

Medical Students' Knowledge and Attitudes Towards Universal Access to Healthcare (UHC) Systems

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Abstract

Aim

With the introduction of universal access to healthcare central to health policy in Ireland, this study aims to examine the attitudes of medical students to the implementation of such policy.

Methods

A cross sectional study of final year students on the MB degree programme at UCD School of Medicine was conducted. Students were asked to indicate the extent with which they agreed / disagreed with several statements using a Likert-scale (where 1=strongly disagree and 5=strongly agree).

Results

A total of 98(42%) of the 236 final year students completed the survey. The statements with which respondents most agreed were: "the GP's workload would increase" and "a UHC system is preferable to one in which only some patients have free access to certain services" (mean 4.3, SD 0.85 and mean 3.85, SD 1.05, respectively). The statements with which students most disagreed were: "it would be straightforward to introduce such a system in the practice(s) in which I have been on placement" and "under a UHC model, patients would receive quicker care" (mean 2.14, SD 0.91 and mean 2.29, SD 1.09 respectively).

Conclusion

The findings suggest that medical students are positively disposed to the introduction of UHC but have concerns regarding workload.

Keywords

Medical students, Universal health care, Universal access, Health system, Ireland

Introduction

The World Health Organisation (WHO) describes Universal Health Coverage (UHC) as existing when "all individuals and communities receive the health services they need without suffering financial hardship¹."

UHC is becoming increasingly common internationally in both wealthy and impoverished countries². The benefits of UHC have been identified in many settings internationally. In their study of 153 countries, Moreno-Serra and colleagues found that expansions in health system coverage through higher publicly pooled spending tend to lead to improved population health, as measured by lower child and adult mortality rates³.

Ireland doesn't currently operate on a UHC system. A government report has described our current system "to be built to tackle episodic diseases or accidental injuries" and "outdated and ill-equipped to tackle the health challenges of the present and the future"⁴. Ireland has the only European health system that does not offer universal coverage of primary care⁵. We also operate an expensive system. In 2018 the funding level available to health reached €16.2bn. This marked a record as the highest in the history of the State⁶.

UHC is reported to be planned for Irish healthcare in governmental plans and is cited in the Sláintecare report as offering better health outcomes, better value for money and reduced waiting times. One of the core reasons proposed for such a reform is to reduce inequality and to create a single tier system. This implementation was planned over a 10-year period and plans for Universal GP care at a cost of €455 million over five years⁷.

It is argued that neither tier in this two-tier system is ideally served at present⁸. In Ireland, public patients do not receive free healthcare, nor do they have universal access. The General Medical Services (GMS) Scheme "provides access to medical and surgical services for persons for whom acquiring such services would present undue hardship"⁹. However, GMS patients still pay for all prescription drugs at €2.00 per item, capped at €20 per family per month¹⁰, and often spend a long time on hospital waiting lists¹¹. In July 2018, 1,578,155 people held medical cards and a further 497,539 had GP visitation cards¹². However, it is not simply public patients who can be poorly served by this system but also those above the income threshold for a medical card. The majority of our population pays out-of-pocket fees to access primary healthcare and 45% of the population purchase inpatient health insurance plans, which can provide faster access to private health services¹³. In a survey pertaining to cancer related referrals, 88.5% of GPs said that ability to pay affected a patient's access to referral services¹⁴. Studies demonstrate that one in three members of the total population and one in four 'paying' patients have previously decided not to go to the GP due to cost^{15 16}.

Instituting a UHC system does not come without difficulties. In a paper tracing the evolution of UHC in Ireland, Burke and colleagues found that despite expressed intentions, the Irish health system was no more universal in 2015 than in 2011¹⁷. UHC has the potential to also increase workload. It has been shown that when older patients become eligible for GMS services in Ireland, more general practice activity follows¹⁸. It has been estimated that universal access to primary care would result in 1.5-1.8 additional GP visits per person per year¹⁹. This is made more complex when paired with a demand for primary care that is already increasing and is expected to increase significantly in the coming years for many reasons, including a growing and aging population. The current primary care system appears to be already operating at capacity across many services²⁰.

Why examine the views of senior medical students on this issue? Firstly, the authors are unaware of any existing literature on Irish medical students' opinions on the proposed health care structures. Secondly, the international literature demonstrates mixed views from medical students on this important systems issue. In a study carried out in the U.S. in 2008, it was found that the most popular reform to the U.S. healthcare system would be a multi-payer system (41%) in which all U.S. citizens would have access to healthcare paid for by the U.S. government, but could also choose to obtain private insurance²¹. More than 86% of the respondents felt that they had not received adequate education in medical school about the U.S. healthcare system. A web-based survey carried out on medical students in Ontario and California found that support for universal health care coverage was higher in Ontario (86.8%) than in California (51.1%)²². Finally, this cohort of students were studied within a year of entering the medical workforce and would potentially enter specialist training within two years – regardless of speciality, the organisation and funding structures of the Irish health care system will impact directly on them and their views will go some way to determining the viability of those new structures. An exploration of their views and the contributing factors to those views may better inform undergraduate education and postgraduate training in the future.

Methods

An anonymous, paper-based and online survey was administered to 236 final year medical students undertaking their 'specialty' rotations of the undergraduate medical programme in University College Dublin (UCD), Ireland. Senior undergraduate students at UCD undertake two years of formal clinical training and clinical placements in university-affiliated sites in specialities such as clinical medicine, surgery, paediatrics, obstetrics, psychiatry and general practice. This cohort included all final year students in the academic year 2017-18.

An original survey design was used in order to assess students' self-perceived knowledge and opinions regarding UHC. This survey contained four questions on demographics; ten five-point Likert scale questions (1=strongly disagree, 5=strongly agree); four open-ended questions; and free text comments. Data were analysed using Microsoft Excel. Scores from the Likert scales (1 = strongly disagree, 5 = strongly agree) were converted to numeric data, and descriptive statistics are reported.

Respondents were informed about the context of the study and they took part voluntarily, indicating consent by checking a consent box in the survey. The UCD Human Research Ethics Committee granted exemption from full ethical review for the study.

Results

A total of 98(42%) of the 236 final year students completed the survey. Fifty respondents (51%) were male, 66(67%) were aged under 25, and 75(77%) were of Irish nationality. 66 respondents had a prior degree (67%; see Table 1).

Table 1: Sociodemographic characteristics of respondents (N = 98)

Characteristic	n	Missing (n)	%
Female gender	48	0	49%
Irish nationality	75	0	76.5%
≤25 years	66	0	67.3%
26-35 years	28	0	28.6%
>36 years	4	0	4.1%
Have a prior degree	66	0	67.3%

On a scale of 1 to 5, where 1=strongly disagree and 5=strongly agree, the respondents demonstrated a mixed awareness of the proposed UHC system when asked “were you aware of the government's goal to introduce UHC in Ireland?” (mean 2.74, SD 1.36). The respondents agreed that a GP's workload would increase with the introduction of UHC (mean 4.3, SD 0.85). Students were also in agreement that a hospital consultant's workload would increase, but to a lesser extent (mean 3.55, SD 1.06). The respondents were in agreement that UHC would be preferable to a system where only some have free access (mean 3.85, SD 1.05). They also believed to UHC to be a viable system in Ireland (mean 3.37, SD 1.08). There were more mixed views on whether this was a key policy for the current government, and whether it would become easier to see your GP under a UHC system (mean 3.12 SD 0.9 and mean 2.85, SD 1.33 respectively). Students did not agree that a UHC system would be easy to introduce into the practices that they had seen, and that patients would receive quicker care under such a system (mean 2.14, SD 0.91 and mean 2.29, SD 1.09 respectively). They did not agree that a UHC system is a cheaper alternative to the current system (mean 2.47, SD 1.1). See Table 2.

Table 2: Perceived knowledge and opinions in regard to UHC (1 strongly disagree, 5 strongly agree; N = 98)

Question	Mean (SD)	Missing Values
The GP's workload would increase	4.3 (0.85)	1
A UHC system is preferable to one in which only some patients have free access to certain services	3.85 (1.05)	0
The hospital consultant's workload would increase	3.55 (1.06)	0
A UHC system is a viable option in Ireland	3.37 (1.08)	1
This is a key policy for the current government	3.12 (0.9)	0
It would become easier to see your GP with the proposed change	2.85 (1.33)	0
Were you aware of the government's goal to introduce UHC in Ireland	2.74 (1.36)	1
A UHC model would be cheaper to run than our current Irish healthcare model	2.47 (1.1)	0
Under a UHC model, patients would receive quicker care	2.29 (1.09)	0
It would be straightforward to introduce such a system in the practice(s) in which I have been on placement	2.14 (0.91)	0

When asked how they had heard of UHC proposals in Ireland, 67 of the 98 participants responded (68%). The most common answer was that they had heard from a news source (n=32). Only two students reported hearing of the proposed change from lectures. 29 of the respondents reported having not heard of the proposal prior to being invited to join this study (see Table 3).

Table 3: Sources (if any) from which students learned about the proposed government UHC policy

Theme	n responses (N=67)
Reported unawareness of the policy	29
From a news source	News source 32 Of whom specifically mentioned; <ul style="list-style-type: none"> ○ Newspaper 12 ○ Online media 9 ○ Radio 6 ○ Social media 1
Discussion with classmates	3
GP placement	3
Lectures	2
Discussion with doctors	2
Election manifesto / Sláintecare report	2
Parents	1
UCD	1
Parent who is a doctor	1
No response	31

When asked about the potential benefits that UHC would bring to general practice, 65 students responded (66%). The most common suggestions were that it would improve access (n=16) and equality (n=14). Students reported potential benefits to both private patients (n=13) and disadvantaged patients (n=8; see Table 4). When asked about potential disadvantages, 70 students responded (71%). The most common potential disadvantages described were an increased workload (n=41), a reduced income (n=17), an increase in waiting times (n=14) and an increase in unnecessary presentations (n=13) See Table 4 (**Next Page**).

Table 4: Named advantages and disadvantages of UHC for the GP practice(s) that students had visited

ADVANTAGES		DISADVANTAGES
Theme	N Responses [n (%)] (N=65)	Theme [n (%)] (N=70)
Accessibility	<ul style="list-style-type: none"> Better access or more accessibility [16 (24.6)] 	<ul style="list-style-type: none"> Increased workload / becoming busier [41 (58.6)]
Equality	<ul style="list-style-type: none"> Better Equality or fairness [14 (21.5)] Reduction in disparity between public & private patients or reduction of a 2-tiered system [5 (7.7)] Similar care for all [1 (1.5)] 	<ul style="list-style-type: none"> Reduced income (or pay or money or remuneration or finances or private practice) [17 (24.3)]
Advantages to non-medical card patients	<ul style="list-style-type: none"> Advantage to private patients OR a reduction in financial barriers [12 (18.5)] Free consultations [1 (1.5)] 	<ul style="list-style-type: none"> Increased waiting times [14 (20)]
Advantages to disadvantaged patients	<ul style="list-style-type: none"> Benefits to disadvantaged patients [8 (12.3)] <ul style="list-style-type: none"> 'Low SEG / low income' [4 (6.2)] 'Medical card holders' [2 (3.1)] 'Immigrants' [1 (1.5)] 'Disadvantaged' [1 (1.5)] 	<ul style="list-style-type: none"> Unnecessary visits (or non-urgent or needless or abuse of system or malingering) [13 (18.6)]
Advantages for the GP	<ul style="list-style-type: none"> Advantages to the GP <ul style="list-style-type: none"> Less perception of GP as a business [2 (3.1)] Guaranteed fixed income or simplified income [2 (3.1)] Better funding / resources to GP [2 (3.1)] Less inequality in payment between GPs [1 (1.5)] State employment [1 (1.5)] Guaranteed workload [1 (1.5)] Satisfaction with system fairness [1 (1.5)] Would offer contract negotiation opportunity [1 (1.5)] Reduction in unnecessary attendances [1 (1.5)] 	<ul style="list-style-type: none"> Shorter appointments / consultation time [11 (15.7)]
Prevention	<ul style="list-style-type: none"> More prevention [5 (7.7)] 	<ul style="list-style-type: none"> Increased patient numbers (or increased patient load or care or burden) [10 (14.3)]
Treatment bias	<ul style="list-style-type: none"> Reduction in treatment bias between public and private patients [5 (7.7)] 	<ul style="list-style-type: none"> Increased demand [7 (10)]
Follow up / continuity of care	<ul style="list-style-type: none"> Better follow up or continuity or care [3 (4.6)] 	<ul style="list-style-type: none"> Diversion of care from those most in need [6 (8.6)]
Services / care / population health	<ul style="list-style-type: none"> Better services / care / population health [5 (7.7)] 	<ul style="list-style-type: none"> Reduced quality / increased errors [5 (7.1)]
Chronic care	<ul style="list-style-type: none"> Better chronic care [2 (3.1)] 	<ul style="list-style-type: none"> Reduced GP incentive / potential apathy [3 (4.3)]
Timeliness	<ul style="list-style-type: none"> Earlier presentations [7 (10.8)] Would encourage presentation before progression of illness [1 (1.5)] Reduction in crisis presentations [1 (1.5)] Earlier detection of disease [1 (1.5)] 	<ul style="list-style-type: none"> Increased administration [2 (2.9)]
No advantage	<ul style="list-style-type: none"> No advantage [4 (6.2)] 	

Discussion

This potential perceived knowledge gap may reflect inadequacies in training in health systems issues in the undergraduate medical programme, as found among US students in other research²¹. When asked how they came to know about UHC, most of the respondents reported hearing from a news source (n=32), while only two students reported learning of the reform in lectures.

Overall, the students who did respond were in favour of a UHC system and demonstrated that they felt it was preferable to a system in which only some patients paid (mean 3.85, SD 1.05). This response is also in keeping with international literature with the majority of students in Ontario and California favouring universal coverage²².

This preference for such a system came with clear concerns. A reoccurring trend in this study was a prediction that work load would increase with this reform. This is something that has been predicted elsewhere in the Irish research¹⁹. Indeed, it would appear to be an appropriate concern given that it has been widely shown internationally that GP utilisation is significantly more likely in the context of free GP care²³.

Another trend in this paper was the students' uncertainty about the ability of the current system to execute such a reform. Some students specifically mentioned a lack of faith in government, whilst others were vaguer in their uncertainty with the system, which made it unclear to the authors who it was directed at.

When asked about potential advantages, there were mixed views on whether the existing system is more biased against those without medical cards. Thirteen students suggested that the new system would reduce financial barriers to access and seemed to suggest that the new system would advantage the current private patients, while eight students commented directly on a potential benefit to a disadvantaged group with the new system, and more specifically, those with medical cards, immigrants and low-income patients. There is further complexity here in that some students in this study described financial barriers to visiting GP in the existing system, but often alluded specifically to those patients just above the income threshold for a medical card. The Irish literature would suggest that this deterrent effect of fees was not confined to this group of private patients only and indeed was more widespread²⁴.

Our study was limited by a low response rate. This may indicate a lack of interest in or knowledge of the topic. Furthermore, the study instrument, which was designed to explore student's attitudes and expectations, was not a standardised instrument nor formally validated.

Declaration of Conflicts of Interest:

The authors have no conflicts of interest to declare.

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