

## CHAPTER 10

# Health: Funding Access and Efficiency

Anne Nolan\*

### 1 INTRODUCTION

This chapter examines the health sector, a key component of Irish economic activity and the subject of much recent policy discussion. In terms of its economic impact, expenditure on the health services accounted for 8.1 per cent of GDP and 9.1 per cent of total employment in 2002.<sup>1</sup> After years of expenditure growth barely in line with inflation during the 1980s and early 1990s, expenditure on the health service in Ireland has increased dramatically since 1997, increasing by nearly 80 per cent in real terms from 1997 to 2002. While Irish health expenditure as a proportion of GNP has increased from 7.3 per cent in 1991 to 8.2 per cent in 2001, health expenditure as a proportion of GNP has also risen across the EU and OECD, with the result that Ireland still ranks among the low spenders on health, in terms of health expenditure as a proportion of GNP (see Table 10.1).<sup>2</sup>

Table 10.1

Health Expenditure as a % of GNP<sup>1</sup> (Selected OECD countries, 1991 and 2001)

	1991	2001	% over 65
Austria	7.2	7.8	15.5
Denmark	8.6	8.8	14.8
Finland	9.3	7.0	15.1
France	8.8	9.4	16.2
Germany <sup>2</sup>	7.2	10.8	16.9
<i>Ireland</i>	7.3	8.2	11.2
Netherlands	8.2	8.6	13.6
UK	6.0	7.6	15.9
USA	12.5	13.8	12.4

Sources: OECD, *Health Data 2004*, OECD, Paris 2004, 1<sup>st</sup> edition and European Commission, *AMECO Macro Economic Database 2004*, www.europa.eu.int 2004.

<sup>1</sup>While health expenditure is usually expressed as a proportion of GDP, the large divergence between Irish GDP and GNP figures means that, for comparative purposes, it is more appropriate to express health expenditure as a proportion of GNP (see also A. Nolan, and B. Nolan, *Ireland's Health Care System: Some Issues and Challenges*, Proceedings of ESRI/FFS Budget Perspectives Conference 2004, ESRI, Dublin 2004).

<sup>2</sup>Data refer to 1990.

The challenges facing the Irish health service today are therefore very different to those of the 1980s and early 1990s. While much discussion in Ireland during that period focussed on the under funding of the health services (public expenditure on the health services decreased in real terms in some years during the 1980s), the emphasis has shifted now to consider issues such as the efficiency and effectiveness of such increased investment, concerns shared by many other countries. In light of increasing expenditure, cost containment measures that aim to make patients and providers more aware of the resource implications of their decisions are becoming increasingly common. While ensuring that increased expenditure delivers services efficiently and with sufficient effectiveness in terms of health outcomes are important concerns, the extent to which access to health services is distributed equitably across the population is a much discussed issue in Ireland and elsewhere. Of crucial concern in Ireland, is the extent to which coverage by private health insurance confers faster access to hospital services.

An additional issue, which receives much attention in discussions about the Irish health sector, is the complex relationship between the public and private sectors in both the financing and delivery of health services. While the government intervenes to a large degree in the regulation and financing of health care in Ireland, and to a lesser degree in the provision of public health services, the private sector also has a significant role to play in the financing and delivery of health services. While the majority of expenditure is funded from general taxation, private insurance and out of pocket expenses by individuals comprise an important element of health sector financing in Ireland. In addition, many health services are provided by private practitioners, such as general practitioner (GP) and dental services, and the majority of hospitals are privately owned institutions which receive most of their funding from the state. This complex interaction between the public and private sectors has important implications for equity and efficiency, particularly in the hospitals sector.

The remainder of this chapter focuses on these themes of access, efficiency, effectiveness and cost control in the context of discussions on key issues with regard to the health services in Ireland. Section 2 briefly outlines the structure of the Irish health service, concentrating on the organisation of eligibility for free health services to ensure equity of access to health care as well as the interactions between the public and private sectors in both the financing and delivery of health services in Ireland. This section also briefly describes the recent *Health Service Reform Programme*, announced by the government in mid 2003. Section 3 discusses the rationale for government intervention in the financing and delivery of health services (see also Chapter 2 on the role of the state), outlining the various efficiency and equity justifications for government intervention in the sector. Section 4 discusses the four sources of finance in the health sector, concentrating on private insurance, which plays such a significant role in the financing of health care. It also discusses the equity and efficiency concerns surrounding this complex intermix between public and private health care, in particular in the hospitals sector. Section 5 outlines trends in health expenditure in Ireland, comparisons with other OECD countries and discusses the problem of measuring output from the health sector and making international comparisons at an aggregated level, or at a disaggregated level between different interventions/treatments. This section also discusses initiatives to support cost

control in terms of health sector expenditure, concentrating on measures at the micro level that attempt to influence the behaviour of patients and providers alike. Section 6 concludes the chapter.

## 2 STRUCTURE OF IRISH HEALTH SERVICE

The Government, the Minister for Health and Children and the Department of Health and Children have overall responsibility for the provision of health services in Ireland. The department's primary role is to support the Minister in the formulation and evaluation of policies for the health service, as well as the strategic planning of the health services in consultation with the health boards, other government departments, the voluntary sector and other interested parties.

The health boards, which were established in 1970, are responsible for the actual delivery of health services in their area of influence. The Department takes account of a range of factors in determining what proportion of total funding should be allocated to each health board. These factors include the cost of providing services in the previous year, pay costs, health service developments and funding for agreed specific items. The boards provide many of the services directly (e.g. district nurses, public nursing homes) and they arrange for the provision of other services by health professionals, private health service providers, voluntary hospitals and voluntary/community organisations. There are currently ten health boards: three area health boards located in the eastern region under the guidance of the Eastern Regional Health Authority (ERHA) and seven regional health boards covering the rest of the country.

### **Eligibility for Free Public Health Services**

All individuals who are ordinarily resident in Ireland are granted either full or limited eligibility for public health care services. Individuals with full eligibility, termed 'medical cardholders' or 'public patients', are entitled to receive all health services free of charge, including GP services, prescribed medicines, all dental, ophthalmic and aural services, maternity services, in-patient services in public hospitals and specialist treatment in out-patient clinics of public hospitals. At present just under 30 per cent of the population are medical cardholders.

The remainder of the population, those with limited eligibility ('non-medical cardholders' or 'private patients'), are entitled to free maternity services, in-patient services in public hospitals (subject to a €45 charge per day), specialist services in out-patient clinics (again, subject to a €45 charge per day), assistance towards the cost of prescribed medicines over a monthly limit (under the Drugs Payment Scheme) and assistance towards the cost of prescribed medicines for certain chronic conditions (under the Long Term Illness Scheme) or high cost treatments (under the High Tech Drugs Scheme). They must, however, pay for all GP consultations and all dental, ophthalmic and aural treatments. Ireland is unique within the EU-15 in the extent to which individuals must pay for GP services: only the Netherlands also excludes a significant proportion of the population from eligibility to free GP care.

Eligibility for a medical card is dependent upon income and is decided on the basis of a means test with the income thresholds set nationally and updated annually. The intention is that the decision to seek medical care should not be

dependent on economic resources/ability to pay. Currently, the weekly income thresholds are €142.50 for a single person living alone, €200 for a married couple and €250 for a married couple with two children. The limits increase for those aged 66 years and over (e.g. for a married couple the limit increases to €224).<sup>3</sup> From 1 July 2001, all individuals aged 70 years and over are also entitled to a medical card, regardless of income. In special circumstances such as a cancer diagnosis, an individual who is otherwise ineligible on the basis of income or age may be granted a medical card.

Table 10.2

Medical Card and Private Health Insurance Coverage (Percentage of the Population, 1980-2002)

Year	Medical card	Private health insurance
1980	35.0	26.1
1985	36.7	31.2
1990	36.7	34.4
1995	35.2	37.9
1996	34.5	38.4
1997	33.6	39.2
1998	32.0	40.5
1999	31.1	41.8
2000	30.3	45.0
2001	31.2 <sup>1</sup>	48.5
2002	29.8	49.4

Sources: Department of Health and Children, *Health Statistics*, Stationery Office, Dublin 2002, 1999, 1990, 1986, 1981; Department of Health and Children, *White Paper: Private Health Insurance*, Stationery Office, Dublin 1999; General Medical Services Payments Board (GMSPB), *Annual Report and Financial Statements 2002*, GMSPB, Dublin 2003; Health Insurance Authority, *Annual Report and Accounts 2002*, Health Insurance Authority, Dublin 2003; D. Watson, and J. Williams, *Perceptions of the Quality of Health Care in the Public and Private Sectors in Ireland*, Report to the Centre for Insurance Studies, Graduate Business School, University College Dublin, Dublin 2001.

<sup>1</sup>The increase in medical card coverage from 2000 to 2001 is accounted for by the extension of eligibility to all over 70s in July 2001.

Table 10.2 shows the change in medical card coverage and private health insurance coverage since 1980. As discussed in further detail in Section 4, private health insurance in Ireland is primarily taken out by non-medical cardholders to cover the costs of private or semi-private hospital care in public and private hospitals. At present, just under 50 per cent of the population are covered. Medical card coverage stayed relatively stable at approximately 37 per cent over the 1980s but fell every year during the 1990s as income guidelines failed to increase in line with increases in average incomes. The growth of private insurance cover in Ireland is often seen as surprising as private health insurance is primarily taken out to cover hospital costs and yet all individuals are entitled to free public hospital services (although non-medical cardholders must pay a modest daily charge). In addition, up to very recently, primary care services such as GP or dental visits were not covered by private health insurance, except where large deductibles were exceeded.

Recent studies have confirmed that a primary reason for taking out private health insurance is to ensure speedy access to hospital rather than superior

accommodation; as public waiting lists increased in the 1980s and household incomes increased in the 1990s, the demand for insurance grew. The private health insurance market in Ireland is further discussed in Section 4. In 2002, approximately 21 per cent of the population did not have a medical card or private health insurance; data from the 2001 Quarterly National Household Survey Health Module shows that over three quarters of the those aged over 18 years without a medical card or private health insurance were aged under 35 years. While these individuals are entitled to receive free public hospital services (subject to the small charges described above), they must pay in full for any primary care consultations or private hospital services. Medical cardholders may take out private health insurance if they wish; however in 2001 only 2 per cent of those over 18 years had both a medical card and private health insurance.<sup>4</sup>

### **Delivery of Health Services**

While the state is heavily involved in the financing of health services in Ireland (see Section 4), it mainly leaves the delivery of health services to the private sector, with the hospital and primary care sectors providing particularly good examples of the intermix between the public and private sectors in the financing and delivery of health services in Ireland. There are three different types of hospital in Ireland: voluntary hospitals, which are run on a not for profit basis by private organisations (usually religious institutions) but which receive most of their funding from the state; health board hospitals which are owned and operated by the health boards and the final category comprises entirely privately owned, operated and funded hospitals. Public hospital services are provided in voluntary and health board hospitals and most of these hospitals also provide private health care but they must clearly distinguish between public and private beds. In 2000, there were 60 publicly funded acute hospitals, 23 of which were voluntary hospitals located mainly in the Eastern Regional Health Authority area and 35 hospitals were entirely privately owned and operated.

Primary care services are mainly provided by independent professionals (e.g. GPs, pharmacists, dentists etc.) who may be contracted to provide services in the public sector, in addition to services provided to private patients (approximately two thirds of GPs also have contracts to provide services to medical cardholder patients). The General Medical Services Payments Board (GMSPB) undertakes the reimbursement of providers for GP, dental, optical and pharmaceutical services supplied to medical cardholders as well as the reimbursement of pharmacists for services provided to non-medical cardholders under the various drugs schemes. Section 5 discusses in more detail the equity and efficiency implications of differing methods of doctor reimbursement.

The Irish healthcare system therefore has a mixture of a universal public health service and a fee based private system. Some services are publicly funded and delivered (e.g. treatment as a public patient in a public hospital), some are publicly funded but privately delivered (e.g. GP consultations by medical cardholders), some are privately funded and delivered (e.g. GP consultations by non-medical cardholders, treatment as a private patient in a private hospital) while some are privately funded but publicly delivered (e.g. non-medical cardholders must pay a modest charge for treatment in public hospitals).<sup>5</sup> This complex mixture has implications for the allocation of resources both between the public and the private sector and between different types of care (see Section 4 for

further discussion of the equity and efficiency implications of the public private mix in Irish health care, in particular the implications for the hospitals sector).

### **Health Service Reform Programme**

While the structure as outlined above still governs the operation of the health services, in June 2003 the government announced its commitment to a major reform of the health service. The *Health Service Reform Programme* aims to implement the recommendations contained in three recent reports on the health system: the *Report of the National Task Force on Medical Staffing* (the Hanly report), the *Report of the Commission on Financial Management and Control Systems in the Health Service* (the Brennan report) and the *Audit of Structures and Functions in the Health System* (the Prospectus report). Issues highlighted for reform included the coordination and division of functions between the different agencies involved in planning, managing and delivering health services in Ireland and the degree of financial accountability exercised by those making most resource using decisions in the health service, in particular hospital consultants.

By far the most contentious aspect of the reforms is that relating to the regional organisation of hospital services contained in the Hanly report. As a result of the European Working Time Directive, the hours worked by non-consultant hospital doctors (NCHDs) must be reduced to 48 hours per week by 2009 with the first phased reduction to 58 hours due on 1 August 2004 (at present NCHDs work an average of 75 hours per week). In response to this directive, the Hanly report recommends a movement away from the current consultant led service towards a consultant provided service, with health professionals working in multidisciplinary specialist teams. To this end, the report recommends, for the two pilot areas examined (the East Coast Area Health Board and the Mid Western Health Board), a reconfiguration of hospital services in each region into a system with one major hospital and a network of local hospitals with certain services still provided on a national (e.g. liver transplant) or supra-regional (e.g. radiation therapy) basis. The most controversial aspects of the report concerned the stipulation that emergency services should be based in major hospitals only. Other aspects of the reform programme include the reduction in the number of health service agencies to reduce fragmentation and facilitate enhanced policy coordination, and the establishment of a Health Services Executive which will undertake the management of the health service on a national level, leaving the Department of Health and Children free to concentrate on policy formation and issues of strategic development.

## 3 WHY GOVERNMENT INTERVENTION?

Despite the fact that the private sector accounts for approximately 20 per cent of expenditure on the health services (see Section 4) and is heavily involved in the provision of health services in Ireland, the public sector remains the main agent responsible for the finance and delivery of health services in Ireland. Chapter 2 discussed the rationale for government intervention in the economy in general. In terms of the health services, efficiency concerns relating to asymmetric information, uncertainty and the existence of externalities, as well as equity or distributional concerns motivate government involvement in health care. Where

the government does not directly involve itself in the provision of health care services, it may have a role in terms of financing, regulation, pricing (taxation and subsidies) and information provision.

While asymmetric information, uncertainty and externalities are the most readily identifiable indicators of market failure in the health sector, health care markets also suffer from imperfect competition in the sense that many of the conditions for perfectly competitive markets are absent or deficient. Many services, e.g. hospital services, are subject to economies of scale, producers can often influence the level of demand and/or price, and price signals are often absent, particularly where third party reimbursement systems are in operation. Most importantly however, the assumptions of perfectly informed consumers, the absence of uncertainty and the absence of externalities are violated in health care markets.

### **Asymmetric Information**

The nature of the relationship between producers and consumers in health care is distorted by asymmetric information. Patients are essentially buying the doctor's knowledge and/or information when they visit. In comparison with other goods and services, information acquisition on the part of the consumer in health care markets is made more difficult by the nature of the product. Learning by experience is complicated by the fact that every illness episode is heterogeneous and the consumer cannot sample the product before purchase or is unlikely to have had prior experience of the same product. In addition, the information is often technically complex, involving many years of study.

The relationship has often been characterised as a principal agent one; due to the high costs of acquiring such technical information, the patient relies on the doctor to act in their best interests in terms of diagnosis and treatment decisions. While asymmetric information justifies a role for government in regulating the behaviour of doctors and other health care professionals through licensing, regulating the pharmaceuticals that can be prescribed to patients and improving consumers' information, it does not follow that government intervention in either the financing or provision of health care is necessary.

### **Uncertainty**

Health care markets are also characterised by uncertainty, i.e. lack of information about the future. This necessitates a role for insurance in offering the consumer protection against uncertainty. Ill health is inherently unpredictable, both in terms of financial costs and physical and emotional suffering. However, the problems of adverse selection, moral hazard and cream skimming may arise in a private health insurance market, leading to efficiency and equity failings. Adverse selection arises when the insurer cannot distinguish between low and high risks, because individuals purchasing insurance have better information about their risk status than the insurer. Insurers must therefore base the premium on the risk pool that includes both low and high risks. Low risk individuals will not purchase insurance because the premium does not reflect their risk status leaving only high risk individuals in the risk pool. This can make the fund unsustainable. The solution is to have compulsory insurance or differential premiums. However, due to concerns that certain high risk individuals would be denied access to health care under a private system with differential premiums on the basis of age and

health status, most governments intervene to provide compulsory health insurance for most basic health services.

Moral hazard behaviour, where an individual's behaviour is affected by their insurance status, may arise in the form of excessive utilisation of resources on the part of the patient and also providers (as they know that their patients do not bear the full costs). Cost sharing initiatives, which aim to make both patients and providers more aware of the resource implications of their decisions are becoming increasingly common and will be discussed further in Section 5. However, to some extent the professional relationship between doctor and patient should limit moral hazard behaviours.<sup>6</sup>

A final problem associated with a private insurance market is that of cream skimming. Insurers will obviously try and encourage low risk persons to insure with their company. Once again, due to equity concerns about certain sections being denied medical treatment, governments intervene to either offer compulsory insurance or to regulate the sector. In Ireland, the government strictly regulates the behaviour of the two major private insurers in the Irish market in an attempt to prevent cream skimming through the principles of open enrolment (no one can be refused cover), community rating (all individuals face the same premium) and lifetime cover (once insured, an individual's policy cannot be terminated). However, as private insurance in Ireland essentially provides cover for services already available free of charge (or heavily subsidised) in the public sector, the rationale for these restrictions on behaviour, in particular community rating, has been questioned.

Due to concerns over the ability of the private market to deliver insurance efficiently and equitably (in particular adverse selection, moral hazard and cream skimming behaviours must be absent), governments in Europe have tended to intervene by providing compulsory insurance for most basic health services (e.g. in France and Germany all individuals are compulsorily insured for most health services and the system is funded through the social insurance scheme with the contributions of those on low incomes or that are economically inactive paid by the state). In Ireland, the state intervenes by providing compulsory insurance for certain services (mainly hospital services) to the full population, providing compulsory insurance for all services to certain vulnerable sections of the population (medical cardholders) and strictly regulating conduct in the private insurance market.

### **Externalities**

The health care sector may also be characterised by the presence of externalities when private costs or benefits are out of line with social costs or benefits. For a positive/negative externality, private benefits/costs are less than social benefits/costs, meaning that output is below/above the socially optimal level. The standard solution to an externality is to levy a Pigouvian tax in the case of goods or services that produce negative externalities or to offer a subsidy in the case of goods or services that produce positive externalities. Free childhood vaccinations against infectious diseases and excise taxes on cigarettes are the most obvious examples of government intervention in the health sector due to the presence of externalities. A vaccinated population confers a positive externality on society while second hand cigarette smoke confers a negative externality on society; in the absence of government intervention vaccination levels would be less than the



socially optimal level due to higher social benefits than private benefits while smoking levels would be greater than the socially optimal level due to higher social costs than private costs. Of course, the efficacy of taxes in changing behaviour to reflect the socially optimal level depends on the price elasticity of demand for the good/service, the availability of substitutes, its budget share etc (see also Chapter 3).

A related concept is that which regards health care as a merit good. While it is commonly assumed that the individual is the best judge of his own interests, with merit goods such as education, healthcare or cultural facilities (e.g. museums) this assumption does not necessarily hold. In the absence of government intervention, too little of the good in question will be consumed as individuals are unaware of the long term benefits. The government therefore intervenes to ensure that all citizens receive free or heavily subsidised basic health services, even if private professionals provide many of these services.

### **Equity**

Apart from efficiency concerns, the desire to ensure that health care should be distributed equitably across the population motivates government intervention in the sector. However, there is much discussion over what is meant by equity in the context of the health services (see also Chapter 6). Is the objective equality of opportunity (i.e. access to health care) or equality of outcome (i.e. health status)? Many governments intervene to smooth out differences in health outcomes that are not related to need factors such as age, gender or health status, but rather to socioeconomic characteristics such as income, area of residence, level of education etc. For example, a recent study found that women in Ireland from the unskilled manual and unemployed social classes were significantly more likely to give birth to low birth weight babies than those in the other social classes.<sup>7</sup> However, most governments also subscribe to the notion of equality of opportunity in the sense that access to health care should be distributed on the basis of need for care, not on the basis of non health related attributes, such as ability to pay (which is the case for many other commodities). But definitional problems also arise here. How do we define access? Most studies proxy access by utilisation, arguing that access to health services is equitable if utilisation rates are similar, even after controlling for need factors such as age, gender and health status. However, it is obvious that even if everyone enjoys the same access to health care, persons in equal need may end up consuming different amounts of care (and types of care) due to differing tastes and preferences.<sup>8</sup>

An additional issue concerns the progressivity of funding sources, i.e. most governments subscribe to the view that health services should be financed in relation to ability to pay (those on higher incomes should pay a higher proportion of their incomes in taxation, social insurance contributions etc.). Such thinking motivates government involvement in the financing of health care services, offering free services to those on low incomes or in particularly vulnerable situations.

In practice, the government uses a variety of instruments to intervene in the health sector. While the government intervenes heavily in terms of regulation, pricing, information provision and financing in Ireland, it mainly leaves the provision of health services to private operators, who consequently receive much of their funding from public sources (e.g. GP services and voluntary hospital

services). While government intervention to correct market failures is an accepted feature of modern economies, government failure may itself lead to efficiency or equity failings. In particular, government intervention in terms of provision may lead to inefficiency, as government owned and operated facilities face a loose budget constraint. In addition, regulatory capture by vested interests may result in regulations that lead to an inefficient level of output, e.g. the restrictions on pharmacy locations which existed prior to the revocation of the 1996 Health Regulations Act in 2001. Ensuring that public funding sources are progressive in their impact is also an important concern (see the following section).

#### 4 HEALTH SECTOR FINANCE

##### Overall Position

Health care is generally financed from four main sources, with different countries assigning different levels of importance to each source. Table 10.3 presents the sources of finance for selected OECD countries for 2001. In terms of public sources of finance, countries such as France and Germany rely much more heavily on social insurance contributions than general government sources, i.e. taxation, for their revenue. Social insurance contributions, which are compulsory and generally shared between the employer and employee, tend to be earmarked for specific purposes; in Ireland the 'health levy' amounts to 2 per cent of taxable income (those earning less than €356 per week in 2004 are exempt). However, it is not a major source of health sector finance in Ireland, amounting to only 1 per cent of total revenue in 2001. As in other countries, revenue from general taxation in Ireland is not earmarked specifically for the health services, which means that it must compete with other areas of public expenditure for attention.

Table 10.3

Sources of Finance for Total Health Expenditure for Selected EU-15 and OECD Countries (Percentage of Total Health Expenditure, 2001)

Country	General government	Social insurance	Out of pocket payments	Private insurance	Other private sources
Austria	28	41	18	7	6
Denmark	83	0	16	2	0
Finland	60	16	20	3	2
France	3	73	10	13	1
Germany	10	69	11	8	2
<i>Ireland</i>	<i>75</i>	<i>1</i>	<i>12</i>	<i>6</i>	<i>6</i>
Netherlands <sup>1</sup>	5	82	10	17	9
USA	30	15	14	36	5

Source: OECD, *Health Data 2004*, OECD, Paris 2004, 1<sup>st</sup> edition and OECD, *Health Data 2003*, OECD, Paris 2003, 2<sup>nd</sup> edition.

Note: Data for the UK are unavailable.

<sup>1</sup> Data for Netherlands refers to 2000

Due to universal eligibility for free public health services in many countries, the share of total expenditure funded through private sources (out of pocket payments by individuals and households, private insurance payments and other sources of finance, e.g. voluntary donations) is much smaller than that accounted for by public sources. The exception is the USA, which provides free health care only for the old and those on low incomes (through the Medicare and Medicaid schemes respectively) and consequently relies more heavily on private sources of finance, particularly insurance.

The prevalence of universal entitlement to free public health services across Europe results in monetary costs for health care consultations that are effectively zero, meaning that there is little incentive to control utilisation. As discussed further in Section 5, cost sharing, either through copayments, coinsurance or deductibles, can help to control utilisation, although there are concerns that such initiatives may reduce necessary as well as unnecessary utilisation. Nonetheless, most countries levy minimal charges on consumers in an attempt to make them more aware of the resource implications of their behaviour. For example, in Ireland, a charge of €15 per day applies to individuals without medical cards for treatment as an in-patient in the public hospital sector. As Table 10.3 illustrates, out of pocket payments are now more important than private insurance as a source of finance for all the countries examined except France, the Netherlands and the USA. However, there are concerns that as governments come under increasing pressure to fund public health programmes and out of pocket payments become more important as a source of revenue, a greater share of the funding burden falls on those in ill health.<sup>9</sup>

A crucial issue concerning taxation and social insurance contributions as well as out of pocket payments and insurance is the extent to which they are a progressive source of revenue, i.e. whether those on higher incomes pay a higher proportion of their income in tax, social insurance contributions, out of pocket payments and insurance. A recent study which examined the progressivity of different sources of finance for a number of OECD countries, found tax and social insurance contributions to be progressive sources of finance in Ireland, with taxation a particularly progressive source. However, Ireland performed poorly when out of pocket payments and private insurance payments were examined, with both found to be regressive sources of finance.<sup>10</sup>

### **Private Health Insurance**

It is useful to examine the private health insurance system in Ireland in more detail, principally because it is unusual in an international context in the extent to which the system interacts with the public system, particularly in the hospitals sector. Much recent discussion has also focussed on regulatory reform in the light of EU regulations regarding competitive behaviour between private insurers. There are two main private health insurance companies in Ireland, VHI and BUPA. As a result of the Third EU Directive on Non-Life Insurance, BUPA entered the market to compete with the VHI in 1996, although both are subject to strict state regulation on their conduct. There are also a number of smaller employer provided health insurance schemes such as the St. Paul's Garda Medical Aid Society, the Prison Officer's Medical Aid Society and the ESB Medical Provident Fund. However, VHI and BUPA accounted for 82 per cent and 13 per

cent respectively of the private health insurance market in 2003, with the restricted membership schemes accounting for the remaining 5 per cent.<sup>11</sup>

The VHI, a state-owned non profit making company, was originally established in 1957 to provide insurance against hospital expenses for the then 15 per cent of the population who were not entitled to free public hospital services. Despite the extension of entitlement of cover for free public hospital services to the remainder of the population in 1991, the reduction in tax relief from the marginal rate of tax to the standard rate of tax in 1996 and increasing premiums, private insurance coverage in Ireland has grown steadily since 1957 to reach nearly 50 per cent of the population by 2002. As stated above, the expansion in private health insurance cover is all the more striking given that private insurance cover does not generally cover the cost of primary care consultations, except where large deductibles are exceeded (although recently the two insurers have introduced additional plans with partial cover for primary care services). However, factors such as differing waiting times for admission to hospital between those with and without insurance, improved economic conditions and increased incomes, continued policy support for private coverage (principally through the tax code) and an expanding role for employer provided private health insurance are all important in explaining the growth in coverage.

The profile of those covered by private health insurance is also worth mentioning. There is a strong relationship between private insurance cover and socioeconomic characteristics such as income, educational attainment and health status. Interestingly however, there is no evidence of adverse selection in the market for private health insurance in Ireland with 53 per cent of those in very good health having private health insurance in comparison with only 15 per cent of those in bad or very bad health.<sup>12</sup>

Table 10.4

Reasons for having Private Health Insurance (Percentage of Respondents citing Reason as 'Very Important')

	Insured	Not Insured
Avoid large bills	88	75
Ensure quick treatment	85	71
Ensure good hospital treatment	73	61
Ensure consultant care	59	41
Arrange time of treatment	57	39
Choose consultant	43	23
Private bed	25	10
Private room	22	8

Source: D. Watson, and J. Williams, *op. cit.*, Tables 6.2 and 6.13.

A number of recent surveys have attempted to explain the appeal of private health insurance in Ireland, in the context of universal entitlement to free or heavily subsidised public hospital care. A survey of a random sample of the population in 2000 found that, among both the insured and the not insured, the most commonly cited reasons for having private health insurance were, in order of importance, to avoid large medical bills, to ensure quick treatment and to ensure good hospital treatment (see Table 10.4). Issues such as being able to have a private bed or a private room were perceived as much less important by both sets of respondents. Similarly, when those that were insured were asked what would

concern them most about having to give up private health insurance and relying on the public sector, 72 per cent cited the length of wait with only 20 per cent citing the quality of care, 5 per cent the choice of consultant and 3 per cent non-medical amenities. Among the uninsured, the main reasons for seriously considering private insurance would be length of wait (74 per cent) and quality of care (19 per cent) with choice of consultant and non-medical amenities being cited by only 5 per cent and 2 per cent of respondents respectively.

### **Access to Hospital Services**

These responses highlight public concern with waiting times and the perception that patients with private insurance have shorter waiting times and are guaranteed consultant care, in comparison with those that must rely on the public system. The Quarterly National Household Survey, in its 2001 health module, found that these concerns were to some extent justified. It found that 25.2 per cent of medical cardholders had waited for 12 months or longer for in-patient admission to a public hospital while only 12.4 per cent of those with private insurance cover had been waiting for 12 months or longer. For out-patient consultations and day care procedures or investigations, the corresponding figures were 8.3 per cent and 9.8 per cent (medical cardholders) and 4.7 per cent and 2.6 per cent (private insurance cover).<sup>13</sup> While there are obviously differences in age and health status across the two groups which may impact on the types and duration of treatments, the results do indicate that public patients face substantially longer waiting times than those with private health insurance.

Statistics for bed occupancy in public hospitals also lead to concerns that access to hospital for elective procedures in Ireland is not distributed by need. Public hospitals in Ireland must allocate a proportion of their beds for private or semi-private use; currently the designations are approximately 20 per cent for in-patient beds and approximately 30 per cent for day beds. However, research on patient discharges shows that for elective in-patient admissions in 2000, private patients accounted for 29.8 per cent of discharges while for emergency in-patient admissions, private patients accounted for 21.4 per cent of discharges. Only for day procedures were discharges distributed in favour of public patients with 23.1 per cent of discharges for day procedures classified as private in 2000. However, in all cases (elective and emergency in-patient services and day procedures), the increase in private discharges from 1999 to 2000 was much greater than that for public patients.<sup>14</sup> There are therefore very real concerns that access to hospital for elective procedures in particular is not distributed according to need, but rather by private insurance cover (and by extension, ability to pay since those with private insurance cover are concentrated in the top levels of the income distribution).

However, quite apart from concerns surrounding access to hospital services as a result of this public private mix, there are also efficiency concerns. Private patients in public hospitals are not charged the full economic cost of their care and treatment; this therefore gives insurers an incentive to encourage the treatment of private patients in public rather than private hospitals and public hospital managers an incentive to encourage the treatment of private patients as they represent an additional income stream for the hospital. This goes against an often cited rationale for the private insurance system in Ireland - that it relieves pressure on the public hospital system. It is also an inefficient use of resources as it reduces the revenue available to the public sector from this source. While not

directly linked to the insurance system, the fact that hospital consultants are remunerated in different ways for public and private patients (capitation and fee for service respectively) may distort their incentives and lead them to devote more time towards private care (see also Section 5). There are therefore concerns that, while private insurance is an important component of health sector financing in Ireland, its intermingling with the public system leads to serious equity and efficiency failings.

The Department of Health and Children on the other hand, argue that the public private mix in the hospital sector in Ireland has a number of advantages: it ensures that staff continue to be attracted to the public sector, consultants' time is used more efficiently as public and private patients are on the same site, it facilitates linkage in terms of medical knowledge and facilities and probably most importantly represents an additional income stream for the public hospital system.

#### **Regulation of the Private Health Insurance Market**

The operation of the private health insurance market in Ireland is strictly regulated by the government, despite the opening of the market to competition as a result of the 1994 Third EU Directive on Non-Life Insurance. The Health Insurance Authority was established in 2001 to act as regulator of the sector. The Irish government obtained permission from the EU to continue to ensure that all insurers abide by the principles of open enrolment, lifetime cover and community rating, and these principles are enshrined in the 1994 Health Insurance Act. Open enrolment means that no one can be refused insurance (subject to a maximum age limit of 65 years and a waiting period before a claim can be made), lifetime cover implies that once an individual is insured, the insurer cannot terminate their contract on the basis of age, risk status or claims history while community rating effectively means that the young and healthy subsidise the old and sick as premiums cannot be differentiated on the basis of age, gender or health status.

The continued stability of the community rating system means that a risk equalisation scheme must be implemented. Risk equalisation aims to remove differences in insurers' costs that result from differing risk profiles among their members; in Ireland, the risk profile of BUPA members is younger than that of VHI members. Risk equalisation involves a transfer of funds from one insurer to the other in order to spread the claims of high cost members between both insurers (in proportion to their market share). However, this has proven contentious, particularly on competition grounds, and to date, no transfer of funds has taken place.

## 5 HEALTH SECTOR EXPENDITURE

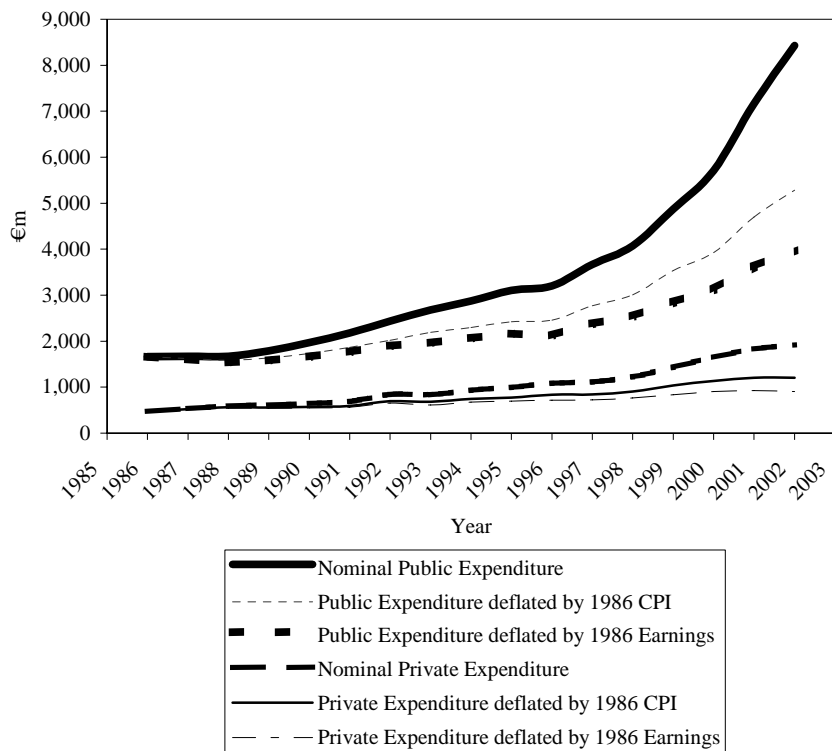
### **Irish Health Care Expenditure**

Public expenditure on the health services has increased greatly since the mid 1980s, from €1.7 billion in 1986 to €8.4 billion in 2002. In real terms, public expenditure has increased by 217 per cent since 1986, with most of this increase occurring since 1997. This is in contrast to the experience during some years of the 1980s when public health expenditures fell in real terms (e.g. between 1987 and 1988 public health expenditure decreased by 2.6 per cent in real terms). Given the share of labour costs in health expenditure (see below), when public

sector expenditure is deflated by real average industrial wage costs (see Figure 10.1), the increase over the latter part of the 1990s remains particularly pronounced, increasing by nearly 103 per cent from 1997 to 2002. While both non-capital and capital public expenditure increased substantially in the late 1990s, capital expenditure increased at a faster pace, thus explaining the increasing share of total public expenditure accounted for by capital expenditure (which increased from 4.5 per cent of total public expenditure in 1986 to 6.0 per cent in 2002).

Figure 10.1

Health Expenditure in Ireland: 1986-2002<sup>1</sup>



Sources: For expenditure data see Department of Health and Children, *Health Statistics 2002*, Stationery Office, Dublin 2003; for consumer price index data see CSO, *Consumer Price Index*, Stationery Office, Dublin various issues and for average weekly industrial earnings see CSO, *Industrial Earnings and Hours Worked*, Stationery Office, Dublin various issues and CSO, *Statistical Bulletin*, Stationery Office, Dublin various issues.

<sup>1</sup> While the CSO publish data on public sector earnings, the data exclude the health sector and are only available back to 1995.

Of the non-capital public health expenditure programme, by far the largest component comprises expenditure on the general hospitals service (which comprised 48 per cent of total non-capital public health expenditure in 2002). The remaining components of non-capital public health expenditure are, in order

of importance, the community health services programme (which mainly includes expenditure on the provision of primary care services to those on low incomes, i.e. GP services, pharmaceuticals, dental, ophthalmic and aural services), the programme for the handicapped, the community welfare programme (which mainly includes cash grants to those incapacitated for work), the psychiatric programme, the general support programme and the community protection programme (which mainly includes expenditure on the prevention of infectious diseases, food hygiene standards and health promotion).

While no programme has seen its level of expenditure decrease, the proportions allocated to different programmes have changed considerably over the last number of years (see Table 10.5). For example, while the community health services and general hospital programmes accounted for 15 and 50 per cent of total non-capital public health expenditure in 1990, the respective allocations had changed to 17 and 48 per cent by 2002. In part, this reflects the aspirations of the most recent Health Strategy published in 2001, which envisaged more emphasis on health promotion and prevention rather than on the traditional roles of diagnosis and treatment, in particular through an expanded role for general practitioner (GP) and other primary care services as the first point of call for most individuals' contact with the health services.

Table 10.5

Components of Non-Capital Public Expenditure (Percentage of the Total, 1990-2002)				
Programme	1990	1994	1998	2002
Community protection	2	2	3	3
Community health services	15	16	17	17
Community welfare	9	10	7	9
Psychiatric	11	9	9	7
Handicapped	10	10	11	12
General hospital	50	49	49	48
General support	5	4	5	4

Sources: Department of Health and Children, *Health Statistics*, Stationery Office, Dublin, 1990, 1998, 2002.

While the government is heavily involved in the financing, and to a lesser extent in the delivery, of health services in Ireland, the private sector plays an important role in both areas. Indeed, when the substantial involvement by the private sector in the financing and provision of health services in Ireland is included, total health expenditure (both public and private) amounted to over €10 billion in 2002. The proportion of total health expenditure accounted for by the private sector has declined slightly over the last decade, from 24.8 per cent in 1990 to 18.5 per cent in 2002, reflecting the proportionately larger increase in public sector expenditure rather than any decrease in private sector expenditure (see also Figure 10.1).

#### *Comparative Perspective*

Despite large increases in Irish health expenditure over the 1990s, Ireland still ranks below many other OECD countries in terms of health expenditure per head of population. Data from the OECD for 1997, presented in Table 10.6, indicate that Ireland was ranked sixteenth out of 20 in terms of per capita total health expenditure, expressed in US dollar purchasing power terms. The USA, Germany



and France topped the table, spending \$3,939, \$2,416 and \$2,163 per capita respectively while New Zealand, Spain and Portugal spent the least (\$1,357, \$1,287 and \$1,219 per capita respectively). Among the EU-15, Ireland's total health expenditure was ranked in twelfth place (spending \$1,417 per capita), with only Portugal, Greece and Spain spending less per capita in 1997. By 2000, Ireland had moved up one place in the rankings among the EU-15 countries (spending \$1,774 per capita), with Finland joining Greece, Portugal and Spain in spending less per capita on health than Ireland in 2000.

### **Effectiveness of Health Sector Expenditure**

However, levels of expenditure per head of population provide no guidance as to whether this expenditure is efficiently and effectively spent or distributed equitably across different sectors of the population. In terms of the effectiveness of health sector expenditure, it is useful to examine where countries rank in terms of health outcomes and whether there is any correlation between such measures and health expenditure. For example, OECD data for 1997 show that Ireland is ranked nineteenth, nineteenth and sixteenth out of 20 OECD countries in terms of male life expectancy, female life expectancy and infant mortality respectively. Among the EU-15 countries, Ireland is placed in fourteenth, fourteenth and thirteenth place on these indicators respectively. However, a study by the OECD found that aggregate measures of health sector output (such as life expectancy, infant and perinatal mortality *etc.*) were only weakly related to health sector expenditures in OECD countries.<sup>15</sup>

The weak association between health spending and health outcome indicators highlights the fact that social, environmental and cultural factors such as diet, exercise, genetic inheritance, lifestyle, education, social status, income distribution, social support and housing, and their complex interactions, may be more important in determining the level and distribution of health outcomes than simple health expenditure. The recent increases in resources devoted to health promotion and prevention (e.g. through the smoking in the workplace ban, breast cancer screening, promotion of healthy eating *etc.*) reflects this realisation that lifestyle factors are also crucial in influencing population health outcomes.

A related strand of research concentrates on the pitfalls involved in using crude measures of health status to assess health sector performance. In its 2000 report (*Health Systems: Improving Performance*) the World Health Organisation (WHO) took a much broader approach to assessing performance than simply examining improvements in life expectancy or infant mortality to include the responsiveness of the system (ascertained through questionnaires) and fairness of financial contribution.<sup>16</sup> In terms of overall health systems performance of the countries of the EU-15 and Australia, Canada, Japan, New Zealand and the USA (see Table 10.6), the top three performing countries were Japan, Sweden and Luxembourg while their rankings in terms of expenditure were thirteenth, tenth and fourth respectively. While there are countries (such as Canada and Luxembourg) who spend a lot and consequently rank high up in terms of health sector performance, there are also exceptions to this trend, namely, Denmark, Germany and the USA whose high levels of expenditure are not reflected in health sector performance and on the other hand, countries such as Japan and Sweden whose spending is in the middle range of countries yet who perform very well.

*Table 10.6*

Total Health Expenditure Per Capita and Health Outcome Rankings (EU-15 and Selected OECD Countries, 1997)

Country	Expenditure	Male life expectancy	Female life expectancy	Infant mortality	World Health Organisation (WHO)
Australia	8	5	6	11	10
Austria	11	13	10	6	8
Belgium	7	12	9	15	11
Canada	5	3	7	12	5
Denmark	6	17	20	10	15
Finland	14	18	11	3	16
France	3	11	2	5	4
Germany	2	15	13	7	12
Greece	17	6	8	17	17
<i>Ireland</i>	<i>16</i>	<i>19</i>	<i>19</i>	<i>16</i>	<i>18</i>
Italy	12	4	5	13	9
Japan	13	1	1	2	1
Luxembourg	4	14	15	4	3
Netherlands	9	7	12	8	6
New Zealand	18	9	14	19	19
Portugal	20	20	18	18	20
Spain	19	8	3	9	14
Sweden	10	2	4	1	2
UK	15	10	16	14	7
USA	1	16	17	20	13

*Source:* For data on expenditure (total health expenditure per capita expressed in USA \$ PPP), male and female life expectancy (at birth) and infant mortality (per 1,000 live births) see OECD, *Health Data 2004* OECD, Paris 2004, 1<sup>st</sup> edition. For data on World Health Organisation (WHO) ranking of countries on overall health system attainment, see WHO, *World Health Report 2000: Health Systems: Improving Performance*, WHO, Washington D.C. 2000, Annex Table 9.

### Measuring the Output of the Health Sector

The above highlights the fact that any assessment of health sector performance is beset with the problem of how to measure the output of the health sector. Cross country comparisons of performance tend to rely on aggregate indicators such as life expectancy and mortality rates, but at more disaggregated levels (e.g. hospital, GP practice) easily available indicators of output such as hospital admissions, in-patient days, discharges, number of procedures undertaken, number of consultations etc. are employed. However, these are essentially throughput measures and, in certain cases, they can provide misleading information on the performance of health service providers. For example, an increase in hospital discharges year on year for the same amount of inputs could be construed as an increase in productivity but it could simply be because the hospital is discharging patients 'quicker but sicker'.<sup>17</sup>

#### *Casemix*

In the context of hospital services, the need to account for the variety and intensity of treatments undertaken has resulted in the increasing use of the casemix adjustment to monitor output. The casemix measure assigns all in-patient cases exclusively to one category – there are approximately, 500 in total, called a diagnosis related group (DRG). Each DRG represents a class or category of cases

which may be expected to have the same clinical characteristics, receive similar treatment and use the same amount of hospital resources, i.e. doctor and nursing input, theatre, laboratory, pharmacy, catering and cleaning costs. A casemix adjusted cost is then estimated for each hospital and hospital group (teaching vs. non-teaching). Hospitals performing poorly relative to others in the group lose funding whereas those performing better receive extra funding; in Ireland, the casemix adjustment to hospital budgets is therefore budget neutral and aims to increase hospital efficiency. In 1993, the casemix adjustment was applied on a pilot basis to fifteen acute public hospitals and was initially used to make adjustments to 5 per cent of the in-patient budget; the remaining 95 per cent was based on the hospital's historical allocation. The rate of adjustment to hospital budgets (known as the blend rate) has increased over time to 20 per cent of the in-patient budget and to 10 per cent for day cases, with all acute public hospitals discharging more than 5,000 patients per annum subject to some degree of casemix adjustment by 2002.

#### *Economic Evaluation of Treatments*

Much recent research has concentrated on assessing the efficacy of different treatments. Essentially, there are three different, but related, approaches to assessing efficacy in this context: cost benefit analysis, cost effectiveness analysis and cost utility analysis. In all cases, costs are measured in terms of monetary units. The measurement of benefits or outputs proves more problematic. Cost benefit analysis is rarely employed as benefits must be converted into monetary units. Cost effectiveness analysis goes one step further by measuring output in terms of natural units of outcome for the programme being evaluated, e.g. life years gained. It is then possible to calculate a cost effectiveness ratio, which represents the additional cost per additional unit of outcome.

Cost utility analysis attempts to overcome the failing of cost effectiveness analysis by accounting for the quality of the additional life years gained. Once again, costs are measured in monetary units but outputs are measured in terms of quality adjusted life years (QALYs), which reflect both the quality and quantity of additional life years gained. Results are presented in terms of a cost per QALY achieved; unlike with cost effectiveness analysis, cross programme comparisons are possible. Much recent literature has therefore centred on the use of the QALY as a generic measure of output, with the construction of league tables of health care interventions, ranking them by cost per QALY achieved. However, the adjustment for quality relies on the subjective evaluations of patients or survey respondents. This inevitably leads to problems: different respondents may place different values on outcomes depending on their own situation (e.g. a patient suffering from a certain condition may value a treatment more highly than a healthy individual surveyed as part of a random sample of the population). Despite the advances in such research in recent years, no approach can deal with the thorny question of what is the appropriate level of resources to devote to certain interventions, i.e. what is the appropriate threshold of resources, beyond which the costs are too large relative to the expected benefits.<sup>18</sup>

#### **Why is Health Expenditure Increasing?**

For the EU-15, per capita total health expenditure (expressed in US dollar purchasing power parities) increased by 5.3 per cent annually on average between

1990 and 2000, ranging from 1.8 per cent in Finland to 8.4 per cent in Ireland. For OECD countries (excluding Hungary and the Slovak Republic for which data are missing), the average annual increase was 5.7 per cent with, once again, no country experiencing a decrease in total per capita health expenditure.<sup>19</sup>

What are the factors driving this increase in health expenditure, both in Ireland and across the OECD? On the demand side, such factors include changing demographic structures (particularly ageing populations), increasing incomes, increasing access to free public health services, increasing insurance cover and rising consumer expectations (see the discussion on Wagner's Law in Chapter 2). Cross sectional studies attempting to explain the factors driving health sector expenditure increases across countries typically find that aggregate income is the most important factor with an elasticity of one or greater. While there has been some debate over the accuracy of such estimates (in particular, micro studies of individual behaviour typically find little or no influence for income on health services utilisation), recent discussion has centred on the role of supply side factors in influencing spending. Attention has now focused on factors such as rising medical prices, technological change, increasing capital stock and labour costs, the regulatory regime governing behaviour in the health sector and the incentive structure facing health care providers. Given the labour intensity of the sector, the impact of labour costs on health expenditures cannot be underestimated. In Ireland, labour costs account for approximately two thirds of health expenditure; therefore changes in the level and type of employees has implications for spending on the health services.<sup>20</sup> Related to this is the concept of Baumol's disease (see also Chapter 2) whereby public sector employees demand wage increases in line with those of their private sector counterparts. However, while in the private sector (the 'progressive' sector), such wage increases are accompanied by improvements in productivity, in labour intensive sectors such as health, education and public administration (the 'non-progressive' sectors), productivity improvements are harder to implement. However, productivity improvements in the health sector are not impossible; for example, increased use of IT in the operation and management of the health service was recommended by the Brennan report as an aid to increasing productivity in the health service.

Attempts to control the growth in spending across the OECD initially concentrated on macro reforms such as caps on spending or employment freezes. However, 'with little attention paid to the underlying structure of incentives, there is growing doubt about the capacity of purely macroeconomic approaches to sustain overall spending control.'<sup>21</sup> In terms of micro economic reforms, measures such as promoting the use of the GP as a gatekeeper to hospital services, remunerating doctors on a capitation (rather than fee for service) basis for services provided in the public sector, funding hospitals on a casemix (i.e. adjusting for the nature and intensity of treatments undertaken) or prospective budget basis with rewards and sanctions for cost savings/over runs rather than on a simple retrospective budget basis, encouraging day surgery over in-patient stays and encouraging the prescribing of generic drugs are all seen as increasingly important in containing costs. On the demand side, implementing some form of cost sharing to make consumers more aware of the resource implications of their behaviour is common.

*Cost Sharing*

As stated in Section 2, cost sharing initiatives take one of three forms. Copayments are a fixed charge (e.g. in Ireland, non-medical cardholders pay €45 if they visit accident and emergency without a referral from their GP), coinsurance is a fixed percentage and deductibles are charges that apply after a certain threshold has been reached (e.g. in Ireland, non-medical cardholders are entitled to free prescription drugs once their monthly drug bill exceeds €78). There has been much criticism of cost sharing initiatives however. There are concerns that while they seek to make patients more aware of the resource implications of their health care consultations, they may reduce ‘necessary’ as well as ‘unnecessary’ consultations, thus increasing the tendency to incur higher costs at a later stage of illness. However, most concern concentrates on the equity consequences with fixed charges being seen as particularly regressive.

In the light of the possible trade off between cost sharing and equity of access, most countries in practice, attempt to protect lower income groups or those who are chronically sick. In implementing cost sharing, most now recognise that the most equitable method is to use a deductible, which has to be reached before the public subsidy is introduced. Even if cost sharing regimes are carefully designed to ensure that low income or vulnerable sections of the population are not disproportionately affected, cost sharing may have a limited impact given that doctors, rather than patients, make most utilisation decisions. In practice, most countries attempt to levy some form of modest charge on consumers, while simultaneously ensuring that the incentives that doctors face do not encourage excessive utilisation.

*Doctor Reimbursement*

The way in which doctors are reimbursed for the services that they provide has important implications for health care spending. Fee for service and capitation payments are the dominant methods of reimbursing doctors for their services. In a fee for service regime, doctors receive a fee for each consultation while in a capitation regime, they receive an annual payment per patient that is weighted for characteristics such as the age and gender of the patient. A study of a cross section of 19 OECD countries in 1987 found that health care expenditure was 11 per cent higher in countries where fee for service was the dominant form of remuneration for out-patient care in comparison with countries with capitation systems.<sup>22</sup>

In Ireland in the 1980s, much discussion centred on the reimbursement system for GPs. Prior to 1989, GPs received a fee for service payment from both their public and private patients (for the former group, this was paid by the state). However, due to concerns that such a payment system encouraged GPs to engage in ‘demand inducement’, i.e. to recommend unnecessary follow up visits, the system was changed in 1989 for medical cardholder patients. Now, the state reimburses GPs for services provided to medical cardholder patients on a capitation basis (a payment that is weighted for the age, gender and distance from the doctor’s surgery of the patient) while GPs continue to receive a fee for service payment from their non-medical cardholder patients. Capitation payments remove the incentive to arrange unnecessary follow up visits but may encourage the GP to discourage necessary as well as unnecessary follow up visits, to shorten consultation periods and to refer patients to secondary care as early as possible.

This distinction between patients is mirrored in the hospital system where consultants receive a fee for service payment from their private patients (often reimbursed by private insurance) and a capitation payment from the state for their public patients. The Brennan report on financial accountability in the health services in Ireland (see earlier) was extremely critical of this practice, arguing that it encourages consultants to minimise the time spent with public patients in favour of private patients. In Ireland therefore, the debate over the role of different payment regimes in controlling spending has been overshadowed by concerns that different regimes for different categories of patient results in inequitable treatment.

## 6 CONCLUDING COMMENTS

In this chapter, an overview of the financing and delivery of health services in Ireland, as well as key policy issues, was provided. The challenges facing the Irish health service today are very different to the concerns of the 1980s when the issue of how to provide services in a climate of real expenditure decreases was paramount. Irish health expenditures have increased dramatically since the latter years of the 1990s; the key issues now facing the Irish health services are how to ensure that access to services is distributed according to need rather than non-need factors such as ability to pay, to ensure that increasing levels of expenditure are spent efficiently and effectively and to ensure that costs are contained.

The discussion on the private health insurance system in Ireland highlighted the distributional issues surrounding the complex intermix between the public and private sectors in the Irish health sector, particularly in terms of hospital care. The increasing popularity of private health insurance cover was seen to be in part a response to concerns about access to services and treatment quality between those with and without private insurance cover. Data from a recent household survey supported these fears with those with private insurance having shorter waiting times than those without. However, there are concerns that any attempt to adopt a common waiting list would remove the incentive to take out private health insurance and could result in a significant fall in membership, which would increase further the pressure on the public system. In addition, the practice whereby medical consultants treat private patients, and junior doctors treat public patients implies differing standards of hospital care between the two groups. On the regulatory side, despite EU regulations on competition between insurers, there has been limited competition between the two insurers in the market, with only one new entrant since the market was opened to competition in 1994.

While access concerns dominate much discussion about the health services in Ireland, the steady growth in health expenditure in recent years has generated increasing concerns as to whether this increased investment is being efficiently and effectively spent. Despite the increases in expenditure in recent years, Ireland still spends less per capita on health than many other OECD countries and performs poorly in terms of aggregate health outcomes such as life expectancy and mortality rates. However, there seems to be little relationship between health expenditure and such aggregate measures of performance; such exercises highlight the difficulties involved in proxying health sector performance with such crude measures of output. Measuring the output of the health sector is

notoriously difficult; throughput measures such as number of consultations may lead to misleading conclusions while concepts such as quality adjusted life years (QALYs) rely heavily on subjective assessments of health care benefits. The development of the casemix method in the context of hospital services however represents an opportunity to explicitly account for the nature and intensity of treatments undertaken, rather than relying on simplistic measures of throughput. In response to ever increasing health expenditures, cost containment measures, which initially concentrated on macro approaches, such as employment freezes, have increasingly considered more micro measures. Measures such as the reimbursement system for doctors and cost sharing initiatives aim to make both providers and patients more aware of the resource using implications of their behaviour.

In terms of the overall structure of the public health services in Ireland, there has been much discussion that profound structural change, rather than piecemeal measures to improve access or efficiency, is necessary. At the heart of this discussion in Ireland is the view that the current structure of the health services, in terms of such issues as staffing, organisation and strategic planning is ill equipped to deal with the challenges of providing health services in Ireland in the twenty first century. As mentioned earlier, three major reports commissioned by the government dealing with respectively, staffing (the Hanly report), financial management (the Brennan report) and structures and functions (the Prospectus report) have consequently recommended wide ranging reform of the health services, particularly in the areas of the concentration of hospital services, medical staffing in hospitals and the number of agencies undertaking the coordination of public health services in Ireland. Whether their findings and recommendations will be implemented, and to what extent they will radically change the structure and operation of the Irish health system, remains to be seen.

### Endnotes

\* I would like to thank Carol Newman and John O'Hagan for comments on an earlier draft of the chapter and Joe Cullen, ESRI for assistance with some of the data. All views expressed are those of the author and are not necessarily shared by the Economic and Social Research Institute (ESRI).

<sup>1</sup> See Department of Health and Children, *Health Statistics 2002*, Stationery Office, Dublin 2003, Table L6 and CSO, *Quarterly National Household Survey (First Quarter 2004)*, Stationery Office, Dublin 2004, Table 2b.

<sup>2</sup> While the proportion of the population aged 65 years and over differs considerably across the countries presented in Table 10.1, there is little relationship between expenditure and age distribution. This is supported by international studies which find that the age structure of the population is a largely insignificant determinant of health expenditure. More important factors are GDP per capita and institutional arrangements (see for example, U. Gerdtham, J. Sogaard, F. Andersson, and B. Jonsson, 'An Econometric Analysis of Health Care Expenditure: A Cross-Section Study of OECD Countries', *Journal of Health Economics*, May 1992 and OECD, *Health Care Reform: Controlling Spending and Increasing Efficiency*, Working Paper No. 149, OECD, Paris 1994, Annex).

<sup>3</sup> The average weekly industrial wage in Ireland in December 2003 was €58.69 (CSO, *Industrial Earnings and Hours Worked*, Stationery Office, Dublin 2004).

<sup>4</sup> See CSO, *Quarterly National Household Survey: Health (Third Quarter 2001)*, Stationery Office, Dublin 2002, Table 1.

- <sup>5</sup> L. Kurunmaki, *The Irish Health Care System: Cost Containment Measures during the 1980s and 1990s*, (LSE Health Discussion Paper No. 11), LSE, London 1999.
- <sup>6</sup> K. Arrow, 'Uncertainty and the Welfare Economics of Medical Care', *American Economic Review*, December, 1963.
- <sup>7</sup> J. Barry, H. Sinclair, A. Kelly, R. O'Loughlin, D. Handy, and T. O'Dowd, *Inequalities in Health in Ireland – Hard Facts*, Department of Community Health and General Practice, Trinity College Dublin, Dublin 2001.
- <sup>8</sup> See A. Culyer, E. Van Doorslaer, and A. Wagstaff, *Comment on Utilisation as a Measure of Equity*, *Journal of Health Economics*, 1992.
- <sup>9</sup> E. Mossialos, A. Dixon, J. Figueras, and J. Kutzin, (editors.), *Funding Health Care: Options for Europe*, Open University Press, Buckingham 2002.
- <sup>10</sup> A. Wagstaff, and E. Van Doorslaer, 'Equity in Health Care Finance and Delivery' in A Culyer, and J Newhouse, (editors.) *Handbook of Health Economics*, North Holland, Amsterdam 2000, Volume 1B. The data upon which this study was based for Ireland relate to 1987. All individuals are now eligible for free public hospital services with non-medical cardholders paying a small daily charge (in 1987, approximately 15 per cent of the population, on high incomes, were ineligible for free public hospital services while the remainder received free public hospital services with no charge) and tax relief on health insurance premiums is now only available at the taxpayer's standard rate of tax (prior to 1996, tax relief was available at the taxpayer's marginal rate of tax).
- <sup>11</sup> Health Insurance Authority, *The Private Health Insurance Market in Ireland*, Health Insurance Authority, Dublin 2003.
- <sup>12</sup> While there is also a strong relationship between income and health status, a study using 1994 data showed that, even after controlling for income, the probability of having private health insurance was significantly lower for those in poor health. See C. Harmon, and B. Nolan, 'Health Insurance and Health Services Utilization in Ireland', *Health Economics*, February 2001.
- <sup>13</sup> See CSO, *Quarterly National Household Survey: Health (Third Quarter 2001)*, Stationery Office, Dublin 2002, Tables 3, 4 and 5.
- <sup>14</sup> M. Wiley, *Reform and Renewal of the Irish Health Care System: Policy and Practice*, Proceedings of ESRI/FFS Budget Perspectives Conference 2001, ESRI, Dublin 2001.
- <sup>15</sup> See OECD, *Health Care Reform: Controlling Spending and Increasing Efficiency*, (Working Papers No. 149), OECD, Paris 1994, Table 12.
- <sup>16</sup> World Health Organisation (WHO), *World Health Report 2000: Health Systems: Improving Performance*, WHO, Washington D.C. 2000 and for a critique of the choice of indicators, see Institute for Health Sector Development (IHSD), *Improving Health Systems by Measuring Health Status: Is WHO Serious?*, IHSD, London 2000.
- <sup>17</sup> B. Nolan, 'Affordability versus Quality, Effectiveness and Equity: Is there a Trade-Off?' in OECD, *Health Care Reform: The Will to Change*, OECD Health Policy Studies, OECD, Paris 1996.
- <sup>18</sup> *Ibid.*
- <sup>19</sup> OECD, *Health Data 2004*, OECD, Paris 2004, 1<sup>st</sup> edition.
- <sup>20</sup> M. Wiley, *Reform and Renewal of the Irish Health Care System: Policy and Practice*, Proceedings of ESRI/FFS Budget Perspectives Conference 2001, ESRI, Dublin 2001.
- <sup>21</sup> OECD, *Health Care Reform: Controlling Spending and Increasing Efficiency*, op. cit., p. 7.
- <sup>22</sup> U. Gerdtam, J. Sogaard, F. Andersson and B. Jonsson, *op. cit.*