Analysing FairCare, Fine Gael's Proposal for Mandatory Universal Health Insurance.

Dominic Haugh, 18th February 2011

Summary of main points –

1. **The Netherlands has gone from a two-tier health system to a three-tier health system. Almost half a million people are now uninsured or defaulting on the health insurance payments.**
2. **Private health insurance companies are findings ways to circumvent the ban on 'risk selection'.**
3. **The current cost of the Universal Health Insurance basic package in the Netherlands is €1194 per person for this year. On top of that Employers deduct a further 6.9% of a workers income up to a ceiling (€2233 in 2009).**
4. **With annual income running at €53,000 per household, the annual cost of health insurance is somewhere between €4,525 and €5,625, or 8.6 to 10.7 per cent of household income.**
5. **Since the introduction of Universal Health Insurance in 2006, premium costs have risen by 41% and could double from the current rates by 2014.**
6. **More than 50% of the hospitals in the Netherlands are facing bankruptcy as a result of the introduction of Universal Health Insurance in 2006.**
7. **There has been a significant and continuing increase in healthcare costs since the introduction of Universal Health Insurance in 2006.**
8. **The necessity to negotiate and implement 30,000 Diagnosis Treatment Combinations (DBCs) between private health insurance companies and individual hospitals has led to a massive bureaucratisation of the system.**
9. **It is not known how many hospital beds there actually are in the Netherlands.**
10. **The Dutch healthcare system has growing waiting lists and short-notice postponement of operations.**
11. **The Dutch healthcare system is no better than average in comparison with other wealthy countries.**
12. **41% of people say that the quality of the health system has worsened since the introduction of Universal Health Insurance in 2006, while 8% indicated that it had improved.**

Analysing FairCare, Fine Gael's Proposal for Mandatory Universal Health Insurance.

In the run up to the election on 25th February Fine Gael has published it "***FairCare"*** plan for the provision of health services in this country.

Fine Gael's ***"FairCare"*** proposals are stated to *"represent the most fundamental reform of the health system since the formation of the State. We will abolish long-term waits on trolleys in A&E, slash waiting lists in hospitals, and eliminate the unfair and inefficient public/private divide by introducing Universal Health Insurance."* [1]

Slashing waiting lists is a laudable target, yet the reality is that at every election, every political party promises to slash waiting lists. However, the proposal to introduce a Universal Health Insurance system deserves to be analysed.

What type of Universal health Insurance system does Fine Gael propose to introduce?

"Fine Gael proposes to introduce the Dutch model of UHI in Ireland, with mandatory health insurance for everyone, to be chosen from a selection of providers." [2]

Why has Fine Gael decided to go down this route? Well Fine Gael seem to have found a very solid argument for adopting the Dutch model of Universal Health Insurance.

"Fine Gael has looked in some detail at the Dutch model. The 2008 Euro Health Consumer Index (EHCI) report suggests that the Netherlands is the most successful health system in Europe." [3]

Fine Gael produces further evidence that Universal Health Insurance would significantly increase the quality and standard of health care in Ireland for all the population –

"REFORM, an independent think-tank, has looked at a variety of international case studies. It has concluded that insurance incentives in healthcare are vital because they:

- *Achieve greater value.*
- *Help de-politicise healthcare.*
- *Provide reasons for individuals and authorities to value long term improvements in health and wellbeing; and*
- *Define exactly what individuals are covered for, ending postcode lottery and empowering individuals to demand their rights from providers.*
- *For all of these reasons, we propose that Ireland should move from its current taxbased system to a UHI system."* [4]

Impressive stuff no doubt! But would you be surprised to be told that all may not be as is claimed by Fine Gael. This article will look that the *Euro Health Consumer Index* and at the *REFORM think-tank* in more detail later but first lets review how the Universal Health Insurance has performed since being introduced in the Netherlands in 2006.

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[1] Fine Gael, *FairCare*, p.10
[2] Fine Gael, *FairCare*, p.7
[3] Fine Gael, *FairCare*, p.13
[4] Fine Gael, *FairCare*, p.32

Background
The Netherlands has a long tradition of mandatory health insurance dating back to the 1940's when it was first imposed by the Nazi-occupying authority during World War Two. Mandatory premiums, while they did exist, were low and a two-tier health system emerged with the expansion of voluntary private health insurance. 63% of the population were covered by the mandatory insurance system while 37% by private health insurance.[5]

Many of the complaints that exist in Ireland in relation to waiting lists, quality of service etc., also plagued the Dutch health system, leading to a twenty-year review that ended in 2006 with the introduction of a mandatory Universal Health Insurance System.

What Fine Gael want to implement
Let's look at the claims Fine Gael make for their proposal for a mandatory Universal Health Insurance system.

Claim No. 1 –
"***Everyone is a member***
Each of the insurance companies will have to offer the standard package to each of its customers at the same price, i.e. there will be strict community rating. There will also be an "obligation to cover", meaning that insurance companies will not be allowed to turn anyone down, or charge differently, on the basis of age, sex, medical history, etc. The State will fund the insurance premiums of everyone holding a medical card, and children under 18 years. Low-income groups will receive a "healthcare allowance" which they would pay to their chosen insurer. Crucially, everyone will be entitled to free GP care packages." [6]

Fine Gael claim that the introduction of Universal Health Insurance will eliminate the two tier public / private health system we currently have. However, in contrast to the above claim, the reality is that the Netherlands has gone from a two-tier health system to a three-tier health system. All citizens are obliged to take out mandatory Universal Health Insurance, but Voluntary Supplementary Health Insurance is also available at extra costs. When the Universal Health Insurance was introduced in 2006 almost 92% of adults paid for Voluntary Supplementary Health Insurance.[7] As premiums have risen, the numbers purchasing Voluntary Supplementary Health Insurance have declined.

Furthermore by the end of 2007, approximately 231,000 people were uninsured and a further 240,000 people were enrolled with insurance companies but were in default on their payments and upwards of six months in arrears.[8] So the effect of the introduction of Universal Health Insurance has not eliminated the two-tier system, but has actually created a third tier, those who are uninsured or are defaulting on their premiums. The Dutch Government has taken steps to deduct mandatory premium payments (and significant fines) directly from the wages and welfare payments of uninsured and defaulting people.[9]

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[5] Bartolomee, Y., & Maarse, H., "Health Insurance Reforms in the Netherlands", *Eurohealth*, Vol.12, N0.2, 2006, p.7.
[6] Fine Gael, *FairCare*, p.10
[7] De Nederlandsche Bank 2006b, 2007c: p. 42
[8] Leu, R. E., Rutten, F. F. H.. Brouwer, W., et al., "The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets", *The Commonwealth Fund*, (January 2009), p.5
[9] Maarse, Hans, *Health Policy Monitor - Health care reform - more evaluation results*, University of Maastricht, Department of Health Organization, Policy and Economics (BEOZ), (2009), p. 12

Claim No. 2

"***The system remains progressive***

Around 75% of funding for healthcare would continue to come from taxation on income, paid into a new Risk Equalisation Fund and to pay for the insurance subsidies for children and lower-income groups. This fund would compensate insurance companies for covering higher-risk, higher-cost patients." [10]

There is a formal ban on risk selection for basic health insurance. Therefore, it is no surprise that insurers do not engage in explicit risk selection. However, evidence has begun to emerge that risk selection is occurring in more subtle ways.

First, insurers may deny a group contract to what they see as groups with a predictable loss. While there is no evidence of this happening at the moment, analysts argue that it is inevitable to happen in the future as the number of insurance providers drops.

Second, one insurer launched a new health plan by the end of 2007. Subscribers accept to visit only eleven hospitals for non-acute care that have been contracted by the insurer as preferred provider. In exchange for their restricted choice they pay a lower premium. This plan is only attractive to young people reporting their health as very good. It is not an attractive plan for a young couple with children.

Third, there is some concern that health insurers may use Voluntary Supplementary Health Insurance as an indirect tool for risk selection. In 2006 and 2007, insurers announced that they would apply open enrolment except for their most inclusive and expensive plans. They did so because of their strategy of protecting and extending market share. However, by 2008 the percentage of insurers asking applicants to fill in a medical questionnaire more than doubled from 12 to 25 insurers after it had declined from almost 50 percent in 2004 to 10 percent in 2006.There is also some evidence that subscribers do not switch to another insurer for their basic health plan because they fear not to be accepted for Voluntary Supplementary Health Insurance plan by the new insurer.[11]

In addition, economists at the Dutch Central Bank worry that this risk equalisation fund may undermine the "stimulus for insurance companies to work towards more cost effective procurement of health care services".[12] They have urged Parliament to modify the risk adjustment system so that it is more future oriented — compensating insurers for taking on patients who may need more health care services without rewarding them, retrospectively, for spending more on such patients.[13] This demonstrates that the risk equalisation fund is both working against the cost-reduction intention of the Universal Health Insurance system while at the same time insurers are manoeuvring to eliminate high-risk patients from their books.

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[10] Fine Gael, *FairCare*, p.36

[11] Maarse, *Health Policy Monitor - Health care reform - more evaluation results*, p. 13

[12] De Nederlandsche Bank 2007c: p. 43 – 44

[13] Rosenau, P.V., & Lako, C.J., "An Experiment with Regulated Competition and Individual Mandates for Universal Health Care: The New Dutch Health Insurance System", *Journal of Health Politics, Policy and Law*, Vol. 33, No. 6, (December 2008), p. 1039

Claim No. 3

"***Economies of scale will reduce insurance costs***

Because the number of insured people in Ireland would rise from about 50% of the population currently to 100% under UHI, the insurance companies would have greater economies of scale, allowing savings to be passed on to customers." [14]

The current cost of the Universal Health Insurance basic package in the Netherlands is €1194 per person for this year. On top of that Employers deduct a further 6.9% of a workers income up to a ceiling (€2233 in 2009).

With annual income running at €53,000 per household, the annual cost of health insurance is somewhere between €4,525 and €5,625, or 8.6 to 10.7 per cent of household income. In Ireland, we spend in the region of €3,800 per person per annum on public health services, or somewhere between 6 per cent and 12 per cent of household income.[15]

Since the introduction of Universal Health Insurance in 2006, premium costs have risen by 41%.[16] In 2009 analysts projected that Universal Health Insurance premiums would double by 2014[17] although this could well turn out to be an under-estimate given the scale of the financial crisis in the Dutch health care system.

Furthermore, in an attempt to cut insurance losses, the Dutch government introduced an excess of €150 per person into the insurance package. Since then the excess has risen to €210 and is expected to rise further. Some insurance companies are already offering a €500 excess package in return for a reduction in premiums.[18]

On top of this over 10% of the health care funding comes from payments by policy-holders for care and medicine not covered by the Universal Health Insurance package. For example, patients are often required to pay a top-up fee for certain drugs because of a cap imposed by the government. These cuts have increased with the 2011 austerity budget in the Netherlands[19] and have resulted in increasing out of pocket expenses for patients.

Claim No.4

"Local hospitals should do well under UHI

Our analysis of the Dutch system suggests that the smaller hospitals have been able to compete successfully with the bigger hospitals, by being more adaptable. We believe, therefore, that UHI offers local hospitals a sustainable role in Ireland's healthcare system over the longer term.

Under UHI, public hospitals will continue to be owned by the State, but will be governed and managed by Local Hospital Trusts. This will allow them to better meet the needs of the

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[14] Fine Gael, *FairCare*, p.36
[15] Baxter, G., "Is going Dutch our best healthcare option?", *Irish Medical Times*, (March 18, 2010)
[16] Dutch News, "Health insurance rises 41% over five years" *Dutch News*, (dutchnews.nl, 9 Nov. 2010)
[17] Maarse, H., "Testing Market Practices", *Health Care Cost Monitor*, (8 June 2009), p. 1
[18] IHS, "Healthcare Premiums Rise Sharply As Netherlands Faces Deficit of €3.5 Billion.", *IHS global Insight,* (30 Sep 2010)
[19] IHS global Insight, 2010

local community and their patients. Instead of the HSE determining the future of a local hospital, its future will now be in local hands.

Voluntary Hospitals will continue to be run by their Boards. The evidence from other countries is that these independent, not-for-profit hospitals tend to do best under systems of universal health insurance. The reasons for this are not fully understood, but it appears that the caring ethos of not-for-profit hospitals leads to higher quality treatment and greater trust among patients and their insurance companies." [20]

More than 50% of the hospitals in the Netherlands are facing financial crisis leading to the likelihood that the Dutch government will have to step in a provide funding to avoid them going bankrupt. Furthermore, some hospitals have difficulty financing their capital investments because of the reluctance of the banking sector to provide them with the necessary capital.[21] The cost overruns, which are clearly associated with the introduction of competition, have elicited growing skepticism in the Netherlands about the effectiveness of regulated competition to control costs. That result may lead to calls for fixed budgets to curb the growth of health care expenditures. Furthermore private health insurance companies are pushing for reductions in regulation, something the Dutch government has acceded to by increasing the percentage of the hospital budget open to negotiation by the private health insurers.[22] The support for delegating public tasks to the market is declining.[23] As a result of the difficulties created, opposition to the use of Universal Health Insurance and a general programme of privatisation of health care is growing further as a result of the current financial crisis faced by the Dutch economy.

Claims No.5 & No.6

"It reduces costs and increases quality. *The Irish State has a very poor track record in driving innovation in the health system and in making deals that generate value-for-money. Properly incentivised and managed insurance companies, by contrast, would have every reason to drive innovation as a way to maximise service and reduce costs."* [24]

In the Netherlands, costs have been reduced in administration, mainly by sacking workers. This has led to delays in processing claims and in rising dissatisfaction with the Universal Health Insurance system.[25] Furthermore, the number of people switching insurance companies has significantly increased administration further clogging up the system.[26] Costs had actually dropped before the implementation of Universal Health Insurance in 2006 and have been rising steadily since then.[27] With the implementation of Universal Health Insurance in 2006 income by GP's rose by an extra €54,000.[28] As a result of Universal Health Insurance, consultants working in the Dutch health system saw their incomes rise by 50% in 2008 alone.[29] Some specialists, including aneasthesiologists,

[20] Fine Gael, *FairCare*, p.36-37
[21] Maarse, "Testing Market Practices" p. 1
[22] Rosenau & Lako, "The New Dutch Health Insurance System", p. 1043
[23] Maarse, "Testing Market Practices" p.8
[24] Fine Gael, *FairCare*, p.14
[25] Rosenau & Lako, "The New Dutch Health Insurance System", p. 1041
[26] Bartolomee, & Maarse, "Health Insurance Reforms in the Netherlands", p. 9
[27] Baxter, "Is going Dutch our best healthcare option?", & Rosenau & Lako, p. 1040
[28] Schäfer W, Kroneman M, Boerma W, van den Berg M, Westert G, Devillé W & van Ginneken E., "The Netherlands: Health system review", *Health Systems in Transition*, (2010) 12(1), p. 58
[29] Sheldon, T., "Dutch hospital consultants threaten legal action over wholesale pay cuts", *British Medical Journal,* (2009) 339:b3408

medical microbiologists, radiologists and pathologists, even doubled or tripled their revenue.[30]

Fine Gael proposes that the 'money-follows-the-patient' and that hospitals will be paid for how many patients they treat. The Dutch Universal Health Insurance system has adopted this model. The have a system whereby there are over 30,000 Diagnosis Treatment Combinations (DBCs) that insurance companies must negotiate charges with each individual hospital.[31] This has resulted in a very bureaucratic system that is clogging up the administration of the hospitals themselves.

What has emerged is the monopolisation of the Universal Health Insurance market in the Netherlands by a small number of insurance companies[32] resulting in the insurance companies taking an increased mark-up rather than reducing premiums.[33]

Prices for treatment are being determined by the dominant players in the market. GP's for example, negotiate with the largest insurer, agree a fee and then tell the other insurers that this is the figure that will apply. Most Universal Health Insurance insurers then accept this figure.[34]

Claim No.7
"The 2008 Euro Health Consumer Index (EHCI) report suggests that the Netherlands is the most successful health system in Europe." [35]

Let's look at the current Dutch health service before we address the ECHI. In terms of quality and efficiency of the health care system, the Netherlands is, with some notable exceptions (e.g. implementation of innovations such as day surgery and electronic patient records), an average performer when compared to other wealthy countries.[36] Shortages in the Dutch health care workforce alarm policy-makers, the media and patient organizations alike. Such shortages are reflected, for example, in the difficulties people experience in finding a GP who registers new patients, or in the growing waiting lists or the postponement of operations at short notice.[37] Since the introduction of Universal Health Insurance in the Netherlands in 2006 the actual number of beds present in the country's hospitals is not known.[38]

The *Health of Nations* profile of the Dutch health system indicated that "some problems remain, most notably long waiting lists for treatment, staff shortages in the hospital sector and the constraining bureaucracy".[39] With the growing crisis demands are now being made for wage cuts for health professionals.[40]

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[30] Maarse, p. 2
[31] Ibid., p.8
[32] Douven, R., Ligthart, M., Mot, E., Pomp, M., "Early experiences with the Dutch health care reform", *CPB Netherlands Bureau for Economic Policy Analysis*, EUROFRAME-EFN Report (Autumn 2007), p. 5
[33] Rosenau & Lako, p. 1041-2
[34] Schafer et. al., "The Netherlands: Health system review", p. 85
[35] Fine Gael, *FairCare*, p.13
[36] Schafer et. al., p. XX
[37] ibid., p.133
[38] ibid., p. 117
[39] Health of Nations, *Netherlands profile* (2010)
[40] Maarse, p. 2

41% of respondents indicated that they considered that the quality of the health system has worsened since the introduction of Universal Health Insurance in 2006, while 8% indicated that it had improved.[41] In terms of public perception only 18% like the new system better than the old one. 41% of respondents report that it is worse compared with the previous system. The remainder stated that it was neither better nor worse.[42]

Despite the claims of the supporters of Unversal Health Insurance it is clear that the 'market competition' introduced has not met policy makers' expectations for achieving cost containment while preserving or improving quality and access. In addition, policy analysts in the Netherlands point to several potential problems that might emerge in the future.

1. Will the benefits in the basic package be eroded?
2. Will mergers and acquisitions in the private insurance sector chip away at consumer choice?
3. Will competition undermine quality?
4. Will risk selection be practiced subtly even though it is not legal?
5. Will stakeholders effectively lobby government to remove the restraints designed to preserve solidarity?

Analysts conclude that while the 2006 reform privatised only health insurance, it set a precedent and will likely lead to the gradual privatisation of other health system programs.[43] This is an accurate assessment if you look at the initial intention of the introduction of Universal Health Insurance in the Netherlands as outlined by the government:

"The current market reform is not only intended to introduce regulated competition in health insurance, but also in the provision of care." [44]

In addressing the suitability of the Dutch Universal Health Insurance model for other countries, among other things, it is clearly outlined that in countries where access, quality and cost-challenges are even greater than in the Netherlands (and Ireland is certainly one of those countries according to Fine Gael), the introduction of Universal Health Insurance will perform even poorer than it has in the Netherlands.[45]

One final issue has to be addressed in relation to the Dutch model of Universal Health Insurance. To date the Dutch government have been able to argue with the European Commission that their mandatory Universal Health Insurance system can be regulated under the 'protection of the social good'. However, the European Court of Justice has yet to rule on whether the Dutch Universal Health Insurance model contravenes the primacy of the internal market within the European Union. Furthermore, even if the ECJ rules in favour of the Dutch government it could at the same time rule that 'risk equalisation' contravenes European internal market competition rules. In either case a ruling against the Dutch government would open the Dutch health care system to a complete free-for-all.[46]

[41] Rosenau & Lako, p. 1047
[42] Ibid., p. 1045
[43] Ibid., p. 1048
[44] Moase, p. 8
[45] Rosenau & Lako, p. 1031
[46] Maarse, p. 9

The REFORM think-tank and the Euro Health Consumer Index (and the Stockholm Network)

Fine Gael's "***FairCare***" health policy document is based on the report of a commission established by Enda Kenny in 2008.[47] This commission was chaired by former party leader and current Anglo-Irish Bank chairman, Alan Dukes. The first question that this raises is this – given that Alan Dukes has repeatedly had to revise upwards the cost to the Irish taxpayer of bailing out Anglo-Irish Bank, how much faith can be placed in his promotion of the introduction of Universal Health Insurance into the health system in this country?

Fine Gael then goes on to criticise the Irish health service and praise the Dutch health service based on the rankings published on the Euro Health Consumer Index. Given the weight that Fine Gael place on the EHCI it is necessary to review what the EHCI is and where it comes from.

The EHCI is produced by a Swedish registered privately-owned European think-tank called the Health Consumer Powerhouse. In 2009 a study was carried out into the 2007 EHCI in the University of Twente. The report goes into detail in outlining the shortcomings of the EHCI. In concluding the author states:

"In the Index 2007 there are serious shortcomings in respect of quality. The most acute concerns are about the Index validity. The Index 2007 is neither transparent (does not elaborate on choice of indicators and their meaning) nor based on relevant information (limited sources of information, irrelevant to the reality statements). As the systematic process of indicators choosing is absent, the Index touches upon only specific services and particular groups of patients. Thus, standards of comprehensiveness are not met. There are concerns in respect of relevance and reasonable. The Index overlooks consumers because takes a high level of aggregation - national health care systems, but not the level of hospitals." [48]

When you actually look into who the Health Consumer Powerhouse are then these conclusions of secrecy are not surprising. The Health Consumer Powerhouse was founded in 2004 by Johan Hjertqvist. He was previously the founder of a venture capital company that invested in private health care in Sweden and was among the foremost promoters of the expansion of private health care into the Swedish health system. Prior to establishing Health Consumer Powerhouse, Hjertqvist has developed a right-wing Swedish based think-tank called Timbro. Timbro's mission is to originate, promote and disseminate ideas and issues supporting the principles of free markets, free enterprise, individual liberty and a free society. Timbro's main research areas going into 2009 are wealth accumulation, health and welfare reform, and aid and global development.[49]

In relation to Health Consumer Powerhouse, what can been seen from an analysis of their EHCI is that countries with privatized or semi-privatised health systems always perform better than state-run healthcare systems.

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[47] Fine Gael, *FairCare*, p. 3

[48] Greku, E., *The added value of the Euro Health Consumer Index to existing mechanisms of national health care systems evaluation provided by the OECD and WHO,* University of Twente School of Management and Governance, (2009), p. 74

[49] Timbro, *About Us*, www.timbro.se

Health Consumer Powerhouse refuses to disclose who funds the group or how much funding it has available to it. Both Health Consumer Powerhouse and Timbro are members of the Stockholm Network.

The second group that Fine Gael use for arguing in favour of their mandatory universal health insurance is the REFORM think-tank.

So where do REFORM come from? It is based in London and was founded in 2001 by Nick Herbert (now a Conservative MP) and Andrew Haldenby (former head of the Political Section in the Conservative Party's Research Department). It function is outlined on its website as follows:
"We believe that by liberalising the public sector, breaking monopoly and extending choice, high quality services can be made available for everyone. Reform would remove public services from the escalator of ever-rising costs. It would enable policy makers to aim for a lower level of taxation and public spending which would better suit the UK's current and future economic challenges." [50]

REFORM argue for cuts in welfare spending and the privatisation of health and education. Many of REFORM's research publications have been heavily criticized. One report into falling standards of mathematics in UK schools was should to have incorrect calculations in the data (Goldacre, 2008). In 2009 REFORM produced a budget submission that argued in favour of cutting back what they call "pensioner gimmicks" such as the winter fuel payment and free TV licensing for the over 75s. and the introduction of market rates for student loans which would result in UK students paying an extra £1.2billion a year in interest payments.[51]

REFORM are also a member of the Stockholm Network.

Finally it is necessary to look at the Stockholm Network. This is a London based privately-owned company that operates as an umbrella group for over 130 right-wing think-tanks. The Stockholm Network outlines it strategy as follows:

- *Reforming European welfare states and creating a more flexible labour market*
- *Updating European pension systems to empower individuals*
- *Ensuring more consumer-driven healthcare, through reform of European health systems and markets*
- *Encouraging an informed debate on intellectual property rights as an incentive to innovate and develop new knowledge in the future, whilst ensuring wide public access to such products in the present*
- *Reforming European energy markets to ensure the most beneficial balance between economic growth and environmental quality*
- *Emphasising the benefits of globalisation, trade and competition and creating an understanding of free market ideas and institutions.* [52]

Among its prominent supporters is former President of the European Parliament and member of the Progressive Democrats, Pat Cox. Among its prominent clients are pharmaceutical companies Pfizer, Merck Sharp & Dohme. The Stockholm Network, while

[50] REFORM, *About Us,* www.reform.co.uk
[51] REFORM, *Back to Black*, April 2009, www.reform.co.uk
[52] Stockholm Network, *Policy Issues*, www.stockholm-network.org

disclosing the names of its sponsors, does not disclose the amount of cash it generates for its activities. In effect the Stockholm Network is a lobbying group for among others, pharmaceutical companies, private healthcare providers and private health insurance companies.

In 2010 the Stockholm Network was accused of being responsible for the removal from the National Institute for Health and Clinical Excellence in the UK of its remit to purchase certain drugs for the NHS. The new method to replace the NIHCE was for drugs to be purchased not on the basis of necessity but on the basis of 'assessed value. Following the publication of a further report in 2010 a number of groups left the Stockholm Network citing its 'promotion of particular business interests'.[53]

Given the background and nature of the groups that Fine Gael has used to promote it mandatory universal Health Insurance system, voters in Ireland should be more than a little sceptical about the proposal being offered.

Conclusion

Fine Gael have proposed the introduction of the Dutch model of Universal Health Insurance into the Irish Healthcare Service. It argues that it will reduce costs, improve quality and lead to lower payments from the general public. However, the evidence shows that there are significant problems with the Dutch model of Universal Health Insurance. In particular, contrary to the claims by Fine Gael, the Dutch model of Universal Health Insurance has seen increasing costs, rejection by the public and rising insurance premiums for policy-holders. Furthermore, it has caused a major financial crisis in the Dutch healthcare system where over 50% of hospitals are heading for bankruptcy.

To back-up their claims Fine Gael use reports from two right-wing pro-privatisation groups who receive funding from a lobbying company with close links to multi-national pharmaceutical companies, private health insurance companies and private health care providers, all of whom would be interested in exploiting the new Universal Health Insurance system that Fine Gael propose to implement.

[53] Harkins, S., & Jones, M., "The Stockholm Network", *British Medical Journal*, (10 Nov. 2010)

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