussed above).

Currently, the levy is 1.0 -1.5% of income for a single taxpayer earning more than \$90,000 per annum and for families earning more than \$180,000 per annum (AIHW, 2016). In relation to the rebate, the rates now vary depending on age and income and it has been means-tested since 2012 (PHIAC, 2014). The rebate does not apply to any late entry loading payable under Lifetime Cover (Private Health Insurance Ombudsman, 2018).

There are currently 37 health insurance funds operating in Australia. Premium revenue for the industry in 2016-17 was just over \$23bn (\$16.6bn for hospital treatment and \$6.5bn for general treatment and ambulance). Funds paid benefits of \$19.6bn (\$14.7bn for hospital plans and \$4.9bn for general treatment and ambulance). The gross margin for the industry was 14.0%, while the net margin (after management expenses) was 5.2%. The largest insurer, BUPA, accounted for 27.7% of premium revenue and 27.6% of members, while the second largest, Medibank Private Limited, accounted for a further 26.5% of premium revenue and 26.3% of members. The third largest, the Hospitals Contribution Fund of Australia, accounted for 10.8% of premium revenue and 11.0% of members. The five largest insurers in the market accounted for just over 79% of premium revenue and almost 81% of members (APRA, 2017). Since 1st July 2015, private health insurers in Australia have been regulated from a prudential point of view by the Australian Prudential Regulation Authority (APRA), which assumed these responsibilities from the Private Health Insurance Administration Council (PHIAC). There is also a Private Health Insurance Ombudsman.

While the regulatory environment for private health insurance in Australia is very similar in many respects to that in Ireland, one significant difference is that in Australia, the Minister for Health and Ageing must approve applications by insurers to increase premiums. Prior to the passing of new legislation in 2007, the Minister had the discretion to disallow price increases, but the Private Health Insurance Act, 2007 made this subtle change.

Debate and Future Direction of the Australian Healthcare System

The Commonwealth Government in Australia has, in the past, been keen to promote the involvement of the private sector in healthcare provision. The government “considers that strong private sector involvement in health services provision and financing is essential to the viability of the Australian health system” (Department of Health and Aged Care, 2000: 2). This is similar to the Irish government’s attitude towards private provision and financing, as set out in the White Paper on Private Health Insurance in 1999 (Department of Health and Children, 1999).

More recently however, policy debates have emerged surrounding the public-private mix and its impact on equity in the Australian healthcare system. The argument that private health insurance contributes to a lessening of public waiting lists has been challenged, and it has been pointed out that public hospitals tend to treat patients with more severe diseases and most emergency cases. Furthermore, there has been some debate around whether the money that the government spends on the private health insurance rebate (estimated to be \$5.7bn in 2015-16 – see Cheng, 2018) would be better spent directly on public hospital services (Parliament of Australia, 2005).

Concerns have also been expressed about the extent of cover of private health insurance, particularly as many patients who are treated privately end up paying out-of-pocket payments towards their care. Indeed, it has been estimated that 20% of private care is paid for through out-of-pocket costs. There have also been proposals to expand the role of private health insurance, through extending it to cover primary care and also a suggestion that high-income individuals would be obliged to take out private health insurance for basic health services, as a substitute for Medicare (Russell, 2015).

Furthermore, ongoing premium increases have led to concerns about the implications of any fall in demand for private health insurance on the public healthcare system (Cheng, 2015). Numerous suggestions have been made for reform of the system, including having public and private insurance compete with each other, restricting the role of private health insurance to cover only top-up cover, and moving away from an insurance model altogether, allowing people to set aside private funds for purchasing healthcare (Boxall, 2015). Another option that has been put forward is to allow people to opt out of Medicare and rely entirely on private health insurance, essentially changing the nature of health insurance to substitutive cover (Paolucci, 2015).

In October 2017, the Government announced a series of reforms relating to private health insurance, designed to make it simpler and more affordable. The media statement regarding the reforms notes “Private health insurance is an essential and valuable part of the Australia’s [sic] health system.” (Australian Government Department of Health, 2017) This gives an indication of the current government’s attitude towards private health insurance.

The reforms include an additional (beyond lifetime community rating) incentive for younger adults to take out private health insurance. From 1st April 2019, insurers will be allowed to

offer discounts of up to 10% on hospital insurance premiums for those aged 18-29 (with the discounts reducing from age 26 onwards). These discounts would remain until the person turns 40, provided that they stay on the same plan. It is estimated that this measure will save the taxpayer AUS\$16m over four years in reduced payments under the private health insurance rebate.

Another element of the reforms is a simplification of plans, with insurers being required to categorise products as gold, silver, bronze or basic, and to use standardised definitions for treatments. Insurers will also be required to allow those whose hospital insurance does not offer full cover for mental health treatment the option to upgrade their cover to include mental health treatment without a waiting period on a once-off basis.

Furthermore, the maximum excess that consumers can choose will be increased for the first time since 2001. From 1st April 2019, insurers will be permitted to offer plans with a maximum excess of \$750 for singles (raised from \$500) and \$1,500 for couples/families (raised from \$1,000). The Government notes that over 80% of people with hospital cover already choose products with an excess.

The issue of private patients in public hospitals will be considered in the context of the National Health Agreement to be negotiated in 2018. The Government notes that the treatment of private patients in public hospitals has increased in recent years, partly driven by State and hospital-level policies to encourage patients to use private health insurance in order to increase hospital revenue, which echoes the situation in Ireland whereby income from private health insurers is seen as a valuable source of revenue for public hospitals.

SECTION IV – GERMANY

Healthcare Funding in Germany

The German health system is a prime example of a primarily social health insurance-based model. Indeed, Germany is where social health insurance was first used as a means of funding healthcare. In the late 19th century, workers began to come together to fund and purchase healthcare.

Employers, seeing the benefits of a healthy workforce, soon began to contribute as well. This system was particularly promoted by Chancellor Otto von Bismarck, and has become known as a Bismarck type health system (for example, in Health Consumer Powerhouse, 2018).

The social health insurance-based nature of the health system in Germany is reflected in the share of funding coming from compulsory contributory health insurance schemes and compulsory medical savings accounts, which accounted for 78% of funding in 2015 (Eurostat, 2017b). However, this figure includes not just social health insurance but also other sources of public funding such as statutory long-term care insurance (Busse & Blumel, 2014). Government schemes accounted for a further 6.6% of funding, out-of-pocket payments accounted for 12.5%, and voluntary health insurance accounted for 1.5% (Eurostat, 2017b).

The mixed funding mechanism is reflected in the funding sources for healthcare providers, with hospitals funded by a combination of sickness funds, private health insurers and out-of-pocket payments from those patients who self-pay. Sickness funds provide the majority of current funding, on a Diagnosis-Related Group (DRG) basis, although private patients also provide a small amount of income. Capital funding comes from the Länder (states), which pay for investments in public, private non-profit and private for-profit hospitals, provided that they are listed in the hospital requirement plans set by the Länder. Payment for primary care is based on predetermined price schemes (one for social health insurance and another for private services) for each profession. (Busse & Blumel, 2014)

Physician payments under the social health insurance scheme are based on a morbidity-adjusted capitation payment paid by the sickness funds to the regional physician associations, which are then distributed to members based on volume of services provided (with some adjustments), while payments for private services are made on a fee-for-service basis using a private fee scale, although some practitioners charge in excess of the scale. Physicians working in hospitals are normally paid on a salary basis, with public and non-profit providers paying public rates, while for-profit providers may pay different salary levels or additional payments. (Busse & Blumel, 2014).

In 2012, there were 2,017 hospitals in Germany providing just over half a million beds, of which 48% were in publicly-owned hospitals, 34% in private non-profit hospitals and 18% in

private for-profit hospitals. Social health insurance and private health insurance payers, as well as the two long-term care insurance schemes, use the same providers. A small number of private hospitals only admit those with private health insurance or who are willing to self-pay and do not treat patients with social health insurance (Busse & Blumel, 2014).

Entitlements to Healthcare Services in Germany

It is mandatory in Germany to have health insurance coverage, and less than 1% of the population is uninsured (Greß, 2016). Around 85% of the population is covered by the statutory social health insurance system, with a further 11% covered by substitutive private health insurance, while around 4% are covered by sector-specific government-run schemes, such as that for the military. Those who are covered by social health insurance have a free choice of sickness funds (of which there were 132 in early 2014) and receive a comprehensive benefits package (Busse & Blumel, 2014).

The statutory social health insurance scheme involves payments made by employers and employees based on a proportion (15.5% since 2009) of the employee's earnings, subject to an upper threshold level of monthly income (€4,050 in 2014).⁹ These contributions are collected by the sickness funds and transferred to a Central Reallocation Pool, which reallocates the resources to the sickness funds based on a morbidity-based risk adjustment mechanism. Any shortfall must be made up by the sickness funds charging a supplementary premium in the form of a flat fee, irrespective of the member's income; however, in early 2011 only 13 sickness funds imposed these additional charges. Prior to 2011, the additional charge (which is not subject to risk adjustment) was capped, with sickness funds having to ensure that it did not exceed 1% of the portion of the member's income subject to social health insurance contributions. (Busse & Blumel, 2014).

Sickness funds reimburse the treatment of members in primary care and hospital settings.¹⁰ Patients have free choice of a number of categories of primary care practitioners as well as emergency room services, but in the case of other services access to reimbursed services comes on the basis of a referral from a physician (Busse & Blumel, 2014).

It has been noted that Germany has traditionally had “the most restriction-free and consumer- oriented healthcare system in Europe, with patients allowed to seek almost any type of care they wish wherever they want it,” and the German system was ranked 7th out of 34 European health systems in the European Health Consumer Index in terms of consumer friendliness (Health Consumer Powerhouse, 2018).

However, other surveys have not been as positive, with Germany ranked 8th out of 11 countries in a Commonwealth Fund report in 2017. In keeping with the European Health Consumer Index, Germany scored well in terms of access (2nd out of the 11 countries), but

⁹ A relatively small amount (officially 5%, but this may be impacted by statistical definitions and it may actually be up to 10%) of the funding of sickness funds comes from taxation (Busse & Blumel, 2014).

¹⁰ However, a co-payment of €10 per day up to a maximum of €280 per annum is payable for hospital stays and inpatient rehabilitation after hospital stays (Busse & Blumel, 2014).

ranked 6th on equity and 8th on both care process and health care outcomes (Schneider et al, 2017).

Private Health Insurance in Germany

In contrast to the Irish and UK health insurance markets, which are for primarily supplementary health insurance, private health insurance in Germany primarily plays a substitutive role. Civil servants must obtain supplementary private health insurance cover (Busse & Blumel, 2014), while self-employed people and those earning above a threshold income (€50,850 per annum in 2012) and aged under 55 (the age rule came into effect in 2009) may opt to voluntarily take out substitutive private health insurance to provide their health cover instead of the statutory system. Since 2000, those aged over 55 who have substitutive private health insurance are not permitted to return to the statutory system. Those who opt to purchase substitutive cover tend to be healthier than average and with higher than average incomes (Greß, 2016).

Substitutive private health insurance is predominantly sold on an individual, rather than group, basis. Premiums are risk-rated and a portion of the premiums paid by younger subscribers is invested in order to fund health care at older ages. Policies usually cover inpatient and outpatient care and medicines, but often do not cover mental health care and some medical devices (Greß, 2016). A 2012 study showed that 80% of individual policies provide less coverage than the statutory scheme (Drabinski & Gorr, 2012).

Complementary voluntary health insurance is available to anyone in Germany, and mainly provides access to services not covered by the statutory system as well as cover for user charges for services not fully covered by the statutory system, such as dental services. Supplementary voluntary health insurance is also available, which gives holders access to treatment by the chief physician in hospitals or to private rooms in hospitals (Greß, 2016).

Both substitutive and complementary/supplementary private health insurance are offered by 42 private health insurers, members of the Association of Private Health Insurance Companies, although there are a further 30 smaller, often regional, private health insurers. The substitutive private health insurance market is over three times the size of the complementary/supplementary market in terms of premium income, with €25.9bn spent on the former and €7bn spent on the latter in 2012 (Busse & Blumel, 2014). Since 2004, statutory sickness funds can cooperate with private health insurers to offer complementary and supplementary voluntary health insurance to their own enrolees (Greß, 2016).

For substitutive cover, private health insurers must, by law, set aside savings for old age while their insured members are still young, and they must offer a policy with the same benefits as the statutory social health insurance scheme at a premium that is no higher than the average maximum contribution to social health insurance. Since 2000, those who have had private health insurance for at least 10 years and are aged at least 65 – or aged at least 55 with

income under the social health insurance threshold – may opt for this ‘standard tariff’ cover (Busse & Blumel, 2014).

Premiums for substitutive private health insurance are set with reference to age, gender and medical history at the time of underwriting, and separate premiums must be paid for spouses and children. As a result of this, private health insurance is particularly attractive for single people and double-income couples. Privately insured people are usually required to pay providers directly for their care and then get reimbursed by their insurer (Busse & Blumel, 2014).

Debate and Future Direction of the German Healthcare System

The concept of substitutive private health insurance is losing political support, both on the left and right of the political spectrum in Germany. Concerns are growing about the impact that substitutive cover is having on the statutory healthcare system, as those opting out of the latter tend to be healthier than those remaining, giving rise to an adverse selection problem against the statutory scheme, with consequent implications for the sustainability of the statutory social health insurance system (Greß, 2016).

Concerns are also growing about inequitable access to healthcare arising from the availability of substitutive cover (Greß, 2016). The differing remuneration mechanisms for physicians mean that they have a financial incentive to treat privately insured patients over those with social health insurance, and there is some evidence to suggest that privately insured patients tend to have longer consultation times with physicians, while there is also some evidence to suggest that patients with private health insurance have shorter waiting times for specialist physicians, though not necessarily for general practitioners (Busse & Blumel, 2014).

Premium increases (averaging 5.4% per annum from 2002 to 2010 inclusive) have also added to concerns about sustainability. These premium increases reflect faster annual growth of healthcare expenditure in substitutive voluntary health insurance than in the statutory healthcare scheme (4.8% versus 2.9% per annum over the same period). These developments have raised questions about the future of substitutive cover (Greß, 2016).

Despite having a generous benefit basket and one of the highest levels of capacity among European health systems, leading to good access (low waiting times), the German health system suffers from low levels of satisfaction, and there are concerns about inequities arising from the combination of social health insurance and private health insurance, with the separate pools that this entails (Busse & Blumel, 2014).

SECTION V – BELGIUM

Healthcare Funding in Belgium

Belgium's health system is predominantly publicly funded, with 78% of funding coming from public sources in 2014. Out-of-pocket payments accounted for 18%, with voluntary health insurance accounting for a further 4% (Gerken, 2016). The 2015 figures are broadly similar, although they show a higher proportion of public funding coming from government sources (18% compared with 11%) with a consequently lower proportion (59% compared with 66%) coming from compulsory insurance schemes, while the contribution coming from voluntary health insurance increased slightly to 5% (Eurostat, 2018). The Government subsidises the social security payments for the compulsory social health insurance scheme (Gerken & Merkur, 2010). However, it should be noted that Calcoen et al (2015) find that OECD estimates of private expenditure can be quite different from estimates of private expenditure gleaned using different data sources on billing information – while the overall figures are reasonably similar, the distribution of private spending is quite different in the alternative set of figures.

GPs are mostly independent, private practitioners and are also paid on a fee-for-service basis. Patients have free choice of GPs (Gerken & Merkur, 2010). There is a mixture of public and private hospitals in Belgium, and public hospitals must accept any patient. Around 70% of hospitals in Belgium are private not-for-profit hospitals and there is little integration between insurers and providers. Hospital specialists are mainly paid on a fee-for-service basis. Patients are free to choose their providers (specialists and hospitals) so insurers are reluctant to have selective provider networks (Gerken, 2016).

Reimbursement may be on a direct payment or third-party payment system. The former, which involves the patient paying for the service and then claiming back from the sickness fund for part of the cost, is prevalent for primary care services, while the latter, which involves the sickness fund paying the provider directly, is widely found at hospital level and for pharmaceuticals (Gerken & Merkur, 2010).

The compulsory social health insurance system is managed by the National Institute for Health and Disability Insurance (NIHDI-RIZIV-INAMI), which allocates a prospective budget to sickness funds. Since 1995, these sickness funds have been held accountable for 25% of the difference between their budget and their actual spending, for which 30% is determined according to a risk-adjustment mechanism. There are six private, not-for-profit, national associations of sickness funds, organised on religious or political grounds, and one public national association sickness fund, which is designed for people who do not want to affiliate with one of the other groups, although the latter only covers around 1% of the insured population. Most people have a free choice of sickness funds, except railway workers, who

are automatically covered by the Belgian railway company's sickness fund. Although people who have been insured for more than a year have an opportunity to switch sickness fund every quarter, switching rates are low, at around 1% per annum (Gerkens & Merkur, 2010).

For employed workers, there is an employee contribution (13.07% of gross income) and an employer contribution (24.77% of gross income without social contributions paid for annual holidays), while self-employed people pay a contribution based on their net professional labour income in a reference year. Health insurance is one of six areas of the social security system which are funded by citizens' income-related contributions. (Gerkens & Merkur, 2010)

Entitlements to Healthcare Services in Belgium

The statutory healthcare system in Belgium covers almost the entire population and provides a broad range of benefits. Major (including hospital care, delivery of babies, major surgery, implantable medical devices and specialist care) and minor risks (including physician visits, dental care, minor surgery, home care and pharmaceuticals for outpatient care) are both covered (Gerkens & Merkur, 2010).

Services covered by the statutory social health insurance scheme are listed in a fee schedule, which also details the fee and reimbursement rates for each listed service. Services not listed in the fee schedule are not reimbursable, and these would include alternative therapies such as acupuncture, homeopathy and osteopathy, although these may be partly reimbursed under complementary private health insurance. The fee schedule is negotiated annually or biennially between representatives of the sickness funds and representatives of the providers (Gerkens & Merkur, 2010).

User charges, payable as coinsurance, vary by service, with rates of 25% for GP consultations, 35% for GP home visits and 40% for specialist consultations, physiotherapy, speech therapy, podiatry and dietetics, although lower income households pay lower user charges (Gerkens, 2016).

Charges are also payable for hospital treatment. Specifically, patients must pay a co-payment per day in hospital, additional room and physician charges for a single room, the costs of some non-reimbursable medicines and medical products, and co-payments for medicines, laboratory tests, radiology and other interventions (Gerkens, 2016).

In some cases, GPs are the first point of contact with the health services, although for some specialities, there is no referral system between GPs and specialists, so patients can go directly to the specialists as the first point of contact.

Private Health Insurance in Belgium

Supplementary, complementary and substitutive health insurance have been available in Belgium at various stages, although substitutive cover was effectively abolished in 2008 when

publicly financed coverage was extended to the self-employed, while complementary cover has been mandatory for members of sickness funds since 2012 and is charged on a community rated basis. Members who do not want this complementary cover may leave their sickness fund and join a special sickness fund that does not provide this cover, but very few people choose to do this, so complementary cover is enjoyed by most of the population. Supplementary private health insurance mostly covers members for the extra cost of a private room in a hospital (Gerken, 2016).

Sickness funds, which provide the statutory cover, also sell supplementary voluntary health insurance, although since 2010 they must establish a separate legal entity, a mutual health insurance fund, to manage the voluntary health insurance and may only sell voluntary health insurance to their members. In 2010, there were 13 mutual health insurers, as well as a further 26 private health insurers (which can sell insurance to the population as a whole), although the four largest insurers had a combined market share of 75%, while the largest 15 insurers covered almost 98% of the market. Mutual health insurers specialise in health insurance, while private health insurers also provide a range of other insurance (Gerken, 2016).

Take-up of (supplementary) private health insurance for hospital cover is estimated at around 60%, many of whom are covered through their employer. Although private health insurers and mutual health insurers are supervised by separate regulators, they are subject to the same rules. They must offer insurance on the basis of lifetime cover and open enrolment, although private health insurers may exclude costs linked to pre-existing conditions for those under 65, while mutual health insurers may limit the cover to a flat rate with a minimum legally fixed level of cover for the same patients (Gerken, 2016). Since 2008, differential payments for voluntary health insurance by gender have been prohibited (Gerken & Merkur, 2010).

Debate and Future Direction of the Belgian Healthcare System

Following a complaint in 2010 by a private insurer to the European Commission about unfair competition due to differences in the treatment of private insurers and sickness funds, new legislation was brought in to specify that complementary health insurance plans sold by sickness funds must be mandatory for all members of the sickness fund, that complementary premiums must be community rated, and that the voluntary health insurance business of sickness funds must be separated out, with the newly-established mutual insurers to be subject to the same regulations as the private insurers (Gerken, 2016).

Some sickness funds have complained that they now face the same constraints as private insurers as well as specific constraints that the private insurers do not face. Examples of these specific constraints are that the sickness funds can only offer voluntary health insurance to their members rather than to the wider population, and that they can only offer insurance- and assistance-related health services and cannot sell other products. (Gerken, 2016)

This has led to some concern that the sickness funds will cease to offer voluntary health insurance, leading to a reduction in access to such insurance. Concern has also been expressed about risk selection and about preserving solidarity across income and health status (Gerken, 2016).

Concerns have also been expressed about equity in the Belgian health system, particularly relating to the relatively high proportion of out-of-pocket payments in the health financing mix. However, unlike in some other countries, hospital waiting lists are not a major issue in Belgium. There is also a worry that Belgium will encounter a GP shortage in years to come (Gerken & Merkur, 2010).

SECTION VI – DISCUSSION

Overall Comparisons

It is clear from the preceding analysis that the healthcare systems and voluntary health insurance markets in the five countries studied – Ireland, the UK, Australia, Germany and Belgium – vary considerably, although they also share some commonalities.

Some of the differences in the private health insurance markets stem from the design of the health systems in the different countries. In all cases, the health services are predominantly publicly funded, although Germany and Belgium are mostly funded through social health insurance, while Ireland, the UK and Australia are predominantly tax funded (see Table 4).

There are widespread entitlements to health services in the UK, Australia, Germany and Belgium, with varying degrees of cost sharing involved. However, entitlements to health services in Ireland are less well defined and depend in many cases on whether a patient has a medical card. This sets Ireland apart from the other countries in this comparison (see Table 4).

The nature of the private health insurance markets in the five countries also vary, with the primary function in Ireland, the UK and Australia being supplementary, while it is predominantly substitutive in Germany and a mixture of complementary and supplementary in Belgium. It is interesting to note that the first three countries have predominantly tax-funded public health systems, whereas Germany and Belgium have predominantly social health insurance-funded public systems.

There are also some differences between the systems examined here in terms of the overlap between public and private funding and delivery of healthcare. In Ireland, the UK and Australia, privately insured patients may be treated in private hospitals or in public hospitals, with differential payment mechanisms for practitioners depending on which type of patient they see, creating incentives to treat some patients over others. This overlap has been increasing in recent years in the UK, where it had previously been quite limited. In Germany and Belgium however, there is more of a contractual relationship, with public and private providers contracting with the same providers.

Table 4: Selected Indicators of Health Systems and Private Health Insurance Markets

	Ireland	UK	Australia	Germany	Belgium
Health system funding	69% public, 15% OOP, 13% PHI	80% public, 15% OOP, 3% PHI	68% public, 20% OOP, 10% PHI	85% public, 13% OOP, 2% PHI	78% public, 18% OOP, 4% PHI
Entitlement to health services	GMS patients have wide access to health services without fees; non-GMS patients face OOP payments for many services	Widespread entitlement to health services without fees or with minimal cost sharing	Free or subsidised access to a wide range of health services under Medicare, though with some balance billing	Widespread entitlement to health services paid for by sickness funds	Widespread entitlement to health services but with cost sharing in many cases
Practicing physicians per 1,000 population (2015)	2.88	2.79	3.52	4.14	3.02*
Practicing nurses per 1,000 population (2015)**	11.9	7.9	11.5	13.3	10.8
Hospital beds per 1,000 population (2015)	3.01	2.61	3.79 (2014)	8.13	6.18
Role of PHI	Supplementary with some complementary	Supplementary with some complementary	Supplementary	Substitutive	Supplementary
Take-up rate of PHI	46%	11%	55% (46% hospital cover)		60%

Note: OOP – Out-of-pocket payments

* According to the OECD, “Belgium sets a minimum threshold of activities for doctors to be considered to be practising, thereby resulting in an under-estimation compared with other countries which do not set such minimum thresholds.” (OECD, 2017b: 150)

** According to the OECD, the figures for Ireland and Australia include midwives, while the Irish figures include not just nurses providing direct patient care but also nurses working in the health sector as managers, educators, researchers, etc.

In all five health systems, there are concerns being raised about equity in the context of a mixed public/private system, where take-up rates of private health insurance tend to be higher among those with higher incomes, and possession of private health insurance in some cases conferring its holders with faster access to treatment. The government subsidisation of private health insurance in Ireland and Australia accentuate the concerns over equity in these countries, while there are also concerns over adverse selection in the German substitutive private health insurance market.

Private health insurance is encouraged in some cases by governments, with the justification put forward that it takes the pressure off the public system, although the degree to which it does this is affected by the degree to which the treatment of private patients takes place in public hospitals.

However, there are also concerns in some countries about the sustainability of private health insurance markets, given premium increases (most notably Australia and Germany, while Ireland has seen a reduction in premiums in recent times after significant ongoing premium increases for many years before that).

Another issue that is common not just to the five countries contained in this study but more widely is the sustainability of long-term increases in health spending, both on a per capita basis and as a proportion of economic activity (whether GDP or another measure is used). In this context, Appleby (2012) suggests that such increases have been driven by a combination of population, income, technology and cost factors, which are predicted to continue into the future, as well as government decisions to widen access to healthcare. He also notes that, as countries have become richer a greater proportion of spending has been devoted to health.

Looking to the future, Appleby (2012) suggests that, while it is difficult to accurately predict long-term changes in health spending, most such projections foresee a higher proportion of economic activity being spent on health in the coming decades. However, he suggests that, even if spending on health as a proportion of GDP in the UK were to double, which would roughly bring it to the proportion currently spent in the US, given real GDP growth projections, a growing share of GDP being spent on health would still allow for real growth in spending on all non-healthcare areas of the economy.

In this context, it is also worth noting that there has been some debate about shifting the burden of payment from governments to citizens, and some countries have seen moves towards increasing privatisation. However, ultimately citizens pay for healthcare, whether through taxation, health insurance premiums, out-of-pocket payments or other mechanisms, so the debate is not so much about who pays but rather about how the burden of payment is spread. In this regard, private funding mechanisms tend to be regressive, while public ones tend to be progressive, so shifting the burden of payment from the latter to the former may not be optimal from a societal point of view.

Learnings for Ireland

What this five-country comparison shows is that, while the Irish health system has some distinct features, it also shares common features and issues with other health systems, and the same can be said of the private health insurance market here. The Irish health system is more similar to those in the UK and Australia than to the German or Belgian systems, while Australia's private health insurance market is the most similar of the other countries' markets to Ireland's.

One of the biggest criticisms of the Irish health system has been the so-called two-tier nature of the system (although it is, in reality, more nuanced than that moniker would suggest). However, it would appear that there are overlaps between public and private funding and delivery mechanisms in other countries also, although perhaps not to the same extent as in Ireland (again, Australia is probably most similar to Ireland in this regard). It is interesting to note that policy in the UK is moving in the direction of increasing the amount of private practice in public hospitals, albeit from a much lower base than that seen in Ireland or Australia.

Another common issue, as mentioned above, is the sustainability of healthcare financing. A report written for the King's Fund in the UK in 2013 suggested that, across the 27 countries of the EU plus Norway, public spending on health and long-term care could almost double as a proportion of economic activity, from 6.7% of GDP in 2007 to 13% by 2060. It is acknowledged that these figures would be considerably higher if private spending were added in. The report notes that, if health spending growth patterns over the next 50 years mirror the previous 50 years, the UK could be spending nearly 20% of its wealth on publicly provided health and social care. However, the report suggests that this could still be affordable if projections for a trebling of real GDP are achieved, although it notes that health and social care spending would, under such a scenario, consume approximately half of government revenues, with a consequent reduction in the proportion of government revenue spent on other areas (Appleby, 2013).

In this regard, Ireland benefits from a relatively young population profile, albeit that this benefit is now beginning to be eroded with the ageing of the population here. Recent census figures have shown an ageing of the population, along with population growth. Demographic projections suggest that, between 2015 and 2030, the total population will increase by 14%. However, the population aged 65 and over is projected to increase by 60%, while the population aged 80 and over is projected to increase by 89% over the same period (Wren et al, 2017).¹¹

Based on these demographic projections, and usage patterns of healthcare services, which are higher for older age cohorts, the ESRI projects that demand for public hospital inpatient services could increase by up to 37% if measured by inpatient bed-days or 30%

¹¹ These figures relate to what the ESRI calls its central population growth scenario. In its high population growth scenario, the total population is projected to rise by 23%, with projected rises in the population aged 65 and over and the population aged 80 and over of 63% and 94% respectively.

if measured by inpatient discharges. The corresponding figures for private hospitals are increases of 32% and 25% respectively. The report projects a growth in demand for GP services of up to 27%. Demand for long-term and intermediate care places and home care hours are projected to increase by up to 54% (Wren et al, 2017).

This population ageing and its associated implications for healthcare demand, was one of the issues considered by the cross-party Oireachtas Committee on the Future of Healthcare in its report released in May 2017, hereinafter referred to as the Sláintecare report, as was the issue of equity.

Among the report's recommendations are the reduction (or removal) of out-of-pocket charges for some healthcare services (which had been increased during the economic downturn between 2008 and 2014); significant increases in capacity in a number of areas of the health service; a shift in emphasis from hospital to primary care and a widening of entitlements to primary care services; and the removal of private practice from public hospitals.

The report estimates that, in order to fund these plans, the State will be spending an additional €2.8bn per annum on health by the end of the 10-year period, over and above any increases in spending arising from demographic factors and medical inflation (which the report estimates will add 3% per annum to the budget)¹². In addition, a transition fund of €3bn over the first six years of the plan was proposed "to boost reinvestment into one-off system changing measures, training capacity and capital expenditure" (Houses of the Oireachtas, 2017: 11).

Since the launch of the Sláintecare report, two other reports, with implications for reform of the health system, have been published. The first was the Health Service Capacity Review, while the second was the National Development Plan, which set out anticipated capital projects for the period 2018-2027.

The Health Service Capacity Review estimates that, if the reforms envisaged by the Sláintecare report are fully implemented, the Irish health system would require an additional 2,590 acute public hospital beds, a 48% increase in the primary care workforce, a 13,000 (43%) increase in residential care beds and a 120% increase in homecare (home help hours and homecare packages). This is based on population projections which indicate that, between 2016 and 2031, the overall population will grow by 12%, with a 59% growth in the population aged 65 and over, and a 95% growth in the population aged 85 and over (Department of Health, 2018).

It is important to emphasise that these projections assume the reform agenda set out in the Sláintecare report is implemented. The report also laid out the requirements of the system if current healthcare delivery patterns are continued, which would include 5,360 additional

¹² This €2.8bn figure has caused some confusion, as it was presented upon the launch of the report as an extra€2.8bn over 10 years, leading some to interpret this as an additional €280m per annum, which would significantly underestimate the cost of the plan.

acute public hospital beds (or 7,150 if bed occupancy rates were to be reduced to the international safe norms), a 37% increase in the primary care workforce, a 40% increase in residential care beds and a 70% increase in homecare.

The review acknowledged that the latter scenario is unsustainable, and that a combination of investment, reform and productivity improvements will be needed in the Irish health system. However, it also accepted that “in practice the achievable shape of the future health system is likely to lie somewhere between the two extremes set out in this report”, (Department of Health, 2018: 5).

The additional 2,600 hospital beds are envisaged under the National Development Plan (Department of Public Expenditure and Reform, 2018), which suggests that €10.9bn will be invested in the health sector, all of which will be provided by the Exchequer. The projects proposed under this investment programme include, *inter alia*, the new Children’s Hospital, the new National Maternity Hospital, a new hospital in Cork, additions of various wards and units in other hospitals, and a primary care centre construction programme across the country. The plan calls for a greater separation of scheduled and unscheduled hospital care, and to this end it envisages new dedicated ambulatory elective-only facilities in Dublin, Cork and Galway, which will provide high volumes of less complex treatments on an outpatient and day case basis.

It is clear that the reforms proposed in the Sláintecare report are ambitious and it remains to be seen to what extent they will be successfully implemented. The increase in capacity will be particularly challenging, not only from the point of view of raising the required funding, but also in terms of recruitment and retention of staff, particularly given the shortages of suitably qualified staff internationally.

On the funding side, the reforms will add €2.8bn per annum to the public health budget by the end of the 10-year plan, over and above the anticipated growth in expenditure arising from demographic pressures and medical inflation. However, it should be noted that this will be partly offset by reductions in direct payments for health by households, which the Sláintecare report estimates will be almost €1.5bn per annum.

One of the more challenging proposals in the report will be the removal of private practice from public hospitals, the practicalities of which are currently being examined by an independent review group. This particular measure would have a significant impact on the private health insurance market.

Firstly, this reform would require a renegotiation of the consultant contract, which previous experience suggests will be neither easy nor quick. In this regard, it is instructive to note that an RTE Investigates documentary, broadcast on 21st November 2017, found that 94% of

consultants employed in Irish public hospitals had private practice entitlements under their contracts.¹³

Secondly, it may result in a situation where consultants would be forced to choose between public and private hospitals (unless they will be permitted to have separate contracts with public and private hospitals). This raises a question regarding the capacity of the private hospital sector to take on more consultants.

The capacity of the private hospital sector for patients will also come into sharp focus if this reform is implemented, as privately insured patients would no longer have the option of being treated in public hospitals. The most recent figures from the Hospital Inpatient Enquiry (HIPE) System show that, in 2016, private patients accounted for 154,404 day-patient discharges (14.6% of such discharges in public hospitals) and 125,758 (19.5%) inpatient discharges (Healthcare Pricing Office, 2017).

To put these figures into perspective, the Private Hospitals Association states on its website (www.privatehospitals.ie) that its member hospitals care for approximately 400,000 patients per annum. The removal of private practice from public hospitals would therefore have a dramatic effect on demand in private hospitals, albeit this might be mitigated to some extent by a reduction in demand for private health insurance if investment in the public hospital system leads to shorter waiting times and greater confidence surrounding access and services in public hospitals.

This comparative study shows that, particularly in the other tax-funded systems of the UK and Australia, private practice in public hospitals is a feature of the health systems. Therefore, the removal of private practice from Irish public hospitals would represent a significant shift in emphasis and there may well be international interest in how this progresses.

The removal of private practice from public hospitals will have a significant impact on the private health insurance market. Firstly, it will remove the option for privately insured patients to be treated as such in public hospitals, although they will still have entitlements to be treated as public patients, although there will (presumably) be a single waiting list. Related to this, if the treatment of private patients is limited to private hospitals, this will likely increase the waiting times for private patients (compared with the current situation) unless the capacity of private hospitals is sufficient to cater for the existing demand.

Given the perception that private health insurance enables faster access to treatment, and that concern over access to public hospitals is one of the main drivers of health insurance demand in Ireland (see, for example, HIA, 2016a), any lengthening of waiting lists for private patients may have an impact on private health insurance demand. Furthermore, if the

¹³ However, private correspondence from the Department of Health shows that 82% of consultants had contracts that conferred private practice entitlements as at the end of 2017.

required investment in public hospitals is made after private practice is removed from them, then confidence in access to the public hospital system may improve, further reducing demand for private health insurance.

However, if this investment is not made then there is a potential for a worsening of the situation for both public (due to reduced income for public hospitals from private patients) and private (due to capacity issues in private hospitals) patients. It is critical therefore, that this element of the Sláintecare proposals is handled satisfactorily.

In conclusion, no two health systems are exactly alike and, while there are similarities between the Irish health system and those of the UK and Australia in particular, the Irish system is quite different in many respects, particularly in terms of access entitlements and the degree of overlap between the public and private funding and delivery mechanisms. Many of the Sláintecare proposals are designed to address these issues, and if they are implemented then the Irish health system will look very different in 10 years' time. Some of the reforms will also have a significant impact on the private health insurance market in Ireland, with the result that this too could look quite different in a decade. Although much uncertainty surrounds the implementation of the proposals, there is greater certainty that the landscape will change in the coming years.

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