Oireachtas Committee on the Future of Healthcare

Inequality and Access to Healthcare

Dr. Sara Burke, Research Fellow, Centre for Health Policy and Management, TCD

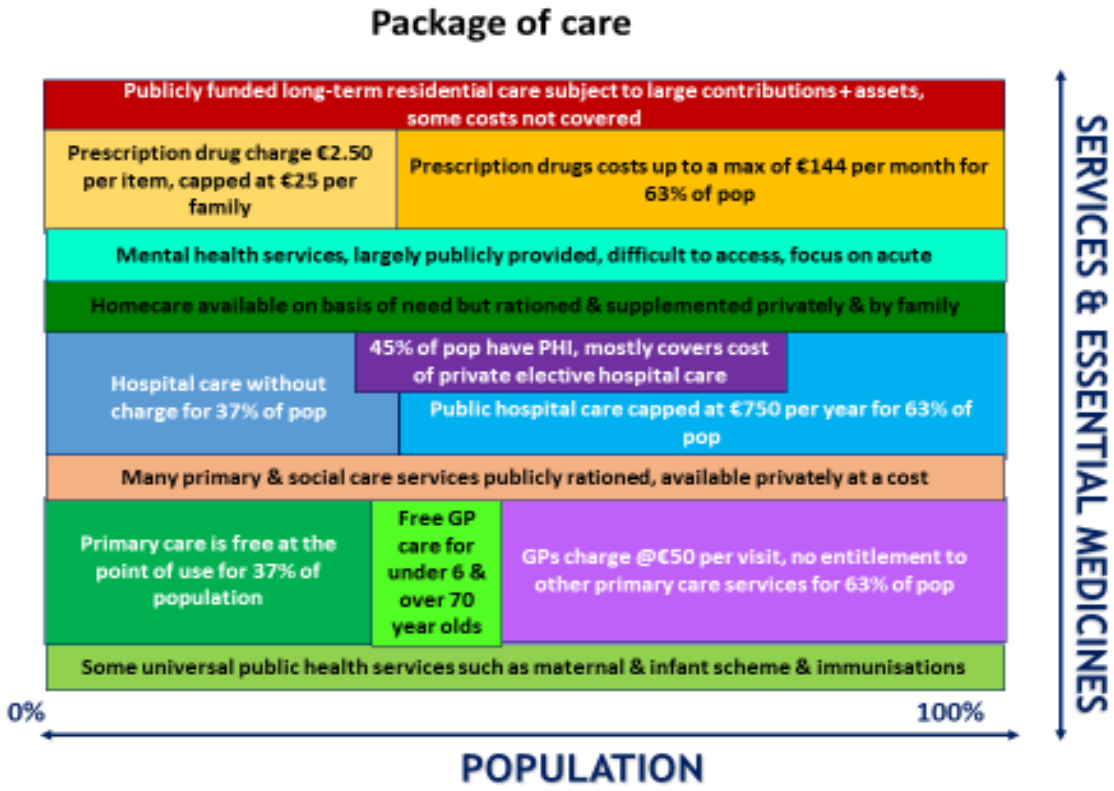
Good morning, thank you for inviting me here this morning.

I really welcome the work of this committee and feel its remit is long overdue but also historical in that it is the first time in the history of our country that any attempt has been made to reach cross party agreement on having a universal health system where access to healthcare is on the basis of need not income.

You have asked me to speak on inequality in access to healthcare. There are many inequalities in access to Irish healthcare. Ireland is exceptional in terms of the fragmented, complex nature of healthcare and in the unequal access to essential diagnosis, treatment and care.

Internationally, universal systems talk about entitlement to package of care ie what services everyone is entitled to in their health system. In Ireland, because we simply do not have a universal system, there is no such thing as a package of care. Accessing services depends on whether one has a medical card, a GP visit card, private health insurance, one's ability to spend private income on health services, where one lives and what type of services one is trying to access.

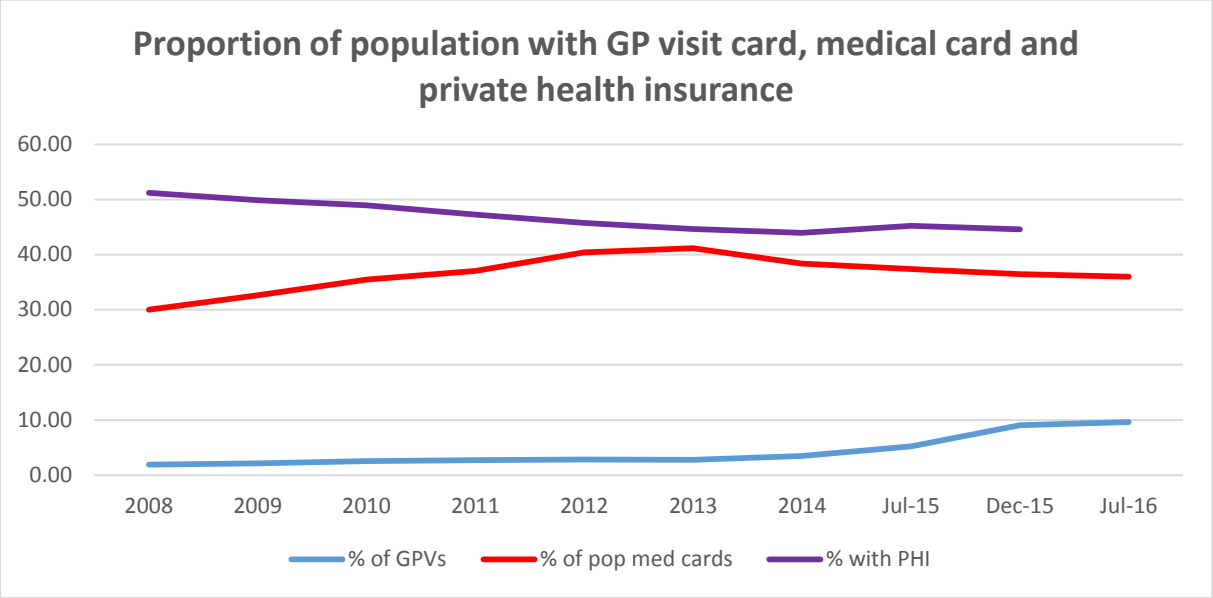
The figure below demonstrates some of the complexity and fragmentation of Irish health and social care provision.



We know that it is the poorest, sickest and those with disabilities who find it hardest to pay charges, to negotiate access, who have to wait longer for care. Medical cards are a proven pro-poor measure so it is those who are poor and sick without medical cards who fare worst in terms of coverage and access.

We are unique in a European context in that we do not have universal access to primary care. Currently, 54% have to pay for each GP visit (on average €52 per visit), 64% pay up to €144 a month for essential medication.

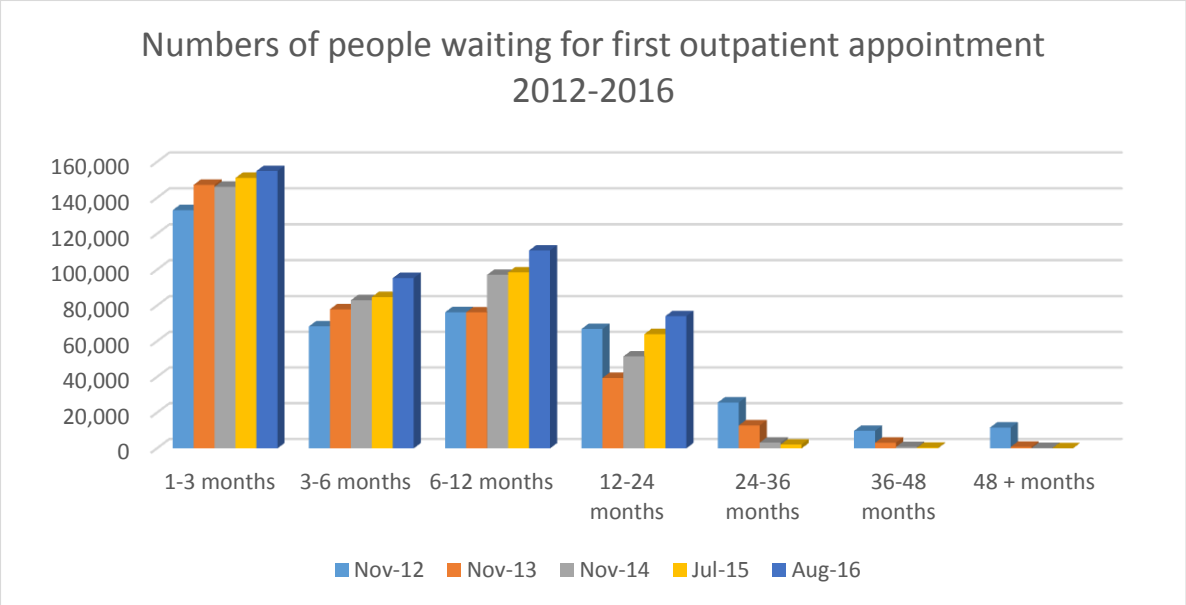
Technically, there is universal access to our public hospital system in that everyone is entitled to hospital care, however charges such as €100 on presentation to an Emergency Department without GP referral or a medical card and up to €750 per year for inpatient care means some without medical cards cannot afford this. And crucially very long wait times for accessing public hospital care means many public patients are denied access. This is further exacerbated by what is called our two tier hospital care which incentivises and pushes people into private care.



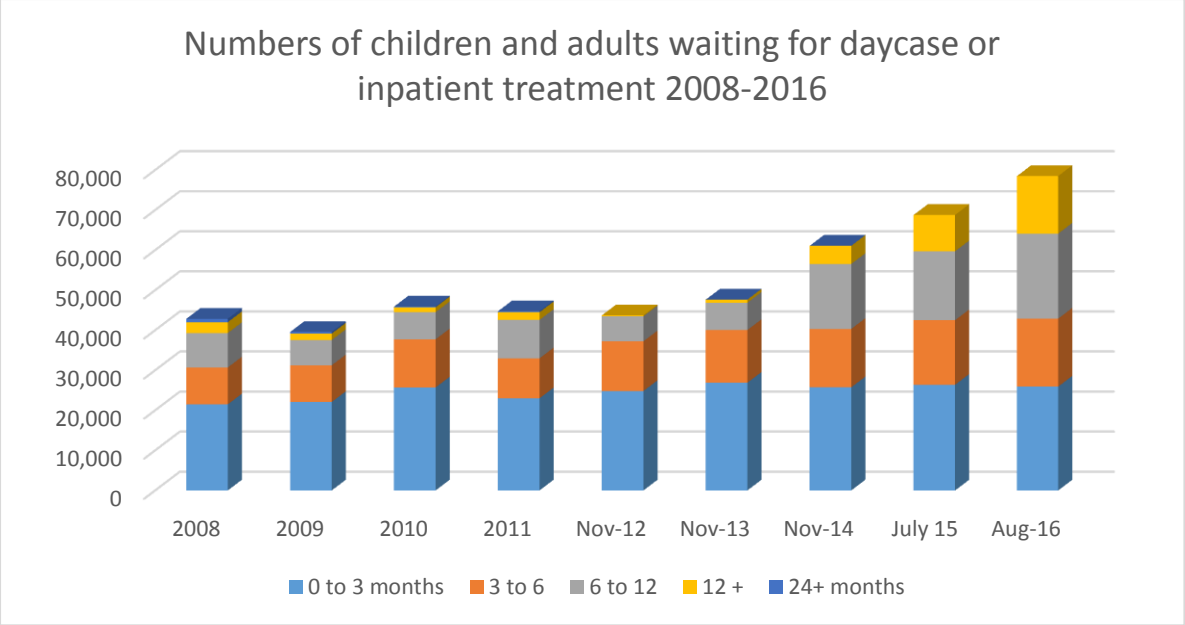
Inequalities in access manifest themselves in different ways – people without free GP care or a medical card delay or do no not go to a GP in the first place due to cost. Data show the difference North and South, 1.8% of people in the North did not go to a doctor in the last year due to cost. In the South it was over 18%. This delays access to initial diagnosis.

When people present at a GP, often she will need to send you for diagnostic tests. The ICGP were with you last week, they have comprehensive research showing the poor access for patients who could not afford to pay privately to access an essential scan or test. 10% of GPs had direct access to a MRI scan in the public system with an average waiting times of 22 weeks. Virtually all GPs had access to MRI in private sector within seven working days. This further delays diagnosis and treatment for public patients.

When a GP decides that you need to see a specialist we know there are extraordinarily long wait times to access that initial specialist outpatient appointment in the public system.



When a specialist decides that treatment is needed, there are also long waits for this.



In addition, none of these points/slides touch on the inequalities in access to community services such as home helps, public health nursing, physiotherapists, OT, Speech and language therapy, mental health services mainly because the data are so bad or do not exist that we cannot present them. But such services are equally, if not more important. And there are huge inequalities in access depending on whether one has a medical card and on the existence or capacity of a service in any area.

Part of the complexity of the Irish system is the existence and overlap of private health insurance on the public health system, that people who can afford to pay privately can get those diagnostic tests quicker, get to see a specialist quicker and if insured may be able to get their treatment quicker.

My current role in the Centre for Health Policy and Management in Trinity College Dublin is co-ordinating a Health Research Board funded project called – Mapping the Pathways to Universal Healthcare https://medicine.tcd.ie/health-systems-research/

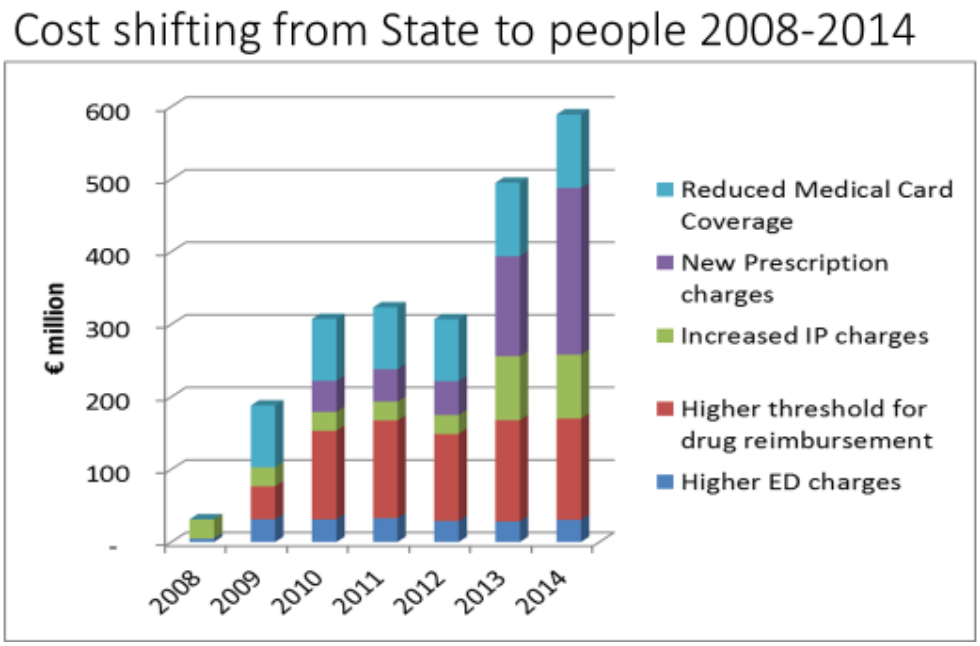
Our working definition of universal healthcare is a*ppropriate, timely, high quality care and care pathways, affordable for all.* In effect this usually means free at point of delivery as we know charges deter necessary use, e.g. we know that drug charges stop people taking or continuing to use drugs.

In this project we are monitoring government progress (or absence of it) on pathways towards universal health care. Our policy analysis work published at the end of last year found that despite an increased rhetoric of universalism and universal healthcare between 2011 and 2015, government measures such as increasing drug charges for medical card holders and the introduction of life time community rating as well as a failure to reduce waiting times for access for public patients means there is less not more universalism now than there was in 2011. The exception of this was the extension of free GP care for over 70s and under 6s.

We know internationally that insurance-based systems, such as the USA or the Netherlands, are more expensive and cause inequalities. In Ireland, 45% of population have PHI yet it contributes to just 9% of overall cost of healthcare. Despite a commitment to universalism, the last government introduced life time community rating, which in the absence of a system of universal health insurance merely perpetuates the two tier system, forcing people into private insurance which in effect largely just covers them for elective hospital care.

In the Pathways to universal healthcare project my colleague Dr Sarah Barry is leading on a systematic review on the organisational challenges of introducing universal healthcare.

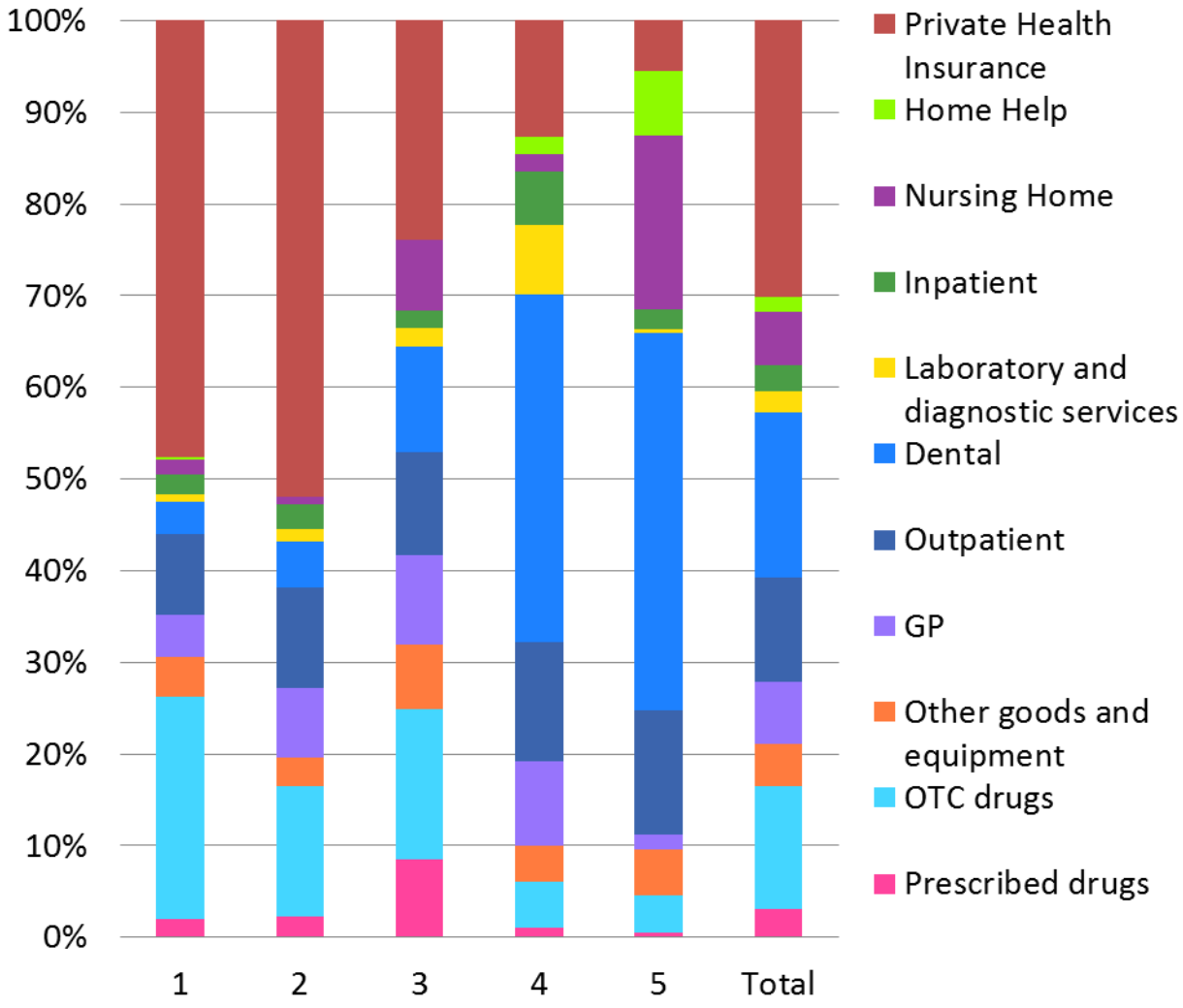
Prof Steve Thomas (the PI of the project) and Bridget Johnston are doing ground breaking work on financial protection – a core component of universal healthcare – that health and access to healthcare should not cause impoverishing or catastrophic health expenditure – catastrophic meaning people are forgoing expenditure in other areas to meet health service payments, usually out of pocket payments.



Initial work we have done on quantifying the amount of out of pocket spending is shown here, showing Irish citizens paid €580 million more out of pocket for essential healthcare in 2014 than they did in 2008. We are doing more detailed work using CSO National Household Budget Survey data.

Initial analysis of 2009/10 data – exploring the extent of affordability of private health expenditure and what proportion (and which) Irish citizens are financially protected, or not, when they access healthcare. We are awaiting 2016 data but analysis of the 2009/10 data show some very interesting findings – that those in poorest groups were most likely to experience catastrophic levels of private health expenditure – 48% of the poorest fifth of the population reported unaffordable levels of private health spending.

Below is a breakdown of unaffordable private health expenditure by income quintile of 2009/2010 data. Two interesting observations from this data is the extent of unaffordable spending on private health insurance by the poorest and the high levels of spend on dental services from middle and high income group. These figures do not catch unmet need and are only a reflection of actual money spent in 2009/10.



Providing timely access to appropriate care for the whole population (a universal health system) in Ireland will cost more money and require more staff. Prof Thomas is looking at workforce requirements and our current staffing profile as a basis for getting to universal health care. He is also reviewing potential areas for positive rationing. In other words, how do we use the resources we have more efficiently so that universal healthcare is affordable and deliverable.

This work we are engaged in with Mapping the Pathways to Universal Healthcare is about devising tangible steps towards a universal health system, work we hope will be of use to the work of this Committee.

Ultimately delivering a universal health system is a political choice. A political choice that is critical to improving all of Irish people's lives, our quality of life and indeed our deaths.

I wish you well with your work and am happy to answer any questions you may have.