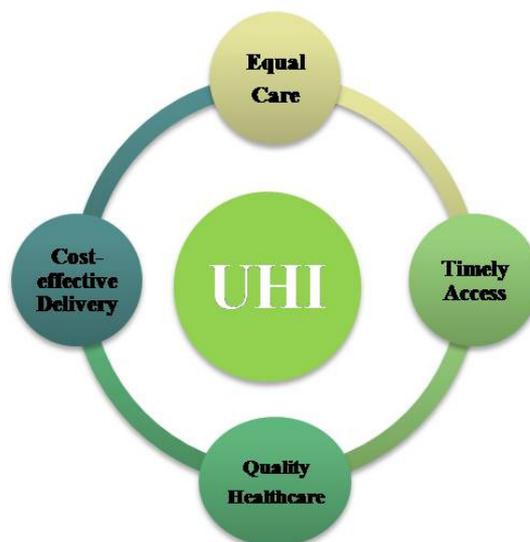


Public Consultation on the White Paper on Universal Health Insurance



The information collected from the submissions made through this consultation process will be used for the purposes of informing the policy development of Universal Health Insurance. With reference to the Data Protection Act, 1988 and the Data Protection Amendment Act, 2003, the Department of Health will be producing a report on the consultation process, and information provided may be included in this report. Please note that all information and comments submitted to the Department of Health for the purpose of this consultation process are subject to release under the Freedom of Information Acts 1997 and 2003.

1 Personal Information

1.1 Are you completing this document:*

- In a personal capacity
- As an authorised representative of an organisation/body, expressing the views of that organisation/body.

1.2 Name:*

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1.3 Organisation: (mandatory if you select the second option at 1.1)

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1.4 Please classify your organisation type: (mandatory if you select the second option at 1.1)

- | | |
|--|---|
| <input type="radio"/> Health Insurer or Other Insurer | <input type="radio"/> Public Interest Group |
| <input type="radio"/> Public Health Service Organisation / Provider | <input type="radio"/> Patient Interest Group |
| <input type="radio"/> Private Health Service Organisation / Provider | <input type="radio"/> Regulatory Body |
| <input type="radio"/> Union | <input checked="" type="checkbox"/> Representative Body |
| <input type="radio"/> Educational Sector | <input type="radio"/> Other |

Age Action Ireland is a national charity which promotes positive ageing and better policies and services for older people. Our research and policy work is underscored by the use of the United Nations human rights framework of Economic, Social and Cultural Rights (UN, 1976) and the Rights of Older People (1991). As an organization with over twenty years of experience with older people's issues in Ireland, we come to this submission urging consideration of the points that we highlight in this submission

Background – Older People and their Well-being

According to the latest census, 532,000 people aged 65 and over were living in Ireland in 2011. The number is predicted to rise to 1.4 million in 2046. The number of people over 80 is set to nearly quadruple, from 128,000 in 2011 to 470,000 in 2046 (CSO, 2011). This population ageing illustrates how good public policies, major developments in medical science and health systems have had positive outcomes. People are now living longer and healthier. Life expectancy for men is 83 years and women 85 years. Life expectancy expressed as years lived in good health at age 65, is 11 years for men and 12 years for women (DOHC, 2013). However, there is a higher risk of chronic disease with ageing, and the prevalence rate for diseases such as hypertension is 70.9% for those 75 and over (Balanda et al, 2010). Healthcare that helps people remain healthy and supports the maintenance and restoration of function keeps people participating in all aspects of society.

This submission addresses the questions outlined in the Public Consultation Document. It begins with a summary of the recommendations, followed by a detailed response to the questions posed.

Summary of Recommendation

- The setting up of an independent Health Connector, who can act as an information broker, to ensure people 65 and over are supported in making good choices when choosing a health insurance through
- Health insurers should be required to purchase sufficient and appropriate care from providers within the different geographical areas to meet demand
- Wait time benchmarks, the amount of time that clinical evidence shows it is appropriate to wait for diagnostic and procedures, should define timely access
- Health insurers must be obliged to cover an illness event rather than particular illness and all of the care required should be provided in the same facility.
- A process implemented to ensure the needs of older people are assessed in a holistic way using a multi-disciplinary approach and their voice is central in discharge decision-making.

- Insurers' responsibility for on-going care should not be time limited but based on achievable outcomes for an older person based on multi-disciplinary assessment.
- Health insurers should be required to provide older people with a choice between care at home and care in a nursing home when purchasing step down care. The focus should be on Care Enablement Services.
- Funding streams within the National Insurance Fund should be ring fenced for the different elements of their remit, the services and financial support insurance payments. Sufficient budgets are needed to meet both subsidies and a defined level of service provision
- The issue of statutory or a minimum basket of social care should be considered.
- Funding of social and continuing services be based on central commissioning and individualised budgeting and there be clarity around allocation
- It is essential that allied health professionals services are included in standard health basket
- .Access to in-patient resources such as private room should be based on need and not on supplementary insurance
- Values based on respect for the worth, dignity and self-determination of the individual (person-centred) be used to determine service coverage
- The subsidy system needs to fully support older people and operate within a person-centred framework, where individual health and social care needs and affordability are considered. Prescriptions need to be covered.
- The licensing system must ensure quality of all provider services
- An advocacy and mediation process established to support individual claimants.
- Co-payments should not be required for the standard package of healthcare
- The cost of the standard healthcare package should be controlled

2 Overview

The White Paper on UHI sets out the policy vision for the most radical ever reform of our health system. The major overhaul of the system will see a move away from a two-tier unequal health system to a single-tier system where access is based on need and not on income.

The key features of the UHI policy are:

- Everyone will have mandatory health insurance and their choice of insurer.
- Everyone will be entitled to the same package of care, which will include primary and acute hospital services, including acute mental health services. There will be no distinction between ‘public’ or ‘private’ patient; access to treatment will be on the basis of medical need, rather than ability to pay.
- Health services which will continue to be government funded and available outside of the UHI package include social and continuing care services, non-acute mental health services and certain social inclusion services.
- Citizens will be given a number of protections under UHI: they will be able to switch insurer annually, they will have the right to renew their policy and they will be charged the same premium for the same policy irrespective of age or risk profile.
- Citizens will also be afforded financial protection. The Government is committed to paying or subsidising UHI policy premiums for those who need support through the new National Insurance Fund.

The White Paper seeks to further develop the above features of the model by setting out a blueprint of how our future health services will be funded, organised and delivered. On that basis this consultation document sets out a number of key questions under the following four headings:

- ④ Proposed Organisation and Delivery of the UHI Model
- ④ Policy and Operational Aspects of the Subsidy System
- ④ Regulation of Healthcare Providers and Purchasers
- ④ Funding of the UHI model and the Overall Health System

You are invited to give your views, in writing, on some or all of the issues raised. Please provide your response to the questions in each relevant box. If you have no views to offer on a particular area, simply leave the box blank. There will be an opportunity at the end of this document for other observations/comments you may have on any aspect of the White Paper or to forward an email attachment.

Thank you for giving us your views.

3 Proposed Organisation & Delivery of the UHI Model

3.1 When the UHI system is in place, health insurers will be responsible for purchasing care on behalf of the population. Do you have any views on safeguards that should be built into this system, e.g. timely access to care, geographic limits etc.?

The proposed Universal Health Insurance system seeks to alter the basis of people's entitlement to health care, particularly public hospital care including out-patient services. Currently, those ordinarily resident in the State are eligible for public hospital care (Health Act 1970). Whilst there are statutory charges of €75 per night to a maximum of €750 per annum for in-patient stays for non-medical card holders (Category 11), everyone has an entitlement to free access to all public out-patient services including emergency department attendance with GP referral. Those who qualify on basis of means to a medical card (Category 1) are entitled to free GP and public hospital in-patient and out-patient care. Under the proposed model of UHI, access to health care, including public hospital care, will now require individuals to purchase insurance that covers them for the care they need. UHI cover will be universal and mandatory. Uninsured individuals can be pursued in respect of their outstanding healthcare costs. In the main, health insurers will be competing for-profit organisations, (exception being VHI, the public option). They will be responsible for purchasing primary and hospital care on behalf of the population. People will have to choose between insurers and whilst all insurers will provide a basic basket of healthcare, this health basket can be purchased from different providers. To compete and be profitable, insurers, having met the core principles of insurance, open enrolment, lifetime cover, minimum benefit and community rating, one must assume will differentiate the products for example through co-payments and/or excess payments.

People 65 and over are the highest users of health care services and therefore it is important that the model of UHI proposed is critiqued from their perspective. In 2012, 49.6% of bed days involved people 65 and over (DOHC, 2013). Hence, much of the care purchased by health insurers will be for the older population, so airtight safeguards will be required to be built into the UHI system if their human right to

enjoy the highest attainable standard of health is to be protected (WHO, 1946). In addressing question 3.1, safeguards are determined using elements that encompass a person's right to health. These include accessibility, availability, acceptability and quality.

Accessibility

Health insurers purchasing care on behalf of the population must ensure health facilities, goods and services are accessible to everyone. Safeguards need to focus on the different dimensions of accessibility – information and physical accessibility, non-discrimination and affordability.

Ensure the provision of accessible and transparent information

The consumer model of UHI proposed, assumes that people are autonomous entities with the appropriate resources to make individual choices and be responsible for the outcomes of these choices. However, users of health care are not true consumers, as in practice, people have little opportunity to exercise real choice due to insufficient knowledge and lack of alternatives. Age Action would argue that

- the model proposed while it purports to ensure equity in accessing healthcare based on need, it is not necessary egalitarian, as the more able (physical/cognitive and with resources like education, financial to buy the best package) will still have privileged access, e.g. there are nearly 300 health care plans on the Health Insurance Authority website, illustrating the variations in cover that can be considered in choosing an insurance plan.
- Whilst the Health Insurance Acts, 1994- 2009 legislate for the four principles of private health insurance in Ireland - community rating, open enrolment, lifetime cover and minimum benefit, insurers have circumvented these principles, such as community rating through segmenting the market where VHI and Aviva introduced co- payments for certain orthopedic and ophthalmic procedures covered under plans, which had up until that time given people full cover for these procedures. People 65 and over are more likely to require these procedures, so in effect; they are paying more for their insurance cover

when co-payments applied.

- The UHI White Paper emphasises a person's right to switch insurers. The assumption being that people will have full knowledge of the services they need to insure, and be able to access the risk and uncertainty associated with illness. The evidence suggests that people 65 and over are not 'switchers' (e.g. energy providers). Switching insurers will require having knowledge of the health system and medical procedures, which is not easily accessible or transparent. A case in point is recent media coverage of older man who switched health insurer to discover he is not covered with new insurer for drug Ipilimumab, which is proven to give melanoma cancer patients a fighting chance against the aggressive disease.

Safeguard required

- To ensure people 65 and over are supported in making good choices when choosing a health insurance, the setting up of an independent Health Connector, who can act as a broker and help people find insurance that meets their requirements (this service is in place in Massachusetts). The State has a duty of care to protect citizen's right to enjoy the highest attainable standard of health, to achieve this people, particularly those less able, need accessible information. Funded by the State, this service could be integrated into existing advocacy and information services for example Age action, Citizen Information Service, or through Primary Care services.

Cost to health insurer must not be the only factor in commissioning care, geographical/ physical accessibility and timely provision must be the priority.

The White Paper outlines how the Healthcare Commissioning Agency will enter into contract with health insurers. The Healthcare Pricing Office will set a maximum price for different services. Health insurers are to commission care for their members from healthcare providers. Health insurers can commission a specific volume and type of service from a provider. Hospitals in the different areas will form Trusts, and these will compete against each other and private hospitals to sell their services to health insurers. Premised on market principles, the higher the specified volume and type of services purchased from a provider, the cheaper it will be to health insurers.

Age Action has concerns that

- Whilst the delivery of primary care in a person's community is a key element of the UHI model proposed, there is little discussion on whether health insurers will have to commission sufficient care in a particular area to meet the demands of the local population. It is important that people have access to health care services in their area, and are not required to travel distances for common procedures and services. For people in their 80s and 90s this is crucial if their spouse/friend/neighbour is to visit and support them in hospital or step down facilities. Public transport networks, particularly in rural areas, are poor and mobility may be an issue for peers. Follow up appointments are often required and older people from more rural areas have highlighted how they may have to book a room in a hotel near the hospital or leave their house very early in the morning to attend.
- In Ireland, over half the population lives in Leinster (CSO, 2011). Dispersion of people 65 and over as a proportion of population varies between counties, with some counties such as Mayo, Leitrim, Roscommon and Kerry, having 14% to 15.3% of population 65 and over (DOHC, 2013). The concentration of people 65 and over in particular areas, for example the West/North West will create greater demand for specific types of services with only one Trust (provider). Hence timely access for certain procedures will vary between areas as is difficult to see how access based on need can operate, as market relationships are based on premises each party will attempt to maximise their own self interest. In this situation, health insurers will have little negotiation power as providers can set their price as they won't need to compete, contracts will be capped, so the incentive for insurers will be to purchase low volume from this provider, and ration care through waiting lists. Insurers may offer quicker access to procedures in other areas where they have bought services at a lower cost and have extra capacity. People, able and willing to travel to other regions would therefore be able to access services faster, with less able people, particularly the older old, having to wait for service to become available with their local provider. There will also be implications for local providers and their ability to maintain, plan and develop services,

required in different regions

Safe guard required

- To prevent insurers from purchasing specific services from providers based solely on cost, with little regard to geography and accessibility, particular for older people. Health insurers should be required to purchase sufficient care from providers within the different geographical areas, the exception being where service is only available in centre of excellence.
- Wait time benchmarks, the amount of time that clinical evidence shows it is appropriate to wait for diagnostic and procedures, should define timely access.
- Regulations implemented to ensure waiting lists are not manipulated to give quicker access to a service in a hospital in another region, where the insurer has purchased a larger volume of services at a lower cost. Health insurers should be obliged to contract with providers in each of the regions and purchase sufficient services to meet the demands of the population in the region

Ensure health insurers do not discriminate against people with multi-morbidity in the purchasing of care.

The majority of people aged 65 and over admitted to hospital, have one or more co-morbidity. In 2006 the figure was 71 per cent (HSE, 2007). Three-quarters of people over 75 years of age in Ireland suffer from chronic illness (HSE, 2005). The average length of stay for people 65 and over was 5.38 days, but this increased with age to 10 days for people between 75-84 and 12.5 for those 85 plus. With increased life expectancy, chronic conditions such as dementia, hypertension and arthritis will become more prevalent. The White Paper acknowledges that the current acute hospital system, oriented towards providing short term specialised care, does not meet the needs of patients with chronic conditions. These patients require on-going management of their condition, rehabilitative input and support to maintain their quality of life in the community following treatment of an acute episode. Older people often carry several chronic health conditions with varying degrees of severity and

duration, and the combined effect can influence health outcomes. Co-morbidity is associated with greater disability, hence the purchase of more complex care by insurers. Current insurance providers largely mitigate the care of chronic diseases, despite the fact that 80% of GP consultations are chronic disease related and 66% emergency admissions are exacerbations of chronic disease (Burke, 2014)

Age Action has concerns that

- Using Diagnostic- Related Groups (DRGs) to determine payment, may make it more difficult for purchasers to obtain care for more complex care, as these cases consume more resources so there is an incentive to discourage more complex patients into a hospital (Brusse et al, 2011). Reimbursement policies, such as payment by DRGs, aimed at shortening hospital stays have been shown to impact on older people's right to self-determination, particularly those with complex care needs, as they restrict the time available for informed decision-making about future care and restrict the examination of discharge options (Pothoff et al, 1997; Dill, 1995).

Safeguards Required

- A requirement that processes are implemented to ensure the older person's voice is central in decision-making about future care (where capacity is an issue, an independent advocate is made available) and that multi-disciplinary teams and not insurers are the decision-makers in determining an older person's fitness for discharge. Penalties should apply where a person is readmitted within a certain period of time after discharge.
- All providers (public and private hospitals) should be required to make available care for older people with complex needs.

Acceptability

The proposal that *"the purchasers will negotiate provision of a specified volume and type of service, and will not continue paying additional amounts for extra services that have not been contracted"*.

Age Action is concerned that

- where purchasers are not required to buy a broad range of services and

sufficient volume to meet needs of local population, particularly those with multiple morbidity, older people will be transferred between providers. For example an older person is admitted to hospital for hip replacement, the person also has dementia, so will require extra resources and input from orthopedic team, old age psychiatry, and rehabilitative services.

Safeguard required

- Health insurers must be obliged to cover illness event rather than particular illness, otherwise person with complex care needs may be discharged after been treated for acute condition only. The purchase of broad range of services from one provider is necessary if older people with complex care needs are to be comprehensively covered in this type of situation. It would be totally unacceptable if health insurers sought to transfer patients (and responsibility for care) from hospital to hospital for treatment of different conditions.
- Multi-disciplinary input and continuity of care are essential for enablement and management of chronic conditions. .

Availability - Health insurers should be required to make available services that enhance the quality of life of older people in the long-term, not just short term fixes.

The present system of health care focuses on the short term, but for older people long term management of their illness is required. Criteria to be met for procedures such as orthopaedic surgery for a hip replacement should not mean for an older person, immobility and pain until they fulfil criteria, rather they should be able to avail of physiotherapy and occupational services so that they can have some quality of life. Insurers should be responsible for both surgery and therapy.

White paper places great emphasis on the choice for consumers in relation to who insures them, and assigns this responsibility to the older person, however there are few references to people's choice of care provider

Age Action is concerned that

- Criteria set by insurers for procedures such as orthopaedic surgery, will still

mean older people will face long periods of time in pain and/or with reduced mobility waiting to meet the criteria.

- For many people, particular older people their GP may be their closest advocate. In commissioning primary care, will older people be delegated to a particular practice that offers an insurer the best price?
- Choice is also an issue where it is proposed that health insurers will be responsible for purchasing short term care for people medically fit for discharge but requiring support. Discharge from acute hospital is a common pathway to placement in long-term residential care. In 2003, half of admissions to voluntary geriatric homes and private nursing homes came from acute hospitals (O'Neill and Coughlan, 2001; O'Shea, 2002). Where there are nursing home beds available, research indicates in terms of cost and organizational resources, it is more efficient to transfer an older person to a nursing home for the specified continuing care period, rather than develop and fund services in the community to support older people to return home, which is their preferred choice (O'Brien, 2010).

Safeguard required

- Hence insurers must be required to commission care such as physiotherapy and occupational therapy to meet older people's care need in the medium term.
- Health insurers purchasing care outside of the hospital setting, should be required to fund and provide older people with a choice between care at home and care in a nursing home

3.2 Do you have any views on the role of the National Insurance Fund in (a) directly financing certain services and (b) being responsible for the financial support payments system?

It is proposed that the National Insurance Fund will have responsibility for directly financing certain UHI services including ambulance services, Emergency

departments, social and community care and for managing financial support payments towards health insurance premiums. Although the White Paper outlines the process for determining the maximum value of financial support payable towards the cost of UHI policy premium (using the 'efficient market rate'), details on how funding will be allocated to the different services the Fund will finance directly are not outlined

Age Action views it essential that

- Funding is ring fenced for the different elements, the services and financial support insurance payments, otherwise where demand for financial support payments increase, there is risk that cuts may be made to the service element. For older people with long term health and social care needs, the National Insurance Fund will play an important role, in subsidising health insurance premiums, but also as the financier of services that are particular relevant for this population, social and continuing care.
- Funding of services be based on central commissioning and individualised budgeting which is proposed as a key element of *Future Health*, the Government's vision for the reform of social and continuing care.
- If UHI is to change the way healthcare is delivered and financed, there needs to be clarity around how services directly financed by the Fund will be allocated. The current discretionary system of providing social and continuing care for older people is unfair, unequal and inefficient. With incidence of chronic disease rising, social and continuing care will be a key factor for older people's health and well-being.
- Services directly financed by the Fund, need to have sufficient budgets to meet a defined level of service provision. There needs to be equity of access and universal cover based on need to these services.

3.3 How, in your view, can integration between health services outside of UHI and those in the standard UHI package best be achieved?

As outlined in the HRB Report, 'Integration of health and well-being services with general health services', there are a number of dimensions of integration, organisational, functional, service, normative and systematic. For older people the service dimension is crucial for their health and well-being. The integration of services outside UHI and those within the UHI standard package will be difficult to achieve, as the focus of UHI is very much on the short term fix. Unlike health, there is no automatic entitlement to social or long-term care services in Ireland. The services and supports in place have developed in an ad-hoc way according to Local Health Offices resources and priorities. For example, the incentive to develop innovative support systems for older people being discharged from hospital can be related to the ease of access to nursing home beds. Where nursing home beds are freely available in an area, support at discharge focuses on funding step down care in a nursing home. In areas with a scarcity of nursing home beds, initiatives such as shared care teams and community intervention teams have been developed (O'Brien, 2010). It is proposed that the 'money to follow the patient' out of the hospital setting will be time limited to a couple of weeks, what happens to an older person, once this time is up?

Age Action wishes to highlight how

- Services important for older people are outside the standard UHI package, such as access to allied health professionals like therapists, social and continuing care. Without timely intervention in the community, older people's chronic conditions will become more acute and require longer stays in hospital, impacting on older people's quality of life.
- Insurers purchasing short term care outside the hospital setting will not have a vested interest in setting up more long-term care arrangements or in providing short term care options that older people want, such as home care. Hence, efficiency, the allocation of least resources that maximises the achievement of aims (discharge into step down unit), will determine the type of short term care services insurers will purchase, and in terms of availability and

accessibility for insurers, nursing home beds will meet this remit.

- To achieve integration in this domain, insurers' responsibility for on-going care should not be time limited but based on achievable outcomes for an older person based on multi-disciplinary assessment on discharge from hospital (adopting a broad understanding of rehabilitation which insurers are responsible for). In this way, insurers will have a vested interest in purchasing services like Home Care Enablement Service, which help older people re-learn skills such as washing, dressing and cooking, or learn new ways of doing things, to enable older people manage at home and get their confidence back and be as independent as possible for as long as possible. In the UK, this service is provided to older people in their home for up to six weeks.
- Being responsible for achievable outcomes based on multi-disciplinary assessment would encourage innovation and the building of capacity within the community care sector, which would also benefit the proposed case management system for those with complex care needs in the community. Case management without the development of community care options is not viable.
- European models, explored in the UHI background paper, provide cover for social care through some form of social care insurance. The issue of statutory or a minimum basket of social care should be considered within the framework of a universal healthcare basket, as in times of economic crisis, essential social care supports are targeted for cuts, leaving older people more vulnerable to acute hospital admissions.
- Dealing with complicated care requirements, like transitions between care settings (e.g. from hospitals to nursing homes or home care after an acute illness) requires a holistic approach delivered by a team of professionals and caregivers which incorporates on-going social supports into care plans. In Northern Ireland, the Eastern Health and Social Service Board systems approach to older people's health and well being illustrates how a partnership involving a wide range of stakeholders from not just health and social care but also housing, transport, community safety, leisure and learning maximizes independence and builds capacity of primary and community care.

3.4 What should be the priorities for phasing the delivery of the UHI model i.e. with full implementation by 2019?

Structural reform, particularly at primary and community care level is essential if the changes to health care system proposed in White Paper are to meet the objective of providing a single tier equitable system. In the White Paper, it is proposed for primary Care centres to take on the role of managing chronic illness within the community, but up to last year, there were only 52 fully functional primary care centres, with another 46 described as 'partially operational'. Over the last two years, HSE has had insufficient funds to continue developing these centres. It is also questionable whether the type of services proposed in the White Paper can be achieved where GP practices within the centres are commercial enterprises and allied professionals are public servant.

Barriers to the delivery of the proposed UHI model include

- Access to primary care stops on Friday evening, if an older person becomes ill, their choice is an on-call doctor or Emergency Department, and neither have access to their medical history. Residents in nursing homes are sent to Emergency Departments, often alone, with conditions that could easily be managed in the nursing home, e.g. urinary tract infections.
- Management of chronic illness is prescription based, as it is impossible to access allied health care professionals in a timely manner. In other European countries, there are well established primary and community care structures, so there is less dependency on the acute care system. In Italy, GPs must be contactable by phone between 9am and 9pm and on Saturday.

3.5 Do you have any views on the role of supplementary insurance under the new system?

Facilities such as private room, satellite TV are really important to people in hospital for long spells, making supplementary insurance a necessity for this group of people. The other concern is that if the standard health basket becomes too expensive to fund, health care will be defined within narrow definition of medical procedures, requiring people to take out supplementary insurance to cover a wider range of health care, recreating a two tier system. Experiences of other schemes highlight how this happens. For example, an increasing number of residents are contacting Age Action regarding extra charges for such things as 'toiletries' and social activities that are being imposed on nursing home residents to compensate for cost-cutting by State under Fair Deal Nursing Home Support Scheme.

In the Dutch model, to cover the cost of adult dental care and glasses, supplementary insurance is required. These are items, essential to older person's health and well being, so should be available within the standard basket and not require supplementary insurance cover.

3.6 The White Paper sets out a proposed values framework to guide the work of the Commission in assessing what services should be included under UHI and the overall health system. Do you have any views on this values framework?

Values are principles or standards of behaviour. Individual values are based on what a person judges as is important in life. Societal values are the assumptions, beliefs or principles that guide people's decision-making and actions in society. A set of consistent values form a 'value system', or ethical framework.

Age Action's views on the values framework outlined in the White Paper

- They are set within the narrow context of health service provision and not in the broader context of societal values. The focus is on justifying the inclusion or exclusion of a particular service under UHI. Both positive and negative replies can be justified to many of the 'values' proposed, depending on the knowledge system informing the decision. For example alternative medicines such as Chinese medicine are not included under UHI, but under the 'values framework' set out and using Eastern knowledge based system, it would meet the criteria of being safe, essential, effective, cost-effective, etc. Hence the decision made in relation to the 'values' posed (particularly in considering 'values' of cost-effective burden of disease, resource impacts, value added) will depend on the values of the professionals and knowledge systems informing these decisions, having a voice and resources available, particularly financial and structural.
- For older people, the inference of many of the questions posed is the value or worth of an older person's life. Older people consulted believe that improving quality of life, regardless of age or life expectancy should guide decisions. These services would include palliative care. Where thresholds are set, there is a concern that Ireland would go down the path of the UK system in terms of the criteria for qualifying for coverage for certain drugs. In the UK, the Department of Health has proposed that drugs should be appraised in relation to cost of medication and its life-enhancing properties. This "fair-innings" approach maintains that every person should receive sufficient healthcare to provide them with an opportunity to live in good health for a normal span of years.
- Values based on respect for the worth, dignity and self-determination of the individual (person-centred) rather than those based on rationing of resources are more in keeping with the fundamental values set out in the Universal Declaration of Human Rights (1948).

4 Policy & Operational Aspects of the Subsidy System

4.1 Do you have any views on how the subsidy system for UHI should operate i.e. how can we ensure that it protects those on low incomes?

The maximum financial support payable towards the cost of a UHI policy premium will be the 'efficient market rate'. The 'efficient market rate' refers to a reasonable UHI policy premium offered by an efficient insurer.

The subsidy system needs to operate within a person-centred framework. Whilst income is an important indicator for affordability, other factors such as particular health and social care needs will also be important. The objective of UHI is access to healthcare based on need, older people have particular needs and require different resources than those included in the standard basket of care, so income alone is not an indicator of need for older people. For example, a high percentage of older people live alone, 36.7% of people aged 75 and over and 44.2% of people aged 85 and over, many with chronic disease. Managing everyday tasks alone is difficult, so a subsidised UHI policy will not meet these needs. Will the National Insurance Fund subsidise these needs? In the Netherlands, people with disability have a needs assessment and this determines the type of health insurance and care services a person requires.

The setting of a maximum financial support payment implies that even those on low income may be required to contribute to the cost of their premium, if insurers fail to provide a standard package at the price proposed. Older people are on a fixed income and over the last couple of years they have seen a substantial drop in their disposable income due to extra charges and taxes. These include increase in prescription charges, loss of medical card, increases in health insurance costs, loss of telephone allowances, reduction in fuel allowance, imposition of property tax, carbon tax and water charges to come.. With no increase in State pension, the cumulative cut backs amount to almost €1,000 per annum, equivalent to four weeks of the state pension. This loss of income means many older people are finding it impossible to survive financially and can not bare the cost of insurance premiums.

In the present climate, private health insurance is unaffordable for many people, as evident in the decline in number of people purchasing private health insurance over the last number of years, falling from 50.9% in 2008, to 45% in 2013. This decline is attributed to the decrease in disposable income and the huge increase in the cost of premiums which have doubled in real terms, since 2000 (McCarthy, 2013). Older people still paying for private health insurance, often get support from family members. For example, instead of Christmas and birthday presents, family members pay for older relatives' private health insurance to ensure they get the care they need when they need it.

4.2 The White Paper notes that the financial subsidy system will be provided on a means tested basis. Do you have any views on whether this assessment should be solely based on income or if other factors such as assets should also be included?

The qualifying criteria for financial support systems need to be transparent and accessible.

- If a means tested basis is to be used, assessment should not take account of assets. For the vast majority of older people, their home is their main asset. Its value will depend on location, with houses in large urban areas being worth significantly more than those outside main population centres, but a home is not a true indicator of wealth. For older people in the lower income group, median net asset holding is very small (TiLDA, 2014). Without the potential to generate more income, savings and other assets must provide a lifetime financial buffer to deal with adverse unexpected events, such as home maintenance and repairs.
- Means testing based on income alone is a crude instrument as the cut off point is somewhat arbitrary, and will always exclude some people who genuinely need support due to their particular circumstances. For older

people, their health status will be relevant to their ability to pay for insurance policy as many older people have to pay for personal and housekeeping assistances.

4.3 Some members of the population currently have entitlements under various schemes e.g. medical cards, GP visit cards, Long term illness scheme etc. Do you have any views on how these benefits may best be delivered when UHI is introduced?

The Medical card is very important to older people particularly for covering the cost of their medication. Older people are regular users of five or more medicines, one in three people 65 and over. Older people consider the present monthly prescription levy capped at €25 for a couple or individual as expensive, particularly for an older person living alone on the state pension (€300 per year = more than a week's income). The long term illness scheme is also crucial in alleviating cost of medication for people with diabetes, epilepsy or other long term condition. For those who don't meet qualifying criteria for a medical care or long term illness, the drug payment scheme maximum of €144 per month is a significant proportion out of a single person's pension of €501, and should be reduced, as the cost of drugs does impact on compliance.

People on limited income will self ration important medication such as hypertensive drugs (High blood pressure is symptomless, so person feels fine without medication) increasing their risk of stroke. Hence the long-term illness scheme and medical card coverage of medications are important if people are to continue taking medication for managing chronic illness, and remain well in the community. .

5 Regulation of Healthcare Providers & Purchasers

5.1 Do you have any views on the proposed system of regulation of healthcare providers and health insurers? Are there any areas you would like to see strengthened?

The White Paper states that “*DRG based payment systems incentivise providers to continually reduce costs, by utilising a more efficient use of resources*”. Although there will be “National Standards for Safer Better Health Care” and a licensing system for healthcare providers (HIQA, the licensing authority), the pressure to sell at the lowest price to insurance companies, will require corners to be cut. The nursing home sector is governed by similar regulations, yet HIQA consistently reports issues around staffing levels etc. Where insurance companies are not buying from a provider, their activity will fall, and this will have outcomes for licensing, as a certain level of activity in particular fields will be required for verification of competency (e.g. orthopaedic procedures, justification for centre of excellences). The outcome will be the survival of the fittest and that may leave some areas with no Trust, just a private hospital as provider. Will there be regulation to ensure that this private hospitals can’t opt out of system, leaving no provider within an area?

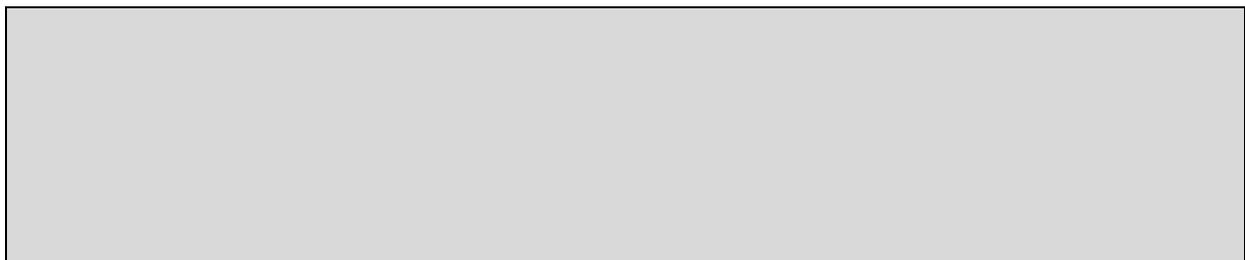
Regulation of Health Insurers will consume huge resources in relation to monitoring their behaviour, evaluating their decisions and applying sanctions. Insurance companies are global businesses with access to very specific resources including risk management and legal expertise They have a responsibility to their shareholders, so their over riding aim is profit. Insurers therefore have vested interest in finding ways of not paying for treatment. Hence timely intervention in the closure of loopholes will be required, as people trying to access treatment for diseases like cancer, will not have six months to wait around until the regulator closes the loophole that an insurer uses to renege on covering the treatment

5.2 Do you have any views on how the management of contractual disputes regarding health insurance might be best achieved?

Under the proposed UHI model, contractual disputes will be common, as it is in the interest of the profit margins of insurers not to pay and seek ways around covering treatment.

- An advocacy and mediation process needs to be established to support individual claimants. People who are vulnerable will be in a powerless position, due to illness or other issues (e.g. cognitive issues, lack of knowledge, passive participation) and will accept insurer and providers decisions without question.
- There is a danger that the right of older people to enjoy the highest attainable standard of health will not be protected, as many will only have the standard healthcare package so will have to take what is offered by insurers. GPs should have a role where there are disputes around necessity of treatment etc.

5.3 Do you have any views on what economic regulation mechanisms should be applied to ensure good governance and financial management of health services?



6 Financing of UHI and the Overall Health System

6.1 Do you have any views on the proposed new financing model for UHI i.e. a blend of premium income, direct taxation and out of pocket payments?

The White Paper refers to how the larger the contribution from tax revenues and co-payments the lower contribution required from insurance premiums, so can it be taken that the reverse is true, the lower the contribution from tax revenue, the higher the contribution required from insurance premiums. Hence the cost of the standard healthcare package for the individual will not be controlled. Health is a 'public good' and so will be provided free to some consumers. If many consumers opt for standard package, insurers will have little incentive to remain in the market as their profit margins will be dependent on selling more than the standard package, Fewer insurers will lead to less competition, and higher price for standard package. Primacy of consumer choice (insurers as commissioners of care) is their choices influence the market by squeezing out inefficient providers and rewarding efficient ones. Competition between Trusts and private hospitals will lead to a race to the bottom, with the downgrading of more hospitals due to lack of activity required for licensing.

The financing model places the cost of health with the individual, paid for through general taxation, premiums and out of pocket expenses. The dependency on private health insurers in this model of UHI militates against social responsibility and re-investment in resources that can contribute in the long-term to citizen's well-being. In Australia, of the 23 private health insurers providing open policies, only 7 are for-profit, the others are not-for-profit and any extra revenue is re-invested back into health and social care programmes. In other countries, revenue for health and social care is raised through taxing such things as lottery winnings (in Finnish: Arpajaisvero; in Swedish: Lotteriskatt). In Finland this tax is used to develop domestic violence supports.

6.2 Do you have any views on the use of co-payments for services?

For the standard package of healthcare, there should be no co-payments for older people. Older people are on a fixed income and as outlined previously there are ever increasing demands on this income. There is no contingency fund for unforeseen expenses such as co-payments for a hospital stay. Much of the focus of the UHI background paper is based on the Dutch Model, where co-payments are common for hospital in-patient care and rehabilitation, €10 per day, capped at 28 days. However these costs need to be considered in the context of the average pension in the Netherlands. The gross pension replacement rate in the Netherlands is the highest in OECD, 90% irrespective of earning rates. Average earnings in the Netherlands is €46,400 and people aged 65 and over had, on average, an income equivalent to 89% of that of the total population in 2010, as a result older people have the lowest rate of poverty in OECD, 1.4%. In Ireland, the gross pension replacement rate that an average wage Irish worker can expect after a full -career is among the lowest in the OECD 36.7% relative to the OECD average of 54.4%. The average worker earnings is €32,600 (OECD,2013). State pensions are the most important source of income among older people and make up two-thirds of gross income for those aged 65 and over (TILDA,2014). Co-payment capped at €280 may seem an insignificant amount in the Dutch context, however in the Irish context, for the majority of older people, €280 is a significant amount, the equivalent of over a week's income for an older woman living alone on a non-contributory pension.

Co-payments will be the basis for creating different healthcare packages. By agreeing a particular level of excess, people will have more choices around providers. Hence, the more vulnerable population will have to make do with the basic standard package. The basic standard package, as the name infers, will provide limited options when it comes to providers. An older person living in a nursing home in Bray, may have to go to Blanchardstown hospital for treatment for pneumonia if that is where her insurer has purchased that type of care. Whilst a professional living in Bray, willing to pay for a higher standard package will have a choice of providers and can opt to be treated in Vincent's private hospital.

6.3 Do you have any views on the cost control measures that have been set out in the White Paper? Are there other cost control measures that could be implemented?

The rationale behind the implantation of the model of UHI proposed is equity - equal access to treatment, where those with equal need of treatment have equal opportunity of obtaining it. Currently 40% of the population is covered by a medical card. Numbers covered have increased by 60% over the decade and by over 9% between 2011 and 2012. With population ageing the numbers meeting the criteria for subsidised health premiums will be substantial. In the long term, the State, through the National Insurance Fund, will still be directly funding the basic package of care for nearly the majority of people. The proposal for the State, i.e. the Minister for Health on the recommendation of the Healthcare Pricing Office, to set the maximum prices payable for specific health services, will not guarantee that insurers will be interested in offering the package at this minimum price. Insurers will be free to choose if they will trade or not and at what price, so 'the efficient market rate' will not be set by the State but by private insurance companies.

The standard basket of care funded will be minimalist and under this model and can not meet the needs of an older population. Allowing the regulator to only issue issuing non-binding recommendations to insurers, gives private insurances companies carte blanche to maximise efficiency by rationing services to ensure their profit . For example through implicit rationing (based on insurers judgement of need) and explicit rationing (a given packages of treatment covered or limit utilisation to a certain amount over the course of a lifetime). Regulation is not conducive to competition so cost control measures proposed are weak, for example the Government may consider limiting insurer profit margins in exceptional circumstances. Capping of insurers overheads and profits need to be set from the outset.

6.4 In your view, how best can the regulatory systems set out in the White Paper provide the state with sufficient means to safeguard the financial sustainability of the health system and secure ongoing affordability of UHI policy premiums?

The regulation required to safeguard the system and provide equitable health care will be so cumbersome and costly that significant resources will be consumed in regulation and administration.

6.5 Do you have any views on how the regulatory and administration costs of the system might be minimised?

The need for multiple administration staff in multiple insurance companies (four presently) and the many regulatory bodies that will be required seems a very inefficient use of resources and waste of tax payers money. Other ways of achieving a single tiered health care system based on need should be explored.

7 Additional Comments / Observations

Should you wish to provide comments on any other aspects of the White Paper please do so in the box below or attach a document in the email response.

Older people are highly dependent on an equitable health care system for their quality of life. The proposed model of UHI takes away what was their right by virtue of residing in Ireland to the public healthcare system. The State will no longer look after their health care needs, this responsibility will rest with private insurers, who will sell insurance policies to older people. Whilst waiting lists for diagnostic tests and procedures may be reduced, how equitable will this system be in providing the care older people need to live a quality live.

