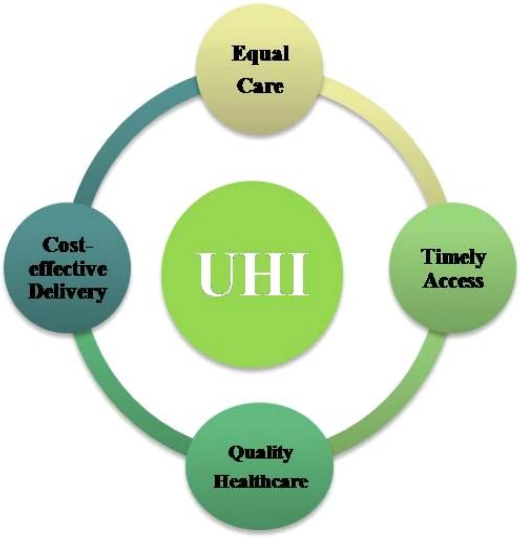
An Roinn Sláinte
DEPARTMENT OF HEALTH

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:*	**Ann Blackmore** **Head of Policy and Strategy at FODO Ireland**

1.3 Organisation: (mandatory if you select the second option at 1.1)	**Federation of (Ophthalmic and Dispensing) Opticians Ireland**

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

• Health Insurer or Other Insurer	• Public Interest Group
• Public Health Service Organisation / Provider	• Patient Interest Group
• Private Health Service Organisation / Provider	• Regulatory Body
• Union	• Representative Body
• Educational Sector	• Other

FODO Ireland is a representative professional body for opticians in business and individual optometrists in Ireland. Our members include both independent and corporate opticians, which operate as primary eye care contractors, and individual practitioners. Between them, FODO Ireland members deliver over 55 per cent of the eye care by volume in the Republic.

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 subsiding 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:

- Proposed Organisation and Delivery of the UHI Model
- Policy and Operational Aspects of the Subsidy System
- Regulation of Healthcare Providers and Purchasers
- 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.?

We would wish to see strong provisions that ensure universal access to care, in particular amongst low income groups, minority and ethnic groups and older people, all of whom are known to be at higher risk of sight threatening conditions.

Universal access to primary care should mean just that. Primary care is not just about GPs. It should include primary eye care, delivered by optometrists and opticians in the community, which generates major public health benefits in early detection of eye problems and a range of systemic conditions, such as diabetes or high blood pressure.

Timely access to care should be underpinned by a commitment to system wide direct referral of patients between registered clinicians and services irrespective of the person's entry to the healthcare system, rather than necessarily going via the patient's GP. Direct referral already operates effectively in parts of the private insurance market and is underpinned by registered professionals' duty to act within their scope of competence, and could be reinforced by agreed protocols across insurers based on best clinical evidence and practice. The aim of introducing this system wide would be to reduce delays in accessing care and to remove costs from the system and pressures on general medical practice. The patient's GP would of course need to be copied into correspondence as they are central to patients' care needs.

We have major concerns about one size fits all contracts for all providers irrespective of risk and scale. The UK has recently gone down this route for the English healthcare system and added significant costs to delivery without benefit for patients. Ireland has an opportunity to avoid such errors through a commitment to a proportionate contractual framework.

The risk profile of different parts of the healthcare system varies considerably, and we would not wish to see every part of the system bound by the same provisions. Instead there should be tailored contracts for high risk aspects of care (for example in the hospital setting) and low risk (eg primary eye care). Community optometry has been shown to be a low risk profession, and therefore we would want to see a proportionate and agreed contractual framework which reflects this.

A proportionate contractual framework is also essential in community eye care to maintain choice. Our sector is a mix of large, small and independent providers. Many of these would struggle to stay open if an onerous contractual framework were put in place. An onerous contractual framework would be likely to result in practice closures, in particular small clinics which provide an important service to rural areas and small towns across the country. That would serve only to reduce patient choice and service accessibility.

In relation to the basket of services contained within UHI, we are pleased to see that decisions will be made impartially and based on strong principles. We will develop proposals for the inclusion of community eye care within the basket and will seek meetings with key officials to discuss further.

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?

The National Insurance Fund should provide a safety net system for individuals who, for whatever reason, fall outside the UHI system. In the case of eye health that would mean funding regular sight tests and eye care as funder of last resort as a public health measure to avoid significant downstream health costs through avoidable visual impairment.

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

Integration between healthcare services and providers is essential to ensure timely access to care. There is a significant risk that if parts of primary care are outside the UHI system, this could lead to a disjointed healthcare system for our patients. A disjointed system would have two effects on care. It would:

- create an unnecessary barrier to seamless and timely referrals between disciplines (urgent referrals are essential to save sight in certain eye care conditions)
- discourage discharge from the hospital system to more accessible community optical practices.

To ensure that eye care is not disjointed (if primary eye care were to be outside UHI and secondary care within the system), we would favour the inclusion of primary eye examinations within UHI. There is significant potential to improve the overall eye care system through the introduction of UHI. We urge the Department, Joint Oireachtas Committee on Health and Children and Commission to review the 'single tier' Scottish model of 'General Ophthalmic Services' (GOS) which has delivered more and better care cost effectively, reduced waiting times and ensured patients are seem promptly close to home.

Integrated care should also be incentivised across the healthcare system, and no part of the system should be rewarded for retaining patients who could receive the same quality of care at a more cost effective and accessible alternative part of the system. Discharge should be encouraged wherever clinically appropriate, and shared care between primary eye care providers and the hospital system should be incentivised. This would ensure that patients can easily access care in their local community.

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

It is important to get the overarching architecture right in the first instance. We take some reassurance that UHI is moving in the right direction, however we would like to be more closely involved in the detailed discussions because they will impact significantly on the care we provide.

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

We welcome the proposal to keep supplementary insurance separate from and not 'tied' to the UHI policy, and the reassurance that individuals with supplementary insurance will not have faster access to services covered by the standard package of care.

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?

We agree wholeheartedly with the five principles outlined on Page 52 of the UHI White Paper and would fully subscribe to their implementation. In fact, community eye care is already operating in line with these principles. Good vision and eye health are essential for 'complete physical, mental and social wellbeing'. We believe this underlines the case for community eye care to be included in the core basket of services.

In terms of the values framework, our only comment is that the values set out focus very much on treatment, rather than prevention. Good healthcare should focus as much on actions to prevent disease, which often result in savings both to healthcare budgets in the future and lost income to the economy. This is particularly true of sight tests, which identify and correct poor vision, identify disease, and help reduce preventable blindness. This provides not only a benefit to the individual but to wider society and the economy. We would therefore suggest explicitly including the social and economic benefits of screening and treatment within the values framework.

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?

We have no specific views on this but as noted elsewhere would wish for the system to be equitable and welcome the Government's commitment to this.

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?

Not applicable to our response.

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?

Patients with a medical card currently qualify for a free eye examination and assistance towards the cost of spectacles or contact lenses. The best way forward would be to provide comprehensive eye examinations for all under the UHI basket of services, which would have several benefits including the early detection of a range of ocular and systemic conditions such as diabetes.

The current system of HSE funded eye examinations requires that a medical card holder applies for prior authorisation for their sight test from HSE officials. We have long argued that this creates an unnecessary barrier to care and generates administrative costs which serves little or no benefit, so should be scrapped and replaced with point of service checks. Prior authorisation for routine healthcare should not feature in the new healthcare system.

Assistance towards low income groups should operate outside the UHI system, through targeted government assistance for those on low incomes or with specific healthcare needs, for example children who should continue to receive State-funded sight tests and an allowance toward the cost of spectacles or contact lenses.

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?

As noted above in response to Q3.1, there should be a heavy emphasis on proportionality when regulating healthcare providers, which should reflect the risk profile for the services they provide. This is essential in the community eye care system which includes a number of small and independent providers who would struggle to meet onerous requirements, which would result in closures of practices in rural locations. This is not in anyone's interests and would reduce choice and access for patients.

We see little or no merit in introducing new regulation for community opticians because the risk profile of our sector is low, and those risks can be managed by a proportionate contractual framework. But more importantly we see no need because optometrists and

opticians delivering our services are already regulated by the Opticians Board and will soon be regulated by CORU. We would not wish to see those arrangements duplicated elsewhere in the system.

Health insurers should be regulated effectively to ensure that the principles of universality and access to care for all, as outlined in the Government's vision, are embedded in the system.

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

In our experience, any procedures that create space for contractual disputes to be resolved through mediation are welcome.

There must be a mechanism to sanction rogue providers to safeguard the public's health and wellbeing, while minimising the impact on patient care. This is especially the case for high risk delivery of care.

We agree that an independent adjudicator is essential to resolve contractual disputes and would serve the public interest better that expensive court battles. We would however like to reiterate that great care should initially be taken to ensure the underlying contractual framework is fit for purpose (through consultation and negotiation with all parties), which in our sector should include a heavy emphasis on proportionality.

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?

Community eye care already operates in an open and competitive market with freedom of entry and exit, subject to meeting proportionate contractual and other requirements. This open, free and proportionately regulated market already incentivises good governance and financial management. Practices that do not abide by these requirements can be closed or would close and be replaced by a more sustainable model of delivering care.

As noted above, community eye care is also a low risk area of the healthcare system with a very high public health return for low commissioner (State or insurance company) costs. The imposition of additional economic regulation mechanisms in community eye care is unnecessary and would reduce those 'public goods' benefits.

Notwithstanding this, newly established Trusts will need to be regulated effectively and supported through that process.

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?

We would like to have further information about how exactly this will operate and will request a meeting with officials to understand better the implications for primary eye care.

Notwithstanding this, we think it is sensible to maintain a variety of funding channels, which will allow the overall healthcare service to remain adaptable to new and changing circumstances. We feel it is sensible to maintain direct funding for services outside the proposed basket because they also provide clear public health benefits to the population, in particular for low income groups.

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

In our opinion, co-payments can have a place in the healthcare system, for example where

- patients might choose to opt for a higher value service, treatment or medical device where a basic service which is adequate for healthcare need continues to be provided to all, or
- a particular assessment or appliance is required for occupational purposes.

We would however have concerns if there were to be co-payments for essential services because this would a disincentive to presenting for care in the first place, which would delay diagnosis and access to care, in particular for low income groups.

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?

We are pleased to see a commitment to keep all services under review with consideration of whether they might be provided more cost effectively elsewhere in the system.

Community optical practices have a lot to offer in respect of moving eye care to the community, which could ease much of the burden on the hospital system, and improve accessibility to high quality eye care at lower cost.

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?

As noted above, flexible funding arrangements would make this easier by allowing different parts of the system to grow or contract as necessary.

As noted in Q6.3, we also welcome the commitment to keep all services under review with consideration of whether they might be provided more cost effectively elsewhere in the system

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

This should be a key concern: overly burdensome bureaucracy will bind up the healthcare system in knots and eat into the funds available for healthcare. A proportionate contractual framework based on relative risk is essential to prevent this.

Please refer to our responses to Q3.1 and 5.3.

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.

We reiterate that we agree with the principles underpinning the framework and feel the proposed split between commissioners and providers would be healthy and in line with international best practice.

We are however disappointed that the full range of primary care, including eye care, does not feature in the Government's plans at present. This is of concern because significant downstream costs arise in health, social care systems, not to mention loss of economic output, due to avoidable sight loss.

We would also like to underline the point that primary care is not just about GPs, but is routinely considered to be the first point in the patient pathway that a patient presents and/or is discharged to for community-based follow up (which we believe would be in line with the spirit of 'Money Follows the Patient Funding Policy').

We see major potential through the introduction of Universal Health Insurance to upgrade primary eye care through the new National Clinical Guidelines and Programmes to introduce a more comprehensive eye examination, and service options reflecting optometrists' and opticians' skills in the 21st Century. We believe this would benefit from being modelled on the 'single tier' Scottish GOS system which can deliver more accessible care and makes best use of all resources.

We would like to meet with the Department to discuss this in more detail and will follow up with the officials involved.