FairCare

Fine Gael Proposals to reform the health service and introduce universal health insurance

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A Message from Enda Kenny

For the last ten years the Government's answer to any problem in the health service was to throw taxpayers' money at it. Billions were wasted and the health service was never reformed in any fundamental way. As a result, Ireland's health system is now ranked 24th in Europe in terms of value for money.

Even today, as we face the worst economic crisis in this State's history, the Government is slashing health budgets without introducing any meaningful reform.

In mid 2008 I established a Health Commission chaired by our former leader Alan Dukes, to develop a radical and patient focused solution that will give us the Health service that we deserve within a five year time frame. Our approach is built around the patient, rewarding performance from doctors and hospitals, and ensuring that there will no longer be a two tier health system.

Fine Gael has looked in particular detail at the Dutch health system as a model for Ireland's health service. The Netherlands spends only slightly more than us on health on a per capita basis, but has minimal waiting lists and is ranked number 1 in Europe for health. Under Fine Gael's proposals, we will move towards the Dutch system, where everyone has mandatory health insurance, either subsidised or fully financed by the State.

In its first 30 days in Government, Fine Gael will work with all the major stakeholders in the health service to agree an implementation plan so that the proven Dutch system of UHI is best adapted to Irish circumstances.

Our health reform programme represents the most revolutionary change in the Irish health system since its establishment. There will be some who will say that we cannot afford major reforms at a time of recession. To them I say: as budgets come under more pressure we can't afford not to reform our €16 billion a year health system.

Enda Kenny
Leader of Fine Gael

A Message from Dr. James Reilly TD

Fine Gael Spokesperson on Health

I want to take this opportunity to tell you how Fine Gael's FairCare Policy will deliver improved medical care for you and your loved ones.

Over the last 10 years the health service has become a shambles. We regularly have over 350 people on trolleys in A&E, waiting lists that go on for months, outpatient waiting lists that go on for years and cancelled operations across the country.

Our health service is a fiasco, getting ever worse under the incompetent management of this Government. So how do we fix this? FairCare will slash waiting lists, for a fraction of the money spent on the NTPF every year.

We will then introduce a "money-follows-the-patient" budgeting system so that hospitals are paid for how many patients they treat. Patients will no longer be seen as "costs" to the health service, but as sources of "income".

Finally, we will deliver Universal Health Insurance where every man, woman and child will be insured, some fully subsidised, some partially subsidised by the Government.

We will also develop new primary care centres where groups of GPs with other health care professionals will treat patients free out of modern purpose built premises with access to x-ray, ultrasound and endoscopy so that patients can be diagnosed in their communities by the doctors who know them best.

In conclusion, I urge you to visit our website www.faircare.ie. There I hope that you can explore the various aspects of FairCare which I believe will bring three very valuable facets to our health service: transparency, accountability and fairness.

James Reilly TD
Fine Gael Spokesperson on Health

SUMMARY

“FairCare”
What It Means for You

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The quadrupling of the Irish health budget since 1997 has proved one thing - a poorly organised and managed health system cannot be fixed with money alone.

Ireland is spending close to the EU average on health, on a per capita basis, but Irish people are receiving a level of service well below the EU average. Ireland’s health service is ranked 15th in Europe for quality and 24th in terms of value for money.

Our health system is broken. For the last ten years the Government has thrown money at every problem, without making any fundamental change to the way the health system works. Even in the midst of economic crisis, it still refuses to make significant reform. Billions are wasted, waiting lists increase, and the sick and infirm pay the price for the Government’s incompetence.

Fine Gael’s ***“FairCare”*** proposals, by contrast, represent the most fundamental reform of the health system since the formation of the State. We will abolish long-term waits on trolleys in A&E, slash waiting lists in hospitals, and eliminate the unfair and inefficient public/private divide by introducing Universal Health Insurance (UHI). We will also reform the Primary Care system to ensure that more patients are treated safely outside hospitals by their GPs.

Primary Care Reform is Crucial

Since it was first announced in 2001, the Government has consistently failed to meet the key targets in its Primary Care strategy.

Fine Gael will give Primary Care the priority it deserves. By the end of our first term in Government, we will have a comprehensive network of new Primary Care centres to serve our communities. The community they serve will determine the size and scale of the centre. Depending on population coverage, their services will include X-Ray, Ultrasound, Endoscopy, Physio, CT and MRI scanning, etc. The centres will also include rooms for visiting specialists and will accommodate a robust community mental health service.

Patient flows to hospital will be further reduced by the availability of a National Body Test (NBT) to pick up illness early, and by the existence of chronic illness programmes for diseases such as high blood pressure, asthma, etc. to prevent the complications that land people in hospital.

We believe that the capital costs of this programme can largely be borne by the private sector, if appropriate long-term contracts are put in place. If additional incentives are required, such as Accelerated Capital Depreciation, this requirement will be addressed.

A 3-Phase Programme

Reforming the Irish health system will not be easy. The last thing Ireland needs is another ill-conceived experiment like the formation of the Health Service Executive (HSE). In addition, any reform must be undertaken within Fine Gael's overall budgetary framework. We have, therefore, divided our FairCare programme into three distinct, but over-lapping phases that will allow us to gradually introduce reforms in a way that is both carefully planned and affordable.

Phase 1: Maximise what we have (Implemented from Year 1)
In the first phase of FairCare, we will change the way hospitals work and, as indicated above, will also significantly strengthen Ireland's Primary Care system.

As part of our hospital reform programme, we will make the Minister of Health directly responsible for hitting key targets. Progress will be measured daily by real time information systems, and a Special Delivery Unit will be established to assist the Minister. A similar unit was successfully used in Northern Ireland to help slash waiting lists, e.g., inpatient waiting lists for those waiting more than 3 months fell by 80% from 2004 to 2008. Crucially, this was done without significantly increasing spending,

Fine Gael recognises that significant bed capacity in hospitals could also be freed-up if patients facing delayed discharge or requiring rehabilitation could be treated in the Community. We will publish specific proposals on this issue over the next few months to address the current deficits in long-term care and rehabilitation.

Fine Gael will also ensure that resources, arising from the sale of psychiatric institutions and lands, will be ring-fenced to mental health. Psychiatric illness must be treated like any other illness, and resourced accordingly.

Phase 2: Introduce "Money follows the patient" (Year 3)
Under the current system of fixed budgets, each additional patient is effectively a "cost" to the health service. This system provides no incentives for efficiency or

productivity. Under MFTP, health providers will be paid for how many patients they treat. Patients will be a source of "income" rather than a "cost", just as they are in private hospitals today.

MFTP will mean that decision-making is increasingly devolved to the hospitals themselves. Once MFTP is introduced, the National Treatment Purchase Fund will be closed, saving around €100 mn a year. Long term, we expect MFTP to increase efficiency by as much as 10%.

Phase 3: "Universal Health Insurance" (Implemented in Year 5)
Once the first and second phases of FairCare have been successfully implemented, Fine Gael will introduce Universal Health Insurance (UHI), a system that is widely used in Europe and in Canada. UHI will only be introduced once waiting lists have been significantly reduced in Phases 1 and 2. In the interim, the current system of voluntary insurance in Ireland will remain in place.

Within its first 30 days in office, a Fine Gael Government will establish a **UHI COMMISSION**, which will include representatives from all of the major stakeholders in the health service. Its primary task will be to build a consensus around the practical measures that need to be taken to prepare the health system for UHI. One of the keys to success for any insurance system is strong regulation. The Regulator will be answerable to the Minister and the Oireachtas.

Fine Gael proposes to introduce the Dutch model of UHI in Ireland, with mandatory health insurance for everyone, to be chosen from a selection of providers. The Netherlands spends only slightly more than us on health on a per capita basis, but is ranked number 1 in Europe for quality and Number 2 for value for money (Source: European Health Consumer Index 2008).

The Dutch system of UHI has strict community rating and an obligation to cover, which means that insurance companies will not be able to discriminate against anybody on the basis of age, sex, medical history, etc. This will be underpinned by a system of Risk Equalisation, which will compensate insurers for covering higher risk, higher cost patients. The insurance model will also address mental health.

Under UHI, everyone will receive a package of free GP care, paid for by some rebalancing of the tax system, and significant savings as the insurance companies bring down costs. There will, in addition, be significant savings in administration. At the moment, Ireland has two administrative systems for health – one public (the HSE) and one private (the insurance companies) – resulting in enormous duplication and waste. Over time, these two systems will become one, run by the insurance companies. As a result, the number of administrative staff employed in the HSE will likely fall by at least 5,000, as its role becomes more focused on long term care, public health, etc.

UHI will require the insurance industry in Ireland to play a much greater role in negotiating contracts with hospitals and other providers, and in driving innovation, than has been the case to date. Fine Gael will not introduce UHI until it is certain that the insurance companies are capable of taking on the expanded role required of them. A Fine Gael Government will encourage insurance companies from other European

countries, who have experience of implementing social insurance models, to enter the Irish market.

Figure 1 summarises Fine Gael's ambitious but achievable targets for all three phases of FairCare. Our goal is to transform the Irish health service into one of the best in Europe, and create a health system that we can all be proud of.

Figure 1: Making Ireland's Health Service One of the Best in Europe

The Current Status of the Health Service	*1st Term of a Fine Gael Government*	*2nd Term of a Fine Gael Government*
No.15 in Europe for Quality	**Well into Top 10**	**Top 3**
No. 24 for Value for Money	**Well into Top 10**	**Top 5**
Significant Waiting Lists, average of 300 on long-term trolleys per day and GP charges	**Minimal Waiting Lists, No long-term waits on Trolleys, Free GP care packages, More and better treatment in the Community**	
Public/Private split at the heart of the system	**Choice for All**	

Five Key Principles of FairCare

Fine Gael's approach to healthcare reform is essentially pragmatic. We are not bound by ideology or dogma, but will apply to Ireland best practice from other successful health systems. However, FairCare is underpinned by five key principles:

1. ACCESS is a right - not a privilege

In health, delayed treatment can lead to pain, complications and even death. More than 150,000 people are currently waiting for an outpatient appointment, some for up to 8 years, and 40,000 people are on the inpatient waiting list. Each day, an average of more than 300 people have long-term waits on trolleys. These delays are unfair and some may well prove fatal.

2. TRANSPARENCY AND EFFICIENCY are not optional extras

The Government seems to believe that efficiency is somehow an optional extra. It is no surprise, therefore, to find Ireland ranked 24th in Europe for value for money. FairCare, by making the system much more efficient and transparent, will allow more patients to be treated, and help ensure that taxpayers' money is not wasted.

3. FAIRNESS: Equal treatment for equal need

The two-tier health system undermines SOLIDARITY within society, and encourages duplication and waste by creating two administrative systems. However, any move to abolish peoples' right to health insurance would reduce choice. The fairest solution is to ensure that everyone has health insurance.

4. CHOICE for all

Fine Gael is <u>not</u> proposing the abolition of private health insurance. We are proposing that Ireland ultimately moves to a single-tier UHI system, where <u>everyone</u> has

mandatory health insurance and can choose from a range of insurance plans. **In other words, we want to give choice to everyone.**

5. ACCOUNTABILITY: The buck stops where?

The HSE has allowed the Minister of Health and her Department to distance themselves from responsibility for the health service. This has created a huge democratic deficit and removed vital leadership. Fine Gael will place responsibility for the health service back where it belongs – with the Minister.

More Detailed Reports Will be Published Over the Next Few Months

The FairCare proposals included in this document provide the road map for radically changing the Irish health system. They are not intended to address every aspect of health policy. Over the next few months, we will publish additional, more detailed reports on key aspects of the health system, such as the role of local hospitals and the future of care in Ireland. All constructive comments and proposals on how we might further strengthen FairCare will be gladly received.

THE CHALLENGE

The Irish health system is broken. The HSE's repeated failure to meet key targets, despite the best efforts of health staff and significant additional resources, has lead to a growing sense of cynicism and despair among the public. The idea that the healthcare system is essentially un-fixable is gaining currency.

Fine Gael's message can be easily summarised:

- We are convinced that the health system can be fixed.
- We have a plan to help fix it, based on our analysis of what other countries have done; and
- That plan can be introduced without major additional resources.

The health system right now faces two key challenges:

First, it is clear that health budgets are coming under severe pressure. Unfortunately, because so much recent spending by the Government on health has been wasted, the existing system will find it very difficult to cope with squeezed funding, without seriously hurting front line services.

Fine Gael's Spokesman for Finance, Richard Bruton, has long argued that the current "Existing Level of Service" model for preparing public sector budgets in Ireland, including health, is fundamentally flawed. It locks into future years all the existing waste and efficiency. Many of the reports on the Irish health service make the same mistake. They take the system as it currently is, and then estimate how much additional money is needed to improve access, quality, etc. They do not tackle the accumulated waste and inefficiency in the system already.

Second, Ireland faces a long-term demographic time bomb. We live at a time of remarkable growth in medical knowledge and technology that is allowing people to live healthier, more productive lives for longer. But this development, though hugely welcome, also poses a massive challenge for Ireland. Currently just 11% of the population is over 65. This is will increase by 59% to 2021 and by a further 142% to 2061. In 2006, there were 5.6 workers for every pensioner. In fifty years time, the figure will be closer to 1.8 workers for every pensioner.

If Ireland is to meet both of these challenges – severe budgetary pressures now, and a demographic time bomb in the future - we need to substantially change the current model of healthcare. Tinkering with the system at the margins will accomplish nothing.

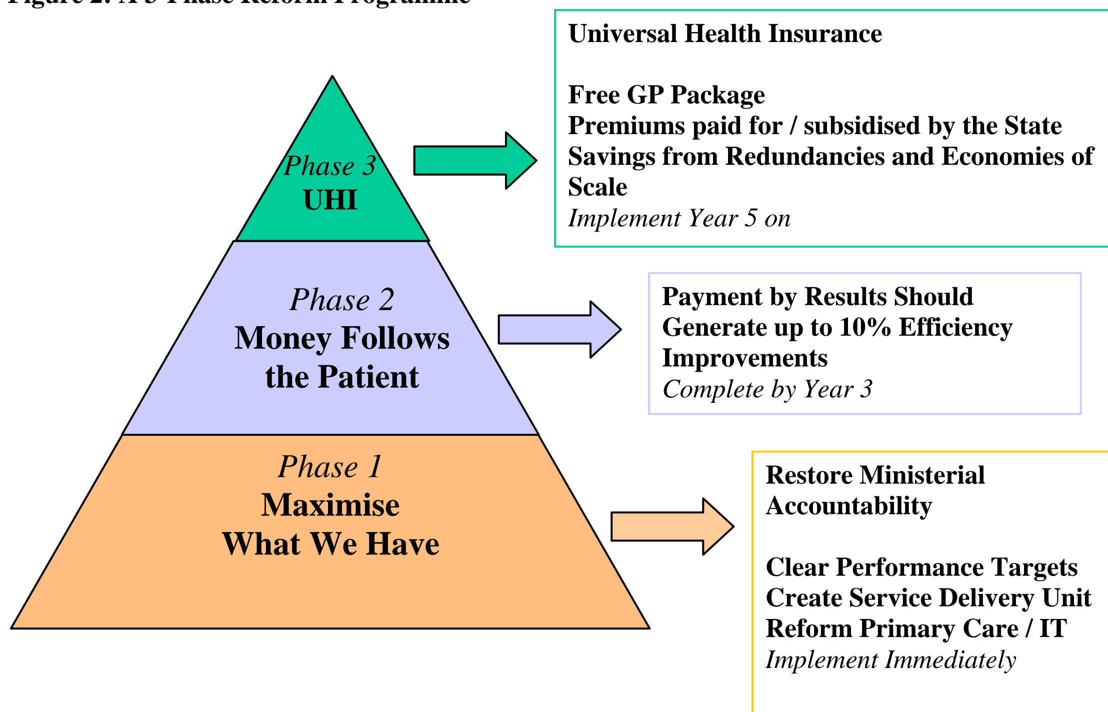
FAIRCARE: A NEW MODEL FOR HEALTHCARE IN IRELAND

Fine Gael's ***"FairCare"*** proposals represent the most fundamental reform of the health system since the formation of the State. We will abolish long-term waits on trolleys in A&E, slash waiting lists in hospitals, and eliminate the unfair and inefficient public/private divide by introducing Universal Health Insurance.

Fine Gael will also give Primary Care the priority it deserves. By the end of our first term in Government, we will have a comprehensive network of new Primary Care centres to serve our communities. Patient flows to hospital will be further reduced by the availability of a National Body Test (NBT) to pick up illness early, and by the existence of chronic illness programmes for diseases such as high blood pressure, asthma, etc. to prevent the complications that land people in hospital.

Reforming an entity as large and complex as the Irish health system will not be easy, and must be undertaken with regard to the overall budgetary framework. We have, therefore, divided FairCare programme into three distinct, but over-lapping phases (Figure 2).

Figure 2: A 3-Phase Reform Programme



Under FairCare anyone with a medical card will retain it, along with all of its entitlements. It is envisaged that all of the insured under UHI will receive a "Health Card", which will specify the range of services to which they are entitled. In the future, this card could also be used to store key medical data, subject to individual privacy being guaranteed.

Phase 1: "Maximise What We Have"

The first phase of our reform programme is designed to squeeze out of the system as much of the accumulated waste and inefficiency as is possible. Phase 1 does not involve major organisational changes, or large injections of cash. It is based on a much more rigorous approach to the management of waiting lists in hospitals, and a much greater focus on the primary care system.

Fine Gael recognises that significant bed capacity in hospitals could also be freed-up if patients facing delayed discharge or requiring rehabilitation could be treated in the Community. We will publish specific proposals on this issue over the next few months to address the current deficits in long-term care and rehabilitation.

Fine Gael will also ensure that resources, arising from the sale of psychiatric institutions and lands, will be ring-fenced to mental health. Psychiatric illness must be treated like any other illness, and resourced accordingly.

Phase 2: "Money Follows the Patient (MFTP)"

The second phase will change the way in which hospitals and doctors are resourced. Instead of receiving fixed budgets, they will receive income on the basis of the number of patients they treat. In this way, they have a positive incentive to become more efficient, and to treat as many patients as possible. In order for MFTP to be introduced, major organisational change will be necessary. Most importantly, the providers of healthcare services (hospitals/doctors) will be separated from the main purchaser of those services (the State).

Once again, this phase of reform does not involve large injections of cash. In fact, money should be saved. Once MFTP is introduced, the National Treatment Purchase Fund will be closed, saving around €100 mn a year. International research also suggests that long term efficiency could be increased by as much as 10%.

Phase 3: "Universal Health Insurance" (UHI)

Phase 3 involves extensive changes to the structure of the health system, which is why it is the final phase of the overall programme. Under Fine Gael's proposals, we will move towards the Dutch system of mandatory health insurance, adapted to meet Irish circumstances. The system will be designed to ensure that no one is worse off financially, to the maximum extent possible, even as the health system is made fairer and more efficient. Everyone will receive a free package of GP care.

The ordering of the FairCare reform programme is crucial. It is essential that Phase 1 ***(Maximise what we have)*** be introduced before Phase 2 ***(Money Follows the Patient)*** that should, in turn, be implemented before Phase 3 (***Universal Health Insurance).*** The reason for this is that UHI can only deliver efficiency and quality improvements if the health service is able to respond to incentives and is not forced to strictly ration services, i.e. UHI can only be introduced once Phases 1 and 2 have significantly reduced waiting lists and freed up capacity.

Although UHI will not be introduced until Year 5 of a Fine Gael Government, planning for UHI would have to start right from day one. Fine Gael will establish, within its first 30 days in office, a UHI COMMISSION that will include representatives from all of the major stakeholders in the health service. Its primary task will be to build a consensus around the how to move to UHI, and to advise the Government on the practical measures that need to be taken to prepare the health system for UHI.

Particular attention will be paid to the key issue of providing clear and strong Regulation, which is essential for any insurance system to work properly. The Regulator will be answerable to the Minister and the Oireachtas.

UHI: The Best Medicine for Ireland's Failing Health System

There are basically three different models of healthcare right now.

- **The Beveridge model** (centralised monopoly health service provider financed from taxation: Ireland, UK);

- **The Business model** (voluntary private insurance: USA); and

- **The Bismarck model** (mandatory social insurance with tax subsidies; decentralized and independent health service providers: Germany, France, the Netherlands).

On most international comparison, the Bismarck model has been shown to produce superior results. REFORM, an independent think-tank, has looked at a variety of international case studies. It has concluded that insurance incentives in healthcare are vital because they:

- Achieve greater value.

- Help de-politicise healthcare.

- Provide reasons for individuals and authorities to value long term improvements in health and wellbeing; and

- Define exactly what individuals are covered for, ending postcode lottery and empowering individuals to demand their rights from providers.

For all of these reasons, we propose that Ireland should move from its centralised model of healthcare based on the HSE to a UHI system.

Going Dutch: Bringing Netherland's UHI Model to Ireland

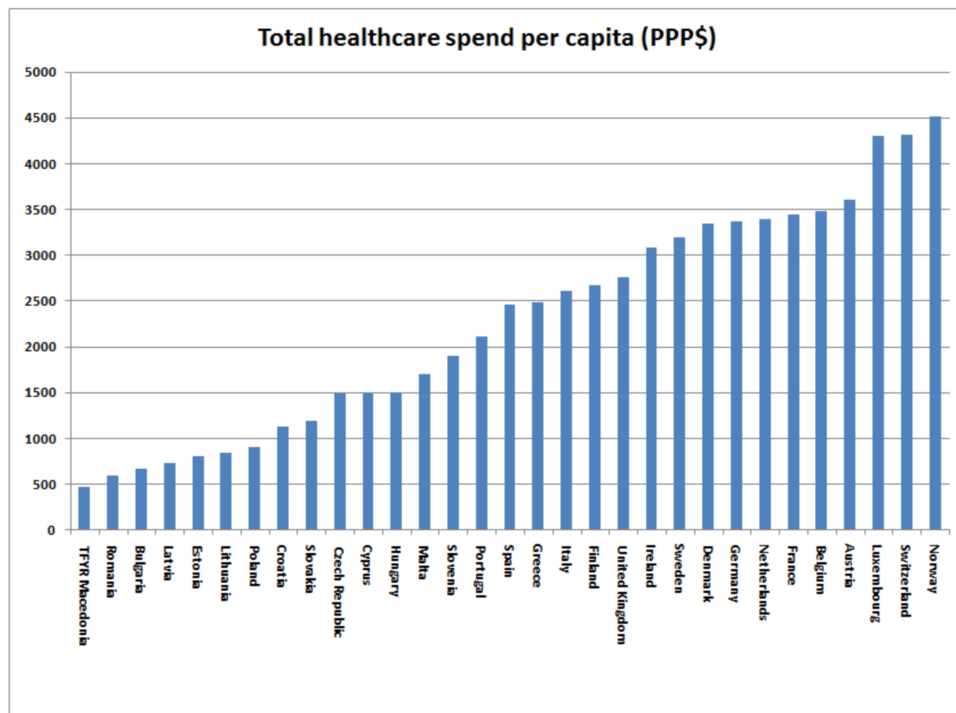
There are two basic models of UHI:

- A Single-Payer model, where insurance premiums are paid into a single health fund, overseen ultimately by the Government. This model is used in Canada and several Europe countries; and

- A Managed Competition model, such as that in The Netherlands, where consumers pay their premiums directly to three or four competing insurance companies, who buy services from the healthcare providers.

Fine Gael has looked in some detail at the Dutch model. The 2008 Euro Health Consumer Index (EHCI) report suggests that the Netherlands is the most successful health system in Europe. It is number 1 for quality, ahead of Denmark. **Ireland is only number 15.** While per capita spending in the Netherlands is slightly ahead of Ireland (Figure 3), the EHCI's analysis of value-for-money suggests that the Netherlands produces a much bigger "bang for its health buck" than Ireland and most other European countries. The Netherlands is in second place for value for money, while **Ireland is ranked an abysmal 24.**

Figure 3: Dutch per capita spending slightly ahead of Ireland



The Netherlands has traditionally used an insurance model to fund healthcare, rather than the tax-based model used in the UK and Ireland. In 2006, it moved even further down the insurance road by introducing the concept of "Managed Competition".

Under the Dutch system, **which is totally different from the inefficient and inequitable US private health insurance model**, everyone must buy a standard healthcare package from one of a number of competing insurance companies. This package covers all of the services and treatments one would normally expect – GP and hospital care, medicines, maternity care, ambulances, etc. In addition, anyone can buy supplemental packages, which include cover for additional, non-essential medical treatments (cosmetic, dental, therapies, etc.).

The insurance companies, in turn, purchase services from the healthcare providers (hospitals, etc.) and cannot turn any customer down, regardless of their health history. Community rating and risk equalisation ensure that no patients are discriminated against when premium are being set. GPs, rather than insurance companies, decide on treatment, while the quality of the health system is guaranteed by the State, which still pays for around three-quarters of healthcare costs through taxes. It also pays the premiums of children and those with medical cards and subsidises the premiums of the less well off.

We believe a version of the Dutch model is the best way forward for Ireland for two main reasons:

1) It reduces costs and increases quality. The Irish State has a very poor track record in driving innovation in the health system and in making deals that generate value-for-money. Properly incentivised and managed insurance companies, by contrast, would have every reason to drive innovation as a way to maximise service and reduce costs.

2) It builds on the current insurance system. We believe it makes sense to construct a UHI system that acknowledges that 50% of the Irish people already have a relationship with a private insurance company. The goal is not to take away their insurance, but to give everyone insurance and choice. We want to level up the playing field, not level it down.

The Work of the "UHI Commission" Will be Crucial

The transitioning of Ireland's health service from a largely tax-based system, to a managed competition, insurance-based system, will be neither quick nor easy. The Dutch have encountered many problems along the way, and their current system is far from perfect. While Fine Gael's 3-phase reform programme sets out the general road map, the UHI Commission will supply much of the detail.

In particular, the UHI Commission will be asked to advise a Fine Gael Government on what lessons we can learn from the experience, good and bad, of the Netherlands and other countries moving to a managed competition model. In addition, the Commission will advise the Government on such key issues as the right balance in funding healthcare under UHI between general taxation, insurance premiums and out-of-pocket payments. The Commission's work will be guided by three basic principles:

- The patient must be put at the heart of the system. Their interests, and not those of healthcare providers and the HSE bureaucracy, must be paramount.

- To the maximum extent possible, no patient should be worse off financially under UHI compared to the tax-based system we have now. When UHI is introduced, insurance premiums should be no higher than current levels, indexed appropriately.

- The system should be both fair and efficient. While value for money is vital, the "not for profit" ethos must remain at the heart of the Irish health system, with the State acting as guarantor for high standards and quality. In addition, although public hospitals will become independent trusts, with local representation, the land and assets will remain in the ownership of the State.

More Detailed Reports Will be Published Over the Next Few Months

The FairCare proposals included in this document provide the road map for radically changing the Irish health system. They are not intended to address every aspect of health policy. Over the next few months, we will publish additional, more detailed reports on key aspects of the health system, such as the role of local hospitals and the future of care in Ireland. All constructive comments and proposals on how we might further strengthen FairCare will be gladly received.

PHASE 1: MAXIMISE WHAT WE HAVE

HOSPITALS: TIME FOR REAL CHANGE

The quadrupling of the health budget since 1997 has proved one thing - a poorly organised and managed health system cannot be fixed with money alone.

Ireland is spending close to the EU average on health, on a per capita basis, but Irish people are receiving a level of service well below the EU average. Ireland's health service is ranked 15th in Europe for quality and 24th in terms of value for money.

For the last ten years the Government has thrown money at every problem, without making any fundamental change to the way the health system works. Even with all of the additional resources, it has failed miserably to implement its two flag-ship strategies to tackle waiting lists and times, i.e., the introduction of Primary Care Teams, which would treat more patients in the community, and the construction of private, co-located hospitals to create more beds (Figure 4).

Figure 4: A History of Failure

Government Policy	Promise	Reality
In 2001, the Government set outs its Primary Care Strategy in a document entitled: "A New Direction" The Social Partnership Agreement of 2006, *Towards 2016*, re-confirmed the strategy	• 300 primary care teams by 2008, 400 by 2009 and 500 by 2011 ***(Reiterated in "Towards 2016")*** • 200 Primary Care centres by 2011	• 97 teams in place, only 10 of which are fully functional • 10 centres have been built to date
In 2005, the Government announced its "Co-Location" strategy for freeing up private beds in public hospitals	1,000 private beds freed up through construction of private, co-located hospitals	Not one new bed yet created

The failure of its two flagship polices means that the Government has had to rely more and more on throwing money at the National Treatment Purchase Fund (NTPF), in an effort to prevent waiting lists spiralling completely out of control. However, this reliance on the NTPF has introduced huge distortions into the system. Consultants are being restricted for budgetary reasons from carrying out additional operations in the public sector, and then encouraged by the NTPF to operate on the same patients in a parallel private system funded by the State.

While some progress has been made, Inpatient waiting lists remain stubbornly high, with significant variations depending on geography. In addition, little or nothing has been done to reduce Outpatient waiting lists and trolley waiting times in A&E (see Figure 5). Fundamental change is clearly essential.

Figure 5: High waiting lists and times

Inpatient waiting lists (total) Inpatient waiting lists (over 3 months)	40,000 approx. 20,000
Outpatient waiting lists	> 150,000
Average. no. of A&E patients on long term waits on trolleys	300

LESSONS FROM NORTHERN IRELAND

In 2004/5, Northern Ireland faced very similar problems to those being experienced in the Republic now. Hospitals were running **large financial deficits,** while targets for reductions in waiting lists/times were seen as **aspirational rather than mandatory**. As a result, there were huge waiting lists and public confidence was extremely low. Against this backdrop, a reform agenda was launched, which delivered dramatic improvements in all of the waiting list metrics:

Huge Improvements in Outpatients…

In December 2004, there were just over 165,000 people in Northern Ireland waiting for a first appointment. By December 2008, that figure had fallen by almost 60%.

Ultimately, waiting times are more important than the number of people on a waiting list. On this metric, progress in Northern Ireland has been even more impressive.

- In December 2004, 65,109 had to wait for over 6 months for a first appointment, of which 12,927 had to wait for over 2 years.
- By 2008, just 232 had to wait for more than 13 weeks for an appointment, with 70% of patients receiving an appointment within 6 weeks.

Outpatient waiting lists have not, until recently, been formally collected or published by the HSE. Estimates suggest that there are over 150,000 waiting for an appointment. While the HSE HealthStat website gives some indication of the extent of outpatient waiting lists on a hospital by hospital basis, FOI material paints an even bleaker picture showing some patients waiting:

- Up to seven years for to see a rheumatology consultant in Kerry
- Four years for an orthopaedic appointment in Tipperary, and
- Three years or more for an outpatient dermatology appointment in Dublin.

This situation is repeated in hospitals across the country.

… and Inpatients

In December 2004, there were approximately 16,000 people waiting for inpatient treatment for over 5 months. By December 2008, there were just 143 people waiting for more than 5 months. The DHSSPS are targeting a maximum 13 week wait for surgey/in-patient/day cases.

Official NTPF waiting list figures show that there are 20,000 adults and children on waiting lists for more than 3 months, half of which are waiting more than six months for treatment. These figures do not count those patients waiting for less than three months. Once these patients are included, the total number of patients on waiting lists doubles to 40,000.

This unacceptable situation continues despite a Government promise in 2002 that waiting lists would come to an end by 2004

A&E: Huge Improvements in Trolley Waits

In 2006, the Northern Ireland Health Service set itself the target of abolishing all long-term trolley waits by 2008, with a few exceptions for medical reasons. For the December 2008 quarter, 87% of patients were waiting less than four hours in A&E units, from the moment they arrived. Although there has been some fall-back recently, initiatives are being introduced to get the numbers back on-track.

In Ireland there are roughly 300 people on long-term trolleys every day. The HSE's own figures suggest that the situation in 2008 is worse than in 2007.

Crucially, all of the improvements in Northern Ireland were made with very limited injections of additional cash, and without any major structural changes. No extra money was put into A&E, while inpatients received only an additional £40m per year for the past 4 years to help reduce waiting lists, according to latest data. The main focus was on achieving more by better use of existing facilities and resources. Hospitals were told that they must break-even. In the event that a hospital failed to do so, it was required to submit a recovery plan to the Department.

We have looked at the latest statistics from the HSE on waiting lists and waiting times, and estimated the reductions that could be made over the next four years if the Northern Ireland model was introduced. The results are startling:

- **Inpatients:** The number of inpatients in Ireland waiting for over 3 months would drop from 20,000 in 2009 to 4,000 in 2014, a massive 80% reduction.

- **Outpatients:** Unfortunately, the HSE does not publish outpatient numbers. However, the estimated numbers are over 150,000. If we make the same progress on outpatients as that made in Northern Ireland, total outpatients will fall to just over 62,000 in 2014, a 60% decrease. More importantly, 90% of these patients will be seen within 9 weeks.

If we are to replicate the success of Northern Ireland, it is clear that a number of key changes will need to be made to how our health service is run and managed. A Fine Gael Government will make the following changes within the first few months of being in power:

The Minister will take direct responsibility for reducing waiting lists/times

One of the key drivers of change in Northern Ireland was direct Ministerial involvement. Indeed, it is safe to say that much of the progress made could not have been achieved without direct pressure/encouragement from the top. The Minister was involved at every step of the reform process, with weekly and sometimes daily

briefings. A system of real-time data allowed the Minister to get instant information on progress at individual hospitals.

In the Republic, by contrast, the establishment of the HSE has isolated and insulated our Minister of Health from what is happening in hospitals on a daily basis. In addition, it has allowed the Minister and her Department to distance themselves from responsibility for how the health service works. This has not only created a huge democratic deficit at the heart of the Irish healthcare, but has removed much needed leadership.

Fine Gael will place responsibility for the health service back where it belongs – with the Minister.

Fine Gael Will Set Non-Negotiable Targets for Access
These targets - for A&E, diagnostics, inpatient and outpatient care - will cover each individual hospital, and be monitored on a real-time basis. The Minister will give a detailed report to the Dail ever month, setting out progress made and indicating what actions will be taken if and when targets are missed.

As part of this effort, a Fine Gael Minister for Health will address the scandalous lack of reliable data in the health service. An effective and responsive health service cannot be created if reliable, real-time information is not available. A standardised data collection system, which does not repeat the mistake of PPARS, is needed throughout the health service. It should be tied into an electronic patient record system (see below).

It is clear from Fine Gael's analysis of other health care systems that efficiency can be hugely increased by doing some very simple things, e.g., pooling consultant lists, ensuring proper pre-op assessments are undertaken, increasing theatre utilisation times, etc. Work done by the NHS has also shown that measures such as improving access to diagnostic tests, increasing the number of day cases, etc., can have a dramatic impact on bed availability and waiting times.

In Ireland, a great deal more work also needs to be done on establishing "treatment pathways", i.e. setting out clear clinical rules for when patients can be seen and treated in the primary sector, how long they should spend in hospital, and what kind of care-in-the community is appropriate once the patient has left hospital.

Fine Gael Will Create a New Service Delivery Unit
A similar-type unit was established in Northern Ireland and proved very effective. We propose that a small cadre of experienced managers, clinicians and health economists staff the Service Delivery Unit (SDU). The SDU's role will be to ensure that targets are met, and to act as a source of expertise for healthcare professionals and managers. Key personnel may need to be seconded from other health care systems that have successfully improved access.

The SDU will be placed within the Department of Health and Children (DOHC) to emphasise the Minister's direct responsibility for improving access. The NTPF will, in turn, be placed within the SDU to ensure that inefficient hospitals are not rewarded with NTPF funding by failing to reach targets. In addition, the current Performance

Management structure in the HSE will be folded into the SDU.

Local Hospitals Have a Key Role to Play under FairCare

Fine Gael has a very different view of the role to be played by local hospitals than the Government, which seems intent on downgrading them.

Local hospitals must be safe, and patient safety must be our first priority. International research suggests that complex trauma and complex surgery is not appropriate in a local hospital setting. However, there is also a very strong argument that local hospitals must have the ability to deal with complex medical conditions and less complex surgery. Safety is not simply about surgical competence, but is also about timely access. Time to treatment, particularly in remote geographical locations, is absolutely crucial.

Over the next few months, Fine Gael will publish specific proposals on the role of local hospitals. The key is to allow local hospitals, which do not have complex surgery, to retain the skillset required to incubate and ventilate, and to have the ability to undertake less complex surgical procedures.

PRIMARY CARE: A BIGGER ROLE

Since it was first announced in 2001, the Government has consistently failed to meet the key targets in its Primary Care strategy.

Fine Gael will give Primary Care the priority it deserves. By the end of our first term in Government, we will have a comprehensive network of new Primary Care centres to serve our communities. The community they serve will determine the size and scale of the centre. Depending on population coverage, their services will include X-Ray, Ultrasound, Endoscopy, Physio, CT and MRI scanning, etc. The centres will also include rooms for visiting specialists and will accommodate a robust community mental health service.

Patient flows to hospital will be further reduced by the availability of a National Body Test (NBT) to pick up illness early, and by the existence of chronic illness programmes for diseases such as high blood pressure, asthma, etc. to prevent the complications that land people in hospital.

We believe that the capital costs of this programme can largely be borne by the private sector, if appropriate long-term contracts are put in place. If additional incentives are required, such as Accelerated Capital Depreciation, this requirement will be addressed.

The Primary Care Challenge

Approximately 120,000 patients per day attend their GP. By contrast, only 3,700 patients per day attend A&E. If we could increase the number of patients attending their GP by just 350 or .3% by switching them from A&E to the primary sector, we could reduce A&E numbers by almost 10%.

Chronic conditions are the leading cause of illness, disability and death in Ireland. They affect a significant proportion of the Irish population and account for the majority of healthcare expenditures. As diagnostic technologies, such as MRI scanning, mature they can be located nearer the patient. In theory, therefore, the primary sector could take on more of the burden of looking after chronic patients, thereby reducing the pressure on hospitals. However, there are two problems:

1. There are not enough primary centres, with the right personnel and diagnostic equipment, to provide chronic patients with the service they require (see below).

Ireland has, as Figure 6 shows, a shortage of GPs compared with almost every other European country.

Figure 6: Ireland has a low number of GPs

EU-15 countries	GPs per 100,000 population
France	164
Austria	144
Germany	102
Italy	94
Luxembourg	91
Denmark	78
United Kingdom	67
Portugal	56
IRELAND	**52**
Netherlands	50

Source: Adelaide Hospital Society (2004 numbers)

In order to cope with the serious shortage of GPs, FG is proposing that better use be made of other skilled healthcare professionals, who could be trained to take on enhanced roles in Primary Care. For example, while Ireland has a shortage of doctors, it does not have a shortage of nurses who could be licensed to prescribe medication in certain circumstances. There are many examples of nurse-led projects in other countries, such as the UK and the Netherlands, that work very well. So far, very little has been done in Ireland in this area.

In addition, we believe the State must look at:

- Attracting more qualified GPs from overseas to practice in Ireland; and
- A reconfiguration of the funding of medical schools so that the necessary number of doctors is available in the longer term.

IRELAND NEEDS AN INTEGRATED HEALTH SYSTEM

It's not simply a question of GP numbers. There has been a great deal of talk about integrating primary and secondary care, as a way of allowing the primary sector to take on more responsibility. Yet when the HSE was established on 1 January 2005, primary and secondary care were deliberately separated into two distinct service "pillars" - the National Hospitals Office, on the one hand, and Primary, Community and Continuing Care, on the other hand.

Fortunately, the Minister is now planning to combine the two pillars under a unified management system. It is, however, going to take a lot more than a bureaucratic reorganisation to ensure meaningful integration of primary and secondary care. Fine Gael in Government will make the following changes:

- There will greater representation of primary care specialists on hospital boards and other policy-making units in the secondary sector.
- There will be more involvement by consultants in community-care initiatives.
- Much greater coordination between the two sectors on budget planning for local areas.

- We will allow "rapid access" by GPs to diagnostic services at hospitals, without having to go through consultants or referring patients to an A&E department.
- We will introduce a scheme for GPs that will incentivise them to undertake simple procedures like suturing patients at their surgeries, rather than sending them into hospital.
- We will prioritise the creation of an electronic patient register/record, with strong personal privacy protection, that will allow authorised GPs and medical consultants to access the same essential information regarding current treatment needs and medications. Although some progress is being made, the effort currently is fragmentary and is without strong central leadership.

The Government's Primary Care Strategy Is Not Working

Eight years since the publication of the Primary Care Strategy (2001), primary care remains fragmented, inadequately resourced & under staffed.

We were supposed to have 300 teams in place by 2008, 400 by 2009 and 500 by 2011 – however years have passed with little or no progress. To date, there are some 97 teams in place, however only 10 of these are fully functioning.

The HSE is rapidly creating phantom primary care teams that are understaffed, under funded & do not have the appropriate infrastructure required for modern care.

Fine Gael will give Primary Care the priority it deserves. By the end of our first term in Government, we will have a comprehensive network of new Primary Care centres to serve our communities. The community they serve will determine the size and scale of the centre. Depending on the population they cover, their services will include X-Ray, Ultrasound, Endoscopy, Physio, CT and MRI scanning, etc. The centres will also include rooms for specialists. The centres will be staffed by doctors, nurses, physios and other healthcare professionals.

We envisage two types of Centres:

1. Model 1 will involve placing a fairly large number of GPs in a centre that also accommodates a full range of health professionals. This model will make most sense for major population centres, where hospitals are overwhelmed with minor cases and public transport is readily available.
2. Model 2 will see GPs remaining in their own buildings but linked to a local centre, which can provide diagnostic tests and outpatient clinics, either in a separate building or in one of the GP practices.

We are confident that the capital costs of this programme can largely be borne by the private sector, if appropriate long-term contracts are put in place. If additional incentives are required, such as Accelerated Capital Depreciation, we will also put them in place.

Fine Gael recognises that significant bed capacity in hospitals could also be freed-up if patients facing delayed discharge or requiring rehabilitation could be treated in the Community. We will publish specific proposals on this issue over the next few months.

PHASE 2

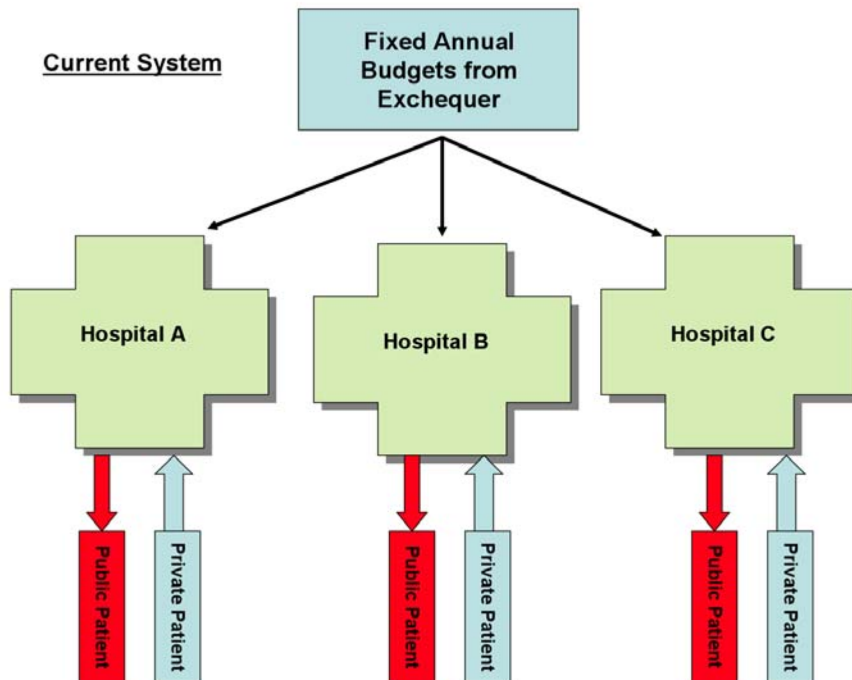
“MONEY FOLLOWS THE PATIENT”

PAYMENT by RESULT

Even if the HSE is forced by a Fine Gael Government to become more efficient, it will never be as effective as it should be for one simple reason: There are no incentives in the system. The goal must be to create a ‘self-improving’ health service where there are specific incentives to encourage improved performance.

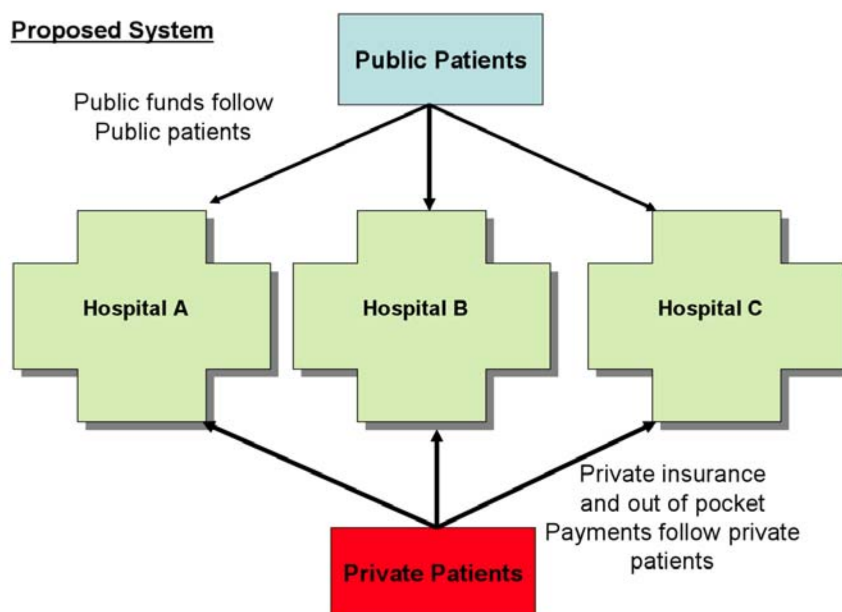
Under the current system of fixed budgets, each additional patient is effectively a “cost” to the health service, and reduces the overall pot of money available for other patients and services. Hospitals are basically penalised for treating more patients. In other words, the current system is actually based around a system of “perverse incentives”.

Figure 7: Current system of fixed budgets



We propose that Ireland should move, once our Phase 1 reforms begin to bear fruit, to an alternative tariff-based scheme where the health service providers are paid based on the number of patients it treats; a system where “money follows the patient (MFTP)”. The key advantage of such an approach is that patients become a source of “income” rather than a “cost”. The more patients that are treated, the more money a hospital earns. Conversely, if fewer patients are treated, the hospital receives less money.

Figure 8: A MFTP system



MFTP is not a policy goal in and of itself, but rather a tool to support the delivery of a reformed health service that delivers both improved health outcome and increased efficiency.

> **Evidence from other countries with MFTP points to shorter waiting times (as in Australia) and shorter lengths of stay in hospital (as in Sweden).**
>
> **According to various studies, tariff-based systems can save up to 10% compared with other financing methods.**

MFTP WILL TAKE TIME TO IMPLEMENT

Implementing MFTP effectively will require a continuous process of improvement and fine-tuning over many years. The UK Department of Health published a document entitled "Reforming NHS financial flows: Introducing Payment by Results" back in 2002. It is only introducing a full "Payment by Result" (PbR) system in 2008/2009, covering 90% of hospital care. Fortunately, Ireland can learn from the experience of other countries, including Sweden and the US (the Government Medicare system has a very sophisticated tariff-based system in place) and speed up the process. We envisage introducing MFTP in Year 3 of a Fine Gael Government.

In order to put MFTP in place, two significant changes will have to be made:

Purchasers will be separated from providers

As part of MFTP, we will separate the providers of healthcare services (hospitals) from the main purchaser of those services (the State). The HSE will be split into two new healthcare commissioning authorities (CAs):

- A ***Healthcare Commissioning Authority*** (HCA) for the acquisition of "cure services" – hospital care, GP care, etc.

- A ***Care Services Authority*** (CSA) for the acquisition and provision of "care services" for the elderly, disabled, children, etc.

One of the major advantages of separating "cure" for "care" is that money for care services could not be siphoned off into the cure sector. Over the last few years the HSE has used money that was allocated for care services to plug gaps in the care budget. This is clearly unacceptable.

Tariffs will be set

Many of the conditions that need to be in place for MFTP are technical, such as accurate, timely and fully coded data on all the main activities delivered by hospitals. Once that information is in place, tariffs for relevant activities need to be set.

The English system bases the tariff on the average costs hospitals have incurred in the past (with adjustments for inflation and efficiency improvements). Other countries have used different approaches to tariff setting. In Sweden, for instance, tariff setting is linked to best clinical practice rather than average cost.

MFTP HAS SEVERAL CLEAR ADVANTAGES

MFTP has five key advantages:

1. Decentralised decision-making

The Government's decision to return the HSE to a regional structure does not go far enough. Too much of the key decision-making will still be done at the centre. Under our proposals, it would be up to each hospital to work out the best way for it to respond to a system where they are paid for what they actually do. Each hospital would have its own board and significantly greater responsibility for financial and manpower management. Such a system could lead to an increase in the number of independent, not-for-profit institutions.

2. Increased Efficiency

To better demonstrate how MFTP will work in practice, we have given an example of how tariffs might be applied to an individual hospital. This example is purely illustrative.

> HOSPITAL A is given a specific target of, say, 100 operations. It is paid in full for each of these operations if it reaches the target within a range of +/-2, i.e., 98-102 operations.
>
> The hospital is paid 50% of the full tariff for every operation it does above 102, to a ceiling of 120 operations in total.
>
> If the hospital does not do at least 98 operations, it will lose 200% of the full tariff for every operation below the target.

Crucially, tariffs can be adjusted each year to ensure increased efficiency, e.g., the tariff for each operation could be reduced by 3% each year in real terms. It would be up to the hospital to respond by performing more procedures or cutting its costs.

3. Greater Flexibility
Using the example above, the purchaser could specify that 5% of any operations conducted would have to be hip operations. Depending on demand, this figure could be adjusted each year.

4. Enhanced Transparency
Under MFTP, it would quickly become clear:

- Where money was being spent in the system; and
- Which hospitals were efficient at certain procedures, and which were not.

If certain hospitals were unable to compete, it would be up to the Department of Health to decide how to increase their productivity levels.

5. More patient choice
If MFTP works properly, hospitals would very quickly be looking for patients, rather than turning them down. This, in turn, would give patients increased choice on where they wanted to be treated.

KEY CHALLENGES CAN BE OVERCOME

International experience shows that it will take some time for the system to adjust to the new incentives. Tariffs will need to be calculated fairly and accurately to discourage tariff manipulation or misuse by participants. Put bluntly, participants need to be sure that the tariff system is not rigged to so that successful hospitals end up subsiding less successful hospitals.

There is a risk that MFTP incentivises “low-cost, low innovation, average-quality” provision, at the expense of quality and innovation. However, this risk will be offset by putting in place a system of targets and rewards for both quality and innovation.

PHASE 3

“UNIVERSAL HEALTH INSURANCE”

INSURANCE FOR EVERYONE

Although MFTP is a vital reform, it is not a complete solution to the problems of the Irish health service:

- First, the State remains the principal purchaser of services. Experience to date suggests that the State is very inefficient when it comes to contract negotiation and procurement. In addition, the State tends to be very bad at encouraging innovation in any system it controls.

- Second, MFTP does not directly address the private/public split that is at the heart of the inequity in the Irish health service.

The existence of a two-tier health system is both unfair and inefficient: unfair, because it delivers privileged access to some based on their ability to pay; inefficient, because it encourages duplication and waste. However, any move to abolish private healthcare would significantly limit peoples' right to choose. Fine Gael, therefore, proposes to move to a **single-tier health system, where <u>everyone</u> has Universal Health Insurance.**

UHI: The Best Medicine for Ireland's Failing Health System

Since WW2, there have been three waves of healthcare reform in Europe:

- The drive for universal healthcare and equal access in the immediate post-war period;

- The introduction of spending caps and rationing particularly in the last 20 to 30 years to keep costs under control; and

- The introduction of competition and incentives over the last few years to make health services more efficient and responsive to patient needs.

While Ireland was part of the first two waves of European reform, it has played little or no part in the third wave. In fact, the centralisation of the HSE in 2004 went in precisely the opposite direction to the decentralising reforms being introduced in many other European countries.

There are basically three different models of healthcare right now.

- **The Beveridge model** (centralised monopoly public health service provider financed from taxation: Ireland, UK);

- **The Business model** (voluntary private insurance: USA); and

- **The Bismarck model** (mandatory social insurance with decentralized, independent health providers: Germany, France, the Netherlands).

On most international comparison, the Bismarck model has been shown to produce superior results, because it combines two crucial features:

1. Universality; and
2. Insurance incentives.

By contrast, as Figure 9 shows, the other two models have only one of these two features.

Figure 9: The 3 B's

CRITERIA	THE BEVERIDGE MODEL	THE BUSINESS MODEL	THE BISMARCK MODEL
UNIVERSALITY	**Yes.**	**No.**	**Yes.**
INSURANCE IS KEY	**No.** Primarily tax-funded. Individuals can purchase supplementary private insurance to "jump the queue". (UK, IRELAND)	**Yes.** The system is primarily driven by the voluntary private health insurance (USA)	**Yes.** Individuals purchase mandatory health insurance. (FRANCE, GERMANY, THE NETHERLANDS)

REFORM, an independent think-tank, has looked at a variety of international case studies. It has concluded that insurance incentives in healthcare are vital because they:

- Achieve greater value.
- Help de-politicise healthcare.
- Provide reasons for individuals and authorities to value long term improvements in health and wellbeing; and
- Define exactly what individuals are covered for, ending postcode lottery and empowering individuals to demand their rights from providers.

For all of these reasons, we propose that Ireland should move from its current tax-based system to a UHI system.

TWO MODELS OF UHI

There are two models of UHI:

- A Single-Payer model, where premiums are paid into a single health fund, overseen ultimately by the Government; and

- A Managed Competition model, such as that in the Netherlands, where consumers pay their premiums directly to competing health insurance providers, who buy services from the healthcare providers.

The main advantage of the Single-Payer system is its simplicity. Like a tax-based system, the Government remains in charge. However, the Single-Payer system also has some very real disadvantages:

1. The 50% of the population with private health insurance would lose it.

2. Second, it does not address the State's very poor track record in driving innovation in the health system and in making deals that generate value-for-money.

Fine Gael is convinced that under the Dutch system, properly incentivised and managed insurance companies will strike better deals than the State with the health providers, and will drive innovation as a way to maximise service and reduce costs. In addition, we believe it makes sense to construct a UHI system that acknowledges that 50% of Irish people already have a relationship with a private insurance company.

The transitioning of Ireland's health service from a largely tax-based system, to a managed competition, insurance-based system, will be neither quick nor easy. The Dutch have encountered many problems along the way, and their current system is far from perfect. In addition, it will be essential that all of the major stakeholders in the Irish health system buy-in to the process.

Within its first 30 days in office, a Fine Gael Government will establish a **UHI COMMISSION**, which will include representatives from all of the major stakeholders in the health service. Its primary task will be to build a consensus around the practical measures that need to be taken to prepare the health system for UHI. In particular, the UHI Commission will be asked to advise a Fine Gael Government on what lessons we can learn from the experience, good and bad, of the Netherlands and other countries moving to a managed competition model.

The Commission will also advise the Government on such key issues as striking the right balance in funding the health system between general taxation, insurance premiums and out-of-pocket payments. It will also advise on the crucial issue of strong regulation, since this is one of the keys to success for any insurance system. The Regulator will be answerable to the Minister and the Oireachtas.

The Commission's work will be guided by three basic principles:

- The patient must be put at the heart of the system. Their interests, and not those of healthcare providers or the HSE bureaucracy, must be paramount.

- To the maximum extent possible, no insured person should be worse off financially under UHI compared to the tax-based system we have now. When UHI is introduced, insurance premiums should be no higher than current levels, indexed appropriately.

- The system should be both fair and efficient. While value for money is vital, the "not for profit" ethos must remain at the heart of the Irish health system, with the State acting as guarantor for high standards and quality.

Going Dutch: How UHI Will Work

Figure 10 summaries how the Dutch model of UHI works in practice. There are two sets of key relationships:

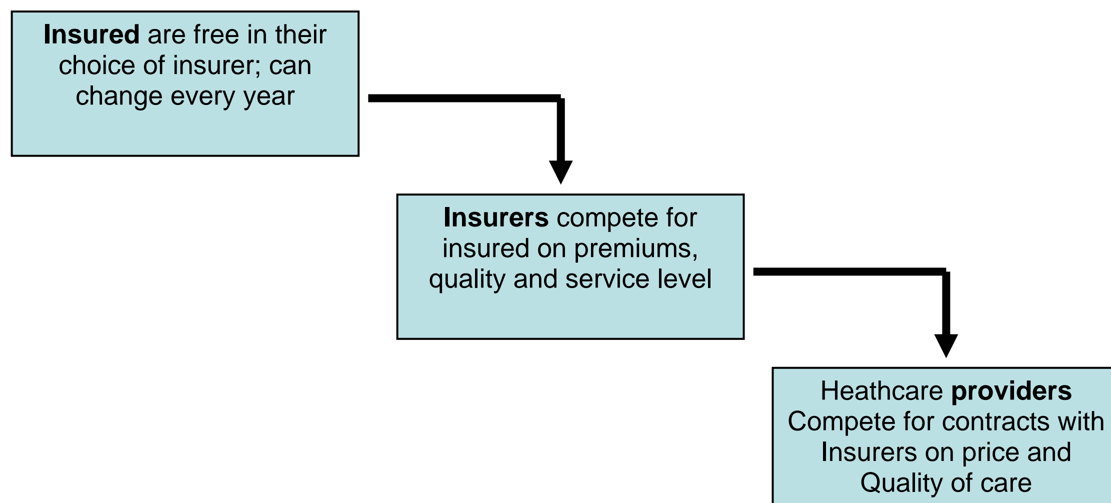
1. Between the insurers and the insured; and
2. Between the insurers and the healthcare providers.

In essence, the insured are free to join any insurer and can change their insurer each year. All of the insurers must offer a standard insurance package, mandated by the State, covering all of the essential services and treatments one would normally expect – GP and hospital care, medicines, maternity care, ambulances, etc. It will also include cover for psychiatric illness. The insurance companies compete for business largely on the basis of price and reputation (the package of services covered is determined by the State). The insured will have every incentive to look for the best package available.

The insurers can offer supplemental packages to cover items not in the standard package – non-essential medical treatments such as additional dental treatments and therapies for adults, etc. – but this will not be regulated by the State and customers will have to pay for this supplementary insurance coverage out of their own pockets.

The final step in the system is the relationship between the healthcare providers and the insurers. The providers compete for contracts with the insurers on the basis of price and quality of care.

Figure 10: The Dutch Model of UHI with Managed Competition



Everyone is a member

Each of the insurance companies will have to offer the standard package to each of its customers at the same price, i.e. there will be strict community rating. There will also

be an “obligation to cover”, meaning that insurance companies will not be allowed to turn anyone down, or charge differently, on the basis of age, sex, medical history, etc.

The State will fund the insurance premiums of everyone holding a medical card, and children under 18 years. Low-income groups will receive a “healthcare allowance” which they would pay to their chosen insurer. Crucially, everyone will be entitled to free GP care packages.

Primary care is strengthened
GPs will remain the gatekeepers to the system, deciding where a patient should be referred. Insurance companies will **not** be able to dictate treatment. Insurance companies will, however, have every incentive to keep as many people out of hospital as possible. As a result, insurance companies will push resources into primary care as a way of reducing overall costs. In the Netherlands, for instance, nurse practitioners are used extensively to perform check-ups on the chronically ill, as a way of keeping them away from hospital.

The system remains progressive
Around 75% of funding for healthcare would continue to come from taxation on income, paid into a new Risk Equalisation Fund and to pay for the insurance subsidies for children and lower-income groups. This fund would compensate insurance companies for covering higher-risk, higher-cost patients.

Economies of scale will reduce insurance costs
Because the number of insured people in Ireland would rise from about 50% of the population currently to 100% under UHI, the insurance companies would have greater economies of scale, allowing savings to be passed on to customers.

The State’s role remains vital…
Under the Dutch model of UHI, the Government is neither the provider nor the chief funder of healthcare. However, it remains the ultimate guarantor of the system. It will be the Department of Health’s job to ensure that safety and quality were maintained at the highest level throughout the system. In addition, it will be up to the Government to ensure that the system remained truly competitive. More generally, the State will still be responsible for the funding of long term care, mental health, services to improve and protect public health, disease prevention, health research, education and training, etc.

… but the system becomes much less politicised and more personalised
The experience of the Netherlands suggests that political involvement in the health system is significantly less than in systems which are tax-funded. All of the evidence from the Netherlands is that the role of the individual has been significantly strengthened.

Local hospitals should do well under UHI
Fine Gael has a very different view of the role to be played by local hospitals than the Government, which seems intent on downgrading them. Over the next few months, we will publish specific proposals on the role of local hospitals, under the current system.

Our analysis of the Dutch system suggests that the smaller hospitals have been able to compete successfully with the bigger hospitals, by being more adaptable. We believe, therefore, that UHI offers local hospitals a sustainable role in Ireland's healthcare system over the longer term.

Under UHI, public hospitals will continue to be owned by the State, but will be governed and managed by Local Hospital Trusts. This will allow them to better meet the needs of the local community and their patients. Instead of the HSE determining the future of a local hospital, its future will now be in local hands.

Voluntary Hospitals will continue to be run by their Boards. The evidence from other countries is that these independent, not-for-profit hospitals tend to do best under systems of universal health insurance. The reasons for this are not fully understood, but it appears that the caring ethos of not-for-profit hospitals leads to higher quality treatment and greater trust among patients and their insurance companies.

CONCLUSION

FairCare is an ambitious but achievable programme of reform, the most radical in Irish health policy since the establishment of the State. There will be some who argue that the health system cannot be fixed. We profoundly disagree. We are convinced that the health system can not only be fixed, but can become one of the best in Europe.

There will be others who will argue that we cannot afford FairCare or any ambitious programme of change right now. To those we way: We cannot afford to keep the current unfair, inefficient and under-performing health system in place. The Status Quo is simply not a credible option. Our people deserve much better.