4. Reform and Renewal of the Irish Health Care System: Policy and Practice

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4.1 Introduction

Rarely a week goes by without some aspect of the Irish health system featuring in media commentary or discussion. The health system seems to be the one area where everyone has a view, probably because everyone has cause to encounter the health system at some stage in their lives, either to address a personal or family need. This factor differentiates this system from other areas like, for example, education where many individuals and families will not have any reason for direct contact for extensive periods of time. Demands on the health services are greatest for the most vulnerable groups in our society including children, the elderly and the disabled/handicapped. The publication of a new Health Strategy proposing to chart the course of health system development in the medium term is imminent. Given widespread public concern regarding the development of our health services, together with the expectation that proposals for further expansion are about to be delivered, it seems timely to raise questions regarding the current state of the Irish health services.

While the scope of the overview presented here does not permit an assessment of all aspects of the health system, key areas are selected for more indepth consideration. The fact that health expenditure has been growing substantially in recent years has been generally recognised. In this review the magnitude of this growth is quantified and assessed in international terms and at the level of health programme expenditure in the Irish context. The analysis of health expenditure trends is followed by

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an assessment of changes in public health service employment over the past decade. As the hospital sector is the single biggest programme within the health system, activity in this area is selected for more detailed analysis. Recognising the widespread public concern over waiting lists for hospital services, the relative utilisation of acute hospital services by public and private patients is reviewed. The discussion and conclusions presented focus on the policy issues to be addressed in ensuring that future health system development is guided by the prioritisation of equity considerations which ensure that access to health services is based on need. Given the very large commitments of exchequer resources to the health system, clarification of productivity and efficiency targets for the resources invested are essential if any advancement is to be made towards the achievement of the objective of securing "value for money" within the public health sector.

4.2 Irish Health Expenditure Reviewed

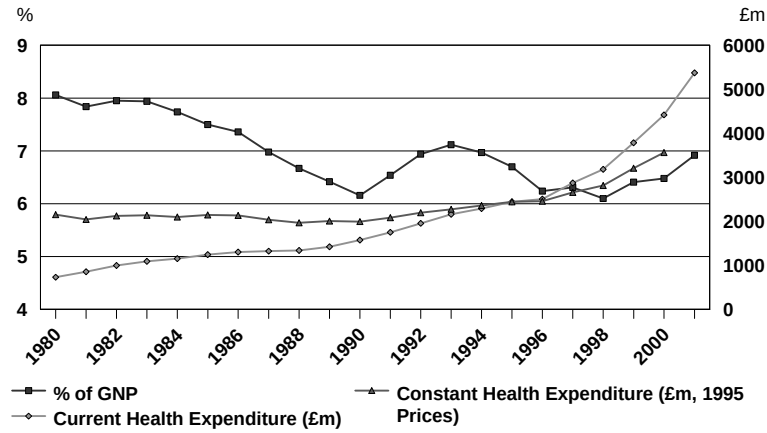
4.2.1 NATIONAL AND INTERNATIONAL CONTEXT

Figure 4.1 presents gross non-capital health expenditure in current and constant terms and current health expenditure as a percentage of GNP for Ireland for the period 1980-2001.[1] Between 1980-1989, gross non-capital health expenditure in current terms increased by 95 per cent while health expenditure in constant terms (at 1995 prices) declined by 7 per cent.[2] This period of contraction in investment in the health services contrasts starkly with the expansionism in evidence for the 1990s. Between 1990 and 2000, health expenditure increased by 180 per cent in current terms and by 79 per cent in constant terms. For current health expenditure over the 1990 to 2001 period, the scale of the increase is estimated at 241 per cent from an estimated £1.6b in 1990 to the current estimate of around £5.4b. It is evident from Figure 4.1 that while there was a steady increase in health expenditure through the early 1990s, it is really from 1996 onwards that the rate of increase in health expenditure began to increase sharply. While health expenditure in current terms increased by 59 per cent between 1990 and 1996, the rate of increase between 1996 and 2000 is estimated at 76 per cent, rising to a staggering 114 per cent for the period 1996-2001. For health expenditure in constant terms, the steep increase in the latter years of the 1990s is clearly in evidence. Health expenditure in constant terms increased by 23 per cent in the period 1990-1996 compared with an increase of 45 per cent from 1996 to 2000.

Figure 4.1: Gross Non-Capital Health Expenditure in Current and Constant Terms and as a percentage of GNP, 1980-2001

[1] The analysis of health expenditure presented in this paper is based on gross non-capital expenditure on the public health system. An analysis of capital expenditure which currently accounts for approximately 4.8 per cent of gross health expenditure is outside the scope of this review. The estimates for gross non-capital health expenditure presented for 2001 are provisional. These data do not include provisions made for payments to individuals under the Hepatitis C compensation tribunals.

[2] Public expenditure price deflator (1995=100) has been used for the estimation of constant health expenditure in this analysis.



Source: Department of Health and Children (2001).

Figure 4.1 provides evidence for the rather unusual phenomenon of health expenditure accounting for a declining share of GNP in the1980s and the 1990s but for very different reasons (Wiley, 1998). Through the 1980s, the share of GNP devoted to current health expenditure fell from a high of 8.1 per cent in 1980 to 6.2 per cent in 1990. The increases in health expenditure in the early 1990s translate into a reversal of this trend and the proportion of GNP devoted to health is seen to rise from 1990 to a high of 7.1 per cent in 1993. The "Celtic Tiger" phenomenon then, however, comes into play as the very substantial increases in health expenditure in the mid- to late-1990s translate into a declining share of GNP devoted to the health services. Subsequent to 1993, gross non-capital expenditure as a percentage of GNP fell to a low of 6.1 per cent in 1998 and subsequently increased to the current level of 6.9 per cent estimated for 2001. The declining share of GNP estimated for health over this period is clearly due to the rapid growth of the Irish economy at this time, as Figure 4.1 shows the substantial increase in expenditure on this sector through the latter 1990s in particular. The strong relationship between health expenditure levels and economic growth is in evidence in Figure 4.2, where GNP is shown together with health expenditure in current and constant terms. Figure 4.2 shows that the economic slowdown in the 1980s was associated with real decreases in health expenditure levels while the accelerated pace of economic growth in the mid- to late-1990s has been associated with substantially increased exchequer spending on the health sector.

Figure 4.2: Gross Non-Capital Health Expenditure in Current and Constant Terms and GNP, 1980-2001

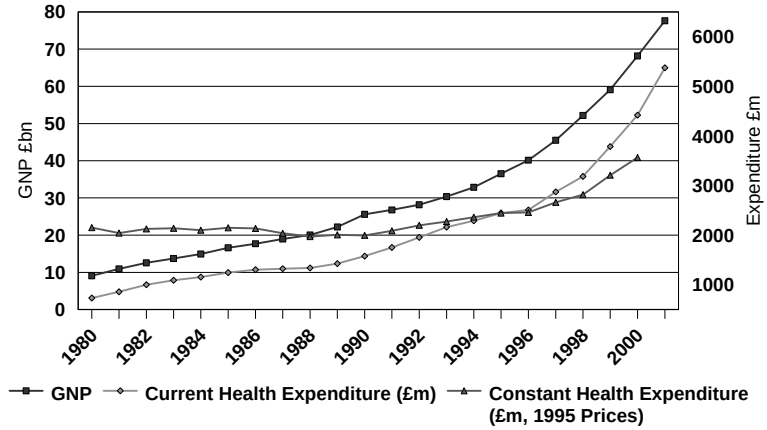
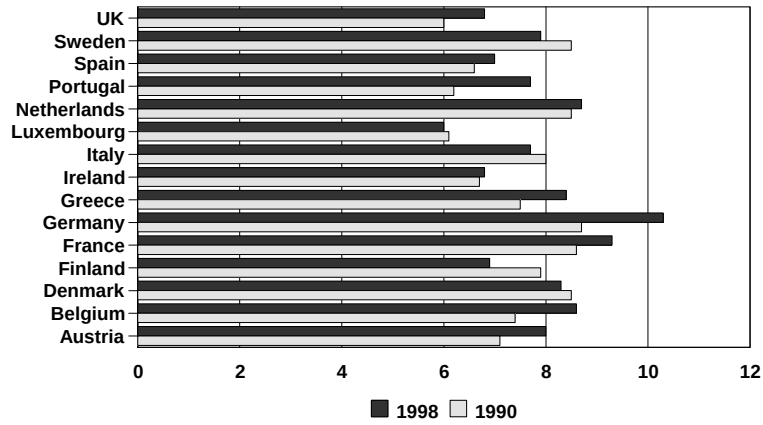


Figure 4.3: Total Health Expenditure as a % of GDP for EU Member States

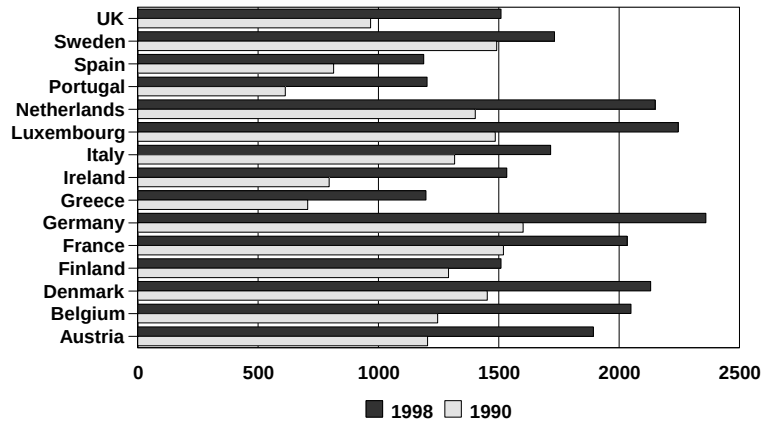


Source: OECD Health Data (2001).

To place the Irish health expenditure profile in an international context, Figure 4.3 presents total health expenditure as a percentage of GDP for EU member states for selected years. For 1998, the most recent year for which data are available for all member states, total health expenditure as a percentage of GDP ranges from a low of 6 per cent for Luxembourg to a high of 9.3 per cent for France and 10.3 per cent for Germany. Ireland and the UK at 6.8 per cent, and Finland at 6.9 per cent rank next to Luxembourg as the countries devoting the smallest proportion of GDP to health expenditure in the latter years of the 1990s. Throughout the 1990s Germany and France were the big spenders on health care within the EU, a position which both countries continue to maintain currently. It is interesting that in the World Health Organisation's review of health systems in 191 member states, the German system ranked 25th, the Irish system ranked 19th and the French system ranked 1st when assessed on the basis of selected performance indicators (WHO, 2000). The findings of the WHO report raise questions about the relationship

between relative health expenditure and overall system performance in the health care sector.

Figure 4.4: Total Health Expenditure/Capita, US$PPP, for EU Member States



Source: OECD Health Data (2001).

It has been indicated in the discussion on Irish health expenditure levels that a simple focus on health expenditure as a proportion of GNP (or GDP) may not tell the full story of changes in expenditure levels, particularly where economic growth has risen rapidly as happened in Ireland in the 1990s. To facilitate some insight into real changes in the level of investment in the health system in an international context, Figure 4.4 presents total health expenditure per capita, using purchasing power parities (PPP, US$) for EU member states for selected years.[3] A different profile emerges here as the data for 1998 show that while Germany continues to rank first in terms of the level of health expenditure/capita, PPPUS$, Luxembourg ranks second and Ireland now ranks in 10th place followed by the UK and Finland. Figure 4.4 shows that for 1998, Germany, Luxembourg, the Netherlands, Denmark, Belgium and France all devoted over US$2,000/capita, PPP to total health expenditure while expenditure levels for other member states ranged from US$1,894/capita, PPP in Austria, US$1,534, PPP in Ireland to the lowest levels of around US$1,200/capita, PPP in Greece and Spain. What is particularly interesting is the rate of growth in per capita health expenditure through the 1990s. When compared with other EU member states, Portugal and Ireland show the highest levels of growth as total health expenditure/capita, US$PPP increased by over 90 per cent in both countries between 1990 and 1998. This rate of increase is substantially higher than that recorded for any other member state as Greece falls into third place in this ranking with an increase of 70 per cent in per capita health expenditure in US$PPP over

[3] Purchasing Power Parities (PPPs) are rates of currency conversion that enable the expression of the purchasing power of different countries in a common unit. In other words, a given sum of money, when converted at the PPP rates, will buy the same basket of goods and services in all countries (OECD, 1993, p.8).

this period which contrasts with an estimated 56 per cent increase for the UK. At the lower end of this spectrum, Sweden records an increase of just 14 per cent and Finland 17 per cent in health expenditure/capita, US$PPP over 1990-1998.

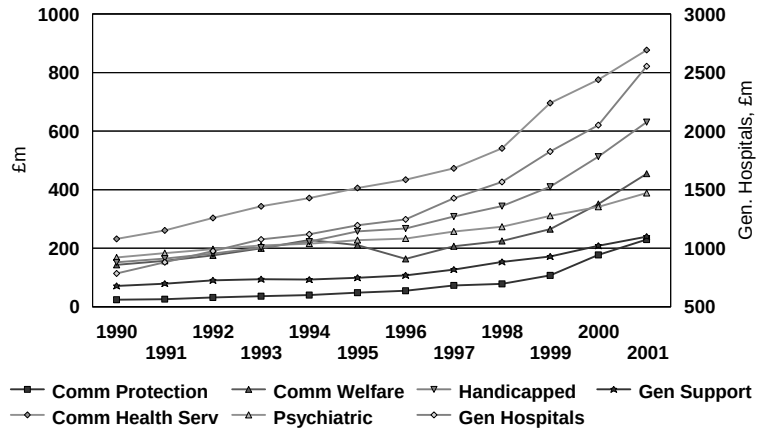
4.2.2 IRISH HEALTH EXPENDITURE AT THE PROGRAMME LEVEL

To enable some appreciation of how Irish health spending has been changing at the programme level, Figure 4.5 shows gross non-capital health expenditure for the seven health expenditure programmes since 1990[4] while Figure 4.6 shows the percentage change in programme expenditure in current and constant terms over the 1990-2000 period.[5] The Community Protection Programme shows the biggest growth with an increase in current expenditure from 1990 to 2001 estimated at 840 per cent. The areas accounting for the highest levels of increase within this programme are the health promotion and disease prevention initiatives together with food hygiene and standards. While the rate of increase for community health services and programmes for the handicapped over the 1990-2000 period was similar, investment in programmes for the handicapped increased at a faster rate between 1990 and 2001 with current expenditure rising by 315 per cent over the period, while expenditure on community health services increased by 278 per cent. Within programmes for the handicapped, the areas accounting for the highest levels of increased expenditure include rehabilitation, assessment and care of specific categories of handicapped persons and provision for institutional and day care for the mentally handicapped. By far, the area accounting for the largest increase in investment in the community health service programme since 1990 is the provision of family planning and pregnancy counselling services where expenditure increased from £160,000 in 1990 to an estimated £7.7m in 2001. Other areas of substantial increases in expenditure within this programme include the drug subsidisation scheme and the dental services.

Figure 4.5: Current (Gross Non-Capital) Health Expenditure by Programme, 1990-2001

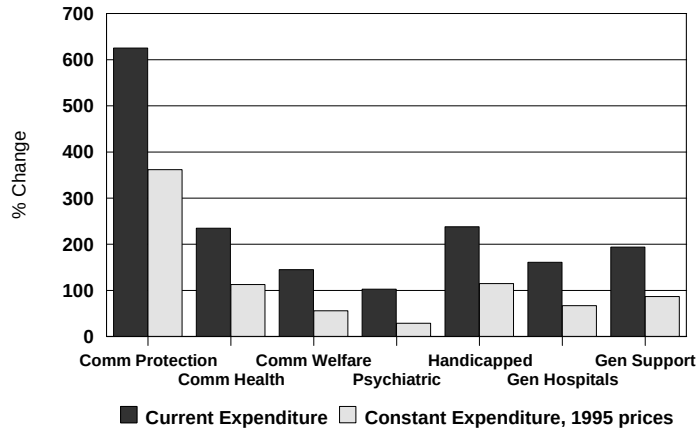
[4] Because of differences in the scale of expenditure relative to other programmes, the data for expenditure on the general hospitals programme are presented on a separate axis as indicated in Figure 4.5.

[5] Given the application of the public expenditure price deflator to gross non-capital health expenditure here, this deflator has also been applied to the estimation of constant expenditure at the programme level. It is readily acknowledged, however, that for some programmes this may not be the deflator of choice but appropriate alternatives are not readily available. As the main objective here is to attempt to provide an overview of the relative distribution of health expenditure, the application of the public expenditure price deflator at the programme level is considered adequate for this purpose.



Source: Revised Estimates for Public Services (1991-2001).

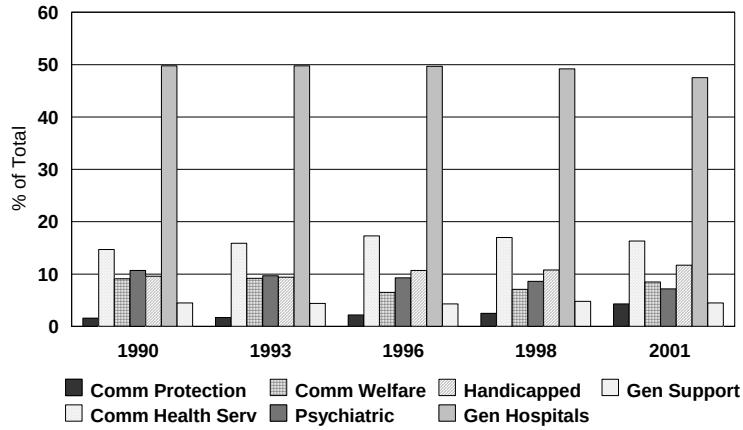
Figure 4.6: Percentage Change for Current and Constant Non-Capital Health Expenditure by Programme, 1990-2000



It is interesting that of the seven main health expenditure programmes, the general support programme incorporating administrative and finance charges ranks fourth in terms of the level of increased expenditure since 1990. The increase in current expenditure on general support is estimated at 237 per cent for the period 1990-2001. Research accounts for the largest increase in expenditure within this programme over this period. Expenditure on the general hospitals programme increased by two-thirds in constant terms between 1990 and 2000 while current expenditure increased by 161 per cent between 1990 and 2000 compared with 226 per cent for the 1990-2001 period. The increased investment in the general hospitals programme is fairly evenly spread throughout the sector though the rise in expenditure levels was marginally higher for regional hospitals and the ambulance services. Even though responsibility for payment of some cash allowances transferred from the Department of Health and Children in the 1990s, current expenditure on the community welfare programme increased by 217 per cent over the 1990-2001 period. The services accounting for the biggest rise in expenditure within this programme include support for childcare services, including the residential care area and the expansion in support for pre-school services. Compared

to all other health expenditure programmes, the psychiatric programme accounts for the lowest level of increase in current expenditure estimated at 131 per cent for the 1990-2001 period.

Figure 4.7: Distribution of Gross Non-Capital Health Expenditure by Programme



Source: Revised Estimates for Public Services (1991-2001).

In addition to variation between programmes in the level of health expenditure over the 1990s, Figure 4.7 shows that the distribution of health expenditure by programme also changed over this period. While the general hospitals programme continues to account for the highest proportion of gross non-capital health expenditure, the relative level of expenditure on this and other programmes has changed. The 50 per cent of health expenditure accounted for by the hospitals sector in 1990 has declined to 47.5 per cent of current investment in 2001. Relative investment in the community welfare and psychiatric services has also declined from 9.1 per cent and 10.7 per cent, respectively, for each of these programmes in 1990 to the 2001 level where 8.5 per cent of current health expenditure is allocated to community welfare and 7.2 per cent is allocated to the psychiatric programme. While the proportion of current expenditure allocated to the general support programme has not varied much from around the 4.5 per cent level through the 1990s, community protection, community health and the programme for the handicapped all now account for a greater proportion of current health expenditure compared with the early 1990s. Community protection now accounts for 4.3 per cent of current expenditure compared with 1.6 per cent in 1990. Community health and the programme for the handicapped have increased the proportion of current expenditure accounted for from 14.7 per cent and 9.6 per cent, respectively, in 1990 to the current levels of 16.3 per cent for community health and 11.7 per cent for services for the handicapped.

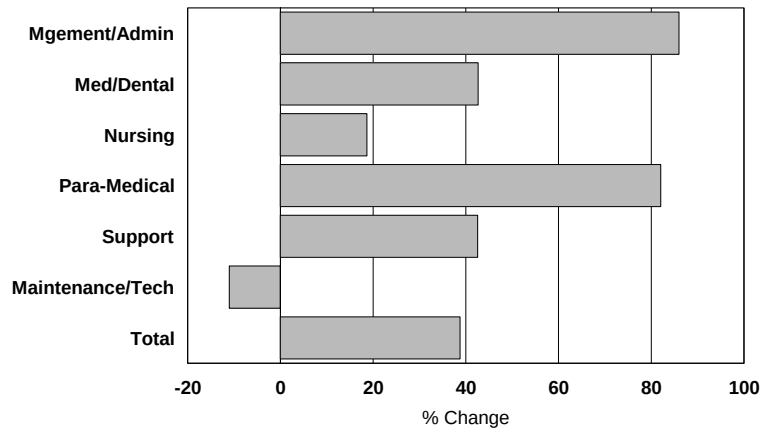
While the very substantial growth in expenditure throughout the health sector in the past decade can be documented in a fairly straightforward manner, accounting for the rise in expenditure levels is a more challenging undertaking. Given limitations on the information available, in addition to

the constraints presented by the scope of this review, some of the factors contributing to the growth in expenditure will be explored here. As approximately two-thirds of health expenditure is generally considered to be attributable to pay costs, changes in the level and type of personnel employed have important implications for the level of investment in the health services. In the next section, changes in the pattern of employment in the health service over the past decade will be reviewed.

4.3 Public Health Service Employment through the 1990s

Figure 4.8 shows the percentage change in the level of employment (wholetime equivalents) in the public health service, by category, between 1990 and 2000. Overall, there has been an increase of around 39 per cent in the numbers employed, rising from 58,737 in 1990 to the 2000 level of 81,513. The category of employment showing the biggest percentage increase over this period is the management/administration group which rose by 86 per cent from 6,649 in 1990 to 12,366 in 2000. Para-medical employment increased from 4,180 Whole Time Equivalents (WTEs) in 1990 to 7,613 WTEs in 2000, which amounted to a rise of 82 per cent in employment levels.

Figure 4.8: Percentage Change in Health Service Employment by Category, 1990-2000

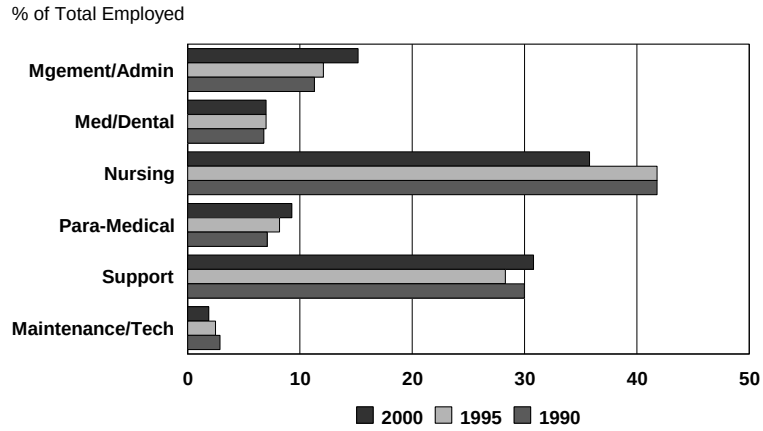


The increase of 43 per cent shown for medical/dental personnel and the support services is similar though the numbers employed in these areas differ considerably. For medical/dental personnel, WTEs rose from 3,994 in 1990 to 5,698 in 2000, while the 25,126 personnel employed in the support services in 2000 represented a substantial increase from the level of 17,619 estimated in 1990. Given that the nursing area represents the single largest category of public health sector employment, the increase of 19 per cent shown for the 1990-2000 period is low relative to other sectors. The 24,573 (WTE) nurses employed in the health services in 1990 only increased by 4,604 to the 29,177 level estimated for 2000. This contrasts with the increase of 5,717 employed in the management/administrative category over the same period. The only area where employment levels dropped was for maintenance/technical personnel which declined by 11 per cent from 1,722 in 1990 to 1,533 in

2000. This reduction is most likely the result of the increasingly prevalent use of "contracting out" for these types of services.

Figure 4.9 shows how the composition of those employed in the public health service has changed over the past decade. While nurses still account for the largest sector of health service employment, the relative size of this sector has declined over this period. The 42 per cent of health sector employment accounted for by nurses in 1990 has declined to an estimated 36 per cent in 2000. The nursing area shows the largest decline in the share of total health sector employment while the management/administration sector shows the largest relative increase, rising from 11.3 per cent of those employed in the health services in 1990 to the 15.2 per cent level estimated for 2000. The only other area to show a reduction in relative share of those employed is the maintenance/technical category which declined from 2.9 per cent of those employed in the health services in 1990 to 1.9 per cent in 2000. For medical/dental personnel and those

Figure 4.9: Health Personnel by Category as a Percentage of Total Employed in Health Services: 1990, 1995, 2000



employed in the support services, there have been marginal changes in relative share of employment between 1990 and 2000. The support service category now accounts for 31 per cent of health service employment while medical/dental personnel account for around 7 per cent of employment in the health sector. The substantial increase in the number of para-medical personnel has resulted in an increase in the relative importance of this sector which now accounts for around 9.3 per cent of health sector employment.

While this review provides some insight into employment patterns and changes in the distribution of personnel who now make up the public health service workforce, some assessment of variations in health service levels must also be undertaken if we are to even approach a better understanding of the implications of the unprecedented increases in health expenditure levels in evidence in recent years.

The assessment of public health service entitlements and private insurance coverage in the next section will be followed by an analysis of available facilities and service use within the acute hospital sector as this

service area accounts for the largest proportion of health expenditure and would also seem to currently be the source of substantial anxiety among the public (Watson and Williams, 2001)

4.4 Entitlement to Public Health Services and Private Insurance Coverage

The public and private sectors within the Irish health system are entwined at all levels of operation as the same personnel may deliver public and private services within the same facilities. The population of health service consumers may be broadly differentiated into those with Category I or Category II entitlement.[6] About one-third of the population (with Category I entitlement) qualify for a medical card which confers entitlement to all health services and medicines without charge as provided for within the General Medical Services (GMS) scheme. Qualification for a medical card is generally determined on the basis of income with a recent additional age categorisation. Since July 2001 people aged over 70 years have also been granted entitlement to a medical card. While the income limits for medical card entitlement are set at the national level, there is a provision for discretion to apply at the Health Board level on a case by case basis.

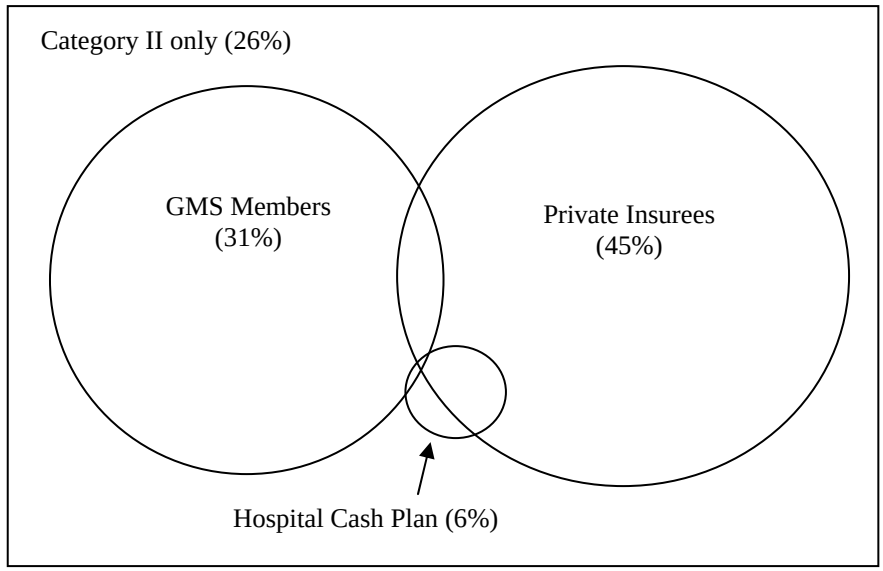
For the two-thirds of the population without medical cards (with Category II entitlement), they must pay for their general practitioner care and up to a maximum of £42 per month for medicines under the Drug Payment Scheme. In addition, those with Category II entitlement qualify for care in public hospital beds on payment of a small per diem for a fixed number of days in any one year. The majority of general practitioners and hospital consultants treat public and private patients and pharmacists dispense medicines for public and private patients.

Notwithstanding their entitlements within the public health system, 45 per cent of the Irish population now choose to buy private health insurance. Figure 4.10, adapted from Watson and Williams, 2001, summarises the distribution of the population according to type of health care coverage. This shows that the majority of those with private health insurance hold Category II status with the exception of about 4 per cent of the population with both medical card cover and private health insurance. Overall, about 6 per cent of the population is covered by a hospital cash plan (which essentially provides cover for hospital accommodation and some compensation for loss of earnings during illness), though about two-thirds of these are also covered by private health insurance (Watson and Williams, 2001). It is estimated that less than 1 per cent of the population have both medical card cover and cover under a hospital cash plan (Watson and Williams, 2001). Approximately 26 per cent of the population have Category II entitlement and no private health insurance. As 4 per cent of the population have both medical card and private health insurance cover, this means that the remaining 27 per cent of medical card holders together with the 26 per cent of the population with Category II entitlement and no private health insurance

[6] The entitlements of particular groups, for example, children will not be addressed in any detail here as the basic objective is to broadly review the relationship between public service entitlement and private health insurance coverage at the population level.

are fully dependant on the public health system. In summary, therefore, 47 per cent of the Irish population have made financial provision for cover for receipt of private health services, while 53 per cent of the population are completely dependant on the public sector for receipt of necessary health services.

Figure 4.10: Graphical Representation of Health Coverage of Adults



Note: Scale is approximate. Numbers do not sum to 100 per cent because some people have more than one form of coverage
Source: Adapted from Watson and Williams (2001).

It is interesting that the "rules" of *entitlement* to public health services seem to be considered broadly acceptable even if, on occasion, different population or political groupings may express a preference for a change in these conditions. There is no evidence of, for example, a groundswell of opinion for an expansion of medical card entitlement to a substantially larger proportion of the population even if the possibility of granting medical card entitlements to children has been mooted at the political level. What does, however, seem to be giving cause for concern for a substantial number of people is the extent to which *entitlement* to public health services equates with *access* to the appropriate services within the public health system. A recent ESRI study found that "nearly nine out of ten people believe that required hospital care would be obtained more quickly on the private health system than on the public system" (Watson and Williams, 2001, p. 45-46). The finding of this study that waiting for care within the public health system was a serious concern for public patients would seem to have some justification given that 26,382 people are reported to have been on the public hospital waiting list at the end of March, 2001. While this estimate represents a reduction of 23 per cent from March 2000, almost half the adults awaiting services within the target (high volume) specialties were on the waiting list for 12 months and over. Over £130m has been allocated since 1993 specifically to address the waiting list problem. The fact that the national targets of ensuring that

adults receive the required inpatient treatment within 12 months and children are treated within 6 months for the target specialties are not being achieved for a large proportion of those awaiting services must raise serious questions about the operation of the hospital system, in particular, especially given the large increases in expenditure on this sector and the health system generally in recent years. While the fact that the demand for hospital services will tend to be higher than utilisation levels is to be generally expected, the key issue for public policy is how access to available public health services is managed and monitored to ensure an equitable distribution of services on the basis of medical need – an objective which underpins the 1994 Health Strategy *Shaping a healthier future*. The next section, therefore, focuses on changes in activity levels within the acute hospital sector with more detailed analysis of relative utilisation of public hospital services by public and private patients. This analysis is intended to enhance our understanding of the issues faced in enforcing equity of access to hospital services for those in need of care.

4.5 Acute Hospital Activity through the 1990s

Table 4.1 presents a summary of selected indicators for the acute hospital sector from 1990 to 1999 (the most recent year for which information is available). Despite a marginal reduction in the availability of acute inpatient beds over the period, inpatient admissions increased by over 3 per cent. Available and used inpatient bed-days also increased slightly with casualty attendances increasing by close to 10 per cent between 1990 and 1999. The most significant increase in activity is undoubtedly in the day care area where the availability of facilities and the numbers treated more than doubled over the period. Outpatient activity also shows a substantial increase with the number of sessions rising by close to 40 per cent. While total outpatient (OPD) attendances increased by around 17 per cent, new attendances at out-patients clinics rose by about one-third.

Table 4.1: Selected Indicators of Acute Hospital Activity, 1990-1999

	1990	1999	% change
Acute Inpatient/Casualty Activity			
Inpatient Hospital Beds	11,868	11,781	-0.73
Inpatient Hospital Admissions	514,932	530,742	3.07
Available Inpatient Bed-Days	4,197,195	4,296,172	2.36
Inpatient Bed-Days Used	3,555,125	3,563,440	0.23
Casualty Attendances	1,119,767	1,229,303	9.78
Day Activity			
Day Beds	284	675	137.67
Day Cases	124,769	296,631	137.74
General Outpatient Activity			
No of Out-Patient Sessions	68,949	96,346	39.74
Total OPD Attendances:	1,675,529	1,957,710	16.84
New OPD Attendances	367,332	490,916	33.64
Return OPD Attendances	1,308,197	1,466,794	12.12

Source: Health Statistics (1990-1999), Department of Health and Children.

The indicators presented in Table 4.1 could be generally considered to suggest something of a steady state for the inpatient sector with substantial expansion in day activity and the provision of out-patient services throughout the 1990s. What is difficult to assess, however, is whether or not this is as would be expected or warranted within an area where

expenditure has increased by 226 per cent in current terms between 1990 and 2001. Any attempt at assessing possible returns on the additional investment is fraught with difficulties given the absence of clear productivity and/or efficiency targets. One area where new data have become available and which has been suggested as a source of public concern is the public/private mix of service utilisation within the acute care sector. As this issue is an essential factor in the determination of prevailing equity considerations within this system, the relative utilisation of public hospital services by public and private patients will be explored in more detail in the next section.

4.5.1 UTILISATION OF ACUTE HOSPITAL SERVICES BY PUBLIC AND PRIVATE PATIENTS WITHIN THE PUBLIC HOSPITAL SYSTEM

Beginning in 1999, information on the public/private status of discharges within the acute hospital system has been collected by the Hospital Inpatient Enquiry System (HIPE).[7] Specifically, the information collected specifies whether the patient was a public or private patient of the consultant on admission and on discharge. Tables 4.2 and 4.3 summarise the findings from the HIPE for 1999 and 2000 for the public/private assignment of patients on discharge, categorised by admission status. Admission status here is differentiated according to whether the patient was admitted on an elective or planned basis or as an emergency admission. As the waiting list problem essentially involves public patients waiting for admission on a planned basis, an important objective in undertaking this analysis is to assess whether or not the distribution of public and private patients within each of these categories approximated the distribution of public and private beds within the public hospital system. The Health (Amendment) Act 1991 provided for the designation of public hospital beds according to public or private status. A small number of public hospital beds remain non-designated in such areas as intensive care, cardiac care, etc. In broad terms, private /semi-private beds have accounted for 20 per cent and public beds have accounted for 80 per cent of acute inpatient designated hospital beds since the process commenced in the early 1990s (Nolan and Wiley, 2000). The balance between these two sectors differs in the case of day beds where approximately one-third of public hospital day beds are designated as private/semi-private and around two-thirds are designated as public day beds (Nolan and Wiley, 2000).

Table 4.2 presents a summary of inpatient and day discharges from all acute public hospitals for 1999 and 2000 according to public/private status and whether the patients were admitted on a planned or emergency basis. For planned, inpatient admissions, Table 4.2 shows that private patients accounted for close to 30 per cent of discharges while public

[7] The Hospital Inpatient Enquiry (HIPE) is a computer-based discharge abstracting system designed to collect demographic, clinical and administrative data on all discharges and deaths from all acute general hospitals nationally. Each HIPE discharge record represents one episode of care. The information presented here relates only to public hospitals.

patients accounted for around 70 per cent of discharges in 1999 and 2000. Given the designation of around 20 per cent of public beds as private, this would suggest that private patients account for a higher than expected proportion of planned inpatient discharges. When the trend between 1999 and 2000 is assessed, we find that while the number of public inpatients treated on a planned basis increased by 2.6 per cent, the increase in the number of private inpatients within this category was 5.8 per cent. This means that the rate of increase in the number of private patients treated on a planned basis between 1999 and 2000 was double that estimated for public patients over this period.

Table 4.2: Acute Hospital Discharges by Admission Status and Public/Private Status, 1999 and 2000

	1999		2000		
Inpatients	**No of Discharges**	**% of Planned**	**No of Discharges**	**% of Planned**	**% Change 1999-2000**
Planned Admissions					
Public	100,761	70.8%	103,421	70.2%	2.6%
Private	41,515	29.2%	43,929	29.8%	5.8%
		% of Total		**% of Total**	
All Planned Patients	142,276	27.8%	147,350	28.2%	3.6%
		% of Emergency		**% of Emergency**	
Emergency Admissions					
Public	292,219	79.2%	295,071	78.6%	1.0%
Private	76,932	20.8%	80,199	21.4%	4.2%
		% of Total		**% of Total**	
All Emergency Patients	369,151	72.2%	375,270	71.8%	1.7%
Total Inpatients	511,427		522,620		2.2%
Day Patients*					
Public	193,399	78.2%	209,805	76.9%	8.5%
Private	54,029	21.8%	62,883	23.1%	16.4%
Total Day Patients	247,428		272,688		10.2%

*Day patients are only admitted on a planned basis.
Source: HIPE Unit, ESRI, September (2001).

When the distribution of emergency patients by public/private status is assessed in Table 4.2, it is interesting that the estimates presented are a much closer approximation to the 80:20 ratio of public:private inpatient beds within public hospitals. Again, however, it would have to be noted that the direction of the trend between 1999 and 2000 may be cause for concern. While there was an overall increase of 1.7 per cent in the number of emergency patients treated over this period, the increase of 4.2 per cent in the number of private patients within this category was four times greater than the 1 per cent increase shown for public patients admitted on an emergency basis. It is interesting that while around one-third of day beds are reported as designated as private (Nolan and Wiley, 2000), the proportion of day patients treated on a private basis ranges from around one-fifth in 1999 to close to one-quarter in 2000. Again, an important point arising from Table 4.2 is the direction of the trend for the distribution of day patients by public/private status between 1999 and

2000. At 16.4 per cent, the increase in the proportion of private patients treated on a day basis was close to twice the increase of 8.5 per cent estimated for public patients over the 1999-2000 period.

Table 4.3 shows the distribution of acute hospital bed-days for public and private patients according to admission status in 1999 and 2000. For planned admissions in each year, public patients accounted for about three-quarters of the bed-days used while private patients accounted for the remaining 25 per cent. While there was an increase of 2.6 per cent in the number of bed-days used by planned admissions between 1999 and 2000, the increase in bed-day consumption of 4 per cent for private patients was close to twice that estimated for public patients. For emergency admissions, bed-day consumption for public and private patients approximates the 80:20 ratio for both years. Bed-days used by public patients admitted on an emergency basis actually decreased by less than 1 per cent between 1999 and 2000 while private patients used close to 4 per cent more bed-days over this period.

Table 4.3: Acute Hospital Bed-Days by Admission Status and Public/Private Status, 1999 and 2000

	1999		2000		
Inpatient Bed-Days	**No of Bed-Days**	**% of Planned**	**No of Bed-Days**	**% of Planned**	**% Change 1999-2000**
Bed-Days for Planned Admissions					
Public	739,160	75.7%	754,986	75.4%	2.1%
Private	236,903	24.3%	246,437	24.6%	4.0%
		% of Total		**% of Total**	
Total Bed-Days for Planned Admissions	976,063	29.5%	1,001,423	30.0%	2.6%
		% of Emergency		**% of Emergency**	
Bed-Days for Emergency Admissions					
Public	1,863,892	80.0%	1,850,333	79.3%	-0.7%
Private	465,672	20.0%	482,584	20.7%	3.6%
		% of Total		**% of Total**	
Total Bed-Days for Emergency Patients	2,329,564	70.5%	2,332,917	70.0%	0.1%
Total Inpatient Bed-Days	3,305,627		3,334,340		0.9%

Source: HIPE Unit, ESRI, September (2001).

In summary, therefore, what the analysis of available data for 1999 and 2000 show is that for each category of admission, including planned (elective), emergency and day care, utilisation by private patients has been increasing at a faster rate compared with the utilisation by public patients. When the utilisation of hospital bed-days for both planned and emergency admissions is examined, the utilisation of private patients is also increasing at a faster rate compared with use by public patients between 1999 and 2000. What is of particular concern is the finding that private patients account for close to 30 per cent of planned admissions even though only around 20 per cent of acute inpatient hospital beds at the national level are supposed to be designated as private. In the next section we try and piece together the different pieces of the puzzle presented heretofore, to try and

glean an overall perspective of the pattern of recent changes within the Irish health system which may help to inform the direction and focus of future development.

4.6 Discussion

Given the information presented in the preceding sections, a number of issues emerge which warrant serious attention. A key factor which underlines this discussion is a recognition of the unprecedented rise in health expenditure in recent years. To summarise the scale of the increase in expenditure levels, between 1990 and 2001, current health expenditure (gross, non-capital) increased by 241 per cent while the period 1996-2001 saw a 114 per cent increase in health expenditure levels. What seems quite extraordinary about the Irish experience over this period is that public confidence in the health system has been plummeting as health expenditure levels have been rising. The available evidence, which is limited and in many instances anecdotal, indicates that it is the hospital system which is the main focus of public anxiety and concern (Watson and Williams, 2001).

It is interesting that difficulties with the primary care service are rarely reported despite the fact that two-thirds of the population have to pay for GP care.[8] Specifically, waiting lists for access to public hospitals and long waiting times for services are a source of high levels of dissatisfaction with the public hospital system in particular. This dissatisfaction seems to be exacerbated by a prevailing perception that people with private insurance gain faster access to public health services, irrespective of medical need. It seems worthwhile, therefore, exploring at the policy level whether the implementation of the appropriate interventions directed at ensuring equity in access to public hospital facilities for all on the basis of medical need would be effective in allaying fears about the fairness and adequacy of the health system. The questions we focus on here, therefore are, first whether or not there is any foundation for public concerns about fairness in accessing the public hospital system in particular and, second, appropriate responses to the problem of waiting lists for public hospital services specifically.

In response to the first question, what we have shown previously is that private patients admitted on a planned (or elective) basis account for a larger proportion of discharges from acute public hospitals than would be expected on the basis of the proportion of hospital beds designated for use by private patients. Private patients account for almost 30 per cent of planned inpatient admissions while only 20 per cent of inpatient beds are designated as private within the public hospital system. This means that about one-third more private patients, estimated at over 14,000 discharges, were treated on an elective basis in 2000 than would have been expected given the distribution of public and private hospital beds in public hospitals. As the waiting list for the end of December 2000 was just less than 28,000, it could crudely be concluded that this waiting list might have been halved if the number of private, elective discharges was maintained at

[8] Difficulties may, however, be reported on specific questions like out-of-hours access to GP services, particularly in urban areas.

the 20 per cent level in keeping with the designation of private inpatient beds in public hospitals. This may, however, be too simplistic as one of the complexities which must be addressed in trying to ensure fairness within the public hospital system is that a substantial proportion of the population have double cover, i.e. they have Category II entitlement to a public hospital bed on payment of a per diem charge and they also have private health insurance. Where people choose to exercise their Category II entitlement, which is their right, then it would be expected that they would be treated as public patients with the consequential possibility of having to join a queue for the required treatment. Where equity within the public hospital system is compromised, however, is when private insurance coverage may facilitate *preferential* access to public hospital facilities, whether in a public or a private hospital bed.

There is no denying the right of all citizens, whether public or private patients, to appropriate health services to address medical need. What differentiates those with private health insurance from public patients, however, is that they may have a choice of receiving care in a private or a public health care facility. In general, public patients are entirely dependant on receiving care in a public hospital – they do not have a choice. It must also be recognised, however, that private patients may not always have a choice in all circumstances as the private hospital system does not offer the full range of medical services. For example, Accident and Emergency (A&E) services are generally only provided by public hospitals and certain types of interventions like organ transplantation may also only be provided within the public system. Our focus here, however, is on elective, inpatient services and this is where, for the most part, private patients may have a choice. Many of the procedures being received by private patients admitted to public hospitals on an elective basis are those for which there are long public waiting lists like cataract procedures, hip replacement and vein ligation. Such procedures are also provided by the private hospital sector. It would also seem that there is capacity in the private hospital sector to provide such procedures as some of the funding from the waiting list initiative has been used by public health authorities to contract with private hospitals for the provision of waiting list procedures to public patients. What this, in turn, means is that the State is paying twice over for the provision of certain types of services. Previous research (Nolan and Wiley, 2000) has shown that there is a substantial State subsidy for the provision of private care in public hospitals. Where private patients in a public hospital receive procedures for which there is a public waiting list, the State subsidises this care and may then provide funding for the purchase of these same procedures from the private hospital sector on behalf of public patients. This does not even begin to take account of the subsidisation of private medical care by the State through the provision of tax relief on private health insurance premia and health expenses. What we would have to conclude, therefore, is that in the interest of ensuring fairness in the treatment of public and private patients in public hospitals for conditions for which there is a public waiting list, the following factors need to be addressed:

- For elective, inpatient admissions, it seems reasonable to assume that the number of private patients treated would be "capped" at the

proportion of hospital beds designated as private where there is a public waiting list for admission to the hospital. A change in the bed designation ratio would be expected to result in a change in the limit of this "cap".

- Where admission is sought on an elective, inpatient basis for private patients in excess of this "capped" limit, these patients may choose to exercise their entitlement to public hospital services which may, in turn, result in being added to a waiting list for care, depending on the intervention or procedure required.
- Private patients needing services provided by private hospitals might also be encouraged to use private hospital facilities where available and appropriate as an alternative to waiting for services within the public hospital system.

What is of particular concern in the information presented in Tables 4.2 and 4.3 is the distribution of the increased utilisation of hospital services between public and private patients. For each category reviewed here, including planned inpatient admissions, emergency admissions, day patients, planned inpatient bed-days and emergency bed-days, the increased levels of utilisation between 1999 and 2000 have been higher for private patients compared with public patients. In the absence of any epidemiological data indicating a greater need for acute public hospital services by private patients, the anxiety being experienced by the public regarding the "fairness" of the public hospital system would seem to have some justification. A focused and prompt response to ensure a "levelling of the playing field" for all in need of acute hospital services, therefore, seems essential rather than optional if public confidence in the health system is to be restored.

While the above discussion on the need to ensure fairness in accessing the acute hospital system does address the waiting list issue, it is worthwhile here giving some consideration to the types of responses that have been put forward to addressing a problem which seems to have become endemic to the health system in recent years. In recognising that a range of responses may have been put forward at the national and regional level at different times, the main proposals which will be considered here include those concerned with the capacity of the acute hospital system and those focusing on funding/financing.

Some assessments of the waiting list problem conclude that the existence of a waiting list is indicative of an inadequate supply of hospital facilities. This view has lead to recommendations for an increase in the capacity of the acute hospital system. Reported commentary in the press suggests that the Minister for Health and Children will shortly bring to Cabinet proposals for a substantial increase in the capacity of the acute hospital system over the next ten years. While there may be many legitimate reasons for proposing an increase in hospital bed capacity, the existence of a waiting list for services, in itself, does not suggest that the supply of hospital beds is inadequate. There are waiting lists in many countries deemed to have an adequate supply of acute hospital facilities. While the capacity issue may be one contributing factor, it is also possible that a waiting list exists because of inefficiencies in managing existing facilities and/or because of organisational or infrastructural problems contributing to difficulties in accessing services. We have already noted

above the increased use of public hospital facilities by private patients between 1999 and 2000. If more private patients are accessing these facilities, this may contribute to increased waiting times for public patients for certain types of procedures. There are also questions to be raised regarding the management of existing resources. Table 4.4 is presented here as an illustration of an area where there is a substantial waiting list for services and where difficulties may exist in the management of access to services. Table 4.4 summarises the number of discharges, average length of inpatient stay and bed- days used in the delivery of lens procedures in selected hospitals (presented anonymously) in 2000. The patients treated within this category would be expected to be similar clinically and require similar levels of resources for treatment purposes. It is interesting, therefore, that the average length of stay of 3.9 days shown for Hospital E is over twice that of the 1.6 days shown for Hospital D and 50 per cent longer than the average of 2.6 days estimated for the group. If the 523 inpatients in Hospital E had been treated on the basis of the group (not the shortest) average length of stay of 2.6 days, then an additional 262 patients could have been offered this service in this hospital. By applying the same process to other hospitals it is clear that *within existing capacity* there would have been capability within the system to increase the numbers treated and substantially reduce the waiting list of 3,253 patients awaiting ophthalmology services in December 2000.

Table 4.4: Number of Discharges, Average Length of Stay, Bed-Days and Day Cases by Hospital for Lens Procedures, 2000

	1999		2000		
				Inpatients	
Hospital	Total Discharges (% of total)	Day Cases	Inpatient Discharges	Ave Length of Stay (Days)	Bed Days
Hospital A	1,737 (23.4%)	671	1,066	2.32	2,470
Hospital B	1,351 (18.2%)	605	746	3.11	2,322
Hospital C	1,122 (15.1%)	284	838	2.28	1,914
Hospital D	1,097 (14.8%)	183	914	1.60	1,461
Hospital E	1,032 (13.9%)	509	523	3.90	2,042
Hospital F	681 (9.1%)	151	530	2.86	1,517
Other	406 (5.5%)	27	379	3.84	1,455
All Discharges	7,426	2,430	4,996	2.64	13,181

Source: Analysis for DRG 39 (Lens procedures with and without vitrectomy), HIPE Unit, ESRI, September (2001)

Staff shortages, particularly in the nursing area, have caused great difficulties in recent years for the operation of the acute hospital system.

This problem has actually resulted in the closure of substantial numbers of hospital beds, particularly in the Dublin area, for extensive periods of time. In addition to bed closures, nursing shortages have also led to cancellations of theatre sessions and elective admissions which, in turn, can be assumed to have contributed to the waiting list problem. We have also seen in the review of personnel recruitment within the health services over the past decade that even though nurses constitute the largest component of health service employees, the level of growth in this sector has been smallest, with the exception of the decline in the numbers of maintenance/technical personnel. Ensuring adequate staffing for the acute hospital system at the current level of capacity continues to prove problematic. Any proposals for substantial expansion in capacity would, therefore, have to be combined with proposals for ensuring an adequate supply of medical and nursing personnel to staff these facilities. It is also worth noting that with over 15,200 hospital beds in 1987 just 512,000 patients were treated while around 12,400 inpatient and day-beds in 1999 supported the treatment of over 820,000 patients on an inpatient or day basis.

Commentary on the operation of the acute hospital system has frequently raised questions about efficiency and approaches to management. Suggestions that the system has been "undermanaged" have regularly been raised. Given that more management/administration personnel than nurses have been recruited over the past decade, questions arise as to whether improved management practices are in evidence. Some of the information presented here would give cause for concern in this regard. Advance commentary on the findings of a "value for money" audit commissioned for the health services indicate that substantial deficiencies in management practices remain to be addressed.[9] Where we have seen possible imbalance in access to services by public and private patients and examples of variations in bed-day utilisation which may limit access to certain services, the need for effective management of all hospital resources is indicated. Management of the acute hospital system, in particular, must be an increasingly collaborative undertaking embracing both clinical and administrative personnel. In so doing, it is essential that there is a clear specification of responsibilities for all parties to the process. In addition to specifying the rights of consultants, the Consultant Common Contract makes important provision for ensuring that adequate information is made available to facilitate effective and efficient management within the hospital. While this contract specifies the consultant commitment of 33 "notional" hours to the public hospital(s) of appointment, what is not clear is what the expectation is regarding the commitment of consultant time to the treatment of public patients. Clarification of the contractual commitment of hospital consultants to public patient care, whether in terms of time or other appropriate measures, is an important starting point for any attempt to "level the playing field" for the treatment of public and private patients within the acute hospital system.

[9] See *Sunday Tribune* May 6 and 13 (2001).

In addition to proposals for an increase in the capacity of the acute hospital system, possible solutions to the "waiting list" problem have included proposals for changes in the funding/financing of the health system. We have seen that proposals to increase the funding of the health system have certainly been put into effect but, unfortunately, increased health expenditure in itself cannot be expected to solve the waiting list problem. With regard to the financing of the health system, the most widely discussed proposals of recent times are based on the introduction of some type of "health insurance for all" proposal.[10] The proposals vary as to whether the type of health insurance system to be introduced nationally would be more private or social in nature. A shift of this type would be considered extraordinary in the European context where nine of the fifteen EU countries support tax-based health systems – whether funded from local, regional or centralised taxation. The six EU countries supporting social insurance systems are in continental Europe. While a number of countries have replaced insurance-based systems with tax-funded systems in the post- World War period, no EU member state has actually switched from a tax-based system to an insurance-based system in this period. In the broader European context the only area where insurance-type systems of funding are being introduced is in regions like Eastern Europe where an important objective of health system reforms is to increase the contributions of citizens to the development of the health services.

Proposals to introduce an insurance-type system of financing as a means of addressing the waiting list problem within the Irish health system are problematic for a number of reasons including the following:

- a switch from tax-based funding to insurance-based funding, in itself, will not solve the problems of access to and supply of services. Providing "health insurance for all" will not resolve medical and nursing shortages to ensure provision of services and will not provide any guarantee that the people in most need of health services have the access when and where they are required;
- the suggestion that providing everyone with health insurance will confer on all the benefits currently experienced by those with private health insurance ignores the fact that middle to higher income earners would probably always be able to buy more health insurance and, presumably, more benefits. It is therefore questionable what additional benefits the very substantial investment on a new state insurance system would deliver to people currently without health insurance;
- a complete shift of the Irish health system to an insurance base has the potential to hand control of access, eligibility and service delivery over to the insurance companies. In many countries where insurance systems prevail, the insurers may impose limits on the level of service provision like, for example, the number of hospital days that may be

[10] See *Curing our ills*, Labour Party proposals for hospital and GP care in a new century (April 2000) and *restoring trust: a health plan for the nation*, Fine Gael's Policy Proposals on Health, November (2000).

used in a particular period, the number of visits to a doctor that will be covered, the medications that will be financed etc. While there are proposals that insurance cover would be associated with entitlement to a basic service package (however determined), such a development would almost certainly also be associated with restrictions on entitlement and the range of service provision;

- insurance systems cost money to run. Increased investment in the administration and bureaucracy necessarily associated with insurance systems is likely to result in a diversion of these resources from health service provision.

Shifting the Irish health system to an insurance base will not, in itself, solve the problems of access, supply or distribution of services. What such a shift could be expected to do, however, would be to impose limits on service provision and divert resources from health service provision into support for an expanded health insurance industry.

Given the overview presented here of growth in expenditure, employment and activity within the health services, together with an assessment of some of the critical issues arising for policy development, key conclusions emerging are summarised in the final section.

4.7 Conclusions

The finding by a recent ESRI study that one respondent in four believed that the quality of care in the public health system was bad or very bad is cause for serious concern at any time but particularly in an environment where current health expenditure has more than doubled over a five year period (Watson and Williams, 2001, p. 36). While the return on this very substantial increase in investment remains an open question, the evidence points to a public view that the public health system has serious problems. The hospital system accounts for just less than half of health expenditure, and it is very much in this area that concerns are most frequently raised. These concerns focus on a range of issues, including difficulties in accessing hospital services and dissatisfaction with length of stay and quality of care (Watson and Williams, 2001). Whether or not the level of anxiety which prevails about these issues is warranted is worthy of investigation in a research context. What must, however, be a priority for public policy is ensuring that the vastly increased levels of resources devoted to the health services are used for the development of a public health system which meets the standards of equity, quality, efficiency and productivity which will restore the confidence of the public in a health service which is intended to serve their needs.

When attempting to account for the recent growth in exchequer funding of the health services there have been suggestions that part of the funding growth is intended to "compensate for underinvestment" in the 1980s and early 1990s. The magnitude of the purported "underinvestment" is not, however, apparent so it is unfortunately not clear how much of the additional expenditure may be credited to this objective. Given that two-thirds of health expenditure is attributable to pay costs, the fact that the numbers employed in the health services have increased by one-third over the past decade will account for some of the increased spending. Increased employment is not, however, in itself an

adequate justification for increased health spending. The question to be addressed where employment levels have risen is what has been the return to the health services for this investment. The review of programme level expenditure presented here indicated that specific non-acute areas of care have been targeted for substantially increased investment. These include care of the intellectually and physically disabled and the development of community nursing units. In addition, areas like childcare has seen a major increase in financial commitment to support unprecedented expansion in services and responsibilities. The absence of standardised output measures for these areas, however, makes it difficult to assess returns to increased expenditure within and between these sectors. An increase in service levels has also been shown for the acute hospital sector with the most significant expansion in this area indicated in the growth of day care facilities, procedures and investigations.

The information presented here regarding the relative distribution of public and private services within the public hospital system are cause for serious concern at a time when waiting lists and waiting times for hospital services are a critical problem for public patients. Our analysis has shown that for 1999 and 2000 the utilisation of hospital services by private patients admitted on a planned, emergency or a day basis has been increasing at a faster rate compared with utilisation levels estimated for public patients. The fact that private patients account for 30 per cent of planned (or elective) admissions even though only 20 per cent of hospital beds nationally are designated as private is cause for grave concern given the lengthy waiting lists for public patients requiring admission for elective procedures. *It is proposed here that one approach to ensuring that equity is a reality rather than an aspiration within the public hospital sector would be to "cap" the number of private patients treated on an elective inpatient basis in public hospitals where there is a public waiting list for admission to the hospital.* It would seem reasonable to expect that the ratio of public to private patients treated within the public hospitals would be maintained at a similar level to the designated ratio of public to private beds. Clearly, where there is a change in the bed designation ratio, the mix of public and private patients treated would also be expected to change. *An additional measure worthy of consideration would be the use of a single waiting list for admission to public hospitals.* This was previously proposed by the Commission on Health Funding (1989) as an important safeguard ensuring admission to public hospitals based on medical need rather than health insurance status.

Given the high levels of demand for health services, it is incumbent upon all responsible for resource deployment to ensure that the available facilities, technology and expertise are used to best possible effect in the delivery of high level care. If this objective is to be achieved, the deficiencies in efficiency must be addressed as a matter of priority. The example presented in this paper of substantial differences in length of stay between hospitals in treating patients for a similar condition was shown to result in the loss of services to patients on waiting lists for cataract procedures in particular. Many other examples could be presented where similar services are being delivered in different hospitals at substantially different cost. Notwithstanding whether the observed inefficiencies result from operational or organisational failures with the consequential waste of

resources, the worst consequence of failure to address inefficiency within the health service is the resulting loss of services to those in need. Taking corrective action to address health system inefficiency is therefore a requirement rather than an option if the substantially greater level of resources allocated to this system is to deliver high quality services to all patients, both public and private, within the public hospital system. *In pursuit of this objective it is recommended that an "efficiency audit" be undertaken, particularly in those areas responsible for delivery of "waiting list" procedures, to identify where resources could be used to better effect to improve delivery of required services. An efficiency audit involving benchmarking of the relevant agencies, whether hospitals and/or health boards, would provide the starting point for interventions aimed at addressing deficiencies and rewarding excellence in health system performance and outcomes.*

Continued growth in expenditure on the health services is the view currently being proposed from within the sector. Proposals for a substantial increase in the number of hospital consultants have been brought forward as a response to some of the difficulties encountered in the medical manpower area. These proposals would require a significant increase in investment in medical manpower on an ongoing basis. No such plans have been put forward to address the nursing shortage which continues to cause great difficulties in maintaining service levels in many Dublin hospitals in particular. The publication of a new Health Strategy which promises to adopt an expansionist perspective throughout the health sector is imminent. In addition, proposals for a substantial increase in the number of acute hospital beds have been signalled. Notwithstanding the implications for huge increases in capital expenditure, such a commitment would obviously also have major implications for increased revenue expenditure, particularly on the pay side. The issue, however, which remains to be addressed is how any proposed expansion in the health system can be staffed given current difficulties in supporting existing commitments to service provision.

There is no denying the challenge presented by health system reform or the complexity of putting in place a system which will address the widest spectrum of health needs to the satisfaction of all. It is because of this complexity that prioritisation of objectives and interventions will be required if commitments are to be achieved in the short run as well as the medium to longer term. Given the enormous increases in government expenditure on the health services in recent years and the very limited information available on the returns to this investment, concerns about efficiency and productivity remain to be addressed. If current levels of health expenditure are to be maintained, or increased as proposed, the prioritisation of the achievement of equity, quality, efficiency and productivity targets would be essential. The pursuit of these objectives demand that appropriate policies are put in place at the earliest possible opportunity to ensure access to health services is primarily based on need and that public confidence in the quality of the public health service is restored. Major improvements in the availability of health information will be required to enable monitoring and evaluation of efficiency and productivity targets on an ongoing basis. It is ironic that at a time when government funding of the health services has been increasing at an unprecedented rate, public confidence in the system is at a low ebb.

Enhancement of transparency and accountability will be essential if all the relevant constituencies are to have confidence that any increased investment in the health system will be directed to where it is most needed.

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