Transforming Health Systems towards Universal Healthcare – The Case of Sláintecare and Ireland

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Scope

The State we’re in
• Irish health care
• Irish Politics

Here’s to Sláinte care!
• Process and Actors
• Design

The Implementation
Cement Mixer

Final Reflections
Irish Health Care System

“Beveridge” but… no entitlement

Long public sector waiting lists (for elective and allied professionals)

Two-tier acute (private insurance)

Market price GP care

Safety net system (not UHC)
- Medical Card
- Narrow

Unmet need
Austerity

Bad and complex...

From 2007 to 2012...

- unemployment rate more than trebled from 4.6% to 14.7%.
- Government consolidated gross debt increased from 25% of GDP to 120%.
- Government deficit which reached 30.6% of GDP in 2009 was cut back to 7.2% in 2012.

Economy contracted (2008-2010), public sector wages cuts, tax increases etc

Bail out €85 bn
Was it all bad?
Impact: System Resourcing and Acute Activity

![Graph showing budget, staffing, inpatient discharges, day case discharges, emergency admissions, and ED attendances from 2008 to 2016. The graph highlights a 'bail-out period.'](image-url)
Impact: Cost-Shifting

Reduced Medical Card Coverage
New Prescription charges
Increased IP charges
Higher threshold for drug reimbursement
Higher ED charges
Impact Acute Waiting Lists

![Bar chart showing waiting lists over time and by duration categories]
Recent Politics — Sick with Austerity

General Election (Feb 2016)
- Government parties lost out hugely
- 2 main parties less than 50% of vote
- Fragmented left and rise of Independents
- Minority Government eventually formed end April/beginning of May
Political System

- Republic, ceremonial President,
- 2 Houses: Senate and Dáil
- Dominated by two parties but with declining share
- PR-STV great fun (but coalitions and policy drift)
- Since 2016 minority government
- Fragmented left
Desperate Times, Desperate Measures

- New minister, May 2016 – Simon Harris
- New Programme for Government
  - Request an Oireachtas (Parliamentary) All-Party committee to develop a single long term vision plan for healthcare over a 10 year period…Key to the long-term sustainability of our health service and Universal Healthcare…is the development of a new funding model for the health service. This will allow the New Partnership Government to make a final decision on the best way forward to finance Universal Healthcare.
Common understanding of problems

• “— the severe pressures on the Irish health service, the unacceptable waiting times that arise for public patients, and the poor outcomes relative to cost;
• — the need for consensus at political level on the health service funding model based on population health needs;
• — the need to establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay;
• — that to maintain health and well-being and build a better health service, we need to examine some of the operating assumptions on which health policy and health services are based;”
Characteristics of the policy process

• First ever attempt at consensus in health
• A political not a technical process
• Make up of the Committee 50/50 centre right/left, Chair not from one of main parties
• 150 submissions, 34 public presentations and more private sessions
• Supported by an academic team
  • Workshops
  • Principles and evidence review
  • Drafting

The contested nature of evidence
Design – Why is getting to UHC tricky?

- 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
Whole of System/Process Approach

- **vision**
- Entitlements
- Funding
- Implementations
- Integrated Care
- Technical Design
- goals/outcomes
Content and Report Structure (I)

- Objective single tier sustainable system
- Population Health Context
  - Ageing
  - Chronic Disease
  - Inequality
- Entitlements
  - Entitlement not Eligibility
  - Removing Financial Barriers to care
Content and Report Structure (II)

• Funding
  • Move to solidarity model
  • Transitional funding
  • Move private care out of public hospitals

• Integrated Care
  • Expand primary and social care (and workforce)
  • Accountability and alignment
  • Changed governance

• Implementation
  • Be its own implementation
The logic—expanding entitlements in Sláintecare...

1. **Quick wins**
   - Reducing drug charges
   - 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
Guards Guards!
Champions of Change and Resistance

FOR

Minister of Health
Political Parties (mostly)
Analysts
International Advisers (WHO, EU etc)
General Trade Unions
Nurses
Civil society?

AGAINST

Doctors
   Hospital Consultants
   GPs (some very against some more open)
Ministry of Finance
Private Health Insurance Industry
The battle for implementation

Sláintecare report (May 2017)

Government Implementation Plan (August 2018)
• Gaps - entitlements, specifics, expansion of staffing

Budget 2019 (October 2019)
• 20-30% of what is required

Election coming…or not?
brexit  
[toht-l krap]

The undefined being negotiated by the unprepared in order to get the unspecified for the uninformed.
This car is not amused
What sort of policy in Sláintecare?

**BLUEPRINT**
- consensus re overall schematic for endpoint; elements to be enacted over timeframe exceeding mandate of initiating government
- new institutions supplant previous institutions, new organizing principles
- typical where members of winning coalition have independent power bases and expect the balance of power to remain fairly stable – e.g., systems with established traditions of coalition government

**BIG-BANG**
- large-scale change in a single comprehensive sweep.
- new institutions supplant previous institutions, new organizing principles
- typical where actors have consolidated authority but face potential loss of power – e.g., Westminster system with competitive parties

**INCREMENTAL**
- gradual piecemeal adjustments to existing institutional arrangements
- new institutions may co-exist with established; no new organizing principles
- typical where members of winning coalition have independent power bases and at least some anticipate improvement of their position of influence in future – e.g., federal states, intra-party factionalism

**MOSSAIC**
- multiple simultaneous adjustments to existing institutional arrangements
- new institutions may co-exist with established; may or may not introduce new organizing principles
- typical where members of winning coalition have independent power bases and at least some anticipate deterioration of their position of influence in future – e.g., supermajorities in veto-ridden systems; unstable coalitions
Figure 2: Ten Cases of Policy Change, 1945-2012, By Strategy Type Chosen within Window of Opportunity
"Nobody knew that health care could be so complicated. I have to tell you, it's an unbelievably complex subject"
You see things; and you say ‘Why?’ But I dream things that never were; and I say ‘Why not?’

- George Bernard Shaw
Thank you!

Link: https://www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/
Waiting…

What could we have had – Year 1 and Year 2

- Removal of IP fees for public hospitals
- Reduction of prescription item charge
- Halving of Drug Payment Scheme Thresholds for single headed households
- Reinstatement of dental benefits for people with medical cards
- Expansion of Primary Care Diagnostics
- Initial expansion of (i) Primary and Community Care providers, (ii) Mental health programmes, (iii) services for people with disabilities
Implications: What if Sláintecare I

Share of Funding from different sources

- **2017**
  - Government: 69.0%
  - Out of Pocket: 15.4%
  - PHI: 12.7%
  - Other: 2.9%

- **2028**
  - Government: 81.8%
  - Out of Pocket: 8.5%
  - PHI: 7.5%
  - Other: 2.2%
Implications: What if Sláintecare II

International Comparisons
Governance and The Troika