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1 Executive Summary

The overall economic position and the policy objectives in relation to fiscal consolidation and meeting the deficit reduction targets continues to influence core budgetary decisions and related policy developments in the areas of pensions, health and long-term care in Ireland.

Some of the shortcomings and pressure points in the Irish pension system have been the subject of official examination and public debate in 2012 and 2013, which included the first government initiated examination of pension charges in Ireland (Department of Social Protection, 2012) and the OECD's (2013) wide ranging review of the Irish pension system.

Having legislated for future increases in the state pension qualification age and introduced a new public service pension scheme in 2011/2012 some key long term sustainability measures were delivered, as per the conditions of the Memorandum of Understanding (MoU) with the EU/IMF. Broader pension relatedrevenue raising measures contained in the MoU, have also been implemented.

A range of weaknesses in the Irish pension system have come into sharper focus including: the major deficit problem confronting DB schemes and the rights of DB members, continuing problems with private pensions in terms of coverage, access, affordability and equity, the adequacy of the state pension, future projected pension costs in the context of the erosion of the National Pensions Reserve Fund and growing demands on the Social Insurance Fund.

Debate has tended to concentrate on discrete aspects of pension provision in the main. More comprehensive and robust debate about the system as a whole is urgently required. The OECD (2013) report provides a key reference and perhaps the government response to this report will provide a focal point for the development of the pension system reform agenda that is undoubtedly required in Ireland at this point.

The Irish health system faced considerable challenges in 2012 and 2013. The HSE continued to provide care to a growing, ageing population with a greater burden of disease with an ever depleted staff and further health budget cuts (HSE, 2013b). It is now six years since the HSE first introduced a staff moratorium, four years since a public sector wide embargo and continuous budget cuts.

Budget and staffing cuts have resulted in cutbacks to key services including a further reduction in home help hours, fewer inpatient and day cases in hospitals in 2013 as compared to 2012 (HSE, 2013a). However, there is increased demands for emergency services. There were new increased charges during 2012/3 transferring further costs from the State to the patient.

There are also new governance structures in place in the HSE, with the abolition of the old HSE and the setting up of a new 'directorate' structure. The new national directors are in place since July 2013. The health and social care systems have been under continuous reforms since 2004 when the old health boards were abolished.

Despite the budget cutbacks, there has been a continuous emphasis on improving quality of care through the clinical care programmes and as a response to various reports published by HIQA on patient safety. While the clinical care programmes are largely hospital based, they are beginning to impact on services in the community.

There is also increased demand for long term residential care, evident at different times during the year in an escalation of new entrants into the Nursing Home Support Scheme (NHSS). Established in 2009, the NHSS is now being reviewed for its effectiveness and sustainability.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The Irish pension system has been shaped by the evolution of a mixed approach to provision in which a Beveridgean style first pillar provides the primary income source for the majority of older people with moderate replacement rates, to be supplemented where possible with voluntary supplementary pension arrangements. Despite numerous reviews of Irish pension policy during the 1990s and 2000s, resulting initiatives were largely system re-enforcing and brought about little structural reform of the Irish pension system.

Ireland is one of the few countries not to have a mandatory earnings related pension built into its pension infrastructure. The introduction of Personal Retirement Savings Accounts was designed to improve supplementary coverage and enhance accessibility to pension savings vehicles. These are now widely acknowledged not to have had sufficient impact. Coverage rates did improve somewhat during the mid-2000s although this was short lived, they have since fallen back and variations in supplementary coverage have become more pronounced.

Significant vulnerabilities in other elements of the pension system, such as in the funding of DB schemes, have been exposed in recent years and this situation remains critical. Overall, the scale and impact of the economic crisis precipitated more substantial pension policy change than heretofore although much of this reform would seem to have been driven primarily by immediate fiscal considerations, as outlined below.

2.1.2 System characteristics

The Department of Social Protection (DSP) is responsible for Irish pensions policy (both state pensions and private pensions, but excluding public service pensions), and for social protection policy more generally. In addition to state pensions, all other social protection schemes, whether based on social insurance or taking the form of social assistance, are administered directly by the DSP. The Department of Finance and the Department of Public Expenditure and Reform are central to pension policy planning and system reform also, setting the taxation rules pertaining to all pension savings and retirement income and in overseeing the operation and financing of public sector pension schemes.

The Pensions Board is charged with monitoring and supervising the operation of the Pensions Act and regulating occupational pension schemes, Trust Retirement Annuity Contracts (RACs) and Personal Retirement Savings Accounts (PRSAs). It also issues guidelines to trustees of schemes and advises the Minister for Social Protection on pensions matters more generally. A separate office of Pensions Ombudsman exists to investigate complaints and disputes related to occupational pension schemes (including in the public sector) and PRSAs and Trust RACs.

The Irish pension system can be said to comprise two/three core components: first pillar state administered social welfare pensions and a complex mix of second pillar voluntary supplementary pension arrangements, including occupational, private and public sector pensions (the latter is often considered separately because they are largely unfunded and pension liabilities are met on a PAYG basis).

The first pillar state administered social welfare (state) pension is provided on a contributory or non-contributory basis, payable from the age of 66 years. A state (transition) pension,

currently available to those aged 65 retired from work with sufficient social insurance contributions, will be abolished when the state pension qualification age is increased to 66 years in 2014. It is not possible to receive the existing state (transition) pension while working, although there is no such restriction on those age 66 and over in receipt of the state (contributory) pension. The state pension qualification age will increase to 67 in 2021 and to 68 in 2028, as legislated for in the Social Welfare and Pensions Act 2011, meeting the requirement set out in the MoU. There is no provision within the Irish social protection system for early retirement or pension deferral at present.

Both contributory and non-contributory state pensions are flat rated payments, currently paid at a maximum rate of €230 and €219 per week respectively. Eligibility (and the rate of payment) for the state contributory pension (SCP) is calculated on the basis of an individual's social insurance contribution record with reference to a minimum number of contributions and yearly average contributions made (MISSOC, 2013). The current (maximum) SCP payment is equivalent to 33.1% of average earnings (OECD, 2013); the stated national policy target is 35% (Government of Ireland, 2010a).

Changes to the eligibility criteria applied to the social insurance based SCP were introduced for new applicants in 2012. These effectively double the contributions required for the full state pension (a lower pension may be payable to those below the yearly average requirement). Credited contributions are available in respect of periods in receipt of cash benefits related to unemployment, disability, illness and maternity payments. Time spent caring for children or incapacitated persons (maximum 20 years) may also be credited. Past earnings or current income are not relevant to the assessment of entitlement for a SCP. Eligibility for the non-contributory state pension (SNCP) is determined via an assessment of means and satisfaction of the habitual residency condition and is paid at a lower maximum rate.

There is no established rule regarding indexation of state pension payments in Ireland. State pension payment rates generally increased in line with government policy during the 2000s, although rates have been frozen since 2009 as per the condition in the MoU that state pensions not be increased over the term of the agreement.

A Household Benefit Package (HBP) is available on a mean-tested basis to those aged 65-69 and to all over the age of 70 years. The Package includes a supplement in respect of electricity/gas, a telephone allowance and free TV licence. The value of this package has been substantially reduced over recent Budgets.

All state pensions are provided via an unfunded pay-as-you-go system. The SCP is financed by the Social Insurance Fund (SIF) and the non-contributory state pension is funded by the Exchequer. Any shortfalls in the SIF are made up by the Exchequer. Pensions accounted for 60% of the SIF's expenditure in 2012 (OECD, 2013). The compulsory social insurance scheme in place has a base contribution rate of 14.75%, with employees (4%), employers (10.75%) and the self-employed contributing, subject to particular exemptions and different classification rules (see KPMG, 2012 for details).

Second pillar pensions operate on a voluntary basis with a very wide variation in coverage rates across the population. Supplementary pensions may be taken up via occupational schemes and personal pensions (including RACs and PRSAs). Most occupational schemes are funded, with the exception of public sector pensions, which are predominantly unfunded and operate on a PAYG basis.

The Exempt, Exempt, Taxed (EET) approach adopted in Ireland exempts pension contributions and the returns on investment from taxation, with the pension benefits taxable as income. Tax reliefs are available to employers and individuals (payable at one's marginal rate

of tax) to incentivise retirement saving through supplementary pensions. A temporary levy of 0.6% has been applied to the capital value of private pension assets since 2011 (see below).

2.1.3 Details on recent reforms

The main pension policy reforms of recent years have been heavily influenced by the emphasis on fiscal consolidation and the overall sustainability of the public finances. The National Pensions Reserve Fund (NPRF) was set up with the objective of providing a fund to defray public sector and state pension costs after 2025. However, legislation initiated in 2009 in response to the banking crisis enabled the NPRF to be used for the purpose of bank re-capitalisation. A major portion of the remaining Fund was subsequently incorporated into the terms of the MoU in 2010.

Public sector pension reforms introduced since 2009 include the introduction of a public service pension related levy (deductions amount to 7% on average) and reductions in current public service pension payments above €12,000 per annum (by 4% on average). The public service pension levy now generates over €900 million per annum. A new single career average based pension scheme with an increased retirement age and indexation linked to CPI was introduced for all entrants to the public service from January 2013.

A temporary pension levy (0.6%) was introduced in 2011 to fund the Jobs Initiative; this levy is applied to the capital values of assets in private pension funds and is expected raise almost €1.9 billion in the four years to 2014.

The increase in the state pension qualification age is to commence in 2014 when eligibility for state pensions will be raised to age 66 years. The speed of the implementation of this reform has given little time for workers, employers and pension schemes to prepare and there are concerns about its impact in this context.

The terms (and extent) of tax relief available for supplementary pensions has been the subject of reform in recent budgets although its core elements remain in place, despite greater attention to the equity of pension tax benefits and their efficacy. The previous government proposed significant change (Government of Ireland, 2010a, 2010b) and while recent budgetary measures have been introduced, as per conditions in the MoU, generating significant savings (estimated at €416 million per annum by the Irish Association of Pension Funds (IAPF, 2013a)), the current Minister for Finance indicated that pension tax relief will remain at the marginal rate of tax. A new cap on pension subsidies is to be introduced from 2014, which would limit subsidy to pensions generating retirement income in excess of €60,000 per annum.

Arising from the recommendations of a recent Critical Review (Steering Group Report, 2013), the government is reforming the existing governance and regulatory framework overseeing occupational and private pensions. These changes were included in the Social Welfare and Pensions (Miscellaneous Provisions) Bill 2013. The functions of the Pensions Board (to be re-named the Pensions Authority) will be split into the Pensions Council, which will review and advise the Minister on matters of pensions policy, and the Pensions Commission, which will oversee pensions regulation, with the position of the CEO of the Pensions Board being renamed the Pensions Regulator. The Offices of the Financial Services Ombudsman and the Pensions Ombudsman are also to be amalgamated.

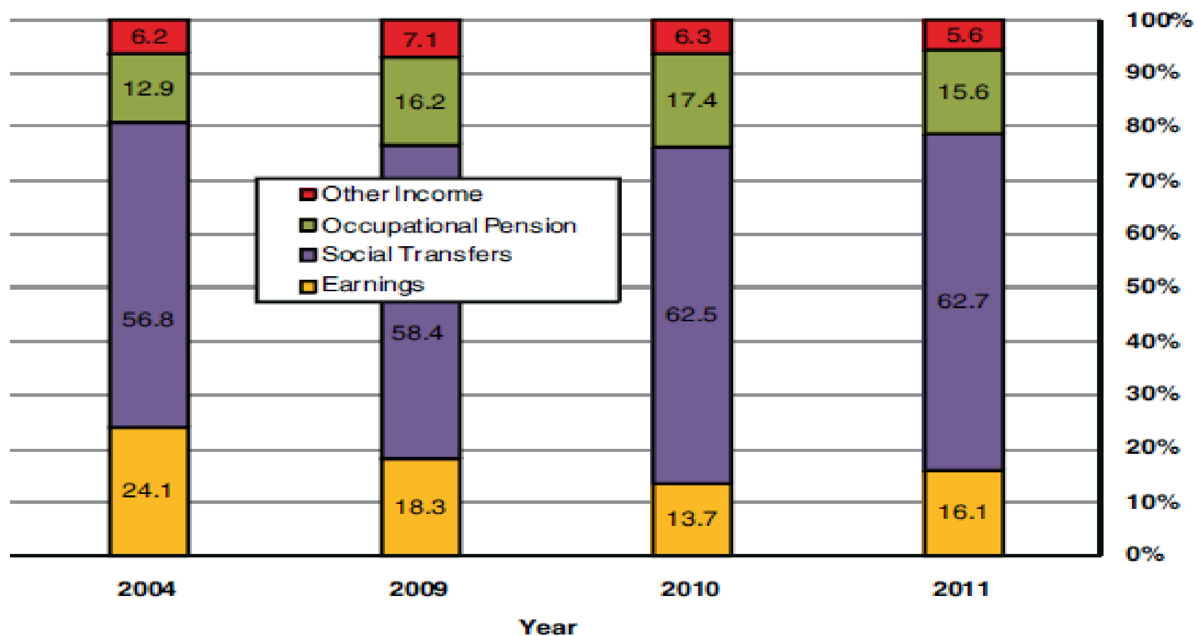
Key reports dealing with various aspects of the Irish pension system and its potential reform have been published over the last twelve months including a Report on Pension Charges in Ireland 2012 (Department of Social Protection, 2012a) and the OECD (2013) Review of the Irish Pension System.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Older people in Ireland derive their main income from social transfers across the board and state pensions continue to be the primary source of income for the majority of older people. The CSO/SILC (2013) data confirms that this trend has intensified since the crisis (see table below for details).

Table 1: Composition of average gross weekly equivalised income of persons aged 65+ (SILC 2004, 2009, 2010 revised and 2011.



(Source: CSO, 2013: 3 Figure 2)

Social transfers have become the most significant income source (37.3%) even for those in the highest income quintile in 2011 (CSO, 2013). The proportion of income derived from earnings fell from 41.5% to 26.5% for this group. Older people in the lowest income quintile remain most dependent on social transfers, which account for 85.6% of their total income.

Women continue to be more reliant on social transfers; in 2004, social transfers accounted for 63.3% of older women's incomes (49.1% for men) and this rose to 69.6% (54.4% for men) in 2010 and to 72.4% (52.3% for men) in 2011 (CSO, 2013). It is clear that any short-term policy reforms introduced in respect of social transfers will impact on the incomes of older people, and older women, in particular (See also Nivakoski and Barrett, 2012).

The at-risk-of-poverty rate for older people has fallen significantly from its very high level in the early 2000s (27.1% in 2004) to 9.7% in 2011 (CSO, 2013). This trend reflects the impact increasing state pension rates (particularly from 2004 to 2008) has had on poverty reduction among this cohort. The overall at-risk-of-poverty rate in Ireland declined in the initial phase of the crisis in 2009 (14.1%) but has since increased (16% in 2011). In the case of those aged

65+, the at-risk-of-poverty rate was at its lowest in 2010 (8.7%) and increased to 9.7% in 2011, although it remains the lowest rate of all age groups.

Higher risk of poverty exists among particular groups of older people including: those living in rural areas (almost 13%), those never married (13.7%), those with 'at work' as their principle economic status (18%), and those aged 80+ (12.5%) in 2011 (CSO, 2013). Deprivation rates have also increased for older people, from 9.5% in 2009 to 11.3% in 2011. Older people who described their health as bad or very bad were at significantly higher risk of deprivation (27.9%), as well as those not working due to illness/disability (25.2%) and those living in rented accommodation (22%).

The OECD (2013) draws attention to the poverty gap index, which for older people in Ireland was 24.7%, higher than both the OECD average (20%) and the EU27 average (15.7%) in 2010. In addition, older people in the lowest income quintile have seen the largest declines in income with average weekly equivilised income down 11.5% between 2009 and 2011 (Larragy, 2013). Income inequality has risen amongst this cohort, with the quintile share ratio rising from 3.8 in 2004 to 4.5 times in 2011 (Larragy, 2013). This data suggests that older people have been differently affected by the austerity measures introduced in recent years and the impact on the cohort of the most vulnerable older persons requires closer monitoring.

State pension rates have been frozen since 2009 and groups advocating on behalf of older people highlight how the incomes of older people have been impacted by expenditure reductions (cuts in the HBP, respite care grant, changes to the eligibility requirements for state pension) and by a range of revenue raising measures (including the Universal Social Charge (USC), property tax, carbon tax, VAT and prescription charge increases) introduced in recent years (Age Action, 2013; Older and Bolder, 2012).

The employment rate of older workers (age 55-64) increased in Ireland over the 2000s but has since fallen back. In 2011 the rate was 50.8%, higher than the EU average (47.7%) but behind the OECD average (54.4%) (OECD, 2013). The employment rate of 55-59 year olds was 58.8%, just below the EU27 average of 60.9%, while the rate for 60-64 year olds was 40.2% well ahead of the 30.7% EU27 employment rate in 2010. Ireland has one of the highest employment rates in the EU for those aged 65+ at 8.6% (Eurostat, 2012).

The average effective exit age from the labour market in Ireland is 63 years for both women and men (OECD, 2013). The OECD notes findings from the European Labour Force Surveys (2010), observing that unlike many other countries where retirement was the most significant reason for exit among this cohort, in Ireland men (43%) reported that unemployment and disability/illness were key reasons for exit, as did over a third of women in this cohort. Family and caring considerations were particularly significant for women with 13% indicating these factors affected their exit from the labour market.

While eligibility for the SCP has risen steadily in recent years there is a significant gender gap in evidence; 64% of men under 70 years received a social insurance pension while 58% of women of same age have no such entitlement and are in receipt of the social assistance based SNCP (OECD, 2013). Duvvury et al (2012) further note that women account for only a third of all SCP recipients and that of these women, only 27% receive the maximum payable rate.

In terms of future pension rights, changes are proposed to replace the current yearly averaging system of calculating social insurance pensions with a total contributions approach (30 years contributions for a maximum pension) to determine eligibility for the SCP by 2020 (Government of Ireland, 2010a; OECD, 2013). It is proposed that credited contributions would be limited to a period of 10 years under the total contributions approach.

Data from the most recent Actuarial Review of the Social Insurance Fund 2010 (KPMG, 2012) suggests that moving to a total contributions approach will have the effect of reducing

pension entitlements and replacement rates with just over half (52%) of state pension recipients expected to qualify for a full pension (90% or more of the maximum rate) in 2020. This projected outcome raises significant questions about the policy approach to pension adequacy for the period ahead. In addition, women are likely to be worst affected by this measure. Furthermore, present economic conditions militate against many workers having the capacity to make provisions to supplement their pension savings. The crisis has had a substantial impact on unemployment rates across the board and while older workers have not been worst affected, the short and longer term consequences remain significant as the unemployment rate for workers aged 55-64 has risen from 3% in 2005 to 9% in 2011 (OECD, 2012).

Future pension rights are also precarious for many DB scheme members in Ireland as the scale of the deficits and how these will be addressed has not yet been resolved in many cases. Waterford Crystal workers are awaiting a decision the Irish Courts in respect of the European Court of Justice ruling earlier this year and other cases have recently been brought before the Commercial Court. The Pensions Insolvency Protection Scheme (PIPS) introduced in 2010 would appear too restrictive in its existing criteria to offer protection to many occupational pension scheme members.

Finally, it should be noted that there are very many more workers with limited or no future pension rights at all accruing outside of first pillar state provision. Hughes (2013) highlights how the policy of incentivising supplementary pension cover has over time shifted the share of total pension resources to private provision, notwithstanding the fact that coverage rates have not substantially changed over this period. This points to the need for much greater attention to be given to how state interventions in pensions are shaped to maximise the pension adequacy outcomes for all.

2.2.2 Sustainability

The EUROPOP 2010 projections suggest that the highest population growth in Europe will be in Ireland, which is estimated to grow by 46% by 2060 (Eurostat, 2013). The old-age dependency ratio is expected to rise (by 19.4%) but to remain amongst the lowest in Europe.

The share of persons aged 65+ in Ireland is projected to grow from 11% in 2010 to 24% by 2060 (KPMG, 2012). The pension support ratio is to decline from 5.3 workers to 2.1 by 2060 (KPMG, 2012). The 2012 Ageing Report suggests that pension related spending will increase markedly in the coming decades, from 7.5% of GDP in 2010 to 11.7% in 2060. In comparative terms however, Irish pension expenditure is projected to be amongst the ten lowest of the EU27 in 2060 (OECD, 2013). When the impact of forthcoming increases in the state pension age are included in projections the pension support ratio may decline more gradually to 3.1 by 2040 and 2.5 by 2060 (KPMG, 2012).

Using and updating data from the 2012 Ageing Report to include recent policy reforms, KPMG's (2012) analysis projects an increase in the labour market participation rates of those aged 55-64 from 56% in 2010 to 64.9% by 2020, 66.9% in 2030, and falling back to 63.9% in 2060. The gender gap in participation rates is expected to have closed substantially by 2040.

In keeping with the recommendations of the European Commission (2012), the state pension qualification age will be 66 years for both men and women from 2014 and will increase to 68 years by 2028. This places Ireland with the group of country frontrunners in increasing the state pension age being introduced in a comparatively short timeframe. In this regard the OECD (2013:95) assesses that 'the scheduled increase in pensionable age is rapid enough to compensate for projected increases in life expectancy and thus to keep the time spent in

retirement relatively stable'. There are no plans to link the pension age to life expectancy at present.

Proposals contained in the National Pensions Framework (Government of Ireland, 2010a) included that provisions be put in place to allow individuals to postpone drawing down the state pension and to later receive an actuarially increased payment, and that a similar deferral would be possible for individuals wishing to make up contribution shortfalls by continuing to work and make paid contributions to a later date. These proposals have not yet been progressed.

In addition to the increase in the state pension age, other policy measures designed to enhance the sustainability of first pillar also have implications for pension adequacy as outlined above. These include the increases in the contribution criteria applied for receipt of the SCP since 2012 and the proposed move to a total contributions approach by 2020.

Part of the monitoring of the Irish Social Insurance Fund includes periodic actuarial reviews of the Fund conducted on behalf of the DSP. The most recent of these reviews was carried out by KPMG (2012) which suggests that pension related SIF expenditure will rise from 57% in 2011 to 85% in 2066. Taking this fifty year horizon and examining all SIF outlays, they estimate that significant deficits are likely with fund growth (3.5 times) well behind the overall rise in claims (5.3 times) on the fund. In this regard, the OECD (2013:69) notes that:

> 'These projections highlight a considerable fiscal challenge: benefit promises, particularly on pensions, are much larger than the revenue source meant to finance them. Moreover, this severely strains the widely valued "contributory principle" – the idea that people have paid for their State pension themselves – because contributions are projected to be only sufficient to pay for 58% of benefits over the period up to 2066.'

The results of the KPMG (2012) report and especially the projection that accumulated deficits of up to €324 billion were possible by 2066 were highlighted in the Irish media and generated some debate.

The Minister (Department of Social Protection, 2012b) acknowledged that 'the prospect of acceleration of this deficit in the future, represents a daunting challenge which must be addressed. This publication provides a platform for understanding the dynamics of funding for social insurance and a basis on which policy options for the future sustainability of the Fund can be explored'. Whilst urging caution in relation to the isolated use of these projected costs, the Minister also stated that 'these trends provide an impetus to take the first steps towards re-assessing the long-term sustainability of the Social Insurance Fund which is both fair and equitable to those contributing to social insurance and those receiving and expecting to receive benefits from it'.

The earlier National Pensions Framework (Government of Ireland, 2010a) also acknowledged the increasing challenges to and demands on the SIF. It indicates that Exchequer contributions were the norm to make up shortfalls for over forty years, until the Fund enjoyed a period in surplus after 1996. It notes however that greater account of the costs of benefits may have to be taken in setting social insurance contribution rates to ensure that, for example, voluntary and self-employed contributors are paying contributions at an appropriate level given the benefits they are accruing (Government of Ireland, 2010a: 20).

As attention shifts to the cost and long-term sustainability of the SIF, the findings of the value for money assessment of the SIF conducted by KPMG (2012: 10) are worth noting, and are outlined in their report as follows:

- Those on lower incomes fare considerably better than those on higher incomes.
- Those with dependants achieve better value for money (when assessing value for money on an individual rather than on a per household basis).
- Those with short contribution histories have the potential to fare better than those with full contribution histories.
- The Fund provides better value to female than to male contributors.
- The self-employed achieve better value for money compared to the employed – when the comparison includes both employer and employee contributions in respect of the employed person.
- For those at the higher end of the income distribution, the Fund is redistributive and these individuals generally get back less than they pay in.
- Higher value for money is achieved where benefits in addition to the State Pension (Contributory) are accessed.

The increase in the state pension qualification age coupled with the fact that there are no restrictions on working for those in receipt of the state contributory pension suggests that at one level, Ireland has put in place key policy measures which require prolonged working lives. However these system reforms do not take account of the varied working history and the need for more flexible and accommodating approaches to retirement in Ireland.

The OECD (2012) notes that while there is evidence of improved flexibility in working arrangements across the Irish labour force in recent years, in terms of older workers, 'not enough attention has been given so far to the set-up of more flexible work arrangements, the abolition of remaining early retirement schemes (still possible for civil servants) and the issue of mandatory retirement ages' (OECD, 2013:106). On the latter point, one element of the fiscal consolidation programme has been a targeted reduction in public service pay and numbers working in the public service. Incentivised retirement schemes were initiated in recent years, essentially encouraging early retirement from the public service as a cost saving measure.

The significant on-going and increasing long-term costs associated with public service pensions has been a focal point of much debate regarding pension system sustainability in recent years. A series of reforms were initiated (see above) which have resulted in a 12.6% reduction in the public sector pay bill between 2009 and 2012, although this has been offset to some degree by increases in the pension bill over this period. Public service pensions now account for 14.8% of total pay and pensions in the public service, which has risen from 8.5% in 2007 (Department of Public Expenditure and Reform, 2013a). The introduction of the new career average approach to public service pension entitlement is expected to generate significant savings by the middle of the century, reducing annual expenditure by up to 35%. The OECD (2013) report recommends more radical steps in this regard, and at a minimum, a fast tracking of the new scheme to cover existing public servants. It also advocates that any new private scheme be extended to public sector workers although this proposal has been the subject of particular criticism (ICTU, 2013).

2.2.3 Private pensions

Overall supplementary pension coverage in Ireland is similar to rates found in the UK, Germany and the USA, with data from the National Household Survey (CSO, 2011) indicating a coverage rate of 41.3% of the working population, aged 20-69 (OECD, 2013).

A key aspect of the pensions policy strategy (National Pensions Policy Initiative, 1998) since the 1990s was that specific targets were set in respect of supplementary pension coverage rates. For persons aged 30-65 the target coverage rate was 62% in 2002, 66% in 2008, with an overall goal of 70% coverage for this age group. Rates did increase for this cohort, from 57% in Q4 2002 to 61% in Q1 2008, but declined (to 59%) by the end of 2009 (CSO, 2011).

Participation in supplementary pensions remains very variable in Ireland, and is highly contingent on income, occupation, employment sector and number of hours worked. There is also a notable gender gap (10.3%) in respect of women's supplementary pension cover (OECD, 2013). Analysis of coverage by decile of earnings indicates that coverage rate rise sharply with income, from less than 20% for the two lowest deciles to over 94% coverage in the highest income decile (Callan, Keane and Walsh, 2009). This study also found that more than 80% of pension tax relief goes to the top twenty per cent of earners.

Highest supplementary coverage rates are found in the public sector owing to the existence of public sector pension schemes whereas the profile is considerably more unbalanced in the private sector. Kingston et al (2013) estimate that 59% of private sector workers have no private pension, 16% are DB scheme members and 25% have DC cover. Data from 2009 indicates that supplementary pension coverage remains highly uneven and variation has become more pronounced. Significant declines in coverage were found in the following sectors in particular: agriculture, fisheries and forestry (39% to 24%), wholesale and retail trade (37% to 30%), administrative and support services (36% to 29%), and in sales (33% to 25%) between Q1 2008 and Q4 2009 (CSO, 2011). Coverage for the self-employed (47% to 36%) and part-time workers (32% to 24%) also fell sharply over the same period.

In response to concerns about the possibility of excessive charging and fees being applied in certain parts of the private pension industry, a report was commissioned by the Minister for Social Protection to examine this matter. The Report on Pension Charges in Ireland 2012 (Department of Social Protection, 2012a) was the first of its kind and it draws attention to the wide variation in charges, with individual and small schemes in particular incurring higher costs. Shortcomings were also found in the provision of information on charges and the report makes a number of recommendations in this regard. Stewart and McNally (2013: 8) however drew attention to the need to further examine certain issues arising in the report and they argue that there is an 'absence of analysis or attempts to explain charging structures' which is problematic. It would seem that much closer examination and regulation is required to bring about greater clarity around pension charges and more transparency for individuals.

There is evidence of an accelerated demise in DB schemes in Ireland in recent years with over 80% of these schemes in deficit at the end of 2012 (Pensions Board, 2013a). Pension fund performance may have been better in 2012 but 'there has been no overall improvement in the position of defined benefit schemes' (Pensions Board, 2013a: 11). All DB schemes in deficit were obliged to submit revised funding standard proposals to the Pensions Board by the end of June 2013.

There were 11,258 fewer active members of occupational pension schemes registered with the Pensions Board in 2012 than in 2011. The number of PRSA contracts exceeded 200,000 for the first time since their introduction, with 206,936 contracts taken out to the end of 2012 (Pensions Board, 2013a). PRSAs are estimated to cover approximately 6.6% of the working age population (OECD, 2013) although concerns remain about whether sufficient

contributions are being made in a proportion of these to make them a viable income source in retirement.

A Consultation Paper has recently been issued by the Pensions Board (2013b) on the future of DC schemes in Ireland. It invites responses to a number of issues it has identified including the very large number of small and single member schemes, governance, regulation, investment, disclosure and value for money. It is possible that proposals for the reform of DC schemes will follow from this.

It is estimated that pension tax expenditures accounted for approximately €3 billion in revenue forgone in recent years. Budgetary measures have sought to generate savings in this area as outlined above. The existing system of tax incentives and subsidies has not been overhauled however despite policy recommendations in this regard (Commission on Taxation, 2009; Government of Ireland, 2010a, b). The OECD (2013: 10) report similarly notes that 'the existing tax deferral structure in Ireland provides higher incentives to save for retirement to high incomes as the incentives work through the marginal tax rates'.

Anomalies have developed in the tax treatment of different pension saving vehicles and the IAPF (2013a) has recently called for the establishment of a working group to address these problems.

Auto-enrolment was proposed in the National Pensions Framework (Government of Ireland, 2010a) to improve supplementary coverage rates. Under these proposals workers aged over 22 not in a pension scheme are to be automatically enrolled in a DC scheme, with contributions to be made by employees, employers and the state. The initial proposed date set by the previous government for its introduction was 2014 but this does not now seem likely. The DSP is considering the OECD (2013) review of the Irish pension system published earlier this year which may provide more detail regarding forthcoming plans in this area.

It is likely that overall coverage rates have fallen further as the economic crisis has become more protracted, incomes have declined, unemployment has risen and confidence in private pensions has been eroded. Only substantial equity centred pension policy reform will succeed in addressing the overall trends in supplementary coverage in Ireland. Careful consideration will need to be given to what policy options would deliver the most optimum and equitable outcomes (see discussion below).

2.2.4 Summary

The key strengths of the Irish pension system include a well-established, working and redistributive first pillar pension provision. Progress has been made in terms of improving the value of state pensions during the mid-to-late 2000s which resulted in lowering the at-risk of-poverty rates for older people during the latter part of the decade. There is a risk that the progress made during this period may unravel as more recent budget austerity measures have impacted on older people, and particularly older people with the lowest incomes.

Older workers within a few years of reaching the state pension qualification age may be viewed as a group that are exposed to the impact of current uncertainties. People born after 1949 in particular have been given relatively little time to prepare for the fact that their state pension rights have been delayed by one year. Some of this cohort may have either lost their jobs since the onset of the recession or the supplementary pension schemes of which they are members have come under considerable pressure in recent years. The decisive measures to improve the fiscal sustainability of the state pension system by way of increasing the state pension qualification age has yet to be accompanied by wider policy strategy to promote and enhance more flexible work and training options for this particular group.

The long-standing existence of supplementary pension arrangements may be viewed as a strength of the Irish pension system in terms of having in place some of the necessary infrastructure to encourage greater private pension saving into the future. However there are significant structural weaknesses with the existing model in terms of affordability, accessibility, equity and value for money. The system has not been designed to maximise any of the above and while significant pension tax benefits have been made available by the state, these have not been structured in a way that delivers maximum benefit to the exchequer or individual workers. The OECD (2013: 10) finds that 'private pension coverage, both in occupational and personal pensions, is uneven and needs to be increased urgently'.

The coverage rate has remained virtually unchanged over thirty years and with over half of the workforce without supplementary pensions under the current system, more substantial reform is long overdue. Whether this should necessarily involve greater private pension input and compulsion as per the OECD (2013) policy preference is also a legitimate question to examine, given that other policy options (including a universal basic pension, expanding the state system, greater flexibility in retirement arrangements and a single means-tested pension) have also been put forward (Hughes, 2013; Larragy, 2013; OECD, 2013).

People covered by occupational or private pension arrangements in Ireland are not immune to risk either and there is considerable unease about the present situation with regard to the crisis in DB schemes. Furthermore the pensions industry and others have repeatedly highlighted its concerns that many DC members' contributions are insufficient to provide an adequate pension in retirement.

The lack of certainty regarding the future of DB schemes and the position of its members remains a significant issue. Interim steps have had to be taken by the Department and the Pensions Board in recent years with regard to the funding standards and obligations of DB schemes. However, social partners came together to issue an unprecedented joint statement to highlight the ongoing concerns about the wind-up and restructuring rules attaching to DB schemes and, in particular, the impact of the 'priority order' which offers little protection or security to workers of these schemes, while retired scheme members are fully protected (IAPF, IBEC, ICTU, Society of Actuaries in Ireland, 2013).

Ireland entered a programme of financial assistance with the EU/IMF in 2010, and country specific recommendations have not been issued in that context. The terms of the MoU make reference to not increasing the nominal value of state pensions and indicate the savings to be made through reform of pension tax benefit measures. Against this backdrop of sustained fiscal consolidation over recent years, the very considerable growth in demand for the services and supports of the DSP overall and the ambitious activation reform agenda set out by the Department, it is hardly surprising that the reform of the Irish pension system is taking some time to develop. Overall though, an up-dated inter-departmental/government policy statement on the future of the Irish pension system could be important in addressing uncertainties arising from the issues and problems that currently exist.

2.3 Reform debates

Recent debates about pensions in Ireland have highlighted a range of issues across the system and attention has been brought to immediate problems as well as a number of longer-term concerns to do with pension adequacy, equity and sustainability.

Public and political debate has not cohered around one central theme or report in recent times. Attention to pension reforms has swung between a range of prescient issues ranging from:

- recent revenue raising budgetary measures and their impact (e.g. the 0.6% pension levy on capital assets in pension funds, the proposed cap on tax benefits to pensions accruing pension income in excess of €60,000 per annum, the impact of other revenue raising measures on pensioners with fixed incomes),
- recent expenditure cuts and their impact (e.g. the state pension and its protection from a rate cut in the early years of austerity to the cumulative impact of other cuts on older people e.g. the HBP, changes to the eligibility criteria for medical cards, reduced community care supports etc. as well as the impact of new taxes on older people with fixed incomes),
- the deficit problems of DB schemes, the impact of the revised funding standards, and the possible implications of the ECJ ruling in the case of the Waterford Crystal workers,
- the lack of equity between public sector workers and private sector workers in terms of access to good DB schemes and those without, and workers carrying the individual risks attaching to DC schemes, where they are members, and the large number of workers with no supplementary provision whatever,
- inequities in the pension tax benefit system, with differing perspectives being brought to bear on debate about the role and efficacy of providing tax relief at the marginal rate of tax,
- reaction to the Report on Pension Charges in Ireland 2012 (Department of Social Protection, 2012a) which varied from those who welcomed its overall findings and supported its recommendations, to those who assessed that the data did not allow for a full explication of the issues and variations in approaches to pensions charges.
- The Actuarial Review of the Social Insurance Fund 2010 (KPMG, 2012) generated some debate and concern about the sustainability of the fund and its future obligations.
- The publication of the OECD report on the Irish pension system in April 2013 resulted in some mixed reactions to its recommendations. The broad overview of the system and the comparative analysis contained therein was broadly welcomed. Many of the overall observations were endorsed in terms of re-iterating what many of the social partners and other interest groups had already identified as key problems. However, serious reservations were also expressed about some of the policy options put forward (IAPF, 2013b; ICTU, 2013) and calls were made for projected costings and closer consideration of how various options might be applied to existing system.

Pension system reform debates in Ireland continue to be significantly overshadowed by prevailing fiscal conditions and constraints. This is not surprising given the depth of the Irish crisis and the scale of the fiscal adjustment programme undertaken. The use of the NPRF for bank re-capitalisation and in the EU/IMF Programme of Financial Assistance has depleted the state's pre-existing pension reserves and its use in this way re-enforces the primacy of dealing with the immediate crisis and putting off some of the necessary structural reforms of the pension system until economic recovery is in sight.

The impact of the financial crisis on Irish pension funds has eroded trust in private pensions and the ongoing problems with DB schemes in particular has done little to restore confidence even though it is now some years since its impact was first felt. However, the rapidity with which particular reforms have been instituted (e.g. increase in the state pension qualification age and the new career average based public service pension) indicates a certain commitment to enhancing the sustainability of pensions in

Ireland into the future. Similar attention to issues of pension adequacy and equity is also crucial to assessing the cumulative impact of Irish pension system reform both in the short-term and in the decades ahead.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system and details on recent reforms

The current Programme for Government introduced in 2011 promised to introduce universal healthcare on the basis of need, not income (Government of Ireland, 2011). It committed to achieve this through the introduction of 'free GP care for all' by 2015 and universal health insurance by 2016 (Government of Ireland, 2011). In November 2012, the government published a document called 'Future Health' which outlined a road map for the commitments in the Programme for Government (Department of Health, 2012a).

The Programme for Government contained an ambitious programme of reform detailing 87 health commitments including the abolition of the Health Service Executive (HSE) which is the public health service. It states 'the HSE will cease to exist over time' returning its functions to the Minister and Department of Health' (Government of Ireland, 2011). It also committed to drive down the cost base of the health system. 'Future Health' outlined the approach to reform in four pillars:

1. ***Health and Well-Being***

Since the publication of 'Future Health', a new Health and Wellbeing Policy Framework was published called 'Healthy Ireland' (Department of Health, 2013b). This focuses on the need to move away from treating ill people to a new concentration on keeping people healthy. 'Future Health' and 'Healthy Ireland' recommend a whole-of-government approach to addressing health issues and commits to the development of a comprehensive implementation plan by the end of 2013 and the establishment of a Health and Wellbeing Agency (Department of Health, 2013b, Department of Health, 2012a).

2. ***Service Reform***

'Future Health' commits to reform health services that move away from the current hospital centric model of care 'towards a new model of integrated care which treats people at the lowest level of complexity that is safe, timely, efficient and as close to home as possible' (Department of Health, 2012a). This is intended to reduce costs, improve access, and move away from the existing emphasis on episodic reactive care towards preventative, planned and co-ordinated care (Department of Health, 2012a).

3. ***Structural Reform***

Future Health acknowledges that structural reform is complex. Its intent is to increase accountability. This includes abolition of the HSE Board, the establishment of a Directorate and a new management structure in the HSE. In July 2013, seven new HSE directorates were established in the areas of Hospitals, Primary Care, Social Care, Mental Health, Health and Well-Being, Child and Family (which is being separated from health services and a new Child and Family Agency is being set up).

The Programme for Government and ‘Future Health’ also outlined plans to reorganise all hospitals into hospital groups and trusts (Government of Ireland, 2011, Department of Health, 2012a). The groups will be established on an administrative basis, with Group CEOs having budgetary responsibility for both the HSE and voluntary hospitals in their group (Department of Health, 2012a). Two reports detailing the future of public and voluntary hospitals were published in 2013 detailing the setting up of seven hospital groups and the role of smaller hospitals (Department of Health, 2013f, Department of Health, 2013a).

‘Future Health’ also committed to review the Integrated Service Areas as well as executive management and governance arrangements which is planned to inform new structures for the delivery of primary care.

‘Future Health’ details the second and third phases, which will lead to the implementation of Universal Health Insurance (UHI) through the development of a formal purchaser/provider split and the dissolution of the HSE. It is planned that the system will move from a tax-funded system to a combination of UHI and tax funding. It states that the essential public nature of the health system will not be changed.

4. *Financial Reform*

‘Future Health’ acknowledges that the ‘financial challenges facing the health system are immense’ (Department of Health, 2012a). ‘Future Health’ outlines how financial control measures include the return of the Vote (budget) to the Department of Health from the HSE; the introduction of programme based budgeting through the new HSE directorates; as well as the development and roll-out of a comprehensive financial management system as a matter of priority.

A new ‘Money Follows the Patient’ (MFTP) funding model will be introduced ‘in order to create incentives that encourage treatment at the lowest level of complexity’ (Department of Health, 2012a). A policy document outlining some of the issues related to the introduction of ‘MFTP’ was published by the Department of Health (2013c). The ‘MFTP’ system will be designed so that ‘money can follow the patient out of the hospital setting to primary care and related services’ (Department of Health, 2013c).

‘Future Health’ also detailed how the reform of the delivery system will take place in Primary Care, Hospitals and Social and Continuing Care (Department of Health, 2012a).

3.1.2 System characteristics

The HSE provides care for the population with 101,435 staff (HSE, 2013b). In Ireland all health and social care comes under the remit of the HSE including residential and long term care for older people and care for people with disabilities. Until July 2013, the HSE was organised in four regions, through networks of 48 hospitals and 32 local health offices which provided health and social care. These regions and local health office are still in place, but there is a new HSE structure with seven directorates. How these will interact with each other is not yet clear.

While health services are provided locally and the aim of policy is to provide care at the lowest level of complexity, closest to people’s home, health policy and health service management is very centralised in Ireland (Department of Health, 2012a).

Ireland does not have universal healthcare system in that ability to pay can determine access to essential healthcare (O'Riordan, 2013, Department of Health and Children, 2010). It has a complicated mix of public, voluntary and private care (Wren, 2003, Burke, 2009).

In Ireland, public hospitals provide care to both public and private patients (Burke, 2009, Wren, 2003). Private care is meant to be capped at 20% of all treatment, however some hospitals provide private care for 30-48% of patients (HSE, 2013c). As both doctors and hospitals are paid a fee for service for private patients and salaries/annual lump sums no matter how many or how few patients they treat (Department of Health and Children, 2010), this provides incentives for hospitals to treat more private patients than they should. Private patients are also advantaged as they can afford to pay to see a specialist privately and gain faster diagnosis and treatment (O'Riordan, 2013).

Access to health and social care is determined by eligibility, those with full eligibility and those with limited eligibility. People with full eligibility have medical cards (Department of Health and Children, 2010). Technically, all Irish citizens are entitled to public hospital care without charge (for those with eligibility/medical card holders) or with a maximum charge of €750 per year no matter how much treatment received, for those with limited eligibility (capped at €75 a day for ten days).

Since the onset of the economic crisis, there has been a persistent increase in charges for other aspects of the 'free' public hospital system e.g. if one does not have a medical card and arrives in an Emergency Department without a letter of referral from a GP, there is a €120 charge, whereas four years ago it was €70 (Nolan, 2013 forthcoming). There are some services which are provided universally without charge such as public health nurses visits to new born babies, vaccinations and palliative care but with reduced staffing and budgets these services have come under pressure and are more limited in the service than the demand for them.

There have also been increased costs for private health insurance which rose 22% in 2011 and 16% in 2012 (Nolan, 2013 forthcoming). While some people have given up their health insurance because they cannot afford it, large numbers have held on to it. Ireland still had 45% of the population with 2,099,000 citizens with health insurance in December 2012, down from a high of 2,297,000 (50.9%) in December 2008 (HIA, 2013). Just over 200,000 have left the private health insurance market since it peaked in 2008, however many more have swapped insurance packages for less expensive and comprehensive cover (HIA, 2013). This means that more people are dependent on the public health system.

Also, there is increased rationing of what is covered by insurance companies with companies limiting what's available on different schemes. While health insurance tends to cover specialist and hospital care as well as other outpatient services such as MRIs and scans, most people take out health insurance as it enables speedier access to diagnosis and treatment in both public and private hospitals (Department of Health and Children, 2010, O'Riordan, 2013).

In June 2013, the highest number (1,868,565) and proportion (40%) of the population had medical cards reflecting higher rates of unemployment and declining incomes (HSE, 2013b).

Full eligibility (a medical card) entitles holders to GP, public hospital inpatient and outpatient care without charge, ophthalmic and maternity services and prescription drugs charged at €1.50 cent per item (capped at €19.50 per month).

The rest of the population pay €40-€60 for each GP visit and prescription drug charges up to €144 a month. Four years ago this charge was €80. Those with limited eligibility also have to pay privately for other allied health professions such as physiotherapy.

There are many criticisms of the Irish health system, including a disproportionate number of administrators in the system, long waits in Emergency Departments (EDs) and for elective care, the absence of consistent quality standards and performance. However, the biggest problem in the Irish health system is the inequality experienced by public patients who cannot afford to pay privately and gain faster access into the public system or avoid queues by going privately (O'Riordan, 2013, Burke, 2009).

3.2 Assessment of strengths and weaknesses

The Irish health system is facing considerable challenges trying to meet the needs of a growing, ageing population with a greater burden of disease despite a declining budget and staff since 2008/9 (HSE, 2013d). Despite the significant cuts of €1.5 billion and over 10,000 staff from the health budget and workforce, it has managed to continue to provide health and social care to the population.

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3.2.1 Coverage and access to services

Full eligibility (access to medical cards) has increased consistently since 2005 from 1,115,000 people covered then to 1,868,565 in June 2013 (HSE, 2013b). As full eligibility provides access to healthcare without charge, apart from prescription charges, it is considered a strong pro-poor measure (Layte, 2007).

However, there has been a slowdown in new people getting medical cards and greater rationing of discretionary medical cards. In the first six months of 2012, 127,000 gained full eligibility whereas in the first six months of 2013, there were 15,000 people who gained new eligibility (HSE, 2013b). Similarly in December 2012, 63,216 people had discretionary medical cards (given on the basis of medical need not income means tested), by July 2013 this had declined to 54,984 (HSE, 2013a).

Increased numbers have accessed the public health system each year during the crisis (Nolan, 2013 forthcoming). HSE figures show that from 2009 to 2012, the HSE managed to provide more care to more people with fewer staff and less money (Nolan, 2013 forthcoming). However, figures for 2013 show that the cut backs are impacting on hospital care with fewer inpatients and day cases in the first six months of 2013 compared to 2013 (HSE, 2013b).

Since 2008, there has been a substantial increase in hospital treatments with numbers of day cases rising considerably. While inpatient case declined between 2008 and 2010 in line with international practice of treating more patients as day cases, since 2011 there have also been an increase in inpatient treatments. Since 2008, there has been a steady increase in emergency presentations and admissions.

However, in 2013, there has been a decline in all hospital patients except for emergency admissions. For example between January and June 2012, there were a total of 494,425 day case and inpatient admissions compared to 491,197 in the first six months of 2013 (HSE, 2013b). There were 198,613 people admitted through EDs in the first six months of 2013, up 3% for the same period last year (HSE, 2013d, HSE, 2013b). There is a target that 95% of all ED attendees are admitted or discharged within six hours, in June 2013, 68.8% were admitted within six hours (HSE, 2013b).

Public patients may have to wait years for treatment. Recent research carried out by the Irish College of General Practitioners found significant differences in wait time for diagnostics between public and private patients. Specifically it found that

- public patients have an average 14 week waiting period for an ultrasound, whereas private patients have to wait four days for the same procedure;
- while 70-80% of GPs have no direct access to CT Scan, where it is available, there is an average 16 week wait. This varied from less than one week to 48 weeks. 90% of GPs have access to CT scans for patients who can afford to pay privately with an average waiting time of 5.5 working days.
- Approximately 10% of GPs have direct access to MRI Scan in the public system. The average wait for MRI Scan in the public system was 22 weeks varying from six days to 72 weeks. Whereas virtually all GPs have direct access to MRI Scan in the private sector within seven working days.
- The majority (86%) of GPs believed that increased access to diagnostics would reduce their referrals to emergency departments and improve the quality of their referrals.
- When questioned regarding out-patient departments (OPD) referrals, 90% felt that improved access would reduce their referrals to OPDs while 92% felt this would improve the quality of these referrals.
- Overall 87% believed that improved access to diagnostics would reduce unnecessary admissions (O'Riordan, 2013).

This government prioritised a reduction in waiting times for public hospital care and have achieved a reduction of the longest waiters (SDU/NTPF, 2013). There was some progress in reducing waiting times in 2012 but this improvement was lost towards the end of 2012 and through 2013 perhaps reflecting the impact of the cut backs on hospital capacity. In August 2012, there were 386 people waiting over 12 months, 2,199 nine to 12 months, 8215 between six and nine months, 21,063 between three and six months and 43,051 between zero and three months (SDU/NTPF, 2013). By August 2013 there were 1,003 people waiting over a year for treatment, 4,729 waiting nine to 12 months, 12,277 waiting six to nine months, 26,933 waiting three to six months, 49,695 waiting zero to three months (SDU/NTPF, 2013).

In 2012, the HSE started publishing out-patient wait times, this found 384,446 people waiting for a public outpatient hospital appointment, with 17% of these waiting between 12-24 months, 6.4% waiting 24-36 months, and 5.2% waiting over three years for a first appointment (HSE, 2012b). In June 2013, of all people waiting for first outpatient appointment, 23% (87,837) were waiting more than a year for first appointment (HSE, 2013b). If one is a public patient, there are long waits for hospital treatment, whereas if one is a private patient, one can get private treatment in a matter of days or weeks in both public and private hospitals (Wren, 2003, Burke, 2009).

Home care services in the form of home help and home care packages were formalised in the mid-2000s. In line with government policy of caring for people at home and in the community, there was a substantial increase in home help hours and home care packages up to 2008. Since 2008, there has been a steady decline in both, reflecting cuts to overall health budget and staffing. In 2005, seven million home help hours were provided. By 2008, this had risen to 12.6 million hours. In 2012, 9.8 million hours were provided, over 2.7 million fewer than four years previously (Nolan, 2013 forthcoming).

3.2.2 Quality and performance indicators

While performance indicators are now published on a monthly basis in the HSE performance reports, they are largely quantitative, detailing how many people used a specific service, how much was spent, or how many staff there (HSE, 2013b, HSE, 2013c). Examples of performance indicators collected and published by the HSE monthly include

- Numbers waiting more than four weeks for an urgent colonoscopy
- % of elective patients admitted on same day as procedure
- Surgical readmission to same hospital within 30 days of discharge
- Average length of stay for medical and surgical patients
- % of children aged 24 months who have received MMR vaccine
- % of new born babies visited by a PHN within 48 hours of hospital discharge
- Numbers of PCTs implementing the national integrated care package for diabetes
- % on waiting list for first appointment with a child and adolescent mental health team
- Numbers of admissions to adult acute inpatient mental health service units
- Total number of home support hours provided to adults and children with a physical and or sensory disability
- Numbers of older persons in receipt of a homecare package
- % of individual service users admitted to residential homeless services who have medical cards (HSE, 2013b).

As yet, there are still very few quality or outcome measures in the Irish health system.

After a series of incidents regarding poor quality in the Irish hospitals, HIQA has published reports on these hospitals (HIQA, 2008b, HIQA, 2008a). In 2012, HIQA published standards new standards called ‘Safer, Better Healthcare’ (HIQA, 2012). However hospitals are not currently inspected for such standards and there are no set standards for other health and social care services outside of hospital settings. Only when all hospitals both public and private are licensed will independent inspections begin. This requires legislation that has not been drafted so it is likely to be years away.

In the meantime some aspects of the system are inspected. For example there have been a series of recent reports by HIQA on hand hygiene showing levels hand hygiene well below targets set by the HSE and standards set by the WHO (HIQA, 2013). Inpatient mental health units are also independently inspected by the Mental Health Commission and in 2013, independent inspections began on all residential services for people with disabilities.

3.2.3 Sustainability

Since 2008, there have been a series of budgets resulting in considerable reductions in public expenditure including declines in the Irish health budget (Nolan, 2013 forthcoming). Ireland’s health expenditure has declined by over €1.5 billion since 2009, declining from €15.6 billion in 2009 to €13.8 billion in 2013, representing a 9% contraction in the health budget (Department of Public Expenditure and Reform, 2012). The overall HSE budget for 2013 is €12.3 billion.

In October 2012, a supplementary budget was given to make up the overspend of €360 million in public health spending (Department of Public Expenditure and Reform, 2013). This demonstrates the ongoing challenge for the health services to operate within budget and to continue to provide safe services to a growing, ageing population with greater burden of chronic disease despite fewer staff and less money (Nolan, 2013 forthcoming). It may also be an indicator that the health system reached its capacity in 2012, that it can no longer continue to do more with less.

Although there were no health conditions contained in the initial MoU, subsequent quarterly reports have highlighted where efficiencies can be achieved in the health system including the high price the Irish health system pays for drugs, the high pay of hospital consultants and the failure of the government to deliver reforms on which savings are dependent such as charging for private patients in public hospitals (European Commission, 2012).

Reductions to the health budget have been achieved since 2009 through reducing the HSE workforce from 112,000 in 2008 to 101,435 in June 2013, reduction in pay for public health system staff, increased charges and the contraction of some services (HSE, 2013c, Nolan, 2013 forthcoming). The EU/IMF agreement stipulated a large reduction in public sector numbers (Department of Finance, 2010).

As stated above, 45% of the population have private health insurance and many aspects of the Irish health system require out of pocket payments. Due to the absence of data on private health spending it is very difficult to estimate how much money is spent on health and social care privately. OECD data show that public expenditure on health as a percentage of total expenditure on health reducing from 75.7% in 2007 to 67% in 2011, the most recent year available (OECD, 2013). This same data also shows that out of pocket expenditure as a proportion of all health expenditure increased from 14.8% in 2007 to 18.1% in 2011 (OECD, 2013). This reflects the significant decline in the public health budget and a government health policy of shifting the cost of care from the state to the people. This is evident in increased charges introduced in consecutive budgets since the onset of the economic crisis in 2008. Examples of increased charges are

- In 2008, it was €60 a day, capped at ten days per year (€600) for all public hospital treatment and €60 charge for emergency departments for all without medical cards. By 2013, this had risen to €80 per day, capped at €800 and €120 Emergency Department charge (Nolan, 2013 forthcoming).
- Up to 2009, there were no charges for prescription charges for medical cards. Budget 2010 introduced prescription charges for people with medical cards of 50 cent per item, capped at €10 per month. These were increased in Budget 2013 to €1.50 per item, capped at €20. People without medical cards paid up to €85 per month for medications in 2008, in 2013, this had risen to €144 (Nolan, 2013 forthcoming).

3.2.4 Summary

Ireland’s public health system has experienced constant flux since the abolition of the health boards in 2004 and establishment of the HSE in 2005. The HSE has been consistently restructured and reorganised since its inception (Burke, 2009). Since 2007, there have been continuous reductions in staffing and since 2009 significant budget cuts (Nolan, 2013 forthcoming).

Up to 2012, despite these constraints, the HSE managed to provide more care to more people, despite fewer staff and less money. However, what is evident in the last year is that the HSE is now doing less with less, apart from areas out of its control such as numbers of emergency

presentations (Nolan, 2013 forthcoming, HSE, 2013b). This is evident in the cuts to the numbers of homehelp hours and increasing numbers waiting for hospital treatment.

The majority of the reduction in health costs is due to unilateral public sector wide cuts to the pay of HSE staff and to professionals contracted by the public system (Nolan, 2013 forthcoming). There has also been sustained attempts to reduce the cost of drugs which has also had some effect (Nolan, 2013 forthcoming).

Another key driver of health reform that goes largely below the public and political radar are the clinical care programmes, these are being rolled out for all diseases and conditions based on the cancer control and acute medicine programme and are beginning to show positive results (HSE, 2010). The clinical programmes have a strong emphasis on improving the quality of care received by patients and improved outcomes. Whether progress made in these areas can be maintained in light of further staff and budget cuts remains to be seen.

3.3 Reform debates

The 2011 Programme for Government and the subsequent document 'Future Health' detail the most radical reform plans in the history of the state. Ireland currently has a complex health system, with complex financial, organisational and eligibility arrangements. This huge scale reform is also taking place in the context of an economic crisis and severe cut backs to the public health budget.

There is much focus in public and political domains on the failure of the HSE to live within its budget. In November 2012, a supplementary budget of €365 million had to be made to the HSE (Department of Public Expenditure and Reform, 2013). The most recent figures for 2013 show the HSE is €63 million over spent (HSE, 2013b).

The main driver for health reform in Ireland is the plan to introduce Universal Health Insurance and free GP care by 2016. Progress has been slow on delivering on this reform. The Programme for Government committed to free GP care for those on the Long Term Illness Scheme by 20 March 2012 and for those on the high tech drug scheme by March 2013. Neither of these deadlines have been met. The government says it was not possible legislate for this and are now talking about introducing free GP care for under five years olds. There is no clarity on how they plan to extend free GP care to the whole population by 2016.

The Programme for Government promised a White Paper on Universal Health Insurance, early in the first term (Government of Ireland, 2011). Government published a policy document called 'The Path to Universal Healthcare – Preliminary Paper on Universal Health Insurance' and has committed to publish a White Paper by the end of 2013 (Department of Health, 2013e). Simultaneous to the publication of the paper on UHI, the Department of Health also published a document on 'Money Follows the Patient' which it states is an essential stepping stone to UHI (Department of Health, 2013c). While MFTP has been piloted and is intended to be rolled out in 2013, the vast majority of hospital budgets are not paid through MFTP.

The government also published two documents in early 2013 on the development of hospital groups and the role of small hospitals (Department of Health, 2013a, Department of Health, 2013f). Three of the seven hospital groups have been established and the others are progressing. There have also been a series of reforms of the private health insurance market including the Health Insurance (Amendment) Act 2012 which came into effect in January 2013.

All of the above reforms are cited by government as stepping stones to Universal Health Insurance. However, there is still no detail on what type of universal health insurance Ireland is going to have. Also all these reforms are taking place in the context of a declining budget, so some government policy is contradictory to other parts of it. For example, the overall thrust of government reform is about universal access, yet austerity measures mean that there are greater barriers to health services such as increased costs of prescription medicines, hospital stays and private health insurance (Nolan, 2013 forthcoming). Also it is not clear if some policies are coherent with each other, for example how do MFTP, the formation of hospital groups and trusts and a multiple competing health insurance system fit with each other.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system and details on recent reforms in the past 2-3 years

The current Programme for Government committed to extensive health reform, it specifically committed to publish a National Positive Ageing Strategy 'so that older people are recognised, supported and enabled to live independent full lives' (Government of Ireland, 2011). In 2012, a National Carers Strategy was published and in 2013, the new National Positive Ageing Strategy was published (Department of Health, 2012b) (Department of Health, 2013d).

The National Positive Ageing Strategy, published in 2013, is the first policy document focussed on older people since the publication of The Years Ahead in 1998. Within Ireland's health reform programme, and of key relevance to the implementation of the National Positive Ageing Strategy, is Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025 (Department of Health, 2013b).

The National Positive Ageing Strategy and Healthy Ireland take a whole government, whole of society approach, to health and well-being, addressing the broader determinants of health (Department of Health, 2013b, Department of Health, 2013d). Specifically, the National Positive Ageing strategy commits to addressing the following priority areas:

- Healthy ageing
- Health and personal social services
- Carers
- Employment and retirement
- Education and lifelong learning
- Volunteering
- Cultural and social participation
- Transport
- Financial security
- Housing
- The built environment
- Safety and security
- Elder abuse.

The Positive Ageing Strategy is the over-arching blueprint for age related policy and service delivery across Government and society in the years ahead (Department of Health, 2013d). A detailed implementation plan is due to be published for the Positive Ageing Strategy by the end of 2013. The Programme for Government also committed to the publication of a National Alzheimer's and Dementia Strategy in 2013. To achieve this, the Department of Health carried out an extensive consultation process in 2012 although the strategy is not yet published.

The Nursing Home Support Scheme (NHSS) was introduced in 2009 with the aim of providing consistency in how nursing home care was funded by the State and individuals. It aimed to 'make long term nursing home care accessible, affordable and anxiety free' (Department of Health and Children, 2009). It replaced a Nursing Home Subvention Scheme

which hugely subsidised some people's care but left many paying for the majority of the extremely high costs of their care (Department of Health and Children, 2009).

All nursing homes both public and private are eligible for the NHSS. Under the scheme people make a contribution of 80% of their income and 7.5% of the value of any assets towards the cost of care and the State will pay the balance. The first €36,000 of assets, or €72,000 for a couple, is not counted in the financial assessment. Where assets include land and property in the State, the 7.5% contribution based on such assets may be deferred and collected from your estate. This is an optional Nursing Home Loan element of the scheme (HSE, 2012a). The Programme for Government committed to reviewing the NHSS in 2013 which is currently taking place (Government of Ireland, 2011).

There has been a consistent decline in public nursing home facilities since and an increase in private facilities, encouraged through generous tax breaks introduced in 2001 and 2002 (NHI, 2011). For example, the NHI 2010 survey found 9,633 public beds, whereas most recent HSE figures show 5,054 public beds (NHI, 2011, HSE, 2013b). The NHI also details how the numbers of private nursing home bed numbers for older people increased from 14,946 in 2003 to 20,950 in 2010 (NHI, 2011). While some of the NHI survey beds could be short term, convalescent and disability beds, many public beds have shut in the last three years. This is a combination of the shortage of funding and many of the public facilities are in old buildings which do not meet new quality and safety standards.

4.1.2 System characteristics

Recent figures show there are currently 21,967 people funded by the HSE in long term residential care (HSE, 2013b). These figures show there are currently 5,056 people in public nursing homes, 14,942 in private sector and 1,849 in 'subvention' and 'contract' beds which are also private sector beds (HSE, 2013b). While the vast majority of these are over 65, some of them may be people with long term residential needs who are under 65 years of age. It is not possible to get an age break down of those funded.

The NHI survey found different figures. Its latest 2010 survey found a total of 30,223 public and private nursing homes beds, 20,590 in private sector, 9,633 in public sector, totalling 30,233 (NHI, 2011). These figures also include people with disabilities who are under 65 and in need of long term care. They also include short term and convalescent beds and empty beds.

The NHI survey found that 4% of residents were under 65 years of age, 11% were between the ages of 65 and 75, 37% were 76 to 85, while 48% were aged over 85 years (NHI, 2011). This survey also found 16% of residents were low dependency, 30% medium dependency, 54% were high dependency (NHI, 2011). It also found that in 2010, there were 15.5 people aged 65 and over per nursing home beds (NHI, 2011).

Home care services in the form of home help and home care packages were formalised in the mid-2000s. In line with government policy of caring for people at home and in the community, there was a substantial increase in home help hours and home care packages up to 2008. Since 2008, there has been a steady decline in both, reflecting cuts to overall health budget and staffing. In 2005, seven million home help hours were provided. By 2008, this had risen to 12.6 million hours. In 2012, 9.8 hours were provided, over 2.5 million fewer than four years previously (Nolan, 2013 forthcoming).

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

Access to health and social care services, apart from long term residential care as detailed above, is the same for those over 65 as under 65. These issues were dealt with in the previous section on healthcare.

4.2.2 Quality and performance indicators

Since 2008, there have been independent, unannounced inspections of all public, private and voluntary nursing homes. These inspections are carried out by HIQA – the Health Information and Quality Authority (HIQA – www.hiqa.ie). HIQA have published standards for residential care and publish regular inspections of nursing homes - http://www.hiqa.ie/social-care/find-a-centre/inspection-reports?field_report_type_centre_value_many_to_one=reportolderpeoples

There are no independent inspections of home care services for older people. Home care is provided in three ways – the HSE has staff who directly provide homecare, the HSE contract the private sector to provide homecare and people buy homecare privately.

Since July 2012, approved service providers are available locally for clients requiring home care services under the Home Care Package Scheme. The approved providers, appointed under the tender process, meet a new uniform level of national standards. All of the Approved Providers have committed to meeting the new minimum required standards, this a first step in an overall plan to raise standards of home care provision. It is planned that home care services will be independently inspected but legislation is required to do this and there is no date by when it shall be in place.

4.2.3 Sustainability

Similar to other high income countries, Ireland is grappling with the sustainability of its long term care system especially long term residential care. When the NHSS was established, it was expected that significant income would be gained through a contribution of up 15% of assets for those whose income was over a certain amount. Due to the economic crises, the value of all assets especially property has declined. This means a smaller private contribution to long term care. In 2011/2, new entrants to the NHSS was suspended for short periods of time due to lack of money. In 2013, significant wait times emerged for nursing home places funded by NHSS again reflecting the constrained budget. The NHSS is currently being reviewed.

4.2.4 Summary

Similar to the health system, long-term care faces considerable challenges – how to meet the needs of a growing ageing population with a greater burden of chronic disease and multi morbidities with fewer staff and less money.

4.3 Reform debates

Apart from cuts to the home help hours and waiting times for securing a NHSS funded nursing home place, there is not much public debate about long term care. The cuts to the home help budget expose the gap between policy and practice, while it is government policy to provide ‘more and better care for older people’ and to provide care in the community, the

reality is that services in the community are being cut for older people (Government of Ireland, 2011, Nolan, 2013 forthcoming).

In nursing homes, there has been a continuous decline in public nursing home bed numbers, which is expected to continue as many are in buildings which no longer meet safety requirements. There is a continued increase in the numbers of beds in private nursing homes.

While two new government policies relevant to older people have been published – the Positive Ageing strategy and Healthy Ireland, they are without detailed action or implementation plans and there is not much hope that they will be implemented in the context of continued economic constraints.

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DEPARTMENT OF HEALTH 2013d, The National Positive Ageing Strategy, Positive Ageing! Dublin: Department of Health.

DEPARTMENT OF HEALTH 2013e, The Path to Universal Healthcare - Preliminary Paper on Universal Health Insurance. Dublin: Department of Health.

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Annex – Key publications

[Pensions]

CSO 2013, Survey on Income and Living Conditions (SILC) Thematic Report on the Elderly 2004, 2009, 2010 (Revised) and 2011, 15 August 2013. Cork: CSO.

This study presents the findings of the SILC as pertain to older people, aged 65+ in Ireland. Details of the composition of gross weekly equivalised income, the at-risk-of-poverty and consistent poverty rates and enforced derivation rates of older people are documented.

CSO 2011, Quarterly National Household Survey Pension Provision Quarter 4 2009, 21 April 2011, Cork: CSO.

This report outlines the findings from a special module on supplementary pension coverage among workers (20-69 years) included in the Quarterly National Household Survey conducted in Q4 2009. It includes information on the rates and type of supplementary pension cover across the sample, the reported reasons for not having a pension, expectations of retirement (age/income) and contributions to pensions.

DEPARTMENT OF SOCIAL PROTECTION 2012, Report on Pension Charges in Ireland 2012, Dublin.

This report was commissioned by the Minister for Social Protection and is the first government report of its kind in Ireland. The report set out to examine the level of pension charges applied to pensions to assess whether charges are reasonable and transparent. It finds considerable variation and notes that smaller schemes and individual arrangements to be more expensive. A need for clearer information and greater transparency is noted in the report and it puts forward a range of recommendations for greater monitoring and transparency in this area.

KPMG 2012, Actuarial Review of the Social Insurance Fund 31 December 2010.

As per the Social Welfare Consolidation Act 2005, the actuarial position of the Social Insurance Fund is to be reviewed at five yearly intervals and KPMG were appointed to undertake this task on behalf of the Department of Social Protection in 2010. A 55 year projection period is covered (2011-2066) and account is taken of all legislative changes and proposed reforms of relevance to the operation of the Fund. The report draws on the EUROPOP2010 projections as contained in the 2012 Ageing Report and results from the Census 2011. The report is expected to inform national policy development in the period ahead.

OECD 2013, Review of the Irish Pension System, Paris: OECD.

This is a wide ranging review of the Irish pension system, which was conducted at the request of the Minister for Social Protection. The review was carried out with attention to four specific objectives: sustainability, adequacy, modernity and equity. This report provides an international perspective on various aspects of pension policy and reform and sets out a number of findings in which it highlights various shortcomings in the existing system. Options are laid out in respect of reform of state pensions and a range of other recommendations are put forward on public service pensions, expanding private pension provision, improvements to the set-up of DC schemes and in the benefit security of DB schemes.

LARRAGY, A. 2013, A Universal Pension for Ireland, Policy Research Series, Social Justice Ireland, September 2013, Dublin: Social Justice Ireland.

This study provides a brief overview of the Irish pension system before outlining detailed proposals for the development of a universal basic pension in Ireland. It examines the costs and proposes a financing model as well as consideration of the transition to a universal penions and its long-term sustainability.

[Health and long-term care]

DEPARTMENT OF HEALTH, Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015, 2012, Dublin.

This provides a road map for the details of the health reform outlined in the 2011 Programme for Government.

DEPARTMENT OF HEALTH, National Carers Strategy, 2012, Dublin.

This is the new national carers policy which sets out a vision to work towards, and an ambitious set of National Goals and Objectives to guide policy development and service delivery, the Strategy seeks to ensure that carers feel valued and supported to manage their caring responsibilities with confidence and are empowered to have a life of their own outside of caring.

DEPARTMENT OF HEALTH, The Establishment of Hospital Groups as a transition to Independent Hospital Trusts, 2013, Dublin.

This document details the establishment of six new hospital groups (seven including the new children's hospital group). The groups will be established initially on an administrative basis and then on an executive basis. In time hospital trusts will be established.

DEPARTMENT OF HEALTH, Healthy Ireland - A Framework for Improved Health and Well-Being 2013-2025. 2013, Dublin: Department of Health.

This is the first public health strategy published by the Irish government. It outlines a cross departmental, multi-disciplinary approach to individual and population well being as well as seeking to reduce health inequalities. A detailed implementation plan is due to be published by year end.

DEPARTMENT OF HEALTH, Money Follows the Patient - Policy Paper on Hospital Financing, 2013. Dublin.

This policy paper outlines how a 'Money Follows the Patient' system of payment can be introduced to all Irish hospitals, following the piloting of Money Follows the Patient.

DEPARTMENT OF HEALTH, The National Positive Ageing Strategy. Positive Ageing! 2013, Dublin: Department of Health.

This is the new policy on Positive Ageing. Similar to Health Ireland, it details a cross departmental and multi-disciplinary approach to promoting positive ageing. A detailed implementation plan is due by the end of 2013.

DEPARTMENT OF HEALTH, The Path to Universal Healthcare - Preliminary Paper on Universal Health Insurance, 2013, Dublin.

This is a preliminary paper on the introduction of a universal health insurance model into the Irish health system. A White Paper on Universal Health Insurance is due to be published by year end.

DEPARTMENT OF HEALTH, Securing the Future of Small Hospitals, 2013, Dublin.

This policy document accompanied the publication of the report on Hospital Groups, specifically detailing the important role that small hospitals can play in the delivery of healthcare.

DEPARTMENT OF PUBLIC EXPENDITURE AND REFORM 2012, Expenditure Report 2013, Dublin: Department of Public Expenditure and Reform.

DEPARTMENT OF PUBLIC EXPENDITURE AND REFORM 2013, Revised Estimates Volume 2013, Dublin: Department of Public Expenditure and Reform.

These reports detail the money allocated to health and social care in 2012 and 2013.

HIQA 2012, National Standards for Safer and Better Healthcare, Dublin: HIQA.

These standards are aimed at protecting patients and they provide, for the first time, a strategic approach to improving safety, quality and reliability in our health services. They will form the basis for future regulation, inspection and licensing of all healthcare facilities in Ireland.

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HSE 2012, Outpatient Data Quality Programme Update, February 2012, Dublin: HSE.

This is the first time oputpatient data has been published. It is updated in the HSE PR reports and in the briefing from the SDU/NTPF outlined below.

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This documents details the amount of money allocated to the health service for 2013, staffing levels and the extent of services to be provided in the year ahead.

HSE 2013, HSE Monthly Performance Report, July 2013, Dublin: HSE.

HSE 2013, HSE July 2013 Supplementary Data Report Performance National Service Plan Dublin: HSE.

These reports are published monthly and provide the most recent available data re performance in the health system.

NOLAN, A., BARRY, S, BURKE, S, THOMAS, S. Observatory-WHO study on the impact of the financial crisis on health and health systems in Europe, Case Study Ireland 2013, London: WHO European Observatory on Health Systems.

This research carried out by the ESRI and Trinity College Dublin's Centre for Health Policy detailed the impact of the economic crisis on the Irish health system for publication by the World Bank.

O'RIORDAN, M., COLLINS, C, DORAN, G. Access to Diagnostics - a key enabler for a primary care led health service, 2013, Dublin, ICGP.

This research carried out by the Irish College of General Practitioners provided for the first time detailed information on the differences in time delays experienced by public and private patients in accessing key diagnostic services.

SDU/NTPF, Special Delivery Unit/National Treatment Purchase Fund Unscheduled Care/Scheduled Care August Performance Report, 2013, Dublin.

The Special Delivery Unit moved into the HSE in 2013 and merged with the National Treatment Purchase Fund. This is a report published in August 2013 on wait times for emergency and scheduled hospital care. It also provides details on wait times for all first outpatient appointments.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)

This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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