HealthManagement
Promoting Management and Leadership

Volume 3 / Issue 3 / 2008 - Country Focus: Ireland

The Healthcare System in Ireland

In spite of some persistent concerns, Ireland's healthcare system has been bracing itself for meeting challenges in the years ahead. The country has a mixed public and private healthcare system. These have been subject to considerable reforms in the past two decades. Yet, there is considerable anecdotal and statistical evidence that healthcare delivery in Ireland lags behind the rest of Europe, and that structural reforms to provide better bang for the buck have achieved less than expected.

Mixed System Seeks to Protect Lower Income Groups

At present, a range of health services (emergency services, maternity care and out-patient treatment) are provided free of charge at public hospitals to all residents in Ireland, while long-term prescription drug treatment is also subsidised (for payments over a monthly threshold). However, hospital stays incur a daily accommodation charge, and GP services too are billed.

Lower-income groups (known as Category 1 patients) are provided a medical card, which entitles them to free healthcare for all procedures – medical/ hospital and pharmaceutical, as well as ophthalmology and dental services.

Private Sector Relief for Others

Ireland also has numerous private health clinics, and a rising number of residents have begun subscribing to

private health insurance. This is largely due to lengthy waiting lists for a variety of treatments at public facilities, for extras such as single room accommodation, and to bring out-of-pocket spending under affordable and predictable ceilings.

The roots of Ireland's private insurance system date back to the VHI (Voluntary Health Insurance) Act in the late 1950s, which set up a non-profit body called the VHI Board. The users of VHI consisted of the highest 15% income group, which was at the time not entitled to public healthcare paid for by the State. VHI's monopoly was broken in 1996 by the entry into Ireland in 1996 by BUPA. These insurance schemes now compete head-to-head and, more recently VIVAS Health. Their entry has increased the sophistication and range of choice available for private insurance subscribers.

Overall, about half the Irish population has some form of private insurance coverage. This is one of the highest rates in the European Union.

Healthcare Financing Reforms Date to the Late 1970s

On its part, the public funding of the Irish healthcare system was reformed dramatically in 1977, when local districts ceded powers of taxation for public health services to the central government in Dublin. In some senses, such a step – barely a few years after the country joined what was then the European Communities – paved the way for more fundamental and profound reforms in healthcare financing and delivery. In 2001, Ireland launched its Health Strategy, as a ten-year plan to meet emerging healthcare challenges. The Strategy identified four goals: Better health for everyone, Fair access, Responsive and appropriate care delivery, and High performance.

Persisting Challenges

Some such challenges persist, and do so worryingly. Though Ireland's breast cancer incidence is among Europe's lowest, the death rate in 2001 from the disease was the highest in Western Europe. Yet another area of concern is cardiovascular disease, whose incidence is far higher than the rest of Europe. In 1997, cardio vascular treatment accounted for as much as 17%of national spending on medicines and medical appliances, just under 20% of all prescriptions. In spite of some reversals, there is still very much to be done.

In 2004, per capita deaths from cardiovascular diseases in Ireland were over twice that in Germany and 70% higher than in Spain.

Waiting lists for medical treatment, too, have long been a key structural problem and a deep source of concern for the Irish public and its healthcare authorities. In a 1997 survey, it was found that the hospital waiting list numbered over 30,000, with 68% of people waiting for 12 or more months for cardiac surgery and 48% for

orthopaedic surgery; in addition, one of five cardiac patients died while awaiting surgery.

These numbers have improved significantly in the years since. One of the main reasons has been an incentive casemix/ quality program, by virtue of which allocation of finances to hospitals was determined by their performance, including a decrease in waiting lists. This system is similar in several respects to that being implemented in France (discussed in the previous issue of *Healthcare ITManagement*).

Indeed, in 2007, the Health Consumer Powerhouse Euro Health Consumer Index (EHCI) ranked Ireland's public health system 16th of 29 European countries - a massive rise on its performance the previous year (at the bottom of 26 European countries. However, there is still some way to go. In 2007, three of four in-patients were admitted to hospital immediately, 11%had to wait up to one month, 4% for three months, 1% up to six months. 4% had to wait for over six months for operations. For outpatients, 23% were seen on time, 44%in 30 minutes, 18%after an hour and 7% for two or more hours.

Healthcare Spending Rises Sharply, Overtakes UK

In the meanwhile, Ireland has seen one of Europe's sharpest increase in healthcare spending. Between 1990 and 2005, OECD figures show per capita spending on healthcare rising 3.7 times – far higher than that of the United Kingdom(2.8 times), or continental counterparts froma variety of healthcare traditions, such as Belgium(multiple of 2.5), France (2.3), or even Spain (up 2.6 fold). Indeed, in purchasing power parity dollars,

Ireland spends more on healthcare per inhabitant than the UK (in 2005, 2,926 dollars against 2,724 dollars), and is not far behind France (3,374 dollars) and Germany (3,287 dollars).

Reforms at the Bottom: The Role of the GP

Given such financial pressures, the government's focus has shifted to enhancing the quality and efficiency of primary care, especially at the general practitioner (GP) level. This is in line with the general Europewide move to emphasise preventive care and avoid adding to further burdens on overextended and expensive hospital-based interventions - especially given the demographic pressures from an ageing population. Indeed, across Europe, GP utilisation rates closely correlate to specific national healthcare cultures and trends towards reform.

Against such a backdrop, the distinctive feature of Ireland's healthcare system is the pricing of GP services. For lower-income patients with medical card cover, GP visits are free. For others, GP consultations are paid out-of-pocket on a fee per service basis. This cost is not reimbursed, even when patients have health insurance). GPs, in turn, are free to set their fees and cover both cardholders and others. The situation therefore contrasts in a major way with other EU countries, where primary care is either free or massively subsidised, for the entire population. GP visits in Ireland are about 3.5 per person per annum, approximately at the EU median, but slightly higher than the United Kingdom. Some experts indicate that GP use in Ireland is especially high at the level of lower-income groups, precisely those eligible for free consultation.

Given the political sensitivities of such an issue, it remains to be seen how exactly the government manages to rationalise access to GPs. Critics already point out that the share of Category 1 card holders in the population has fallen significantly, from 35% in 1996 to 28% in 2005.

Symbiosis or Dependency: Private and Public Healthcare

A related challenge is the role of the private insurance component in healthcare delivery. Physicians have the right to treat privately-insured patients in public hospitals, within fact account for about half of total 'private' hospital care. Insurers reimburse both the physician and the hospital (although so far this has been principally for the residency rather than the treatment portion of the care).

Complicatingmatters further is the fact that physicians provide services for Category 1 patients in public hospitals as part of their salary, but treat private patients on a feefor- service basis.

From Past to Future

To bring the Irish healthcare system up to speed, experts believe far more remains to be done. The government has made some moves in its new National Development Plan (NDP) for 2007-2013.

The previous NDP 2000-2006 had outlays of approximately 3.3 billion Euros for new or upgraded healthcare services. Included were over 1,300 inpatient and day treatment places, alongside a variety of capital projects in both acute and non-acute hospitals, additional spending for the aged and people with disabilities, and the development of 13 nurse-training centres.

Healthcare and the National Development Plan 2007-2013

Health Infrastructure:

4.7 billion Euros. 2.7 billion Euros will be spent on acute care hospitals, including the new National Children's Hospital in Dublin. Another aspect is the location of private hospital facilities on public hospital sites to free up to 1,000 additional public beds.

The rest will be earmarked for primary community and continuing care facilities, including establishing 500 primary care

teams by 2011 and extending community care services to enable older people to live independently in their own homes for longer periods.

Health Research:

301 million Euros, part of a 6.1 billion Euro commitment to Enterprise, Science and Innovation.

IT and e-Health:

490 million Euros (see next article).

Explicit healthcare projects also play a (small) role in Island Investment and Social Inclusion projects.

Published on : Mon, 3 Mar 2008