



CERIS

CENTRE FOR ECONOMIC RESEARCH
ON INCLUSIVITY AND SUSTAINABILITY

The Sustainability of Ireland's Health Care System

Working Paper Series 2020/02

Cite as: Cullinan J, Connolly S, Whyte R (2020) The Sustainability of Ireland's Health Care System, Centre for Economic Research on Inclusivity and Sustainability (CERIS) Working Paper Series, 2020/02.

The Sustainability of Ireland's Health Care System

John Cullinan^{1*}, Sheelah Connolly², Richard Whyte³

¹ School of Business and Economics, National University of Ireland Galway, Galway, Ireland.

² Economic and Social Research Institute, Dublin, Ireland.

³ The Centre for Health Policy and Management, Trinity College Dublin, Dublin, Ireland.

* Corresponding author: Discipline of Economics, School of Business and Economics, National University of Ireland Galway, Galway, Ireland. Tel: +353 (0)91 493996. Email: john.cullinan@nuigalway.ie.

1. Introduction

Ireland's health care system has been characterised as a unique mix of a publicly funded health service and a fee-based private system (Nolan, 2017). The distinctive and complex structure of the sector, which involves both public and private financing and delivery of services, has important implications for the allocation of resources and for overall sustainability. In addition, though Ireland currently has a comparatively small and relatively young population of 4.9 million people, it has experienced, and continues to experience, significant population growth. Moreover, the effects of Ireland's financial crisis and subsequent economic contraction, when GNP fell by almost 20% between 2008 and 2011, had a major impact on the sector (Thomas et al., 2014).

Long-term risks to the sustainability of health care expenditure have been identified. For example, European Commission (2018) states that public spending on health as a share of gross domestic product (GDP) is expected to increase by one percentage point between 2016 and 2070 and by two percentage points for public spending on long-term care. These projected increases are above the EU average and mainly due to demographic factors. There are also a range of additional challenges that are relevant for sustainability. These include high rates of chronic disease and unmet need, as well as supply side issues such as labour costs and pharmaceutical prices, new technologies and drug therapies, and health care provider incentive structures.

The situation is not all bleak however. In a recent country health profile for Ireland, OECD/European Observatory on Health Systems and Policies (2019; p.3) noted that “the health status of Irish people has improved substantially since 2000, with life expectancy registering huge gains and most people reporting being in good health.” Nonetheless, they also state that “despite this progress, there is consensus in Ireland that the health system is underperforming and that a fundamental transformation is needed to make it fit to meet future demands associated with an ageing society” (*ibid.*; p.3). In terms of specific sustainability-related issues, they highlight a need to improve access to health care services, as well as more consistent workforce planning and better budget management at all levels of the system.

Within this broad context, this chapter examines the sustainability of Ireland’s health care system. It starts with an overview of the key features of the system, followed by an analysis of recently compiled and up-to-date data on trends in health care expenditures. The chapter then sets out and discusses a number of key issues relating to sustainability. This is followed by a discussion of a number of policy strategies and reform proposals relating to the Irish health care system that have sought to address, or which impact on, sustainability. The final section concludes.

2. Features of the Irish Health Care System

While many European countries moved towards universal health care in the first half of the twentieth century, this did not happen in Ireland (Wren and Connolly, 2019). Rather than regarding health care as a human right, in Ireland a libertarian perspective underlined much of the health policy developments during the twentieth century (Smith and Normand, 2011). Consequently, a means-tested medical care system was introduced in 1970, which extended free general practitioner (GP) care only to those who could not provide care for themselves “without undue hardship” (Wren, 2003). While free hospital care was introduced in 1991, ‘two-tier’ access became institutionalised, as hospital consultants retained the right to earn private fee income in public hospitals and to work simultaneously in public and private hospitals (Wren, 2003).

Despite significant changes in the governance and organisation of the sector in more recent years¹, the policy developments of the 1970s still underlie entitlement to, and provision of,

¹ There are currently three main bodies responsible for the governance and organisation of the Irish health care system. The Department of Health is tasked with the strategic development of the health service and with the

health care services in Ireland as of 2020. There are two main categories of entitlement to public health services, with eligibility largely determined by income and to a lesser extent health status. Those in ‘Category I’ (medical card holders) are entitled to, largely, free public health care services, while those in ‘Category II’ are entitled to subsidised public hospital services and prescription medicines, but pay the full cost of GP services and other primary and community care services.

In addition, individuals may access privately delivered health services in private and public hospitals, as well as in the primary and community care setting. These services are funded through a combination of out-of-pocket payments and supplementary private (voluntary) health insurance (PHI) (Thomson et al., 2014). Approximately 46% of the population are covered by PHI (mainly higher income groups), and it is mostly used to access private services delivered in both public and private hospitals. In addition, primary care services are mostly delivered by self-employed GPs, who are paid by capitation for public patients and fee-for-service for private patients².

Overall health spending in Ireland has increased at a relatively moderate rate in recent years and, at €3,406 per capita, was approximately one-fifth higher than the EU average in 2017 (OECD Health Statistics, 2019). This is despite a comparably young demographic and is mainly due to high health prices, with the use of both primary care services and hospital care lower in Ireland than the EU average (OECD/European Observatory on Health Systems and Policies, 2019). Overall, public funding accounts for 73% of all health spending, compared to an EU average of 79%, with out-of-pocket payments and PHI accounting for 12% and 13% respectively.

A number of notable and likely inter-related features of the Irish health care system stand out. First, as Nolan (2017; p.330) states, “what sets Ireland apart [in terms of health care financing] is the large proportion of the population that must pay out-of-pocket for primary care, particularly GP care”. In this regard, OECD/European Observatory on Health Systems and Policies (2019, p.16) note that “Ireland remains the only western European country without universal coverage for primary care”. Second, as Thomson et al. (2014; p.14) highlight, Ireland

translation of government policies into actions, while the Health Service Executive (HSE), established in 2005, provides all public health services in hospitals and communities across the country. The Health Information and Quality Authority (HIQA) is an independent agency responsible for monitoring and ensuring standards of care. It was established in 2007 and its mandate extends across a specified range of public, private and voluntary sector services.

² For more on the Irish system, see Nolan (2017).

has “poorly developed primary and community health services ... and a model of care delivery that favours hospitals over community-based care”. They also point out that “an additional challenge relates to the growing need for long-term care that, if not met, will add to pressures on hospital capacity and efficiency” (*ibid.*; p.14). Third, the increase in PHI in Ireland has facilitated the development of a two-tier system with long waiting lists in the public system.

Together the unique features of the Irish system, along with the aforementioned economic contraction, have resulted in capacity constraints in both primary and secondary care and long waiting lists in both settings, low numbers of hospital beds (2.9 per 1,000 population compared to an EU average of 5.1), challenges and constraints in recruiting and retaining health care professionals, as well as large rates of avoidable hospital admissions, suggesting room for improvement in primary care (OECD/European Observatory on Health Systems and Policies, 2019). In addition, there are concerns around bed occupancy and discharge rates in the hospital sector, which are likely related to cutbacks on spending on home help hours and transitional care. This is all in the context of repeated HSE spending overruns, amounting to an average of €500 million per annum from 2014-2018, which have been largely driven by hospital spending (IFAC, 2019).

Given all of these issues, a range of challenges to the sustainability of Ireland’s health care system have been identified (Nolan, 2017; Thomson et al., 2014; OECD/European Observatory on Health Systems and Policies, 2019; Brick et al., 2010). While some of these factors are outside the direct control of those running the health care system (e.g. demographic shifts and changing consumer expectations), there are other important supply-side drivers of health care expenditure (e.g. labour costs, expenditure on pharmaceuticals, provider incentives) that are amenable to policy change, some of which are directly related to the peculiarities of the Irish system. We discuss these factors in more detail in Section 4.

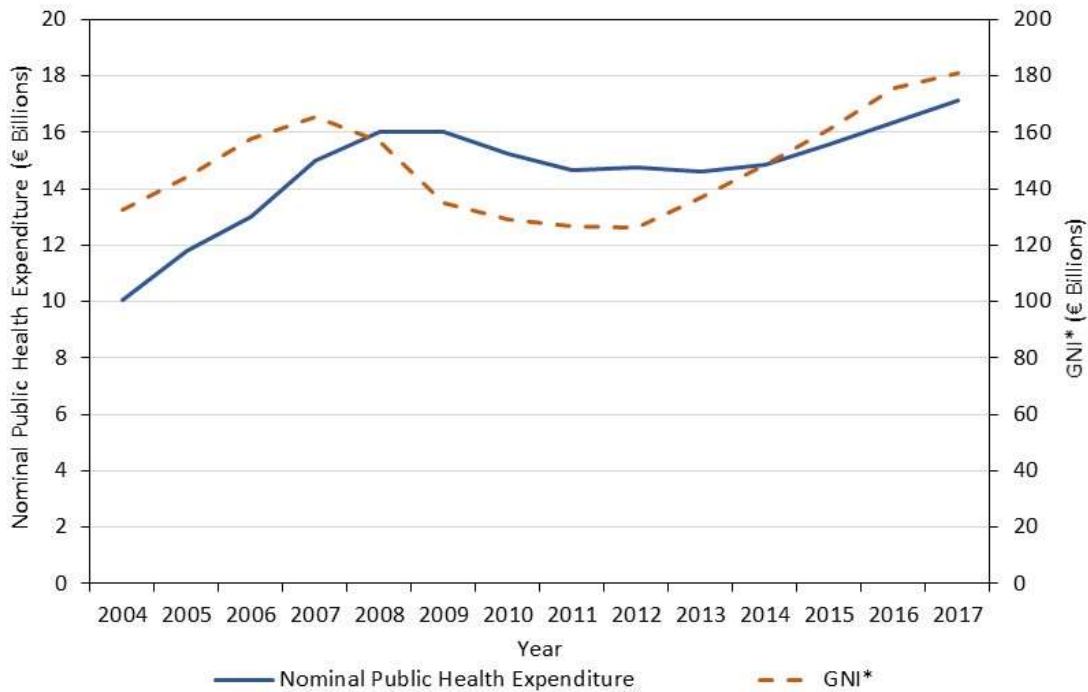
3. Recent Trends in Public Health Care Expenditures

In this section we review trends in public health care expenditures in Ireland to give a sense of how changes in national income, prices, and demographic factors have impacted total expenditure in recent years. We also consider changes in the components of (non-capital) expenditures by health sector, as well as a breakdown of pay and non-pay spending, to illustrate where costs arise in the system. We mainly focus on data relating to gross public health expenditure over time, which includes expenditure by providers of public services that may be

partly funded *via* income receipts such as private charges to patients – see Whyte et al. (2020), upon which this section is based, for more details³.

To begin, trends in nominal public health expenditure and modified gross national income (GNI*) for Ireland are illustrated in Figure 1⁴. Irish GNI* increased substantially between 2004 and 2007, before decreasing sharply during the recessionary period. Similarly, Irish nominal public health expenditure also grew considerably between 2004 and 2007, from €10 billion to €15 billion, and then by a further €1 billion in 2008, before the effect of the economic downturn was realised. Since 2012, GNI* and nominal public health expenditure have both increased, the former at a faster rate (43% versus 16%).

Figure 1: Nominal Public Health Expenditure and GNI*, 2004-2017.



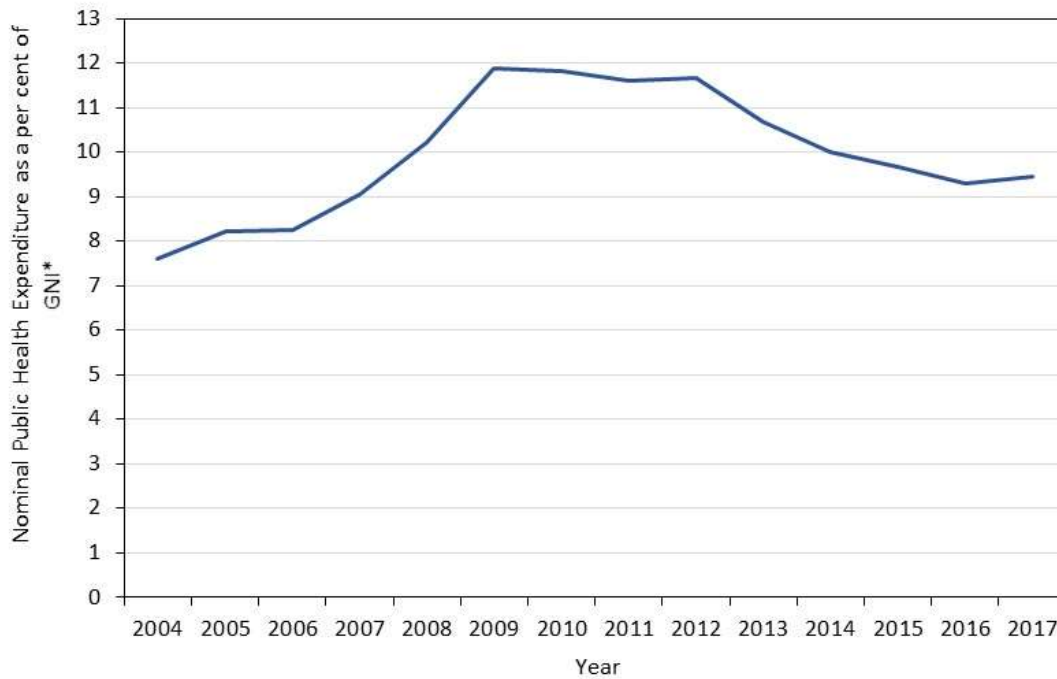
Source: Whyte et al. (2020).

³ In contrast, net expenditure excludes any expenditure not funded through taxation. Therefore, our analysis tracks expenditure on public health care services, as opposed to government financing of these services, though trends in the two are likely to be closely related.

⁴ GNI* was chosen to represent Ireland’s economic performance as other measures, such as GDP, are exaggerated by the returns of large multinational firms based in Ireland (Fitzgerald, 2015).

Figure 2 shows how nominal public health expenditure as a percentage of GNI* evolved over the same period. Pre-recession, between 2004 and 2007, there was an increase from 7.6% to 9.1%, indicating that public health expenditure was growing at a slightly faster rate than national income. It peaked at 11.9% of GNI* in 2009, after two years of decline in GNI* and no corresponding reduction in public health expenditure, before stabilising between 11.9% and 11.6% of GNI* between 2009 and 2012, as both decreased at similar rates. Since 2012 there has been a marked decrease in nominal public health expenditure as a percentage of GNI*, reflecting the relatively higher growth rate of GNI* shown in Figure 1.

Figure 2: Nominal Public Health Expenditure as a Percentage of GNI*, 2004-2017.



Source: Whyte et al. (2020).

So far the analysis has focussed on nominal public health care expenditure. In contrast, Table 1 presents changes in both nominal and real spending, in overall and per capita terms, and for different time periods⁵. It shows that although there was a large increase in overall nominal

⁵ To account for changes in prices, a deflator was constructed using the ratio of net expenditure by government on current goods and services in current prices to net expenditure by government on current goods and services in constant (2016) prices. See Whyte et al. (2020) for more details.

public expenditure over the period 2004-2017, the rate of increase is much lower when adjustments are made for changes in price, population growth and, in particular, population ageing. For example, the 74.2% increase in overall nominal expenditure over the 14-year period is 49.4% in real terms, 25.8% in real terms per capita, and 2.1% in real terms per capita of those aged 65 years or over.

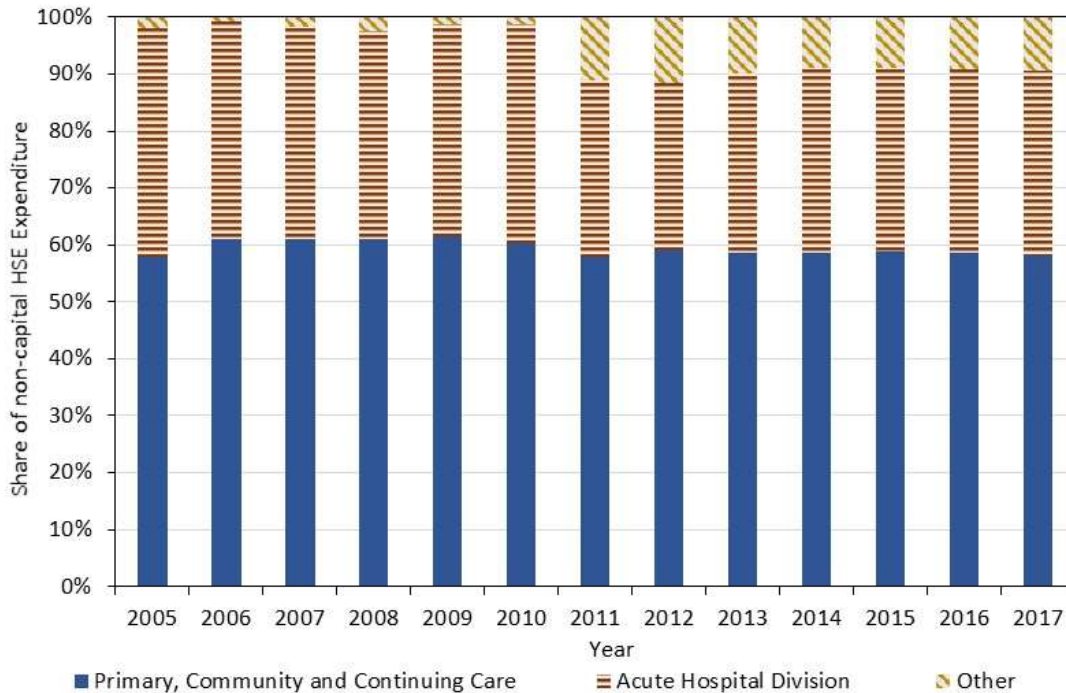
Table 1: Trends in Public Current Health Care Expenditure

	Change 2004-08 (%)	Change 2008-13 (%)	Change 2013-17 (%)	Change 2004-17 (%)	Annual Average Increase (%)
Nominal					
Overall	60.6	-7.2	16.9	74.2	4.4
Per capita	44.9	-10.4	13.0	46.7	3.0
Per capita (65+ years)	49.3	-21.4	1.4	19.0	1.3
Real (base = 2004)					
Overall	35.7	-4.1	14.8	49.4	3.1
Per capita	22.4	-7.3	10.9	25.8	1.8
Per capita (65+ years)	26.2	-18.7	-0.5	2.1	0.2

Source: Whyte et al. (2020).

In Ireland, the HSE provides all public health services and Figure 3 shows the share of non-capital HSE expenditure that was attributable to the acute hospital division and to primary, community and continuing care between 2005 and 2017. It is important to note here that some centralised costs that had been apportioned across divisions up to 2010 are recorded separately from 2011. As such, the shares of expenditure between 2011 and 2017 cannot be compared with those in the preceding years. Overall Figure 3 shows that the share of current HSE expenditure accounted for by primary, community and continuing care remained stable at about 60% between both 2005 and 2010, and 2011 and 2017, while the share accounted for by the acute hospital division remained stable at around 40% between 2005 and 2010, and at around 30% between 2011 and 2017.

Figure 3: Components of HSE Non-Capital Expenditure, 2005-2017.



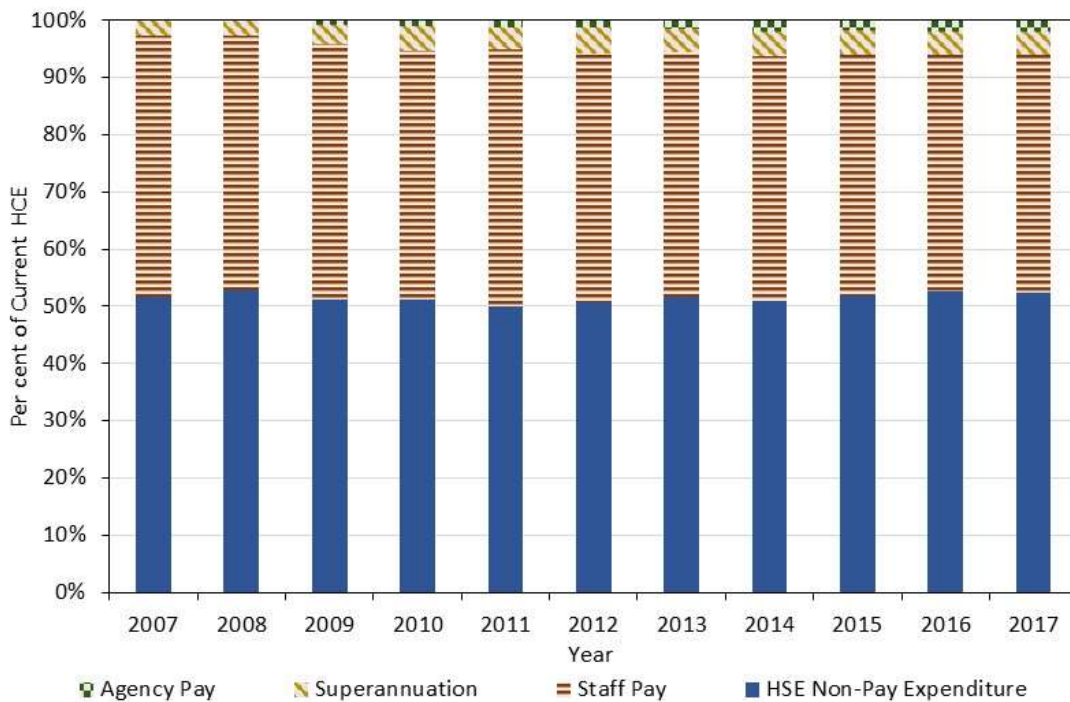
Source: Whyte et al. (2020).

Finally in this section, Figure 4 presents HSE non-pay expenditure, HSE staff pay expenditure, HSE superannuation, as well as agency pay, between 2007 and 2017⁶. Overall, HSE non-pay expenditure accounted for just over 50% of public current health expenditure in each year⁷, while HSE staff pay increased from €6.5 billion in 2007 to €6.9 billion in 2017. Despite this increase, the share of public current health expenditure attributed to HSE staff pay decreased by 9.4% between 2007 and 2017. This was due to increases in agency pay and HSE superannuation during this time. Agency pay was first recorded in 2009 and, between 2009 and 2017, tripled from €108 million to €326 million, with its share of public current health expenditure increasing by 180%. Superannuation increased from €368 million to €693 million between 2007 and 2010, with its share increasing by 62%.

⁶ It is important to note here that a large portion of non-pay expenditure is accounted for by pay to so-called Section 39 staff. These staff provide services similar or ancillary to services provided by the HSE, but are not bound to the HSE salary scales or subject to the employment control framework (ECF) (see Section 4). Payment to these staff could not be disentangled from HSE non-pay expenditure.

⁷ HSE staff pay includes pay to Section 38 staff, who provide health or personal social services on behalf of the HSE, are bound by HSE salary scales, and are subject to the ECF.

Figure 4: Pay and Non-pay Elements of HSE Expenditure, 2007-2017.



Source: Whyte et al. (2020).

In summary, the data presented in this section highlights that while there has been a considerable increase in nominal public health care expenditure since 2004, annual expenditure was highly variable due to fluctuating economic conditions, and the overall rate of increase is reduced when adjustments are made for increases in price, population growth and population ageing. In addition, the data illustrates that primary, community and continuing care account for the majority of current HSE expenditure, while there have been important changes in the pay component of HSE expenditure in recent years.

4. Challenges to Sustainability

Known drivers of health care expenditure growth internationally include demographic factors, income and wealth effects, technology, and cost pressures (Mason et al., 2019). In this section we review a number of factors that have been identified as presenting a potential challenge to the sustainability of the Irish health care system, distinguishing between demand and supply

side factors. In doing so, we also focus on how such challenges relate to the specific issues and trends identified in the previous sections.

4.1 Demand Side Factors

While there is considerable evidence that national income is likely to be the most important driver of overall public health expenditure (see Figure 1), important demand side factors that are also of particular relevance in the Irish context include demographic change and an increasing burden of chronic disease (Nolan, 2017).

In terms of demographic change, while Ireland's population is ageing like in many countries, what is unusual is the accompanying rapid growth in population size. At the time of the last census in 2016, the usually resident population was 4.7 million. However, according to the most recently available data from Ireland's Central Statistics Office (CSO)⁸, by 2051 there will be about 1.7 million more people in Ireland, with the percentage of the population aged 65 and over expected to increase from 13.3% in 2016 to 18.1% by 2031, and to 24.6% by 2051. Overall, the population aged 80 years or over is projected to increase by a noteworthy 270% over this period. Importantly, this projected demographic change follows a period of similar change. For example, Whyte et al. (2020) notes that the total population grew by 19% between 2004 and 2017, while the populations aged 65 plus and 85 plus grew by 46% and 63% respectively.

In this context, international research suggests that population ageing is not, and will not become, a major driver of growth in health expenditures (Williams et al., 2019), while Thomson et al. (2014; p.9) state that "growth in the overall size of the population is a much more important health-care cost driver than ageing". They also point out that, in the Irish context, population growth has not been matched by an increase in the capacity of the public health system, and that this has led to increases in waiting lists and waiting times. This is a pattern that has continued into 2020. While projected population increases in Ireland will undoubtedly lead to challenges for the sustainability of overall health care expenditures, the projected population ageing will also likely shift the type of care and range of services that is needed. In this regard, a recent report found that as a result of continued rapid population growth, demand for health and social care is projected to increase across all sectors, with

⁸ See <https://www.cso.ie/en/releasesandpublications/ep/p-plfp/populationandlabourforceprojections2017-2051/>. Accessed January 17, 2020.

substantial increases in the demand for those forms of care which are particularly required by older people sector (Wren et al., 2017). In terms of sustainability, this will “give rise to demand for additional expenditure, capital investment and expanded staffing and will have major implications for capacity planning, workforce planning and training” in the health and social care sector (*ibid.*; p.xxviii).

A second demand side factor of importance for sustainability, in part related to population ageing, concerns the incidence of chronic disease. While life expectancy has increased in Ireland, not all the additional years are healthy (OECD/European Observatory on Health Systems and Policies, 2019). In terms of risk factors, 17% of adults in Ireland smoked tobacco every day in 2018, a rate slightly below the EU average and down from 27% in 2002. However, almost a third of adults reported regular heavy alcohol intake in 2014, well in excess of the EU average, while the obesity rate increased from 15% in 2007 to 18% in 2015, also above the EU average (OECD/European Observatory on Health Systems and Policies, 2019). Chronic disease is particularly important in the Irish context since it accounts for 80% of total health expenditure (Nolan, 2017; Brick et al., 2010). Furthermore, given the predominant focus on hospital care relative to primary care and prevention, further increases in chronic disease may therefore have implications for sustainability. On the other hand, Nolan (2017) argues that shifts in care models, and a move to more preventive care in the community in particular, could mean that the impact on health care expenditure might be more modest.

4.2 Supply Side Factors

On the supply side, factors such as high and increasing health care prices, new technologies and therapies, as well as health care provider incentive structures, have all been identified as relevant in the Irish context (Nolan, 2017). For example, Thomson et al. (2014) highlighted that over the period 2005-2011, health care costs in Ireland increased at a much faster rate than other costs, with Ireland having the second highest health care cost inflation among EU15 countries. In relation to prices, there has been particular focus on both salaries and pharmaceuticals.

As shown in Section 3, labour costs are a key component of total health care expenditure in Ireland, accounting for around 50% of total health care expenditure and close to 70% of acute hospital spending (Nolan, 2017; Whyte et al., 2020). Overall, wages and salaries are relatively high internationally. For example, according to recent OECD data, average self-employed GP

remuneration in Ireland in 2016 was the second highest of 8 countries that reported in 2016, average salaried nurse remuneration was the fifth highest of 26 reporting countries, and average salaried specialist remuneration was the highest among 22 reporting countries (OECD, 2020).

In relation to trends in HSE pay expenditure and staffing, Whyte et al. (2020) provide a recent review. They find that while overall HSE pay increased by a relatively modest 4.4% between 2007 and 2017, there were decreases of 1.6% and 5.6% during the periods 2007-2010 and 2010-2013 respectively. These decreases were a direct result of an ECF, introduced in response to the economic crash, which consisted of incentivised early retirement, voluntary redundancy, and a moratorium on recruitment. As a result, reductions in HSE pay during this period were mainly driven by reductions in HSE staff numbers⁹. As HSE staff numbers rebounded post-2013, following the end of the ECF, this led to an increase in HSE pay. Data from Whyte et al. (2020) also indicates that incentivised early retirement and voluntary redundancy schemes, as well as the opportunity to retire with a pension based on pre-recessionary benefits until 2012, likely led to increases in superannuation during this period – see Figure 4. These decisions, alongside a moratorium on staff recruitment, may also have contributed to increases in agency pay. Overall, 119,000 staff were employed by the HSE (or in affiliated organisations) in 2017 and most of these staff can be expected to retire with a pension. Given increases in life expectancy, these staff may also be expected to live longer at pensionable age than previous generations of HSE staff and this may result in increases in HSE superannuation in years to come.

Overall, further increases and changes in the number and mix of employees in the sector will have important implications for health care expenditure and sustainability. This is particularly relevant given Ireland's growing and ageing population and the associated projected future demand for health care services (Wren et al., 2017). In this context, however, it is also important to note that a large number of posts, in particular GP and consultant posts, currently remain vacant, with difficulty filling them. This is likely, in part, a result of perceived poor working conditions, as well as relatively high rates of emigration by health care professionals.

Another area of concern in relation to sustainability in Ireland is expenditure on pharmaceutical drugs. In comparative terms, pharmaceutical expenditure (retail) per capita in Ireland is the third highest in the EU and the second highest for government/compulsory schemes (OECD,

⁹ Whyte et al. (2020) also point out that the reduction in HSE staff between 2007 and 2013 was associated with a 201.2% increase in agency pay from 2009 to 2017 and an 88.3% increase in HSE superannuation between 2007 and 2017.

2018). Ireland's relatively high pharmaceutical spend per capita is attributed to both higher-than-average prices and high medicine consumption per capita (Connors, 2017). Despite this, Ireland is below the EU average in pharmaceutical spending as a percentage of health expenditure, while the generic drugs market share is relatively low (OECD, 2018). Affordability is now a key issue, with pharmaceutical expenditure estimated to have exceeded €2.5 billion in 2019, with the key drivers of increasing expenditure being high-tech drugs and new hospital drugs (Connors, 2017). The former increased by €250m (76%) over the period 2009-2016, while pharmaceutical expenditure in hospitals increased annually by 8% in 2015 and 2016.

Given long-standing general concerns over the sustainability of pharmaceutical expenditure, legislation for a system of reference pricing and generic substitution was introduced in Ireland in 2013 and a new pricing agreement with pharmaceutical manufacturers was negotiated in 2016 (Nolan, 2017; Gorecki, 2018). While the Irish government claimed cumulative savings of €600 million for the 2016-2019 framework agreement, Gorecki (2018) argues that a better estimate is €290 million. Regardless of what the exact savings have been to date, it seems clear that funding new innovative medicines will be a significant challenge in the future, given the continued advancements in technology and the scale of new drugs coming on stream, as well as the high price attached to these new treatments (Connors, 2017).

A further issue relates to wasteful pharmaceutical spending and low-value care in general, including unnecessary tests, treatments, and diagnoses. Figueroa et al. (2020) claim that there is now broad consensus among experts that a considerable portion of health care spending is wasteful, though there is little evidence on the topic for Ireland. One exception is recent work by Byrne et al. (2019), who found that statins may be an example of low-value care in certain groups of patients and, in some cases, represent a waste of health care resources. They recommend that the concepts of overuse and low-value care should become integral to policy making and resource allocation decisions more generally. It would also help address sustainability concerns.

Another supply-side issue that has particular relevance in Ireland concerns financial incentives for health care provider. Both primary and secondary care physicians receive payment *via* a fee-for-service mechanism for their treatment of private patients, while they receive capitation or salary for treating public patients. While these conflicting financial incentives obviously raise equity issues in terms of physicians potentially preferring to treat private patients who represent an additional source of income, the use of fee-for-service in particular can contribute

to escalating health care expenditure. Given the link between activity and income, providers may provide too much care resulting in an increase in costs and potentially inappropriate care. In addition, fee-for-service payment mechanisms may discourage providers from delegating to other (more appropriate) providers (Saltman and Figueras, 1997), and generally do not provide any incentives to improve quality of care (Steinbrook, 2009). Recognising the potential limitations of fee-for-service, some countries have implemented alternative measures including blended payment mechanisms as well as measures which attempt to improve quality. This has not yet happened in Ireland.

A final threat to the sustainability of the Irish health care system relates to the aforementioned hospital-centric nature of the Irish health care system. The failure to adequately resource primary and social care services has contributed to increasing pressure on both the primary and secondary care sectors. While universal hospital care was nominally introduced in Ireland in the 1990s, this has not happened in primary care and a majority of the population pay out-of-pocket fees (approximately €55) for each GP visit. Given that public outpatient appointments are free at the point of use, it might be expected that individuals with, for example, a chronic condition, would seek to have their condition managed in the costlier out-patient department, rather than in primary care. Despite various proposals about reorienting the health system towards primary care, with an assumption that it could reduce overall costs, this has yet to happen in any meaningful way.

5. Policy

A number of strategies and reform proposals relating to the Irish health care system have been produced over the past twenty years. From an ideological perspective, it could be argued that in the decade to 2011, some of the significant health system reforms implemented centred on a neo-liberal ideology (Wren and Connolly, 2020) and, in particular, the promotion of the private sector. For example, government tax subsidies from the early 2000s promoted the growth of for-profit private hospitals, while opening up the formerly state-provided PHI industry to competition promoted the growth of tax-subsidised for-profit PHI (Tussing and Wren, 2006). It is likely that the promotion of the private sector was, in part at least, motivated by an attempt to ensure the sustainability of the public health care system, by moving expenditure from public to private. During the most recent economic downturn, the move from public to private was further compounded. For example, the automatic entitlement to a medical

card for those aged 70 and over was removed in 2009 and prescription charges for medical card holders were introduced for the first time in 2010. At the same time, there was an attempt to improve the efficiency of the health care system, including reducing staff numbers while maintaining levels of activity (Burke et al., 2014).

In 2011, there was a major shift in Irish health policy. For the first time in the history of the State, a government committed to universal health care and proposed to develop a health care system designed according to the European principle of social solidarity, where access would be according to need and payment would be according to ability to pay (Department of the Taoiseach 2011). In 2014, a White Paper *The Path to Universal Healthcare: White Paper on Universal Health Insurance* was published, which proposed a system of universal health insurance where every member of the population would be insured for the same package of services (Department of Health, 2014). The White Paper noted that people would buy insurance for this standard package from one of a number of competing health insurers, including for-profit health insurers, as well as the state-owned not-for-profit VHI Healthcare. Financial support would be available to ensure affordability with the State directly paying or subsidising the cost of insurance premia for all those who would qualify (Department of Health, 2014).

It might have been assumed that the proposed system of managed competition would encourage insurers to reduce their costs and premia in a bid to attract more customers; however, the available evidence does not readily support this assertion (Hsiao et al., 2011; Connolly and Wren, 2016). Indeed, subsequent analysis estimated that the proposed model would increase health care expenditure by between 3.5% and 10.7% (Wren et al., 2015). While some of this additional cost was associated with addressing unmet needs within the current system, the bigger driver of costs were the insurers' margin and transaction costs associated with this type of financing. Consequently, the policy was abandoned on cost grounds in 2015 (Department of Health, 2015).

While universal health insurance was no longer on the political agenda, an all-party parliamentary committee was established with the aim of achieving a single long-term vision for health care and the direction of health policy in Ireland. The Committee's 2017 *Sláintecare* report made a number of recommendations, including the introduction of universal GP and primary care, expanding primary and social care, delivering care at the lowest level of complexity, a move towards integrated care, reducing or removing out-of-pocket fees, and substantially increasing public health care expenditure and capacity in a tax-funded system (Houses of the Oireachtas Committee on the Future of Healthcare, 2017). While it was

acknowledged that the implementation of the proposed reforms would result in an increase in public health care expenditure for a number of years, the report did include some measures that it thought would ensure the health system would remain affordable and sustainable in the longer term, including increased use of health technology assessment (HTA) to guide service provision. In addition, the authors of the report noted that “better value for money will be achieved by ensuring that care is delivered at the lowest level of complexity that is clinically appropriate, that most care is delivered in primary and community settings, that the necessary priority is given to health promotion and preventive care, and that there is a strong focus on medicines management” (Houses of the Oireachtas Committee on the Future of Healthcare, 2017; p.28).

It remains to be seen what aspects and to what extent the Sláintecare proposals will be implemented. However, if the proposals were implemented in full, they could go some way to addressing some of the issues which have been identified as challenging the sustainability of Ireland’s health care system. For example, the emphasis on health promotion, preventive and primary care could help reduce the prevalence of chronic disease, as well as ensuring that such conditions are managed within the primary and community sectors, rather than the costlier hospital sector. In addition, the increased use of HTA may help to control expenditure by reducing or eliminating non- or less effective health care interventions, as well as providing guidance on which new drugs and health technologies should be publicly funded. However, to have a meaningful impact on health care expenditure, HTA would need to be extended to many existing and established interventions and treatments, rather than just new technologies.

Overall it appears that the Sláintecare proposals could help address the long-term sustainability of the Irish health care system. However, while an important first step in reforming health care systems (including ensuring sustainability) is to identify what needs to be done, even more important is identifying how it will be done and implementing the necessary reforms. There is a precedence in Irish health policy of identifying potential reform proposals that are not subsequently fully implemented. For example, as previously noted, the 2014 White Paper proposals on universal health care were subsequently abandoned on cost ground. Previous reform proposals about reorientating the health care system away from hospitals towards the community have also failed to be fully implemented. For example, the 2001 primary care strategy ‘A New Direction’ outlined a vision for primary care teams working in Ireland; however, a review of the policy 16 years after the publication of the report found that

interdisciplinary team working is not a routine way of working in Irish primary care (MacFarlane et al., 2017).

6. Conclusion

At present, health care expenditure in Ireland is relatively high. However, there is no universal entitlement to health care and access remains an issue for a number of services, with high out-of-pocket costs, inequitable access and long waiting lists. Increasingly, there is a recognition that a changing demographic structure (including population growth and ageing), an increase in chronic diseases, as well as the development of new health technologies, will put further pressure on the health care system in the coming years. This raises questions about what can be done to ensure the sustainability of the Irish health care system.

A number of approaches can be implemented to increase the financial sustainability of a public health system, including shifting expenditure from the public to the private (either *via* increasing out-of-pocket payments or PHI financing of health care), increasing the budget allocated to health care, or increasing the efficiency with which health services are delivered. In Ireland, shifting expenditure from public to private has been used in the past; however, it conflicts with current policy of moving towards universal health care, while given current public health care entitlements, is unlikely to address the growing demands on the public system. Similarly, it is unlikely that the health care budget can be increased to an extent that it will address existing limitations in the current system and the growing demand for health care services, without having significant repercussions for other sectors of the economy. One area where there may be some scope to increase expenditure is through the introduction and development of taxes on unhealthy goods. In 2018, for example, a sugar-tax was introduced in Ireland. However, the revenues raised from such taxes are relatively small and tend to decrease through time, as consumers and manufacturers change their behaviour. In addition, in Ireland at least, the dedication of a specific tax for a particular purpose is not common practice.

A final approach to ensuring the financial sustainability of the Irish health care system involves achieving efficiency gains. During the most recent economic downturn, in addition to decreasing population coverage, attempts were made to increase the efficiency of the health system. Implemented measures included, for example, reducing the prices paid for drugs and moving towards paying hospitals according to the care they deliver rather than lump sum budgets (Thomson et al., 2014). In addition, some of the current Sláintecare proposals also

attempt to increase efficiency of the health care system by, for example, increasing the use of HTA and delivering care at the lowest level of complexity (Houses of the Oireachtas Committee on the Future of Healthcare, 2017). However, improvements in efficiency have been limited and this may in part be explained by the lack of an evidence base on which to justify efficiency decisions. The discipline of health economics came relatively late to Ireland, though there are now a number of specialised postgraduate programmes that are helping to build greater capacity in the field.

While there has been a notable increase in the number of health economics researchers in Ireland in recent years (Cullinan, 2019), as well as research specifically relating to topics such as costs, efficiency, and expenditure (Gannon 2005; Boate, 2011; Wren et al., 2017; Gorecki 2018), there nonetheless remains a dearth of good quality evidence on which to base decisions around efficiency in Ireland and more is needed to forensically examine where efficiency gains can and should be made. For example, as discussed earlier, during the recent economic downturn, in a bid to cut costs, a range of staffing measures were introduced, including reductions in workforce pay, restrictions on recruitment, ceilings on staffing, redundancy schemes and incentivized early retirement. While these measures were successful in curbing public health care expenditure, they subsequently gave rise to a range of new challenges, including issues with the resulting configuration of staff and very high expenditure on agency staff (Thomson et al., 2014). Such examples highlight the need for an evidence base to distinguish between crude cuts and measures that secure real efficiency gains.

Thomson et al. (2014) have identified a number of areas where there is potential for efficiency gains in the Irish health care system, including paying GPs and consultants, increased use of diagnosis-related groups (DRGs) within the hospital setting, enhancing the primary and community sector and better integration between the hospital, primary and community sectors, as well as on the costs of pharmaceuticals. If these issues were appropriately addressed in the Irish context, they would likely go some way to ensuring the sustainability of the Irish health care system, especially in light of the challenges for sustainability identified in Section 4. While the Sláintecare report does identify many of these as areas to reform, there is a lack of detail about how they might be implemented in practice. In addition, three years after the publication of the Sláintecare report, progress has been slow and it remains unclear if, and to what extent, the proposals will be implemented. Notwithstanding the need to ensure sustainability of the Irish health care system (in terms of expenditure), there are also many other issues with the system that need to be addressed as a matter of urgency, in particular long waits for public

hospital services and poor provision of many primary and community based services. Therefore, a key challenge will be to address the limitations of the current system, while at the same time balancing the need for expenditure control.

References

Boate C (2011) Competition in primary healthcare in Ireland: More and better services for less money. *The Economic and Social Review*, 42, 313-342.

Brick A, Nolan A, O'Reilly J, Smith S (2010) *Resource Allocation, Financing and Sustainability in the Health Sector*. Dublin: Department of Health and Children and Economic and Social Research Institute.

Burke S, Thomas S, Barry S, Keegan C (2014) Indicators of health system coverage and activity in Ireland during the economic crisis 2008-2014 - From 'more with less' to 'less with less'. *Health Policy*, 117, 275-278.

Byrne P, Cullinan J, Smith S (2019) Statins for primary prevention of cardiovascular disease. *The BMJ*, 367:15674.

Connolly S, Wren MA (2016) The 2011 proposal for Universal Health Insurance in Ireland: Potential implications for healthcare expenditure. *Health Policy*, 120, 790-796.

Connors J (2017) *Future Sustainability of Pharmaceutical Expenditure*. Dublin: Department of Public Expenditure and Reform

Cullinan J (2019) Health in *The ESR*: Observations and reflections. *The Economic and Social Review*, 50, 653-665.

Department of Health (2014) *The Path to Universal Healthcare: White Paper on Universal Health Insurance*. Dublin: Department of Health.

Department of Health (2015) Statement by Minister Varadkar following cabinet discussion on UHI. Dublin: Department of Health.

Department of the Taoiseach (2011) *Programme for Government 2011-2016*. Dublin: Department of the Taoiseach.

European Commission (2018) *The 2018 Ageing Report – Economic and Budgetary Projections for the 28 EU Member States (2016-2070)*. Institutional Paper 079. Brussels: European Commission.

Figuerola J, Wadhwa R, Jha A (2020) Eliminating wasteful health care spending – Is the United States simply spinning its wheels? *JAMA Cardiology*, 5, 9-10.

Fitzgerald J (2015) *Problems Interpreting National Accounts in a Globalised Economy – Ireland*. Dublin: ESRI.

Gannon B (2005) Testing for variation in technical efficiency of hospitals in Ireland. *The Economic and Social Review*, 36, 273-294.

Gorecki P (2018) State/industry medicine pricing agreements, cost savings and counterfactuals: The case of Ireland. *The Economic and Social Review*, 49, 111-126.

Houses of the Oireachtas Committee on the Future of Healthcare (2017). *Slaintecare Report*. Dublin: Houses of the Oireachtas.

Hsiao W, Knight A, Kappel S, Done N (2011). What other states can learn from Vermont's bold experiment: Embracing a single-payer health care financing system. *Health Affairs*, 30, 1332-41.

IFAC (2019) *Fiscal Assessment Report*. Dublin: Irish Fiscal Advisory Council.

Macfarlane A, Tierney E, Hannigan A (2017) *Policy Brief: Interdisciplinary Team Working in Ireland: A New Direction 16 Years On*. University of Limerick.

Mason A, Rodriguez Santana I, Aragon MJ, Rice N, Chalkley M, Wittenberg R, Fernandez JL (2019) Drivers of health care expenditure: Final report. Working Papers 169, Centre for Health Economics, University of York.

Nolan A (2017) Health: funding, access and efficiency. In *The Economy of Ireland: Policy-Making in a Global Context*, John O'Hagan, Francis O'Toole (eds.).

OECD (2020) Health Care Resources: Remuneration of Health Professionals [Internet]. 2020 [cited 18/01/2020]. Available from: <https://stats.oecd.org/>.

OECD (2019). Health expenditure and financing [Internet]. OECD. 2019 [cited 14/03/2019]. Available from: http://stats.oecd.org/OECDStat_Metadata/ShowMetadata.ashx?Dataset=HEALTH_PROC&showOnWeb=true&Lang=en.

OECD (2018). *Health at a Glance: Europe 2018*. Paris: OECD Publishing.

OECD/European Observatory on Health Systems and Policies (2019), *Ireland: Country Health Profile 2019*. Paris: OECD Publishing.

- OECD Health Statistics, 2019 <http://www.oecd.org/els/health-systems/health-data.htm>
- Saltman RB, J Figueras (1997) *European Health Reform: Analysis of Current Strategies*. Copenhagen: World Health Organisation.
- Steinbrook R (2009) The end of fee-for-service medicine? Proposals for payment reforms in Massachusetts. *New England Journal of Medicine*, 361, 1038-1038
- Smith S, Normand C (2011). Equity in health care: The Irish perspective. *Health Economics, Policy and Law*, 6, 205-217.
- Thomas S, Burke S, Barry S (2014) The Irish health-care system and austerity: Sharing the pain. *The Lancet*, 383, 1545-1546.
- Thomson S, Jowett M, Mladovsky P (2014) Health system responses to financial pressures in Ireland: Policy options in an international context. European Observatory Studies Series 33. Copenhagen: WHO Regional Office for Europe.
- Tussing D, Wren MA (2006). *How Ireland Cares: The Case for Health Reform*. New Island.
- Whyte R, Wren MA, Keegan C, Brick A (2020) An Analysis of Trends in Irish Public Healthcare Expenditure and Staffing. ESRI Working Paper. Forthcoming.
- Williams G, Cylus J, Roubal T, Ong P, Barber S (2019) *Sustainable Health Financing with an Ageing Population*. Copenhagen: WHO Regional Office for Europe.
- Wren MA (2003) *Unhealthy State – Anatomy of a Sick Society*. New Island Books.
- Wren MA, Connolly S (2020). Healthcare and health policy in Ireland. In: Boucher and Watson (Eds), *Contemporary Ireland and Northern Ireland*, UCD Press.
- Wren MA, Connolly S (2019) A European late starter: Lessons from the history of reform in Irish health care. *Health Economics, Policy and Law*, 14, 355-373.
- Wren MA, Connolly S, N Cunningham (2015) An examination of the potential costs of universal health insurance. ESRI research series report 2015-11-18.
- Wren MA, Keegan C, Walsh B, Bergin A, Eighan J, Brick A, et al. (2017) *Projections of Demand for Healthcare in Ireland, 2015-2030. First Report from the Hippocrates Model*. Dublin: Economic and Social Research Institute.