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Sláintecare – a Pathway to Universal Healthcare

#TCDpathways
#slaintecare

Pathways to Universal Healthcare seminar

The Science Gallery, Trinity College Dublin

19 September 2017 9am-1pm

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Introduction to the Pathways Research Project

Prof Steve Thomas, Dr Sarah Barry, Dr Bridget Johnston, Rikke Siersbaek, Dr Sara Burke

Centre for Health Policy and Management

Mapping the Pathway to Universal Health Care in Ireland

Health Research Award from HRB (2014-2018)

Centre for Health Policy and Management, Trinity College Dublin

WHO Barcelona Office for Health Systems Strengthening

European Observatory for Health Policy and Systems

Second of three Annual Workshops

Website - https://medicine.tcd.ie/health-systems-research/

Twitter : @healthsystemie

Scope of the project

Aim: to provide an excellent evidence base that will inform strategic direction and implementation of universal healthcare in Ireland

1. Assessing the gap between current Irish health system performance and universal healthcare
2. Evaluating the strengths and weaknesses of different models of universal healthcare and assessing their feasibility of implementation
3. Assessing the organisational challenges of moving to universal healthcare by reviewing the experience of other countries & exploring the current capacity & constraints facing decision makers throughout the system

Project Component 1

Assessing the gap between Irish health system performance and UHC

Year 1 Project report (Available from http://www.tcd.ie/medicine/health-systems-research/pathways-links/)

Indicators and brief commentary - http://www.tcd.ie/medicine/health-systems-research/indicators.php

Peer-review publications

Burke, S, Normand, C, Barry, S, Thomas, S. (2015). From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis. *Health Policy*

Barry S, Burke S, Tyrrell E and Thomas S (2017) 'Is someone going to saw off the plank behind me?' – Healthcare managers priorities, challenges and expectations for service delivery and transformation during economic crisis. *Health Systems and Policy Research*

Williams D, Thomas S (2017) The Impact of austerity on the health workforce and the achievement of human resources for health policies in Ireland (2008-2014) *BMC Human Resources for Health*

Project Components 2 and 3

<u>Which Pathway?</u>

Identify possible distinct options

Assessing their feasibility of translation and implementation

Resource requirements

<u>Organisational Challenges</u>

Systematic review of the experience of other countries moving to UHC

Surveying health managers on current capacity constraints

Case studies and problem solving with managers

Sláintecare

Report of the Oireachtas Committee on Future Healthcare

http://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Slaintecare-Report-May-2017.pdf

Centre research team provided support in terms of:

- Pre-existing Pathways research
- Series of workshops to review and discuss material and scope out report (Nov-Dec 2016)
- Substantial technical assistance to Committee for the report production (Jan-May 2017)
- Carlsberg principle

Focus of the Day

Not just a presentation on Sláintecare

Review of technical analysis to support achievement of UHC in Ireland

1. **Technical work as presented to the Oireachtas committee and in Sláintecare**
2. **Technical analysis presented but not included in Sláintecare**
3. **New technical analysis (new data or fresh evaluation)**

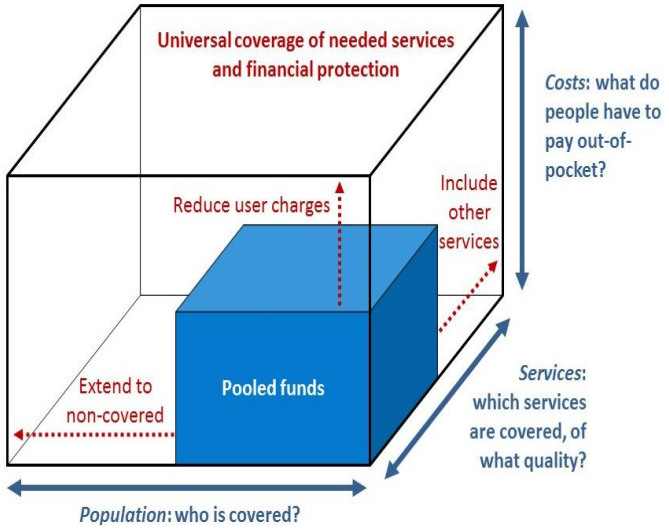
Workshop Programme

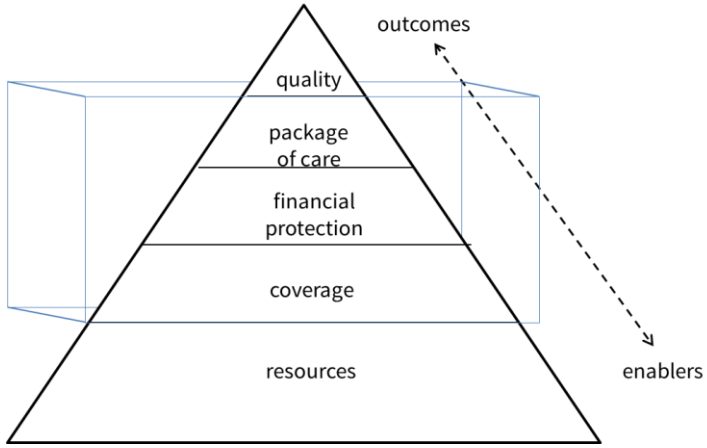
9.00	Welcome	Prof Michael Gill, Head of School of Medicine, Trinity College Dublin
9.15	Introduction to the Pathways research project	Dr Steve Thomas, Director of the Centre for Health Policy and Management, Trinity College Dublin
9.30	Technical foundations of Sláintecare • Entitlements • Integrated care • Financing	 Dr Sara Burke and Rikke Siersbaek Dr Sarah Barry Dr Steve Thomas and Dr Bridget Johnston Centre for Health Policy and Management, Trinity College Dublin
10.30	Panel discussion	Open to the floor (Chaired by Prof Charles Normand, Edward Kennedy Professor for Health Policy and Management, Trinity College Dublin)
11.00	*Coffee*	
11.30	Reflections from the Chair	Roisin Shortall, TD, Chairperson of the Oireachtas Committee on the Future of Healthcare
11.50	A policy analysis perspective	Dr Sara Burke
12.10	Learning from the international experience of implementing major health system reform	Dr Josep Figueras, Director of European Observatory on Health Systems and Policies and Head of the WHO European Centre on Health Policy in Brussels
12.30	Panel discussion	Open to the floor (Chaired by Prof Normand)
1.00	Close and lunch	

UHC and *Representations*

The goals of universal health coverage are to ensure that all people can access quality health services, to safe guard all people from public health risk, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments for healthcare or loss of income when a household member falls sick…

UHC consists of three inter-related components: i) the full spectrum of quality health services according to need; ii) financial protection from direct payment for health services when consumed; and iii) coverage for the entire population (WHO/World Bank, 2013: 1/10)

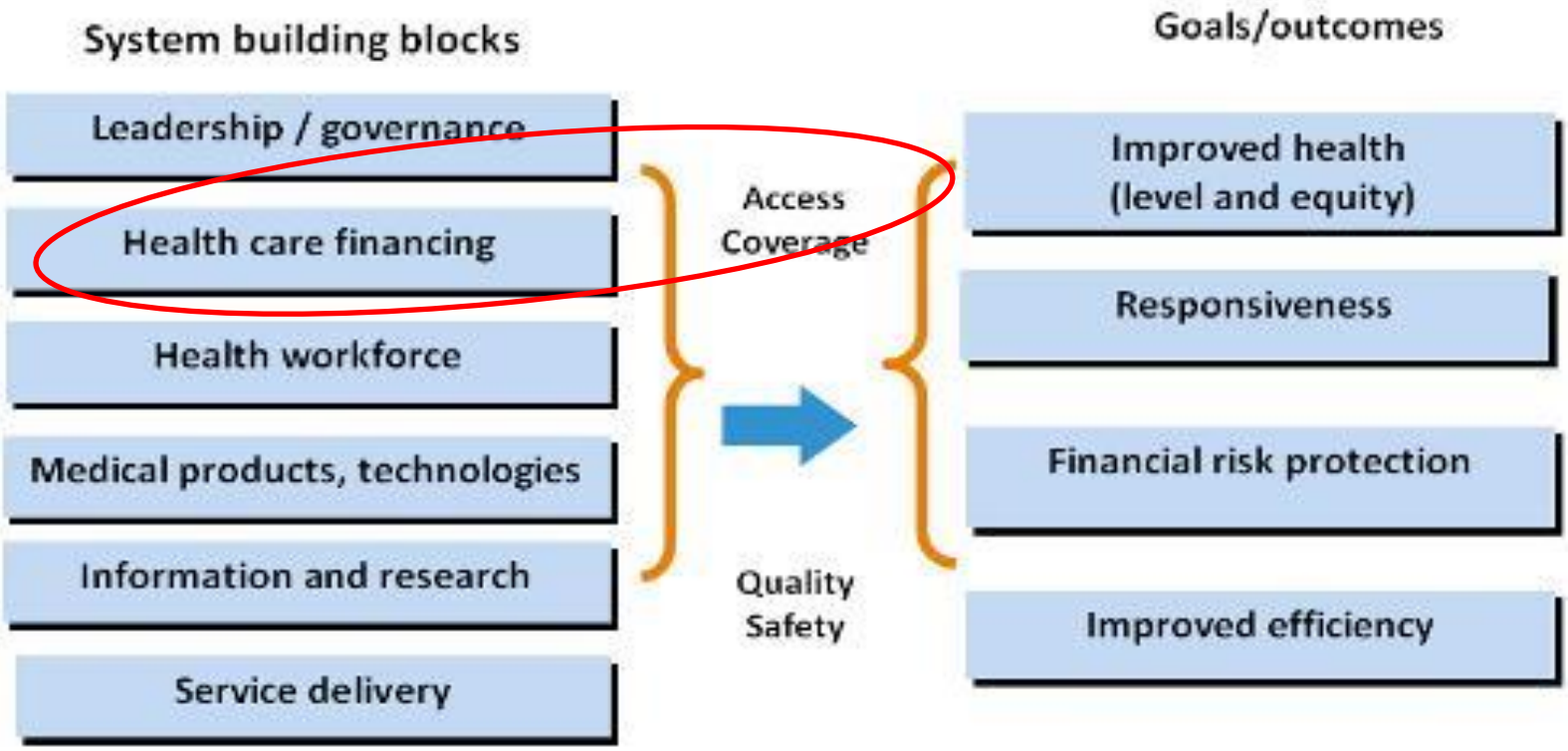




Appropriate, timely, high quality care and care pathways, affordable for all

Why is getting to UHC so tricky? (1)

It requires a whole system approach

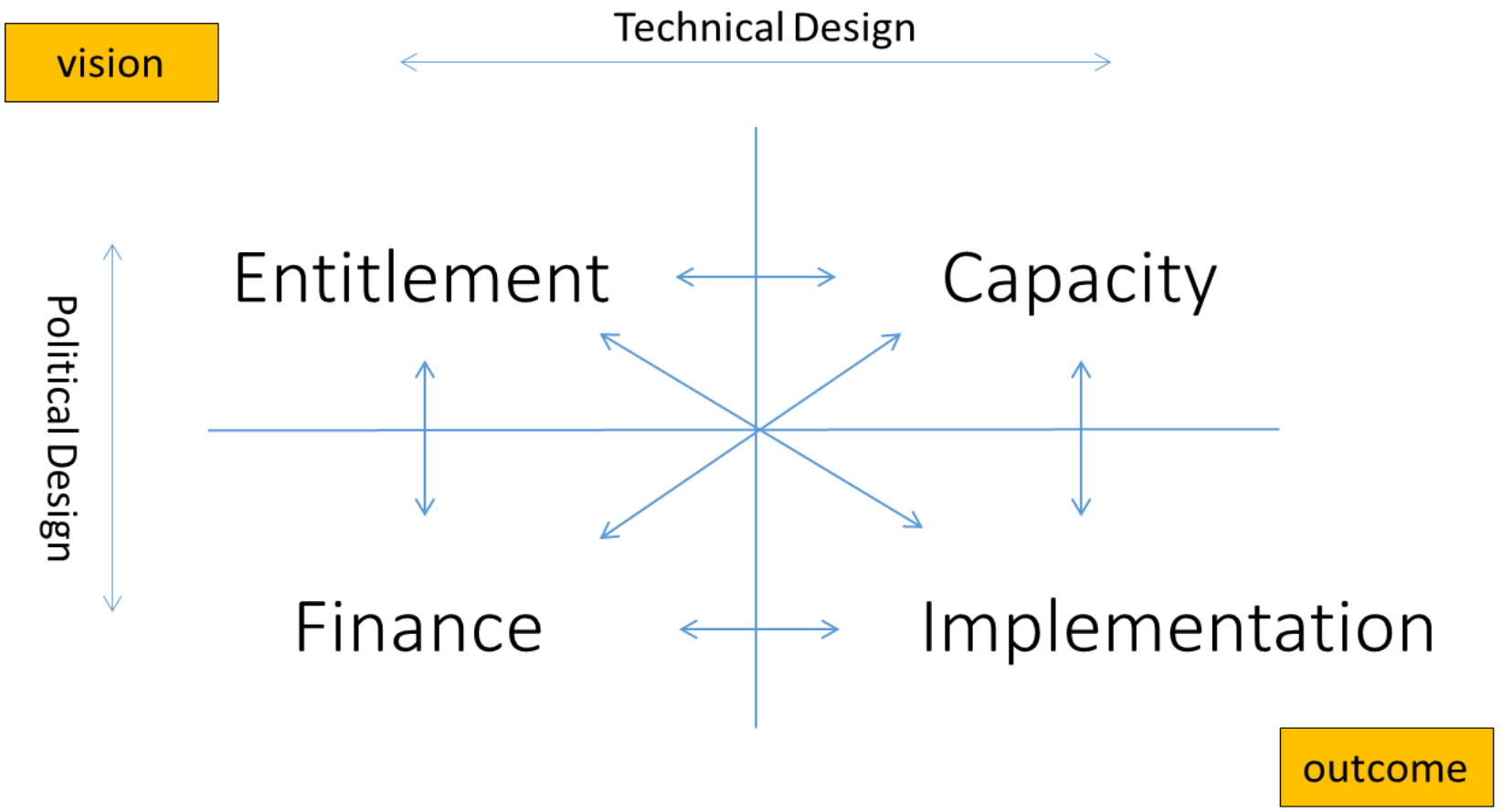


Why is it so tricky? (2)

Demand and Supply must match

1. **Removing price barriers creates more demand**
2. **Bolstering supply and capacity in response**
3. **Implicit decisions about patient pathways and resource deployment**
4. **Need for integrated reform – careful timing and phasing**

Integrated Reform for UHC



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Technical foundations of Sláintecare

Entitlements

Overview of presentation

- The context of entitlement expansion
- The basket of care – internationally and nationally
- International coverage
- Oireachtas Committee on the Future of Healthcare remit on entitlement
- Defining universal healthcare for Sláintecare
- A whole system approach
- The logic of the entitlement expansion

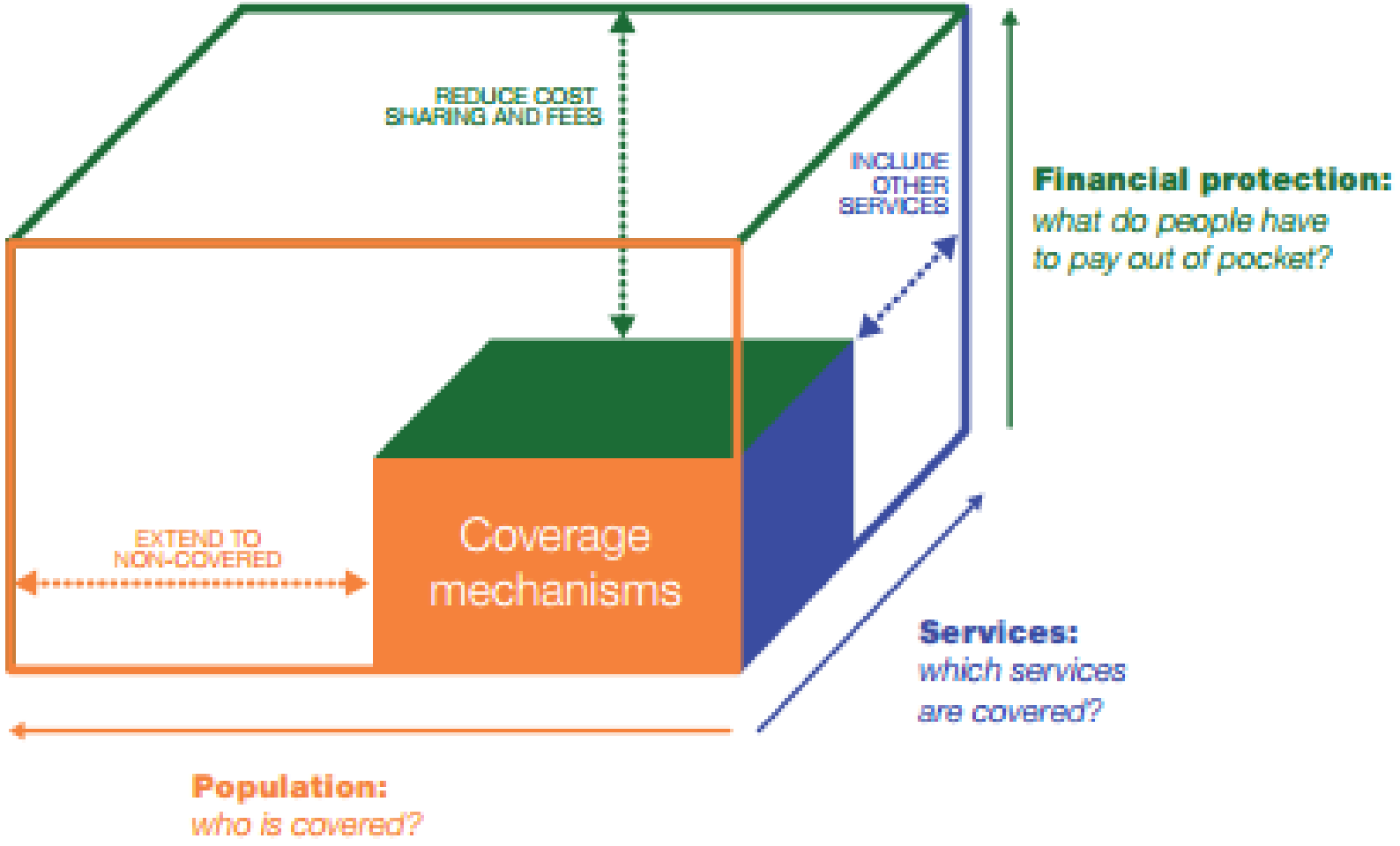
Expanding entitlement – the logic

Sláintecare – a pathway to universal healthcare

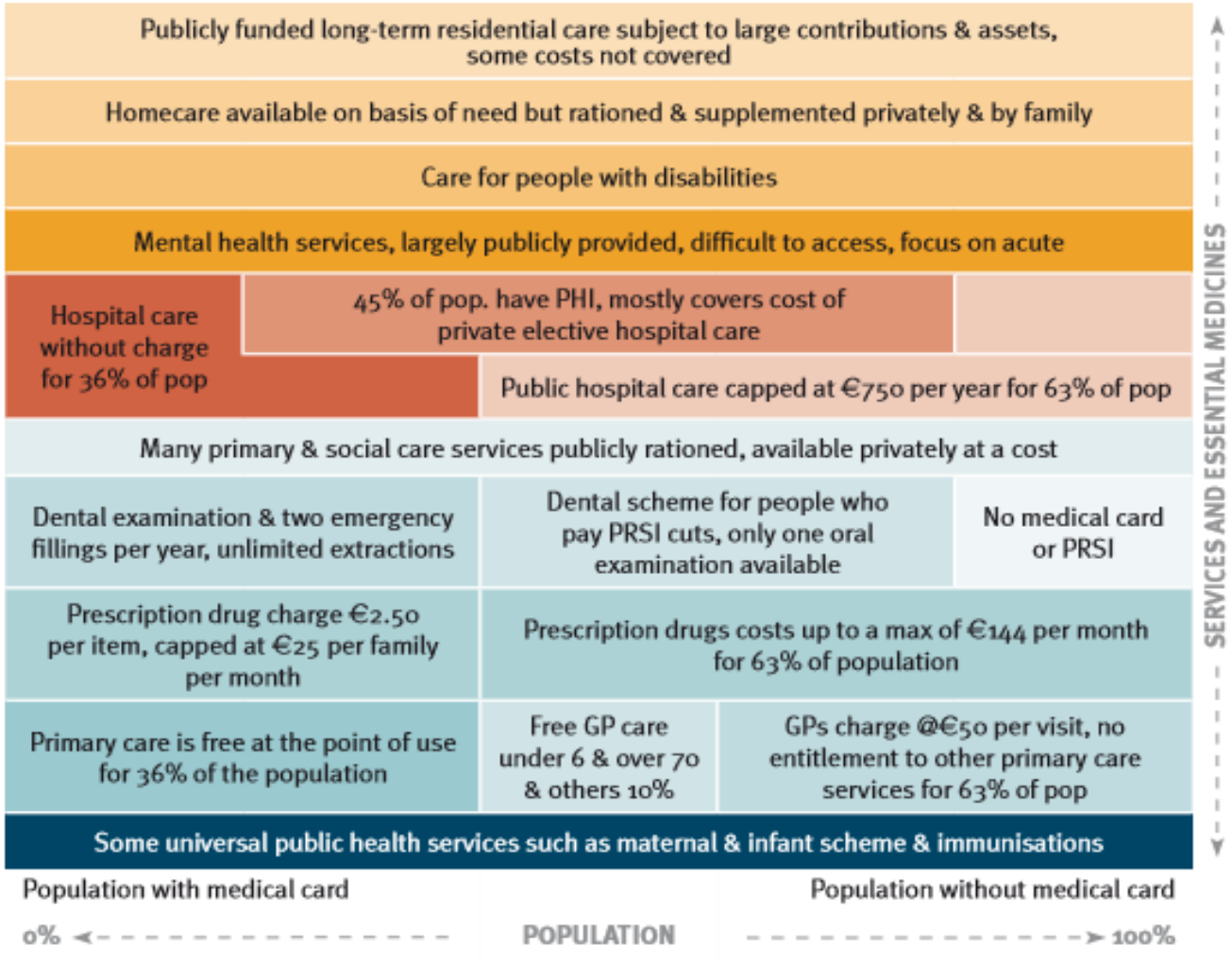
- No universal access in Ireland
- No legal entitlement to health and social care in Ireland
- Extremely complex system of ‘eligibility’, often determined (or not) by 1970 Health Act
- Eligibility does not guarantee access. Variation in access by type, location and volume of service leads to long waits or complete unavailability.
- Internationally recognised as ‘complex’, unfair, costly at the point of entry

What is a basket of care?

'the range of services covered/the scope of benefits package' WHO 2012



Coverage for care in Ireland 2016



Scope of benefits from public financing across eight European countries (2015)

Table 2. Health Services for Adults Covered by Public Financing[a]

Services	BE	ENG	FR	GE	NL	SC	SWE	SWI
Primary care physician	Y	Y	Y	Y	Y	Y	Y	Y
Medical specialist	Y	Y	Y	Y	Y	Y	Y	Y
Maternal care	Y	Y	Y	Y	Y	Y	Y	Y
Hospital care	Y	Y	Y	Y	Y	Y	Y	Y
Rehabilitation	Y	Y	Y	Y	Y	Y	Y	Y
Prevention	Y	Y	Y	Y	Y	Y	Y	Y
Dental care	Y	Y	Y	Y	N	Y	Y	N
Mental healthcare	Y	Y	Y	Y	Y	Y	Y	Y
Physical therapy	Y	Y	Y	Y	S[b]	Y	Y	Y
Occupational therapy	Y	Y	Y	Y	Y	Y	Y	Y
Speech therapy	Y	Y	Y	Y	Y	Y	Y	Y
Medical devices	Y	Y	Y	Y	Y	Y	Y	Y
Cosmetic surgery	N	N	N	N	N	N	N	N

Abbreviations: NL, the Netherlands; BE, Belgium; GE, Germany; ENG, England; FR, France; SC, Scotland; SWE, Sweden, SWI, Switzerland; Y, Yes; N, No.

[a] Comparisons in this table refer to adults aged 19-60 without chronic disease or low income.

[b] S■Specification: Only covered for certain chronic conditions after 20 sessions.

Sources: Health Systems in Transition, European Observatory on Health Care Systems; International Profiles of Health Care Systems 2012, The Commonwealth Fund; MISSOC; WHO Medicines Documentation (http://apps.who.int/medicinedocs/en/d/Jh2943e/11.3.html).

http://www.ijhpm.com/article_3094_be19fc8a45cba1393645a104f3aa78c3.pdf

Oireachtas Committee on the Future of Healthcare

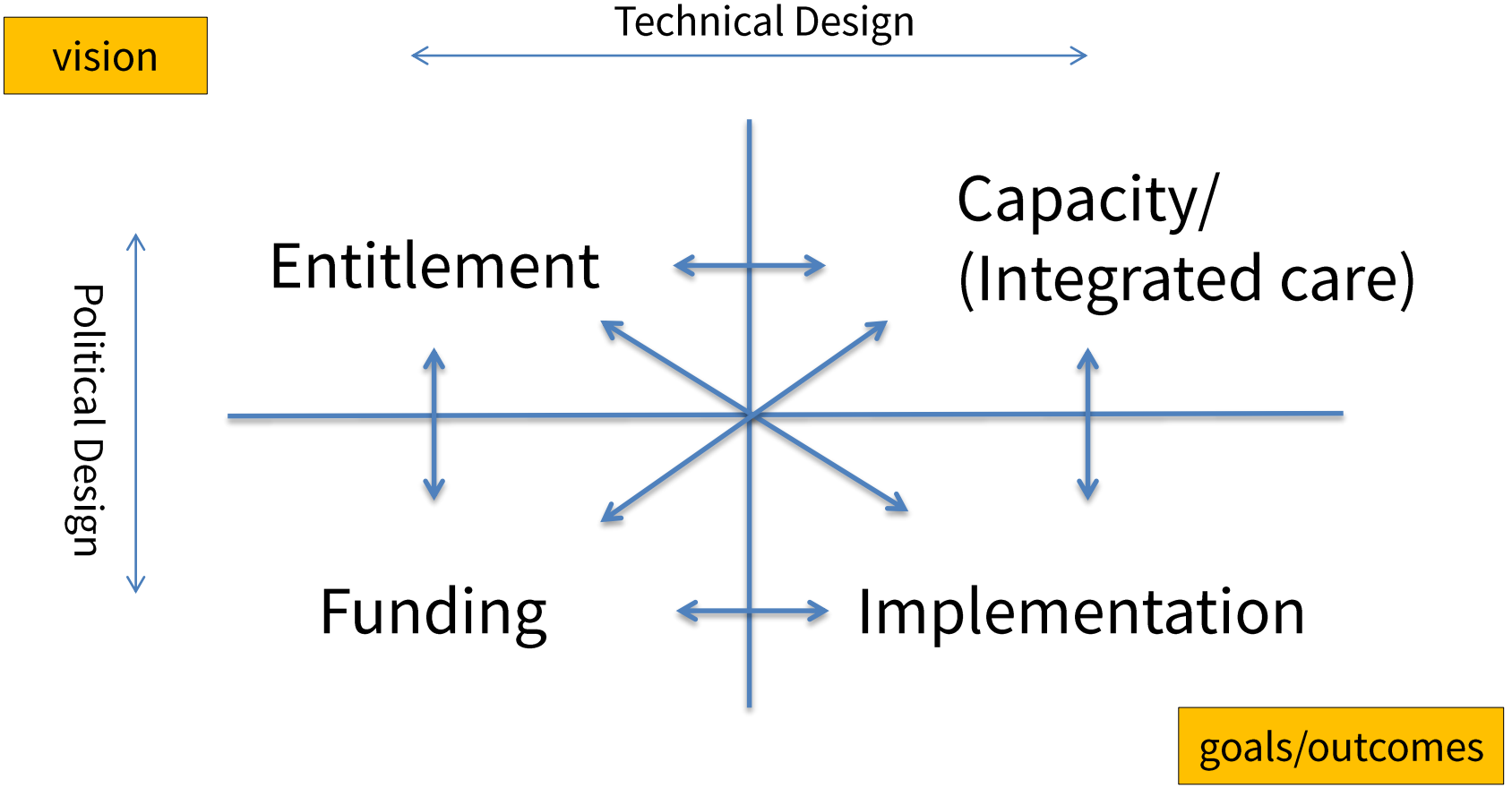
Specific remit to provide universal care, extend package of entitlements to everyone

- *Need to establish a universal single tier service where patients are treated on the basis of need rather than ability to pay*
  - Terms of Reference (7/16)
- *To establish what healthcare entitlements should be covered under an agreed definition of universal health*
  - First Interim Report of the Committee (8/16)
  - *Timely access to all health and social care according to medical need*
  - *Care provided free at point of delivery based entirely on clinical need*
  - *Patients accessing care at most appropriate, cost effective level with a strong emphasis on prevention and public health*
    - Sláintecare Report, 2017

Defining universal healthcare

The agreed definition of universal healthcare including the following services :

An integrated approach to universal healthcare in Ireland



The logic – expanding entitlements in Sláintecare…

1. **Quick wins**
   - Reducing drug charges for GMS
   - Remove inpatient hospital charge
2. **System capacity, timed with financing and workforce expansion**
   - Big ticket items – universal child health, primary care, palliative care
3. **System integrity, no perverse incentives**
   - Remove private care from public hospitals between year 2 & 8
   - Remove Emergency Dept fee, year 8

The logic – expanding entitlements in Sláintecare…

4. **Financial affordability**
   - Frontloaded, doable within 7% health budget increase
5. **Financial protection versus free**
   - Where possible free at point of delivery, sometimes FP
6. **Meaningful phasing (age, means, condition)**
   - Each considered, used age and means for largest phasing
7. **Whole system/process approach**

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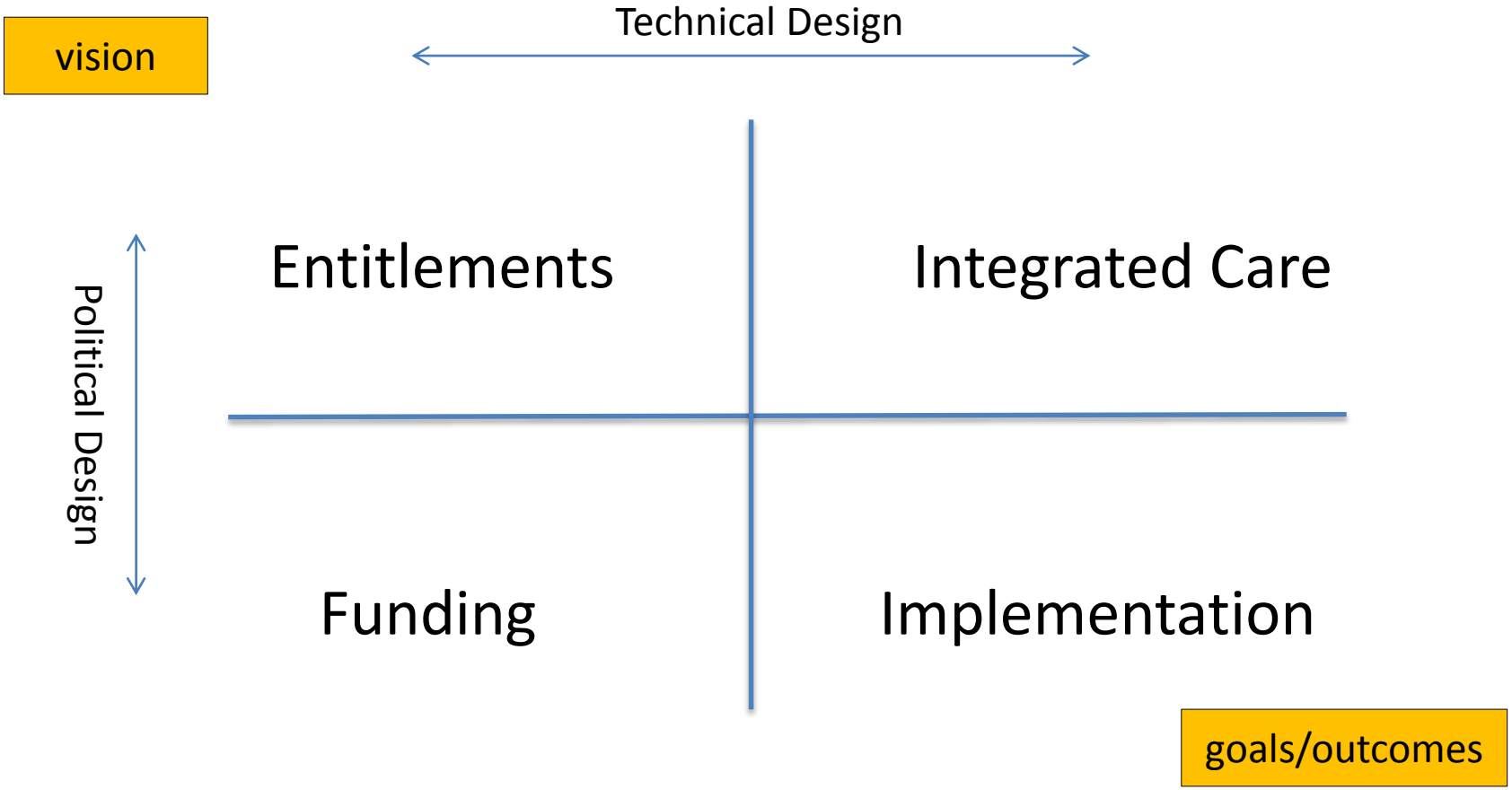
Technical foundations of Sláintecare

Integrated care

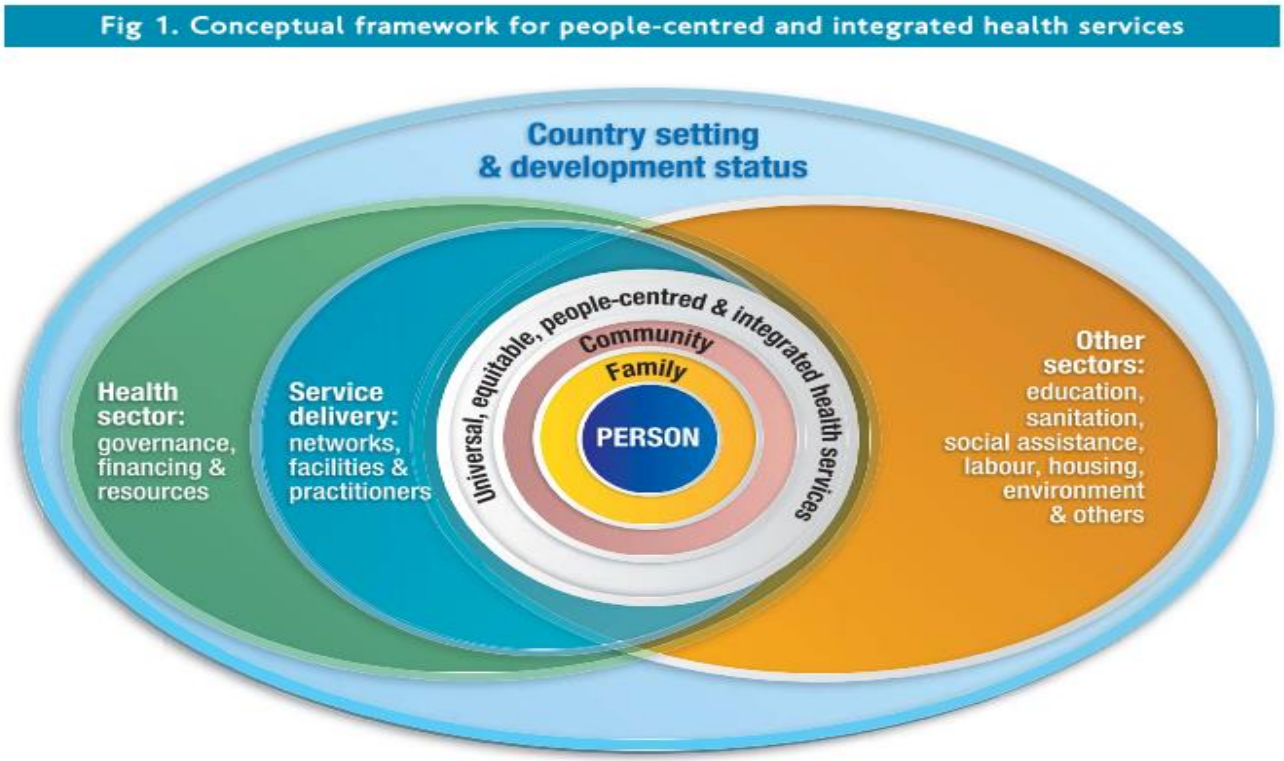
Overview – Integrated Care

- The holistic determinant …
- Why Integrated Care for UHC?
- Integrated Care for Ireland – the Sláintecare Approach
- How to implement UHC through integrating healthcare delivery in Ireland – some examples

Whole of System/Process Approach – holistic determinant



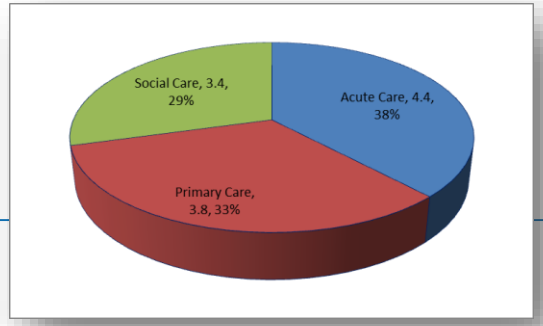
What is Integrated Care?



FOCUS on
environment & ecology
NOT diseases

WHO, 2015

Why Integrated Care for UHC?

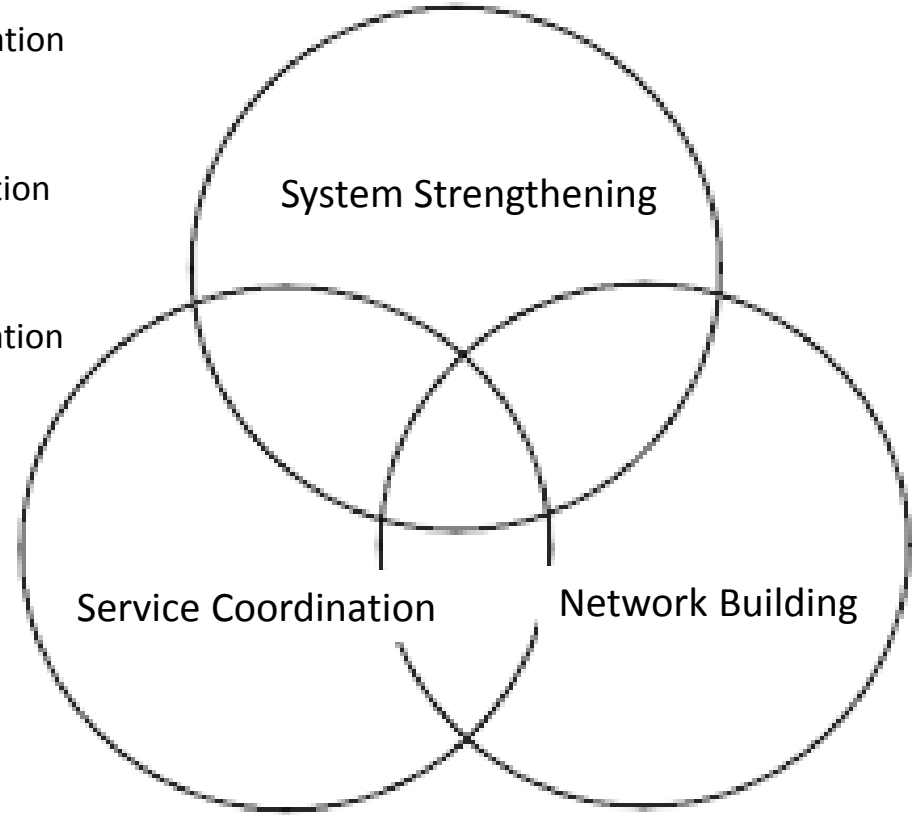


- A preferred model of healthcare …
  - Cradle to grave … 'and whatever you're having yourself'
  - i.e. access to public health, health promotion, diagnostics, treatment and care when needed, in best setting, within reasonable time, with little if any charge at point of access
- Needs a better model of health care delivery
  - Oriented towards primary & social care (budget allocation 2017)
  - LOTS of operational, cultural, legacy and political challenges …
  - Phased, incremental, system shifts – through engagement, communication, technology, change management etc.
  - A complex adaptive system … working with …

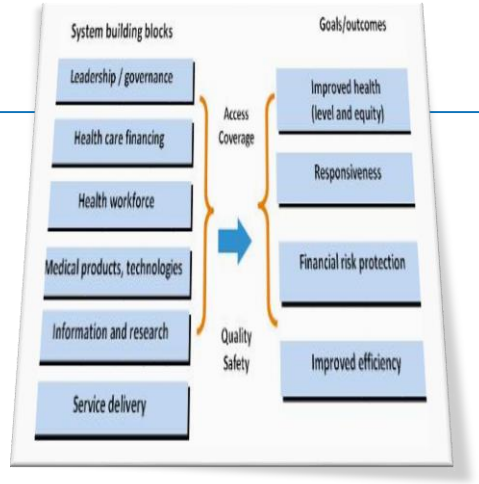
e.g. Ham & Curry, 2011

The Sláintecare Approach – 3 Streams

- International evidence … health need = right system?
- Integrated Approach to Integrated Care
  - **System Strengthening** – i.e. system integration
    - e.g. Mgt. systems, eHealth
  - **Service Coordination** – i.e. service integration
    - e.g. care pathways, MDTs
  - **Network Building** – i.e. community integration
    - e.g. ICPOP 10 Step Framework, LICCs



‘A Comprehensive Model of Integrated Care’ (1)

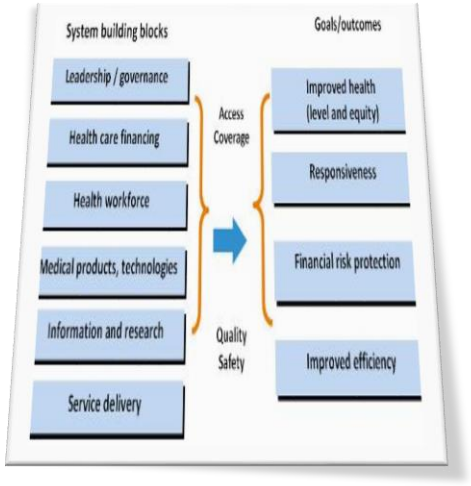


- **Leadership & governance**
  - Delivery structure
    - HSE Board
    - Strategic ‘national centre’,
    - ‘Integrated Care Regional Organisations’
  - Safety & clinical governance
    - Clinical governance framework
    - Culture shift & Legislation
    - Section 38 & 39s
- **Funding mechanisms**
  - Phased pooling of funding
    - primary & social care budgets
  - Multi-annual budget process
    - 3 to 5 years (phased in over next 10 years)
  - Geographic resource allocation
    - Update & refine the model to expand primary/social care workforce
    - Harmonised with primary care provider contracts
    - Area specific funding models
    - Expansion of activity-based funding

WHO, 2007; 2010

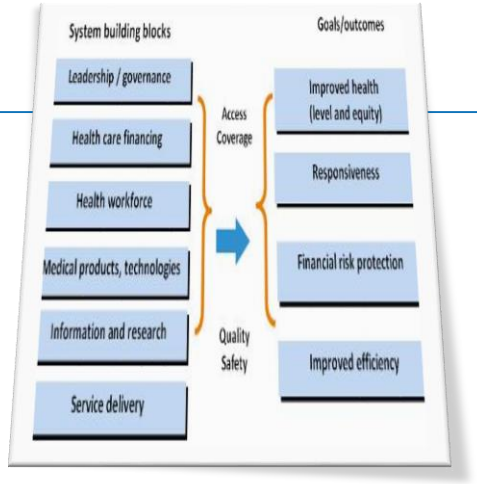
‘A Comprehensive Model of Integrated Care’ (2)

- **Healthcare workforce**
  - Integrated Workforce Planning
    - National Integrated Strategic Framework for Health workforce Planning
    - Appropriate skill mix throughout the system, e.g. roles for practice nurses etc.
      - » Recruitment at regional level
      - » Consultants & NCHDs recruited for Hospital Groups
    - Investment in staff training and upskilling – retraining for integrated care
    - Staff need to have a voice/ valued and rewarded
  - New GP contract (in process)
  - Consultant contract – elective work in the public sector



- **Medicines and medical technologies**
  - Comprehensive, best practice approach
    - International best practice re: evaluation, procurement, usage
    - Collaboration with EU states (single market)
    - Oversight and audit of prescribing/dispending practices (PCRS data)
  - Population-based HTA (broaden from current focus on new drugs spending)

‘A Comprehensive Model of Integrated Care’ (3)



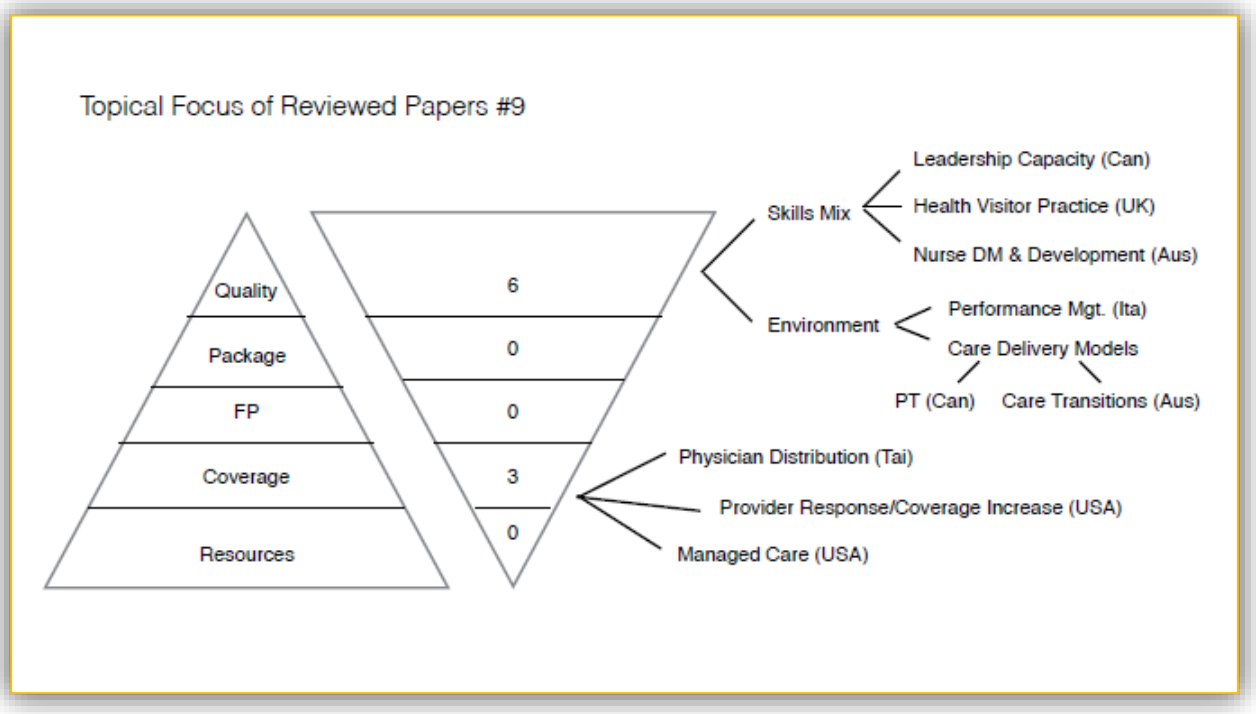
- **Fast-track eHealth**
  - Electronic Health Record (EHR)
  - Unique Patient Identifier (UPI)
  - National, integrated hospital waiting list management system
  - Tele-healthcare system …
  - Guidelines re parental access to the EHRs of their children
  - Streamline the approval to spend process bt DoH & CIO, HSE

- **Information and research**
  - Data collection & integration (optimal at CHN level)
  - Develop research capacity of clinicians, managers, healthcare professionals
  - Integrated management systems (e.g. finance, workforce planning)
  - Properly resourced change management/organisational learning
  - Skills development & collaboration across disciplines/CHOs and hospitals

- **Service Delivery … all of the above**

Implementing UHC – organisational challenges

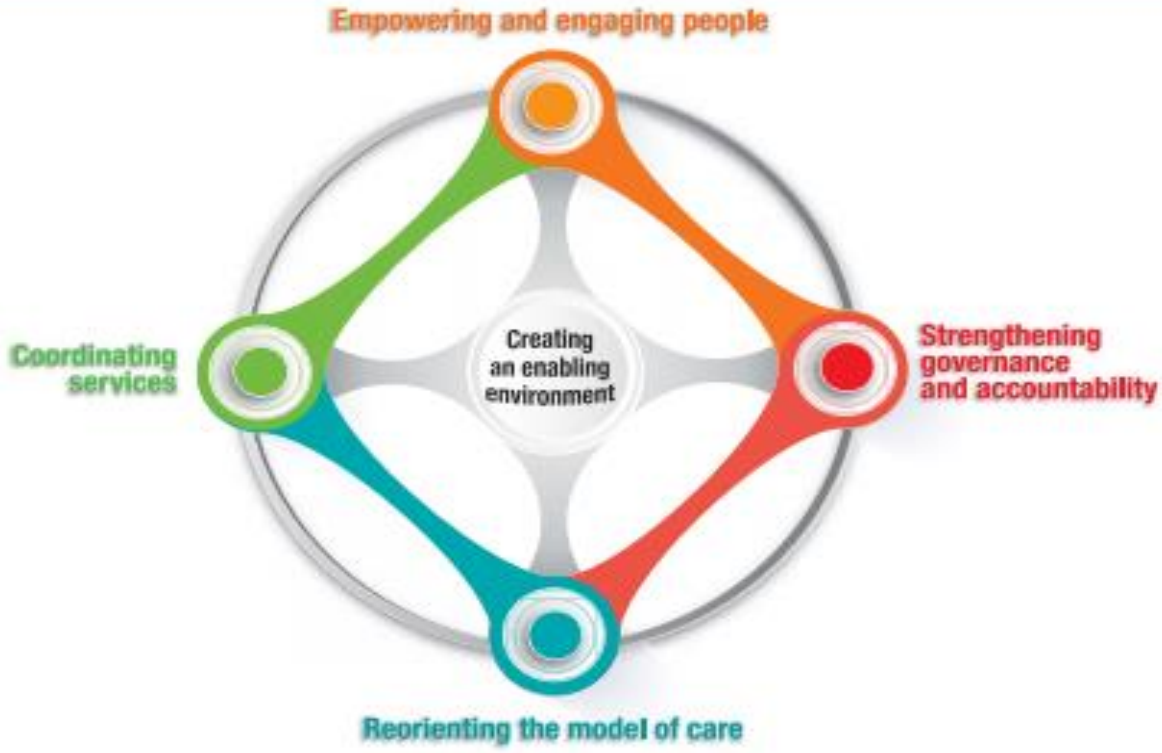
Systematic review – scant data or evidence but focal points identified relate primarily to coverage and quality issues (5 dimensions)



Barry et al. 2016 ; Goddard and Mason, 2017

Implementing Integrated Care – Enablers

Fig. 2. The interdependency of the five strategic directions to support people-centred and integrated health services



WHO, 2015

Get busy livin … or get busy dyin ….

‘There may be trouble ahead ….

but while there’s music and moonlight …..

… Let’s face the music and dance!’

Busy livin…

- Survey of ICP-OP Participants
- ICP-OP Case Studies

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Technical foundations of Sláintecare

Funding

Scope

1. Funding Objectives
2. Review Funding of Irish healthcare system
3. Evaluate options against criteria
4. Sláintecare
5. Beyond Sláintecare

Objectives

Of any funding system… (McPake et al 2014)

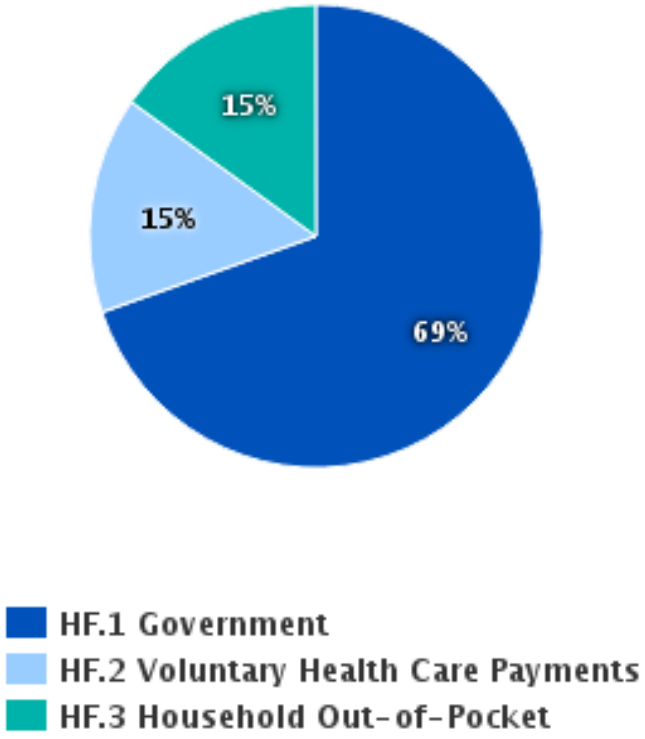
- Mobilise funds (to pay for health care)
- Share risks (across the population)
- Subsidise access (for those with limited income/wealth)

Of funding UHC systems…(World Bank and WHO 2014)

- Maximise financial protection
- Timely access/minimise unmet need

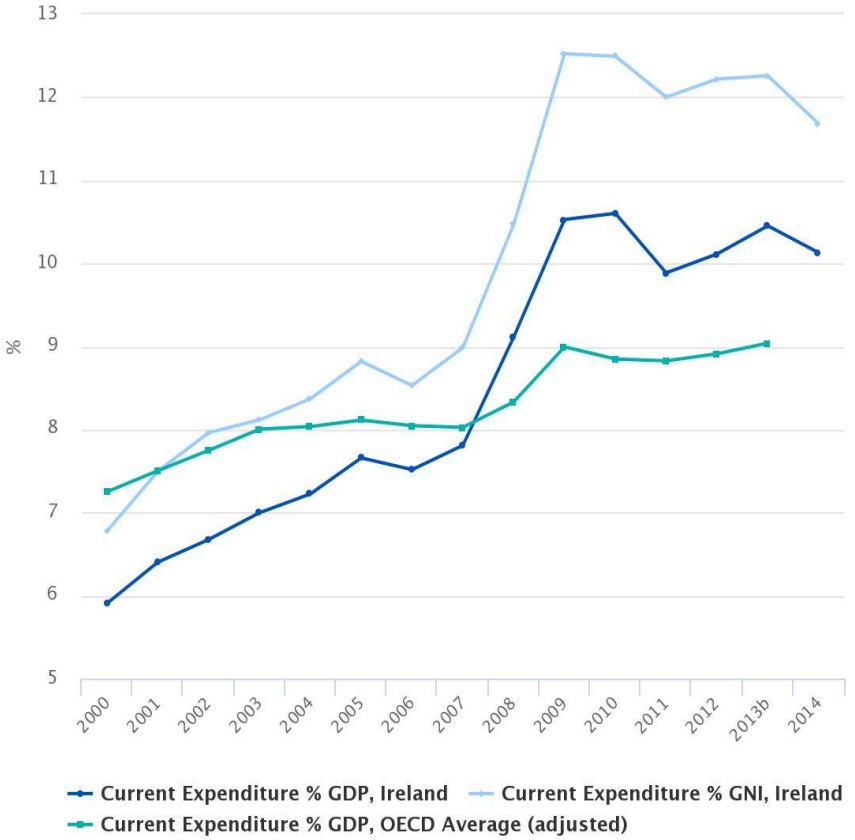
Health Care Funding in Ireland

Ireland's Health Care Expenditure by Financing Scheme, 2014



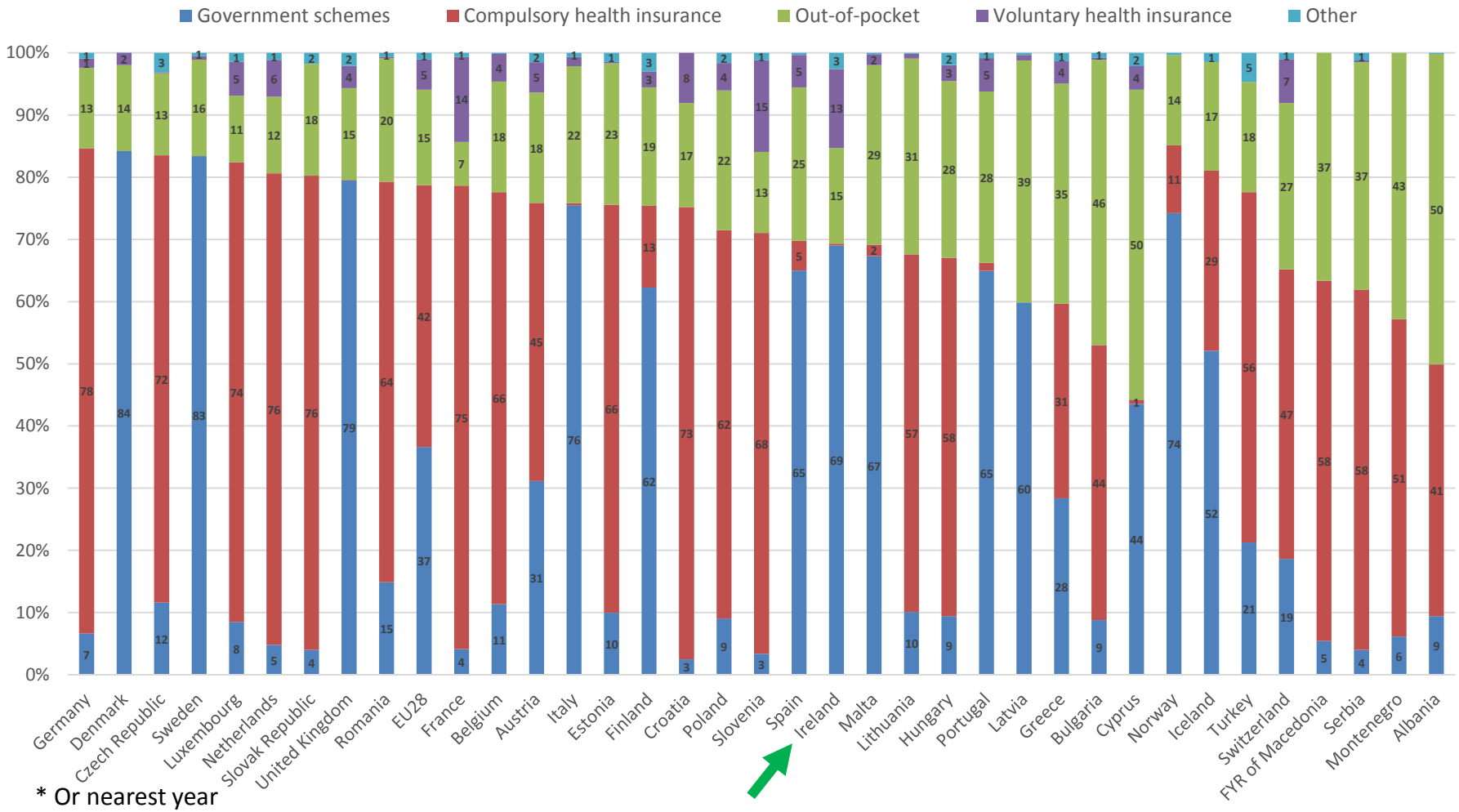
Source: CSO Ireland

Figure 5: Current Health Care Expenditure as a % GDP and GNI – Ireland and , 2000 to 2014



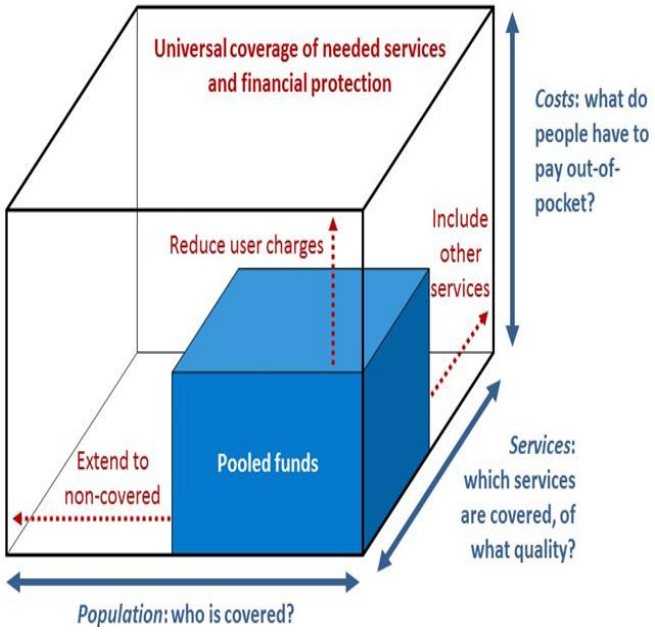
CSO and OECD

Composition of health financing according to financing agents, 2012*



* Or nearest year

To transition to UHC



- Reduce co-payments
  - Discourage use when in need
  - Can cause hardship at even low levels
- Increase solidarity financing mechanisms
  - Tax, Social Health Insurance, (Compulsory Private Insurance?)
- International Evidence: Moreno-Serra and Smith (2015, 2013)
  - Expanded coverage through higher public funding and lower OOP results in better health outcomes

Reviewing the Different Archetypal Pathways

1. **Universal Private Health Insurance**
   - As in the Netherlands, Switzerland, Japan
   - Compulsory PHI (but subsidised and regulated)
   - Managed Competition (Enthoven 1993, amongst others)
2. **Social Health Insurance**
   - As in Germany, Belgium (multiple) Taiwan (single - NHI)
   - Pay like tax but earmarked to fund(s), contracting with public and private
   - Pay for what you get, transparency (Normand and Weber et al 2009)
3. **General Taxation**
   - As in UK, Denmark, Italy
   - Public funded through general taxation, Budget process and publicly provided
   - Few price barriers, solidarity (McPake et al 2013)

Comparing System Transition Challenges

	Private Insurance	Social Insurance	General Taxation
Financial: Raising Sufficient Revenue	OK (but see affordability)	Some good examples of protection in austerity	Problematic in times of austerity
Economic Efficiency and Affordability	Very Costly – may have technical but not allocative efficiency	OK – cost control getting better	Cheaper, extensive non-price rationing (may undermine financing)
System: Complexity and degree of change	Very complex organisation, regulation and system of subisidies	Culture change – no SHI presence	Simpler – largely in place
Political: Fit with Values	Private Insurance well-embedded	No significant history of social insurance	Taxation tolerated But what about two-tier hospital access and insurance?

If I were you I wouldn't start from here

Solving the problems - Slaintecare financing

Starting Place: All systems are mixed (Normand and Thomas 2008)

Mainly tax funding

- **established, progressive**
- **easiest to implement (no great structural change)**
- **But more hostage to economic fortune (sustainability)**

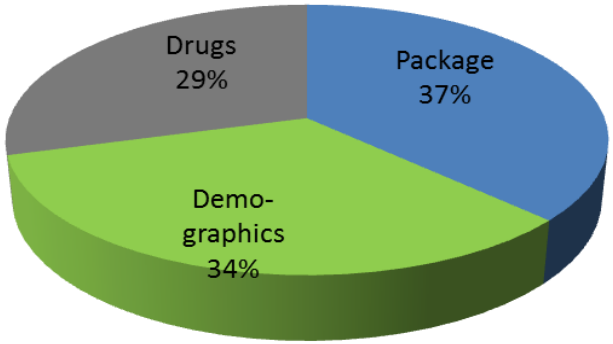
Suggestion of supplementary earmarking into a National Health Fund

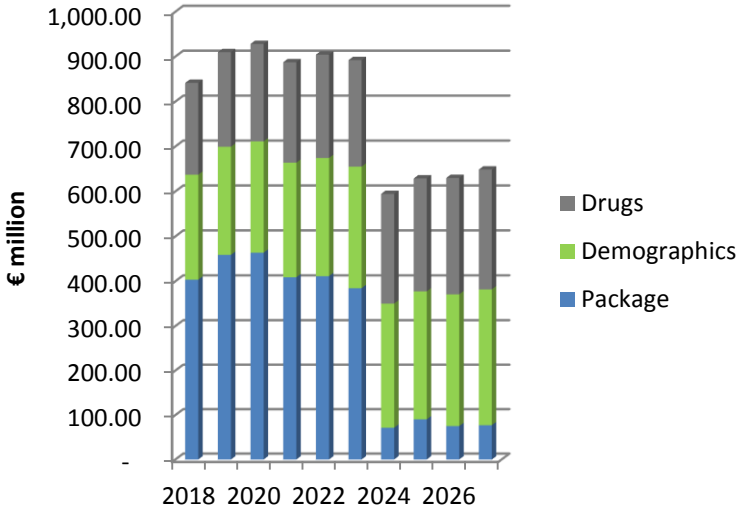
- **Exactly how?…Government of the day**

Estimated Future Costs

Slaintecare

- **Demographic trends (ageing and chronic disease)**
  - 1.6% Public budget increase per annum
- **New drugs**
  - 1.4% Public Budget increase per annum
- **Expanded package of care**
  - Variable increases each year but front-loaded
- **Cost of Systems Transition**
- **But also fewer direct payments by households and lower payments for PHI**





Affordability of Required Increases

7% increase in health budget per year (more than enough) – general taxation

5% increase per year (almost enough)

1) additional temporary earmarked funding source – PRSI

PRSI progressive, low by EU standards, small shifts

PRSI	Employer (+0.25% on higher rate)	€170.8m	2018-2023
PRSI	Employee (+0.5%)	€343.2m	2019-2023

2) rephasing of entitlement package

Transition Fund

One-off funding, exceptional: €3 billion over 5 years

International Precedent

- **New York (NY State DoH 2012), Denmark, England (The King's Fund 2015 i, ii)**
- **systems change and capital investment**

System change (ehealth), workforce training expansion and capital development (primary and acute)

Very similar totals (HSE Plan 2017 - "Shifting the balance to High value healthcare"):

- **€ 2.2 – 2.9 billion**

Conclusions

Current funding system causing hardship and inequity

Slaintecare funding is ambitious but do-able

1. **Business as usual (demographics, new technologies)**
2. **Package expansion (net of savings?)**
3. **System change**

For 1 and 2: tax + some earmarking (PRSI) and maybe some re-phasing

For 3: Strategic one-off investment – windfall tax

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
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Thank You

#TCDpathways
#slaintecare

Panel discussion
Questions from the floor