Sláintecare: Could Ireland's Universal Healthcare Model Work in the U.S.?

"I'm not a researcher of the health system in your country, but if you look at the headline indicators, it does appallingly badly. It spends way more money per capita with really poor health outcomes. So I would say the lesson there is that what you're doing is absolutely wrong and a big driver of that is for for-profit medicine and for-profit insurers." Dr. Sara Burke

911. What's your emergency?

America's healthcare system is broken and people are dying.

Welcome to Code WACK!, where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, Brenda Gazzar.

(music)

This time on **Code WACK!** How is Ireland's plan for single-tier, universal health care known as **Sláintecare** funded and is it sustainable long term? What improvements has the nation's healthcare system seen so far – and what can America learn from this? To find out, we spoke to **Dr. Sara Burke,** associate professor and director of the Centre for Health Policy and Management in Trinity

College Dublin's School of Medicine. Her research interests include health policy, inequities in health, healthcare access and the politics of health reform. This is the second of two episodes with Dr. Burke.

Welcome back to **Code WACK!, Sara!** So last time we spoke about Sláintecare, Ireland's reform plan for single tier, universal health care that's based on people's needs rather than on their ability to pay. How is *Sláintecare* funded and is it financially sustainable in the long run?

Burke: So *Sláintecare* is funded out of public money, which is largely coming from what people pay in taxes in some form or other, in income taxes, in VAT [value-added tax] or whatever. So it's very much the model of economics in Ireland that we have this tax-funded public system that funds social protection, so it pays pensions to elder people and people with disabilities. It pays for education, transport and health. So that's our funding model.

I also spoke about private health insurance, how nearly half the population have private health insurance, but it only contributes about 12% of our total health spending and about another 10% or 12% is in out-of-pocket payments. While the poorest third of the population can access their GP without charge, the rest of the population would have to pay 60-70 euro for each GP visit.

So that's about $65 or 75 American dollars for each primary care visit.

Burke: And insurance policies tend not to cover or maybe only cover an aspect of that.So we have out-of-pocket payments voluntary health insurance 'cause it's not a compulsory insurance system, but the vast majority comes out of public money and the aim of *Sláintecare* would be for that to increase. So our publicly funded aspect was about 70% and under *Sláintecare* we would be looking to bring it up or above the European average as 80, 82%. So decreasing those private spending 'cause we know that's not the best way to be spending money, that when we spend it in a pooled way, it's a more effective use of the same resources. I would argue that it's not sustainable not to implement *Sláintecare* that the system we have is overly expensive, it rewards treating people in the most expensive settings and therefore there has to be this entire system reset that does much more

prevention, early intervention, providing care at home as close as at the lowest level of complexity.

That said, we know that transferring care out of the hospital into the community and meeting people's needs doesn't necessarily cost less. You know that you just spend the money differently and it has different health outcomes. But I think the model we have at the moment of funneling too many people into hospitals at too late a point in time is absolutely not sustainable. But I also know that's a challenge faced by health systems all over the world and European health systems are much more sustainable than the health system in the United States of America. The United States America has the highest per capita spend on health with amongst the poorest outcomes of any OECD country. So we know what's happening in the USA is absolutely not what to do and it's not that we know the perfect thing to do, but I think we know the elements of that and I think those ingredients are in *Sláintecare* and there is consensus among most healthcare professionals amongst the leadership, the political leadership, the health system leadership that this is the way to go.

Q: Right. Do you have any examples or stories of some successes of Sláintecare and where it still falls short or is it too early for those kinds of stories?

Burke: I won't tell stories, but I can tell you based on data, certain things and it takes a long time to do the change and to see the impact. So we know it takes 10, 20, 30 years to impact on health outcomes. So it's very hard to see. So the indicators of change aren't improved health yet. Like in Ireland, we're seeing better outcomes for cancer and stroke because we invested in good data on cancer and stroke and better services 20, 30 years ago. And we're beginning to see that now. Similarly with smoking, we're seeing better outcomes because we've significant cuts to the population that engage in smoking. So it's a long-term gain and although in Covid what we saw were quick changes and some quick wins for the system in general, this system change is a long term, has to be a long term project.

I think some of the wins, evident wins are for [poor] people. So at the moment in Ireland, about the bottom third of the population, the poorest third, there's a

safety net, which means they're not charged and they have access to care, albeit with long waits. But it's the lower income people above those thresholds that were really deterred – often the sort of working poor – who were deterred from care due to charges. And the last minister did quite a bit to get rid of those charges, hospital charges for GP's, charges for children. And there has been an uptake in those people seeing medical professionals and that's meeting their needs. So I think that is a success for the couple of hundred thousand people who have increased access to care without charges so they're getting access to care based on need

Oh, that's great.

But what Sláintecare wants to do is it wants to do that for the whole population and we're definitely not there yet. But I think for those who have got that based on their low income or their population group, that's been a positive. There's been a big issue with access to diagnostics. So when a GP, a general practitioner, sees someone in their clinic and they need a diagnostic test, there was big bottlenecks for that and as part of *Sláintecare,* for certain groups, for lower income groups, there's much faster access to those diagnostics and that's all part of getting an earlier intervention in the system.

Oh, that's wonderful. What other changes have there been so far in Ireland's healthcare system?

Burke: Another, and one of the most controversial elements of *Sláintecare* was to remove private practice from public hospitals. So up to now we've had publicly and privacy practicing doctors within the public hospital system and there's a *Sláintecare* commitment to remove that and as part of that we've introduced a public only so they can only work publicly in the public hospital medical consultant contract.

And there was a lot of noise about that and obviously consultants are the most powerful or amongst the most powerful sort of vested interest within health. And we have a situation now where the sky has not fallen in, the system is continuing to function as before and 60% of all medical consultants within the public system are now on these public only contracts. So I think there are indicators of some

successes, our progress, particularly in areas where people thought it was very hard to take on vested interest and influence change.

Another area where there have been wins and yet we need way more investment at this is an area called the *Sláintecare* healthy communities where investment has been made in the 20 most disadvantaged communities and the local authority and the public health system working with communities to really support community groups and individuals living in those to learn healthier cooking habits, to be supported to stop smoking, to really trying to engage those people to support them to a better health.

And I think there have been some successes in those, but again, that can't happen over three or five years. This needs sustained decades of activity and it's also connected – directly connected – to poverty and inequality. And unless you invest in those, in the underlying causes of poverty and inequality – unless you create better educational opportunities, better play environments, better job opportunities for parents living in those communities – that's only a sort of a plaster band on the issue. But there is also a current government priority in relation to child poverty and so the *Sláintecare* healthy communities overlaid with a political priority for child poverty has the potential to really result in better outcomes for children. But ultimately addressing those issues, addressing health inequalities, health starters inequalities and say child poverty is about the redistribution of income and wealth and it's about taking money off people who have more money and giving it to people who have less money.

Q; Which reminds me, I wanted to ask you about the tax system. Are the taxes based on people's income and therefore progressive?

Burke: Yes, it is quite progressive. Yes, there's other taxes on sort of goods and services that are less progressive, but our income taxes are progressive.

Q: So is the money going into Sláintecare, progressive also?

Burke: It comes from a variety of sources. But we absolutely have income inequalities in Ireland. But they haven't, it depends what you measure. They

haven't got much worse if you look at people after the sort of public supports are put in place,

Q: Yeah, so in order for Sláintecare to be launched, did people have to pay increased taxes?

Burke: No, we haven't and that's because we've been doing well economically. But ultimately I think we will, and that's connected back to your sustainable question. People often say in Europe, if you want Nordic-style public health services, then you need to pay Nordic-style levels of tax and we don't do that in Ireland. We [are like] Boston meets Berlin. We quite like that sort of American economic model, but yet we want northern European public services and they're not really compatible for *Sláintecare* to be sustainable or for the health system or health reform to be sustainable. Absolutely we need to pay more taxes, but the politicians don't say that obviously 'cause they've got to get elected. I don't.

Q: That makes sense. If the U.S. were to transition one day to a single-payer system, which we hope it will, what lessons both positive and cautionary should policymakers take from Ireland's experience?

Burke: For me, the great achievement of *Sláintecare* is it was adopted through political consensus and having worked with that committee and there's lots of it in the public domain, there's public hearings you can watch and read online and the final report or submission. So it's accessible. But it's a very good example of how at that moment in time in Ireland with good information and good chairing and a nearly a safe space for politicians who are a very different political creeds, They could reach consensus on about 85% of the issues. There wasn't consensus on everything, but there was consensus on every child deserves to be born in a good healthcare environment and get the best opportunities in life and should be supported through its life, whether it's through immunizations or tooth washing or access to whatever services they need. There was real consensus around that.

It was similarly in relation to palliative care people feeling very strongly nobody should have to die on a hospital ward in a bad environment. Everyone has the right to die with dignity. There was real elements of consensus amongst the politicians. So that and my estimation of politicians went up significantly as I

worked with them over time. Now I think the world is a different place now than it was when this committee did its work, which is eight, nine years ago. I also think America, the USA, is a very different place politically to what Ireland is now or was then. So I'm not sure that suggesting political consensus in the USA in 2025 is in any way useful given the state of play that's there at the moment. So I'm not really sure what I can say that is applicable to the USA right now. Maybe you can prod me a bit more. I'm not sure.

Q: Well it is 2025 and things can change in four years or more. So if there were to be political consensus, what lessons have you learned or has Ireland learned that American policymakers could take from Ireland's experience?

Burke: I think if you're looking at the data, letting the data tell the story, and … I'm not a researcher of the health system in your country, but if you look at the headline indicators, it does appallingly badly. It spends way more money per capita with really poor health outcomes. So I would say the lesson there is that what you're doing is absolutely wrong. And a big driver of that is for for-profit medicine and for-profit insurers. And we know globally that systems where there's these pooled systems of money which prioritize population health. What happens in the health system in the USA it's survival of the fittest, and if you the money are the right insurer, you can get access to that care, but it's solely based on the individual and there isn't that population health approach. So I think, *Sláintecare i*s absolutely driven by a population-based approach.

And one of the recommendations is that actually resource allocation with health care would be driven by a population health model. And that's not what we do at the moment, but that's the plan to do that. So that funding for the health care is driven by the population health needs. So I think you can use health system levers like financing to really shift how you provide that care.

Similarly with workforce, we tend to overtreat people in the most expensive places and under-resource prevention and public health and that care in the community and you can use health system incentives and workforce planning over time to really provide a different type of care in different settings with better population health outcomes than you're currently getting. So I think a lot of the essence of 'what is a good health system and how do you get it functioning' are

there in *Sláintecare a*nd that they could be used as the basis for the beginning to change your own health system.

Q: And what do you mean exactly by population health?

Burke: When I say population health, I mean you're interested in the whole population of Ireland and then in Ireland at the moment we're introducing regions, the plan is that money will be allocated through the regions and we look at the regions and we go, 'okay, what's the age profile? What's the level of deprivation? What's the disability levels in this population group of maybe say a million or 2 million people? What are the health resources in this region? And then how can we better organize and fund our services to better meet the needs of this population group So the health system is responding to the needs of the population rather than vice versa, which is what has tended to happen in most systems.'

Thank you, Dr. Sara Burke of Trinity College Dublin.

Do you love Code WACK!? Keep us on the air with a tax deductible donation at heal-ca.org/donate.

Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at heal-ca.org.

And don't forget to subscribe to Code WACK! wherever you find your podcasts. You can also find us on ProgressiveVoices.com and on Nurse Talk Media.

Code WACK!'s powered by HEAL California, uplifting the voices of those fighting for healthcare reform around the country. I'm Brenda Gazzar.