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Stephen Thomas Padhraig Ryan Charles Normand



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# Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland



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Stephen Thomas  
Padhraig Ryan  
Charles Normand

Contact:  
Centre for Health Policy and Management,  
Trinity College Dublin  
3-4 Foster Place, Dublin 2  
Tel: 01 – 8962201  
Email: [hsmsec@tcd.ie](mailto:hsmsec@tcd.ie)

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## Preface

### Effective Foundations for the Financing and Organisation of SHI in Ireland

The health reforms and policy developments which have taken place in Ireland since the launch of the *Health Strategy Quality & Fairness A Health System for You* in 2001 have not resolved the fundamental problems experienced in healthcare by patients or their families. Now that we are confronted by sharply declining public finances an already inadequate healthcare capacity at all levels will struggle even more to cope with waiting lists, hundreds on trolleys in A&E departments, underdeveloped primary care services and rising out-of pocket payments and supplementary health insurance costs. The shameful 'two-tier' system- whereby financial means rather than clinical need often determines appropriate access- remains embedded in our current system of financing healthcare.

The Adelaide Hospital Society has advocated since before the launch of the *Health Strategy* radical reform of the way we fund healthcare. It has proposed a comprehensive social health insurance model drawing upon the best experience across the more than 27 countries in the world which have adopted social health insurance as the optimum method to fund universal healthcare. The Adelaide Hospital Society has commissioned and published a ground-breaking set on research studies from the Health Policy & Management team in Trinity College, Dublin commencing with **Social Health Insurance: Options For Ireland** (Thomas, S. et.al.) published in 2006 followed by **Social Health Insurance: Further Options for Ireland** (Thomas, S. et.al.) published in 2008. These reports established for the first time the costs associated with the introduction of social health insurance in Ireland and in effect the price we need to pay as a society for a 'one-tier' equal and fair system of universal healthcare. They demonstrated the feasibility of achieving this in Ireland and analysed the factors we need to consider as steps towards this great national goal.

The Adelaide Hospital Society is pleased to publish this third Report **Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland** as a further fundamental contribution towards funding fairly universal healthcare. We thank the authors Dr. Stephen Thomas, Mr Padraig Ryan and Professor Charles Normand for their expertise and skill in presenting their independent study updating the financing of various options in relation to social health insurance and setting out the factors involved in organising social health insurance in Ireland. We believe that this Report like the previous Reports will become mandatory reading for all concerned with healthcare reform in Ireland.

The Adelaide Hospital Society has produced a range of healthcare policy statements in recent years setting out a new vision for Irish healthcare and proposals to address many of the problems we face in our healthcare system. Building on the evidence-base now available through the Reports we have commissioned and upon the best evidence and international experience we are publishing a new Health Policy Paper entitled **Universal Health Insurance: The Way Forward** which sets out definite proposals designed to reform the financing of Irish healthcare as quickly and as effectively as possible in the years ahead. We hope that it will contribute to a growing consensus that unless we reform the financing mechanisms we cannot achieve the goals of equity, effectiveness and efficiency in the Irish health system.

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*Chair, Health Policy Advisory Board*

Dr. David Moore  
*Chairman*

Ms Rosin Whiting  
*Chief Executive*

Dr. Fergus O'Ferrall  
*Adelaide Lecturer in Health Policy  
Trinity College, Dublin*



# Executive Summary

## Scope:

This report conducted by the Centre for Health Policy and Management in Trinity College Dublin and commissioned by the Adelaide Hospital Society, is the third in a series on developing Social Health Insurance (SHI) for Ireland. Its findings, therefore, build on the earlier reports which reviewed:

- the strengths and weaknesses of the current system of health financing,
- the nature of capacity constraints and strategies to tackle them and
- potential models of SHI for Ireland.

The distinction between SHI and taxation systems is narrowing, particularly in Europe. Performance is frequently determined by the precise details of the design of financing and organisation along with the health system context and the values of society. Consequently, this report sets out to evaluate fully detailed options for financing and organising SHI within likely conditions.

## Key Findings:

### 1. Context

Despite extreme pressure on resources, the current macro-economic climate presents a real opportunity for reform of health financing. The severe economic problems:

- emphasise the weaknesses in the current system and the need for changes in health financing.
- enable efficiency gains in the system (and some have already come into effect)
- lower the resistance of stakeholders to valuable reform.

One of the key advantages of SHI is that it is typically much more resilient to macro-economic shocks than general taxation both because it is an ear-marked tax, and thus not subject to government budget processes, and because its financing is typically based on household income which tends to be more stable in a recession than other funding sources.

### 2. Values

It is not possible to make sensible recommendations about the key choices in developing SHI for Ireland without clearly stating the likely objectives in such a change. Key objectives are:

- The new system should increase transparency
- The new system should improve incentives to patients and providers of care
- The new system should minimize harmful effects on overall economic performance
- The new system would provide an increase in the resources available for total health spending

- The new system should spread the burden of health spending more equitably and reduce the relative burden on those on lower incomes
- The new system should increase the quality of health care
- On the introduction of the new system the aim should be to minimize the disruption caused by the changes.

### 3. Costs

Typically SHI systems cost more because they deliver more services. It is estimated that the financing of the comprehensive “levelling up” model would require the equivalent of an extra 3% of payroll deductions, taking into account likely efficiency gains. Such efficiencies are based on the following potential areas for cost-savings:

- Case-based hospital contracting (instead of global budgets)
- Administrative savings through rationalisation and/or competition
- Cost-cutting measures in contracting with providers (such as GPs)

It is worth noting that efficiency gains that lower costs by 19% across the health care system would allow the introduction of comprehensive SHI with no additional running costs.

Such costings mean that a single person on €25,000 would only pay an additional amount of €20 per month for a single tier system with good access to comprehensive primary and acute care and would no longer pay fees at the point of contact for GPs, hospital services or drugs.

### 4. Financing

The report considered four designs for SHI financing:

- **Pure SHI:** funded by earmarked payroll and income deductions into an insurance fund. Those who earn below the threshold amount do not pay.
- **Subsidised SHI:** deductions are levied on all income, but Government pays, from general taxation, the contributions for all earned income below the threshold.
- **Mixed Bag:** financed through a variety of taxation sources (rather than just on income) including ear-marking existing ‘sin’ taxation and new property and carbon taxes.
- **Flat Premium plus Subsidy:** financed by charging adults a per-capita premium. Government will subsidise the premium for those less able to afford it and pay into a Risk Equalisation Fund which then distributes funds across the insurers to balance risk.

The **Pure** model is excellent for equity and transparency but is not achievable in the short to medium term because of the amount by which taxes, and primarily income taxes, would have to be lowered in compensation. The

**Subsidised** model is far more practical and less disruptive but loses the principle of earmarking and is not as equitable nor as transparent. (However, it could be a useful stepping stone to a Pure SHI model.) The **Mixed Bag** option retains the principle of earmarking and is slightly more progressive than the Subsidised SHI model but it is complex and requires substantial compensatory tax reductions. The **Flat rate premium** model is administratively complex, not at all transparent, and less equitable and risks fragmentation. It is the model which offers the least gains. The authors recommend that the **Subsidised or Mixed Bag models** are the best initial options for SHI in Ireland.

## 5. Organisation

### Providers

Providers should ideally be independent of funds allowing legal contracts to determine standards and outputs. Direct reimbursement of providers by funders offers better protection of patients. Provider payment mechanisms are increasingly moving towards prospective payments to control costs and away from itemised billing, such as fee-for-service. While competition is not always possible, accreditation of providers may help promote quality and efficiency.

### Effective Choice

Choice of providers at lower-levels of service provision can be very useful where such providers act as gatekeepers to more specialised and expensive services. The weight of international evidence indicates that unrestricted access to, and choice from, specialists may result in high costs, inefficiency and a lack of coordination.

### Single SHI Fund

The international evidence is clear that larger sickness funds operate more efficiently, both in being able to hold reserves, benefit from economies of scale in administration and have larger risk pools. Further, the weight of international evidence suggests that competition between multiple funds is difficult to get right and complex to regulate.

Consequently, the authors propose a single SHI fund to minimize administration costs, avoid risk equalization systems and emphasise cost reduction rather than cost-shifting. This will be much simpler and transparent than moving to a complex multi-fund system. The best option is probably for a not-for-profit private organization to maximize the visible change. Nevertheless, it will be essential to ensure that such a fund operates within an incentive framework that encourages cost-control and efficiency. To heighten incentives for efficiency and good performance, for-profit management teams could be allowed to compete to run the single SHI fund.

## 6. Regulation

Delineating appropriate roles and responsibilities is essential. Government must enshrine in law the general design of the SHI system (membership and coverage, responsibility and authority, financing and contractual links with providers) as well as the benefit scheme. While government takes the lead in defining the benefit package, according to technical criteria, it will also need to consult with other stakeholders. The Department of Health should create the appropriate policy and framework for SHI and monitor performance. Legislation must also give SHI funds special powers to negotiate and enforce provider payments, accredit providers and enforce relevant laws (collection of revenues, imposition of fines for fraud).

## 7. Next Steps

The analysis highlights the challenges and benefits of introducing SHI into the Irish context. There is need for political dialogue across stakeholders, and in particular the public, to consider the most desirable and feasible financing model for SHI with reference to key policy objectives. This will involve debating the importance of, and trade-offs between, transparency, equity and earmarking within the system. There is also need for key stakeholders to discuss the recommended establishment of a single private not-for-profit SHI fund and the environment in which it will operate. The incentive framework created for such a fund will be all important.



# Table of Contents

Executive Summary .....	4	Chapter 4:	
Chapter 1:		Fitting SHI Financing to Ireland .....	27
Introduction.....	9	Introduction.....	27
Background .....	9	Review of SHI Costs.....	27
Objectives .....	9	Box 4.1: Options for SHI Design	
Overview of Methods and Structure of the Report	10	(Thomas et al, 2006 & 2008).....	28
(i) Financing: .....	10	I) Levelling up access and quality of all services .	28
(ii) Organisation.....	10	II) The Priority to Primary Care Model .....	28
SHI and Health Financing Policy.....	10	III) The Priority to Hospital Services Model .....	28
Chapter 2:		IV) Making only small improvements in access ..	28
The Irish Economic Context.....	13	Option 1: Pure SHI.....	29
Crisis or Opportunity.....	13	Option 2: Government subsidised SHI .....	32
Taxation policy and the Macro-Economic		Option 3: Mixed Bag.....	33
Context.....	13	Sin Taxes.....	33
Government response: Stabilisation.....	15	Carbon tax .....	34
Analysis of Taxation Portfolio.....	15	Wealth/Property tax.....	34
Summary and Reflection on SHI Financing .....	17	Option 4: Flat premium. ....	34
Chapter 3:		Assessing the Best Option .....	35
International Experience with SHI.....	19	Chapter 5:	
International Trends .....	19	The Organisation of the Irish	
A long history in Europe.....	19	Health System .....	39
The Mix of Funding.....	19	Policy and Reform.....	39
SHI Design details .....	21	Governance .....	39
Recent Switchers – Eastern Europe		Funding.....	40
and Central Asia.....	22	Provision .....	40
The Mix of Funding.....	23	Purchaser – provider relations:.....	41
The Financing Base and Design Details .....	24		
SHI Adoption in other middle and high income			
countries.....	24		
Funding Mix.....	24		
Reflections on how SHI systems can help achieve			
goals for Health Financing.....	25		
1) Mobilising Funds.....	25		
2) Sharing Risks .....	25		
3) Equity.....	26		

## Chapter 6:

Principles of Organisational Reform for SHI .....	43
Minimising transition difficulties.....	43
Responsiveness.....	43
Efficiency and Transaction Costs.....	43
Stewardship and Governance.....	43
Transparency and Accountability .....	44

## Chapter 7:

International Experience with the Organisation of SHI.....	45
Patient Choice.....	45
Choice of Fund.....	45
Choice of Provider .....	46
Sickness Funds .....	47
Size and Number of Funds .....	47
Pooling and Risk Adjustment.....	48
Fund Reserves.....	49
Governance and Regulation .....	49
Decision making.....	49
Legislation.....	50
Link between Funds and Government.....	50
Benefit Package .....	51
Generics and Costs of Drugs .....	51
Providers, Contracting and Payment .....	52
Providers .....	52
Summary of International Experience.....	53
Choice .....	53
Funds.....	53
Governance .....	53
Contracting and Provision.....	53

## Chapter 8:

Organisational Design of SHI in Ireland.	55
Single or Multiple Funds?.....	55
Degree of independence of the fund or funds....	55
Governance and Regulation .....	56
Suggested choices on structure, ownership and gov- ernance of the SHI.....	56
Paying for Services .....	56
Who should be allowed to provide services?.....	56

## Chapter 9:

Conclusions and Recommendations.....	57
Prevailing Context .....	57
Values.....	57
Health Financing Design.....	58
International Experience .....	58
Best fit for Ireland .....	58
Organisation.....	59
International Experience .....	59
Best fit for Ireland .....	59
Next Steps and the need for Enhanced Dialogue.....	59
References .....	60





# Chapter 1: Introduction

## Background

There is little doubt that the Irish health system is in urgent need of reform. Previous reports on Social Health Insurance (Thomas, Normand et al. 2006; Thomas, Normand et al. 2008) highlighted key weaknesses of the Irish health system including perverse incentives, rife inequities, inefficiency and limited capacity in infrastructure and human resources. The reports also analysed the introduction of SHI as a means of meeting policy goals. In so doing they provided a new foundation for fresh policy debate and formulation, as can be seen by recent political initiatives (Fine Gael, 2009).

Nevertheless, the current macro-economic context represents a key challenge to any reform of the health system. Declining tax revenues curtail room for investment in infrastructure and transition. It is important to review how this will impact on shifting to SHI. In addition, while the range of topics covered by the previous SHI reports is broad (see Table 1), there are several aspects of SHI which need further exploration if it is to become a feasible option within the Irish context. SHI is a complex financing form, requiring that not only issues of financing but also provision, management and actor support are properly considered (Normand and Weber 2009; Thomas and Gilson 2004). Financing reform is never introduced in a vacuum and it is important to consider the inheritance of previous policies, trends and economic circumstances (Collins, Green et al. 1999). This is the backdrop for change. In addition, it is important to draw on international experience of health financing, as many new lessons have emerged recently around the performance of SHI in high and middle-income countries (e.g. Wagstaff 2009a,b; Evans 2009).

**Table 1.1: Themes in previous Adelaide-funded TCD reports on SHI**

<i><b>SHI: Options for Ireland (2006)</b></i>	<i><b>SHI: Further Options for Ireland (2008)</b></i>
<ul style="list-style-type: none"> <li>• Need for health financing reform to improve the Irish health system performance</li> </ul>	<ul style="list-style-type: none"> <li>• Options for SHI which might help boost the access to care for children</li> </ul>
<ul style="list-style-type: none"> <li>• The strengths and weaknesses of SHI</li> </ul>	<ul style="list-style-type: none"> <li>• Causes and consequences of cost inflation in the Irish health system</li> </ul>
<ul style="list-style-type: none"> <li>• Specific models of SHI for Ireland</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity bottlenecks and the costs of relieving such capacity constraints</li> </ul>
<ul style="list-style-type: none"> <li>• Costs and financing burden of such models</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of system change, and phasing, to introduce SHI.</li> </ul>

Consequently, the TCD research team, supported by the Adelaide Hospital Society, propose developing two additional reports over 2009 and 2010 which explore issues of financing SHI, organisation of SHI and stakeholder support for SHI. The aim of the reports, building on previous research, would be to construct a relevant and viable design (politically and technically) for the financing and organisation of SHI in Ireland.

**The objectives of this first report on financing and organisation are highlighted below.**

## Objectives

### **1. To review and evaluate fully a range of options for *financing* Social Health Insurance, by:**

- exploring the current taxation profile, yields and burden on households in Ireland
- reviewing the financing of Social Health Insurance systems from other relevant countries
- developing options for financing social health insurance (exploring both direct and indirect taxes/levies on income, expenditure and wealth)
- reviewing such options against key criteria of performance such as equity and financial sustainability.
- highlighting the most viable options for Ireland

### **2. To develop options for the *organisation* of SHI in terms of institutions and their interrelationships, including:**

- characterising and briefly reviewing the current organisation and institutional interactions in the Irish health systems
- identifying key criteria for assessing organisational performance and change
- exploring organisational designs in relevant SHI systems according to arrangements for the number of funds, contracting with providers and reimbursement, referral, patient choice of scheme, regulation and risk-pooling
- developing 'best fit' strategies for organising Social Health Insurance in Ireland.

## Overview of Methods and Structure of the Report

In line with the above objectives the report is divided into two parts. The first examines questions of financing (Chapters 2-4) while the second explores organisation (Chapters 5-8). While the two issues are interrelated, and some aspects of SHI design straddle both aspects (such as the number of SHI funds and risk equalisation), they are separated for ease of analysis. Further the conceptual literature and frameworks for evaluating financing and organisation are distinct and thus separation is useful. Nevertheless, the conclusions and recommendations combine the results noting also where there are tensions and complementarities.

### **(i) Financing:**

The authors collected and analysed Irish literature on current macro-economic trends, taxation policy, the portfolio, and importance of different forms of, taxation and the taxation burden on the population (Chapter 2). This provided an important reality check and backdrop against which any new financing scheme for SHI must be developed.

In addition, to understand the range of financing options the authors mapped out and reviewed key design features of different SHI financing schemes across the world (Chapter 3). This includes assessing alternative tax bases and premia in SHI countries. To achieve this, the team collected data on other relevant SHI systems from institutions such as the European Observatory, the European Office of the World Health Organisation and OECD and key journals such as Health Economics, Journal of Health Economics, and European Journal of Public Health. The experience of these financing systems is reviewed and relevant lessons highlighted for Ireland.

Drawing on this, the authors outline options for SHI financing which might fit best with the Irish system. For each of these options the team model and present the required rates and premia and their impact on sample households (see Chapter 4). The databases and modelling used for estimating financing burdens and rates are updated for the different options using costs from earlier studies (Thomas, Normand et al. 2006; Thomas, Normand et al. 2008). Potential current efficiency gains are also considered. The financing options are then reviewed against their likely impact on the performance of the Irish health system. Preferred financing options are identified.

### **(ii) Organisation**

Since 2001 there has been substantial organisational reform in the Irish health system. The authors review initially the key arrangements and structures in place and their impact on future organisational capacity and governance (Chapter 5). The authors also review key technical criteria for assessing organisational performance, drawn from international literature, such as ease of transition, transparency and good governance (Chapter 6)

To assess the institutional structures required for SHI, the authors also reviewed international experience of organising SHI, particularly around choice, funds, governance and contracting (Chapter 7). Data were collected from key institutions and journals. Trends in organisation across SHI countries are highlighted and assessed.

Based on the current Irish system and international findings, the authors develop strategies for the organisation of SHI in Ireland. The authors reflect on the most viable technical structures and institutional relationships for SHI in an Irish context (Chapter 8). Conclusions follow in Chapter 9.

## SHI and Health Financing Policy

In the remainder of this chapter the authors review the basic features of SHI and how it contributes to health policy goals. The underlying principles of SHI are that access to care is on the basis of need, and that payment for insurance is on the basis of income or ability to pay. The basic characteristics of SHI are that:

- Insured persons pay a regular contribution based on income or wealth, and not on the cost of the services they are likely to use.
- Access to treatment and care is determined by clinical need and not ability to pay.
- Contributions to the social insurance fund are kept separate from other government mandated taxes and charges.
- The social insurance fund finances care on behalf of the insured persons, and care is delivered by public and private health care providers.

If a government has an objective of securing access for its citizens to some or all effective treatments, the chosen system of financing will have three main objectives (Normand and Thomas 2008):

- mobilising funds for when they are needed
- sharing risks,
- subsidising access for those with low income or wealth.

We can therefore analyse the different components in a health care financing system in terms of the degree to which they meet these goals. Further, when designing a SHI system for Ireland these three factors must be taken into account and used to shape the precise design of SHI in line with stated priorities.

While the focus of this report is SHI, it is nevertheless informative to understand how each of the major financing mechanisms typically performs against the three general health financing policy objectives noted above and this is laid out in Table 1.2. Further, countries often employ a mix of financing mechanisms and therefore it is important to see how each will further the achievement of policy goals.

**Table 1.2: Policy Objectives, Financing Mechanisms and Typical Performance**

Policy Objectives of Financing Mechanisms	Solidarity based schemes		Non solidarity based schemes	
	Taxation	Social Health Insurance	Private Health Insurance	Out-of-Pocket Payments/free Market
1. Raising Revenue	Typically raises much revenue. Yet decreasingly effective as general taxation is unpopular and is subject to economic shocks. Nevertheless taxation-based health systems are often cheaper to run because of extensive rationing of services.	More popular than general taxation which may allow more revenue to be raised. Yet cost escalation can be a feature depending on provider payment mechanisms	Will raise revenue but often system costs more because of lack of cost control. It may also crowd out public sector resources.	Limited revenue raising ability. However, can be an important revenue source for specific facilities where revenues are retained.
2. Sharing Risk	Risks are fully shared	Risks are shared for those covered. In universal systems risks are fully shared	Risks are shared for those who have bought the insurance/can afford.	Risks are not shared
3. Protecting the Poor	Typically the most equitable system	Quite good though not as good in general as taxation-based systems, though this is dependent on precise design.	Poor are not protected. Yet there will be some cross-subsidy from younger and healthier to older and sicker for those covered by insurance.	Typically the least equitable financing mechanism. Poor are not protected, except by exemption mechanisms.

Source: Derived from Normand and Thomas (2008)

The most obvious point is that SHI systems tend to perform better than the non-solidarity systems (private health insurance and user fees), though not always as well as taxation-based systems on some criteria. Nevertheless, it is worth making several other key points. First, SHI systems tend to be **more popular** with their populations than taxation-based systems, possibly because they have less rationing and greater transparency and possibly because the money follows the patient. **Second** the two systems have recently tended to borrow features from each other resulting in less distinction in performance (McPake and Normand 2008). **Third**, and most importantly, the term SHI covers a multitude of different options and often it is the specific design features adopted in a country and the prevailing context and values which determine performance rather than the loose-label of SHI.

Furthermore, it is often **the mix of financing mechanisms** which can affect performance. Ireland's current financing of its health system is based on taxation. However, the use of user fees and private insurance, albeit minor in total funding, has affected the overall performance of the system. Replacing taxation-based funding with SHI, without attending to the issues of the better access afforded by private insurance and user fees would leave many existing problems intact. **Finally**, introducing SHI in Ireland could be used to increase the role of contracting in the health system and thus instil incentives for efficiency (often referred to as **"money follows the patient"** in the hospital sector).

Potential strengths and weaknesses need to be reviewed within specific contexts and according to each design. Nevertheless, it is important to review the wealth of international experience with SHI and universal systems to ensure all viable options have been duly considered and reviewed for Ireland's health system. Careful analysis at this stage may help avoid common traps and maximize the chances of success.





## Chapter 2: The Irish Economic Context

### Crisis or Opportunity

Reforming health financing never occurs in a vacuum. To understand the possibilities for SHI in Ireland, it is necessary first to explore the current macro-economic context and the taxation portfolio. That is the purpose of this chapter. The financing of health through a new SHI system must be compatible with general government policy, the state of the economy and people's willingness and ability to pay.

The current economic crisis may not, at first sight, seem conducive to SHI. A contracting economy might appear to make SHI unaffordable. Government is under pressure just to balance budgets and maintain spending priorities. Nevertheless, the recession may turn out to be an opportunity for radical change which would not have been acceptable or deemed necessary during the Celtic Tiger years. SHI will take time to introduce, particularly where it is tied to the alleviation of capacity constraints as the authors have previously argued (Thomas et al., 2008). This gives scope for some economic recovery and an upturn in the ability and willingness of the population to pay for health care.

In addition, one of the key advantages of SHI is that it is typically much more resilient to macro-economic shocks than general taxation both because it is an ear-marked tax, and thus not subject to government budget processes, and because its financing is typically based on household income which tends to be more stable in a recession than other funding sources. Indeed, the resilience of SHI to macro-economic shocks compared with general government taxation is a key argument in favour of SHI (McPake and Normand, 2008).

Nevertheless, the Irish health system is currently predominantly funded through general taxation. To explore the leeway for transition the authors identify and analyse the portfolio of taxation measures in Ireland, how they have performed and how they compare to other EU and OECD countries. This will help shape the most appropriate options for financing SHI (in Chapter 5).

An additional reason for analysing Irish taxation in this chapter is that the difference between systems of general taxation and SHI is becoming increasingly blurred (Hassenteufel and Palier, 2007; McPake and Normand, 2008). As will be seen in Chapter 3, governments often subsidise SHI with taxation revenue, either by paying the premia of those who cannot afford or by paying for particular services deemed to be a priority. While this reduces the transparency of SHI funding, it is a widespread practice internationally.

### Taxation policy and the Macro-Economic Context

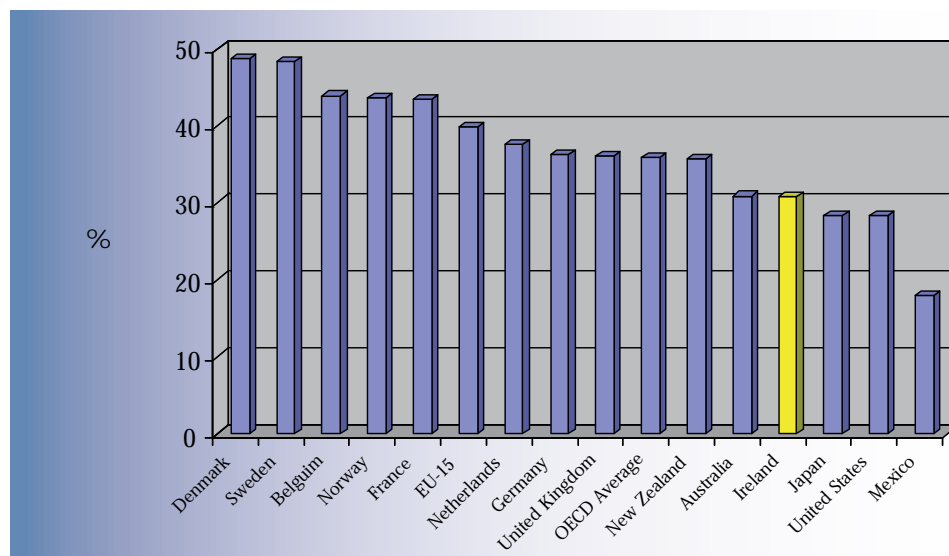
Taxation is important not just for raising revenue for spending. It can also dictate incentives for investment and work, redistribute resources across the population, and stabilize an economy whether in recession or boom (European Commission 2009). Ireland's tax regime has changed substantially over the last two decades and was, up until the financial crisis, characterized by lower direct taxes and higher consumption taxes. Ireland's shift towards consumption taxes has its basis in economic theory in that consumption taxes have less labour related disincentives than direct taxation and thus may encourage employment (Combat Poverty Agency, 2006). Nevertheless, there are both advantages and disadvantages with this approach. The European Commission (European Commission Directorate-General for Economic and Financial Affairs, 2009, pp45) notes that:

*"Consumption taxes leave savings untaxed and are thus conducive to capital accumulation and growth... However, such effects tend to be modest in size and cannot serve as substitutes for more appropriate structural reforms. Moreover, such tax shifting may have adverse equity effects and the timing and the magnitudes of such policies need to be carefully assessed, to avoid inflationary pressures."*

Another key aim of government policy has been to improve the progressivity of taxation (Department of the Taoiseach, 1999; Government of Ireland, 2002) so that those on average wages only pay tax at the standard rate and increasing numbers of low wage workers are removed from the income tax net altogether. Consequently, the decade preceding 2008 saw a sizeable decrease in the income tax burden for those earning lower wages. In the 1997-98 tax year only 25% (380,000) of all income earners were outside the tax net. By 2008 this had increased to 38% of income earners (almost 880,000). Budget 2006 alone removed an estimated 55,000 low income earners from the tax net (Tax Strategy Group, 2006).

Prior to the global financial crisis, Ireland's tax burden was one of the lowest in the industrialized world (see Diagram 2.1). In the EU27 in 2006, the average tax revenue as a proportion of GDP was 41%. Ireland's proportion was just 34%, while Denmark recorded the highest proportion at 50.0% (Eurostat, 2008).

Diagram 2.1: Tax revenue as a proportion of GDP, 2007, in fourteen OECD countries<sup>1</sup>

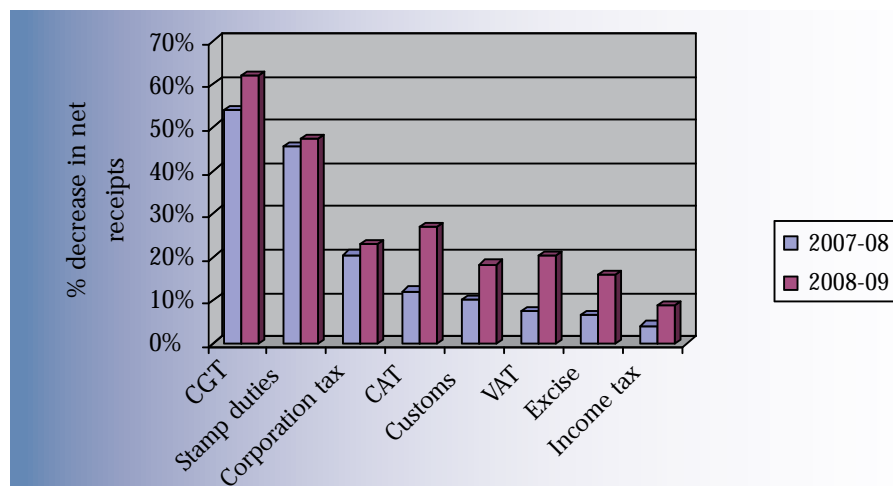


Source: (OECD, 2009)

An important recent policy initiative was the Commission on Taxation, established in February 2008, with the aim of formulating Ireland's tax policy for the next decade. Key aims include maintaining economic competitiveness, to which low corporation tax is deemed crucial, and keeping the overall tax burden on households low to enhance the rewards of work and maintain incentives for productivity. However, the Irish economy has been hit particularly badly by the global economic downturn and the collapse of the housing market, and the aims of the Commission on Taxation have been superseded by the need to balance government finances. The ESRI predicted that the Irish economy would contract by about 14% during the 2008 to 2010 period, in what may be the steepest fall in economic growth in an industrialized country since the 1930s (Barrett et al., 2009). The standardised unemployment rate increased dramatically from 4.8% in the last quarter of 2007 to 12.7% in January 2010 (Central Statistics Office, 2010), the latter reportedly the highest rate in over fifteen years (Bloomberg Business Week, 2010).

The extent of the collapse in revenue by type of taxation is highlighted in Diagram 2.2 which shows the proportionate decreases year-on-year from 2007 to 2008 and from 2008 to 2009. Total net tax receipts fell dramatically in 2009, amounting to just €33.8 bn, compared to €41.1 bn in 2008 and €47.5 bn in 2007. The 2008 figure was €8 billion (16%) less than the Budget estimate (Revenue Annual Report, 2008; Department of Finance, 2010).

Diagram: 2.2 Year-on-year decrease in annual net tax receipts, by taxation type (2008)



Source: (Revenue Commissioner, 2009; Department of Finance, 2010)

The revenue sources hardest hit were Capital Gains Tax and Stamp Duties, which both endured a massive drop in revenues between 2007 and 2009 (see Diagram 2.3 also). VAT revenues for 2008 were projected to be €15.55 billion, however only €13.4 billion was collected (Revenue Commissioner, 2009) and in 2009 this decreased sharply to just €10.7 billion. The budget deficit for 2009 was over €24.6 billion<sup>2</sup>(Department of Finance 2010). It appears that a key factor in this the reduced focus on income tax increased the sensitivity of the tax base to economic cycles and exacerbated the effects of the downturn (Barrett, 2009; Bergin, 2009; Whelan, 2009). This fragility has harmed the stability of health sector funding (Irish Times, 2010).

<sup>1</sup> OECD and EU-15 figures are unweighted averages.

<sup>2</sup> Government spending amounted to €60 billion, with total revenues (current plus capital) of €35.3 billion.

## Government response: Stabilisation

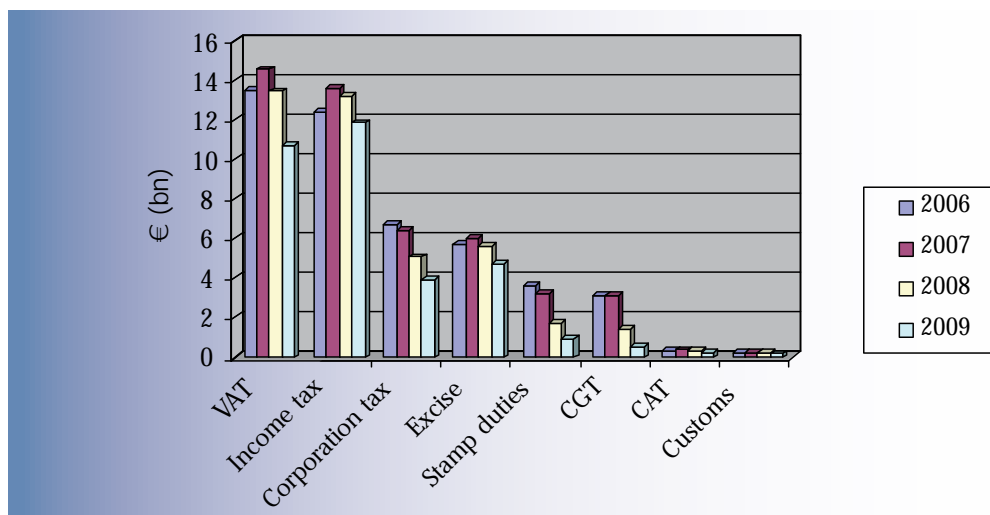
Traditional responses to faltering government tax revenues are to raise tax on corporate profits, labour or income. This is more challenging in the current Irish context in light of the potentially negative impact on domestic competitiveness and inward investment (KPMG, 2008). The dramatic decrease in tax receipts, exacerbated by an increase in social welfare payments as unemployment rises, has provoked sizeable increases in taxation and in particular in the number, and rate, of taxes on income. Such taxes have proved to be more resilient (see Diagram 2.2) and are moving from a comparatively low level in Ireland (Callan et al., 2009a).

In 2008 tax raising measures targeted to generate over €2 billion additional revenue over 12 months were announced<sup>3</sup>. Nevertheless such measures proved insufficient. Consequently in February 2009 further reforms were announced to stabilise the government's finances, with a pension levy increase on public servants' wages. The pension levy claw-back comprised the bulk of the €1.4 billion annual savings in payroll adjustment. Furthermore, the Government announced expenditure savings with an effect of €1.8 billion in February 2009 (Department of Finance, 2009b), and another €4 billion in December 2009 (Department of Finance, 2009c).

## Analysis of Taxation Portfolio

To understand better Ireland's taxation base it is worth reviewing the taxation portfolio in more detail. This will help highlight how an SHI scheme might be integrated into current revenue raising systems. The four largest components of the tax system of the Irish taxation systems are VAT, personal income tax, excise duties and corporation taxes. These comprised close to 90% of net tax revenue in 2007, with stamp duties and capital gains tax making up most of the remainder (Revenue Commissioner, 2008). Net tax receipts from 2006 to 2009 are highlighted in Diagram 2.3.

Diagram 2.3: Net Tax Receipts from 2006 to 2009



Sources: (Revenue Commissioner, 2007, 2008, 2009; Department of Finance, 2010)

Notes: i) these figures are 'net' and so do not include Pay Related Social Insurance (PRSI), Health Contributions and Employment and training levy which together amount to close to €10 billion.

ii) Income tax: in addition to payroll deductions this also includes Deposit Interest Retention Tax, Withholding Tax (fees) and Dividend Withholding Tax.

iii) VAT = Value Added Tax; CGT = Capital Gains Tax; CAT = Capital Acquisitions Tax.

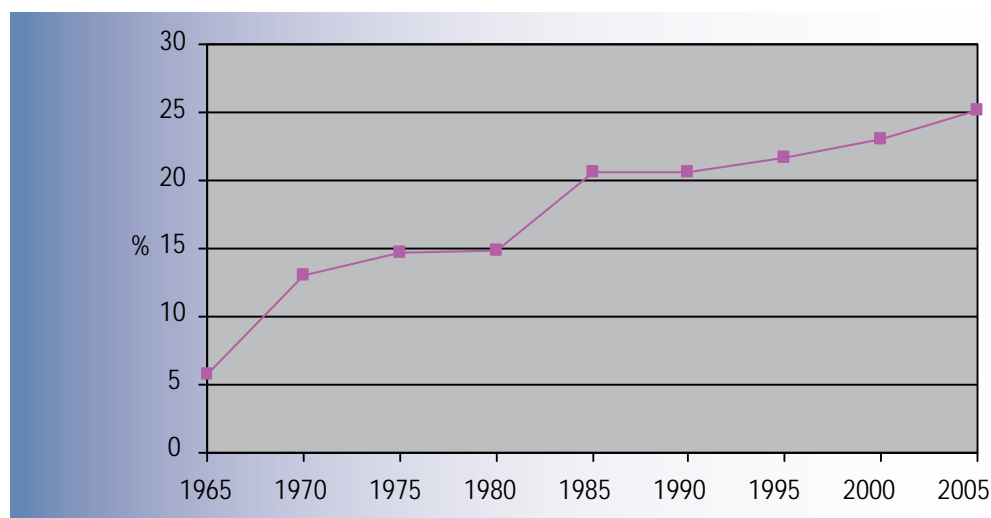
As noted earlier in this chapter, the Irish authorities have deliberately changed the balance across different types of taxation toward taxes on consumption and this is shown in Diagram 2.4. From just 5.7% of total taxation in 1965, by 2007 general consumption taxes had grown to account for 24.1% of total taxation. This proportion was joint third largest out of thirty OECD countries, over five percentage points higher than the OECD average and substantially greater than the United Kingdom (18.2%) and the United States (7.7%) (OECD, 2009).

Correspondingly, in 1997 income tax comprised 37% of revenues (over 10 percentage points more than VAT) (Revenue Commissioner, 1998) but by 2007 had decreased to just 29% of net receipts. Ireland's level of payroll deductions has been particularly low by international standards. Considering payroll deductions as a percentage of gross pay, Ireland's proportion of 14% meant it ranked 28th lowest out of 30 OECD countries in 2005, above only Korea and Mexico (see Diagram 2.5). Nevertheless, other EU states have also been attempting to reduce the tax burden on labour in recent years due to worries about increased capital mobility and the accession of numerous low-tax countries, meaning that some of the trends in Ireland's tax system have been mirrored abroad (European Commission, 2009).

<sup>3</sup> €550 million of this was one-off due to an accelerated collection of corporate tax and capital gains tax.



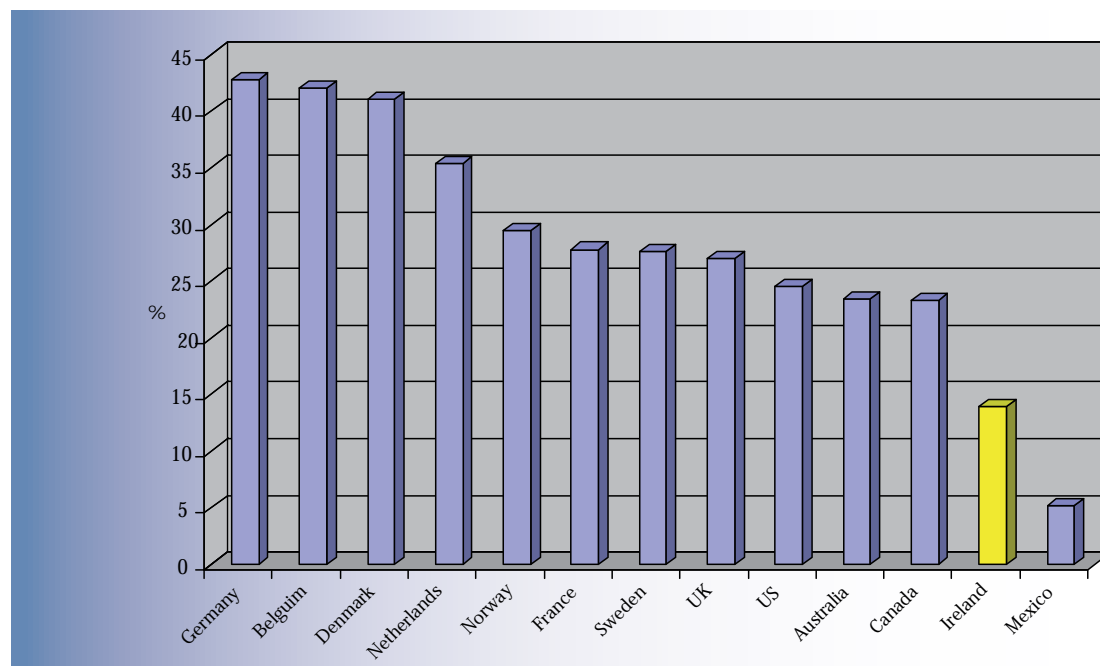
Diagram 2.4: Ireland's taxes on general consumption as % of total taxation; the evolution, 1965 – 2005:



Source: (OECD, 2007b)

Other key features of the Irish taxation portfolio are the comparatively low rate of corporate taxation, the fairly high levels of excise duties, particularly sin taxes and the revenue from stamp duties. The current low rate of corporation tax, at 12.5%, is viewed as central to Ireland's economic success with improved business investment and employment creation. KPMG (2009) noted that Ireland's headline rate of corporation tax is the lowest in the OECD. Any increase in this tax risks aggravating unemployment and discouraging investment. Sin taxes, for alcohol and tobacco, are interestingly often regarded as appropriate source of health system revenue as they only affect those who use the products (Normand and Weber, 2009) and may be more easily accepted by the public, although further tax increases in Ireland might face the opposition of powerful vested interest groups. The unique feature of Irish taxes has been the substantial revenue generated from stamp duty on the sale of houses (€3 billion in 2006). This revenue base collapsed with the recession and the possibility of replacing it with a more conventional annual property tax, as in the UK, has been discussed (Collins et al., 2009). Other taxes that may be introduced include those that support a green agenda, such as a carbon tax on fuel and/or flights (see Appendix 1 for more information on different taxes).

Diagram 2.5: Payroll deductions as a proportion of gross pay for thirteen OECD countries (2005):



(OECD, 2007b)

## Summary and Reflection on SHI Financing

The Irish taxation system has been, at least up until recently, highly dependent on consumption taxes and in particular VAT, Stamp Duty and Excise Duty. Any move towards SHI financing would mean that general taxation funding was replaced by revenue earmarked for health.

One option would be to add an earmarked payroll levy. At the same time to compensate partially for this increase in the payroll burden on the consumer there would have to be a reduction in general taxation. This could be in the form of lower income tax. Up until recently this would have been difficult as income taxes were comparatively low and any further reduction might look unstable. Nevertheless, the recent shift toward more income-based levies and charges (and the recent decision to consolidate PRSI and two other income based levies) might actually create a basis from which a relevant and sizeable compensation of households could be made without destabilising income tax levels.

Alternatively an increase in earmarked payroll contributions could be partially compensated by a decrease in the VAT rate. The advantage of this is that VAT is already quite high by European standards. Lowering it in the current economic climate might well boost incentives to consumers to purchase goods and to purchase them within Ireland. Nevertheless, VAT reductions may well be absorbed by retailers and not passed on to consumers. Still, by adding in income related charges for SHI and removing non-income related charges around VAT, the financing of government services could become more progressive, furthering equity.

Where a payroll charge for financing SHI is not thought to be feasible or where additional sources of finance need to be found, there exist possibilities around green taxation, wealth taxes and sin taxes. While these are less common forms of financing SHI internationally, they are not without precedent as can be seen from the analysis of the French system in Chapter 3.









## Chapter 3: International Experience with SHI

In this chapter the authors explore international trends in SHI. In particular, it is useful to analyse the variety of SHI designs as worked out in different country contexts. The chapter concludes by analysing these designs against the performance criteria outlined in Chapter 1. This will help illuminate appropriate options for the design of SHI financing in Ireland in Chapter 4.

### International Trends

Three key themes are apparent reviewing international evidence:

1. A long evolution of SHI in high income European countries
2. A much faster transition to SHI for many countries in Eastern Europe and Central Asia
3. Increasing adoption of SHI in middle to high-income countries in East Asia, Central and South America and the Middle East.

Any adoption of and move toward SHI would in all probability be relatively fast in Ireland (five to ten years) and therefore it is important to review those countries which have adopted SHI over a shorter time period as well as those high-income country systems where SHI has evolved over decades.

### A long history in Europe

Several high income countries in Western Europe have a significant SHI component in their health system financing including Belgium, France, Germany, Austria and Luxembourg<sup>4</sup> (Normand and Busse 2002), though none have recently shifted to such a system. Indeed, most have taken decades to evolve into a Universal Health Insurance scheme with high levels of coverage (Saltman et al., 2004). The overall pattern of financing of these countries is outlined in Diagram 3.1, along with Ireland for the sake of comparison.

### The Mix of Funding

Only Germany and France, of the countries shown, finance more than 50% of their total health funding through earmarked taxation based on some measure of income. Interestingly, while SHI forms the major financing mechanism in these countries it is often complemented by spending from government through general taxation. Government spending frequently is targeted at public health programmes or health promotion activities which are less amenable to insurance. Furthermore, all countries have significant contributions from households, in terms of out-of-pocket spending. The rationale for this relates to helping with cost-control by reducing incentives to consumers to use services, though often this can defer necessary as well as frivolous use and it is often highly inequitable (as shown in Chapter 1).

In all countries there is always some **additional private insurance** presence, albeit typically very small except in the case of France. It is important to realise that even in these mature health financing systems that Social Health Insurance does not eliminate the role of private health insurance. Furthermore, a pure SHI system, where SHI is the only financing mechanism, does not exist. It is therefore important to think about how SHI will interact with the other financing mechanisms whether government taxation, out-of-pocket spending from households or private insurance.

Similarly, it is often quite difficult to disentangle what funding for SHI comes from earmarked taxes, such as payroll taxes, and what comes from Government subsidies. Hence the funding of SHI in Diagram 3.2 actually hides government subsidies to SHI. Such subsidies can be in the form of a general subsidy to a SHI mechanism, such as paying directly for services (e.g. certain hospital services in Austria and Switzerland), subsidising insurance funds (as in Belgium), or paying all or part of the premium for vulnerable groups, a feature of most European systems. Another mechanism, as employed in France, is to let insurance funds accumulate sizeable debts which are then paid off by government through a levy on all forms of income.

While government subsidies are quite common, the authors have argued previously (Thomas et al, 2006) that such practices may decrease transparency in the system, making it more complex, less attractive to the population and more difficult to evaluate performance. Nevertheless, there may be political reasons for government intervention of this form, to preserve influence and to fulfil its responsibility to sustain health system financing levels.

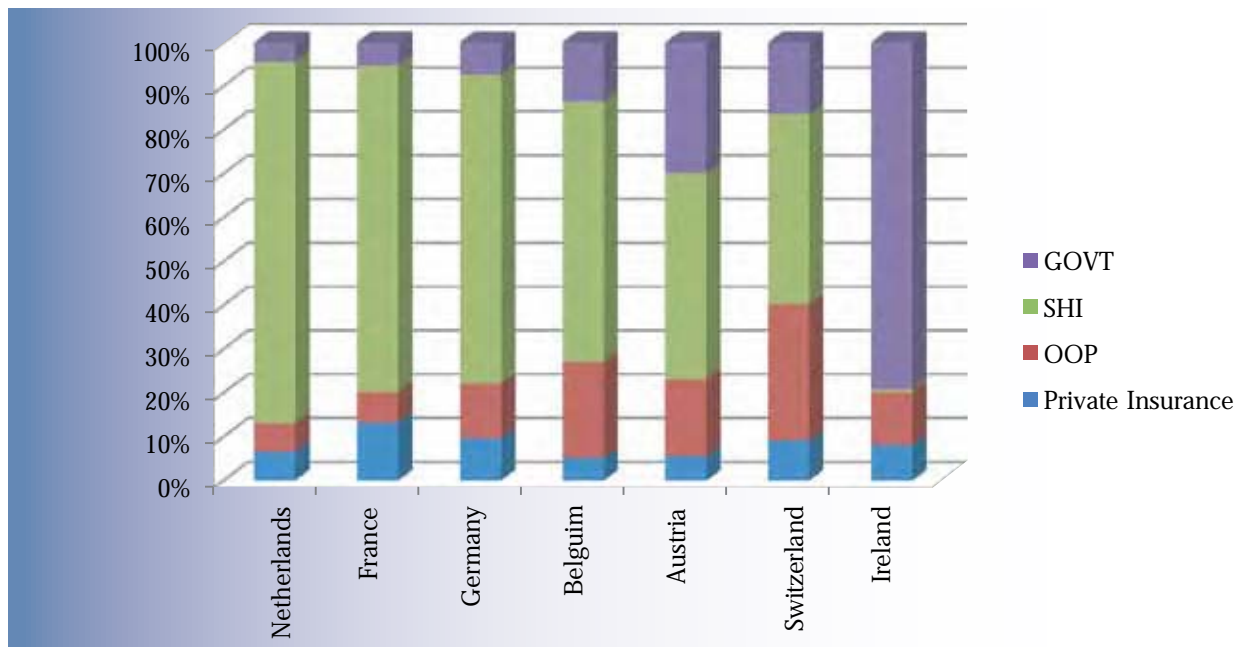
All the Western European SHI systems have achieved **universal coverage**, or close to it, as is shown in Diagram 3.2. Ireland's taxation based system, with private health insurance for approximately half the population, results in a two-tier system (and possibly three-tier if the population is divided into those with medical cards, those with private insurance and those without either). Nevertheless, the universality of coverage with these SHI systems comes at a price and the international literature confirms that SHI systems typically run at higher costs than those that use general taxation (see Normand and Thomas, 2008 & 2009). The authors previously estimated that adopting a UHI system would increase an-

<sup>4</sup>and the Netherlands prior to reforms in 2006



nual health expenditure from 7.5% to 8.9% of GDP in 2006 prices (Thomas et al 2008). This would be relatively cheap by European standards where it can be seen that most SHI systems cost around 10% of GDP. Where current macro-economic conditions do not allow an increase in spending to accommodate this then savings will have to be made through increased efficiency. Such themes will be returned to in Chapter 4.

Diagram 3.1: The financing of major Western European SHI systems and Ireland, 2006



Source: OECD 2008. Notes: Data for the Netherlands are prior to the recent reforms. Data for Austria relate to 2004

Diagram 3.2: Coverage of Health Insurance Systems by country and total health expenditure as % of GDP 2006 for select Western European SHI systems and Ireland



### ***Financing Base for SHI***

More detailed information on the features of the European SHI systems are shown in Table 3.1. It is clear that most SHI systems rely on a payroll tax to fund SHI, though as noted earlier there are often sizeable subsidies from direct taxation. Only Switzerland has a charging system entirely independent of income and based on a uniform per capita charge. The new Netherlands system, which amounts to compulsory private insurance, relies partly on such a premium and partly on an income-related charge. The weaknesses of such charging policies are that equity in financing is compromised as those on lower incomes pay higher proportions of their earnings.

The French system deserves exploration partly because it performs very well in comparative studies and also because it has a different approach to financing Social Health Insurance than the other European countries (as can be seen in Table 3.1). The French financing of SHI is unique in Western Europe in being neither solely based on payroll nor reliant on per capita fixed premiums. In fact the financing is a mixture of charges on payroll, on all forms of income (including pension income - at a reduced rate, rental income, investment income, bank interest and capital gains), and subsidies from general taxation as shown in Diagram 3.3. The logic of relating premia to overall incomes is that insurance premia based on wages and salary is not a comprehensive measure of income or ability to pay.

Diagram 3.3: Social Health Insurance funding by Source in France, 2000



Notes: CSG\* – General Social Contribution; VAT\*\* - Targeted at car sales, tobacco and alcohol; Source: (Sandier et al., 2004).

The diversity of funding bases used in the French system shows that successful SHI systems can utilise a mixture of sources for the insurance premia. While this increases complexity, and perhaps decreases transparency, it can also spread the apparent weight of the financing burden, and meet other objectives. For instance, the pharmaceutical industry pays funds into social health insurance in the form of a tax on sales and advertising expenditure. Further, there are also some funds raised from “sin taxes”, such as alcohol and tobacco, as they contribute to higher spending on health care. In addition, the state subsidises premia and, as noted earlier, charges an all-income tax to fund the debt of insurance funds. Further diversification of funding was expected in the 2009 budget, with increased taxes on spirits, a 2% tax on company shares and bonuses and a new tax on “golden parachutes” over €1 million (IHS 2008).

## SHI Design details

### **Premia**

SHI premia vary across the high income European countries but contributions tend typically to be between 5 and 10% of payroll-based income (see Table 3.1). The mean contribution rate in Germany is quite high at 14%, possibly because there are fewer subsidies from general taxation. Premia are mostly uniform but may vary by profession or fund.

### **Ceilings**

Ceilings on contributions are present in some countries for those who earn over a threshold amount, and particularly for the self-employed, see Austria and Germany. Such ceilings are inadvisable where equity is an important policy goal as it means the rich pay proportionately less than poorer groups. This explains why some SHI systems can perform less well from an equity standpoint than taxation based systems (Wagstaff et al 1999). Ceilings also reduce revenue generation but may increase political acceptability with elites.

### **Financing of vulnerable groups**

Some groups are exempted or charged lower rates where they are deemed vulnerable (see Table 3.2). For instance pensioners are charged lower rates in France and Belgium but not in Germany or Luxembourg. Interestingly, in Austria pensioners pay a higher rate than employees perhaps because of their higher use of the system. For the unemployed there is also a mixed response. In Germany and Belgium no contribution is paid. In other countries, the unemployed

must pay a proportion of their benefits, such as in Austria and France. In Switzerland and the Netherlands subsidies are available for those who cannot afford the standard premium.

### **Risk Equalisation**

In all countries, there are multiple insurance funds. To compensate those funds with older and sicker members and to reduce incentives to attract low cost members some mechanism for equalising risk across funds exists. A fuller discussion of this topic is included in Chapter 7.

**Table 3.1: Contributions and Premia by Select Western European SHI Schemes**

	Payroll rate: uniform or varying	Ceiling on contributory income (in €1,000/year)	Other personal contributions to funds (i.e. excluding co-payments to providers)	Distribution employer/ employee
AUSTRIA	Varying by profession: 6.4 – 9.1	Yes (46k)	No	Variable **
BELGIUM	Uniform: 7.4	Generally no (for self-employed 73k)	Non-income related per capita premium (nominal amount)	52/ 48
FRANCE	Uniform: 0.75% (employee)	Generally no (for self-employed 146k)	General Social Contribution based on non-wage income at a uniform rate (effectively 5.2%)  Government levy on income to pay fund debts	94/ 6 ***
GERMANY	Varying by fund: mean 14.1%	Yes (normally 43k, higher for miners' fund)	No	50/ 50
LUXEMBOURG	Uniform: 5.1 (+ 0.3-5.0% sick pay)	Yes (82k)	No	50/ 50
SWITZERLAND	No (premium per capita)	Not applicable	Only premium per capita	0/ 100

Sources: (Saltman et al., 2004)

**Table 3.2: Financing of Vulnerable Groups in European SHI systems (2002/03)**

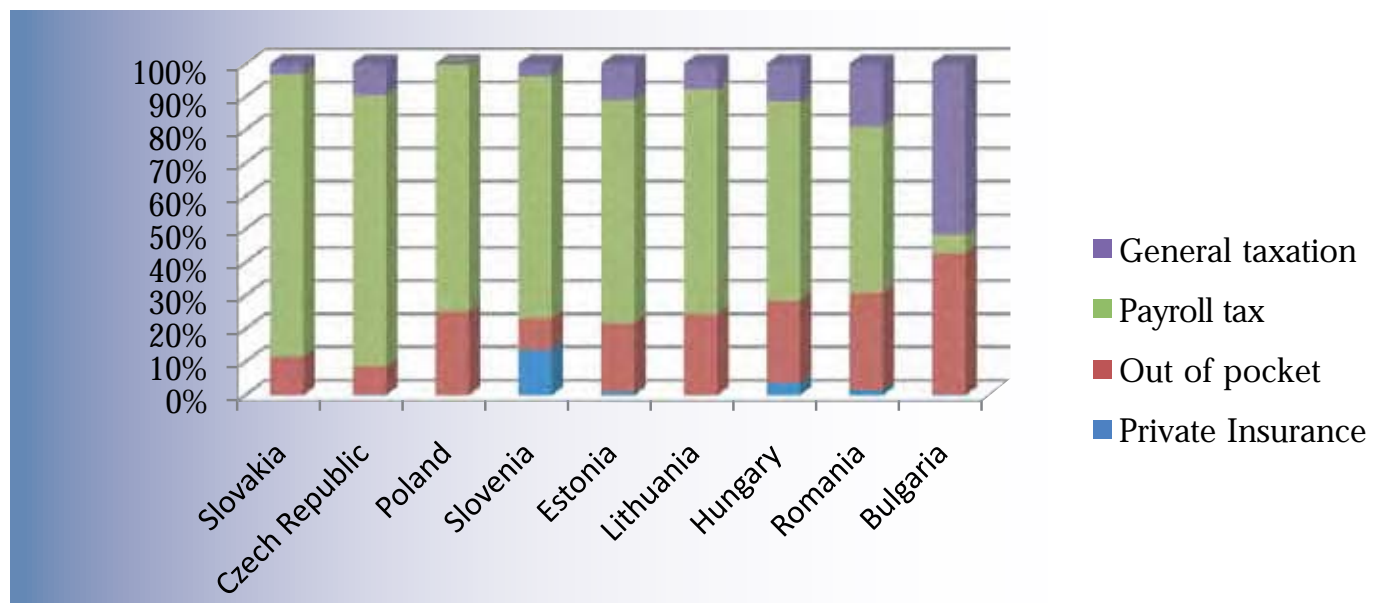
	Unemployed	Pensioners	Persons on low wages
Austria	6.8% of unemployment benefit	3.75% from individuals. 7.25% from pension fund.	No contribution below €3,700 per annum
Belgium	No contribution from individual. Sick-ness fund pays	No contribution if worked more than 15 years. If less, then €50 per annum, topped-up by Government	No contribution below €4,650
France	3.95% of benefits	3.95% of benefits	No contribution below €6,600. Lower contribution, 0.6% up to €29,200
Germany	No contribution from individual. Government pays.	Same as employees (variable payroll tax depending on fund)	Below €4,800, individuals do not pay, but employers pay 11% - but no health insurance is provided. Between €4,800 and €9,600, rates are reduced
Luxembourg	No compulsory payment but no coverage. Voluntary contribution level as with minimum guaranteed income, €16,500	No payment for those earning below €21,350. For those above, same rate as for the employed.	No compulsory payment but no coverage below €16,500. Voluntary contribution level as with minimum guaranteed income
Switzerland	Flat rate payment but subsidies available for those unable to pay	Flat rate payment but subsidies available for those unable to pay	Flat rate payment but subsidies available for those unable to pay

Source: Adapted from Saltman and colleagues (2004).

### **Recent Switchers – Eastern Europe and Central Asia**

In Central and Eastern Europe and Central Asia, social health insurance has emerged as the dominant financing model (Waters, Hobart, Forrest et al, 2008; Wagstaff and Moreno-Senna 2009), after the collapse of the state with the demise of the Soviet bloc. Of the 28 Eastern European and Central Asian countries, half abandoned tax-finance and adopted SHI between 1990 and 2004, and four others had adopted it prior to 1990. By 1995, seven countries had SHI systems with a share of total health financing over 50% and this rose to fourteen countries by 2003. Diagram 3.4 summarises key financing data for the Eastern European systems.

Diagram 3.4: Financing of Eastern European SHI Systems, 2000



Sources: (World Bank 2006, World Health Organization 2005, Koulaksazov 2003, all in: Waters et al 2008).

## The Mix of Funding

Interestingly SHI is accountable for larger proportions of overall health spending in many countries than in Western European systems. In four countries in particular (Slovak Republic, the Czech Republic, Poland and Slovenia) SHI accounts for over 75% of all health expenditures. This suggests, at least superficially, that a quick development of SHI with broad coverage is possible even without a previous history of health insurance. Nevertheless, out-of-pocket payments tend also to account for a higher share of overall funding than in the Western European systems, implying that such systems may be less equitable. Copayments may well undermine the positive equity effects of SHI.

Table 3.3 highlights the low levels of spending on health as a proportion of GDP even with SHI. These are markedly lower than in Western Europe, except for Slovenia. Undoubtedly this is partly due to the lower costs of care and lower income levels, with associated lower expectations, of the population. Nevertheless, Wagstaff and Moreno-Serra (2009) estimate that the switch to SHI in Eastern Europe and Central Asia actually increased government spending by 15% and total spending by 11%. This appears mainly to have gone to increases in salaries of health providers and to a lesser extent increased inpatient admissions, which increased by 3%.

**Table 3.3: Levels of Health Spending In Ten Central and Eastern European Countries, 2004**

Country	Health spending per capita, current US\$	Health spending per capita, SPPP	Percent of GDP
Bulgaria	191	595	4.3-7.5
Czech Republic	667	1,382	7.5
Estonia	366	722	5.3
Hungary	684	1,327	8.4
Latvia	301	756	6.4
Lithuania	351	838	6.6
Poland	354	827	6.5
Romania	159	508	6.1
Slovakia	360	854	5.9
Slovenia	1,218	1,833	8.8

Sources: (World Bank, 2006, World Health Organization, 2005, both in: (Waters, 2008)).

Note: PPP = purchasing power parity; GDP = gross domestic product.



## The Financing Base and Design Details

SHI is again predominantly financed through payroll taxes. Table 3.4 shows that premia are significantly higher in many countries (Czech Republic, Estonia, Hungary, Romania, Slovakia, Slovenia) than in most Western European systems (except for Germany). This is potentially because the tax base in some Eastern European countries is quite low and so there is less room for government subsidies.

**Table 3.4: SHI Contributions and share of overall financing in Eastern Europe**

Country	Contribution rate (% of earnings)	% of payroll tax paid by employee	Private Insurance (%)	Out of pocket (%)	Payroll tax (%)	General taxation (%)
Bulgaria	6	35	0.4	44.8	5.8	54.5
Czech Republic	13,5	33	0.3	8.4	82.3	9.4
Estonia	13	0	1.0	20.2	65.6	10.7
Hungary	23,5	25	3.5	24.5	58.9	11.3
Latvia	n/a	n/a	2.8	45.9	0.0	68.2
Lithuania	6	0	0.1	23.2	64.5	7.2
Poland	7,75	100	0.0	26.4	78.4	n/a
Romania	14	50	1.7	33.5	56.8	21.6
Slovakia	14	28	0.0	11.7	85.9	3.1
Slovenia	13,25	47,3	14.0	9.7	75.2	3.9

Source: Mossialos et al 2002, Kozierkiewicz et al 2005, World Health Organization 2005, Semerdjiev 2006, World Bank 2006, all in: Waters (2008).

While SHI systems have been put in place quite quickly in Eastern Europe and Central Asia it is less clear whether they have delivered substantial benefits. Wagstaff and Moreno-Senna (2009) note that while SHI seem to have increased spending, increased inpatient admissions and reduced average length of stay; this does not appear to be associated with a general improvement in health outcomes. The only clear cut improvement seen is in relation to a reduction in post-neonatal mortality. One reason for the indifferent outcome results could be that there is an increased risk that public health programmes can suffer with SHI, as they are less amenable to insurance and so need separate and clear funding. Nevertheless, Wagstaff and Moreno-Senna (2009) also note that there is a wide variety of SHI schemes in place in the region and it may be unhelpful to treat them as one model. Certainly, the experience of adopting new financing mechanisms in Central and Eastern Europe illustrates the difficulty in implementing a system in the absence of supportive traditions (Volcina et al 2007). It also highlights that the specific design of SHI matters (See Diagram 3.5).

## SHI Adoption in other middle and high income countries

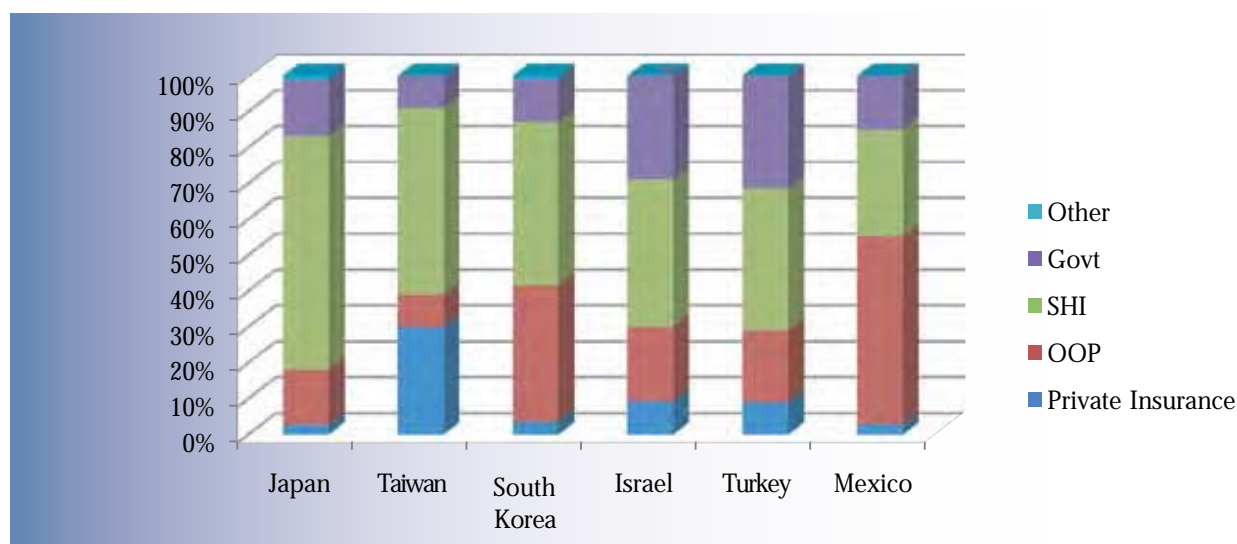
Several non-European middle and high income countries have established or recently moved toward a Universal Health Insurance model including Japan, Taiwan, South Korea, Colombia, Turkey and Mexico (Chieng and Chian 1997, Moon and Shin 2007, Ruiz, Amaya and Venegas 2007, Akbulut, Sarp and Ugurluoglu 2007, King et al, 2007).

## Funding Mix

Apart from Japan, SHI typically accounts for a smaller proportion of overall funding than in Western or Eastern Europe. Consequently universal coverage has not been achieved in some of these countries, such as Mexico and South Korea where there is also a very high proportion of out-of-pocket spending. Indeed, the South Korean system does not provide coverage for the poor and this alongside the extensive use of out-of-pocket payments has made the system regressive. This highlights again the importance of reviewing the mix of funding sources and the effects of their interactions.

South Korea and Taiwan have a SHI model where the state is responsible for administering health care financing centrally whereas the private sector plays the dominant role in provision (Lee et al, 2008). This is a different model of SHI which concentrates purchasing power with the state. While the European systems often rely on competition between funds, these East Asian SHI models are based on the rationale that there are economies of scale in fund size and that one centralized fund will be able to secure better deals with providers. This raises the issue of the conditions for competition between funds to yield efficiencies. Where there are only a few funds, and therefore limited competition, the model must rely on effective regulation to stop anti-competitive practices such as the creation of cartels.

Diagram 3.5: Financing of SHI schemes in select non-European middle and high income countries



Source: (Organisation for Economic Cooperation and Development, 2008)

### Lessons Learned

Additional lessons that emerge from the international literature on SHI are (Normand and Thomas 2008):

- the importance of calculating the financial affordability of the packages offered (Eastern Europe)
- the importance of changing the institutional relationships when shifting from a tax-based system (Eastern Europe)
- the importance of planning for the costs of transition (Colombia),
- The higher cost to the scheme of bringing in poorer, sicker groups (Taiwan, Mexico)
- The need for subsidisation of premia for the poor by government (Colombia).
- The need for a sequenced and comprehensive programme of reforms targeting financing, pharmaceuticals and provider payment mechanisms (South Korea).
- Transition is easier where care is not already free at the point of contact (universal).

## Reflections on how SHI systems can help achieve goals for Health Financing

### 1) Mobilising Funds

There are three main models for paying for SHI. By far the most popular method is a payroll tax. Where there is little government subsidy, as in Germany and many Eastern European models, the premia needs to be quite high. Most high income country models though have quite substantial subsidies to SHI from general taxation. These risk making the system more complex and less transparent but may be more politically acceptable and involve less upheaval where taxation systems are firmly rooted.

The second method, employed in Switzerland and in part in the Netherlands, is to have a uniform flat fee regardless of income. The advantage of such an approach is simplicity. The disadvantage is that it is by itself very inequitable. To compensate, subsidies are needed from government so that the poor are not penalised. It is possible but complicated to develop a system of subsidies that preserves equity though it requires effective government regulatory capacity.

The third method of funding SHI is to use a variety of financing bases, as in the French system. Here premia are based on all income sources and not just payroll payments. Furthermore there are additional sin taxes and corporation taxation to spread the financing burden. This can be complex but where the burden cannot be absorbed by a payroll tax alone it may be more acceptable. There is also a resonance with the population relating sin taxes to health spending.

### 2) Sharing Risks

#### Coverage of population

A key choice is evident between the Western European models and those in Central and Eastern Europe. In the former there is universal coverage but they are typically more expensive than taxation based systems. In the latter, there is often significantly less than universal coverage, often with quite high user fee payments. The latter systems are far less equitable, both in terms of access and financing, but cheaper to run. They may, however, fail to meet key policy objectives

The dominant European model relies on competition between several funds. However, this encourages insurers to cherry-pick the younger and fitter populations and engage in competition that is not helpful for the system as a whole. Risk-equalisation becomes more important in this context. Although some risk equalisation schemes possess much better predictive power for morbidity risk than others, all risk equalisation systems are imperfect (see Chapter 7).

### 3) Equity

#### ***Exemptions, Ceilings and Progressivity***

More than any other design issue, policy decisions about exemptions, ceilings on payments and the general progressivity of the system reflect a nation's values. Hence, even in Western Europe there is a broad range of approaches to different target groups such as the unemployed, pensioners and household on low wages. From an equity perspective in financing – where paying for health care should be paying according to ability – the progressivity of a system requires that the rich pay not only more but a larger proportion of their income. More specifically, a system which has exemptions or very low payment rates for those who cannot afford is better, as is any system which does not have ceilings on payment for the rich.

#### ***Additional funding mechanisms***

SHI will not entirely remove the demand for private insurance, as is clear from reviewing mature SHI systems in Western Europe. Nevertheless, as long as private insurance does not allow the member an advantage in the waiting list, demand for private insurance will likely drop sharply. It will consequently not skew access towards those who can afford to pay.

While SHI is more easily implemented into a system where user fees exist, it often does better to replace user fees than live alongside them. The reason is that user fees are often poor at promoting equity. They limit access to services, especially for those on lower incomes, and frequently do not generate significant funds for the system as whole. They can therefore undermine the progressive features of SHI financing.

## Chapter 4: Fitting SHI Financing to Ireland

### Introduction

The International literature makes clear that there is a variety of financing options even within SHI. It is therefore essential to consider the design of SHI that will best fit the Irish context and policies. In this chapter the authors describe and evaluate possible options for financing SHI in Ireland. Further using cost data from earlier studies and new financing data the authors calculate the impact on select household groups of implementing SHI.

The four main options for financing SHI that will be considered in this chapter are:

- **Pure SHI:** SHI is typically funded by payroll deductions into an earmarked fund (or funds) as in Germany. In this model SHI deductions are levied on all income above the income tax threshold. Those who earn below the threshold amount do not pay, while those who earn just above the threshold pay little.
- **Subsidised SHI:** In a variant to the above model the authors explore a system in which deductions are levied on all income, but in which Government pays, from general taxation, the contributions for all earned income below the income taxation threshold.
- **Mixed Bag:** In this model SHI is financed through a variety of taxation sources, as in France. Hence rather than based solely on income, there is a mix of funding bases. This reduces the reliance on payroll deductions and may consequently be more acceptable.
- **Flat Premium plus Subsidy:** In this model all adults are charged a per-capita premium. This is used in the Netherlands and Switzerland to enhance market competition between insurance funds. Government, in this case, will subsidise the premium for those less able to afford it. Government also pays into a Risk Equalisation Fund which then distributes funds across the insurers to balance risk.

Furthermore, this chapter will also reflect on the mechanics of financing reform. Shifting from the current taxation based system to a SHI system will change government budgetary policy and may require reductions in income taxation. Issues such as, and options for, compensation will also be explored, as these will typically alter the equity impact of the shift to SHI and its perceived feasibility.

It is very important to note that the choice of financing mechanism does not affect the total amount of revenue that must be raised to fund the SHI system. That is instead dictated by the package of services and their cost. The choice of financing option does however affect the distribution of the financial burden across the population. It may also impact on the acceptability to households of using SHI. Furthermore, different SHI financing schemes will create different incentives for behavior which may impact on economic activity. Such effects need to be identified.

### Review of SHI Costs

While the current economic recession may reduce available finances, it will also help lower costs. Government, dealing with tight resource constraints, will face more pressure to curtail previously high medical inflation, dampen public sector wage expectations and negotiate more stringently when contracting out services (see Thomas et al, 2008). Prospects for lower costs and efficiency gains are not reviewed in depth in this report, as the focus is to review financing and organisational options. Nonetheless, it is not unreasonable to envisage possible efficiency gains resulting both from the existing economic conditions and from a shift to activity-based funding with SHI. Three areas for potential efficiency gains may be:

- Case-based hospital contracting,

There is evidence from countries such as Sweden and Australia that hospital efficiency can be increased by shifting to case-based payment systems instead of global budgets (Aparo et al. 1999; Gerdtham et al. 1999; Hakansson 2000; Hilless and Healy 2001, Robinson 1991).

- Administrative savings,

Administrative savings in insurance funds were a key consequence of the recent Dutch reform towards more competition. However, it is unclear whether such savings are sustainable or whether they consisted of just a short-term strategy to undermine competitors (Ryan et al, 2009). Nevertheless, rationalisation of administrative bodies in Ireland may produce savings.

- Cost-cutting measures in paying for primary health care (PHC) services, such as capitation rates for GMS patients.

Potential cost-savings in PHC have recently garnered attention, especially with the lower capitation rates paid for the over 70s and the removal of the universal right for the over 70s to medical cards in 2008. Given the changing composition of the GP workforce it might also be worth reviewing the payment basis for GPs. A fixed salary for GPs at a slightly lower level, but with no risk, may be an attractive option for many new GPs facing the uncertainties of private competition in a recession and the possibility of increased competition from other professions, such as pharmacists.



In light of this, any cost estimate for SHI drawn from previous Adelaide reports is likely to be a maximum. The first Adelaide Report utilised 2005 costs updated to 2006 values (Thomas et al. 2006) for key SHI options, which are shown in Box 4.1. This report updates these figures to the cost scenarios shown in Diagram 4.1 based on medical inflation (Central Statistics Office 2009).

#### **Box 4.1: Options for SHI Design (Thomas et al, 2006 & 2008)**

##### **I) Levelling up access and quality of all services (The 'Levelling Up' Option)**

This version of SHI involves upgrading the access to health care services for the worse-off segments of the population to that of the best-off. Hence it ensures provision of all hospital services currently available in the public and private sectors through supplementary insurance to the entire population, including guaranteed and timely access to hospital consultants. In addition, members will receive free primary health care (PHC) consultations, free PHC prescriptions and some limited support for long-term care.

##### **II) The Priority to Primary Care Model**

This involves the provision of the same package offered for PHC as in the 'Levelling Up' Option, with free PHC consultations and prescriptions. It also involves some minimal hospital support through the removal of fees to be paid for inpatient stays for the uninsured and the removal of charges for all for using Accident and Emergency and OPD services .

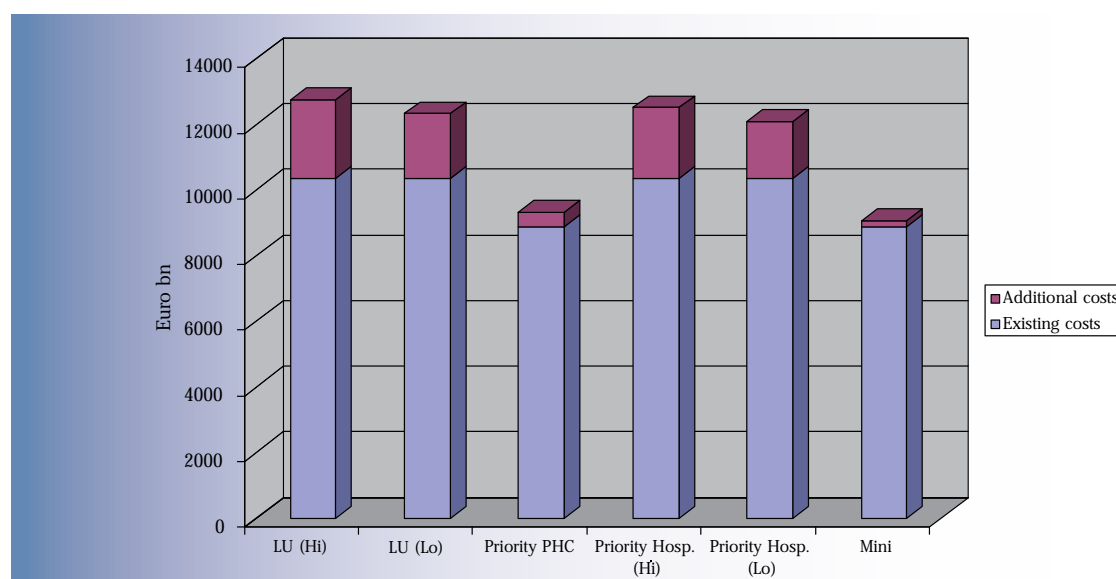
##### **III) The Priority to Hospital Services Model**

As in the 'Levelling Up' Option, members are entitled to a comprehensive package of hospital benefits, including semi-private and private rooms and quick access to consultants. There is also some support to PHC attendance. It is proposed that all PHC visits for those currently not on medical cards are charged at a fixed price of €20, with SHI providing a capitation fee to compensate GPs. €20 per visit still represents a potential barrier to use of GP services but would reduce the cost to patients by around 50% compared with current prices.

##### **IV) Making only small improvements in access**

This involves the removal of all fees for hospital attendance and fixed price charges for PHC. All inpatient (IP), and OPD charges are removed, as with II, and all A&E attendances and PHC visits for those currently not on medical cards are charged at a fixed price of €20. Further, the provider payment system is shifted towards a DRG or capitation based system and the savings incurred, once the new system is running well, will be invested in expanding public sector services to alleviate current bottlenecks.

Diagram 4.1: Costs of SHI Options (updated to 2009 prices)



A realistic expectation for efficiency gains may well be around a 10% reduction in costs, based on the above potential areas for cost-savings. This will consequently lower the amount of revenues needed to be raised. It is worth noting that efficiency gains lowering costs by 19% across the health care system would allow the introduction of the 'Levelling Up' option of SHI with no additional spending.

### Option 1: Pure SHI

The most popular financing method for SHI systems internationally is an earmarked<sup>6</sup> payroll tax.

The authors suggest implementing such an insurance charge on payroll for those in formal sector employment and on income tax assessment for the self-employed. As in Thomas et al (2006), several principles apply:

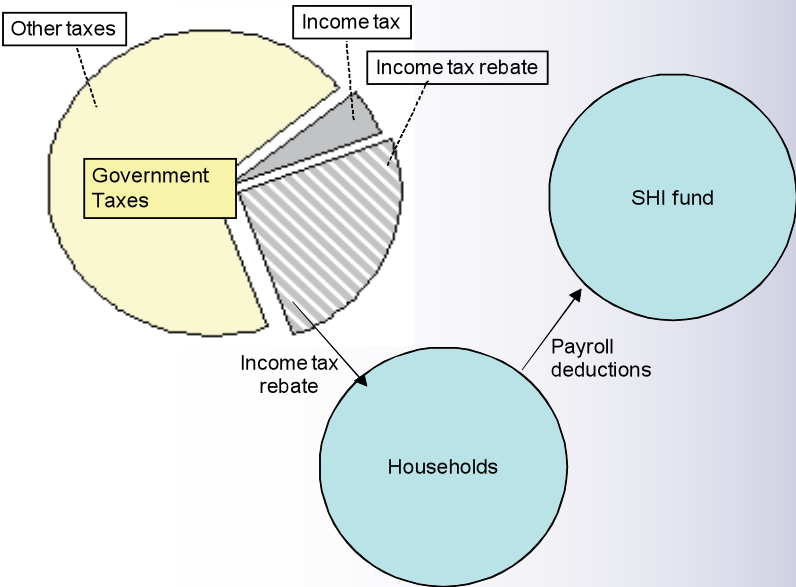
- those earning below the income tax threshold will be exempt from any payments. For a single person in formal sector employment the threshold is €18,300 while for a married couple with one income earner in the formal sector it is €27,450 (Revenue Commissioners 2009)<sup>7</sup>.
- those in work will be charged according to a fixed proportion of their pay above the income tax threshold, with an income tax rebate compensating for most of this earmarked payroll charge.
- there are no limits or ceilings on payments to protect the rich
- the government does not pay the premia of any citizens.

<sup>6</sup>Transparency in SHI is vital. Earmarked taxes provide a more transparent mechanism for bringing public preference to the political process, which can increase the accountability of priority setting for public expenditure. The more opaque process of allocating resources from general taxation could lower public acceptance of increased taxes, as additional payroll deductions can be siphoned away to other activities over time and often the public cannot see a link between increased taxation levels and improved public services. Nevertheless, the Government opposes earmarked taxes due to its reduced role in resource allocation (Dail Eireann 2006b). In this case it is precisely that reduced role that could allow public acceptance of the novel payroll deductions and make the system feasible.

<sup>7</sup>For the self-employed subtract €9,150 from the above figures.

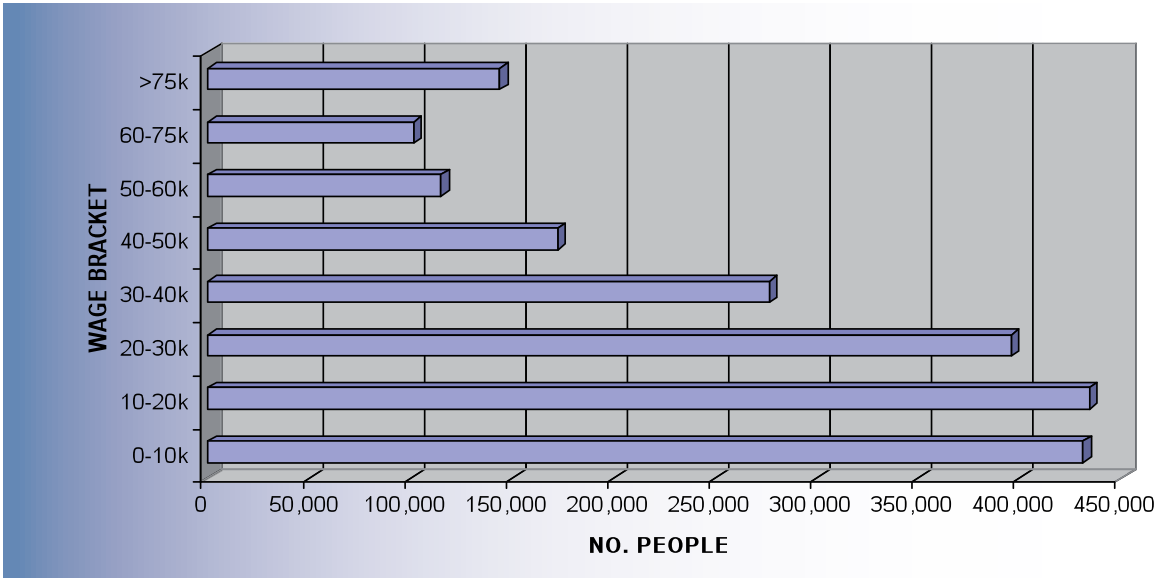
This mechanism has the advantage of being simple, transparent, and equitable. However it places significant emphasis on pay related to income and will be less popular among the rich who will bear the greatest burden. Furthermore the PAYE rebate/compensation would be so large as to virtually abolish the current PAYE/ income tax system and this may look peculiar in terms of taxation financing even if politically acceptable (see Diagram 4.2).<sup>8</sup>

Diagram 4.2: Flow of Funds with Pure SHI



To calculate the necessary payroll deductions for the pure SHI model it is important to understand the income tax regime, as it is the equitable aspects of income tax that the pure SHI model seeks to mirror. The taxable income profile, showing the number of people in a taxation band in 2005 is shown in Diagram 4.3.

Diagram 4.3:Taxable Income Profile (2005)



Source: Revenue Commissioner 2008b.

The whole and additional payroll deductions are calculated based on the 2005 distribution of income earners (Revenue Commissioner 2008b), extrapolated to the 2009 level of income tax receipts (Department of Finance 2009). Results are shown in Table 4.1 for the Levelling Up high cost option. The rates needed to raise the total sum required for running the

<sup>8</sup>Shifting health care funding from tax to SHI frees up an estimated €8.1 billion (from Thomas et al. 2006, 2008), thus allowing a decrease in income tax levels. If the €8.1 billion was used solely for PAYE compensation this would virtually abolish the income tax take. Indeed, an associated reduction in the PAYE rate of 22.5% would exceed the 20% PAYE rate in Band 1. While recent additional income levies and charges may mean that there is more scope for income taxation reductions, the pure SHI model would still be associated with very low levels of income taxation.

Levelling Up (high-cost) SHI system is 35.4% on earned income above the threshold, on average, most of which could be offset by an income tax rebate. (Other SHI options are more affordable.) This is the same order of magnitude as in Thomas et al (2006) and confirms earlier results. Nevertheless, the rates are slightly higher than the earlier estimates due to health system costs outstripping taxable income growth over the period as a whole. The marginal effect is to increase spending by households by 6.6% on current levels (see Table 4.1), assuming no efficiency gains (for rates adjusted for efficiency gains, see Table 4.2).

**Table 4.1: Payroll deduction rates on taxable income for Pure SHI:**

	Levelling up (Hi)	Levelling up (Lo)	Priority PHC	Priority PHC	Priority Hosp (Lo)	Mini
Whole	35.4%	34.2%	25.9%	34.8%	33.6%	25.1%
Additional	6.6%	5.4%	1.2%	6.0%	4.8%	0.5%

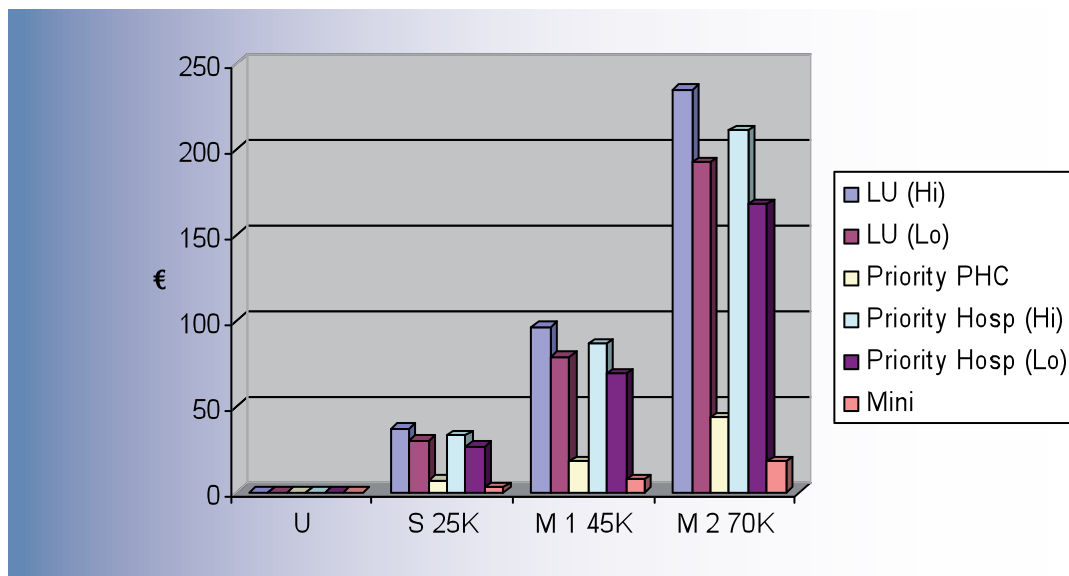
Notes: The term “additional” refers to the spending required from households to fund SHI over and above existing spending of all types. The Levelling Up option was in previous reports referred to as the Rolls Royce option.

The impact of this on different types of households is shown Diagram 4.4 below. Four household types are considered, after Thomas et al (2006):

U	Unemployed person
S 25K	Single person on €25,000
M1 45K	Married couple on a single income of €45,000
M2 70K	Married couple with a combined income of €70,000

The Levelling Up option would involve a payroll deduction of €1,253 per month for a married couple with two earners who earn a combined total of €70,000. However this does not consider compensation accruing to these individuals as a result of freeing up general taxation funds currently used for health services. Hence the additional costs of the Levelling Up high-cost SHI option would be €235 per month for the M2E €70k household, while only €37 a month for the S €25k household.

**Diagram 4.4: Pure SHI: required additional spending from select households**



Furthermore, as argued earlier, efficiency gains are likely. The impact of these efficiency gains on financing rates is shown in Table 4.2. As can be seen, with a 10% efficiency gain, the payroll deductions required to cover the entire costs of SHI Levelling Up (high-cost) are reduced from 35.4% to 31.9%, and the additional costs are reduced from 6.6% to 3.1%. Note that with efficiency gains, the Priority PHC and Mini options are affordable at no extra cost.



**Table 4.2: Financing Rates for pure SHI with 10% efficiency gains:**

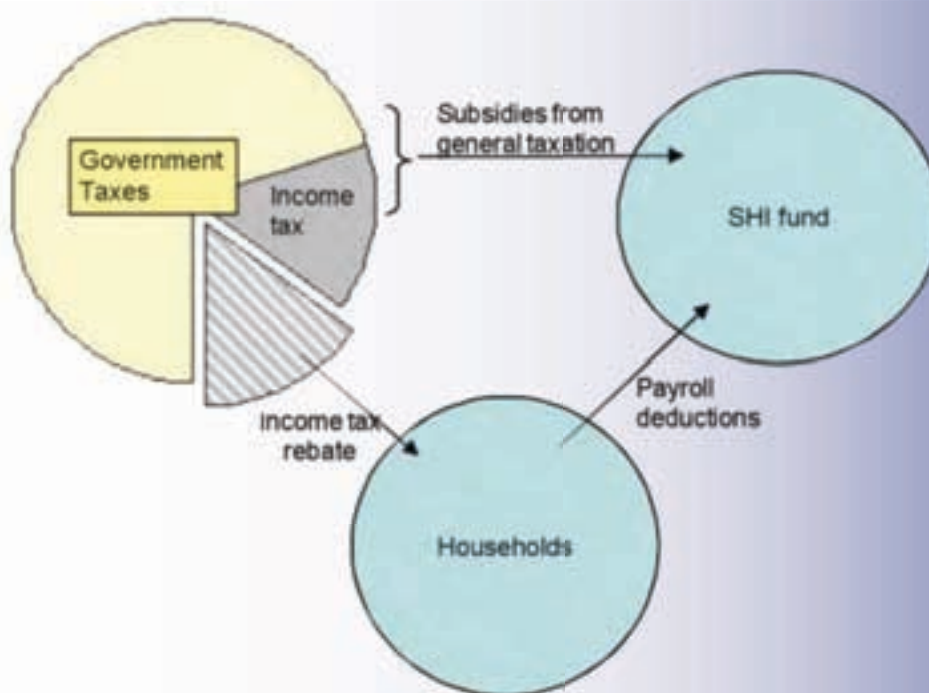
Scenario	LU (Hi)	LU (Lo)	Priority PHC	Priority Hosp (Hi)	Priority Hosp (Lo)	Mini
Whole	31.9%	30.8%	23.3%	31.3%	30.2%	22.6%
Additional	3.1%	2.0%	0.0%	2.5%	1.4%	0.0%

## Option 2: Government subsidised SHI

In this scenario a flat rate is levied on all earned income regardless of whether or not it is above the income tax threshold. All payroll deductions levied on income below the threshold are paid directly by government from general taxation revenues, while payroll deductions on income above the threshold are paid by individual earners. This reduces the earmarked payroll deduction rate from 35.4% to 16.9% to cover the entire costs of the Levelling Up (Hi) SHI scenario. The income of those earning below the threshold is unaffected.

This approach would be similar to SHI funding in many high income countries where there are substantial government subsidies to SHI. In extreme this model might look like the Canadian system where most of the funds for Universal Health Insurance come from government general taxation revenues (Marchildon, 2005).

**Diagram 4.5: Flow of Funds with Subsidised SHI Option**



**Table 4.3: Tax subsidized SHI: Earmarked payroll deductions.**

	LU (Hi)	LU (Lo)	Priority PHC	Priority Hosp (Hi)	Priority Hosp (Lo)	Mini
Whole	16.9%	16.3%	12.3%	16.6%	16.0%	12.0%

The Government contributes around half of the costs of the SHI system through general taxation (see Diagram 4.5), therefore approximately halving the rate of payroll deductions levied on those earning above the income tax threshold. This however is cancelled out by the corresponding smaller income tax rebate, meaning that subsidised SHI can be conceptualised as merely shifting the costs of SHI from earmarked SHI payroll deductions to general taxation. Such an approach may increase the political feasibility of implementing SHI. However transparency is lowered and the government's increased role in resource allocation needs to be carefully monitored to ensure SHI revenues are not eroded over time. Loss of transparency and accountability can threaten the willingness of households to spend additional funds on

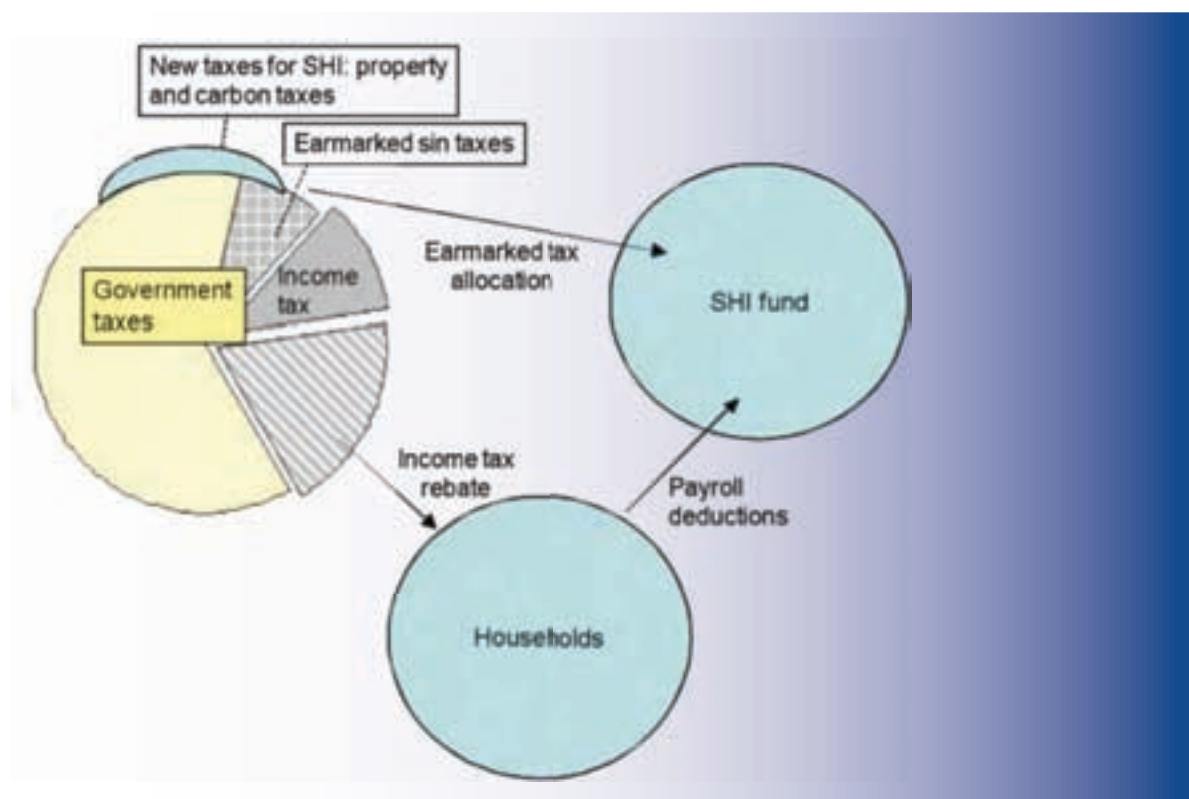
health. In addition, because general taxation in Ireland is less progressive than income tax, the subsidized SHI option could be less equitable than the pure SHI option.

It is important to reemphasize that there is no difference between the average additional costs to households for the pure model as for the subsidised model. More of the insurance is paid through general taxation in the subsidised model. Such taxation-subsidised SHI models are popular in Europe, as noted in Chapter 3.

### Option 3: Mixed Bag

This option would use a diverse funding base to finance the SHI system, as in France. A potential advantage is that the burden of financing SHI is spread across different modes of taxation and may be more acceptable. The model presented has SHI funded by sin taxes (alcohol and tobacco), a carbon tax and property taxes, in addition to earmarked payroll deductions (see Diagram 4.6). Due to the earmarking of existing sin taxes the income tax compensation/reduction would be smaller than in the Pure option, though there would be no general government subsidy.

Diagram 4.6: Flow of Funds with Mixed Bag Option



This option may offer a number of advantages, as a well-designed property tax could be even more equitable than payroll deductions. Further a lower reliance on payroll deductions may be more politically expedient in a contracting economy (ESRI 2009).

Each tax base is discussed in turn:

### Sin Taxes

Hypothecating excise from alcohol and tobacco for the health services could conservatively be expected to raise approximately €2.2 billion per annum. It can be argued that as these products lower the health status of the population it is reasonable that this money be allocated to health services. Regressivity is a disadvantage of increasing excise, as poor people are hardest hit. However there are no additional negative effects on equity if existing taxation is diverted by hypothecating existing excise receipts for SHI instead of payroll deductions, as outlined earlier.

## Carbon tax

Measures to increase the burden of environmental taxes may be favoured by society's growing focus on environmental protection, although increased oil prices can result in electoral pressure to lower energy taxes (European Commission 2009). In the EU energy taxes are the most significant source of environmental tax receipts, and comprise roughly one twentieth of the EU's entire tax receipts and social contributions.

A tax of €20/tCO<sub>2</sub> on carbon dioxide emissions would be expected to raise €550 million per year. It is predicted that between 2010 and 2020 carbon tax revenues would increase at a substantially faster rate than the overall government budget, and revenue losses as a result of fuel tourism are expected to be minimal (Tol et al 2008). Nevertheless, a carbon tax would be mildly regressive (Callan et al 2009).

## Wealth/Property tax

Opinion is divided on the effects of property tax (European Commission 2009). Advocates emphasise that they encourage production and redistribute resources. Property taxes are an efficient method of taxation and a source of sizeable revenues (European Commission 2009). This would offer a more stable taxation base than stamp duty and a property tax of €1,000 levied on each of the 1.7 million homes in the state could raise €1.7 billion a year (Collins et al., 2009).

Revenue from these three sources would comprise just fewer than 35% of total SHI funding. Although the property and carbon taxes are novel, the earmarked sin taxes are already being collected as general taxes. The distinction is worth noting, as earmarking existing taxes commensurately lowers any rebates from income tax. Further the approach may be more transparent than utilising subsidies from general government taxation.

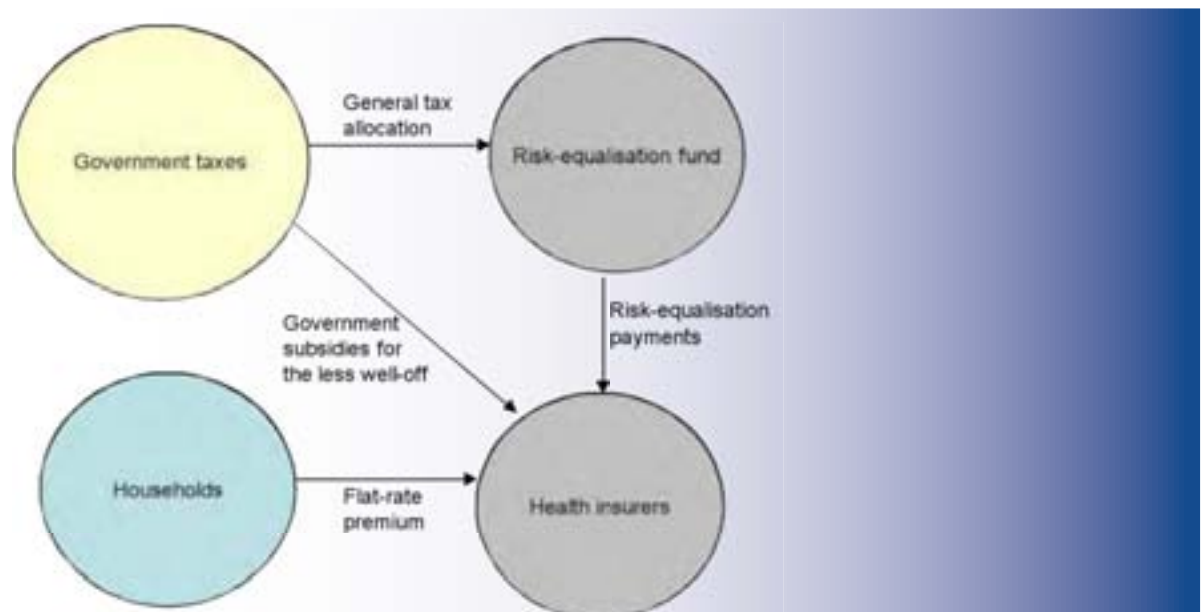
**Table 4.4: Mixed Bag Scenario Total payroll deductions:**

	LU (Hi)	LU (Lo)	Priority PHC	Priority Hosp (Hi)	Priority Hosp (Lo)	Mini
Whole <sup>9</sup>	23.1%	21.9%	13.5%	22.4%	21.2%	12.8%

## Option 4: Flat premium.

This model of financing is partly based on the Dutch and Swiss system of a uniform premium per person alongside government subsidies. Rather than setting region-specific premiums as in Switzerland, the Irish model would be similar to the Netherlands in that each insurer would set its premium nationally based on estimated costs of care. The model also draws on the Fair Care proposal outlined by Fine Gael where all individuals select from range of private insurers and Government subsidises this choice according to the income levels of the household (partly through paying premia for the less well-off and also through a risk equalisation fund). The funding flows are outlined in Diagram 4.7.

**Diagram 4.7: Flow of Funds with Flat Premium**



<sup>9</sup>It is assumed that non-payroll deduction revenue is divided equally between additional costs and existing costs.

It is important to note that the premiums charged would vary between insurers, depending on factors such as administrative and clinical efficiency, and in a for-profit system the amount of profits retained by the insurers<sup>10</sup>. This would be strongly influenced by the degree of competition in the insurance market. Initially insurers may choose to temporarily set premiums below cost price in order to build market share, as occurred in the Netherlands (Ryan et al, 2009). If an individual chooses a more costly insurer for the basic package, the additional cost will not be subsidised by government, creating an incentive for all individuals to enroll with more efficient insurers.

For illustration and to help complete Table 4.5, the authors have made some further assumptions for the flat-rate option:

- 1) The maximum premium to be paid per person is €1,000 per year
- 2) This maximum rate is only paid by adults in the top 40% of the income bracket
- 3) Those with medical cards or those under 18, have their premia paid by government
- 4) Those adults without a medical card who fall outside the top 40% of income earners pay on average half of their premia, with the government paying the remainder
- 5) The remaining health financing is paid by government from general taxation into a risk equalization fund.

The result of such assumptions is a heavily subsidised SHI scheme which also needs to raise extra taxation revenue (€2.7 billion) to cover additional costs of providing universal SHI, unless there are substantial efficiency gains.

## Assessing the Best Option

The funding flows indicated in each of the four options are compared in Table 4.5 and Diagram 4.8. All raise the same quantity of funds but achieve this in different ways. The Pure and Mixed Bag options preserve the notion of earmarking, and therefore transparency, but require large reductions in taxation, and probably income taxation. The Flat premium and Subsidised models require large subsidies from general government revenues and, while less disruptive to current taxation, do little to increase transparency.

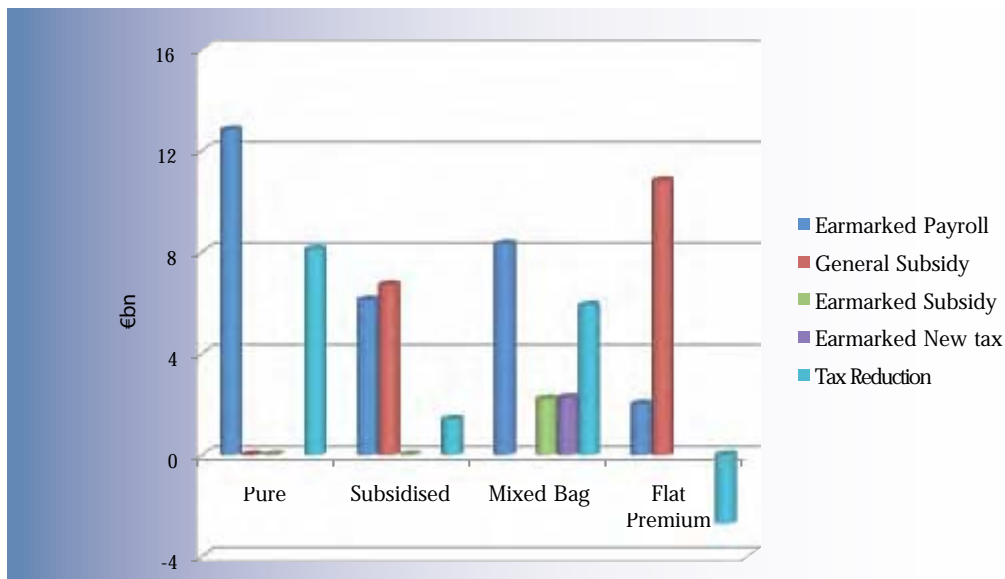
**Table 4.5: Comparison of Funding Flows for the SHI Options**

	Pure	Subsidised	Mixed bag	Flat-premium
<b>Total payroll deductions (rates)</b>	€12.8 bn (35.4%)	€6.1 bn (16.9%)	€8.3 bn (23.1%)	€2.0 bn (Flat premium of €1,000*)
<b>Total general government subsidy</b>		€6.7 bn		€10.8 bn
<b>Specific government earmarked taxation</b>			€2.2 bn earmarked existing taxes €2.25 bn earmarked new taxes	
<b>Total compensation/reduction in tax (rates)</b>	€8.1 bn (22.5%)	€1.4 bn (4%)	€5.9 bn (16.4%)	- €2.7 bn (i.e. an increase in general taxes)

<sup>10</sup>In the Swiss system insurers must operate the basic benefits package on a non-profit basis, but profit is permitted on the supplementary health insurance market.

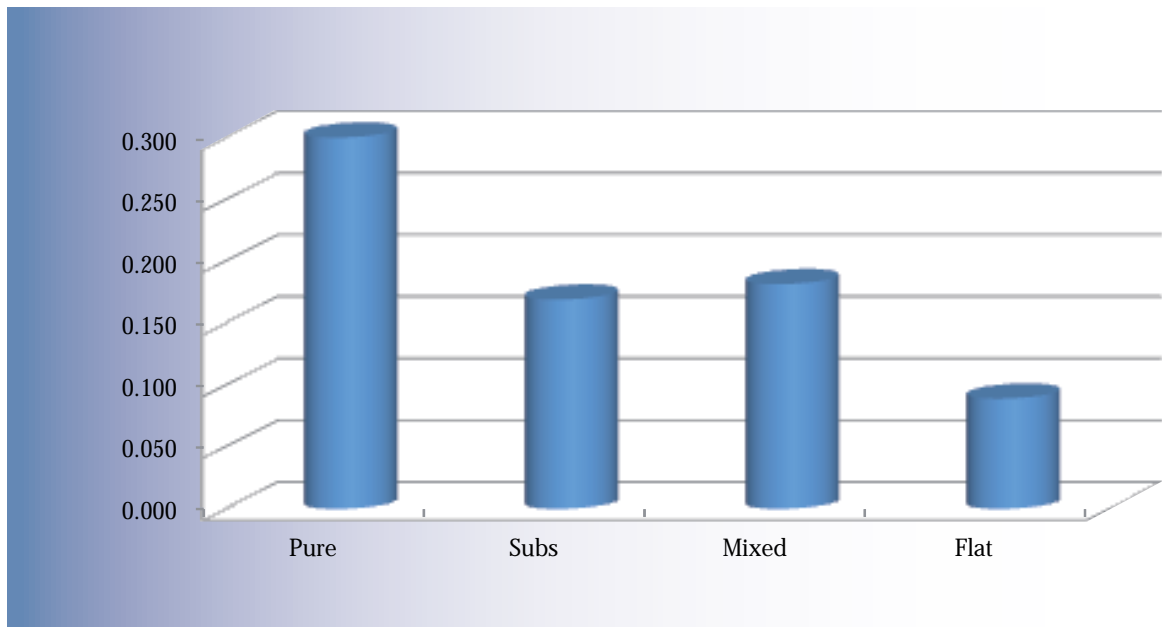


Diagram 4.8: Size and Type of Funding Flows in the SHI options



The contribution of the four options to health policy objectives is shown in Table 4.6 (pp 43). The Pure model scores well in relation to equity and transparency but its Achilles heel is the amount by which income taxes would have to be lowered. The Subsidised SHI model is far more practical and less disruptive but loses the principle of ear-marking and is not as equitable. The Mixed Bag option retains the principle of ear-marking and is slightly more progressive than the Subsidised SHI model (see Diagram 4.9) but it is complex and requires substantial compensatory tax reductions. The Flat rate premium model is administratively complex, not at all transparent, is less equitable and risks fragmentation. Hence, it is clear that no option meets all health policy objectives satisfactorily in the Irish context. Nevertheless, the Flat premium model appears to be the option that offers the least gains.

Diagram 4.9: Index of Progressivity for SHI Options



Notes: Progressivity scores derived from Smith (2009)

A key issue in choosing among the remaining options is how reductions in taxation compensate partially for increased payroll costs through SHI. If significant income tax reductions to compensate for increased earmarked payroll deductions are not possible then it would appear that the Subsidised model emerges as the most viable compromise candidate. If income tax reductions could be lessened by also reducing VAT then the Pure and the Mixed Bag models would become more viable. Nevertheless, the direct burden on high income earners of SHI payroll deductions and income tax

might be considered to be too high and they might also have a negative effect on employment. This analysis highlights how important the existing taxation portfolio is to the viability of introducing SHI to Ireland.

**Table 4.6: Summary strengths and weaknesses of each SHI option against key criteria**

	<b>Equity</b>	<b>Solidarity/ Risk-sharing</b>	<b>Mobilising Funds and Transparency</b>	<b>Compensation /Financing Reform</b>	<b>Comments</b>
<b>Pure SHI</b> (income-related)	Good	Good (but may depend on number of funds and risk equalization mechanism, see Part 2)	Good. Likely to be popular with the public.	Problem if purely related to income tax reductions.	Theoretically strong but may be practically difficult in the short to medium term because of impact on taxation policy
<b>SHI (income related) with government subsidies</b>	More dependent on overall taxation policy and so likely to be less good than pure model. (General taxation is only slightly progressive.)	As with Pure model	Less transparent but potentially easier to implement for Government	Less disruptive than the pure model to overall taxation policy. Compensation much reduced from pure model.	More practical but less equitable than Pure model. Principle of ear-marking is lost. Nevertheless, it could be a stepping stone to a Pure SHI model.
<b>Mixed Bag</b> (payroll, sin, property & carbon taxes)	Worse than Pure SHI. Progressivity slightly better than Subsidised model. While sin and carbon taxes tend to have a disproportionate effect on poorer households the mixed bag option has higher payroll deduction rates.	As with Pure model	Sin taxes may have an emotive appeal. Potentially easier for government to implement. More transparent than with general subsidies	Compensation still significant even if lower than with the Pure model.	Ear-marking preserved so boosts transparency. Nevertheless, quite complex and requiring a significant reduction to income tax (though less than with the Pure model)
<b>Flat Rate</b> (premium plus govt subsidies & risk equalisation)	Depends on precise design of subsidy and the progressivity of overall taxation	Associated with multiple funds to induce competition. Risk of fragmentation of funding pool even with risk equalisation mechanisms (see Part 2)	Not transparent at all	Minimal changes to current taxation regime. Subsidies and risk equalization may be administratively complex.	Unlikely to be a worthwhile option for equity without strong administrative capacity. Lacks transparency.

As a result of the economic downturn the tax burden has been sizeably increased to bolster government revenues. Although this has reduced the capacity of the system to absorb SHI-related payroll deductions, our analysis clearly indicates that SHI remains a feasible option. SHI will become increasingly attainable as the economy emerges from recession. Close involvement of macroeconomic and taxation experts will be essential to the timing of this process.



## Chapter 5: The Organisation of the Irish Health System

Introducing SHI in Ireland requires more than new financial flows and incentives. It also must involve organisational reform. This will mean creating new organisations or changing the roles of existing institutions. It will also mean different relations between existing organisations. More specifically there will be new relationships between households (that contribute premia and access services), funders (who purchase services) and providers in the public and private sectors, alongside different roles for regulatory authorities.

The second part of this report focuses on developing appropriate health system architecture and processes for SHI. This chapter reviews the current organisation and arrangements in the Irish health system. Chapter 6 explores key principles for effective organisation of health services, while Chapter 7 reviews international experience with organisational design for SHI. Chapter 8 consolidates these ideas and develops and appropriate strategies for Ireland.

### Policy and Reform

Ireland's single-payer, tax financed health service has undergone significant structural reforms over the last decade. In 2005 the fragmented Health Boards system was abolished and replaced by the Health Service Executive (HSE), a single entity responsible for the delivery of health care nationally (McDaid et al., 2009).

A number of key policy documents have been influential in guiding the health service to its present structure. In 2001 the national health strategy was set out in "Quality and Fairness: A Health System for You", (DOHC 2001b) prompting the Prospectus Audit of the Health System (Prospectus, 2003) and the "Brennan report" (Brennan, 2003). The Brennan report highlighted the fragmentation in the Health Boards system, and that the Department of Health and Children (DOHC), ostensibly responsible for devising health policy and strategic planning, had been drawn into service delivery issues to the detriment of its other roles (Brennan, 2003). It was also argued that decisions by the local Health Boards were overly influenced by local political interests and that national health policy priorities often lost out. The subsequent "Health Service Reform Programme", announced in June 2003 (Department of Health and Children, 2003a) led to the formation of the unitary HSE structure in 2005 (McDaid et al., 2009).

### Governance

The Minister for Health oversees the organization and strategic development of the health service and sets statutory instruments. The DOHC's principal task is to advise on the strategic development of the health system including policy and legislation, and evaluate the performance of the health sector (DOHC 2005h). The HSE is directly accountable to the Minister for Health and Children, who decides whether to approve the HSE national plan.

The HSE is split into four administrative regions, each with a local manager held directly accountable by the HSE Chief Executive Officer. The delivery of services is organised as follows:

- An Integrated Service Directorate has oversight for the planning, organization and co-ordination of acute hospital services, general practice, mental health and community-based health services. This is done through eight local hospital networks, two in each administrative area, and thirty two Local Health Offices which liaise with hospitals to meet patient needs.
- The Population Health Directorate aims to promote and protect the health of the whole population, with a particular focus on reducing health inequalities. The Directorate is also responsible for infection control, immunizations and environmental health, and operates locally through the Local Health Offices and hospital networks (McDaid et al., 2009).

The Integrated Service Directorate was created through a merger in October 2009, reflecting Government's policy of delivering an Integrated Health System (Health Forum Steering Group, 2009). Similarly, the regional networks are now responsible for both hospitals and primary, community and continuing care services. The HSE's Reform and Innovation area deals with corporate and strategic planning (Health Service Executive, 2005), while support services in the HSE include a Finance Directorate, Human Resources Directorate, Information and Communication Technology, Office for Procurement, and Estates Office (McDaid et al., 2009).

**The Health Information and Quality Authority (HIQA)** sets standards for the delivery of public health and social care services, with the exception of mental health services (Health Information and Quality Authority, 2009). Standards are currently being implemented for the quality and safety of services such as symptomatic breast cancer treatment. It is worth noting that the health system currently lacks a regulatory regime for private health care providers (Health Information and Quality Authority, 2007).



The private health insurance market is overseen by the **Health Insurance Authority (HIA)**, an independent regulatory body. It is funded by a small levy on premiums<sup>11</sup>. The HIA oversees the registration of new insurers, monitors the performance of the market and assists in enforcing compliance with the laws. The private insurance market in Ireland is regulated according to four principles: community rating, open enrolment, lifetime cover and minimum benefits (HIA, 2009). The HIA were to be responsible for the risk equalisation scheme across insurance (compensating those funds with older and sicker enrollees). However, given the Supreme Court ruling that the Irish Risk Equalisation Scheme, as enacted, was unconstitutional, another mechanism has been put in place to compensate insurance funds for older members. This is the Health Insurance Levy, which taxes each consumer but also provides an exactly equivalent rebate for consumers over 50. The HIA administers this Health Levy. In addition, the HIA is responsible also for providing relevant information both to the Minister for Health and Children and to the population.

## Funding

The key source of funds for the health system is general taxation, around 80% (Thomas et al, 2006). Additional payments by households are made for:

1. Private insurance
2. GP consultations
3. Drugs (over the counter, many prescriptions)
4. Specialist consultations
5. Hospital Services (outpatients, emergency department, inpatient)

There are a range of waivers and subsidies from government which reduce or eliminate the above costs for particular sections of the population. Nevertheless, there is no entitlement to free care at any level for all the population.

The Department of Finance plays a pivotal role in allocating funds from general taxation among health and other departments, and deciding with the DOHC the maximum number of employees in the health service. A vote is held annually in Dail Eireann to specify the level of HSE funding for the year<sup>12</sup>.

Approximately half the population have private insurance cover (Insight 2008), though this is decreasing with the current economic contraction. Most enrollees, 71%, are in the top half of the income distribution (Insight 2008). The market is characterised by a high degree of concentration with three open private insurers in addition to a range of smaller employment-related funds. VHI is the main insurer with approximately two thirds of the consumer market with QUINN and VIVAS increasing their share in recent years. The restricted membership schemes made up the remaining 4% (Insight 2008). Funding of the three private health insurers is through households selecting specific plans and paying the associated premia to the relevant company. Private insurance companies are not permitted to charge according to risk of individuals or households (community rating). However, by diversifying their products they can identify the general levels of risk of enrollees.

## Provision

There are over 11,500 publicly available beds in the public sector, including those in the 29 voluntary hospitals (PA Consulting 2008). There are a further 2,500 private beds in these hospitals. In addition there are estimated to be just under 2,000 beds in the private-for-profit hospitals. The HSE, which retained many of the staff and functions from the previous Health Board system, directly employs over 65,000 staff plus another 35,000 indirectly through its funding of voluntary hospitals and bodies.

The National Treatment Purchase Fund has since its creation in 2002 provided care for public patients in private hospital beds (in both public and private hospitals), with patient eligibility based on the length of time spent on waiting lists for hospital services.

General practitioners (GPs) are self-employed, and thus in the private sector, with the majority treating both public and private patients. GPs act as gate-keepers to secondary care, meaning referral by a GP is required in order to access specialist care in hospitals (McDaid et al., 2009).

<sup>11</sup>The HIA had a budget of €2 million in 2007.

<sup>12</sup> A further two votes are held to specify the level of funding for the Offices of the Minister for Health and Children and the Minister for Children.

## Purchaser – provider relations:

The recurrent costs of hospitals are funded largely by incremental budgeting, though increasingly the budget of certain acute hospitals is adjusted based on case mix and activity levels. In 2007 the 37 largest acute hospitals, which together accounted for 95% of all acute hospital admissions, had 50% of their budgets adjusted based on the previous year's costs and activity. The system operates on a budget-neutral basis, meaning that funding is deducted from those hospitals that perform below average and redistributed to better performing hospitals. To date, however, the sums involved have been quite small. While in 2005 30% of the budget was adjusted, only €7.5 million was redistributed from a total of €3 billion (McDaid et al., 2009).

Capital expenditure in the hospital system is planned by the HSE (Health Service Executive, 2006) in the framework of the Department of Finance's National Development Plan, (Government of Ireland, 2007) and the Department of Finance must approve any capital projects costing over €6.3 million. Some capital expenditure is contained also in the HSE annual budget and a capital plan is sent to the DOHC for approval on an annual basis (McDaid et al., 2009).

Hospital consultants in the public sector are paid by salary, while those in the private sector operate on a fee-for-service basis. In primary care, general practitioners (GPs) are paid by government for medical card patients on a capitation basis, while most other patients pay GPs out-of-pocket on a fee-for-service basis (McDaid et al., 2009).





## Chapter 6: Principles of Organisational Reform for SHI

To evaluate different options for the organization of SHI it is useful to highlight principles to guide reform. Drawing on theoretical and international literature the authors propose a number of key principles:

- Minimising transition difficulties
- Ensuring responsiveness to needs
- Efficient operation of administration and provision
- Good governance and stewardship
- Accountability and transparency

### Minimising transition difficulties

Reform is never conducted in a vacuum. Existing structures and practices need to be changed and contexts and pre-existing values must be considered. Radical change is likely to be time and resource consuming. It may take three years before a reform has any positive effect on health system performance (Normand 2004). Hence reforms that build on existing structures or institutions may be more likely to succeed. Nevertheless, structural reforms may be ineffective if work practices and organisational culture remain sub-optimal (Handy, 1993). Hence, it is important to build on those aspects of the existing system which function effectively.

### Responsiveness

Responsiveness to disease trends in the population and to the needs of individual patients is a key goal of the health system and an important criterion on which to assess the performance of purchasers of health care (Goodwin et al, 2005). Deciding on the basic package of care is an important task in purchasing, along with deciding which providers to buy health care from and how to pay for care. It is critical to distinguish between high and low priority services, and resources should be allocated to appropriate, high-quality health services at minimum cost (Goodwin et al, 2005). Incentives and payment mechanisms should be utilised to discourage the provision of health care of marginal benefit and encourage appropriate and timely treatment to meet the needs of the population. Over-reliance on market forces, through consumer choice and profit motives, may mean that low-priority care for the rich is prioritized.

### Efficiency and Transaction Costs

Technical efficiency implies that services are delivered using the minimum necessary amount of resources and the optimal mix of different kinds of resources. In designing a SHI system it is important to consider both efficiency in the provision and running of the new system. **Contracting** is typically used to boost efficiency in provision in SHI systems (Thomas et al, 2008) but there are associated transaction costs with the negotiation and operation of these contracts. The magnitude of transaction costs is an important factor in deciding whether to contract out services or to incorporate funders and providers into a government hierarchy (Williamson, 1975; McPake and Normand, 2008).

Transaction costs in an SHI system include administration, processing claims and reimbursements, and, where there are competing funds, marketing costs. In unregulated private health insurance markets such as the US transaction costs can amount to 25 – 30% of total costs. (Goodwin et al, 2005). Further, staffing levels in administrative and support units often increase unnecessarily due to subjective assessments of staffing requirements, a phenomenon known as **Parkinson's Law**<sup>13</sup> (Parkinson, 1958; Goodwin et al., 2005). Hence, incentives and appropriate regulation are important to lower unnecessary transaction costs. Nevertheless, an excessive focus on administrative efficiency and lowering transaction costs may have knock-on effects that adversely affect the responsiveness of the health service and its ability to maximise health gain.

### Stewardship and Governance

Carrin and James (2005) highlight the importance of government stewardship in their review of SHI schemes as a means to creating solidarity and making the sharing of risks politically feasible. Stewardship can be best understood as “as a function of government that is responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry.” Carrin and James (2005) argue that this is key to the development of an effective SHI scheme. It involves encouraging debate, openness and accountability, providing full information and, in turn, generating trust.

<sup>13</sup> Work expands to fill the time allocated to it.

Stewardship may involve the government making strategic policy decisions and setting out the goals<sup>14</sup> of the system (Hunter et al., 2005). Monitoring mechanisms and an accreditation system for provider organisations should be implemented, and planning, external financing and human resource management are other critical issues to address (Gruen and Howarth, 2005).

In most SHI systems laws have been enacted to allow **consumer participation** in the management of sickness funds<sup>15</sup>. Citizens can influence purchaser behaviour through political or administrative channels, known as “voice” mechanisms, while market-based systems also offer the option of consumer choice (“exit” mechanisms). Methods to strengthen the role of citizens in the health services include provision of information, public consultation, the establishment of patient advocacy groups, complaint mechanisms, and enhanced patient rights (den Exter, 2005).

Effective governance is best when backed up with responsibility and autonomy for funders and providers, to avoid micro-management and inefficiency. In particular, two key elements are:

- responsibility for financial losses, or rights to profits. Efficiency can be detrimentally affected by soft budget constraints, meaning that deficits originating from poor performance are covered by the government (Kornai and Eggleston 2001).
- autonomy, such as in the setting of contribution levels and determining purchasing strategies (WHO 2000)

## Transparency and Accountability

Transparency is a key characteristic of good governance. This implies openness and disclosure of information to promote confidence in the organisation (Gruen and Howarth, 2005). Transparent financial flows may increase the amount that citizens are willing to contribute to the health service (McKee et al., 2002).

Transparency can increase the ease of achieving accountability, a key principle of corporate governance. Accountability is the mechanism by which managers are held responsible for their actions, which allows the organisation to stand up to public scrutiny and professional standards. The financial and social goals of the health service should be explicitly stated with appropriate incentives in place to encourage their attainment, and management should be subject to both external (performance monitoring against plans) and internal accountability (self-regulated policies and procedures) (OECD, 2004) (Gruen and Howarth, 2005)

An effective health system requires multiple tiers of accountability, with providers held to account by purchasers, then upwards to the government, and finally public accountability whereby the electorate holds the government responsible for the outcomes of their policies (Hunter et al., 2005). In addition accountability may be assessed in terms of both results and processes (Hunter et al, 2005):

- “Accountability for performance” relates to outcomes and successful implementation of policies
- “Accountability for reasonableness” is concerned with reaching decisions in a transparent and appropriate manner.

<sup>14</sup>Although in certain countries such as Germany the government has focused on regulation rather than dictating patterns of service provision.

<sup>15</sup>In Germany for example the German Social Code Book explicitly states the rights of the insured. The insured are entitled to representation on a key decision-making body in each sickness fund, the assembly of delegates. In most funds this assembly is composed of enrolee and employer representatives, but consists entirely of representatives of enrolees in certain funds.



## Chapter 7: International Experience with the Organisation of SHI

While it is vital that any SHI system must be implementable in the Irish context, it is also useful to consider the organisational designs of SHI that exist in other contexts. Rationalising key organisational decisions taken in other countries can help Irish policy makers think through what could be done in Ireland and also what might be involved in transition. This chapter explores key aspects of SHI organisation and the justifications for them in different contexts. There are four elements of organisation:

- The mechanics of patient choice of fund and provider
- The organisation of SHI funds
- The governance of the system
- The relationship between SHI funds and providers

### Patient Choice

Patient choice relates both to funds, where there are more than one, and to providers, including human resources and facilities.

### Choice of Fund

As noted, in high income European settings there tend to be multiple funds. **This works in one of three ways:**

- where there is freedom to compare different funds and choose between them, such as in Israel and Switzerland (OECD, 2006; Rosen and Samuel, 2009) (though there may be a cooling off period in which patients cannot switch);
- where there is no choice for those in formal employment because the insurance is related to the place of work. For example in France the second largest fund covers farmers (about 7% of the population) (Sandier et al., 2004). In some systems this has contributed to “job-lock” where employees are afraid of moving jobs because they might lose insurance benefits (Kornai and Eggleston 2001).
- where there is no choice because the funds cover specific geographical areas, i.e. there are local monopolies, as in Austria (Hofmarcher and Rack, 2006).

Such factors are noted in the final column of Table 7.1. Nevertheless, the dominant paradigm in SHI systems in Western Europe is where consumers choose between multiple funds. This use of competition to produce efficiency is the key rationale for having multiple funds. Where such choice exists it needs to be backed up with data on performance to allow informed choices to be made.

**Table 7.1: Patient Choice in Provision and Fund: Select High Income Countries**

	GP	Ambulatory specialist care	Hospital (inpatient care)	Choice of fund & interval for change
AUSTRIA	YES	YES	YES	NO (geographical/ occupational)
BELGIUM	YES	YES	YES	YES (for 99%) 3 months
FRANCE	YES	YES	YES	NO (occupational)
GERMANY	YES	YES	YES	YES (for 96%) 18 month interval
ISRAEL	PARTLY YES	PARTLY YES	YES	YES (for 100%) 12 months
LUXEMBOURG	YES	YES	YES	NO (occupational)
SWITZERLAND	PARTLY YES	PARTLY YES	PARTLY YES	YES (for 100%) 6 months

Sources: Saltman et al (2004); Brandt OECD (2008)

In other contexts, however, including both East Asia and Central and Eastern Europe, single funds are more common, with no choice of funder (see later discussion on the optimal number and size of funds). The issue of choice and competition is explored further in Box 7.1

### Box 7.1: Competition and Choice in SHI systems: the evidence

The concept of managed competition in health services holds an innate appeal for many governments (Light, 2001). This system potentially offers a means of improving cost control, quality and responsiveness of health care through market forces (i.e. patient choice of insurer) (Enthoven, 1993). However, although a number of European countries have introduced such systems the perceived benefits have yet to be demonstrated in practice.

The Swiss system of managed competition is experiencing serious problems with cost containment (Crivelli and Ries, 2009) and the country's estimated health spend of 11.3% of GDP in 2006 was second only to the USA (Organisation for Economic Cooperation and Development, 2008). Moreover, the system performs poorly on measures of equity (Wagstaff et al., 1999; Bilger, 2008). Risk-selection of more profitable patient subgroups has had adverse consequences in both Switzerland and Israel (van de Ven et al., 2007; Leu et al., 2009). These health systems are particularly vulnerable to such practices due to their rudimentary risk-adjustment mechanisms (see Chapter 7: Pooling and Risk Adjustment).

The Israeli system in particular offers a stern warning to those who advocate instilling insurer choice and competition into a SHI system. The "real value" of the Israeli health benefits basket is reported to have eroded by more than a third between 1995 and 2005 (Shmueli et al., 2008) and insurers have engaged in a variety of opportunistic behaviours in response to the incentives they face (Gross, 2003; Gross and Harrison, 2006). In the Netherlands a system of managed competition more sophisticated than either Switzerland or Israel was introduced in 2006. Although some minor benefits have emerged, the system is still a work in progress (Ryan et al., 2009; van de Ven and Schut, 2009).

### Choice of Provider

Freedom of choice has traditionally been a characteristic of SHI systems. Yet, uninhibited access to providers has contributed to the increased health service costs traditionally associated with SHI systems. One reason for this is that patients will often wish to seek care at more specialised and costly levels of the health care service than may be strictly necessary. Hence inappropriate choice may result in ineffective expenditure and harm coordination of patient treatment and monitoring (Hassenteufel and Palier 2007). In Japan total freedom of choice is allowed (Kaiser Family Foundation 2007) but most systems settle for a more efficient, if restricted, choice scenario. A key variant is to allow choice at lower levels of service provision but then to use these lower level providers as gate-keepers to specialised providers and services.

There have increasingly in SHI systems been moves toward more gate-keeping at the GP level, improved information flows regarding medical files and developing networks of providers under the same fund. These developments limit freedom of choice and often increase the importance of GPs, but may well have contributed to the narrowing of the expenditure gap between SHI and taxation based systems (Hassenteufel and Palier 2007).

## Sickness Funds

### Size and Number of Funds

There is much debate over whether single or multiple payers offer the better mechanism for efficient health service provision. Table 7.2 below highlights the different approaches of countries. The predominant European model is one where there are several SHI funds which compete with each other. Instead in Canada, South Korea and Taiwan there is only one central SHI fund.

**Table 7.2: Number of Funds in Select SHI Systems**

	No. independent sickness funds	Largest fund; % of all insured
AUSTRIA	24	18
BELGIUM	94 (organized into 7 associations) (vi)	45(i)
FRANCE	17	84
GERMANY	275	10(ii)
ISRAEL	4	55
LUXEMBOURG	9	38
NETHERLANDS	14(iii)	20
SWITZERLAND	66(iii)	16(iv)
JAPAN	Over 3,600	27
CANADA	1(v)	100
TAIWAN	1	100

Sources: (Saltman et al., 2004; Marchildon, 2005; Rochaix and Wilsford, 2005; Corens, 2007; van de Ven et al., 2007; Matsuda, 2009; Tatara and Okamoto, 2009).

Notes:

- (i) refers to the largest association of funds.
- (ii) General regional (AOK) funds, which are not in competition with each other and have regionally separate markets, account for 36% of market share.
- (iii) There are 33 (87) insurers in total however many of these belong to a larger holding firm (conglomerate) (Switzerland in brackets).
- (iv) 13% if a conglomerate is considered as individual insurers.
- (v) One insurance fund per federal region.
- (vi) In Belgium there are six associations of private, non-profit SFs and one public fund.

Key issues for consideration relate to both the number of funds and their optimal size. There has been a trend toward fewer and larger funds in most SHI countries over the last two decades and some functions were shifted to national unions of sickness funds, for example in Luxembourg, France, and Poland (Saltman et al 2007, pp 29). **Many commentators argue that larger funds are better than smaller ones because they:**

- possess economies of scale in administration<sup>16</sup> (Maarse et al, 2005)  
Evidence of this exists in the Israeli health insurance market (Messika and Shmueli 2007). Further, in Argentina before 1996 there were over 300 pooling organisations for workers and their families, many with less than 50,000 members. This resulted in excessive and duplicated administration leading to benefits of health care packages being very limited (Goodwin et al. 2005). In Germany, the average fund size increased from an average of 16,000 enrolees in 1970 to 91,000 in 1997. The introduction of competition in 1996 triggered a wave of mergers as funds were forced to realise economies of scale (Barnighausen and Sauerborn 2002).
- are more able to spread risk and ensure adequate funding is available to pay for health services (Goodwin et al. 2005).

In Estonia, twenty two funds were formed when SHI was introduced (including one fund solely for seamen). This number was subsequently reduced due to worries that the risk of catastrophic care was inadequately spread (Barnighausen and Sauerborn 2002). With smaller funds, increased levels of contribution may be required to protect against uncertain needs (Goodwin et al. 2005). In addition, the rise during the 1990s of high risks such as AIDS and costly MRI procedures may have meant larger pools of insured were necessary (Barnighausen and Sauerborn 2002).

Given the weight of evidence towards the use of larger funds, it is also important to review the key arguments for and against using a single centralised fund. Such arguments are summarised in Table 7.3 below:

<sup>16</sup>Administrative efficiency relates to "administrative costs, the speed and correctness of administrative procedures, the costs of marketing, and so on" (Maarse et al. 2005)

**Table 7.3: Advantages and Disadvantages of a Single SHI Fund**

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• It has been argued that a single payer creates an institutional environment whereby ingenuity is directed towards containing costs, whereas when multiple payers exist ingenuity is diverted to shifting the costs onto others (Evans 2003).</li> <li>• A single-fund system possesses monopsony power, meaning it may be able to negotiate better contracts with health care providers.</li> <li>• Risk-selection is not possible. Consequently there is no need for a risk adjustment mechanism and regulation to promote competition which can be complex and demanding of resources (Barnighausen and Sauerborn 2002).</li> <li>• Multiple funds may not necessarily realise the potential advantages of competition (Barnighausen and Sauerborn 2002).</li> <li>• Older and sicker patients tend to be less mobile (van de Ven et al., 2007; de Jong et al., 2008; Mosca and Schut-Welkzijn, 2008) and so consumer choice of fund may not help boost efficiency.</li> <li>• Even where there has been competition there is always the risk of merger and oligopoly. In the Netherlands mergers may have reduced competition as funds seek economies of scale and premia are now rising sharply to cover initial losses. The gains from competition are thus less clear (Ryan et al. 2009).</li> </ul>	<ul style="list-style-type: none"> <li>• A single fund system will lack competition which may be an important source of efficiency gain in administration and provision. In Eastern Europe many sickness funds are regional monopolies and lack incentives for selective purchasing, which may contribute to health service inefficiencies (Cretu 2008).</li> <li>• The recent reforms in the Netherlands use competition between private insurance funds to increase efficiency and innovation in the health system (Enthoven and van de Ven 2007). Cut price competition ensued in the short run with firms cutting administrative costs.</li> </ul>

Again the weight of evidence seems to be towards a single fund. Certainly, the international literature is clear that extreme caution is required if considering introducing competition between SHI Funds. **Such funds can engage in a wide range of undesirable behavior:**

- Reimbursing the costs of services not included in the benefit package, such as acupuncture, to boost market share.
- Taking advantage of an unclear demarcation between public and private expenditure. In Israel, where sickness funds also provide supplementary health insurance, costs of an episode of care often consist of basic package costs plus supplementary insurance costs (such as the fee charged for choice of surgeon in elective surgery). Funds can increase the likelihood of qualifying for efficiency bonuses by assigning the entire costs of care to supplementary insurance, thus distorting their accounts and lowering the basic package deficit<sup>17</sup> (Shmueli et al. 2008).
- Risk-selecting through selective marketing or through sole use of internet facilities for enrollment. Intermediary agents may be given a larger bonus for enrolling good risks.
- Offering of illegal unofficial premiums (e.g. discounts for certain population groups).

Supervisory authorities must ensure that internal fund organizational and financial arrangements are transparent (Maarse et al. 2005). All this highlights the importance of effective regulation. As Evans (2003) notes with multiple funds the emphasis may be on shifting costs on to others, with a single fund the emphasis is more likely to be on cost savings.

## Pooling and Risk Adjustment

To increase incentives for efficiency in a system with competing insurers/ sickness funds<sup>18</sup> it is critical to have pooling of revenues and a detailed risk-adjustment process. Risk-adjustment involves varying the premium paid to insurers for individual enrollees based on the enrollee's predicted morbidity risk<sup>19</sup>, which stimulates efficiency by compensating those insurers with older and sicker patients and thus reducing incentives for "cream-skimming"<sup>20</sup>. Inadequate risk-adjustment creates incentives for sickness funds to enroll those individuals whose health care costs are expected to be below average, meaning that an insurer which operates efficiently but has patients with an unfavourable risk profile may operate at a loss while a less cost-effective competitor earns a profit (Brandt 2008), thus undermining the rationale for a competitive insurance market.

<sup>17</sup>This may have positive redistributive effects by keeping supplementary health insurance premiums (which tend to be paid by high-income, healthier individuals) artificially high to subsidise basic package care.

<sup>18</sup>That is, where individuals can switch insurer/ sickness fund.

<sup>19</sup>Risk-adjustment can be applied to both community-rated and risk-rated premiums.

<sup>20</sup>Whereby the insurer attempts to enrol profitable individuals whose health care expenditure is predicted to be of a lesser magnitude than the insurance premium, for example younger and wealthier individuals.

Risk-adjustment can play an important role also in non-competitive SHI systems with multiple funds. For example, in Germany in the mid-1990s the flawed risk-adjustment formula was partly responsible for a contribution rate differential of 9 percentage points between some sickness funds (Barnighausen and Sauerborn, 2002). This harmed the equity of financing.

Different countries have different bases for calculating risk ranging from Switzerland, based only on age and gender, to the Netherlands, which uses many criteria (see Table 7.4 below). In the design of any risk equalisation mechanism, there is a trade-off between calculating with greater accuracy the risks accrued by each fund and incurring greater costs in the collection and analysis of the data and the implementation of the scheme.

**Table 7.4: Bases for Risk Equalisation Schemes**

Belgium	Age; gender; socioeconomic variables
The Netherlands	Age; gender; region; employment status; disability; diagnostic cost groups and pharmacy cost group
Germany	Age; gender; disability; income; morbidity
Switzerland	Age (15 age cohorts) and gender within a geographic area
Israel	Age; presence of 5 major medical conditions

Sources: Busse and Riesberg 2004; Saltman et al. 2004; OECD 2006; Schokkaert et al. 2006; Hassenteufel and Palier 2007; Brandt 2008.

Even in the case of the sophisticated Dutch system it is **not possible** to adjust completely for risk (van de Ven 2007). For instance supplementary insurance packages (Gross 2003) and deductibles may be used as risk selection devices. Research suggests that the Swiss and Dutch systems do not fully adjust for differences in risk between those who select a plan with a deductible and those who do not (van Kleef et al. 2008). Further, it may never be possible to adjust completely for risk given that technology will always alter the relative costs of different types of treatment. In this case any additional improvement in risk adjustment may be temporary and such gains must be compared with the additional administrative costs. This may undermine the rationale for multiple funds.

## Fund Reserves

Bankrupt sickness funds can have serious consequences for enrollees, providers, and the stability of the system. Reserves are intended to keep the risk of insolvency at an acceptable level. A greater number of enrollees lowers the likelihood of insolvency (Crivelli 2008) which again makes the case for fewer larger funds.

In Belgium, Israel, Germany, the Netherlands and Switzerland consumer protection exists in the case of a sickness fund going bankrupt and, with the exception of Israel, all sickness funds must have financial reserves. In 2000 Belgium has the lowest required reserves, at 0.25% of annual expenditures. Switzerland's minimum of 15% was the largest (van de Ven et al. 2003), but this has since been reduced to 10% for funds with more than 150,000 enrollees<sup>21</sup> (Crivelli 2008).

In Switzerland the reserves are non-transferable meaning that if consumers switch insurers (which they can do at the end of each calendar year) the reserves remain with the previous insurer. This may somewhat reduce the incentive for the adverse selection of good risks by insurers (Crivelli 2008).

Sickness funds should not be permitted to operate with consistent losses. Financial subsidies to funds should be temporary at most, with a stern warning that they will gradually be reduced and will cease on a specific date. In countries such as Hungary and Croatia the state has in the past been legally obliged to cover any fund deficit. These “**soft budget constraints**” can lead to large and sustained deficits compared to countries without such a guarantee (Kornai and Eggleston 2001). In Belgium, the creation of the CDZ supervisory body was intended to restore the public's trust in the stability of complementary health insurance funds. The CDZ subsequently enforced strict measures to improve the financial situation of the funds, with new laws regarding the minimum mandatory financial reserves for coping with future financial setbacks (Maarse et al. 2005).

## Governance and Regulation

### Decision making

It is vital to get clarity about which decisions need to be taken by Government alone, Fund managers alone and Government and Funds together and which decisions need to be enshrined in legislation or governed by rules and regulations. The following table outlines a typical balance between government setting an overarching framework for SHI and the Funds managing the more regular activities (Normand et al, 2009).

<sup>21</sup>All percentages are of total revenues.



**Table 7.5: Who makes Key Decisions and How in SHI Systems**

Key Decisions	Who?	How/Where?
General design of the health system: - Membership and coverage - Organization responsibility and decision-making authority - Method of financing - Relationship with providers	Government	Defined by law
The benefit scheme - The benefits provided by health insurance	Government	Defined by law
Adjustment of contributions	Health Funds with Government	Defined by regulations
Investment decisions	Health Funds with Government	Special Procedures
Employment of staff	Health Funds	Defined by regulations
Contracts with providers	Health Funds	Defined by regulations

Source: Normand et al (2009)

**Hence the role of the Ministry of Health will typically be:**

- To set overall health policy goals,
- To create the policy framework for SHI
- To monitor the performance of the health fund(s) and providers
- To monitor the quality of care
- Look after staff training and development
- Ensure overall costs of health services are kept under control

## Legislation

As noted in Table 7.5, several aspects of SHI design should be incorporated into legislation including both the general design of the scheme and the benefit package. Furthermore, particular aspects which need legislation relate to the following (Normand et al 2009)

- Where SHI membership is compulsory it needs to be stated in the law
- A SHI scheme must have the power and effective instruments to enforce the law. For instance, a SHI scheme must be able to enforce the collection of contributions and this may need an exchange of sensitive information with employers and tax offices and so on.
- SHI must have power to audit and to prevent fraud, enforce payments and impose fines
- SHI funds need legal instruments to negotiate and enforce provider payments and to accredit providers.
- SHI may need a not-for-profit statute, depending on their status
- SHI should be exempt from VAT, corp. tax and insurance taxes, to help keep contributions low

Normand et al (2009, p110) note:

“...experience with both SHI and tax collection shows that if SHI has to go to court for every fraud detected this may hamper effective enforcement, increase costs and cause delays. This is why in many countries SHI is a public or semi-public institution equipped with special laws and privileges.”

## Link between Funds and Government

There are two options for the status of an SHI fund. It can be:

- A Government body – employing civil servants and directed by the Ministry of Health (Kornai et al, 2001)
- An Independent body – with its own funding, legal status and management which may be elected or nominated by government. This can be for-profit or not-for-profit.

Nevertheless, as Normand et al (2009) note: “It is generally advisable for the health fund to have a certain degree of independence from the government”. This is because of: the advantages of separate budgets; an increased likelihood that decision-making will be oriented towards long-term objectives and that management practices will more closely resemble a private enterprise.

<sup>22</sup>The person appointed as director of the insurance fund Assura in 2008 was previously in charge of the FOPH.

Examples of public sector SHI funds include Canada, South Korea and Taiwan. Examples of private but not-for-profit single SHI funds include Hungary. In Germany, sickness funds are governed by an executive committee and an elected governing board (Barnighausen and Sauerborn 2002). In France, by contrast, the main sickness fund is managed by trade unions and employers associations, organised into various schemes according to occupation, and covers the entire population (Saltman et al, 2007).

Nevertheless, independence of funds is not always desired by governments. Governments are increasingly centralising power in SHI systems because of concerns about controlling costs. In France, the state has increased its role in the health system due to concerns over its financial sustainability (Saltman et al, 2007). Parliament is now obliged to vote an annual national health spending objective which targets limits for health insurance expenditure growth so as to assist government cost-containment efforts.

Where funds are independent, there is need for effective supervision or regulation to ensure good performance particularly in relation to efficiency, stability, and lawful implementation. Three processes are involved: gathering information, assessing sickness fund performance, and intervening. Supervisory bodies differ in their degree of autonomy. The Swiss body BSV and some German state supervisory agents can be seen as government departments. The BVA in Germany is formally independent of government, but the government retains strong influence such as appointing board members and instating observers on the board. (Maarse, et al. 2007)

Supervision may be compromised if the supervisory agent is responsible for administrative roles, such as the BVA which is directly involved in risk pooling and accreditation of disease management programmes. In the Netherlands the formation of the CTZ in 1999 was intended to strengthen supervision by separating it from administration (Maarse et al. 2005). In Switzerland the Federal Office on Public Health does not have a large number of staff at its disposal and is not entirely independent of political power. The risk of regulatory capture by the regulated companies always exists<sup>22</sup> (Crivelli, 2008). Hence appropriate resourcing of supervisory bodies is critical.

## Benefit Package

Benefit packages specify the entitlements of the insured persons and determine the costs of a health insurance scheme. Defining a benefit package includes specifying:

- Package of services available
- Standard diagnostic and treatment guidelines
- Quality assurance mechanisms
- Generic drug list
- Referral rules
- Acceptable waiting period

Defining a benefit package is never a one-off process. It needs continuous commitment to review priorities at various levels. Dror et al (2006) note “...priorities will have to be politically determined. Ideally this should be done through a guided consensus-building process with many stakeholders – including private health care providers, patients and potential customers for the insurance.”

Issues to be considered in developing a benefit package are: epidemiology – most common illnesses and causes of death; most cost-effective interventions; and equity – equal treatment for equal need and unequal but fair treatment of unequals. The most common and catastrophic conditions for which cost-effective interventions or preventive services are available should rank high on the list. A limited number of high-priority interventions and services may be selected from this list to serve as a nucleus around which the basic package can be built. In addition, a quality check on the quality of the benefit package and on the quality of the delivery of the benefit package should be conducted, against national and international guidelines. Quality should be enforced through contracts (Normand et al, 2009).

In countries such as Belgium, Israel and Luxembourg the government defines specific benefits (Saltman et al, 2004). In France, the public health insurance funds have since 2004 been responsible for defining the benefits package (Durand-Zaleski 2008).

## Generics and Costs of Drugs

Reducing expenditure on medicines is a key concern of the HSE. In 2007 over €1.7 bn was spent on medicines prescribed under the community drugs schemes (Barry et al., 2008). The rate of generic prescribing in Ireland is among the lowest in Europe (European Generic Medicines Association, 2007; NCPE, 2009) and savings are possible by increasing this rate (DOHC, 2009).

In SHI countries, government-led reforms in the area of pharmaceuticals have included reference pricing, overall spending caps and reducing drug prices to the international average (Saltman et al, 2004). In the Netherlands insurers are permitted to provide cheaper drugs by negotiating prices with pharmaceutical companies (van de Ven, 2009).

## Providers, Contracting and Payment

### Providers

#### *Mix*

Providers in SHI systems are typically a mixture of public, private not-for-profit and private commercial in each Western SHI country (Saltman et al, 2004). Indeed, SHI systems tend to contain a higher proportion of private providers of inpatient care than tax-funded systems (Freeman, 2000). For example in Germany, the public non-profit sector accounts for roughly half of beds, private non-profit accounts for approximately a third of beds, and private, for-profit roughly 17%. The latter sector has grown principally through takeovers of public hospitals (Busse, 2008).

#### *Ownership and Independence*

SHI organizations should not both own and operate providers as there is a conflict of interest between the financing and the provision aspects (Normand et al, 2009). This separation is generally found with the exception of the Netherlands and Israel. In the former insurers can provide care directly using their own facilities and staff. Preferred provider organization arrangements are also permitted. (Enthoven, van de Ven, 2007). It is argued that this may place insurers in a stronger position to negotiate good deals with external physician groups/ networks, though there is currently no evidence for this.

Further, legally binding contracts between funds and providers are important to enforce clarity and transparency and these can only be made between independent legal entities. Hence an important additional step is to establish providers as legal entities.

### Contracting

The form of payment to the provider is critical for cost-control, quality and administrative efficiency. Thomas et al (2006) review the evidence for different forms of payment. There is a move away from fee-for-service payment in many countries, as they are very expensive and administratively complex and time-consuming. For instance France and Germany now make greater use of prospective budgets than itemised payments to limit costs. Normand et al (2009) suggest that it is important to link payment to the package of services and not to individual items. Thus an SHI fund will pay the provider directly on the basis of agreed fee levels for all services within the benefit package. This allows patients a choice of provider; it offers the best control of costs and the fund can monitor directly the cost and quality of care.

Another key issue is whether to have direct or indirect methods of reimbursement. For instance the French system relies on an indirect method, where patients pay providers and are then reimbursed by SHI. This stands in contrast to direct methods where providers are contracted and paid by SHI. Arguments for and against direct methods are summarised in Table 7.6

**Table 7.6: Arguments for and against Direct Methods of Reimbursement**

For	Against
<ul style="list-style-type: none"><li>• SHI able to negotiate and control fee schedules and quality standards.</li><li>• SHI provides consumer protection.</li><li>• If providers need immediate payment, patients may not be in a position to pay (leading to financial or access problems)</li><li>• Indirect method is administratively cumbersome</li><li>• Indirect method may be at risk of fraud through manipulations of the bill</li></ul>	<ul style="list-style-type: none"><li>• Patients may think entitlements are unlimited and there are no costs involved.</li><li>• Contracting and monitoring PHC services with many providers may be demanding</li></ul>

Ideally there would be competition between providers for contracts to encourage efficiency (improve quality and reduce costs). Nevertheless, competition can lead to duplication of capacity and waste and loss of economies of scale. Further, sufficient numbers for competition may not be practicable. In such circumstances, competitive accreditation may be an option. Hence while it may not be possible to have more than one hospital in an area, there may be a competitive market for the management of the hospital.

The French government closely controls the hospital system from the Ministry of Health in Paris, particularly regarding capacity and standards (Rochaix and Wilsford, 2005) with complete control over the location and distribution of hospitals (Barnighausen and Sauerborn, 2002). Regional hospital agencies were also set up to increase competition by distributing budgets between hospitals based on performance evaluation, taking over the powers of the sickness funds. They have the power to close inefficient hospitals subsequent to an accreditation (Hassenteufel 2008).

**Quality assurance** is an important element of any contract, as noted earlier, and accreditation is an important starting point for quality assurance. In addition though quality assurance implies:

- a system of quality standards and indicators
- a functioning information system
- monitoring and evaluation of provider services on the basis of indicators for the information system
- effective accreditation and possible sanctions for accredited providers that do not meet quality standards

For instance in the Netherlands insurers use numerous techniques to improve quality of care, including protocols, incentive contracting, standardized approaches to disease management and provider selection (Enthoven, van de Ven, 2007).

## Summary of International Experience

### Choice

While this has traditionally been a feature of SHI systems the weight of evidence shows that the benefits of unrestricted choices are few. First, with respect to choice of funds, authorities must work hard to ensure that consumers have full information on fund performance. Second in relation to choice of providers, full freedom for patients may be expensive and inefficient, harming coordination. Nevertheless, choice at lower-levels of service provision may be useful particularly where such levels act as gatekeepers to other services.

### Funds

The evidence is clear that larger sickness funds operate more efficiently, both in being able to hold reserves, benefit from economies of scale in administration and have larger risk pools. Further, international evidence seems to suggest that competition between multiple funds is difficult to get right and complex. A single fund system may well be simpler and more transparent, with the emphasis on cost reduction rather than cost-shifting. Nevertheless, it is essential to put in place appropriate incentives whatever the system.

### Governance

Sorting out appropriate roles and responsibilities is essential. Government must enshrine in law the general design of the SHI system (membership and coverage, responsibility and authority, financing and contractual links with providers) as well as the benefit scheme. While government takes the lead in defining the benefit package, according to technical criteria, it will also need to consult with other stakeholders. Ministry of Health should create appropriate policy and framework for SHI and monitor performance. Legislation must also give SHI funds special powers to negotiate and enforce provider payments, accredit providers and enforce relevant laws (collection of revenues, imposition of fines for fraud). Independence of funds from government is usually preferable, though because of cost control appropriate supervision of funds is required. Supervisory bodies should ideally be separate from the administration of the SHI system.

### Contracting and Provision

Providers should ideally be independent of funds allowing legal contracts to determine standards and outputs. Direct reimbursement of providers by funders may not be as good at controlling costs as payments from patients but offers better protection of patients. Provider payment mechanisms are increasingly moving towards prospective payments to control costs and away from itemised billing, such as fee-for-service. While competition is not always possible accreditation may help promote quality and efficiency.







## Chapter 8: Organisational Design of SHI in Ireland

In designing the most appropriate system of SHI for development in Ireland it is important to recognise contextual issues (such as the size of the country, the current infrastructure and certain traditions) and the available evidence from other countries on how different features make it easier or more difficult to achieve stated policy objectives.

### Single or Multiple Funds?

In choosing between having a single or multiple SHI funds the key issues are economies of scale (which would clearly point to having only one fund for less than 5 million people) and diversity, choice and competition (which would favour many funds). It should be noted that real competition between SHI funds has been rare (and in most cases multiple funds have operated in parallel serving different parts of populations). There is as yet no convincing evidence that competition between funds has achieved greater overall efficiency (but equally the evidence is too limited to suggest otherwise). Further it may be possible to replace competition between funds with competition between teams of managers and administrators to run the single fund.

In terms of risk sharing it is now widely agreed that there is too much year on year variation to operate with very small populations, and that for the full range of services it is unwise to have a risk pool much less than 1 million people. This means that any competition would be inevitably oligopolistic, and there would be a remaining need for skilled and strong regulation. Experience in countries that have tried to introduce multiple funds is that quite quickly mergers reduce their number and diversity. Advantages of greater diversity and choice are therefore likely to be limited by a tendency towards collusion between funds and for funds to try to merge to enjoy scale economies. Evidence suggests that scale economies operate well beyond the population of Ireland, so that the tendency to merger will persist (and will need to be prevented if multiple funds are to survive).

The greater diversity that can come from having more than one fund will be valued by some, but it is increasingly understood that the demand for choice is often a demand for quality of service. The preliminary experience of choice in drug reimbursement plans in the American Medicare system suggests that choice can be a burden as much as benefit. Extended choice can lead to inefficiencies which in turn may lead to a loss of benefits (e.g. Kreisz and Gericke, 2009).

The last key issue is not strictly about the choice between a single or many funds. Cost control is usually stronger in tax funded systems than in SHI, and a large part of this seems to be related to monopsony buying. It is inevitable that there will be elements of monopoly in the supply of health care (indeed this is a natural consequence of the necessary constraints on and licensing of providers of care). Monopsony buying is sometimes described as 'single pipe' reimbursement since it allows a high level of control over what is provided and at what cost. Single pipe systems have operated in Germany to some extent despite the presence of a large number of health insurance funds, with the association of funds being the level at which fees and funding is agreed. Single pipe arrangements have a useful role in ensuring cost control, are inevitable in the case of a single fund, but can be achieved even where there are several funds, although this is more complicated to achieve.

Risk equalization is already an important issue in the context of supplementary insurance in Ireland. If there were multiple competing funds risk equalization would be a key requirement, and would be complicated to put in place and operate. The sums to be transferred would be potentially large, and the basis for doing this would have to be robust and sophisticated.

Perhaps the most important point in considering the choice of one or more funds is that the choice does not really have to be taken now. In some cases countries have established several funds (e.g. the Czech Republic) and the number reduced with mergers, and in others a single fund was established (e.g. in Hungary) and then consideration was given to allowing more to be set up. Given the general desire to minimize the (inevitable) chaos that results from major organizational change it may be wiser to start with a single SHI fund, even if the plan in the longer run were to allow competing funds to be established. When this is allowed the regulation would have to be changed and mechanisms for cost control and risk equalization would be needed.

### Degree of independence of the fund or funds

Transparency is a key objective in SHI, and it is sometimes argued that this is best achieved if the operation of the system is clearly separate from government. The legal status of a health insurance fund can be anywhere on the spectrum between a government agency, through a semi-state body to a not-for-profit private or for-profit private organization. Evidence from experience in other countries does not provide clear guidance but it is probably important for a change in system to be marked with at least a move to a certain degree of independence from the State. It probably does not matter whether this is semi-state or public, and whether it is for-profit or not-for-profit – the key issues will be the incentives and regulation that are put in place.

## Governance and Regulation

The extent to which there is need for regulatory systems will depend in part on the formal status of the SHI fund or funds. The governance of the SHI system needs to ensure that it works efficiently and that it pursues policy objectives. If the main policy drive remains with government, the main need is for incentives and regulations that ensure that the SHI bodies pursue these, and the main governance question is to ensure efficient and prudent operation of the fund(s). It is unlikely, even if there are multiple funds that the competition will in itself be adequate to ensure efficient operation and management of SHI, so some form of quality assurance and regulation will be needed.

Hungary experimented with a nationwide election for the board of the National SHI fund, hoping by this to give a feeling of ownership to the population and accountability to the board. There is no good evaluation of this experiment.

## Suggested choices on structure, ownership and governance of the SHI

At least in the first instance the balance of advantage probably lies in establishing a single SHI fund, to minimize administration costs, avoid risk equalization systems and to minimize the disruption of the initial reforms. The best option is probably for a not-for-profit private organization to maximize the visible change.

## Paying for Services

The shift from tax funding to SHI would make it necessary to have a formal split between the funding and commissioning of services, and the provision. This can of course be done with a tax funding system but is not a requirement.

There is extensive experience and some good evidence about the effects of different payment systems, and there is clear consensus that a mix of payment systems is needed to achieve the right balance of incentives. As a general principle the payment system should ensure that the 'money follows the patient', but there are various ways in which it can follow.

Services such as Emergency Departments, the main requirement is to reward access and availability (and not necessarily to reward treatment of more patients). It is therefore probably best to have a single annual payment for such services, adjusted each year to account for the gradual changes in patients using the service. In such a case the contract has to be specified in terms of well designed and strongly monitored service standards. For chronic disease patients and some primary and community care the key requirement is continuity, so the best payment system is likely to be some form of capitation with additional reward for achieving certain targets (such as rates of child vaccination or cervical smears).

Hospital procedures that are clearly elective can be funded on a per case basis. This incentivizes hospitals to provide more services, so control over the budget has to come in the form of limiting the entitlements to ensure that the SHI funds are adequate for the services covered. Hospitals that fail to attract patients for a particular service will not be funded to provide it. In per case funding the key issue is the price. It may not always be possible to impose the same price nationally (for example costs may be higher in some hospitals due to geographical or volume constraint). In principle prices can be fixed (as they are in England), encouraging competition between hospitals on quality, or can be agreed separately with each hospital. The theoretical advantage of separate contracting with each hospital may be offset by the higher costs of administering such a system.

Ireland already has a system of recording hospital episodes in terms of diagnosis related groups (DRGs), which forms a basis for classifying the workload by complexity and likely cost. There is always a trade off in case mix systems between more complex and sophisticated measurement and wider categories with more variation in likely costs. The number of DRGs in most systems has tended to increase to allow differences in costs to be reflected in tariffs. While it is arguable that a more disaggregated system would reduce the chances of "gaming" the system, and would allow incentives to be more exactly set, the current system provides a basis for contracting on a cost per case basis. International experience suggests that it is necessary to have some regulation and clear rules to reduce the extent to which providers of care choose easier and lower cost cases within any category.

Payment systems operate at different levels in any health system. For example a capitation system may be used at higher levels, but the funds may then be paid out on a cost per case to hospitals or hospital departments, who in turn may pay salary to staff. The exact mechanisms for money to follow the patients should be designed to maximize the incentives for providing high quality services efficiently, to control costs and to encourage innovation and development.

## Who should be allowed to provide services?

Although it is increasingly common for government funded health services to be provided on a contract basis by private and voluntary organizations, in most cases the providers are public or quasi-public. Since SHI separates the responsibility for raising and managing the funds from the delivery of care it is possible to place contracts for service delivery with any public or private provider. Attempts to encourage private organizations to provide services in some countries have often involved higher prices and hidden subsidies, but the best approach is to allow a 'level playing field' in which the choice of provider is based on the combinations of quality and volume of service and the prices charged.

## Chapter 9: Conclusions and Recommendations

The scope of this report has been to consider the best financing and organisational models of SHI for Ireland. The international literature makes clear that there are a variety of SHI designs and options which produce quite different health system performance. Furthermore, the prevailing context and values of a health system are key in discerning which version of SHI to pursue and what can be achieved.

### Prevailing Context

The current macro-economic context represents a key challenge to any reform of the health system. Declining tax revenues curtail room for investment in infrastructure and transition. A contracting economy might, therefore, appear to make SHI unaffordable. Nevertheless, the recession may turn out to be an opportunity for radical change which would not have been acceptable or deemed necessary during the Celtic Tiger years. SHI will take time to introduce, particularly where it is tied to the alleviation of capacity constraints as the authors have previously argued (Thomas et al. 2008). This gives scope for some economic recovery and an upturn in the ability and willingness of the population to pay for health care.

Prior to the global financial crisis, Ireland's tax burden was one of the lowest in the industrialized world. Ireland had a very low rate of corporation tax and was focussed on lowering the overall tax burden on households, to enhance the rewards of work and maintain incentives for productivity. Consequently, taxes on consumption have played an unusually large role in financing general government. However it appears that the reduced focus on income tax increased the sensitivity of the tax base to economic cycles and exacerbated the effects of the downturn (Whelan 2009, Barrett et al, 2009)). Taxation revenue crashed in 2008 and 2009 and while health spending was partly shielded from this, government health spending will fall by 8% in 2010.

While the current economic recession may reduce available finances, it will also help lower costs. **Three areas for potential efficiency gains** are:

- Case-based hospital contracting (instead of global budgets)
- Administrative savings through rationalisation and/or competition
- Cost-cutting measures in paying for PHC services, such as capitation rates for GMS.

A realistic expectation for efficiency gains may well be around a 10% reduction in costs, based on the above potential areas for cost-savings. This will consequently lower the amount of funds needed to be raised. It is worth noting that efficiency gains that lower costs by 19% across the health care system would allow the introduction of comprehensive SHI with no additional running costs.

### Values

It is not possible to make sensible recommendations about the key choices in developing SHI for Ireland without clearly stating the likely objectives in such a change. For the purpose of the recommendations here it is assumed that the objectives are:

- The new system would provide an increase in the total health spending that falls within the main financing mechanisms (although much of the increase is likely to be in the form of transfers from private expenditure)
- The new system should increase transparency
- The new system should spread the burden of health spending more equitably and reduce the relative burden on those on lower incomes
- The new system should minimize harmful effects on overall economic performance
- The new system should improve incentives to patients and providers of care
- On the introduction of the new system the aim should be to minimize the disruption caused by the changes.
- The new system should increase the quality of health care

## Health Financing Design

### International Experience

Internationally, there are three main models for paying for SHI.

- By far the most popular method is a payroll levy. Where there is little government subsidy the premia needs to be quite high. Most high income country models though have quite substantial subsidies to SHI from general taxation. These risk making the system more complex and less transparent but may be more politically acceptable and involve less upheaval where taxation systems are firmly rooted.
- The second method is to have a uniform flat fee regardless of income. The advantage of such an approach is simplicity. The disadvantage is that it is by itself very inequitable. To compensate, subsidies are needed from government so that the poor are not penalised but this tends to be complex and costly.
- The third method of funding SHI is to use a variety of financing bases, as in the French system. To spread the financing burden use can be made of 'sin' and corporation taxation. This can be complex but where the burden cannot be absorbed by a payroll tax alone it may be more acceptable. There is also a resonance with the population relating sin taxes to health spending.

The evidence that, in general, SHI systems are slightly less equitable than tax funding and that SHI has been associated with some reductions in overall employment suggests that payroll related insurance contributions should be used only if the other charges on the payroll are significantly reduced. The scope for this is now higher since the total burden of income related taxes and levies in Ireland is now higher.

The progressivity of a system requires that the rich pay not only more but a larger proportion of their income. More specifically, a system which has exemptions or very low payment rates for those who cannot afford is better, as is any system which does not have ceilings on payment for the rich. Equity considerations would suggest that there should be no ceiling on SHI contributions, and the overall level of taxes and SHI contributions should be planned together to ensure the desired pattern of progressivity.

SHI will not entirely remove the demand for private insurance. Nevertheless, as long as private insurance does not allow the member an advantage in the waiting list, demand for **private insurance** will drop sharply. **Co-payments** may damage equity and should be avoided

### Best fit for Ireland

Any move toward SHI financing would mean that general taxation funding was replaced by revenue earmarked for health. The four main options considered were:

- **Pure SHI:** funded by earmarked payroll and income deductions into an insurance fund. Those who earn below the threshold amount do not pay. This option scores well in relation to equity and transparency but its Achilles heel is the amount by which taxes, and primarily income taxes, would have to be lowered in compensation
- **Subsidised SHI:** deductions are levied on all income, but Government pays, from general taxation, the contributions for all earned income below the threshold. This model is far more practical and less disruptive than Pure SHI but loses the principle of earmarking and is not as equitable nor as transparent.
- **Mixed Bag:** financed through a variety of taxation sources (rather than just on income) including ear-marking existing 'sin' taxation and new property and carbon taxes. The Mixed Bag option retains the principle of earmarking and is slightly more progressive than the Subsidised SHI model but it is complex and requires substantial compensatory tax reductions.
- **Flat Premium plus Subsidy:** financed by charging adults a per-capita premium. Government will subsidise the premium for those less able to afford it and pay into a Risk Equalisation Fund which then distributes funds across the insurers to balance risk. The Flat rate premium model is administratively complex, not at all transparent, less equitable and risks fragmentation. This model appears to offer the least gains.

Practicality may rule out the **Pure** model, at least in the short to medium term, because of the necessary reduction in income tax. On the other hand, desirability eliminates the **Flat Premium** option. This leaves a choice between the **Mixed Bag** option, which is more transparent and slightly more equitable, and the Subsidised SHI option which is more practical and simpler. If the long run aim is to get to the **Pure** model then the **Subsidised SHI** option would be a better stepping stone.

## Organisation International Experience

While **choice** has traditionally been a feature of SHI systems the weight of evidence indicates that the benefits of unrestricted choices are few with high costs, inefficiency and a lack of coordination. Nevertheless, choice may be useful at lower-levels of service provision who act as gatekeepers to other services.

The evidence is clear that **larger** sickness funds operate more efficiently, both in being able to hold reserves, benefit from economies of scale in administration and have larger risk pools. Further, international evidence seems to suggest that competition between multiple funds is difficult to get right and complex. A single fund system may well be simpler and more transparent, with the emphasis on cost reduction rather than cost-shifting. Nevertheless, it is essential to put in place appropriate incentives whatever the system. A single fund must operate within an incentive framework that encourages cost-control and efficiency.

Delineating appropriate roles and responsibilities is essential. Government must enshrine in law the general design of the SHI system (membership and coverage, responsibility and authority, financing and contractual links with providers) as well as the benefit scheme. While government takes the lead in defining the benefit package, according to technical criteria, it will also need to consult with other stakeholders. The Department of Health should create the appropriate policy and framework for SHI and monitor performance. Legislation must also give SHI funds special powers to negotiate and enforce provider payments, accredit providers and enforce relevant laws (collection of revenues, imposition of fines for fraud).

Independence of funds from government is usually preferable, though because of cost control appropriate supervision of funds is required. Supervisory bodies should ideally be separate from the administration of the SHI system.

Providers should ideally be independent of funds allowing legal contracts to determine standards and outputs. Direct reimbursement of providers by funders may not be as good at controlling costs as payments from patients but offers better protection of patients. Provider payment mechanisms are increasingly moving towards prospective payments to control costs and away from itemised billing, such as fee-for-service. While competition is not always possible accreditation may help promote quality and efficiency.

## Best fit for Ireland

At least in the first instance the weight of evidence would appear to point toward establishing a single SHI fund, to minimize administration costs, avoid risk equalization systems and to minimize the disruption of the initial reforms. The best option is probably for a not-for-profit private organization to maximize the visible change. Nevertheless, it will be essential to ensure that such a fund operates with an incentive framework that encourages cost-control and efficiency. It may be useful to allow competition for who runs the fund to heighten incentives for efficiency.

The governance of the SHI fund should reflect its membership in some ways either through direct elections or nomination by relevant representative bodies. The governance should be clearly independent of government (but might have government representation on the board). The government itself will need to play an active role in creating the right regulatory and legislative framework for the fund and for its operations.

## Next Steps and the need for Enhanced Dialogue

The analysis highlights the challenges and benefits of introducing SHI into the Irish context. There is need for political dialogue across stakeholders to consider the most desirable and feasible financing model for SHI with reference to key policy objectives. This will involve debating the importance of, and trade-offs between, transparency, equity and earmarking within the system.

There is also need for key stakeholders, and in particular the public, to discuss the recommended establishment of a single private not-for-profit SHI fund and the environment in which it will operate. The incentive framework created for such a fund will be all important.



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