CHAPTER 15

Financing the Irish Health Services: From Local to Centralised Funding and Beyond

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INTRODUCTION

With the establishment of the Department of Health in Ireland in 1947, an extensive range of responsibilities was defined, including the prevention and cure of disease and the treatment and care of those suffering from mental and physical illness. The effective discharge of these functions meant that responsibility for ensuring the resourcing of the health services also had to be vested in this new government department. The evolution of the approach to financing the health services over the past five decades is the subject of this review. It will be apparent that the financing of the health services has, at times, been both reactive to changes in the broader health service system and proactive in the implementation of innovations within this system. This paper begins with an assessment of how a health service which was primarily funded from local sources, when the Department of Health was established, ultimately came to be reliant on the central exchequer for funding purposes. Having traced how the source of funds came to be determined, the approach adopted to resource allocation within the health services will then be addressed. Finally, the development of the health insurance sector within the overall health financing system will be briefly reviewed.

THE EARLY YEARS

Prior to 1947, responsibility for health service provision was vested in the local authorities, and the health services were essentially financed from local rates with limited support from state grants. By 1947, state grants met just 16 per cent of the total cost of health service provision (Hensey, 1959). An extension of state support for health service financing was associated with the establishment of the new government department which was expected to

expand the services available to the public. This undertaking was put forward in the 1947 White Paper and given effect in the Health Services (Financial Provisions) Act, 1947. The objective of this legislation was to make provision for the state to pay for the cost increases associated with the expansion of health service provision. The specific mechanism put in place was that for each health authority, the state agreed to meet the full amount of the increase in the cost of service provision up to the level at which state support amounted to twice the level of commitment from local taxation in the year ending March 31, 1948. Subsequently, the cost of funding the health service was to be divided equally between the local rates and the exchequer. This division of responsibility for health service funding had been achieved by the time the provisions of the 1953 Health Act were to become effective. The establishment of the Department of Health and the enactment of the Health Services (Financial Provisions) Act, 1947 were therefore associated with an increase in state support for health service provision at the local level.

The emergence of a debate on the appropriate division of responsibility for health service financing between the state and local authorities is noted in a submission by the Department of Health to the Dáil Select Committee on the Health Services in May 1962. In recognising that the expansion of the health services since 1947 was largely financed by the state, it was stated that this 'was not intended to alter the traditional framework of a service which has always been and still is strictly local in character and which is financed and administered primarily by local bodies under the general direction and supervision of the central authority' (p. 64). In this memorandum, the Department of Health estimated that when the state contribution to health service financing was combined with the contribution from the Agricultural Grant, the central exchequer was actually bearing close to 65% of health service costs compared with a contribution of 35% from the local rates. It was clearly recognised in this memorandum that any decision to shift the majority of the health service cost burden away from the local authority on to the central exchequer would have to be considered in association with changes in the administration of the services. The Department's perspective, at the time, on the relationship between health service financing and adminstration is very effectively summarised as follows:

> In the provision of health services, there is very considerable scope for extravagance and unless the authority which is responsible for day-to-day decisions in the operation of the services is governed by the sense of financial responsibility which arises from having to contribute a considerable part of the rise in expenditure which might result from its actions,

> then there is the possibility that expenditure might rise unnecessarily and wastefully (*Dáil Select Committee on the Health Services*, 1962, 67).

THE 1966 WHITE PAPER

The division of responsibility for health service financing between the state and the local authorities was subsequently the subject of a detailed review in the White Paper on *The Health Services and their Further Development*, published in 1966. This White Paper presented a framework for substantial reform and expansion of the health service system and recognised the substantial demands that such reform would make on the financing of the health services. In so doing, the government acknowledged that 'the local rates are not a form of taxation suitable for collecting additional money on this scale' and it was proposed that 'the cost of the further extensions of the services should not be met in any proportion by the local rates' (p. 59). One reason put forward for this decision was the inequity which could result from the variation in health rates between different local authorities, reflecting local differences in the capacity to develop the health services as proposed. Political opposition to financing health services from the local rates had also begun to grow, as the health services were accounting for an increasingly large proportion of local authority expenditure (Barrington, 1987). It was therefore proposed that the contribution from the local rates to the health services would be fixed at the level prevailing in the base year 1965-66, and the additional cost of any expansion of this service would be met by the state. While there were difficulties in maintaining this commitment in subsequent years, annual discretionary grants from the Exchequer helped to alleviate the demands on the rates (Barrington, 1987).

Given the recognised inter-relationship between financing and administration, the government concluded that as the health services would be expected to draw an increasing proportion of the required resources from central sources, a new administrative framework combining national and local interests would also be required. As the Minister for Health's responsibility to the general taxpayer increased as funding from the central exchequer was expanded, so also did the accountability of the minister. The government therefore proposed that legislation should be introduced to transfer the administration of the health services from the existing local authorities to newly enacted regional health boards. These boards were to represent a partnership between local and central government and the vocational organisations, taking over responsibility for the hospital service, the general medical service and the community health services. This proposal was subsequently given effect in the Health Act, 1970.

THE HEALTH ACT, 1970 AND BEYOND

Following the Health Act, 1970, eight regional health boards took over responsibility for service provision in April 1971. Over this period, the proportion of total expenditure met from the local rates was decreasing and between 1973 and 1976, the local contribution to health service financing was phased out completely. As this source of financing was being eliminated, additional sources were being developed with the introduction of EEC regulations governing liability for the cost of health services for pensioners and the insured, in addition to the enactment of the Health Contributions Act, 1971. This act was introduced at the same time as the abolition of hospital charges for that proportion of the population which had limited eligibility. The contributions which were collected through the Social Welfare stamp were intended as part payment for the services which were being made available without charge to this segment of the population. While a system of flat-rate contributions was introduced when the scheme was initiated, in April 1979 a scheme of pay-related contributions was introduced whereby all income earners were liable, with the exception of those with full eligibility and those in receipt of specific social welfare benefits. Employers were liable for the contributions of those with full eligibility.

One of the most fundamental reviews of health service funding in recent decades was undertaken by the Commission on Health Funding which reported in 1989. This commission was established in 1987 in response to the pressures on public expenditure experienced in the mid- to late-1980s with the objective of examining the financing of health services and making 'recommendations on the extent and sources of the future funding required to provide an equitable, comprehensive and cost-effective public health service and on any changes in administration which seem desirable for that purpose' (p.1).The report of the commission covers a wide range of areas, including health service funding, expenditure and eligibility, together with the relationship between the public and private sectors. A key conclusion of the commission's deliberations was that the solution to the problem of financing the Irish health services did not lie primarily in the system of funding but was closely related to the way in which services were planned, organised and delivered.

Issues raised by the commission with regard to accountability and role definition at the health board level have more recently been addressed in the Health (Amendment) Bill, 1996 which is concerned with the combined objectives of (i) improving financial accountability and expenditure control procedures in health boards; (ii) clarifying the respective roles of the members of health boards and their chief executive officers; and (iii) initiating the process of removing the Department of Health from detailed involvement in

operational matters. The commission also made a number of important recommendations concerning the interface between the public and private sectors, in particular that tax relief on private insurance contributions should be phased out. To date, progress towards this objective has involved a reduction in tax relief to the standard rather than the marginal tax rate.

The recommendation by the commission that health service funding should be primarily tax-based continues to be supported. Additional funding sources subsequently introduced include the National Lottery and income from hospital charges. Table 1 provides an overview of how the sources of health service funding have changed since the early 1970s. While exchequer funding for the health services increased from 80.5 per cent in 1973/3 to 94.5 per cent in 1977, by 1996 the contribution from this source had dropped to 82.4 per cent. As a proportion of total health expenditure, however, the public component has dropped from a level of 85 per cent in the 1980s to just 75 per cent in the mid-1990s. The growth in the private sector over this period accounts for the 25 per cent of total health expenditure now credited to such sources as health insurance companies and household expenditure on general practitioner visits, pharmaceuticals and private hospital stays.

RESOURCE AVAILABILITY

To facilitate some insight into changes in the level of health expenditure over time, Table 2 shows the percentage change in health expenditure as a proportion of GNP for the five decades since the establishment of the Department of Health in 1947. Up to the most recent decade, the general trend in evidence is an increase in the proportion of GNP devoted to health care. The level of the increase can be seen to vary. The first decade of the Department of Health's existence was associated with the greatest increase in health expenditure as a percentage of GNP, but for each of the four decades between 1947 and 1986 the proportion of GNP devoted to health expenditure increased by over 30 per cent. For the most recent decade, however, there is a dramatic reversal of this trend, with the proportion of GNP devoted to health expenditure being reduced by 6.8 per cent over the 1987-96 period.

A different picture emerges if, instead of taking the establishment of the Department of Health as the starting point, calendar decades are assessed. The expansionism of the 1970s is clearly in evidence as the proportion of GNP allocated to health increased by 56.8 per cent, from 4.4 per cent in 1970/71 to 6.9 per cent in 1979. During this period, public spending increased substantially and health service eligibility and availability were also expanded. The 1980s sharply contrasted with the previous decade, however, as a public

expenditure crisis and economic recession were associated with a reduction of 16 per cent in the proportion of GNP allocated to health expenditure, from 8.1 per cent in 1980 to 6.8 per cent in 1989. While the 1990s has developed as a period of greater stability in the proportion of GNP devoted to health expenditure, the downward trend has continued, with a 2.6 per cent reduction from 6.97 per cent in 1990 to 6.79 per cent in 1996.

RESOURCE ALLOCATION

Since responsibility for health service funding was transferred to the state, exchequer spending on the health services has been determined in negotiations between the Department of Finance and the Department of Health, which retains responsibility for policy development and overall planning within the health services. Funding for the provision of public health services is provided on the basis of annual budgets to the eight regional health boards. In general, these budgets constitute a global allocation with the health board having responsibility for allocating funding across the three main programmes, i.e. the general hospital programme, the special hospital programme and the community care programme. In making these allocations, the Department may however indicate a level of funding which would be assumed for a particular service such as, for example, the regional hospital within the health board area.

Health board budgets are determined by demographic factors, commitments to service provision, and the general economic guidelines being applied to the operation of the public service as a whole. These guidelines have particular reference to public sector pay levels which generally constitute the largest component of health expenditure. In addition to service delivery agencies, other corporate bodies and registration boards are now supported by the Department of Health. These include such bodies as the Blood Transfusion Service Board, Comhairle na nOspidéal (The Hospital Council) and the Health Research Board.

When the health boards were established in 1971, the voluntary public hospitals which had traditionally been run by religious orders were maintained outside of this structure. The voluntary agencies providing care for the mentally handicapped were also maintained outside of the health board structure. Funding for the voluntary hospitals and the major mental handicap agencies has therefore continued to be negotiated individually with the Department of Health. Following on the recommendations of a number of consultative reports, the Minister for Health in 1996 announced the establishment of a high-level task force to oversee and manage the development of a new health authority in the Eastern Region (Report of the Dublin Hospital Initiative Group, 1991). This authority would be responsible for the funding of all health services in

the region, including those provided by the voluntary hospitals. It is expected, however, that full transition to the proposed arrangements would take two to three years. A working group reporting in late 1995 recommended that responsibility for funding the mental handicap agencies should also be transferred from the Department of Health to the health boards. Following discussion between the Federation of Voluntary Bodies, the Department of Health and the health boards, a framework for implementation of this recommendation has been agreed. Responsibility for funding the mental handicap agencies is being transferred to two health boards in 1997, with the transfer to other health boards planned for implementation on a phased basis.

In considering the funding of acute hospital services in particular, the Commission on Health Funding recommended that hospitals should receive global budgets for the provision of an agreed service level. The calculation of these budgets should be based on an assessment of the activity level implied by the hospital's agreed role and catchment area, and the case-mix based cost indicated by the level of service provision. In addition, it was suggested that techniques such as Diagnosis Related Groups (DRGs) or other case-mix measures should be used to determine the level of funding required for the service level agreed.

The establishment of the National Case-Mix Project by the Department of Health in 1991 was a partial response to this recommendation, prompted by the recognition that 'the principal problem in promoting equity and clarity in the way the Department of Health funds hospitals lies in the difficulty in measuring hospital workload in a manner that is equally meaningful to both clinician and funder' (Casemix Manual, 1993, 3). Prior to 1991, the Department of Health had supported initiatives aimed at testing the applicability of DRGs as a measure of workload in the acute hospital setting. A report published in 1990 demonstrated that this technique could be successfully applied to Irish hospital discharge data, and the department then proceeded with the development of a system within which hospital workload measured by DRGs could be related to resource allocation for acute hospital services (Wiley and Fetter, 1990).

In 1993, the budgets for the largest acute hospitals for the first time incorporated a case-mix adjustment within the allocation process. The essentials of this case-mix adjustment may be summarised as follows: hospitals are stratified according to teaching or non-teaching status; activity data from the relevant hospitals are assigned to DRGs and a case-mix adjusted cost is estimated for the individual hospital and hospital group; a budget allocation rate is then determined on the basis of a 'blend' of the hospital's case-mix adjusted case cost and that estimated for the relevant hospital group (Wiley, 1995).

The 'blending' approach was considered necessary because, while the case-mix adjusted costs estimated for individual hospitals showed considerable variation in relative efficiency, it was recognised that sudden and large reductions in the amount of resources available to a hospital would cause insurmountable difficulties for the operation of the hospital. The application of a blend rate of 95% in the first year meant that 95% of the budget allocation rate for the hospital would be determined on the basis of the hospital's own case-mix adjusted cost, while 5 per cent was determined by the case-mix adjusted cost for the hospital group. The blend rate currently in operation has been modified to a level of 85%. With the application of this adjustment, the most inefficient hospitals receive some financial penalty while the more efficient hospitals receive a financial reward, though the adjustments would have to be considered marginal in the context of the overall hospital budget.

HEALTH INSURANCE

The Voluntary Health Insurance (VHI) Board was established in 1957 as a state-sponsored organisation for the provision of private health insurance in Ireland. This initiative was intended to enable the 15 per cent of the population without entitlement to free public health services to make financial provision for their health service needs, and particularly to insure against the higher costs associated with hospital care. With the exception of a number of small occupation-based schemes, the VHI has operated as a virtual monopoly for the provision of private health insurance since its foundation.

With the passing of the Third Directive on Non-Life Insurance for the European Union, however, the Irish government was required to introduce legislation allowing competition within the private health insurance market. The Health Insurance Act, 1994, which came into effect on 1 July 1994, is the legislative basis for the regulation of the Irish private health insurance market and the introduction of competition within this market. The principal objectives proposed for the introduction of this legislation include the following:

* the maintenance of the current system of community rating, open enrolment, and lifetime cover;

* the provision of a 'level playing field' for health insurers with the minimum regulation possible;

* the development of a regulatory environment which would maximise the incentives for health insurers and health care providers to operate efficiently;

* the maintenance of the position of private practice within the well-established public/private mix of the health system as a whole.

In March, 1996 the supporting regulatory framework necessary for the successful implementation of this legislation was signed and laid before the Houses of the Oireachtas by the Minister for Health. Community rating, open enrolment and lifetime cover are now mandatory requirements for all health insurers operating within the Irish market. Under the 1994 legislation, each individual will pay the same premium for a given level of health insurance cover, irrespective of age, sex or health status. Open enrolment means that all health insurers are required to accept applications for membership from all individuals aged under 65 and that once enrolled, membership cannot be terminated or renewal refused. The regulations do, however, provide for maximum waiting periods in respect of pre-existing medical conditions.

The regulations governing risk equalisation are intended to ensure that, under a community rated system with open enrolment, no insurer incurs disproportionately heavy claims because of preferred risk selection by other insurers in the market. Under this system, an insurer with a higher than average risk profile will receive a transfer of funds from the system while one with a lower than average risk profile will pay into the system. While the operation of the risk equalisation mechanism will only be triggered with the development of serious competition in the market, all insurers are now required to return data in a specified format on a quarterly basis.

Currently, BUPA is the only major international health care company to announce its intention to offer health insurance on the Irish market. The announcement in April 1996 indicated that through the establishment of a new health care company, BUPA Ireland Ltd., BUPA would be the first company to offer Irish consumers an alternative to VHI. While there are suggestions that other companies may also enter the market, these have not yet materialised.

CONCLUSION

When reflecting on the historical evolution of the financing of the Irish health service, the following comment by Hensey (1959) is worthy of note: 'In the absence of new or extended services, the percentage of the gross national product spent by public authorities on health services will tend to fall in future' (p. 47). This statement was made against the background of a fall in the proportion of GNP devoted to health, from a high of 2.92 per cent in 1956 to 2.74 per cent in 1958. Hensey was reflecting a view, generally held internationally at the time, that the need for health care in the community could somehow be contained and addressed if the 'appropriate' level of resources

could be dedicated to the problem. This view would have contributed to the expansion of state involvement in health service provision in many countries after the second world war, including the development of the National Health Service in Great Britain in the late 1940s. History has, however, now shown this perspective to be misguided as the demand for the commitment of resources to health care has increased throughout the latter half of the twentieth century, with a corresponding increase in the perceived level of health needs in the community.

The historical review presented here shows how the commitment of state resources to the health services has increased over time to the point where this sector now accounts for one of the largest items of public expenditure. While the exchequer commitment to the health sector has been shown to vary somewhat according to the prevailing economic climate, total expenditure on this sector continues to grow.

The extent to which public health expenditure is intrinsically linked to overall government policy on the economy is clearly indicated in the Department of Health's strategy document, *Shaping a Healthier Future* (1994). To an extent, this document builds on, and develops, a number of the issues addressed by the earlier strategy document *Health – The Wider Dimensions* (1986) and the Commission on Health Funding (1989). In particular, a reorientation of the health service environment in accordance with the principles of equity, quality of service and accountability is proposed. In pursuit of greater accountability, the strategy proposes that mechanisms must be put in place which ensure that those with decision-making powers are adequately accountable to the funders and consumers of the services. This strategic overview is accompanied by a four-year action plan for the period 1994-1997 which is intended to present national objectives for service development on the basis of the principles of the Strategy. In addressing the resource commitment necessary for the implementation of the specified targets, the Department of Health states: 'The Government will aim to provide over the next four years the resources for the development needs identified in the Action Plan which is incorporated in this Strategy, while observing the budgetary policy set out in its Programme for a Partnership Government' (Department of Health, 1994, p.12).

While the Department of Health has now achieved the milestone of being in existence for half a century, any review of the development of the Irish health service environment must recognise that the health system of to-day which originated with the 1970 Health Act has its roots firmly in the White Paper of 1966. The fact that, thirty years later, the vision for the health services proposed in 1966 has achieved maturity must reflect well on the wisdom and farsightedness of the architects of this policy document. The summarisation in the 1966 White Paper of the factors influencing health expenditure, and the

likely direction such expenditure would take in the future, continue to hold true to-day and may also be expected to remain valid through to the next millennium:

> The government fully accept that those employed in the health services should benefit from periodic rounds of pay increases, in the same way as others in public employment, and recognise that rises in the cost of the services will follow from this. There are other factors, too, which continually tend to augment the cost of the services, including the increasing complexity of medicine, better standards of staffing, rises in prices of drugs and medical requisites . . . and the increasing cost of maintaining the fabric of institutions and the equipment in them. Therefore if there were to be no further developments or expansion in the health services, health expenditure would continue to inexorably rise (p. 58).

TABLE 1

SOURCE OF FUNDING FOR HEALTH EXPENDITURE: SELECTED YEARS, 1973/4–1996

Funding Source	1973/4* %	1977* %	1980* %	1996† %
Exchequer	80.5	94.5	87.9	8.24
Rates	13.9	—	—	—
Hospitals Sweepstakes	0.6	0.5	—	—
Health Contributions	3.8	4.0	6.4	8.7
EU Receipts	1.2	1.0	1.5	2.1
Lottery	—	—	—	0.8
Local Income	—	—	4.2	6.0
Local Income	100	100	100	100

Source: *Hensey, B. (1979)

†Department of Health, 1996.

TABLE 2

HEALTH EXPENDITURE AS A PROPORTION OF GNP: CHANGES IN THE FIVE DECADES SINCE 1947*

Health as % of GNP

*The data presented here are intended to show broad changes in trends over the period and should be treated with caution as approaches to compiling this series may have changed over time.

Source: [1] Hensey (1959)
[2] Tussing (1985)
[3] Department of Health (1996)

	Beginning of Period % of GNP	*End of Period % of GNP*	*Percentage change in health expenditure as % of GNP*
1947[1]–1956[1]	1.7	2.9	7.06
1957[1]–1966/67[2]	2.9	3.8	31
1967/68[2]–1976[2]	3.8	6	57.9
1977[2]–1986[2]	6	7.7	30
1987[2]–1996[3]	7.3	6.8	–6.8