European Observatory on Health Systems and Policies
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Houses of the Oireachtas
Committee on the Future of Healthcare

# The Irish Health System in an International Context
# Improving Performance - A framework for decision making

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## The potential for international learning

Although the Irish health system was definitely more severely hit by the effects of the sovereign debt crisis compared to most other EU Member States, the challenges it faces today are in many respects very similar to the ones in other countries: ensuring financial sustainability, increasing value for money, improving access and responsiveness, addressing the changing needs generated by an ageing population suffering from multiple chronic conditions, etc. Always bearing in mind that any solutions and reforms need to be context-specific, there is a significant potential for learning from international evidence and experience.

This document provides a brief preliminary outline of the health system trends and issues that will be presented to the Committee on the Future of health care. Following the presentation and discussion with the members of the Committee, the document will be revised and a number of suggestions for consideration in the Irish reform will be included.

## How does Ireland compare with main international trends?

### *Health outcomes*

In terms of health outcomes Ireland is doing relatively well. However, some of the indicators seem to suggest that there is scope for improving the effectiveness of the health system.

- Life expectancy in Ireland is above the EU average in males and close to the EU average in females, with a pace of improvement overtaking that of the EU28 in the past decade. This is largely due to reduction in premature mortality from CVDs, where good progress has been achieved over the recent years.
- Amenable mortality[1] in Ireland is below the EU average (92 per 100,000 for males and 73 per 100,000 for females compared to respectively 148 and 93 per 100,000 in the EU), and has had the fastest pace of decline in amenable mortality among EU countries in males in 2000-2014, with reduction of 4% per year. There also was a similar decline in females.
- For preventable mortality[2], Ireland is below the EU average for males (58 compared to 91 per 100,000), but similar for females (32 and 31 per 100,000 respectively), with pace of decline slower than many other EU countries.

[1] Mortality from conditions which, in the presence of timely and effective medical care, should not lead to premature death
[2] Mortality from conditions that could have been prevented if effective measures had been in place

### *Health expenditure and coverage*

As a result of the financial crisis the level of total health expenditure (THE) in Ireland dropped sharply below 8% of GDP, with reductions in public spending that were among the highest in the whole European region. The cuts in funding but also in health workforce are likely to impact on accessibility of health services and overall performance of the Irish health system.

With public expenditure covering 66% of the total health spending (7th lowest share in the EU28), there is quite a high reliance on private expenditure (user fees: 18% of THE; and voluntary health insurance: 16% of THE). Cost shifting from the public to the private purse has negatively affected affordability of health care for households, especially those whose incomes are above the minimum. Ireland is one of the few EU countries, where unmet medical need due to cost in medium income households is higher than among the poor households, which benefited from existing mechanisms to protect the most vulnerable.

A recent assessment of coverage in the Irish health system found that gaps in population and cost coverage distinguished Ireland from other EU countries, particularly for GP services (Smith, 2010). Ireland is the only EU health system that does not offer universal coverage of primary care. (Noland 2014). It also has the highest in the EU admissions for COPD, indicating that patient management in primary care may be weaker than in other countries.

## What policy options can be considered?

In the light of the above observations various policy options for reform need to be carefully considered.

### *Lessons for reforming funding and coverage*

Health systems have gradually moved towards mixed funding. Significant changes in the funding mix generally require a comprehensive and long reform process. More important than the labelling or funding source is the stability and predictability in statutory revenue at an adequate level as well as the alignment within financing sub-functions (collection, pooling, purchasing, benefits and user charges) and with the other health system functions (governance, delivery, workforce, information).

Increasing out-of-pocket expenditure need to be carefully considered, as it is generally considered to be a blunt instrument to contain – or rather shift - costs that besides increasing inequalities in access may also generate considerable inefficiencies. Also voluntary health insurance (VHI) has considerable trade-offs: even in countries where voluntary health insurance has a more important role it doesn't really achieve to absorb user charges. A strong regulation of VHI and special protection mechanisms to protect the most vulnerable groups from the effect of increased user charges may help to alleviate some of the drawbacks.

There is a trend towards a more explicit definition of benefits, with health technology assessment being increasingly used in coverage decisions about new technologies (mainly drugs). Taking into account the considerable amount of waste and health services with questionable therapeutic effect existing in any health system, there is scope for improving performance and value for money.

### *Lessons for improving performance and delivery*

Changing the way health care is organised and delivered is probably the area where most changes can be expected in the future.

Most countries have aimed to strengthen primary care. In most Western European countries there is a trend towards a collaborative model where GPs work with other health professionals in group practices or health centres. With an increasing shifting of tasks, nurses in particular are likely to play a more prominent role in the delivery of primary care services and carry more responsibility.

As the burden of chronic conditions is growing the need for more integrated and coordinated care and disease management is growing, requiring a strengthening of links between different settings of care to ensure continuity and between health and social care. This also needs to translate into provider payments as well as into changing the care landscape (role of specialised and hospital care).

Within a new model of care that is being developed various countries are exploring a higher focus on public health interventions and prevention to act on the determinants.

### *Lessons for implementing change*

Good governance is a key factor for success for any health system reform. Change is only likely to happen when reforms are based on a clear vision and leadership, with transparent and flexible decision making and with the involvement of all stakeholders.