REPORT

of the

COMMISSION

on

HEALTH FUNDING

September 1989

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Salus populi suprema est lex

—Cicero: De Legibus III, iii, 8.

(The welfare of the people is the supreme law).

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(Pl.6763)

Chairman's Preface

The terms of reference of the Commission on Health Funding were

> "To examine the financing of the health services and to make recommendations on the extent and source 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."

Background

Financing and operating health services give rise to serious problems throughout the world. In many countries there is concern that mounting costs and future demands may take so much of national resources, public and private, that too little is left for other social and economic development. Other countries are so poor that they do not have enough to give even minimum healthcare to their people.

Ireland has a high standard of health services, very skilled medical personnel and a tradition of caring for those who most need help. There is however a perceived crisis in the financing and delivery of its health services and there is public concern about their future.

The current priority assigned to reducing the national debt in order to provide more effectively for the needs of the population, in particular to ensure more jobs, is accompanied by a reduction in public spending. Such a policy requires that public spending should represent the best possible value for money. In this context the health services must come under close scrutiny, both because they represent such a large proportion of spending and because they are so vital to the quality of life in Ireland.

The increase in expenditure on health care in Ireland has been fuelled by a combination of extensions of the scope of health services, pressure for expensive, high-technology procedures from the medical suppliers, patients' expectations of prescriptions and interventions as a necessary part of doctors' care and a political awareness of the role of the health services as employers in a time of high unemployment.

The reduction in the rate of increase has had varying effects on different sectors of the services and has not always promoted a more efficient use of the available resources. It has, however, brought a welcome emphasis to the quality of care and the need to have more and better information on which to judge that quality.

It is therefore essential to ensure that decisions committing resources are taken in as rational and consistent a manner as possible. It is necessary to improve management at all levels of the health services and to introduce greater integration between the delivery of health services and accountability for the resources used in healthcare. It is equally necessary to provide more information for individuals on the implications of their own behaviour, on the medical treatment available and on the cost of providing the health services they demand.

Total Spending

There are no objective rules to determine the appropriate amount of spending on health services. International comparisons show only that richer countries spend more, both absolutely and relatively, than poorer countries. Total public or private spending on health reflects demographic differences, the values of a community and environmental and other factors. Differences in accounting practices lead to classification of similar expenditure under different headings. The amount of public spending also indicates a degree of political choice.

Values

Choices in the provision of healthcare depend on the values of those who make them. For this reason, we think that we should state clearly our values in this area.

We start from the principle that no person should be refused necessary healthcare because he or she is unable to pay for it. We believe that most people agree with this.

However, this principle needs to be qualified as more and more highly-technical and expensive medical intervention becomes available and, at the same time, the basic caring services come under increasing strain as funds are overstretched. There must be some limit to the expense which the community is required to bear, so careful and accurate assessment of the benefits and costs of treatment are essential.

The Future

The medical profession itself must take more responsibility for planning and controlling as well as delivering health care, extending its role beyond the merely clinical aspects of medicine. But the best means of ensuring an appropriate amount of spending, given the health needs and competing requirements of the population, is a structure of decision-making which separates the political process of setting policy objectives and the executive or management role of fulfilling them. Decisions, large or small, can then be taken at the correct level, performance can be judged and action taken accordingly. Such a structure is a central part of our recommendations.

Method of Funding

The extent to which the method of financing the health services is central to their efficiency or responsiveness to national priorities is discussed at some length in the report but two aspects can be mentioned here. Some countries have largely relied on private funding, only to find that it has left huge gaps which have had to be met by the state and has not controlled costs. Others have operated a state-funded system in which costs were carried partly by depressing pay in the health service to unsustainable levels, and these now face an increasing financial burden as pay rises - without necessarily improving healthcare in line with the additional expenditure. Ireland has relied on a largely tax-funded model with important modifications and its system is described in the report.

It is vital that the method of funding should be fair and efficient. It must also provide, as far as possible, signals about the cost of relative courses of treatment to those who make decisions about care. Furthermore, it must not prevent or render difficult the most effective national use of resources. Finally, the method of funding must not be so complex and cumbersome that it is too costly to bear.

Our Approach

In order to address the financing of the health services properly and to fulfil the terms of reference which asked us to consider the future funding of "an equitable, comprehensive and cost-effective health service", the Commission had to examine a wide range of issues and all the services delivered under the "health" umbrella. This necessarily prolonged our work but has given our recommendations a wider and more solid base than could have been constructed from a narrower and more selective approach.

The majority of the Commission's members have recommended a new structure based on tax funding which will reflect the respective political and executive aspects of health services and make each element more clearly accountable for its particular responsibility. The Minister for Health would set objectives and allocate the funds to achieve stated goals. An Executive Authority would manage the funds to ensure that people receive the service to which they are entitled as a result of political decisions about access to services. Health Councils would monitor and review performance at local level, reflect local public opinion and help to shape the direction of policy and delivery.

The VHI is an important element in the funding of healthcare in Ireland. It has already had to alter its general policy since we began our work. One of the attractions of the VHI has been that premia are set on the basis of 'community rating'. It seems as though community-rating may not be sustained indefinitely as a basis for private health insurance. However, the principle of equal access is more effectively covered by a totally tax-funded comprehensive health service for the lowest income sector and the availability of a core service, covering the most expensive forms of care for the rest of the population. General practitioner services, for example, would continue to be paid for as they now are. Certain other services would attract modest charges which could be administered efficiently and would not represent an undue burden on those paying for them.

Competition in funding (through competing insurance companies) and competition in supply are separate issues. Competition in *funding* between private insurers of healthcare has not satisfactorily controlled costs elsewhere, and there is no evidence that it would do so in Ireland. We believe that competition in *supply* is the best spur to efficient delivery of healthcare. Competitive suppliers, both public and private, would make better use of resources. Such competition will require sophisticated management to ensure that the best quality of care is obtained.

Public and Private Hospital Care

Since private medical practice, including private hospital in-patient care, will inevitably continue to exist, we considered the option of removing it from the public domain. We decided against this to ensure that patients in public hospitals reflect the mix of the population and that the best skill, care and technology are available to, and used most effectively by, the whole population, particularly the lower income groups. However, within the public hospital system priority of admission should be determined solely by medical need

and not by the public or private status of the patient. We consider that the creation and use of a common waiting-list for admission to publicly-funded hospitals would be an important step towards the removal of a serious inequity which exists at the moment.

Prevention and Control

The State and the individual share a responsibility to prevent and control illness, accidents, suffering and death caused by factors within human control. The State exercises its role in different ways ranging from regulation to persuasion. It is obvious that any saving in the high medical cost of accidents on the roads, at work, or in the home, releases funds for other purposes. The environment cannot be regulated by individuals acting alone but they can pollute it; the health hazard caused by smoke and other emissions has been well documented. In the area of regulation generally, it is incumbent on the State, acting on behalf of the community, to ensure that the standards enforced in Ireland are as stringent as are necessary. (In that context, for example, it seems strange that the alcohol levels permitted for driving in Ireland are higher than those elsewhere in Europe.) The task of giving accurate and intelligible information on the consequences of various patterns of eating, drinking, smoking and other behaviour will not be done by the producers concerned but must be undertaken by the State: Information should be widely available. Furthermore, the Minister for Health should be in a position to ensure that the health implications of all government policies are thoroughly assessed.

Freedom of Choice

The degree of choice available to recipients of healthcare, whether publicly or privately funded, is also a matter of debate. The extent to which patients, rather than their medical advisers, or insurers, or employers, or family, actually decide on their consultant, hospital or medical treatment is more limited than most people care to acknowledge. The recipient does not usually have the knowledge or freedom of manoeuvre to make a final decision alone. As far as equity is concerned, freedom of choice on the part of consumers of health care is a valuable principle insofar as it contributes towards treating people with dignity, gives the patient some power over the suppliers and procures the best and most appropriate treatment. As far as efficiency is concerned, freedom of choice helps to maintain standards of skill and courtesy but must not be allowed to prevent the proper use of resources for the maximum benefit.

An appropriate degree of patient choice also requires a fine degree of balance in and between the public and private sector but we

believe that our recommendations will provide this equilibrium. The results will depend on the professional standards of the medical profession, the ability of management to ensure that the highest possible quality of service is delivered, within the resources provided and, in particular, the clear statement of the objectives of the health services.

Implications

Under our proposals, the Irish health services, with a different management structure, would continue to represent a mixture of public and private funding and delivery of services. The more obvious anomalies would be removed and responsibility and accountability would be much clearer. The taxpayer would no longer receive subsidies for private health insurance but would instead, be covered for essential health care through a tax-funded system.

Since the Irish people wish to maintain a standard of healthcare comparable to that of their partners in the European Community but have a lower than average income per head, they will either have to spend more per person or get better value for the money spent. To the extent that the cost of health services is pay-related, differences in absolute spending on health care in different countries can be consistent with similar standards of care if pay disparities reflect mainly differences in the cost of living in each country. This wider issue of pay is relevant to the health service but lies outside our competence.

While the proportion of income devoted to competing social and economic demands must be a political choice, we have made recommendations which are designed to ensure that the best return is received for expenditure. It is also apparent that member states of the European Community will have to coordinate the prevention and control of the spread of disease, health safety measures (including standards of health products) to a greater extent than they do now and to provide certain new high-cost procedures on a shared basis.

Implementation

Some of our recommendations can be introduced immediately; others require legislation, and others again should be phased in over a period of time.

The future direction and cost of health care is difficult to predict. For example, a cure for some conditions which now affect the elderly could change the health implications of the demographic trends for

the better. The possible extent of AIDS or some other as yet unidentified condition could place an unknown burden on the system. Our report emphasises the need to use national resources to the full, to channel funds where they will be most effective and to have an adequate system to monitor and judge performance of the service providers.

On a different level, the survival of "community-rated" health insurance as operated by the VHI may be in jeopardy when health insurance companies anywhere in the European Community can target the groups least likely to be a drain on their funds. Whether or not the present Irish system is allowed to remain, the provision of essential core services for the entire population ensures that a safety-net is in place should there be a change.

Conclusion

As we state in Chapter Two:

> "The kernel of the Commission's conclusions is that the solution to the problem facing the Irish health services does not lie primarily in the system of funding but rather in the way that services are planned, organised and delivered."

There are minority views on certain recommendations and these reflect differences in approach to the complex issues outlined in our terms of reference. We believe, however, that the analysis contained in this report and the proposals it outlines, provide Government, the health professionals and the general public, which includes both those who use and those who pay for health services, with a future programme for funding and operating a health service sufficiently stable to allow for proper planning and sufficiently flexible to respond to changing political policies and health developments.

GLOSSARY

Capital expenditure	Expenditure on items with a lifetime of more than one year, e.g. buildings, certain medical equipment etc. The distinction between capital and non-capital expenditure is not always clear.
Community-rating	A method of calculating insurance premia which does not take account of risk factors such as (in the case of health insurance) age and condition of health. It contrasts with experience-rating (see below).
Co-payment	A proportion of costs met by an insured person; the insurer meets the remainder.
Deductible	A specified amount payable by an insured person before the insurer becomes liable for any costs. It may be accompanied by a threshold above which the insurer is no longer liable.
Ear-marked tax	A tax raised for a specified purpose and normally allocated to a separate fund.
Ear-marked funding	A system of raising all or most funds for a service by way of an ear-marked tax.
Epidemiology	The study of the incidence of illness, disease and other medical conditions in a defined population or area.
Experience-rating	The standard approach to calculating insurance premia under which relevant factors of risk are taken into account. It contrasts with community-rating above.

Funding model	A term used in this report to describe alternative systems of raising funds for the health services. Models based on general taxation, ear-marked taxation and private insurance are described.
General taxation funding model	A system of funding all or most (health) services from general taxation.
Generic drug	A drug product marketed without a brand name after its patent has expired. It can then be produced by companies other than the original manufacturer, often at a cheaper price than branded equivalents.
Health Maintenance Organisation	An organisation comprised of, or contracting with, medical personnel which undertakes to provide all necessary health services in return for an annual capitation payment. It contrasts with traditional insurance arrangements where patients are reimbursed all or part of costs incurred.
Iatrogenic disease	Disease induced by medical treatment.
Insurer	A company or "carrier" which indemnifies individuals against the costs of specified occurrences such as (in the case of health insurance) costs arising from illness.
Monopsony	A market in which there is only one buyer of a commodity (as opposed to a monopoly in which there is one seller).
Morbidity	The incidence and type of illness in a group, often expressed per 1,000 population.
Mortality	The incidence of death in a group, often expressed per 1,000 population.
Private hospitals	Hospitals which are owned and managed privately and receive no direct funding from the State.

Third-party funding	A phenomenon observed in healthcare where neither patient nor doctor meets the cost of services directly. Costs are met by a "third party", usually the State or an insurer.
Voluntary public hospitals	Certain hospitals not owned by the State but which receive funding directly from the Department of Health acting as agent for the health boards. Some are owned by religious orders; others are incorporated by charter or statute and work under boards which, in many cases, are appointed by the Minister for Health.

Throughout this report the use of masculine pronouns connotes feminine gender unless the contrary intention appears.

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INTRODUCTION AND SUMMARY

CHAPTER ONE

INTRODUCTION

Establishment of Commission

1.1 A statement issued by the Government Information Services on 5 June, 1987 on behalf of the Minister for Health announced the establishment of a Commission on Health Funding with the following terms of reference:

> "To examine the financing of the health services and to make 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."

Approach to our Terms of Reference

1.2 In his address to the Commission on 17 June, 1987, the Minister for Health, Dr. Rory O'Hanlon T.D., stated that he had made our terms of reference sufficiently wide to enable a broad consideration of issues affecting the funding and administration of the health services. This broad consideration is the context in which we have approached our work.

1.3 The term "public health services" as contained in our terms of reference has a specific meaning in certain contexts. Throughout our report we interpret it as meaning *the total health and personal social services available to the public, including all services provided by public, private and voluntary agencies, irrespective of source of funding.*

Method of Work

1.4 At the Commission's first meeting, it was decided to invite written submissions from interested organisations and individuals. Advertisements were placed in the national newspapers on 3 July, 1987. The Commission also wrote to a large number of organisations, including health boards, hospitals, voluntary agencies, professional organisations and other bodies with an interest in the health area. A

closing date of 7 September, 1987 was set for receipt of submissions and, while the majority were received by that date, we continued to receive submissions until March, 1988.

1.5 A total of ninety-four written submissions were received, of which sixty-three were from organisations. A full list of submissions is contained in Appendix 1. Where we felt it appropriate, we invited a number of organisations (marked with an asterix in Appendix 1) to expand orally on their submissions.

1.6 In addition to these discussions, we also consulted widely both on a formal and informal basis with organisations and individuals at home and abroad (see Appendix 2). The Chairman and Secretary visited the United Kingdom, and the Chairman travelled to the United States and Belgium to discuss health issues with officials of Governments, the European Commission and other organisations. We invited a number of European experts in health funding and administration to visit us (see Appendix 3). Their experience and insights were of considerable value.

1.7 We visited a number of healthcare facilities in the Eastern Health Board area on 4 May, 1988, including a health centre, a community workshop and a psychiatric hospital.

1.8 We commissioned a paper on "Suggestions for Organisation of the Health Services" by Professor Geoffrey MacKechnie, Trinity College, Dublin. Professor Stephen Cang of Brunel University also prepared a paper on organisational issues.

1.9 We held a total of thirty-five formal meetings between June, 1987 and July, 1989, in the preparation of our report. This included two weekend meetings at Barrettstown Castle, Co. Kildare.

Commission Membership

1.10 We were greatly saddened by the death of Mr. Thomas Moore on 21 April, 1988. He was a source of knowledge and wisdom in our deliberations. We hope our final Report will reflect his contribution and personal commitment to our work.

1.11 Mr. Paddy O'Brien resigned on 25 January, 1988 due to pressure of work; we thank him for his contribution to the early part of our discussions. We were happy to welcome Mr. Dermot McCarthy to the Commission in November, 1988.

Acknowledgements

1.12 We are grateful to the many organisations and individuals who helped us in our work by making submissions, engaging in formal or informal discussion, supplying information and offering advice. We hope that our report adequately reflects their assistance.

1.13 In particular we wish to acknowledge the co-operation and assistance of the Secretary of the Department of Health, Mr. P.W. Flanagan, and his officials who responded most efficiently to our requests for information. We also thank Dr. Ruth Barrington for her advice in the drafting of Chapter Three. Mr. Tony McCashin read part of the draft report and offered useful and constructive criticism for which we are grateful.

1.14 Mr. Philip Berman, Director of the European Healthcare Management Association arranged the visits of European experts to the Commission; we are very grateful to him for his assistance in this regard.

1.15 Our terms of reference required us to examine a very wide range of complex health policy issues and to consider the views of many groups and individuals. We were able to achieve our task through the energy and support of our Secretariat. We wish to record our appreciation of the contribution made to our work by Tom O'Mahony who provided the initial drafts, research and analytical framework. We were greatly impressed by his efficiency and expertise. Following his recall to other duties in the Department of Health, he was replaced as Secretary by Paul Kelly who continued the work with the same dedication and helped us to revise and finalise our report. Fergal Lynch, Assistant Secretary, gave continuous and courteous assistance of a very high order and Caroline Field coped with the considerable secretarial demands of the report with efficiency and unfailing helpfulness.

Structure of the Report

1.16 The report is divided into five major sections as follows:

Part One is a self-contained summary of the report, incorporating a brief discussion of the key issues and our major conclusions and recommendations. We would emphasise that this is merely a summary and that the main text should be consulted for the full import of our proposals.

Part Two sets the context of the report, with an outline of the development of the health services (Chapter Three); details of health

expenditure and trends (Chapter Four); and a discussion of equity, efficiency and cost-effectiveness (Chapter Five).

Part Three sets out in detail our proposed framework for healthcare in the future, including sources of funding (Chapter Six); eligibility for services (Chapter Seven); the role of public and private sectors (Chapter Eight); the structure and organisation of health services (Chapter Nine); and the planning and delivery of health services (Chapter Ten).

Part Four (Chapters Eleven to Nineteen) evaluates each of the major health and personal social services as currently provided and proposes changes aimed at achieving greater equity, efficiency and cost-effectiveness.

Part Five (Chapter Twenty) suggests an approach to implementing our recommendations and considers their financial implications.

CHAPTER TWO

SUMMARY OF REPORT

INTRODUCTION

2.1 This chapter summarises the major issues examined by the Commission and its conclusions and recommendations. A number of members of the Commission have reservations to the report on some issues.

2.2 It should be emphasised that what follows is a summary of the major recommendations and of the primary arguments which led the Commission to its conclusions. The main text of the report should be read for a more detailed discussion of the issues.

2.3 The first sections of this chapter discuss the context within which the report is written, including international trends in healthcare expenditure and the manner in which issues of equity, cost-effectiveness and efficiency have been addressed by the Commission. There follows a discussion of the major framework of funding, eligibility, organisation and information upon which the Commission's proposals are based. Finally, the main issues and recommendations regarding individual service areas such as general practitioners, hospitals and consultants are summarised.

HEALTH EXPENDITURE

2.4 During the last thirty years, there has been a substantial increase in the quantity and quality of medical technology. Before this time, the scope for medical intervention in the treatment of disease was quite limited. It largely consisted of providing rest, care and nutrition. Obviously, the cost of providing an open-ended commitment to provide this type of low-technology medical care was relatively small. However, with the scientific revolution that transformed medical care, there has also come a never-ending spiral of costs. At the same time, populations accustomed to a constantly developing medical service have developed expectations which continue to rise. These two factors have combined in recent years

to produce a situation where the funding demands of the health services have posed huge problems in most Western states.

2.5 Despite its relatively low GDP per capita compared with the rest of the Western world, Ireland has managed to maintain a parity with most of the technological developments which have taken place in much richer countries. Having created a climate of rising expectation for services which are found to be increasingly difficult to fund, the time has now come to examine the nature of the services which should be provided and the way in which they should be funded.

2.6 The Commission has concluded that the level of funding which this country should spend on healthcare cannot be determined by reference to a fixed proportion of Gross Domestic Product or by reference to international comparison. The level of funding can only be decided in the context of the available resources and the priorities attached by Irish society to different social objectives. It is, of course, essential that we have a clear view of what these social objectives are and the priority in which we rank them.

CHOICES IN HEALTHCARE

2.7 Choices must be made in the allocation of funds to differing social programmes, such as health, education, housing and income maintenance. Within each of these types of programme, further choices must be made in terms of allocating resources to the most appropriate and cost-effective forms of policy option.

2.8 Many of the decisions which face policy-makers contain a very substantial ethical element. Healthcare in modern societies is now seen as a "right". The Commission does not believe there is any fundamental disagreement in Irish society on this issue. On the contrary, we believe that more than in any other social area there is a general consensus that the health needs of all the population must be attended to as a matter of priority and of social justice. How this is to be done in the most equitable and yet cost-effective manner possible is among the Commission's key concerns.

2.9 The fundamental problem in allocating limited resources in healthcare is the trade-off that occurs between different services and client groups. A major problem in the Irish healthcare system is that such allocative choices are currently made without sufficient knowledge of the consequences. Policies in this regard are often based on intuitive rather than objective criteria.

Comprehensiveness and Cost-Effectiveness

2.10 The Commission's terms of reference refer to equity, comprehensiveness and cost-effectiveness. Both comprehensiveness and cost-effectiveness can be discussed in terms of efficiency; the former is concerned with the efficiency of *allocating* resources while the latter relates to efficiency in their *use*. In order to determine the most cost-effective use of resources and, hence, the most comprehensive service that can be provided with a given level of those resources, adequate information must be available on which to base decisions regarding allocation.

2.11 Comprehensiveness cannot be defined in absolute terms; inevitably the level of comprehensiveness of a health service is dependent on the total amount of resources placed at its disposal, and on the extent to which it is used cost-effectively. Given the imperfect information available, it is not possible to judge with certainty whether the level of resources currently being used by the health services is, in fact, delivering the maximum output possible.

Equity

2.12 The principle of equity should be defined in terms of (i) contribution to the cost of services and (ii) access to and utilisation of services. The Commission regards it as a guiding principle that the cost of health services should be shared on the basis of equal contributions by those of equal means and a proportionately greater contribution by those more favourably placed. Such contributions can arise through taxation, payment of insurance premia or user charges.

2.13 In relation to access, the Commission believes that all necessary health services, determined on the basis of objective criteria, should be available by reference to individual need rather than, for example, ability to pay or geographic location. In particular, concern for the position of the poorest sections of the community must be accorded a high priority. The Commission's definition of equity, therefore, embraces the concept of equality of utilisation of services, ensuring that services are availed of by those for whom they are designed, as well as the concept of equal access for equal need.

THE FRAMEWORK

Funding the Health Services

2.14 At the centre of the Commission's terms of reference is the question of how best to fund the health services. There are three

main methods. Some countries such as the United Kingdom fund the great bulk of services through general taxation; others such as West Germany and France use "social insurance" systems, involving essentially a form of compulsory ear-marked taxation with contributions from employers and employees. The United States relies primarily on private health insurance for the majority of the population. No country relies entirely on any one of these approaches; private insurance often supplements social insurance or general taxation systems, while the lowest income groups in predominantly private insurance systems are normally served by tax-funded care.

2.15 A clear distinction should be made between funding of health services and their delivery. It is possible, for example, to combine a largely public funding system with a mainly private delivery system, as in the case of Canada; the two components, though related, are not entirely interdependent. The most appropriate funding system is considered first, followed later by an examination of the role of the public and private sectors in delivery.

Public versus Private Funding

2.16 The two main forms of public funding for health services, general taxation and social insurance, can be discussed together when considering their merits against a private insurance system. It must be emphasised again that the choice at issue is that of a *main* funding model; a predominantly public funding system can be supplemented by private arrangements, or vice versa.

2.17 Arguments for a private funding model for health services are normally accompanied by provision for compulsory or optional private health insurance due to the unpredictability of need for services and the potentially high costs that individuals would otherwise face. The case for a largely private system is usually based on arguments regarding improved consumer choice, efficiency and cost control.

2.18 Competing private health insurers must minimise costs and maximise benefits for their own viability. To achieve this they must demand the most cost-effective services from providers, who, in turn, have an incentive to compete on the basis of price and quality. Consumer choice is aided by the offer of alternative insurance packages and alternative providers. Proponents also argue that if all but the lowest income group are not entitled to most publicly-funded health services (effectively requiring them to make their own arrangements through insurance), the redistributive impact of the system as a whole is improved since public resources are concentrated on those who can least afford to provide for their own healthcare.

2.19 While the potential advantages of a private funding model are attractive at first sight, particularly where the lowest income group is still served through the public system, a majority of the Commission rejected it for reasons of equity, comprehensiveness and cost-effectiveness. In terms of equity, systems using private insurance tend to discriminate against high-risk groups (such as the elderly and chronically ill) since premia would be related to risk factors such as age and health status. This results in serious gaps in coverage (a lack of comprehensiveness), as has happened in the United States. A system of subsidies to assist the insurance premia of high-risk groups would be very complex to operate and would diminish the perceived benefits of free competition.

2.20 In addition to the gaps in coverage, comprehensiveness is made more difficult by the problems in enforcing compulsory health insurance, as evidenced by the numbers who fail to obtain cover for the mandatory element of motor insurance. It seems unacceptable to refuse treatment to those failing to insure, and costs may not be recouped after treatment if the uninsured patient cannot afford to pay. The knowledge that treatment is unlikely to be refused makes purely optional health insurance impracticable.

2.21 International evidence suggests that a private funding model does not compare well against public systems for the purposes of cost control. Costs in the United States have risen at least as fast as those of public systems and per capita expenditure there is significantly higher than in most other developed countries. There is evidence that the administration costs of a single fund for health services are lower than those of competing insurers.

2.22 A majority of the Commission favours a public funding system. It would achieve a greater degree of comprehensiveness since the State as central funder is favourably placed to plan and organise the delivery of a unified, integrated service for all categories of patient. Policies such as the transfer of resources from institutional to community-based care can more easily be achieved where there is a single major health funder.

2.23 A public funding system can achieve equity of contribution towards the cost of services by way of progressive taxation or social insurance; equity of access can be controlled administratively to ensure that necessary services are available to all on the basis of need. There are clearly problems with equitable access to public hospital services under the present public funding model but recommendations in this regard are made later.

2.24 As argued earlier, the private funding model has not proved more successful in controlling health costs. While much of the argument favouring it is based on the efficiency that would result from competition among providers, it has been emphasised earlier that competition in delivery is still possible in public funding systems. Indeed, a large single public funder would be at an advantage when purchasing services from many alternative providers.

General versus Ear-marked Taxation

2.25 The particular type of public funding model is open to further debate. A minority of the Commission favours a compulsory health insurance or ear-marked tax system which would link clearly the services provided with their cost and provide a secure source of funding for healthcare. A majority of the Commission favours the retention of general taxation as a means of funding health services. They see compulsory health insurance effectively as another tax, which would be costly to establish separately and would offer no real advantages over general taxation. Other arguments for ear-marked taxation, such as greater acceptability of levies designated for a specific purpose, remain to be substantiated.

Other Sources of Funding

2.26 The existing health levy of 1.25 per cent on income of up to £16,000 per annum raises only a small proportion of total health revenue and does not establish entitlement to health services. It should be abolished and the revenue raised instead from general taxation.

2.27 Local taxation was a major source of funding for the health services in the past but it should not be reintroduced for this purpose. It would hinder national planning of facilities and could undermine equity of access since more prosperous areas would have the capacity to raise greater resources.

ELIGIBILITY FOR HEALTH SERVICES

2.28 The population at large should have *available* to it a certain level of necessary health services, including primary care, hospital care, long-term care and personal social services. This does not necessarily mean that they should all be publicly-funded or delivered by public agencies, nor that they should be provided free of charge.

2.29 The lowest income group should continue to be eligible for all necessary services, including general practitioner care, free of charge. The rest of the population should be eligible for a core set

of publicly-funded services comprising specified acute hospital care, long-term care and personal social services.

2.30 While the entire population should therefore be entitled to a core publicly-funded health service, patients should have to make an explicit choice between public and private hospital care and should not be able to combine the two (for example, linking private consultant treatment with public ward accommodation). Those opting for private care should meet the full cost of treatment. This approach would distinguish clearly between public and private care; at present private patients of consultants can benefit from public accommodation while paying only consultants' fees and the £10 daily hospital charge.

2.31 The top fifteen per cent of income earners, Category III, are liable for consultants' fees in hospital but otherwise have largely the same entitlements as persons in Category II. The existence of Category III gives rise to a number of anomalies and to the scope for preferential treatment in public hospitals by patients who can gain speedier access as private patients of consultants. Anomalies in assessment can result in families qualifying for Category II eligibility with higher combined incomes than some households in Category III, depending on the distribution of income between spouses. In addition, the present arrangements make Category III patients who avail of a public entitlement (hospital accommodation) liable for charges (consultants' fees) over which the State has no control. This is particularly undesirable if the likely change to non community-rated health insurance premia, as discussed below, renders insurance too costly for some patients.

2.32 In view of these considerations, Category III should be abolished and eligibility for health services should consist of two categories — Category I (medical card holders) and Category II (the rest of the population). Category II would then be entitled to the set of core services described above. The only major change would be the removal of liability to pay consultants' fees. While fifteen per cent are liable at present, over thirty per cent of the population still insures itself for these and other private charges; it is thus unlikely that uptake of private consultant care will decrease very sharply as a result of abolishing Category III.

User Charges

2.33 Category I patients should be exempt from charges. For Category II, core services should, in general, be provided free at the point of use, except where modest charges might be justified in

terms of regulating demand by directing it to the most appropriate providers. This is especially obvious in the case of people who attend hospital out-patient and casualty departments when they would more appropriately receive attention from a general practitioner. Other charges might be justifiable on the basis of contribution towards "hotel costs" in long-term institutional care. None of these charges should be set at a level where they would require insurance to cover them and it is essential that all of these charges be regulated at central level to ensure that they are applied in a uniform manner throughout the country.

Other Issues relating to Eligibility

2.34 It is important that the procedures for assessing eligibility for medical cards be fair, efficient and uniform throughout the country. Procedures should, to the greatest extent possible, ensure that those in genuine need of medical cards receive them and that those not in genuine need do not. The present degree of discretion relating to eligibility for medical cards is a useful and flexible means of ensuring against individual hardship but the system of assessment must be subject to regular review so that uniformity and efficient targeting of eligibility is achieved. In addition, a detailed analysis of the income distribution of medical card holders and of the factors indicating their need for medical cards where their income exceeds the normal guidelines, should be undertaken.

2.35 The basis of eligibility and charges for most health services are specified in health legislation, but health boards are empowered (rather than obliged) to provide a range of discretionary services such as home helps, paramedical services and ambulance services. This gives rise to a considerable lack of uniformity in availability and in the level and incidence of charges. In future, eligibility criteria and the imposition of charges should be the same for all such services and applied in a uniform manner. However, there must remain scope for the exercise of discretion by fieldworkers to take account of factors peculiar to individual cases. Guidelines should be specified to assist in decisions where it is necessary to depart from the formal criteria.

2.36 Eligibility for health services in the case of road traffic accident victims has been a controversial issue. Present legislation renders persons receiving compensation from traffic accidents liable for charges in public hospitals. Similar charges are not payable where the accident arises in other settings such as the workplace. In future, in any case where damages are awarded arising from accidental injuries (whether motor, industrial or other accident) the Court

should take account of these costs and be empowered to award an appropriate share of the damages to the services concerned.

THE PUBLIC/PRIVATE MIX OF HEALTHCARE

The Role of Private Health Insurance

2.37 The Commission's proposals envisage a continued mix of public and private care in the Irish health services. The future role of private health insurance is an important issue in this regard; at present there is a perception, often borne out in practice, that those with cover for private care can obtain speedier access to treatment than those relying on the public system. A fundamental principle of the majority of the Commission is that it should not be necessary, nor should it be perceived as such, to take out private insurance in order to secure access to necessary treatment. The role of private health insurance should therefore be

(a) to provide cover for those wishing to avail themselves of private healthcare; and

(b) to provide cover for the costs for which certain income groups will be liable, i.e. non Core Services and the modest charges envisaged for certain Core Services.

2.38 It is inevitable that those able to obtain treatment in the private sector may be able to obtain certain treatment more quickly, and that some treatments will be available only in the private sector, where the public sector has decided against offering them. It could only be otherwise if the public sector were to offer an unlimited range of treatment regardless of cost-effectiveness. In summary, therefore, the Commission does not consider it inequitable that private insurance should enable individuals to obtain speedier or otherwise unavailable treatment, *provided* that comprehensive and cost-effective publicly-funded health services are available within a reasonable period of time to all those assessed as in need of them.

The Future of Private Health Insurance in Ireland

2.39 There has been much debate concerning the case for having competing private insurers within the predominantly public funding system. The VHI has an effective monopoly on the sale of health insurance at present. The Commission sees some advantages in a competing complementary insurance system but also sees a considerable case for retaining the existing monopoly, particularly in view of the desirability of protecting community-rated insurance premia. As described earlier, the experience of other countries

suggests that competing insurers would base premia on risk factors such as age and health status, thereby making insurance more expensive for those most in need of healthcare. Community-rating, which spreads risks across all categories of subscriber, would be difficult to sustain alongside risk-rating.

2.40 It has not been possible to determine with certainty whether the VHI monopoly, and hence community-rating, will be sustainable after completion of the EC Internal Market. Differing views have been advanced, but the Commission has concluded that it would be unwise to base its recommendations on an assumption that the monopoly will be permitted to remain indefinitely. This conclusion has strongly influenced the Commission's recommendations for a core publicly-funded service for the whole population.

Tax Relief

2.41 Payments to VHI and certain unreimbursed medical expenses qualify for tax relief, at a total cost of about £44 million in 1989. A number of recent reports have argued for the abolition or restriction of these reliefs on grounds of inequity and inefficiency. In addressing the issue, three questions must be asked:

(a) Should private healthcare be subsidised by the State?

(b) If so, is tax relief the best way of doing so?

(c) Even if the method of subsidy is questionable, would it be unwise to curtail it because of the likely practical consequences?

2.42 Other than in some limited circumstances, the Commission is opposed to public subsidisation of private healthcare where the State is already providing a core service to the entire population. Even if it is decided that private healthcare should continue to be subsidised, the Commission believes that tax relief is an inefficient means of doing so. Tax relief subsidises both high-priority and less important procedures indiscriminately and even assists treatments which the public system is unable or unwilling to provide. It is also inequitable since, like all tax allowances, it discriminates between taxpayers and non-taxpayers, and between those who pay tax at different rates.

2.43 Income tax relief on health insurance premia and on unreimbursed medical expenses should be phased out. The pace of phasing out should be adjusted over time, as necessary, in response to the pattern of demand for health insurance that emerges as tax relief is reduced. The Commission does not believe that the effect on the demand for health insurance will, in itself, be very large since

present demand is relatively inelastic and the relief would be withdrawn gradually. Other factors, however, such as the likely advent of competing insurers and the consequent removal of community-rating may have a more significant impact on the demand for health insurance. This is discussed in Chapter Twenty.

Private Delivery of Health Services

2.44 It was emphasised earlier that funding and delivery, while linked, need not both be provided by the same sector. While the Commission recommends a predominantly public funding system, there is no reason not to arrange delivery of services through the private sector if this would be more cost-effective. Area General Managers of the proposed Health Services Executive Authority should therefore have flexibility to arrange for the provision of services either directly or by other Areas, or through competitive tendering in the private sector. This approach is dependent on a proper analysis of the relative costs of alternative methods of delivery, and on adequate monitoring to ensure that quality and cost-effectiveness are maintained.

ADMINISTRATION AND MANAGEMENT

2.45 The kernel of the Commission's conclusions is that the solution to the problem facing the Irish health services does not lie primarily in the system of funding but rather in the way that services are planned, organised and delivered.

2.46 The present administrative structure has a number of weaknesses. It confuses political and executive functions, undermining both; it fails to achieve a proper balance between national and local decision-making; the decision-making process does not provide a sufficient role for information and evaluation; accountability within the structure is inadequate; there is insufficient integration of related services; and the interests of individual patients and clients are inadequately represented.

2.47 The Commission examined a number of alternative approaches. It concluded that the administration of the health services should be restructured by

— clearly defining the roles of the Minister and Department, the health boards and their Chief Executive Officers (or Area General Managers under our proposals) and the relationships between each;
— transferring responsibility for the overall management of health services to an executive authority;

— clearly defining the role to be played within the healthcare system by voluntary agencies and, in particular, the nature of their relationship with local management in terms of coordinating objectives of service provision;
— enhancing the evaluation function within the planning and monitoring of services, including the capacity to carry out technical appraisals of service levels; and
— establishing an independent appeals mechanism for patients and clients.

2.48 Under the Commission's proposals, the Minister for Health should retain ultimate responsibility for the provision of health services under legislation passed by the Oireachtas and for overall policy, but the Department should no longer be directly involved in the management of individual services. A Health Services Executive Authority should be appointed by the Minister for Health, with responsibility for the overall management and delivery of health and personal social services in the context of the overall health policies set by the Government and the Minister for Health. Within this framework, the Executive Authority should be free to decide how best to translate the objectives given to it into action.

2.49 The Executive Authority should have comprehensive responsibility for ensuring that patients and clients have access to a designated level of service on the basis of specific eligibility criteria. It should have a rolling multi-annual budget and be free to determine the appropriate mix of services to be provided by its own facilities or through arrangements with voluntary hospitals and the private sector to meet its performance targets within its allocated budget. The Executive Authority should devise its own management structure below the level of Area General Manager (equivalent to the present Chief Executive Officers of health boards) and should experiment with various management structures in different areas before arriving, if at all, at a single model for general application. The functions of every existing executive board and agency in the health area should be examined to establish whether they could best be undertaken by the Executive Authority or whether they should continue to be provided by a separate agency.

2.50 The confusion of political and executive roles is most acute at the level of the health boards. The boards have a crucial role to play in representing local consumer interests by influencing the formation of policy and monitoring the quality and adequacy of local services. They should be freed of their executive functions and, to underline their representative role, should become known as Health Councils. They should have statutory power to delay, for up to three months,

the implementation of major decisions concerning services. Area General Managers should have to provide public justification for such decisions. The power of delay should, however, be limited to service-related issues rather than executive functions such as staff deployment or budget formulation. The Health Councils should publish regular reports on the quality and adequacy of services.

2.51 Given the proposed Health Services Executive Authority's responsibility for ensuring the delivery of a specified range, level and quality of services, there should be independent appraisal of its performance. While this is primarily a matter for the Minister and Department, the further technical resources of a Performance Audit Unit would be valuable. The Unit should monitor access to services and identify deficiencies. Its findings would be of importance to the Minister, the Health Councils and to professional associations and consumer interests; its reports should therefore be published.

2.52 There is no independent appeals system for individuals dissatisfied with decisions on their entitlement to health services. This inevitably increases the complaints channelled through the political process, involving politicians in detailed executive issues. An independent appeals officer should be appointed for each functional area to investigate complaints in individual cases.

THE ROLE OF INFORMATION AND EVALUATION IN PLANNING, MANAGEMENT AND DELIVERY

2.53 Of crucial importance in this new administrative system is the role of information and evaluation. In order for the Health Services Executive Authority to make its funding requirement explicit to the Government, it is essential that it has the fullest possible information available to it on how such resources can be used to maximum effect. Chapter Ten discusses the role of information and evaluation in the planning, management and delivery of services and makes specific recommendations which should be implemented as soon as possible, even before the establishment of the Executive Authority. The object of these recommendations is to establish and develop a climate in which information and evaluation becomes the normal basis for the making of decisions concerning the provision of health services and the way in which they are managed, both at an overall policy level and in terms of day-to-day operational decisions.

2.54 It is only by using properly developed information systems that decision-makers can see clearly the consequences of the choices available. At present, because of a serious inadequacy in the availability of information in the Irish health services concerning the

costs of treatment, the level and quality of the need for services and some attempt at quantifying the outcome of different forms of treatment, the true nature of the problems facing the Irish healthcare system are often misunderstood.

2.55 Among the major recommendations made in Chapter Ten are
— the need to develop information systems in each region, which would include comprehensive population registers with demographic and health profiles and detailed information on the usage of different public and private health services;
— the importance of developing information on the effectiveness of specific services and methods of service delivery;
— the need for the Health Services Executive Authority to take full responsibility for epidemiological research, the allocation of grant-aid to clinical research and the organisation of health services research.

GENERAL PRACTITIONER SERVICES

The new GMS Contract

2.56 Until recently, general practitioners were paid for their services to medical card holders on a fee-per-item basis. A capitation-based system was introduced in March, 1989, details of which are summarised in Appendix 11A. While it is difficult to assess the likely effect of the new contract given its very recent introduction, it offers a number of potentially important advantages. In particular it should remove the incentive towards over-visiting of medical card patients that existed under the previous arrangements. In turn, this should result in an associated decrease in prescribing and drug costs since there is an observed relationship between consultations and prescribing patterns. However, it is important that the operation of the new scheme be monitored over time to ensure that it does not lead to inadequate or poorly targeted services.

2.57 The concept of funding selected simple medical procedures in a general practitioner's surgery in preference to hospitalisation is useful but services funded in this way must be carefully chosen and reviewed periodically to ensure that they are having the desired effect on hospital referral rates.

Eligibility for GP services

2.58 Medical card holders (i.e. Category I patients) should continue to be eligible for a publicly-funded general practitioner service without charge. The cost of general practitioner services to the rest

of the population (Category II) is not a severe financial burden; all except hardship cases should, as at present, be required to meet these costs themselves.

Other issues

2.59 A number of steps are required to improve the effectiveness of general practice in Ireland. In particular

— there is a need for greater co-ordination between general practitioners and other personnel providing services to the community, such as public health nurses, social workers and paramedical staff;
— general practitioners should have access to appropriate hospital-based diagnostic facilities through uniform arrangements; and
— the improvement of practice organisation and facilities is important, and will be aided by the recent financial commitment by the Department of Health towards the cost of employing practice nurses and secretarial support.

GENERAL HOSPITAL SERVICES

Roles and Funding

2.60 Acute general hospitals are the single most expensive area of the health services, accounting for about forty per cent of the public resources spent on healthcare. A major problem in the present system is the absence of clearly specified roles for many hospitals within the public sector. The role of each public hospital at local, regional and national level, and its catchment area, should be defined explicitly. Each hospital should then be funded for the provision of an agreed level of service to public patients, based on the activity level implied by its role and catchment area, and the case-mix based cost of meeting this. Techniques such as Diagnosis Related Groups (DRGs) or other case-mix costings should be used to determine the level of funding required for a specified level of service.

Access to public hospitals

2.61 There is a major problem regarding access to public hospitals; the common perception is that those opting for private care are able to obtain admission more quickly than those using the public system. An objective system of assessment for access to public hospitals should be introduced for all planned (as opposed to emergency) admissions, involving a common waiting list for both public and private patients, from which cases would be taken in order of medically-established priority. The new approach would require the regular publication of criteria for hospital admission and of maximum

waiting-periods for access to specific non-emergency procedures. The operation of a common admissions policy would have to be monitored closely, having regard to the pattern of admissions over time (rather than a case-by-case review) and would depend heavily upon the co-operation of the medical profession.

User charges

2.62 There are three main types of user charges applicable to public hospitals: those in respect of private accommodation; regulatory charges to deter unnecessary or trivial usage of services; and cost-sharing charges to raise revenue. Charges for private accommodation should be set at a level which would recover the full economic cost of provision. Hospital managements should determine the quantity and quality of private accommodation by reference to the market demand for it at that price.

2.63 Regulatory charges such as the present £10 out-patient charge are useful as a deterrent against unnecessary demand and as a means of directing patients towards the most appropriate level of care, such as general practitioner rather than out-patient hospital services. However, regulatory charges are unnecessary in the case of in-patient treatment; the proposed uniform admissions policy should ensure that only those in genuine need of care are admitted.

2.64 Cost-sharing charges for in-patient services can be justified as a means of reducing the cost to taxpayers of services to those patients who can afford to contribute towards their own care. However, given the Commission's recommendation for a core set of publicly-funded health services, including in-patient care, the charges should not be of a size that would require insurance to cover them. Any such charges should be on the same scale as the existing regulatory charges for out-patient services. User charges should be framed to avoid unnecessary complexity or high administrative cost. Medical card holders should be exempt.

Other Issues

2.65 In order to preserve standards, all public voluntary hospitals and private hospitals should be required to obtain a licence from the Health Services Executive Authority which would be renewable periodically. At present, there are few statutory controls over the establishment and operation of hospital services. Hospitals owned by the Executive Authority should be subject to the same standards but need not be licensed.

2.66 Subject to the licensing requirement for the purposes of standards, there should be no restriction of the development of private hospitals, but public policies should not insulate them from competitive forces. The scope for private hospitals to provide services on a contractual basis on behalf of the public system should be taken into account, particularly where temporary backlogs could be cleared without the need for a permanent addition to public facilities.

CONSULTANT SERVICES

Private Practice in Public Hospitals

2.67 There are strong arguments both for and against (i) restricting the private practice of public hospital consultants and (ii) separating private practice from public hospitals. On balance, the Commission favours the retention of a mix of public and private practice in public hospitals but believes that there should be some restrictions. Outside the hospital in which they hold their main public appointment, consultants should not undertake private practice without the agreement of the employing public hospital, and then only to an extent compatible with the overall policies of the Health Services Executive Authority.

Remuneration and Conditions of Employment

2.68 The present common contract for consultants (summarised in Appendix 13A) is unsatisfactory in a number of respects. It should be altered to allow for an agreed system of monitoring the public time commitment of consultants and should be more flexible to reflect local circumstances. In future, the contracting of consultants should be on a fixed-term basis, with conditions of employment and remuneration tailored to the requirements of particular disciplines or positions. Contracts should be in respect of individual institutions, specifying core responsibilities for all consultant posts and other functions relevant to each individual post.

Other Issues

2.69 There should be a comprehensive review of the medical manpower requirements of all public hospitals. It has been suggested, for example, that there are insufficient consultants to meet the needs of the health services and also that an intermediate grade of consultant should be introduced. The review should therefore place particular emphasis on establishing a sufficiently broad grading structure for consultant-level appointments.

2.70 Health insurers should negotiate maximum chargeable fees with consultants and provide their subscribers with regular details

of such fees, the extent of cover and the consultants who have agreed to abide by them.

OTHER MEDICAL AND ASSOCIATED SERVICES

Dental, Ophthalmic and Aural Services

2.71 There are serious deficiencies in the publicly-funded dental, ophthalmic and aural services provided to medical card holders. Health board dental services are largely confined to certain priority groups; most people in Category I receive only emergency services despite their statutory entitlement.

2.72 These problems must be addressed as a matter of priority. Any improvement of dental, ophthalmic and aural services must focus on the needs of the lowest income group. To this end, the resources of the present PRSI-funded Treatment Benefits scheme should be channelled into providing a better service under the Health Services Executive Authority. Other improvements to achieve a more cost-effective and equitable use of resources include the more widespread use of dental auxiliaries for specified procedures and the delivery of certain ophthalmic and aural services at a lower level of complexity. Dental auxiliaries would free dentists to concentrate on more complex work, and certain ophthalmic services could be provided safely and more cost-effectively by less qualified personnel.

Paramedical and Home Nursing Services

2.73 The availability of paramedical services (such as physiotherapy and occupational therapy) throughout the country is patchy; services have not developed in response to objectively determined need, and patients with similar needs have access to differing levels of service depending on where they live. Home nursing services also appear restricted. Formal studies should be undertaken to quantify the relative cost-effectiveness of the various paramedical services and on alternative methods of delivering them. In the case of home nursing there should be an urgent review of its role and workload to define the appropriate level of service required; Area General Managers should then be free to decide how these services can best be provided.

2.74 National guidelines on appropriate service levels and eligibility criteria for paramedical services should be developed. Local managers should decide the most cost-effective way of meeting these requirements in their areas through the use of hospital out-patient services, community personnel employed on a full-time or sessional

basis as necessary, and contracts with private practitioners where appropriate. There should be uniform guidelines on the applicability and level of any user charges for paramedical and home nursing services. The level of charges should not be so great as to provide an incentive to seek hospital admission.

DRUGS AND OTHER MEDICAL SUPPLIES

Drug Prices

2.75 Drugs and medical supplies account for nearly £200 million of public expenditure on health services. There is scope for substantial improvements in the existing arrangements for funding these costs, and for negotiating prices. Drug prices in Ireland are controlled by an agreement with the Federation of Irish Chemical Industries (FICI), which relates the price paid in Ireland to the U.K. trade price. Ireland's drug prices are among the highest in the EC. The FICI agreement limits prices but prohibits such steps as restricting doctors' rights to prescribe medicines of their choice, allowing pharmacists to dispense (cheaper) substitute products or reducing the range of drugs available under the GMS scheme.

2.76 The FICI agreement, which is terminable on 31 July, 1990, should be replaced by a different system for controlling costs. This would involve a number of features including

— drugs and therapeutic committees in hospitals and one for general practice;
— a "limited list" of pharmaceutical products for supply through the public system, subject to specified safeguards;
— a new approach by the Health Services Executive Authority to negotiating the trade price of products on the limited list, using central or local negotiation as appropriate;
— a single integrated system for funding or contributing towards drug costs for both medical card holders and others (as described below).

Entitlement to Drugs

2.77 Category I patients should be eligible for prescribed drugs from the proposed limited list free of charge; even a nominal prescription charge could act as a deterrant to obtaining necessary medicines. However, the Drugs Refund Scheme and Long Term Illness Scheme for non-medical card holders are unsatisfactory. The former is open-ended, leaving patients with no incentive to economise after the £28 threshold has been reached, and it can contain items

not funded by the State for medical card holders. The latter scheme is open to certain abuses.

2.78 In future, a single integrated scheme should supply prescribed drugs, through pharmacists, on the basis of a limited list to medical card holders free of charge and to all others at subsidised prices. The rates of subsidy for each product would vary according to factors such as cost, therapeutic benefit and frequency of repeat prescriptions. Non-medical card holders would purchase drugs at the subsidised price, meeting the balance (if any) themselves. The present Drugs Refund and Long Term Illness Schemes would be absorbed into the new system. The proposed system would target available resources more accurately and reduce the administrative cost of the present schemes.

Other Issues

2.79 Health education programmes should lay particular emphasis on educating the public on the role of drugs in treating routine illness, and on reducing the common expectation of a prescription for every ailment.

PROMOTING AND PROTECTING HEALTH

Immunisation and Screening

2.80 Immunisation programmes are of proven value but the rates of vaccination against many illnesses are apparently lower than desirable. The relative effectiveness of many types of screening programmes, however, is the subject of a scientific debate upon which the Commission cannot adjudicate. Comprehensive record systems should be used to ensure the required coverage of immunisation and screening programmes but epidemiological assessment at national level should be used to help assess the need for the introduction, expansion, restriction or targeting of specific programmes. They should be kept under continuous review in light of their own results and outside evidence. Immunisation and screening under these programmes should be free to those in the identified target groups.

Child Health Examinations

2.81 Child health examinations are of immense importance in identifying treatable defects but a number of criticisms of the service have been made. In particular, it is claimed that the service has been curtailed or withdrawn in some areas. Inappropriate use of manpower through use of doctors for routine examinations which could be

performed by nurses, and poor follow-up of defects are among the other deficiencies alleged. There should be a reappraisal and reorganisation of the child health services, including consideration of the scope for a single, comprehensive examination to replace the existing developmental paediatric examinations.

Health Education and Health Promotion

2.82 Despite their obvious importance, it is difficult to evaluate the effectiveness of health education programmes aimed at persuading individuals to modify their lifestyles. A substantial portion of the resources available for health education should be devoted to evaluating programmes and refining evaluation techniques; all programmes should have specific goals relating to short-term behavioural change and long-term health indicator targets.

2.83 Responsibility for health education should be assigned, as an executive function, to the Health Services Executive Authority. There should be particular emphasis on targeting programmes suited to low-income groups (who do not benefit from these to the same extent as others at present), and also on increasing public awareness of the appropriate use of medical services.

2.84 The recent re-orientation of the Department of Health's role in the area of health promotion, which would be facilitated by the transfer of executive functions to the Health Services Executive Authority, is to be supported if it results in the assessment of the health implications of public policies becoming a major concern of the Department.

WELFARE AND CONTINUING CARE SERVICES

2.85 A number of issues (and the Commissions's recommendations regarding them) are of relevance to a wide range of largely non-medical, often long-term services such as community social services and services for the elderly, the physically handicapped, mentally handicapped and mentally ill. These services account for over £500 million of public health expenditure, almost as much as the total spent on acute hospitals. The issues common to all such services are discussed first.

Assessment and Provision of Appropriate Services

2.86 Inadequacies in a number of institutional and community-based services have regularly been identified by various reports dealing with welfare and continuing care. However, the solution is not simply the introduction or expansion of some services at the

expense of, or in addition to, others. It is crucial (a) to have adequate assessment and evaluation procedures to determine what form of care is appropriate in response to different needs and (b) to ensure the availability, when and where required, of those services assessed as appropriate.

2.87 For assessment purposes, the evaluation of the relative costs and effects on patient welfare of alternative forms of care for different client groups should be a continuing part of the planning of services. In relation to availability, decisions should be taken nationally on what services should be provided and to whom, based on an objective assessment of need and the appropriate response to them within the constraint of available resources. They should then be implemented on the basis of uniform criteria in all areas. The same criteria used in determining appropriate forms of care overall should also be used in individual cases. The criteria should include such factors as level of dependency and social circumstances, but those carrying out assessments must be given flexibility to take account of factors specific to individual cases.

User Charges

2.88 The question of user charges for a range of these services should be addressed in a uniform manner. Decisions on whether charges should be made for specific services, the appropriate levels of charge, the circumstances in which they are payable and the basis for assessing ability to pay should all be taken at a national level as part of the overall planning of services to ensure that appropriate care is availed of to the greatest extent possible. They should be implemented on the basis of uniform guidelines, which would provide for the exercise of discretion in the application of charges in individual cases where hardship would otherwise result.

Administration and Coordination

2.89 Most, though not all, of the welfare and continuing care services are provided under the community care programme; some also involve the special and general hospital programmes. Organisational barriers to the present multi-disciplinary approach in community care have been identified in a number of recent reviews. As recommended in Chapter Nine, there should be experimentation with a number of approaches to the division of responsibility for delivering services at local level. Any such approach should ensure that the roles, objectives and accountability of all personnel are clearly defined and that there is effective coordination between different providers such as case-workers and general practitioners

and between different types of services such as housing, transport and income maintenance.

Voluntary Organisations

2.90 Numerous voluntary organisations serving the elderly, the physically and mentally handicapped, the mentally ill and many other groups provide very valuable services both locally and often on a national basis. However, problems of coordination between and within the statutory and voluntary sectors and gaps in service provision have been identified. It is important that all publicly-funded agencies, whether statutory or voluntary, work together effectively without jeopardising the independence of the voluntary sector. To this end, the grant-aid to voluntary organisations should be related to the provision of a specified, agreed level and type of service; agreements should take the form of medium-term contracts. The inter-relationship between statutory and voluntary workers should be clearly set out and there should be an agreed basis for evaluating each agency's contribution.

Other Issues

2.91 A range of recommendations relevant to individual services are made in Chapters Eighteen and Nineteen. These include

— the need to revise the legislation governing residential accommodation for the elderly to specify clearly the circumstances in which charges are payable and to standardise the element of personal income allowable before a charge is made;
— the targeting of subsidies to persons in registered private nursing homes who have been assessed as in need of residential care and the scope for varying levels of subsidy by reference to financial and medical dependency of the patient;
— the levying of charges towards the cost of certain services, depending on income, using the principles described in paragraph 2.88 above;
— the funding of agencies providing care for the disabled on the basis of appropriate costs per place for particular levels of handicap and type of care setting; and
— the transfer of certain income maintenance allowances to the Department of Social Welfare.

PART TWO

THE CONTEXT

CHAPTER THREE

THE DEVELOPMENT OF THE HEALTH SERVICES

INTRODUCTION

3.1 The Irish health services have changed radically over the past century and particularly since the formation of the State. This chapter outlines how they evolved, were extended to new areas and increased in cost. It also examines the expansion of state involvement and the shift from local to central funding arrangements. The key developments are considered under the headings of scope and development of services, administration and finance[1].

SCOPE AND DEVELOPMENT OF HEALTH SERVICES

3.2 During the nineteenth century, the State assumed increasing responsibility for the control of infectious disease and medical care of the very poor. These responsibilities were known to contemporaries as "public health" and "medical relief" respectively. Although the organisation of public health and medical relief was rudimentary, it provided the foundations on which the present health services developed. With the rapid development of medical science in the early years of this century, and the growth of democracy, it was increasingly accepted that the State had an obligation to ensure a high standard of health and medical services for the whole population and equitable access to medical services for those unable to pay. Since the foundation of the Irish State, the capacity to prevent illness has greatly increased, the quality of medical care available to the whole population has been vastly improved and eligibility for health services has been gradually widened.

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[1]This Chapter is based largely on material published in Brendan Hensey: *The Health Services of Ireland* (IPA, 4th Edition 1988); Joseph Robins: *Fools and Mad* (IPA 1986); and Ruth Barrington: *Health Medicine and Politics in Ireland 1900-1970* (IPA, 1987). Dr. Barrington has also provided considerable assistance in the preparation of the chapter.

(i) Preventive Services

3.3 The protection of public health through the control of environmental factors such as water, sewerage, food and housing were among the first health-related tasks assumed by the State. The most important piece of legislation in the nineteenth century was the Public Health (Ireland) Act, 1878. This Act formed the basis for statutory regulation of water supplies, sewerage systems, food hygiene and infectious diseases until the 1940s. The Health Act, 1947, codified and updated earlier legislation on food hygiene and infectious diseases and forms the basis for the present controls.

3.4 The appointment of County Medical Officers in the late 1920s increased the efficiency of the preventive services; school medical services, limited maternity and child welfare schemes and some immunisation schemes were developed. The anti-tuberculosis services developed slowly until the concerted campaign which began in the 1940s. Maternity and child care services were considerably extended under the Health Act, 1953.

3.5 Legislation passed in 1960 resulted in the flouridation of most public water supplies, while control on the sale and distribution of drugs and poisons was strengthened by laws enacted in 1961, 1977 and 1984. During the 1970s and 1980s the importance of health education and promotion was increasingly emphasised. The Health Education Bureau (now the Health Promotion Unit of the Department of Health) was established; steps were taken to combat the growing problem of substance abuse and to control tobacco sales and advertising; and campaigns were launched to eradicate measles through immunisation and to meet the new problems posed by the emergence of AIDS.

(ii) General Practitioner Services

3.6 The establishment in 1851 of a dispensary system under which medical officers were appointed in each area to provide medical care and dispense drugs to people with "dispensary tickets", which were issued to those unable to pay the cost of medical care for themselves or their dependants, was a milestone in the history of the health services. Patients were treated in dispensaries and in their homes. Dispensary doctors received a salary for treating public patients and were entitled to treat and charge private patients. Despite various proposals for change, the dispensary service remained largely intact until it was replaced in 1972 by the General Medical Service. The new service gave a choice of doctor and of chemist to those unable to pay the cost of medical care for themselves and their families.

The aim was to eliminate as far as possible the distinctions between private and public patients. Participating doctors and chemists were paid a fee for each item of service given under the scheme. Changes in the method of payment for doctors have recently been agreed; these are discussed in Chapter Eleven.

(iii) Hospital Services

3.7 Many of the voluntary hospitals began as "medical charities" for the relief of the sick poor, established in the eighteenth century by lay persons and later by religious orders of nursing sisters. These hospitals were mainly in Dublin, Belfast, Cork and Limerick. In the early nineteenth century a network of county infirmaries for the treatment of the sick poor was established, funded by a combination of state grants and public subscriptions. The introduction of the Poor Law to Ireland in 1838 led to the rapid provision of 163 workhouses, each with an infirmary for the sick poor. These were funded by a new system of local taxation on property, called the Poor Rate. The county and workhouse infirmaries provided the foundation for today's county, district and geriatric hospitals. The Poor Rate was rapidly expanded to fund other medical and public health functions.

3.8 Developments in medical science in the early years of this century radically altered the role of hospitals. Hospitals had been places of last resort for the poor whose housing or family circumstances were so bad that they did not permit even a mimimum standard of nursing care. Those who could afford to pay for medical and nursing care were treated at home. With the development of radiology, bacteriology, surgical techniques and the control of sepsis, hospitals became more successful in treating disease, and admission to hospital was seen as necessary for the treatment of many diseases, even among the better off.

3.9 By the 1930s, the government was faced with major problems in the development of hospital services. Many voluntary hospitals found it difficult to meet the cost of modern hospital treatment for the poor from their philantropic and investment income and began to rely to an increasing extent on paying patients. Outside the main cities, the standard of accommodation and the quality of service owed more to the concepts of the Poor Law than to modern thinking on medical care. However, the introduction in 1930 of the Hospitals Sweepstakes, which proved immediately successful, particularly in attracting income from abroad, raised large sums of money to build, equip and develop hospitals. Voluntary hospitals were able to pay their deficits and fund capital developments. The interests of the

poor were protected by the stipulation that no institution existing solely for profit could receive Sweepstakes funds. A substantial proportion of the funds was used for a major programme of developing new county, district and fever hospitals to replace out-of-date facilities, between 1931 and 1942 and again in the post-war period.

3.10 During the 1960s the emphasis began to shift towards providing fewer and larger hospitals. The 1966 White Paper[2] argued that the more specialised medical care now available could best be organised from national and regional centres. The Fitzgerald Report[3] recommended the concentration of available resources on a strictly limited number of hospitals, each with the staff and technology to provide a high-calibre service to the population of its own area. It followed that the hospitals not selected for development should be down-graded or closed and the detailed recommendations arising from this led to vigorous opposition from those in the areas concerned. During the 1970s and 1980s there has been major investment in new facilities. The rationalisation of the smaller and older services had proceeded very slowly until recently. However, 1987 and 1988 have seen a number of hospital closures.

(iv) Psychiatric Services

3.11 The lunatic asylums of the nineteenth century were concerned with the protection of society and the patients themselves through detention, rather than with the treatment and proper nursing care of the mentally ill. There was little awareness of the need to provide for care outside the institutional environment. The law and procedures under it remained almost unchanged until the Mental Treatment Act, 1945, which introduced a more flexible system of admissions to psychiatric hospitals. It provided for temporary and voluntary admissions and for the establishment of out-patient clinics. Since the 1960s, community-based facilities such as hostels, group homes and day centres have been developed, as well as rehabilitation services.

(v) Welfare Services

3.12 Responsibility of the health services for certain welfare schemes grew out of the traditional association of health with public assistance. This responsibility has greatly expanded over the years,

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[2] *The Health Services and their Future Development* (Stationery Office, 1966).

[3] *Consultative Council on the General Hospital Services — Outline of the Future Hospital System* (Stationery Office, 1968).

reflecting both a widening view of what "health" services should comprehend and an increased awareness in society of the needs of disadvantaged groups. In many cases voluntary organisations have identified a need and initiated a service which has then been further developed by the State. Rehabilitation services and income maintenance schemes for the mentally and physically handicapped were established from the 1940s. In 1974 the Department of Health assumed responsibility for co-ordinating child care services. Since 1984 the Department of Health has had overall responsibility for the general welfare of travelling people and it also plays a key role in relation to services for the elderly.

(vi) Eligibility

3.13 At the beginning of this century, only the very poor were entitled to medical services without charge. In 1912 the Government introduced a system of free treatment for tuberculosis sufferers, regardless of income. A school medical service was gradually expanded to all national schools in the 1920s and 1930s, providing free medical inspection and referral to specialists where necessary. Maternal and child welfare services, where available, were also provided free of charge regardless of the person's income. However, those with small or moderate incomes were obliged to pay their general practitioner and hospital bills. As the cost of hospital treatment rose, those on small incomes found it increasingly difficult to pay consultant and hospital expenses.

3.14 The post-war era saw the development of comprehensive services for the entire population in a number of European countries. This trend, and particularly the introduction of the National Health Service in Britain, influenced developments in Ireland. The Health Act, 1947 extended a comprehensive tuberculosis service to the entire population without charge. The Health Act, 1953 extended hospital and specialist services, with nominal charges, to 85 per cent of the population, and a similar proportion was covered for free maternity and infant services.

3.15 The Health Act, 1970, introduced a scheme to assist persons not entitled to the General Medical Service to meet the cost of drugs, and to meet the full cost of drugs for persons with certain long-term illnesses, regardless of income. The entitlement to free hospital treatment in public wards was extended to the entire population in 1979, but those earning above a certain income remained liable for consultants' fees.

3.16 There are thus at present three categories of eligibility:

Category I: persons who are unable without undue hardship to arrange services for themselves and their dependants and are issued with medical cards by the health boards. They have full eligibility for all health services.

Category II: persons, together with their dependants, whose income is below a specified limit. While entitled to free hospital treatment[4] in public wards or as out-patients, they are not eligible for free general practitioner services or for drugs other than under the special schemes mentioned above at paragraph 3.15.

Category III: persons, together with their dependants, whose income is above the specified limit. Their entitlements are broadly similar to those of Category II, except that they are liable for consultants' fees.[5]

ADMINISTRATION

(i) Central Administration

3.17 Just as the scope and type of health services altered over the years, so too did the administrative structures responsible for overseeing their provision. The Poor Law Act, 1838 and the appointment in 1847 of Irish Poor Law Commissioners brought a measure of central co-ordination to services for the relief of the destitute poor. The establishment of the Local Government Board in 1872 was the first significant step towards co-ordination of health services at national level, but a number of functions, such as the provision of lunatic asylums, remained outside its remit.

3.18 By 1920 the Inspectors of Lunatic Asylums, the Registrar of Births, Marriages and Deaths and the Office of the Chief Secretary all exercised health-related functions independently of the Local Government Board, and of each other. The Report of the Irish Public Health Council highlighted this lack of co-ordination and influenced the establishment, after Independence, of a Department of Local Government and Public Health in 1924. The new Department assumed national responsibility for all health services.

3.19 In 1947 a separate Department of Health was established with responsibility for health services, other than sanitary services and

[4]In 1987 a charge of £10 was introduced for each day's maintenance in a public hospital, or out-patient visit, subject to a number of exclusions and limits. These charges do not apply to Category I.

[5]Certain former Social Welfare voluntary contributors qualify for Category II eligibility although their income may be above the specified limit.

water supplies which remained under the Department of Local Government. Other developments at central level included the establishment of a National Health Council in 1947 to advise the Minister for Health on matters relating to the health services, and the passing of the Health (Corporate Bodies) Act, 1961 enabling the Minister to establish bodies such as the Blood Transfusion Service Board and the National Drugs Advisory Board to carry out executive functions on a national basis. In 1972 Comhairle na nOispideal was established to regulate the number and type of consultant medical staff in hospitals, and to advise the Minister in relation to the organisation and operation of hospital services.

(ii) Local Administration

3.20 During the nineteenth century, the Poor Law services were organised on the basis of 126 areas or "Unions", each under the control of a Board of Guardians. These were further divided into 723 districts for the dispensary service. When elected county councils were established in 1898 their responsibilities in relation to health extended only to the administration of the district lunatic asylums. However, in the early part of the twentieth century the county became recognised as the appropriate administrative unit for the health services. Councils were given functions in relation to the tuberculosis and school medical services, initiated in 1908 and 1919 respectively. Poor Law Unions were abolished in 1923 and rural district councils, which had been responsible for rural sanitary functions, in 1925. Their functions were transferred to boards of health and public assistance — specialised committees of the county councils, who became responsible for the Poor Law services for the entire country and for sanitary and preventive health services in rural districts. Urban district councils retained responsibility for the latter services in their areas.

3.21 The introduction of County Medical Officers of Health in 1927 was an important development. These officers of the county council had responsibility not only for the efficient operation of the tuberculosis and school medical services administered by the council, but also for the infectious diseases services, maternity and child welfare services and other preventive services which were the responsibility of boards of health and public assistance in rural areas and urban district councils. The County Medical Officers' responsibilities did not, however, extend to dispensary, hospital or mental health services.

3.22 Legislation passed in 1939 and 1940 combined to transfer responsibility for public assistance functions to the county councils.

The Health Act, 1947 took the process a step further by transferring responsibility for preventive services to county councils and county borough corporations alone, a function which had previously rested with the local authorities generally, including urban district councils. The net effect of the 1947 Act was, therefore, to reduce from about 90 to 31 the number of bodies responsible for health services, and to ensure that in most counties just one local body was responsible for administering the health services.

3.23 In Dublin, Cork, Limerick and Waterford unified health authorities, fused with the existing local government system, were established under the Health Authorities Act, 1960 with comprehensive responsibility for services. This reduced the total number of local administrative health bodies from 31 to 27. The White Paper on the Health Services, 1966 reflected the growing view that the county had become too small a unit for the efficient administration of the hospital services. Because of the interdependence of hospital services with the other health services, all local health administration was removed from the local government system and assigned to eight regional health boards under the Health Act, 1970. The boards, each covering a number of counties, form the basis of local health administration today.

FINANCE

3.24 Prior to 1947 the health services were financed largely from local taxation; by 1977 the system had become almost totally centrally financed. Several factors combined to bring about this change. The increasing cost and extent of services was felt to be placing too heavy a burden on local sources of finance and the standard of services was seen to differ considerably across counties because of differing abilities to finance them.

3.25 At the beginning of this century, the bulk of publicly-funded health services was met from local taxation, subvented by small central grants. Fixed proportions of taxation raised from Estate Duty and Licence Duty schemes were paid by the State in respect of certain local services, including part of the medical staff and drug costs in the workhouses. Central funding gradually expanded after 1900 with the introduction of a number of special grants for particular services, including treatment for tuberculosis patients and the school medical service.

3.26 As already mentioned, the Hospitals Sweepstakes, from its inception in 1930, provided a significant source of capital funds for the building and equipping of hospitals. It also met part of the

operational deficits incurred by voluntary hospitals. However, the Sweepstakes had declined in importance by the 1970s and ceased to operate in 1986. A wider National Lottery commenced operation in 1987 from which some proceeds were allocated to the health services.

3.27 In 1947 State grants accounted for just 16 per cent of the total cost of health services. Growing expenditure and a desire to encourage further developments at local level led to the enactment of legislation in 1947 in which the state undertook to meet any increases in the costs borne from local taxation by health authorities after 31 March, 1948 until the total cost of such services was shared equally between the State and each health authority. The State also undertook to meet thereafter half the cost of any subsequent increase in locally-funded services.

3.28 In the 1950s the need was felt for an insurance system for those not entitled to public hospital services, as well as for those wishing to avail of private or semi-private care. Following the report of an Advisory Body in 1956, the Voluntary Health Insurance Act, 1957 established the Voluntary Health Insurance Board, a non-profit making body under the aegis of the Minister for Health. The schemes operated by the Board proved popular and now cover about 30 per cent of the population.

3.29 In 1966 the White Paper on the Health Services accepted that local rates were not suitable for funding the various extensions to services then taking place. The Government undertook to restrict the sums borne by local taxation to their 1965/6 level. The restriction was not maintained in full for each subsequent year, but supplementary grants to relieve the additional local burden were made and by 1970, 56 per cent of health service costs were being met centrally by the State. The health charges on local rates were phased out between 1973 and 1976, with a proportional shift from local to central funding.

3.30 In 1971 the Health Contributions Act introduced a scheme of flat-rate health contributions levied on persons with limited eligibility for health services, the proceeds of which were credited to the health vote. At the same time, hospital charges for this group were abolished. The scheme was replaced in 1979 by a pay-related system, with contributions payable up to a maximum income limit. Contributions are collected under the PAYE system; the self-employed are required to pay their annual health contribution directly to the Revenue Commissioners. There has been a poor collection rate from some groups. A second new source of funding arose in 1973 from Ireland's membership of the European

Community. Under EC Regulations Ireland recoups costs in respect of health services provided to EC nationals. This sum accounts for about 2 per cent of total health expenditure. In addition, Ireland has received substantial grants from the European Social Fund towards the cost of rehabilitation services for the disabled.

3.31 By 1977 direct exchequer grants accounted for 94.5 per cent of total health costs, but this has now fallen to about 83 per cent, due mainly to the introduction of pay-related health contributions in 1979 and a number of substantial increases in public hospital charges for private accommodation in the intervening years. Table 3.1 sets out the breakdown of health expenditure by source of funding for 1987.

3.32 Health expenditure in Ireland grew rapidly during the late 1960s and the 1970s but has been contained, in relative terms, since 1980. The level of expenditure on health is discussed in greater detail in Chapter Four.

TABLE 3.1

Sources of funding of non-capital health expenditure, 1987

	%
Exchequer Grants	82.7
Health Contributions	7.6
Hospital charges and other income	7.6
Receipts under EEC Regulations etc.	2.1
	100.0

(*Source:* Department of Health)

CONCLUSION

3.33 The scope, cost and delivery of health services in Ireland have developed dramatically since the foundation of the State. This development has been accompanied by a growing demand for services, a wider view of what should be provided, medical advances which have opened up new possibilities of treatment and demographic changes which have medical implications. All have contributed to a sharply increased cost of providing the services. Public financing of the health service has shifted from a mainly local responsibility to a national one; co-ordination of health services at central level has increased and the number of administrative bodies at local level has fallen substantially.

CHAPTER FOUR

EXPENDITURE

INTRODUCTION

4.1 This chapter describes how estimates of total national expenditure on healthcare in Ireland have been derived. It examines how spending has grown over the past two decades and the implications of this pattern for future funding of the health services. It also considers the validity and relevance of international comparisons of health spending.

ESTIMATING TOTAL EXPENDITURE

4.2 Table 4.1 presents the Commission's estimates of total health expenditure in Ireland for a number of years between 1960 and 1987. There is no official, comprehensive series for this data, nor even an agreed definition of the precise composition of health expenditure. Consequently, some brief discussion of the approach adopted in drawing up these estimates is warranted.

4.3 The Department of Health's annual data on net[1] expenditure under its programmes have usually been used as a convenient and consistent indicator of the level of health expenditure. However, these data include some items which would not be regarded as health expenditure in other countries, while excluding all spending on health other than by the Department or its agencies.

4.4 The Department of Health, for historical reasons, administers a range of schemes which provide financial and other support to persons in need, under the Community Welfare Programme. There is a case for excluding this expenditure, which amounted to £100 million in 1987, from the estimate of total health expenditure, particularly when making international comparisons (as discussed later in the chapter). However, we regard all expenditure by the

[1] i.e. excluding income from hospital charges and other sources

Department of Health as falling within our terms of reference and it is therefore included in full in Table 4.1.

4.5 The European Social Fund gives grants to a number of agencies towards the training of disabled persons for open employment. As this expenditure is associated with (and indeed conditional upon) corresponding Department of Health expenditure, it is appropriate to include it in Table 4.1.

4.6 A limited range of medical benefits is available under the Social Insurance Fund, administered by the Department of Social Welfare; known as treatment benefits, these consist of dental and optical benefits and the supply of hearing aids. Information on the cost of this scheme only covers the amount of benefits paid; precise overhead costs are not available. The figures in Table 4.1 for treatment benefits therefore include an additional provision of 10 per cent which is assumed to be a reasonable approximation of the administration costs of the scheme.

4.7 There are, of course, many other expenditures by public bodies which relate to some extent to health, including, for example, the Department of the Environment's programmes for environmental protection and sanitary services. These are not included in our estimates of health expenditure because of the substantial conceptual and measurement difficulties which would arise.

4.8 The estimates in State 4.1 thus show that net total public expenditure on health rose from 3.2 per cent of GNP in 1960 to 8.3 per cent in the early 1980s, with a slight decline thereafter as a proportion of GNP. It fell more sharply in 1987 to 7.4 per cent of GNP.

4.9 A large element of private spending on healthcare is channelled through health insurance (mainly for hospital costs). Expenditure on claims and administration of the Voluntary Health Insurance Board, established by the State and with a virtual monopoly in this area, is included in Table 4.1. There are also a few schemes operating under licence, small in size, which provide health insurance for a workplace or union membership, and some employers who provide or finance medical care directly for their staff. Negligible data are available on such expenditure. Tussing[2] arrived at a very tentative estimate of £2.9m (including a 10 per cent overhead provision) for 1980 by following up organisations identified by respondents to a household

[2] A. Dale Tussing: *Irish Medical Care Resources: An Economic Analysis* (ESRI, 1985): chapter 5

survey on medical expenditures. Table 4.1 extrapolates this estimate in line with the trend in Department of Health current expenditure.

TABLE 4.1.

ESTIMATED OVERALL HEALTH EXPENDITURE (£m) SELECTED YEARS, 1960-1987

	1960	1970	1975	1980	1983	1986	1987
Health Net Non-capital Expenditure[1]	19.5	72.8	242.6	701.0	1033.0	1219.0	1221.5
European Social Fund[2]	0.0	0.0	0.6	8.2	20.7	18.6	18.3
National Lottery[3]	0.0	0.0	0.0	0.0	0.0	0.0	3.5
Treatment Benefits[4]	0.4	1.0	2.8	6.3	12.5	16.6	16.7
Net Public Non-capital Expenditure	19.9	73.8	246.0	715.5	1066.2	1254.2	1260.0
Health Capital Expenditure[5]	0.8	3.7	10.0	35.0	53.0	58.7	57.6
Net Total Public Expenditure	20.7	77.5	256.0	750.5	1119.2	1312.9	1317.6
VHI Expenditure[6]	0.3	2.8	8.7	30.9	81.3	117.4	150.1
Other Non-Household Private Expenditure[7]	0.1	0.3	1.0	2.9	4.3	5.0	5.0
Household Expenditure[8]	10.1	25.6	34.4	79.7	142.9	201.0	224.7
Total Private Expenditure	10.5	28.7	44.1	113.5	228.5	323.4	379.8
Total Expenditure	31.2	106.2	300.1	864.0	1347.7	1636.3	1697.4
As Percentage of GDP:	%	%	%	%	%	%	%
Total Public	3.3	4.8	6.8	8.0	7.6	7.1	6.7
Total Private	1.7	1.8	1.2	1.2	1.6	1.7	1.9
Total	5.0	6.6	8.0	9.2	9.2	8.8	8.6
As Percentage of GNP:							
Total Public	3.2	4.7	6.7	8.3	8.3	7.9	7.4
Total Private	1.6	1.7	1.2	1.3	1.7	1.9	2.1
Total	4.8	6.4	7.9	9.6	10.0	9.8	9.5

Sources

1. Department of Health. 1960 and 1970 are based on financial year data.
2. Department of Health.
3. Allocated to community health services and the Health Education Bureau.
4. Department of Social Welfare, adjusted to include allowance of 10% for administrative costs (see text). 1960 and 1970 are based on financial year data.
5. Department of Health. 1960 and 1970 are based on financial year data.
6. VHI Annual Reports — sum of claims expenditure and administration costs for year beginning 1 March.
7. Extrapolated from Tussing's 1980 estimate (see text)
8. CSO estimates of household expenditure on medical goods and services net of refunds under health insurance and drug subsidy schemes.

4.10 Estimates of the remaining elements of private expenditure are quite tentative. The Central Statistics Office uses the Household Budget Survey, supplemented by data from a variety of sources, to estimate the total expenditure by households in the State on doctors', dentists' and opticians' fees, hospital charges, medicines and other medical expenses. The estimates supplied to us, and included in Table 4.1, omit all refunds to households from health boards, health insurance etc. since these are already taken into account elsewhere in the Table. It should be noted that the margin of error in the estimates of household expenditure may be significant. This is particularly so in the case of the data for 1960 and 1970.

4.11 No data are available on private sector capital expenditure related to health e.g. construction and equipping of private hospitals, pharmacies and surgeries. However, Tussing points out that capital costs, such as depreciation charges are presumably provided for in the setting of charges and adding them again at this point would involve double-counting. This factor has become more relevant with the advent of the new "high technology" private hospitals in which there has been a much higher capital investment than was previously the case in such facilities.

4.12 The estimates in Table 4.1 do not include all health-related private expenditure since comprehensive data are not available on, for example, spending by voluntary agencies financed through their own fund-raising, or household expenditures on health-related but non-medical activities. Allowing for this lack of completeness, and also for some margin of error in the estimates of household spending, it is nonetheless clear that the trend of private expenditure growth has been quite different to that of public expenditure. As the scope and level of public expenditure increased, the relative importance of private expenditure fell significantly, although some slight reversal of this pattern is evident in recent years.

4.13 Table 4.1 presents expenditure data as a percentage of both Gross Domestic Product and Gross National Product. In earlier years there is no significant difference between the two, but in later years the two measures have diverged markedly due to the growth in interest payments on foreign borrowings which, among other factor payments, are deducted from GDP to estimate GNP. International comparisons commonly show health spending as a percentage of GDP. However, its share of GNP provides a better measure of the extent to which health expenditure absorbs the resources which are actually at the disposal of the economy.

TABLE 4.2.

COST OF INCOME TAX RELIEF

	1980	1983	1986	1987*
	(£m)	(£m)	(£m)	(£m)
VHI Premia	6.0	19.5	35.6	41.4
Unreimbursed Medical Expenses	0.5	0.8	2.2	2.4
Total	6.5	20.3	37.8	43.8

Source: 1980 and 1983: Minister for Finance (Parliamentary Question, 7 April 1987)
1986 and 1987: Revenue Commissioners.

* Preliminary

TABLE 4.3.

BREAKDOWN OF HEALTH EXPENDITURE ADJUSTED FOR TAX RELIEF

	1980	1983	1986	1987
	(£m)	(£m)	(£m)	(£m)
Net Total Public Expenditure (Table 4.1.)	750.5	1119.2	1312.9	1317.6
Add cost of Tax Relief	6.5	20.3	37.8	43.8
Adjusted Public Expenditure	757.0	1139.5	1350.7	1361.4
As percentage of GDP	8.1	7.8	7.4	6.9
As percentage of GNP	8.4	8.4	8.3	7.6
Total Private Expenditure (Table 4.1.)	113.5	228.5	323.4	379.8
Deduct Tax Relief	6.5	20.3	37.8	43.8
Adjusted private Expenditure	107.0	208.2	285.6	336.0
As percentage of GDP	1.1	1.4	1.5	1.7
As percentage of GNP	1.2	1.5	1.7	1.9

4.14 The estimates in Table 4.1 do not fully reflect the relative levels of public and private expenditure. While the income to public hospitals from charges for private accommodation has been subtracted from total non-capital public expenditure on health, no account is taken of income tax relief on VHI premia and other medical expenses. Data is not available for earlier years, but Table 4.2 shows the amounts involved in 1980, 1983, 1986 and 1987. Table 4.3 adjusts some of the estimates in Table 4.1 to take account of tax relief.

TABLE 4.4

COMPOSITION OF DEPARTMENT OF HEALTH NON-CAPITAL EXPENDITURE (£m)

	1976[1]	1980	1983	1986	1987
Community Protection	6.1	13.0	16.9	21.0	19.7
	(2.1%)	*(1.8%)*	*(1.5%)*	*(1.6%)*	*(1.5%)*
Community Health	45.1	90.4	139.2	177.9	186.3
	(15.5%)	*(12.3%)*	*(12.8%)*	*(13.7%)*	*(14.1%)*
Community Welfare	16.8	46.8	83.4	99.6	102.6
	(5.8%)	*(6.4%)*	*(7.6%)*	*(7.7%)*	*(7.8%)*
Psychiatric Services	39.1	93.5	131.1	160.9	158.2
	(13.5%)	*(12.8%)*	*(12.0%)*	*(12.4%)*	*(12.0%)*
Services for the Handicapped	22.2	59.7	107.7	127.9	132.8
	(7.6%)	*(8.2%)*	*(9.9%)*	*(9.8%)*	*(10.1%)*
General Hospitals	139.5	393.8	558.1	647.9	655.8
	(48.0%)	*(53.8%)*	*(51.2%)*	*(49.9%)*	*(49.7%)*
Support Programme[2]	21.7	34.8	54.2	63.6	64.7
	(7.5%)	*(4.8%)*	*(5.0%)*	*(4.9%)*	*(4.8%)*
Gross Non-Capital	290.6	732.0	1090.5	1298.7	1320.0
	(100.0%)	*(100.0%)*	*(100.0%)*	*(100.0%)*	*(100.0%)*
Income	16.0	31.0	57.5	79.7	98.5
Net Non-Capital	274.6	701.0	1033.0	1219.0	1221.5

The figures in brackets show each programme as a percentage of gross expenditure.

[1] Information in this format is not available for any year prior to 1976.
[2] Including central and local administration, research, superannuation and finance charges.

Source: Department of Health.

THE COMPOSITION OF EXPENDITURE

4.15 The Department of Health has published a breakdown of its non-capital health expenditure by programme since 1976. Table 4.4 provides this breakdown for selected years; a more detailed breakdown by sub-programme for 1987, 1988 and 1989 is included at Appendix 4A. The breakdown illustrates the predominance of institutional services which, including the entire General Hospitals Programme and the bulk of the Psychiatric and Handicapped Services, account for about 70 per cent of total non-capital expenditure. As would be expected these services also account for almost all capital expenditure.

4.16 The delivery of health care is, inevitably, highly labour-intensive and pay accounts for over 60 per cent of spending by health agencies. The most significant areas of non-pay expenditure

are drugs, other medical supplies, non-medical supplies for hospitals such as provisions and energy; and grants and allowances to individuals and voluntary bodies, particularly under the Community Welfare Programme. Table 4.5 presents a breakdown of Department of Health spending by category of expenditure.

TABLE 4.5

PERCENTAGE BREAKDOWN OF DEPARTMENT OF HEALTH GROSS NON-CAPITAL EXPENDITURE, 1987

	%
Pay	62.4
Medicines	8.9
Other Medical Supplies	4.8
Non-Medical Supplies, Maintenance etc	7.8
Grants and Allowances	10.0
Other	6.5
TOTAL	100.0

Source: Department of Health

INTERNATIONAL COMPARISONS

4.17 Table 4.6 presents international comparisons of health expenditure in absolute and relative terms. As would be expected, richer countries spend more on health in absolute terms and Ireland's per capita spending is thus among the lowest of the OECD countries. However, OECD's data also reveal a statistically significant relationship between the share of health spending in GDP and GDP per capita i.e. richer countries tend to devote a greater share of their total income to health. This relationship is illustrated in Figure 4.A, from which it can be seen that the share of resources devoted to health care in Ireland is of the same order as those of a number of wealthier countries and thus, arguably, "out of line". However, there are a number of important reservations about the use of the available data in this way, particularly in drawing any conclusions as to whether there is an "appropriate" level of health expenditure for a country at Ireland's stage of development.

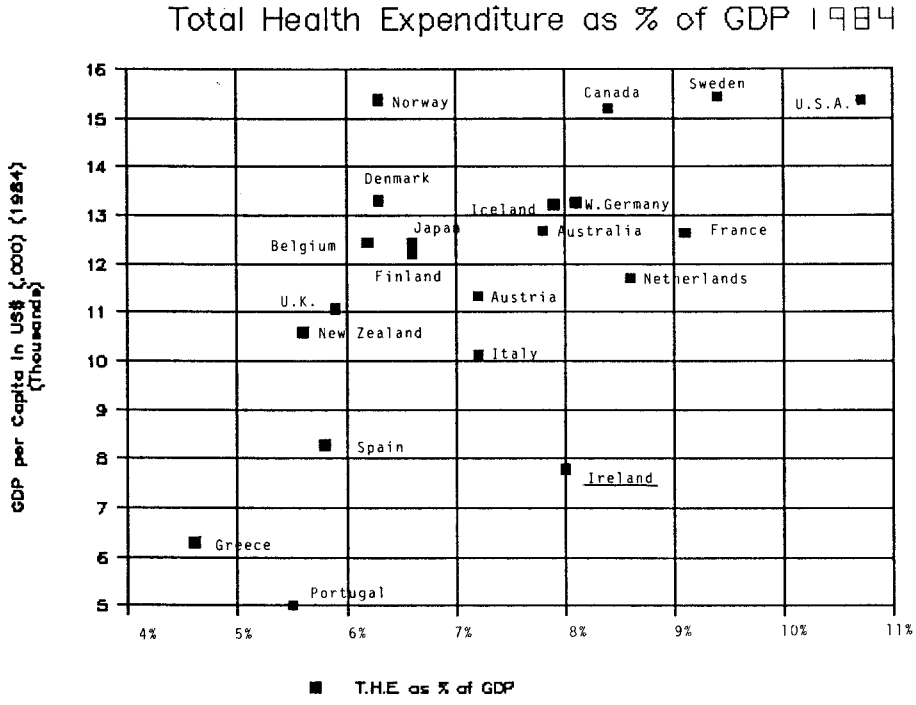
4.18 There are no universally accepted statistical definitions for measuring health expenditure. The OECD[3] acknowledge that, while they have made a substantial effort to standardise their comparative

[3] *OECD: Financing and Delivering Health Care* (1987) chapter 2

data, there are still problems of comparability. The boundaries of health systems differ from country to country, in terms of inclusion or exclusion of some social services, school health and environmental health services. Ireland, in particular, classifies as health expenditure a number of services which are categorised elsewhere as relating to social services, education or justice.

4.19 Even if health expenditure could be accurately compared across countries, the interpretation of the findings would still be problematic. Countries vary immensely in respect of a number of factors, all of which will influence the level of health expenditure required. A country with a relatively high dependency ratio (i.e. the population under 15 and over 65 as a proportion of the population in productive age-groups) will tend to have a high demand for health services, with a relatively small proportion of the population working to produce the income to finance it. Ireland's dependency ratio is the second highest in the OECD, although this reflects a high proportion of children rather than of the elderly.

4.20 Environmental factors, and particularly climate, are known to have a significant impact on the extent of illness. The more favourable climate in countries such as Greece, Spain and Portugal is particularly relevant in comparing their positions to that of Ireland in Figure 4A.



4.21 Factors other than the organisation and practice of the health system itself affect expenditure on health and lead to conceptual difficulties in international comparisons. These factors include population density and distribution, industrial and occupational mixes, prevailing wage levels and cultural attitudes about health and family care. Differences between countries in lifestyle and, in particular, associated factors such as stress and diet also make it difficult to establish a valid basis of comparison.

TABLE 4.6.

INTERNATIONAL COMPARISONS (1984)

	Public health expenditure as % of GDP	Total health expenditure as % of GDP	Total health expenditure per capita in U.S. dollars	GDP per capita in U.S. dollars
Australia	6.6	7.8	994	12,679
Austria	4.4	7.2	818	11,345
Belgium	5.7	6.2	777	12,439
Canada	6.2	8.4	1,275	15,198
Denmark	5.3	6.3	841	13,310
Finland	5.4	6.6	806	12,217
France	6.5	9.1	1,145	12,643
Germany	6.4	8.1	1,079	13,265
Greece	3.6	4.6	287	6,300
Iceland	6.5	7.9	1,045	13,238
Ireland	6.9	8.0	622	7,795
Italy	6.1	7.2	725	10,093
Japan	4.8	6.6	818	12,419
Netherlands	6.8	8.6	1,011	11,710
New Zealands	4.4	5.6	595	10,601
Norway	5.6	6.3	965	15,367
Portugal	3.9	5.5	275	5,021
Spain	4.2	5.8	476	8,279
Sweden	8.6	9.4	1,445	15,434
United Kingdom	5.3	5.9	658	11,068
United States	4.4	10.7	1,637	15,357

Source: *OECD: Financing and Delivering Health Care* (1987) — derived from Tables 1 and 20. In converting to common currency, OECD use GDP Purchasing Power Parities.

Note: The data for Ireland in this Table are based on OECD's methodology. Certain Department of Health expenditures are considered to relate to social welfare rather than health and are excluded; VHI expenditure is treated as public rather than private. The data are thus not directly comparable with those in Table 4.1.

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4.22 Even if these problems of measurement and comparison did not exist, we see no reason why the observed relationship between a country's wealth and the proportion of it which is devoted to healthcare should set any normative standard for the level of such expenditure in Ireland. Each country will choose a level of expenditure in accordance with its own perceived priorities which are determined by the nature of the healthcare problems facing it, the resources available and its own culture. A statistical relationship between levels of health expenditure and reductions in ill-health and mortality might provide more useful criteria but, as discussed in Chapter Five, such limited indicators as are available do not indicate a relationship.

4.23 **We conclude that the overall level of funding required for the Irish health services cannot be determined by reference to international comparison. On the contrary we feel that the appropriate overall level of expenditure can only emerge in the context of the resources allocated to each of the services, having regard to their relative cost-effectiveness as influenced by their organisation, delivery and financing.**

THE CAUSES OF GROWTH

4.24 The major growth in health spending took place in the 1960s and 1970s. Price inflation over this period is, of course, the principal cause of the expenditure growth in *money* terms. While there is no health services price index as such, the implicit deflator contained in the public authorities' net current expenditure series in *National Income and Expenditure* published by the Central Statistics Office may be regarded as a reasonable approximation in relation to Department of Health expenditure. Table 4.7 uses this deflator to illustrate the growth of expenditure in real terms.

TABLE 4.7

DEPARTMENT OF HEALTH NET NON-CAPITAL EXPENDITURE

	1960	1970	1975	1980	1983	1986	1987
Current Prices (£m)	19.5	72.8	242.6	701.0	1033.0	1219.0	1221.5
Index (1960 = 1)	1.0	3.7	12.4	35.9	53.0	62.5	62.6
Constant (1980) Prices (£m)	170.6	324.6	505.5	701.0	698.1	692.1	668.9
Index (1960 = 1)	1.0	1.9	3.0	4.1	4.1	4.1	3.9

SOURCE:
Current Prices: Department of Health
Constant Prices: Derived using implicit public current expenditure deflator from CSO National Accounts

4.25 It can be seen that, in real terms, the 1960 level of expenditure doubled by 1970, trebled by 1975 and quadrupled by 1980, but has since remained broadly constant. The rate of growth between 1960 and 1980 was twice that of GNP, a pattern common to most developed countries over the same period. A number of underlying factors explain this growth.

4.26 *Demographic factors*: health expenditure is affected by changes in population size and distribution, particularly in relation to age. Most developed countries now have an ageing population and recent estimates[4] suggest that medical care expenditures on those aged 65 and over are on average four times greater than expenditure on those under 65. Table 4.8 shows that the ageing factor had not yet emerged in Ireland over the period of expenditure growth, but that the overall population rose by 600,000 between 1961 and 1981 and by a further 100,000 between 1981 and 1986. A recent analysis[5] suggests that about one-eighth of the real growth in Irish health expenditure between 1960 and 1983 was attributable to population growth, but that the ageing factor had no effect.

TABLE 4.8.

POPULATION AND AGE-DISTRIBUTION

	1961	1971	1981	1986
Population	2.82m	2.98m	3.44m	3.54m
Percentage aged:				
0 — 14 years	31.1	31.3	30.3	28.9
15 — 64 years	57.7	57.7	59.0	60.2
65 and over	11.2	11.1	10.7	10.9

Source: CENSUS OF POPULATION

4.27 *Increased average utilisation*: the health services have been used to a greater extent than would be explained by the growth in population. Among the indicators of this trend are:

(i) the number of admissions to acute public hospitals (excluding district hospitals) rose from 249,000 in 1962 to 549,000 in 1986, although it fell to under 500,000 in 1987;

(ii) admissions to psychiatric hospitals and units rose from 12,500 in 1960 to 29,000 in 1986;

[4] OECD: *Financing and Delivering Health Care* (1987) — chapter 8
[5] *ibid* — chapter 5

(iii) the visiting rate per patient under the Choice-of-Doctor Scheme rose from 5.27 in 1973 to 6.49 in 1987.

This trend is common in most countries. It may to some extent reflect a growing demand for attention to conditions and disabilities which would have been left untreated in the past. The widening of third-party cover for the costs of such treatment, through public schemes and private insurance, is also likely to have been significant since the financial disincentive to seek treatment would have been removed. Eligibility for free public services was increased in Ireland over the period, as discussed in Chapter Two; while membership of the Voluntary Health Insurance Board grew from 106,000 in 1960 to 436,000 in 1970 and over one million in the early 1980s. The rise in psychiatric admissions may reflect a high level of re-admission for short-term care resulting from the policy of moving away from long-term institutionalisation.

4.28 *Technology change*: the last two decades have seen unprecedented advances in medical technology. While the focus of attention has tended to be on the emergence of high-cost equipment and drugs, changes in procedures have also led to a more intensive use of medical personnel. Contrary to the experience in most industries, technological advances in healthcare tend to require additional rather than fewer staff and frequently supplement rather than replace the existing techniques. Many of the advances have reduced the period of hospitalisation required for particular conditions but, as other advances brought more conditions within the scope of treatment, the net effect has been a sharp increase in hospital throughput at a substantially higher cost per episode.

4.29 *Manpower level*: comprehensive manpower data for the health services are not available for earlier years. Table 4.9 illustrates the expansion in personnel from 1977, but (for reasons explained in the note to the table) the figures should not be regarded as precise. These data relate to employment by health boards and by other publicly-funded agencies, such as voluntary hospitals and homes for the mentally handicapped. They thus exclude private practitioners and personnel employed in private hospitals. As an indication of the overall trend, Table 4.10 shows the growth in the total numbers of medical practitioners, dentists and nurses in the State since 1961, as recorded by the Census of Population. The latter figures include private practitioners and those in private hospitals and have been adjusted to exclude those recorded as being out of work.

4.30 A number of factors contributed to the growth in manpower. The increased demand for services, the development of technology

and increased specialisation had a major impact on the numbers of medical and support staff required. There were also increases in the numbers of nurses due to reduced working hours, of maintenance staff due to job-creation programmes in the late 1970s, and of hospital consultants following the introduction of the Common Contract in the early 1980s.

TABLE 4.9

EMPLOYMENT IN THE PUBLIC HEALTH SERVICES

	1977	1981	1984	1986	1987	1988
Medical, Dental, Paramedical and Nursing	26,219	38,811	40,052	39,522	36,518	35,781
Catering, Housekeeping, Maintenance etc.	17,342	12,876	13,200	12,992	11,873	11,090
Clerical and Administrative	4,496	6,143	7,313	7,333	7,158	7,044
Other	2,554	2,682	2,512	2,617	2,542	2,442
TOTAL	50,611	66,060*	63,077	62,464	58,091	56,357

SOURCE: Department of Health

NOTE: The figures refer to whole-time equivalents rather than actual number of employees. They are based on returns by agencies. Those prior to 1984 are considered less reliable due to variations among agencies in approach to counting part-time staff, locums, etc. Methods have been refined in recent years.

* The figures above amount to 60,512. There are no detailed staffing statistics available for 1981 in respect of homes for the mentally handicapped and specialist agencies, but the total employment at the date of the staff embargo was, as shown, 66,060.

TABLE 4.10

MEDICAL PRACTITIONERS, DENTISTS & NURSES EMPLOYED IN IRELAND

	1961	1971	1981	1986
Medical Practitioners	2,395	3,530	5,119	5,588
Dentists	564	657	860	972
Nurses	14,730	18,794	29,512	32,284

SOURCE: Census of Population (figures exclude those not at work)

4.31 *Expansion of scope*: apart from the increased demand for and cost pressures on existing services, there was also a widening in the scope of the public health services. This has been described in Chapter Two; the responsibilities of the health services have grown

particularly rapidly in the area of the welfare of underprivileged groups in society.

4.32 *Increased prosperity*: the relative prosperity of the era also contributed to growth in health expenditure; Gross National Product more than doubled in real terms between 1960 and 1980. However, since 1980 the real level of GNP has fallen slightly and public expenditure has faced severe constraints. Public spending on health has been held constant in real terms since 1980 (Table 4.7). In contrast to the previous experience of growing utilisation and expenditure, the underlying factors described above have thus resulted in an increased perception of unmet demands.

IMPLICATIONS FOR FUTURE FUNDING REQUIREMENTS

4.33 Recent demographic projections for Ireland[6], based on 1986 Census data, suggest that population growth has ceased. On medium emigration assumptions, a significant decline in population is forecast after 1991, while even on low emigration assumptions any population growth will be negligible. Population growth of itself is thus likely to have a negative effect, if any, on health expenditure over the next twenty-five years. However, taking the age distribution of the projected populations into account and, in particular, an increasing proportion aged 65 or over, Keegan and McCarthy[7] calculate the trends set out in Table 4.11 for the usage of the health services over the next twenty-five years. These calculations are based on the assumption that existing usage rates will not be affected by other factors such as policy changes. The figures for acute hospitals exclude maternity hospitals, the use of which is likely to decline dramatically. Such projections are, of course, entirely dependent on the assumptions made, but they provide a useful background for our consideration of the requirements of each of the services.

4.34 The 1987 OECD study[8] finds that it is difficult to make generalisations about the future cost impacts of new technologies which may prove either cost-inducing or cost-saving. Much will depend on whether they substitute for other older technologies or are used as alternatives.

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[6] O. Keegan & C. McCarthy: *Ireland's Changing Population Structure* (DKM Economic Consultants, September 1987) and Central Statistics Office: *Population and Labour Force Projections 1991-2021* (Stationery Office, April 1988)

[7] *op. cit.*

[8] OECD: *Financing and Delivering Health Care (1987)*: chapter 8

TABLE 4.11

PROJECTED UTILISATION OF HEALTH SERVICES

	Total change between 1986 and 1996	Total change between 1996 and 2011
Acute Hospitals (In-Patient)	+ 3%	+ 3.5%
Psychiatric Hospitals	+ 6.5%	+ 7%
Residential care for Mentally Handicapped	– 1.5%	– 8%
GMS Consultations	+ 3.5%	0%
Geriatric Services	+ 7%	0%

Source: Keegan & McCarthy

4.35 Health expenditure is in part influenced by the largely external factors of demographic change and technological innovation. It is also influenced by internal factors which affect the interaction of the demand for health services and their supply. Such factors are both inter-related and dependent on policies adopted for the provision, organisation and funding of services. The nature and importance of these relationships are examined in later chapters.

AIDS

4.36 We referred to the way in which health expenditure is influenced partly by external factors such as demographic change and technological innovation. To these must also be added the emergence of new types of disease. By far the most serious development in this area in recent years, and the one which has potentially the most far-reaching consequences for health expenditure, has been the appearance of Acquired Immunity Deficiency Syndrome (AIDS). Steps have already been taken by the authorities to educate both the general public and specific high-risk groups of the dangers of contracting the causative agent, Human Immunodeficiency Virus (HIV). It would, however, be foolish to ignore the potential of this disease to become a major burden on the public health services if the present pattern of its spread remains unchecked.

4.37 For this reason, we believe that consideration must be given to the future possibility of funding the treatment of diseases resulting from AIDS separately from the rest of the health services. There is a precedent for this in the tuberculosis eradication campaign of the 1940s and 1950s. We do not believe that the present level of demand on resources being made by AIDS requires this type of action now

but we must emphasise that, given the high cost of some treatments associated with AIDS and the possibility of its becoming a major epidemic in the future, it may be necessary to deploy a much higher level of resources in future to meet increased demands for treatment. It would clearly be impossible for such requirements to be borne by the existing health services. Realistically, the future necessity for additional and separate public funding for the consequences of AIDS must therefore be accepted as a possibility. The Commission considers that nothing useful can be served by speculating on the magnitude of the potential cost of AIDS to the health services. However, if the worst prognosis is realised, there will obviously have to be a major reappraisal of the priorities accorded to other public expenditure.

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APPENDIX 4A

PROGRAMME BREAKDOWN OF DEPARTMENT OF HEALTH NON-CAPITAL EXPENDITURE, 1987–1989

Programme and Service (Non-Capital)	1987 £000	1988 £000	1989 £000
1. *Community Protection Programme*			
1.1 Prevention of infectious disease	5,670	5,500	5,600
1.2 Child health examinations	6,840	6,700	6,800
1.3 Food hygiene and standards	3,490	3,450	3,520
1.4 Drugs advisory service	790	806	1,000
1.5 Health education	290	1,044	1,040
1.6 Other preventive services	2,620	2,500	2,540
Programme Total	19,700	20,000	20,500
2. *Community Health Services Programme*			
2.1 General practitioner service (including prescribed drugs) (Choice of Doctor)	116,900	133,200	135,000
2.2 General Medical Services	9,000		
2.3 Subsidy for drugs purchased by persons ineligible under 2.1	10,500	12,000	13,250
2.4 Refund of cost of drugs for long-term illnesses including hardship cases	8,500	9,200	9,400
2.5 Home nursing services	21,155	21,200	21,600
2.6 Domiciliary maternity services	1,960	1,760	1,800
2.7 Family planning	145	150	150
2.8 Dental services	13,290	13,000	13,000
2.9 Ophthalmic services	4,000	3,900	3,900
2.10 Aural services	850	800	800
(2.8, 2.9 and 2.10 are provided mainly for medical card holders and national school children)			
Programme Total	186,300	195,210	198,900
3. *Community Welfare Programme*			
3.1 Cash payments and grants for disabled persons	57,680	60,430	61,475
3.2 Mobility allowance for handicapped persons and grants to disabled drivers	380	390	405
3.3 Cash payments to persons with certain infectious diseases	545	550	570
3.4 Maternity cash grants	70	60	50
3.5 Domiciliary care allowances for handicapped children	5,490	5,641	5,745
3.6 Cash payments to blind persons	1,050	1,100	1,115
3.7 Home help services	6,500	6,500	6,630
3.8 Meals-on-wheels services	1,620	1,600	1,630
3.9 Grants to voluntary welfare agencies	9,900	9,710	9,850
3.10 Supply of milk to expectant and nursing mothers and children under five covered by medical cards	950	900	910
3.11 Pre-school support services	540	540	550
3.12 Boarding out of children	2,700	2,780	2,920
3.13 Payments for children in residential homes	6,750	6,800	6,940
3.14 Welfare homes for the aged	7,840	7,849	8,000
3.15 Adoption services	560	550	560
Programme Total	102,575	105,400	107,350

APPENDIX 4A (Continued)

PROGRAMME BREAKDOWN OF DEPARTMENT OF HEALTH NON-CAPITAL EXPENDITURE, 1987–1989

Programme and Service (Non-Capital)	1987 £000	1988 £000	1989 £000
4. *Psychiatric Programme*			
4.1 Service for diagnosis, care and prevention of psychiatric ailments	158,200	154,300	155,800
Programme Total	158,200	154,300	155,800
5. *Programme for the Handicapped*			
5.1 Care in special homes for mentally handicapped	77,300	79,430	83,100
5.2 Care of mentally handicapped persons in psychiatric hospitals	28,560	28,200	28,500
5.3 Care in day centres for mentally handicapped	7,620	7,800	8,200
5.4 Assessment and care of blind	1,920	1,900	1,940
5.5 Assessment and care of deaf	590	590	600
5.6 Assessment and care of persons otherwise handicapped	13,550	13,300	13,600
5,7 Rehabilitation service	3,260	3,350	3,460
Programme Total	132,800	134,570	139,400
6. *General Hospital Programme*			
6.1 Services in regional hospitals	151,750	158,300	160,700
6.2 Services in public voluntary hospitals	259,700	258,500	264,350
6.3 Services in health board county hospitals and homes	125,155	125,400	127,700
6.4 Contributions to patients in private hospitals	15,000	15,000	15,300
6.5 Services in district hospitals	25,990	26,200	26,500
6.6 Services in health board long-stay hospitals	60,680	61,330	62,000
6.7 Ambulance services	17,500	17,880	18,000
Programme Total	655,775	662,610	674,550
7. *General Support Programme*			
7.1 Central administration	7,400	8,640	9,560
7.2 Local administration (health boards)	35,000	35,700	36,000
7.3 Research	2,300	2,329	1,300
7.4 Superannuation	14,250	16,041	16,440
7.5 Finance charges (including interest on borrowings).	5,700	3,700	3,700
Programme Total	64,650	66,410	67,000
GROSS NON-CAPITAL TOTAL — ALL PROGRAMMES	1,320,000	1,338,500	1,363,500
8. *Income*			
8.1 Charges for maintenance in private and semi-private accommodation in public hospitals	38,400	39,500	39,500
8.2 Other Income	60,100	67,500	67,500
Total Non-Capital Income	98,500	107,000	107,000
NET NON-CAPITAL TOTAL — ALL PROGRAMMES	1,221,500	1,231,500	1,256,500

Source: Revised Estimates for Public Services, 1988 and 1989 (Stationery Office, 1988, 1989).

CHAPTER FIVE

CRITERIA FOR EVALUATING THE HEALTH SERVICES

INTRODUCTION

5.1 Each of the criteria referred to in the Commission's Terms of Reference, comprehensiveness, cost-effectiveness and equity, is related to one of three fundamental decisions which determine the organisation of the health service in any country:

— what services will be provided and to what extent i.e. comprehensiveness;

— how these services will be delivered so as to derive the greatest benefit possible from the available resources i.e. cost-effectiveness;

— who will receive the services and how will their cost be shared i.e. equity.

5.2 This chapter examines the practical implications of these criteria, and the extent to which it is possible to measure the performance of the health services against them.

COMPREHENSIVENESS

5.3 The criterion of "comprehensiveness" is particularly difficult to define; it might, however, be generally understood to imply the availability of all treatment or other forms of care necessary to satisfy the broad aim of the health services in Ireland i.e. "to promote the enjoyment by all of the highest possible levels of health".[1] Since the idea of good health includes mental and social well-being as well as freedom from disease and infirmity, the health services include not only the prevention and treatment of specific medical conditions but also a wide range of activities which include, for example, the care of the handicapped and measures to help with social problems which would give rise to ill-health.

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[1] *Comprehensive Public Expenditure Programmes* (Stationery Office, 1985)

5.4 Two major difficulties arise when trying to express the objective of health services in terms of a level of health:

(i) *there is no satisfactory measure of "health".* The measures which are widely used for comparisons across country and time are, in fact, crude measures of ill-health relating to mortality, life expectancy and the incidence of diseases. They cannot take account of qualitative factors, and a reduction in mortality from one condition must inevitably result in increased mortality from another since, for all of us, death can only be postponed. The development of health status indicators which would measure changes in the medical, psychological and social function of individuals is a major area of international research, but there remain enormous conceptual and measurement difficulties to be overcome.

(ii) *the effects of "healthcare" on "health" are also difficult to measure.* It is difficult to separate the effects of healthcare from the many other factors, environmental, economic and social, that affect health status. Such evidence as there is shows little connection, in the modern world, between increased expenditure on health services and improvements in the broad indicators of health. In the century or so up to the mid 1950s there had been enormous improvements in mortality and morbidity rates, as infectious diseases declined due to better living standards and public health measures. As a result, the majority of deaths and disabilities are now due to chronic illnesses, the causes of many of which are little understood and many of which are relatively unresponsive to medical intervention.

5.5 Despite these difficulties in measuring both health and the aggregate effect of health services, it is true that medical intervention cures many conditions and that the various health services prevent the occurrence, or relieve the discomfort, inconvenience and indignity, of many others. We need, therefore, to consider the objective of providing a "comprehensive" service and the extent to which it implies that it should be capable of meeting all demands upon it.

5.6 Until comparatively recently the scope of medicine was extremely limited; for most conditions it did not extend far beyond providing rest, care and nutrition rather than medical intervention as such. Aaron[2] points out that the decision by most Western states during the twentieth century to provide, as a "right", all medically

[2]H. Aaron: *Economic Aspects of the Role of Government in Health Care* in *Van Der Gaag & Perlman (ed): Health, Economics and Health Economics* (North-Holland, 1981)

beneficial care was made easier by the prevailing technology of health care since the overall cost of this open-ended commitment was relatively small. However, a scientific revolution has transformed medical care in the last thirty years to the extent that no country can now afford to exploit *all* the available opportunities to improve the health of its citizens. There are now many medical procedures which promise the possibility of a beneficial outcome at very high cost and there is an understandable reluctance on the part of patient and physician alike to forfeit this possibility on the grounds of cost. Furthermore, the expansion in the scope and resources of the health services has itself created a demand for attention to ailments which in the past would have been left untreated. It has been suggested that this demand will grow as long as there are resources to meet it.

5.7 *It follows that, if, after this technological revolution, we now set ourselves the target of meeting all demands for medical care, the potential cost will be virtually limitless. Since, in reality, resources are finite, it is not possible to meet all such demands. Society must inevitably make choices about what services should be provided based on its perception of what constitutes a comprehensive health service.* While the articulation of society's priorities and the making of choices are primarily functions for the political process, it is desirable that, where possible, objective criteria be sought upon which to base them. The criterion of comprehensiveness is ultimately a subjective one, but to give it workable expression in a collective context it must be related to the concept of *efficiency in the allocation of available resources* so as to achieve the greatest benefit. The theoretical approach to this problem would involve applying resources to healthcare until the marginal health gain from the last unit applied was equal to its cost; the sub-allocation of resources as between healthcare programmes and even as between individuals would be determined on a similar basis. In practice, of course, the need to define and measure the benefits of health expenditures, and to assign values to these benefits, presents insurmountable difficulties in relation to this theoretical approach, and so a *purely* objective solution to the problem of resource allocation is not feasible.

5.8 Choices must nonetheless be made about the overall allocation to the health sector and between the expenditure programmes within it. These choices will reflect the relative priorities accorded by government to the competing demands of society. However, the efficiency of the health services will be increased to the extent that these priorities, and the choices which they determine, are based on an evaluation of the healthcare needs of the population and of the relative effectiveness of the available responses to different forms of need. Such an approach places considerable emphasis on data

collection and analysis. Its advantage is that, despite our often limited understanding of the effects of healthcare, it provides some objective basis for how we allocate resources. Otherwise, choices will continue to be made in an arbitrary way and mainly in the interests of those groups able to exert the most influence on the resource allocation process. Without an objective basis, services which could provide relatively large benefits, in terms of potential lives saved or improvements in the quality of life, may fare less well than others in the distribution of the available resources. It can be argued strongly that a very high priority should be given to preventive services and those services likely to promote the quality of health. Such an approach would be likely to reduce gradually the demands on curative services and improve the quality of life for the population in general. However, in practice it is unlikely that the public demand for such a policy will be particularly significant — understandably, public pressure will focus on curative and therapeutic treatment rather than preventive services. It is therefore a matter for government to take a lead in this area.

5.9 The relevance of efficiency to the criterion of comprehensiveness also arises in the context of how the component parts of the health service relate to each other. Some forms of care can substitute for others, an example being the choice of residential or community-based care for many long-term patients. Other forms of care are complementary; for example, drug prescriptions and referrals for specialist investigation will often ensue from a general practitioner consultation. *The evaluation of the provision and operation of individual services must therefore take account of their impact on the efficiency of the health service as a whole.*

5.10 The availability of a comprehensive health service as an objective of public policy does not imply that the services must necessarily be provided or funded entirely by the State. This issue is discussed in Chapter Six, which examines funding models in detail.

COST-EFFECTIVENESS

5.11 The previous section discussed comprehensiveness in terms of efficiency in the allocation of resources. We might similarly discuss cost-effectiveness in terms of *efficiency in the use of resources* by the individual services. This can be more easily measured.

5.12 Very many of the submissions we received related to the potential for increasing the efficient use of resources in specific areas of the health services. This reflects the fact that in any employment

or service there is likely to be scope for efficiency improvement which can be realised, given the appropriate organisation and motivation of those involved in its operation. The measurement of efficiency is, in some cases, straightforward, such as the comparison of prices paid for identical supplies by a number of similar hospitals. In other cases it is considerably less so. For example, very detailed analysis on the quantity and cost of inputs is required in order to compare the relative efficiency of hospitals in carrying out specific procedures.

5.13 In our detailed examination of the various areas of the health services in later chapters we pay particular attention to the scope for increasing efficiency and to the potential effect of alternative funding and administration arrangements on the motivation of healthcare personnel to seek out efficiency improvements.

EQUITY

5.14 The equity criterion relates to the distribution of the costs and the benefits of health services among the population. The definition of the concept is relatively straightforward in relation to the distribution of costs, but particularly problematic in relation to the distribution of benefits.

5.15 *It is generally regarded as equitable that the costs of services should be shared on the basis of equal contributions by those of equal means and a proportionately greater contribution by those more favourably placed.* Contributions arise in two ways:

— taxation, insurance premiums or other contributions to the cost of collectively-funded services; and

— user-charges reflecting part or all of the costs of specific services.

The arrangements for funding health services vary greatly from country to country, as discussed in more detail in Chapter Six. In most cases, the equity criterion is implemented by relating contributions to the cost of publicly-provided health services to ability to pay, through income tax or income-related earmarked taxes. The criterion is also applied in varying ways to the issue of entitlement to free services. Some countries, including the United Kingdom, have adopted the objective that most public health services should be available to all without charge, while others have considered it more equitable that those in a position to pay some

charge should do so. The basis for Ireland's approach to this issue was set out in a White Paper[3] in 1966 as follows:

> "The Government did not accept the proposition that the State had a duty to provide unconditionally all ... health services free of cost for everyone, without regard to individual need or circumstances. On the other hand, no service is designed so that a person must show dire want before he can avail himself of it ..... general medical services have remained available only to about 30% of the population, because it is considered that the expenses arising from attending a general practitioner are not normally an undue strain on families in the middle income group. On the other hand, eligibility for hospital and specialist services, which are likely to be much more costly, has been extended to a far wider group".

5.16 The definition of equity in the distribution of the benefits of health services is more difficult. Since the objective of the health services is stated to be the promotion of the highest possible levels of health, it could be argued that the equity criterion should be defined in terms of *equality of health.* Quite apart from the measurement difficulties which would be involved, this argument ignores the extent to which an individual can influence his or her own health. It is therefore more useful to focus on some measure of *equality of necessary healthcare.*

5.17 The concept of *equal access for equal need* is commonly used as a definition of equity. This does not have to imply the widespread geographical distribution of all services; efficiency criteria also determine the location of services, so that patients in certain areas may have to travel further than others for access to more specialised procedures. The concept does, however, imply that, *for those services which are considered necessary on the criterion of comprehensiveness, access of patients should be determined on the basis of their individual need for the service, rather than on, for example, their geographical location or their ability to pay.* The concept requires not alone that those meeting the criteria of need should have formal entitlement to services; it also requires that the necessary services are available to satisfy their entitlement, that these services are of high quality and are available within a reasonable waiting period.

5.18 Although equal access for those with equal need may be available, the utilisation of the services may differ because some individuals may not be fully aware of what they need or the

[3] *White Paper: The Health Services and their Further Development* (Stationery Office, 1966).

treatment to which they are entitled. This would be particularly relevant in the case of preventive services and those geared towards the welfare of the elderly and various disadvantaged groups. *The definition of equity should therefore associate equality of access with equality of utilisation, to ensure that the services are availed of by those for whom they are designed.* The extent to which the criteria of equality of access and of utilisation are satisfied can be assessed in different ways for the various services, by reference to, for example, differences in the geographic coverage of welfare services, the take-up of preventive services as between social classes, and patterns of access to hospital services. In some areas it may be necessary to introduce some element of positive discrimination to ensure that such objectives are promoted more effectively.

5.19 The preceding paragraphs defined equity in terms of equality of access to, and utilisation of, some objectively-determined level of service. However, the question of access to services beyond that level has raised, for many countries, difficult and contentious issues. As the advance of technology has drawn the scope for health spending ahead of the ability of nations to finance it, the gap has been manifested in waiting-lists for some services and the non-availability of others. The international dilemma has been summarised recently by the OECD:

> "In the extreme this can result in two-tier medicine and raises difficult equity and ethical questions about whether the rich should be able to purchase new life-saving technologies which are not covered by the public programmes. In some countries discussions have focussed on adequate access to high quality but not necessarily the top quality. Is there a concept of "quality second-class care" and, if so, how should it be defined? In other countries, access to the same exhaustive set of benefits for the entire population is seen as a fundamental aspect of the welfare state. Despite these apparent differences, however, all countries place some limits on service coverage and upper income (and other) individuals are not precluded from expressing their demand for non-covered services through private market mechanisms. Yet, the question of placing limits on overall societal consumption of health services has been raised along with the difficult question of the justification for singling out health care as the sole (legal) service for which individuals are not allowed to express their preferences through free market mechanisms. These conflicts and questions can not be resolved analytically. Clearly societal choices expressed through the

political systems of the various countries will have to resolve this issue".[4]

5.20 *The Commission believes that, in keeping with the political and social philosophy of our society, the individual should have access to self-funded medical treatment if he so desires. However, we would regard it as inequitable if the provision of such treatment to those in a position to pay for it should act in any way to the disadvantage of those of lesser means by reducing the availability of resources such as skilled manpower. We believe that those in a financial position to obtain medical treatment which is generally unavailable should not be subsidised at public expense in doing so.*

CONCLUSION

5.21 In this Chapter we have defined the criteria of *comprehensiveness* and *cost-effectiveness* in terms of *efficiency* in, respectively, the allocation of resources and the use of resources. We have discussed the extent to which these can be measured. We have pointed out that these criteria do not imply that all demands on the health services must be met, nor that all services must be provided or funded by the State.

5.22 We have defined the criterion of *equity* in terms of ensuring equal access to and utilisation of those services which are considered necessary on the criterion of comprehensiveness, for patients with similar needs, regardless of their geographic location or ability to pay. We have argued that this does not imply that restrictions should be imposed on the freedom of individuals to arrange for self-funded medical care, provided that these arrangements do not operate to the disadvantage of those of lesser means, and do not involve public subsidisation of treatment which is not generally available.

5.23 In later chapters we evaluate in detail the existing provision and delivery of services in terms of these efficiency and equity criteria, as a basis for our recommendations on their funding and administration.

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[4]*OECD: Financing and Delivering Health Care (1987) p. 94.*

PART THREE

THE FRAMEWORK

CHAPTER SIX

FUNDING THE HEALTH SERVICES

INTRODUCTION

6.1 In this chapter we examine the rationale for the collective funding of the health services and consider the implications of a market allocation contrasted with a public allocation of resources for such services. These represent two types of approach to funding and we consider them in the context of the criteria of cost-effectiveness, equity and comprehensiveness. Any system of funding will have implications for the nature of the access to, or eligibility for, the services they fund, and so we also consider this area briefly. Chapter Seven examines the present eligibility structure and sets out in detail our proposals for improvements.

6.2 At present the Irish health services are primarily funded from general taxation, with the addition of full or part payment for certain services by people in different income groups, sustained in part by a monopoly Voluntary Health Insurance Board operating on what are known as "community-rating" principles. This has given rise to a mixture of publicly and privately delivered health services with the majority being directly financed through taxation and publicly regulated. Some private spending is also supported, indirectly, from the public purse through tax relief on health insurance premia.

6.3 In some respects healthcare may be regarded, like other goods and services, as having a market with a demand side (patients and potential patients) and a supply side (medical and non-medical personnel, hospitals, manufacturers and providers of services). However, unlike most markets, healthcare has intermediaries between the demand side and the supply side, acting as:

(i) a channel of funding from patients to providers; and

(ii) the regulator of the supply of services to patients by determining which services are covered by the available funding.

6.4 Because healthcare has also the dimension of a "public good" and its availability is used as a measure both of the equity and efficiency of a society's social system, its funding has to reconcile these two concerns.

6.5 Throughout this report, the Commission makes a clear distinction between funding and delivery of health services. It is possible, for example, for health services to be funded wholly or partially from public sources while at the same time for some of them to be delivered through the private sector. Thus, decisions about funding and delivery, while related, are not totally interdependent.

COLLECTIVE FUNDING

6.6 The reasons for the collective funding of health services vary according to the type of service:

— some form of collective funding is necessary even for medical services for the general population because of the very nature of medical care. The individual cannot predict when illness will occur, and is least able to act as an independent consumer when it does. He has little or no control over the costs of treating his illness, and these may be so great as to be catastrophic if he must meet them from his own resources. As in other areas of life where similar problems arise, the risk can be spread over time and across a large number of those at risk, through insurance;

— services which aim to prevent illness through public health measures and to promote better health confer benefits on society as a whole. The appropriate allocation of their costs to individuals is not possible, so compulsory collective funding is appropriate;

— welfare and long-term care services are needed by groups such as the mentally and physically handicapped. The collective funding of these services arises from society's altruistic desire to provide for those who are unable to provide for themselves.

6.7 All countries rely on some form of taxation (compulsory collective funding through the public sector) to provide the resources necessary for most or all of the services in the latter two of the above categories, i.e. public health measures and care of the disadvantaged. There is, however, scope for greater choice in the funding arrangements for medical and associated services for the general population.

6.8 All forms of collective funding of health services can be regarded as insurance in that they spread financial risks over a large

number of people. However, those forms based on taxation or other income-related contributions differ from the conventional understanding of insurance, since the level of "premium" is not related to the level of risk. Private health insurers determine premia on the basis of "experience-rating" (i.e. in accordance with actuarial assessment of the risk associated with each category of client) except as in Ireland where the State requires insurers to operate "community-rating" (spreading risk evenly across all categories of patient, irrespective of factors such as health status or age-group). It is also possible to have life-time spread of some risks.

6.9 The systems of collective funding in Western countries cover a wide selection of arrangements, but in general one of three models predominates, usually combined with some features of the others. These are the public or general taxation model; the quasi-public or social insurance model; and the private, or competitive insurance model.

6.10 The *public or general taxation* model is characterised by the universal availability of some level of basic health service, either free of charge or at relatively low cost at point of use. The United Kingdom's National Health Service is regarded as the typical example of this model; the current Irish system also has some, although not all, of its features. The "intermediary" is a State agency which may provide services directly to patients or may arrange for their provision by the private sector. Reimbursement to patients of fees paid by them to providers is not typical of the taxation model, although it can arise, as in the Irish scheme for the refund of expenditure on drugs and medicines.

6.11 The *quasi-public* or *social insurance* model is dominant in many European countries. It is essentially a form of compulsory ear-marked taxation, in that premia for employees are usually shared by employer and employee, and are proportionate to the level of income. The premia are collected through the tax system, but are paid into a specific insurance fund. There may be a number of such funds in the country, each catering for a different occupational group; in some countries, the individual may choose between competing funds. The premium for retired persons is often at a flat-rate, with State subsidy; the State pays premiums into the fund on behalf of the unemployed and other low-income groups. The arrangements for coverage of the self-employed vary from country to country, and in some cases those above specified income limits are excluded. Typically, patients pay their own medical bills to private sector providers and then claim reimbursement from the insurance fund, but this is not an essential feature of the model and the funds may

employ or contract providers to supply services free or at low cost. Non-personal health services, and the welfare and long-term care of disadvantaged groups, are usually financed from general taxation rather than the insurance fund.

6.12 The best-known example of the optional/voluntary *private insurance* model based on competing insurers is that of the United States. Again, general taxation is used to provide non-personal health services and to cater for the needs of disadvantaged groups. Other patients look to the open market for personal medical and associated services. Commercial insurers are generally free to reject or accept potential subscribers and to set premium levels on the basis of experience-rating. Subscribers are free to switch between those insurers who are willing to accept them. The State can either provide services directly for low-income groups or pay premia on their behalf to the insurance companies. In the traditional version of the model, insurers are not involved in the provision of services, but refund costs incurred by their members. In recent years, a variant of the model has emerged in the United States in response to escalating costs, which combines the role of insurer and provider in agencies such as Health Maintenance Organisations, which undertake to provide a comprehensive healthcare service to their subscribers in return for a per capita payment.

6.13 Almost all countries have a mixed system. Thus, while private health insurance schemes may complement or substitute for cover under public or quasi-public schemes, countries relying on private insurance as the principal form of intermediary must also provide for those unable to afford the premia from tax revenue. There is thus no "purely public" or "purely private" system in the Western world. Moreover, the problems facing health systems in all countries in recent years have been similar: third-party funding of health costs, whether by public or private agencies, leaves neither patient nor provider with incentives to use resources efficiently, and the demand for resources rises at a rate which is unsustainable regardless of the source of funding. Each type of system has responded to these problems by trying to change the financial incentives to providers in order to encourage more cost-effective use of the resources under their control.

6.14 There is a long-standing and continuing international debate on whether the demand for and supply of healthcare should be regulated primarily by public or private agencies. Any consideration of the appropriate funding model for the Irish health services must address this question. However, while much of the argument on either side of the international debate is ideological, reflecting the

divergence of views on the broader question of central or market control of the economy, the primary concern of the Commission's approach is to examine whether administrative control under a public regulatory system, or competition between insurers under a private regulatory system, is more likely to be fair and efficient.

THE BASIS FOR CHOOSING A FUNDING MODEL

6.15 The Commission believes that health services are most effectively funded on a collective rather than individual basis so that each person can share, with others, his risk of needing health services given the unpredictable nature of that risk and the often high costs of healthcare. Furthermore, the Commission believes that this sharing of risk must be compulsory since it is unacceptable for healthcare to be denied those who neglect to provide for the contingency of illness. The broad approaches in which this collective funding can be achieved through a public or private system have been outlined above; each has implications for the efficiency with which healthcare resources are allocated and the cost-effectiveness with which they are used.

6.16 Again, we would emphasise the distinction between arrangements for funding and delivery of health services; it is not simply a question of deciding between overall systems such as the United Kingdom's NHS or the United States' private system. The sections that follow are concerned with choosing a funding model appropriate to Irish circumstances and later chapters consider the best methods of delivery.

6.17 However, in addition to implications for efficiency, there are also implications for equity and comprehensiveness contained in the choice of funding model. Before considering what system of healthcare funding is most appropriate to Irish conditions, the Commission considers it desirable to restate the basic principles, already elaborated in Chapter Five, which have guided our thinking about a choice of a funding model.

6.18 *The Commission considers two precepts to be fundamental: firstly that necessary health services should be available to all persons on the basis of their need for such services and not on their ability to pay for them, and secondly that the costs of such services should be shared on the principle of proportionately greater contributions from those of greater means.* There are certain classes of person who, because of chronic or congenital illness, old age or handicap, may have a higher than average utilisation of health services. The Commission holds, in particular, that such persons should not be liable to contribute to

the cost of the health services except in accordance with their means and should effectively be subsidised by those who enjoy good health.

6.19 The Commission realises that these principles form the basis of most social services but that their implementation in practice often falls short of the ideal. However, because of the essential nature of healthcare, the Commission believes that such principles must be given the greatest practical expression in the provision of health services, since we believe that society holds the value of good health to be antecedent to the effects of other social services.

"Necessary" Services

6.20 In stating the above principles, the Commission has referred to "all necessary health services". This prompts the question of what constitutes a "necessary" level of services. We have addressed this issue in Chapter Five under the discussion of the criterion of comprehensiveness (paragraphs 5.3 — 5.10) and have concluded that, while the degree of comprehensiveness can be enhanced by maximising efficiency and cost-effectiveness, in the final analysis the level of health services which may be called comprehensive is a political decision to be made by the people through its elected government, having regard to available resources and social priorities.

6.21 The Commission believes that the existing mix of public and private services providing

Primary Care,
Hospital Care,
Long-Term Care and
Personal Social Services

constitute the type and approximate level of services which should be available generally and with equity of access for all. This does not mean that they should necessarily be publicly funded or available free of charge. In later chapters we deal with each service in detail and make specific recommendations about the level of provision.

6.22 Given widespread agreement about the existence of a considerable degree of poverty in our society, the Commission has concluded that the poor must be protected in terms of healthcare. For this reason, **we recommend that the lowest income group should remain eligible for all necessary health services free of charge and that the cost of providing these services should be borne from some form of taxation**. The income level which determines this group is a political decision and must be subject to review. This issue is dealt with in Chapter Seven.

6.23 A funding structure for the rest of the population must now be considered. Arising from the conclusions that follow, we consider eligibility for publicly-funded health services in more detail in Chapter Seven.

ALTERNATIVE FORMS OF FUNDING MODEL

6.24 The dominant form of allocation of resources to healthcare in Ireland is at present a public one. The bulk of health expenditure is financed from general taxation, and decisions on the allocation of resources to providers, and patients' access to services, are made by the Government and agencies acting on its behalf. One could not claim that the system has been strikingly successful in achieving equity and efficiency; it can also be argued, however, that the potential for imposing equity and efficiency through tight administrative control has never been realised because of the relative absence of accountability in the delegation to service providers of substantial control over the use of resources.

6.25 An alternative to the existing system as funded from general taxation could be one based on either a form of ear-marked taxation or national health insurance. The issues relevant to the choice between these are discussed in this chapter.

6.26 Another alternative form of allocation of resources would be to rely on *competing private insurers* other than in the case of low income families eligible for services funded by the Exchequer. It is often argued that, under such a system, it would be essential that a certain level of insurance cover should be compulsory for every citizen to ensure that a full and comprehensive range of necessary services are available to all. The case for compulsory insurance and the practical difficulties which it would present are discussed later in the chapter.

6.27 The choice under discussion, therefore, is whether necessary health services should in the main be funded by

(i) some form of compulsory contribution or taxation, giving consumers no choice (except in the long-run through the ballot-box) in relation to what they pay and the services available to them; or

(ii) insurance through private schemes which compete for members on the basis of premium rates and the level of service provided (subject to the minimum level compulsory for all).

6.28 The choice between these two options relates to the *principal* funding source for the health services. Elements of both options can

be combined to make up the overall system. For example, if the system is primarily tax-funded, there can still be a role for private insurance for those who wish to supplement the cover available to them, or for income-groups which do not have full entitlement to the tax-funded services. Similarly, if the system is primarily organised on the basis of competing private insurers, the State must either provide cover directly or indirectly for those who cannot afford private insurance, or else must subsidise some or all of the cost of their insurance premia. Indeed, the second approach could even be based on taxation funding, in order to preserve the objective of contributions in accordance with ability to pay. Under such an approach, the State would pay premia on behalf of all citizens to the insurers of their choice, this choice being based on the level of service offered by insurers in addition to the statutory minimum.[1]

6.29 There are a number of background factors which differentiate the healthcare market from other markets and which must be taken into account in considering alternatives for a funding structure:

— while the individual may be aware of his health 'wants', he is ignorant of his health 'needs'. He thus relies on the advice of medical professionals who determine what services he will require and not on his own judgement;

— there are, and will likely be in the future, inherent upward cost pressures on health expenditure. The increasing availability of high-cost procedures, rising expectations of cures from expensive treatments and pressure for better recompense from all sectors of the health service industry are combining to create an explosion in healthcare costs which must be checked;

— the long-term ability of government to resist the demands of voters to expand the scope of services by increasing expenditure may be doubted where the Exchequer is seen to be bearing the cost.

PRIVATE INSURANCE FUNDING

6.30 Insurance is generally regarded as an essential element of any healthcare system in which responsibility for meeting costs rests largely with the individual. Minor expenses can, of course, be met directly, but the unpredictability and substantial costs associated with many illnesses make health insurance essential in a predominantly private funding system.

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[1] A taxation-based approach along these lines was recommended by the Netherlands Commission on Health Funding in 1987. See: *Commissie Structuur en Financiering Gezondheidszorg: "Bereidheid tot verandering"* (March 1987).

6.31 The case for a private-based funding system underpinned by private health insurance generally focuses on considerations of efficiency, control of costs and consumer choice. Proponents argue that competing insurers must, for their own viability, minimise costs and maximise benefits to their clients by demanding the most cost-effective services from providers. The argument continues that such competition between providers and its associated benefits will not become a reality without competition among funders (i.e. insurers) also.

6.32 In addition, it is argued that a system of private insurance allows consumers to decide how much they wish to spend on their healthcare, through a choice of different insurance packages, and to choose between different providers of health services. Proponents criticise systems based on public allocation on the grounds that they are unresponsive to consumer demands and offer little or no scope for competition.

6.33 It is argued that a system based on private health insurance for all other than the lowest income group would increase the redistributive impact of healthcare by focusing as much as possible of public health expenditure on those groups least able to meet the cost of health services themselves. The lowest income category would be catered for by government, either through meeting the cost of premia or funding services directly from tax revenue.

6.34 The system of funding healthcare for those outside the lowest income group by competitive private insurance may now be examined in terms of the criteria of cost-effectiveness, equity and comprehensiveness.

Cost-Effectiveness

6.35 The arguments concerning the cost-effectiveness of a predominantly private funding system are not persuasive when the case against the system is examined. In particular, the belief that costs can be controlled more successfully than in a public system is not supported by evidence from the United States.[2] While neither public nor private systems have been very effective in containing cost escalation in the past,[3] private insurance has experienced

[2]Total health care spending in the U.S.A. rose from approximately 8.6 per cent of GDP in 1975 to 10.7 per cent in 1984 (*Financing and Delivering Health Care* OECD, 1987).

[3]This is due to such factors as "third party payment" problems, where providers and patients have little or no incentive to minimise the costs met by a third party — the insurer or Government.

particularly rapid cost increases, especially where cover is open-ended.

6.36 The administrative costs associated with private insurance must also be taken into account. If insurance cover is offered on the basis of recoupment of patients' medical outlays, considerable expense will be incurred in promoting the company, and in processing, verifying and reimbursing claims. Under a public system, services can be provided directly to eligible patients without the need for a payment mechanism. Private insurers could provide cover on the basis of direct provision of services to patients (or by arranging for services to be delivered by contracted providers) without administrative costs being passed on to consumers but there is no certainty that insurers would operate in this way. Overall, it is likely that administrative costs would be greater with competing funders than with a single, public funder.

6.37 Arguments about greater choice under a private system are hampered by the limited ability of the average consumer to make informed decisions regarding his healthcare needs. He cannot assess the likelihood of requiring particular services, and has little information about the appropriate forms of treatment and the likely outcome of alternative types in the event of illness. This lack of information has two important consequences:

(i) his "wants" may not correspond to his "needs" and the *level and range* of cover sought from insurers may therefore be quite different from that which he might choose had he better information;[4] and

(ii) he may not be able to assess properly the *quality* of the cover offered to him until serious illness occurs, at which stage it may be too late to rectify any inadequacies. The interest of insurance companies in differentiating products in order to enhance their competitiveness tends, in particular, to make choices less clear for the individual.

6.38 Competition in markets for other goods and services can ensure the efficient allocation of goods and services, provided that, among other things, the consumer has sufficient information to make an informed choice. He also has advertising to advise him of the choices available and consumer legislation to protect him from any

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[4]The American experience has been that resources have flowed, through insurers, to medical specialties with a more glamorous image or a higher profit margin, while those with a lower profile are relatively neglected regardless of their relative importance on an objective basis. (See, for example, *Financing the Health Care System: Is Private Financing an Alternative?* ESRI Policy Research Series, Paper No. 9, October 1988).

serious consequences of a mistaken choice. These considerations do not hold for healthcare where the individual can be distracted by an apparent range of choice for what are, in some cases, relatively unnecessary facilities and treatments; furthermore the result of a wrong choice can be considerably more dramatic.

6.39 Inadequate consumer information can therefore lead to inefficient allocation of resources in the area of healthcare unless it is carefully regulated. Such regulation is, however, an interference and distortion which reduces the scope for competition and therefore the efficiency of a system based on private funding and private health insurance.

Comprehensiveness

6.40 The Commission has already argued that a certain level of basic service must be available to all. However, under a private insurance system some individuals might elect to insure themselves at a level below this basic service or they might choose not to obtain any cover. Irish society is unlikely to regard it as acceptable that those without cover should be left untreated or face bankruptcy, should serious illness occur. The State would therefore have to take responsibility for them, and the knowledge that this "safety-net" was available would itself act as a disincentive to paying for insurance cover.

6.41 The State could, of course, make private health insurance compulsory, possibly to cover a basic level of services, with scope for insuring for additional services on a voluntary basis. However, the Commission does not believe that compulsory private insurance is enforceable in practice. Experience with motor insurance in Ireland has shown that a substantial proportion of drivers ignore the legal requirement to have a minimum level of cover, despite the possibility of catastrophic liabilities in the event of serious accident. The problem of uninsured drivers has persisted despite various measures to counter it. It would be all the more difficult to identify those without health insurance cover, until such time as expensive treatment was needed.

Equity

6.42 A system based on private health insurance does not perform well against the criterion of equity. It is likely that the arrangement would give rise to serious gaps in coverage which would ultimately have to be filled (directly or indirectly) by the publicly-funded State system.

6.43 The primary reason for the inadequate coverage is the need for competing insurers to calculate premia on the basis of risk-rating, under which the rates applicable to customers are directly related to age, health status and other factors relevant to the likelihood of a claim. Persons considered to be in a high-risk category, such as the elderly, those with pre-existing illnesses and other chronic conditions would find it difficult to obtain reasonably-priced insurance. It is likely to be available only at higher cost or subject to restricted benefits, or both.

6.44 The shift to risk-rated insurance would involve a significant redistribution of income towards younger age-groups and, in general, towards those with a lower likelihood of illness. While the subsidisation of older age-groups by the younger ones under community-rating[5] is sometimes questioned, there is a tendency to overlook the fact that this is, in fact, a form of compulsory inter-temporal insurance; the younger groups are, effectively, contributing towards the greater likely cost of their own healthcare when older. This form of redistribution spreads over time those costs which fewer individuals might be able to afford if they were less evenly distributed.

6.45 Furthermore, a move to risk-rating in a system where private health insurance acted as dominant funder would be particularly inequitable for those in middle-age or beyond. Such persons have been contributing towards the health services over a number of years through the tax system on a basis which is closer to community-rating, in that contributions are entirely detached from any assessment of risk. There are, however, always transitional costs associated with a change in a system. If private health insurance were considered desirable on other grounds, this issue could be accommodated in other ways, such as life-cycle based premia.

6.46 One approach to the problems of gaps in coverage associated with risk-rated insurance premia would be for the State to pay a varying subsidy to individuals in respect of their health insurance costs. This, however, would prove extremely complex to operate, particularly as it would require two systems of actuarial assessment — one by the public authorities to determine the compensating subsidy appropriate in each case, and one by insurers to determine the appropriate premia. Such a degree of regulation would also diminish the perceived advantages of free competition in any event.

[5]The system of community-rating and its future applicability is discussed in more detail later in this chapter.

Furthermore, it would mean that the taxpayer was subscribing indirectly to the profits of private insurance companies.

6.47 The introduction of private insurance involving competing companies has, of course, particular implications for the Voluntary Health Insurance Board and for the role of health insurance in the Irish market generally. The issue is discussed further in Chapter Eight. The alternative to a private system is considered in the next section.

PUBLIC FUNDING

6.48 Under a public funding approach the individual shares the risk of his need for healthcare with the community at large by subscribing on a compulsory basis to a public fund which is used to provide healthcare services. It is effectively a risk-sharing "insurance" fund on a grand scale (although the size of contribution is not related to individual risk). Services can be provided directly by the State itself or contracted by the State through competing providers. The form of compulsory contribution can be through general taxation or an ear-marked taxation such as a national health insurance contribution. Their relative merits are discussed later.

6.49 This system of funding is now examined against the criteria of comprehensiveness, equity and cost effectiveness.

Comprehensiveness

6.50 The publicly funded model emerges in a favourable light when considered against the criterion of comprehensiveness. Since resources are limited it is inevitable that all demands on them cannot be met, but as the political process, which is designed to articulate the priorities of society, would determine the level of publicly funded basic services, it follows that such a determination represents the best satisfaction of the criterion of comprehensiveness.

6.51 A further advantage of a public funding approach is that the State acting as central funder is most favourably placed to plan and organise the delivery of a unified, integrated service for all categories of patient. We believe that this represents the best means of getting the most comprehensive service for a given level of resources. This is particularly relevant in the efficient use of highly expensive high technology medicine. In addition, the implementation of national policies, such as the substitution of primary care for institutional care, is more easily achieved under a single major health care funder.

Equity

6.52 The publicly funded model satisfies the criterion of equity from the point of view of contributions to the risk-sharing fund. Assuming that the rate of compulsory contribution, whether from general taxation or national health insurance, is progressive, income would be effectively redistributed from the better-off to the less well-off. In addition, under such a system, a subsidy is effected from those with a lower likelihood of illness (particularly the younger age-groups) to those with a higher likelihood of illness (particularly the older age-groups).

6.53 With regard to equity of access to services, the publicly funded model, which can control such access administratively, is best placed to ensure that necessary services are available to all on the sole basis of need. Under the existing Irish eligibility structure everyone is entitled to public hospital services (subject to the Category III proviso discussed below). The existing problems of *equity* of access to public hospitals arise from the way in which private practice is organised in such hospitals at present. Those who can afford to pay for private treatment out of their own pockets or through voluntary insurance, although relieving the state of expenditure, are able to queue-jump ahead of public patients. The present obligation on the top 15 per cent of the population (Category III) to obtain consultant services privately in reality only contributes to an institutionalisation of this inequity.

6.54 The Commission accepts the right of those who can afford it to avail of private medicine. The question of how to overcome the potentially disruptive effects on equity of access caused by private medicine in public hospitals is addressed in Chapter Twelve. The answer lies principally in having a clearly stated policy of admission of patients on the sole basis of assessed medical need.

Cost-Effectiveness

6.55 The key issue in any debate between a public or private approach to risk-sharing is ultimately the question of which system promotes greater *cost-effectiveness* and efficiency in the use of resources. A large part of the argument in favour of private insurance is based on the efficiency which would result from competition among providers. There is no reason, however, why such competition in delivery should be associated only with private funding systems. Under a single public funder it would still be possible for services to be provided on a competitive basis and, in particular, a single public funder would be at an advantage in buying services from

competing providers since effectively it would be in a position of monopsony.

6.56 Furthermore, the empirical evidence, referred to earlier, suggests that to date the private insurance model is not more successful in containing costs than a public model.[6] While competition among private deliverers could mean that some services were efficiently provided, there are other services which might be more cost-effectively provided by the State itself or indeed by a combination of both systems. In Chapter Nine, dealing with Administration and Management, the Commission makes recommendations in this area.

CHOOSING THE FUNDING MODEL

6.57 In assessing options based on the two approaches discussed above, the Commission is concerned with identifying a funding system which reconciles the demands of comprehensiveness, equity and efficiency. We have been conscious at all times of the problems associated with evaluating these factors and in particular the danger of allowing money-measurement to become the pre-eminent means of assessing efficiency.

6.58 We have already stated that a fundamental principle is that all necessary health services should be provided for the population on the basis of need and not of means. We have seen that, apart from the case of the lowest income group, there are certain types of catastrophic or long-term illnesses and handicaps which require services so costly that only a tiny proportion of the population could be expected to afford to provide them for themselves. *We regard it as an extension of this fundamental principle that such services must be available to those outside the low-income group who need them, at a cost they can afford.* The two basic approaches to funding are examined below with this principle in mind.

6.59 A number of factors crucially influenced the Commission's choice of an appropriate funding model. These include efficiency considerations, administrative costs and the effects of risk-related insurance on comprehensiveness and equity.

Efficiency Considerations

6.60 The Commission agrees with the view that the healthcare market cannot be regarded in the same way as the market for other

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[6]See also, for example, R.G. Evans: *Strained Mercy: The Economics of Canadian Health Care* (Toronto, 1984).

services. The individual is frequently ignorant in buying health insurance of the timing of his need for healthcare, of the extent and range of the cover for services he requires and of the quality of that cover. For this reason a market mechanism does not lead to the most efficient allocation of healthcare resources.

6.61 The Commission is not convinced by a second efficiency-related argument — that competition among funders is a necessary prerequisite for competition among providers. On the contrary *we consider that a competitive insurance market could open the way to an unnecessary and inefficient duplication of facilities in both public and private sectors. Furthermore, the integration of services in the interest of overall efficiency would be considerably more difficult under the market approach than under the public system.*

6.62 A third issue in this area is the extent to which efficiency in provision is influenced by the number of funders involved. Under both public and market-based systems there have been considerable developments in recent years to alter the nature of the financial incentives to providers of health services in the interest of the more efficient use of resources. *There is no theoretical or empirical reason to believe that the scope for imposing greater efficiency on providers is better or worse where there is one central funder or a number of competing funders.* In theory, competing insurance companies would have a greater incentive to achieve economies but lower costs may not lead to more competitive policies for those who actually need them.

Administrative Costs

6.63 *The Commission believes that it is likely that administrative costs will be greater with competing funders than with a single, public funder.* These costs will arise from the duplication of outlays by companies for promotional purposes and in the processing, verifying and reimbursement of claims and the collection of premia. These costs would be considerably less in a public system free at point of use, particularly if the compulsory contribution was tax-related and collected by the tax system.

Risk-Related Insurance

6.64 The fact that it is doubtful whether community-rating could be operated in practice under a market-based approach has greatly influenced the Commission. Even if there were a requirement that similar premia be offered to all seeking cover, it would still be possible in practice for insurers to discriminate in favour of better

risk subscribers. They could, for example, concentrate their recruitment of members on specific occupational groups, or in specific geographic areas, where the demographic composition of the catchment group was most favourable.

6.65 There is also the possibility that health insurance would be available by post from other countries of the European Community after the completion of the Internal Market. It would thus become more difficult for individuals with higher health risks to obtain cover except on less favourable terms. Although it might be possible to overcome these difficulties through stringent regulation and monitoring of insurers, this could involve considerable administrative cost and is hardly consistent with the concept of true competition between insurers.

6.66 *The Commission believes that one of the principal disadvantages of the competitive insurance approach is that it would be extremely difficult to enforce community-rating by competing insurers. In these circumstances, older age-groups and other poor-risk categories could be left without insurance cover except at prohibitive rates.*

6.67 We believe that it would be regarded as unacceptable in our society to deny needed care on the grounds that the patient could not afford it, even in circumstances where the individual (or his parents or guardians) could have taken out insurance cover but neglected to do so. In practice, the State would have to seek to recover the cost of treatment from such patients after the event. This would be cumbersome and costly. *Under these conditions, it is thus likely that those without adequate cover would present an ongoing problem under the private insurance approach.*

Choice for Public Funding

6.68 In summary, while the arguments contained in this chapter suggest that, in some respects, a private insurance approach could, in theory and with considerable modification, be made as equitable as the publicly-regulated model, the Commission believes that in practice it would involve a less efficient allocation of resources, increased administrative costs and difficulties in the planning and integration of services, and that, in particular, it could be very detrimental to older age-groups, people with chronic complaints and other poor-risk categories.

6.69 Based on these considerations, the Commission considers that a shift to private competitive insurance would give rise to major problems. A further important argument is that there is already a

publicly-regulated system in place, with potential for securing considerably more equity and efficiency than has been realised to date.

6.70 **We therefore conclude that the Irish health services should continue to be primarily publicly funded and regulated.** However, it should be stressed that this conclusion does not rule out a significant degree of non-tax funding within the overall healthcare system, nor does it rule out the pursuit of efficiency through competition among providers in the delivery of health services.

Health Maintenance Organisations

6.71 In the course of its deliberations, the Commission also considered the scope for introducing a system based on Health Maintenance Organisations in Ireland. Appendix 6A examines this issue and concludes that the HMO model is not appropriate to Irish conditions for the forseeable future.

ELIGIBILITY FOR SERVICES UNDER PUBLIC FUNDING

6.72 Before it decided on its preferred model for funding the health services, the Commission concluded that the lowest income group should continue to be eligible for all necessary services free of charge and that, as a general principle, all necessary services should be available to those outside the lowest income group at a cost they can afford.

6.73 **We recommend that non medical card holders should be eligible for a group of publicly-funded "core services" comprising specified**

— acute hospital care;

— long-term care; and

— personal social services.

The core services should include eligibility for welfare and continuing care services, such as those for mothers and children, the elderly, the disabled and the psychiatrically ill, with scope for charges based on income as discussed in Chapters Seventeen to Nineteen. It should also cover those services for which there is universal entitlement at present such as treatment for infectious diseases, certain child health services and rehabilitation services.

6.74 The specification of a core level of publicly funded services for those outside Category I does not imply that all these services

must be provided free of charge. We discuss the issue of user charges later in this chapter. The Commission has in mind the provision of a level of service designed to ensure that, in keeping with the principles arrived at earlier, necessary services are available to all at a cost they can afford. We discuss more detailed aspects of eligibility in Chapter Seven and in the service chapters.

THE FORM OF TAXATION

6.75 Having concluded that the health services should be primarily publicly funded and regulated, the Commission considers in this section different forms of taxation and their relevance to financing the health services.

General v ear-marked tax

6.76 Within the European Community, only Denmark, the United Kingdom and Ireland finance a large proportion of healthcare expenditure from general taxation. Most Western European systems are based on ear-marked Social Insurance contributions. It has been suggested that there would be advantages in funding the Irish health services through an ear-marked tax, paid into a specific fund, rather than from general taxation. Payment of the tax would be necessary to establish entitlement to services; it would be proportionate to income, and the State would pay the premium for low-income groups. Those proposing the ear-marked tax have envisaged it as a substitute for an equivalent amount of general taxation, rather than a net addition to overall tax levels.

6.77 The principal arguments put forward in favour of funding the health services from a compulsory national health insurance or ear-marked tax are, firstly, that such an approach creates a clear link between the services desired by and provided to the population and the cost of their provision; and, secondly, the existence of a specific health fund would provide a secure basis for the flexible, multi-annual approach to financing for the independent executive authority which (as we recommend in Chapter Nine) should assume responsibility for the central management of the health services.

6.78 It can be argued that funding through compulsory health insurance has important psychological effects. It is contended that the tax would help the public to appreciate the actual value of each individual's contribution to the cost of the health services, and that this awareness would help to moderate unnecessary demands. It is also suggested that the payment of the tax, represented as a national health insurance premium, might be regarded more positively than

the payment of income tax. Proposals to expand or curtail services could be debated in the light of the estimated impact on the "health premium".

6.79 It has been noted earlier that, in the long run, it is difficult to resist demands for increasing levels of public health expenditure, whether as a result of demographic change, technical developments or otherwise. Such increased expenditure may be necessary in order to provide the type and level of service necessary to meet, in an efficient and effective manner, the criteria which we have adopted to determine the way in which the health care needs of the population should be met. It can be argued that the increased funding which may thus be required as a result of the unique characteristics of healthcare can best be found through an ear-marked tax when the general thrust of fiscal policy is otherwise toward reduced expenditure and income tax levels.

6.80 A further argument relates to a perceived increase in equity under the approach, since a contribution would be required by or on behalf of everyone. Proponents of this argument suggest that funding through general taxation involves a disproportionate sharing of the total burden because of deficiencies in the tax collection system, and that it should be possible to devise a more satisfactory system of collection of health insurance premia.

6.81 The collection of revenue by ear-marked taxes into a health insurance fund administered by the proposed executive authority would not preclude the availability of optional, top-up health insurance which would cover services which are not part of the core services available to the population as a whole. Such additional insurance cover could be provided either by the executive authority or by commercial insurance companies on a competitive basis. It should be possible for optional, top-up insurance to be provided by the executive authority on the basis of community-rating, even if commercial insurers, as seems inevitable, adopt a risk-rating approach.

6.82 The view that there would be greater acceptability for a designated levy than for general taxation is, of course, a matter of opinion with little empirical evidence to support or refute it. Similarly, it is difficult to assess whether awareness of the costs involved would, in practice, encourage people to be more economical in their use of the health services, since it is a common phenomenon of insurance that, having paid their premium, consumers tend to maximise their use of the cover provided.

6.83 The case for insulating the health services from the effects of fiscal policy could also be applied to equally worthy areas of expenditure such as, for example, education or social welfare. Furthermore, separate funding for healthcare might mean that inadequate attention was given to assessing priorities regularly and ensuring that, across all public expenditure programmes, the best use was made of overall resources.

6.84 It is clear that there would be significant costs associated with setting up a fair and efficient collection system, separate from the present arrangements for collecting general taxation and for this reason it would appear preferable on cost grounds to collect an ear-marked tax as part of the income tax system, as is done in the case of PRSI. However, this might reinforce the perception of the ear-marked tax as being merely a part of income tax. If public appreciation of the cost of the health services is considered desirable, it would be appropriate to indicate the percentage of taxation absorbed under this heading in a notice accompanying tax returns. This could be done irrespective of the form of taxation used to fund health care.

6.85 The option of funding services by means of a compulsory health insurance contribution or ear-marked tax is favoured by a minority of members. However, a majority of the Commission was not attracted by this concept. In addition to the arguments above, it was felt that it would be undesirable to narrow the funding base for the health services by making them dependent mainly on direct taxation. At present, revenue raised from all sources, including taxes on health-averse goods such as tobacco and alcohol, can be used to finance the health services. It was also felt that since the State would control the rate of ear-marked tax (and the amount of any necessary "top-up" element) arguments about protecting health expenditure from the effects of fiscal policy were not persuasive.

Reservation by Mr. P Flynn, Mr. D. McCarthy, Mr. D. O Shea and Mr. P. Teahon

While accepting the central importance of public funding of core services provided for the entire population, we consider that there is a significant advantage in funding such services in part through a compulsory health insurance contribution, acknowledging it to be a form of ear-marked taxation. The unique characteristics of health care and the pursuit of the policy goals set out in the Commission's report require such a funding policy. We recommend that a national health insurance fund be established on a statutory basis. The fund would be supported by income from the health insurance contributions and by Exchequer funding. The

fund would be managed by the Health Services Executive Authority recommended in Chapter Nine. The Authority would be required to prepare estimates on a realistic basis of the cost of providing core services in accordance with the policy guidelines determined by the Minister for Health, as well as the services additionally provided to medical card holders. The cost of the personal core services provided to non-medical card holders would be funded entirely through the compulsory health insurance contributions. The bulk of the costs, which would relate to medical card holders, would be paid into the fund by the Exchequer. If the level of funding required by the Executive Authority's published estimates was not available, the Minister would issue guidelines on the manner in which the shortfall would be eliminated. The national health insurance system would incorporate the existing health contribution and the treatment benefit element of the present PRSI contribution. In the interests of efficiency and equity, the national health insurance contributions would be collected by the Revenue Commissioners in association with income tax and PRSI.

The Health Contribution

6.86 There is already in existence a form of ear-marked health tax i.e. the Health Contribution, which is collected by the Revenue Commissioners under the PAYE system and separately from the self-employed. The estimated yield from the Health Contribution was £99 million, or 7.5 per cent of Department of Health non-capital expenditure, in 1987. The Health Contribution is not equivalent to a Social Insurance payment, as it is not paid into a separate fund, does not establish an entitlement to benefit[7] and does not seem to be perceived by the taxpayer as in any way distinct from general taxation.

6.87 The deficiencies in the assessment and enforcement of the collection of the Health Contribution from non-PAYE workers were such that the Commission on Taxation[8] recommended that it should be abolished. The Revenue Commissioners informed us that only 23 per cent of all self-employed persons assessed for the Health Contribution in 1985/6 had paid it over twelve months after the ending of the relevant tax year. They stated that the collection of the Health Contribution had failed because, as it represented only a small fraction of the yield from any of the main taxes, the available staff had to be devoted to the collection of the latter instead.

[7]Except to the extent that those in arrears with health contributions are liable to a £150 hospital admission charge.

[8]*First Report of the Commission on Taxation* (Stationery Office, 1982): chapter 22.

6.88 With the introduction in 1988 of a new system of self-assessment for the self-employed in which income tax, PRSI contributions, the Youth Employment Levy and the Health Contribution are now assessed and collected as a single integrated sum, it is expected that there will be a very considerable improvement in the overall collection rate and that this will be reflected in the collection rate of Health Contributions from the self-employed. However, the fact that the Health Contribution is now being collected from the self-employed on this integrated basis underlines the fact that it is really a part of general income taxation in all but name. We feel that nothing worthwhile is achieved by continuing to have such a separate Health Contribution.

6.89 **We agree with the recommendation of the Commission on Taxation that the Health Contribution should be abolished.** Its scale does not justify the additional administrative complexity involved in maintaining a separate identity for what is essentially part of income tax.

Local Taxation

6.90 The shift from local to central taxation in the financing of the health services was described in Chapter Three. The change occurred over time because the increasing cost and extent of services was felt to be placing too heavy a burden on local sources of finance and the standard of services was seen to differ considerably across counties because of differing abilities to finance them.

6.91 It has been argued to us that there is a case for a return to some degree of local funding for health services. It is suggested that, initially, a percentage of local taxation revenue might be allocated, and that, at a later stage, health agencies should be encouraged to develop their own sources of funding. The purpose of local funding would be to enable those services to be developed which were considered most important by the local community.

6.92 We see some difficulties with this proposal. Local responsibility for the "topping-up" of the centrally-funded services could lead to a proliferation of facilities (particularly those perceived as conferring status on the area) in locations where they would not be justified on the basis of objective national planning. The principle of equity in relation to access to services could also be undermined. There is no correlation between differing regional levels of need for services (which may reflect regional differences in age structure and dependency in the proportion of the population covered by Category I and in morbidity patterns) and the differing abilities of regions to

provide these services based on the prosperity of the local economy. More affluent areas would have significantly greater resources available to them. **Consequently, we do not recommend a return to local taxation as a source of funding for the health services.**

USER CHARGES AND COST-SHARING

6.93 The option of user charges or cost-sharing is available within the framework of a taxation-based or insurance-based model. Where a service is supplied directly, or contracted on behalf of the patient, a charge can be levied as a contribution towards the cost. Where the provider's bill is reimbursed to the patient, the equivalent option is that of cost-sharing, whereby the insurer does not provide cover for a certain amount of the expenses incurred. This exclusion may take the form of a "deductible" i.e. the amount of each claim (or of total claims within a set period) below a specified threshold is not covered; or a "co-payment" requiring the insured to pay a certain percentage of the expenses incurred.

6.94 Category I patients in the Irish health services face no user charges of any kind in availing themselves of their entitlements. In-patient accommodation in public wards and out-patient treatment in public hospitals were provided free of charge to the other Categories until 1987, although Category III patients were liable for consultants' fees. A small charge is now made to these groups, but this is effectively a deductible, since it applies only to the first 10 days' hospitalisation in any 12 months, and to the first out-patient visit for any medical condition. Those insured under the Voluntary Health Insurance Scheme face no cost-sharing for in-patient accommodation or treatment, but there is a significant deductible in relation to out-patient expenses, including general practitioner services.[9]

6.95 There are three main arguments in favour of user charges. Firstly, charges can be used as a device to direct people towards the appropriate level of care. For example, a stated objective of the introduction of hospital out-patient charges in Ireland in 1987 was to deter patients from attending hospital casualty departments for free treatment, at relatively high cost, for conditions which could adequately be dealt with by the general practitioner. The efficiency of this deterrent may, however, have been diluted by the availability of insurance cover, without a deductible, for the charge in question.

[9] At present cover is not provided for the first £105 of out-patient expenses per year for an individual or £170 for a family.

Secondly, there is considerable evidence that the demand for health services is affected by price. Where a service is either free or fully covered by insurance, it is argued that patients are more likely to utilise services unnecessarily e.g. for trivial complaints. Thirdly, user charges help to keep down the overall cost of providing a service, or insurance cover, by charging an affordable contribution to those making use of it. This is particularly relevant in the case of institutional long-term care where it is reasonable that those who can afford it should make some contribution to their upkeep. In the case of certain personal social services, such as home helps, the requirement to make a small contribution may be of psychological benefit to the individual.

6.96 There are also a number of arguments against such measures. Firstly, charges which are intended to influence the level of utilisation are of doubtful value when directed at patients, as most decisions on the utilisation of resources are made by doctors. As noted in Appendix 6A, the resource savings in HMOs in the United States were achieved without user charges. Secondly, the effect of deterring patients from early utilisation of services may be to increase the requirement for more expensive care at a later stage. Thirdly, it is argued that the measures are inequitable, since they have the greatest impact on those of limited resources while being, in monetary terms, relatively insignificant to the better-off. Fourthly, it is argued that user charges of a token nature are particularly wasteful of resources because of the amount of administrative expense involved in collecting them.

6.97 In general, **the Commission believes that modest user charges may have a useful role to play in a public funding system provided that they are either regulatory in nature, or serve as a contribution towards certain costs and do not impose hardship on patients.** We do not see them as an efficient means of raising revenue for the health services but, properly used, they can help to direct patients towards the most appropriate level of care and discourage unnecessary usage of services. The detailed application of user charges and cost-sharing devices must be considered separately in the context of each service. This is done in subsequent chapters.

Reservation by Mr. P. Flynn

I am of the opinion that all charges, even those which appear relatively modest, are actually a deterrent to service utilisation and that this effect in turn produces negative results in terms of health status. People who need care may not seek it and suffer further illness as a result. To the

extent that their conditions deteriorate, the cost of treatment to the health system will be higher at a later stage. It would appear that public authorities in most countries have concluded that charges at the point of use have little role to play in encouraging optimum utilisation of health services and expenditure. In fact, it is clear from international research that measures to increase cost-effectiveness have to be applied in the main to the supply side of the system.

CAPITAL EXPENDITURE

6.98 One of the main difficulties in assessing the role of capital expenditure within the Irish public health services is in arriving at a satisfactory definition of what exactly constitutes capital expenditure. Obviously the building of new institutions such as hospitals or the purchase of major items of plant and equipment is normally regarded as capital expenditure. In other areas, however, such as the maintenance of existing buildings and the purchase of smaller items of equipment, the cost is borne out of revenue despite the capital nature of the expenditure. This is compounded by the accounting system employed in the health services generally which does not provide for a statement of assets and liabilities nor for the depreciation of assets or provision for their replacement. In present terms, therefore, capital expenditure has come to mean the building and equipping of health institutions, mainly hospitals.

6.99 Table 6.1 shows the capital expenditure of the Department of Health over the last ten years. There are no estimates available of the level of capital development in the private sector. Most of this capital expenditure has been on the public hospital system — building and equipping new units. It has formed part of the Public Capital Programme and has been funded accordingly. Previously the capital funding of hospitals had received a significant subsidy from the Hospitals Sweepstakes but, with its declining fortunes, this contribution diminished and in the ten-year period covered by Table 6.1 the vast bulk of capital expenditure was funded by Exchequer borrowing. The planning of new hospital developments, together with the control of their design and supervision of their construction, is the responsibility of the Hospital Planning Office of the Department of Health. Because of the nature of hospital development, an interval, often as long as fifteen years, can elapse between the inception of a plan to build a hospital and its final completion.

6.100 Capital developments generally and hospital building in particular have historically tended to have a high political profile in the health services mainly because of the employment they provide and also because they are perceived by local interests as a measure

TABLE 6.1

DEPARTMENT OF HEALTH CAPITAL EXPENDITURE

1980-1989

	£m
1980	35.003
1981	44.501
1982	49.200
1983	53.000
1984	55.500
1985	57.000
1986	58.745
1987	57.615
1988	44.343
1989	39.000

Source: Department of Health

of the success of local politicians in catering for the needs of the community. While this is understandable, the changing nature of medical technology has meant that such hospital developments are now enormously expensive and that the exaggerated role played by the political process in determining the extent and location of such developments can no longer be justified.

6.101 There is a need for a more co-ordinated approach to the development of capital projects in the Irish health services. **We recommend that the Health Services Executive Authority should take a primary role in creating a strategy for capital development in both the short and long terms and that it should therefore produce and publish a forward capital programme which would detail the objectives of this strategy.** There is, furthermore, an urgent necessity to develop techniques to measure the relative cost-effectiveness of capital expenditure policy options. In particular, the revenue costs and savings associated with capital expenditure must be clearly identified and taken into consideration when the benefits of such investment are being assessed. It has been suggested to us that the implementation of some cost saving initiatives is being held up because of restrictions on providing an initial capital outlay. It is clearly essential that this type of inflexibility be removed and that projects which have a capacity to pay for themselves relatively quickly be allowed to proceed. Obviously the major constraint on capital development is government policy on the public finances generally and the Exchequer Borrowing Requirement in particular. However, we envisage that

the new Executive Authority will be able to advise Government on levels of annual capital expenditure in a manner which reflects cost-effective solutions to the problems posed by service needs.

6.102 Capital developments in any area of the health services can be classified as:

— *essential*: those arising from safety requirements or the need to repair or replace seriously dilapidated buildings or other obsolescent facilities immediately in order to preserve the existing level of service;

— *necessary*: those which are required if the thrust of present policy objectives is to continue and expanding service needs fulfilled, given factors such as population growth and an increasing level of technology.

— *desirable*: those which, although important, must occupy a lower level of priority because of the need to concentrate resources in areas where service requirements are greatest i.e. such developments which *improve* the existing service.

6.103 There are major capital consequences contained in the stated public policy of moving from institutional to community-based care. For example, three major areas where this will occur are

— Psychiatric Services;

— Mental Handicap Services; and

— Welfare/Social Services.

Within each of these services differing levels of new community-based facilities will be required in order to give effect to the change to community-based care. These include the provision of hostels and day-care centres. It is essential that the implications for capital expenditure of transferring to community-based facilities be examined thoroughly in the planning process.

6.104 The main source of funding of capital expenditure will continue to be through the Public Capital Programme and Exchequer borrowing. The main advantage of this is that the Public Capital Programme provides the cheapest source of large scale capital funds since the Government can borrow at lower rates of interest than other organisations. There is obviously a dichotomy of interest for the Government here. On one hand, it wishes to provide the cheapest funding for capital projects, while on the other, it is seeking to minimise Exchequer borrowing. The Commission considers, however, that capital projects which are efficiency-generating and have a short

pay-off period should receive priority in the health services area. They should not be deferred by reason of the short-term search for fiscal rectitude while inefficiencies in revenue expenditure are allowed to remain. In this regard, we note that the payment of EC Structural Funds to this country (none of which are applicable for health purposes) will have the effect of lessening demands on the Exchequer for investment in infrastructural development, thus rendering the size of health-related capital expenditure less critical.

6.105 The Commission considers it essential that existing deficiencies in the management of capital assets be remedied immediately. It is important that all assets, whether plant or land, be used to maximum advantage over their lifetime. This function should be clearly identified and responsibility delegated accordingly. Inventories of assets should be properly compiled, together with estimates of realisable market value. Where it is deemed appropriate to dispose of land assets in order to raise capital, due account should be taken of future needs. When established, the executive authority should produce an integrated policy for the management of capital assets. In the meantime, work should commence on establishing inventories, valuations and a move towards a more professional approach to estate management.

6.106 Recent developments in information technology have revolutionised the extent to which financial and activity data can be used as management tools in the health services. We address the role played by such information in chapter Ten. It must be noted here that the expanded role which we envisage in that chapter for management information in the future is largely dependent on the implementation of a major programme of computerisation both at unit level and centrally. There are problems of timescale here. Information systems cannot be imposed on inadequate manual systems. The drawing up of a comprehensive information specification for a given institution could take up to two years. Because of the necessity to tailor this to local requirements, it might not be feasible simply to transfer such a specification to another institution. For this reason, it could take up to five years to put a comprehensive service-wide system in place. Such a timescale is also necessary to allow for the gradual introduction of information technology, the adjustment in attitude of both medical and administrative staff towards these innovations and the implementation of comprehensive training programmes.

Voluntary Fund-Raising

6.107 Voluntary fund-raising has always been of great importance to the health services. Many voluntary organisations have pioneered the provision of services which were later extended and made part of the national health services. Much of the spending of voluntary organisations, especially in the welfare area, is raised in this way, although we are not in a position to estimate the total scale involved. Insofar as this activity derives from the essentially humanitarian nature of the health services, it is very much to be encouraged.

6.108 A possible area of difficulty may arise, however, as the effect of voluntary fund-raising may sometimes be to commit public funds for the future because of the considerable consequent costs. For example, expensive diagnostic equipment may be presented to a local hospital as a result of a fund-raising campaign. This will require considerable funds to operate and maintain it, whereas, on objective criteria, it might not be located in the particular hospital at all. Co-operation is therefore needed between health care professionals, local health services managers and voluntary organisations to try to ensure that voluntary fund-raising activities are directed in the most appropriate way.

6.109 Voluntary fund-raising, despite its importance, is, in effect, a "bonus". It would not be appropriate to make any explicit allowance for it in our consideration of the sources of the funding required for the health services.

The National Lottery

6.110 The National Lottery has also emerged as an important source of funding for the health services. The Commission is conscious of an ongoing debate as to the appropriate allocation of National Lottery funds both as between and within the sectors specified in the relevant legislation, particularly where it can be argued that the funds substitute for existing Government expenditure rather than financing new projects. We note, however, that Lottery tickets are sold on the explicit basis that some of the proceeds will be allocated to Community Health; and we believe that the same objective criteria as to the most appropriate use of resources should apply to all health expenditure, irrespective of the source of funding.

6.111 The Commission believes, however, that continuity of funding is important for the health services in general and that it

would be unwise to rely on sources such as the National Lottery where the funds available from year to year may be unpredictable. Where resources from the Lottery are allocated to the health services they should preferably be used for once-off projects rather than those requiring continuing public support thereafter.

Receipts under EC Regulations

6.112 Receipts under EC Regulations relating to the treatment in Ireland of nationals of other Member States are based on the number of patients involved and average costs as calculated in accordance with the provisions of the regulations, and are thus outside the scope of domestic policy.

Levies on certain products

6.113 It has been suggested to us that specific taxes should be levied on products such as tobacco and alcohol to contribute towards the cost of treating conditions related to their consumption. There are, of course, substantial excise taxes on these products. If it is desired to increase their contribution to tax revenue in general, or to discourage their consumption, the rate of excise tax can be varied. Other products, such as coal and leaded petrol and environmental pollutants can be dealt with by a combination of taxes and regulations. It is difficult to see what benefit would ensue from increasing the administrative complexity of the tax system by introducing a new ear-marked tax.

RECOMMENDATIONS

6.114 In this chapter we have made the following recommendations:

1. The Irish health services should continue to be primarily tax-funded and publicly regulated. This does not rule out a greater contribution from other sources, nor does it rule out the pursuit of efficiency through competition among providers.

2. The lowest income group should remain eligible for all necessary health services free of charge.

3. Non medical card holders should be eligible for a group of publicly-funded core services comprising specified

— acute hospital care;

— long-term care; and

— personal social services.

4. The core service should also include eligibility for welfare and continuing care services, such as those for mothers and children, the elderly, the disabled and the psychiatrically ill, with scope for charges based on income as discussed in Chapters Seventeen to Nineteen. It should also cover those services for which there is universal entitlement at present such as treatment for infectious diseases, certain child health services and rehabilitation services.

5. Modest user charges may have a useful role to play in a public funding system provided that they are regulatory in nature and do not impose hardship on patients.

6. A majority of the Commission recommends that the health services should continue to be funded from general taxation. A minority sees advantages in a system based on an ear-marked tax.

7. We agree with the recommendation of the Commission on Taxation that the Health Contribution should be abolished.

8. We do not recommend a return to local taxation as a source of funding for the health services.

9. The Health Services Executive Authority should take a primary role in creating a strategy for capital development in both the short and long terms and should publish a forward capital programme which would detail the objectives of this strategy.

APPENDIX 6A

A NOTE ON HEALTH MAINTENANCE ORGANISATIONS

1 The Commission received some submissions which suggested that the Health Maintenance Organisation (HMO) concept, which has developed in the United States over the last twenty years, might provide a useful model for application here. While the HMO has emerged in the United States as a response to many of the problems associated with the traditional private insurance model, its key characteristic is one which is already available under the public model i.e. the role of the insurer as the provider or contractor of services.

2 HMOs undertake to provide a comprehensive health care service to their members in return for an annual payment. The HMOs employ their own doctors, or may indeed be owned by groups of doctors. Some of the larger HMOs include a broad range of specialists, and own hospitals. However, any service which the HMO is unable to provide directly is contracted out at no cost to the member. HMOs have grown rapidly in the United States; enrolment grew from under 6 million in 1975 to 19 million in 1985, and it has been suggested that it may reach 50 million by 1990.[1]

3 The major attraction of the HMO is that the individual making a resource-using decision — the physician — is either an owner or an employee of the organisation which bears the resultant cost. Consequently, preventive care is emphasised; medicines, X-rays and tests are not ordered unnecessarily; and, although studies show that patients in these plans have as many, or more visits to the doctor as under traditional models, they typically have less hospitalisation. This has been found to be the principal reason for the savings, which are estimated at 10-40 per cent on traditional models.[2]

4 The HMO developed as a response to the open-ended tendency for cost increases under a system where traditional insurers offered full reimbursement of their members' medical bills, giving neither

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[1] *OECD: Financing and Delivering Health Care* (OECD, 1987): Ch. 9
[2] *idem.*

patient nor provider any incentive to avoid wasteful expenditure. Much of the information on the relative performance of HMOs and conventional insurers is now becoming outdated, and it is reported[3] that there is growing evidence of equally good performances from conventional insurers who have sought to regain their competitiveness by negotiating terms with a limited number of providers and restricting their members' choice to these.

5 Each HMO must have a spread of risk large enough to make the scheme viable; but consumers must have a choice of competing HMOs as a safeguard against inadequate services. Large centres of population are thus essential for the success of the approach, which would, as a result, appear unsuited to Irish conditions.

6 In any case, the potential for imposing efficiency on providers, which the HMO achieves through integrating insurer and provider, and which conventional insurers are now achieving by negotiation, is already available under the public model. In both Ireland and the United Kingdom, for example, the State directly employs most of those providing the services which it funds, and has contractual arrangements with most of the others. Indeed, some commentators have likened the entire UK National Health Service to a large HMO. Efficiencies can thus be imposed on providers, as HMOs have done, without necessarily having competition among funders.

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[3]Petchley, R. (1987) *HMOs: Just what the doctor ordered?* (Journal of Social Policy, Vol. 16, No. 4).

CHAPTER SEVEN

ELIGIBILITY FOR HEALTH SERVICES

INTRODUCTION

7.1 Chapter Six concluded that the health services should continue to be primarily publicly funded and publicly regulated and that questions of funding and eligibility for health services were closely linked. In relation to eligibility, the chapter recommended that

(i) all necessary health services should be available on the basis of need rather than of ability to pay;

(ii) the lowest income group should remain eligible for *all* necessary health services free of charge; and

(iii) the rest of the population should be eligible for a specified group of publicly-funded core services, with scope for modest user charges.

7.2 This chapter examines the present system of eligibility for publicly-funded health services, the criteria which apply and their operation in practice. The Commission's proposals for revised eligibility arrangements are set out in detail. In addition, we discuss certain "discretionary" services which health boards are not statutorily obliged to provide or have flexibility regarding those to whom they should be supplied.

THE PRESENT IRISH ELIGIBILITY STRUCTURE

7.3 Chapter Three described the gradual extension of entitlement to public health services, leading to the present structure of three categories of eligibility.[1] About 37 per cent of the population are in Category I, 48 per cent in Category II and the remaining 15 per cent in Category III.

7.4 Persons in Category I (i.e. medical card holders), referred to in law as having "full eligibility", are defined as

[1]The entitlements of those in each category are summarised in Appendix 7A.

"adult persons unable without undue hardship to arrange general practitioner medical and surgical services for themselves and their dependants"

and the dependants of such persons.[2] A person who is not deemed to require full eligibility for all of the services provided to medical card holders may[3] be given full eligibility for a specific service if this is necessary to avoid undue hardship.

7.5 Information regarding the number, age profile and geographic distribution of the medical card population is contained in Tables 7.1, 7.2 and 7.3 respectively. The marked growth in the proportion of the population covered by medical cards between 1972 and 1974 is believed to have reflected an increased take-up as a result of the introduction of the General Medical Service scheme, rather than any major change in the proportion of the population meeting the eligibility criteria.

7.6 People with full eligibility are charged only for services which fall outside those specified in Appendix 7A, such as private or semi-private hospital accommodation, private consultant services or, in some circumstances, attending a general practitioner other than the one with whom they are registered (or his locum).

7.7 Non-medical card holders whose gross annual income in the preceding tax year was below a specified threshold[4] have Category II eligibility. Certain former Social Welfare voluntary contributors also qualify for Category II, although their income may be above the threshold. Other persons whose incomes exceed the threshold have Category III eligibility.

7.8 These three categories govern entitlement to most public health services. However, access to certain services such as community nursing, social work services, home helps and meals on wheels is not determined by eligibility category alone. The level of service provided and the guidelines for access may differ from health board to health board, and field workers have a role in assessing the need for services in each individual case and what charges, if any, should apply.

7.9 There are two exceptions to the general provisions governing eligibility for health services. These involve services required as a

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[2]Health Act, 1970, section 45(1).

[3]Health Act, 1970, section 45(7).

[4]For example, those who earned less than £16,000 in the 1988-9 tax year are entitled to Category II status for 1989-90.

result of injuries received in road traffic accidents where compensation will be payable to the injured party, and services required by nationals of non-member states of the EC. These exceptions are discussed in more detail later in the chapter.

7.10 A person's eligibility for Category II, and that of his or her dependants, is determined solely on the basis of gross income in the previous tax-year. The Minister for Health lays down by regulation[5] an income level above which persons are liable for consultants' and maternity fees, i.e. have Category III eligibility. The limit, currently £16,000, is revised annually so that approximately 15 per cent of the population will be in Category III. Family members with separate incomes are assessed separately. For example, a wife without independent income has the same category as her husband; if she has income, her category is assessed accordingly. Children without independent income are in Category III if either parent exceeds the income threshold. No account is taken of differing circumstances, such as family size or exceptional costs, unlike the means-testing system for Category I.

TABLE 7.1

MEDICAL CARD POPULATION (INCLUDING DEPENDANTS), 1972-1987

	Number in Category I	As a % of Total Population
1972	864,106	29.00
1973	1,010,090	33.92
1974	1,083,136	36.37
1975	1,162,386	37.17
1976	1,193,090	37.75
1977	1,233,150	38.63
1978	1,219,178	37.86
1979	1,224,351	36.39
1980	1,199,599	35.62
1981	1,226,568	35.65
1982	1,280,758	37.13
1983	1,343,618	38.30
1984	1,299,165	37.03
1985	1,303,273	36.84
1986	1,323,035	37.40
1987	1,342,233	37.88

Source: GMS (Payments) Board Reports.

[5]Health Services (No. 2) Regulations, 1983 (S.I. No. 139 of 1983), as amended each year. The limit relates to income earned in the previous tax year, ending on 5 April.

TABLE 7.2

AGE PROFILE OF MEDICAL CARD POPULATION AVAILING OF SERVICES, SELECTED YEARS

Age	1982 %	1984 %	1986 %	1987 %
0 — 4	7.55	7.05	7.23	7.97
5 — 15	18.43	18.48	20.32	19.32
16 — 21	13.05	14.78	10.34	8.34
22 — 44	16.16	20.05	21.74	22.24
45 — 64	15.10	13.75	14.48	16.15
65 — 74	14.18	11.71	11.92	13.12
75 +	11.78	12.14	13.12	11.84
Unknown	3.75	2.04	0.85	1.02
	100.0	100.0	100.0	100.0

Source: GMS (Payments) Board Reports.

TABLE 7.3

PROPORTION OF POPULATION COVERED BY MEDICAL CARDS, SELECTED YEARS

Health Board	1973 %	1980 %	1983 %	1986 %	1987 %
Eastern	20.71	22.00	27.27	29.01	31.16
Midland	41.31	44.40	46.68	41.82	40.67
Mid Western	33.61	37.18	34.96	33.88	34.58
North Eastern	37.30	40.28	43.63	42.96	44.58
North Western	48.80	60.31	59.76	51.44	50.89
South Eastern	38.23	42.45	45.30	43.29	40.93
Southern	35.81	31.93	37.96	37.08	37.27
Western	52.87	55.53	57.48	48.27	47.49
TOTAL	33.92	35.62	38.30	37.40	37.88

Source: Derived from GMS (Payments) Board Report (1973) based on Census of Population 1971; GMS (Payments) Board Reports 1980; 1983; 1986 and 1987.

TABLE 7.4

MEDICAL CARD GUIDELINES: ALLOWABLE WEEKLY INCOME, 1989

	Single Person, Living Alone	Single Person, Living with Family	Married Couple
Age	£	£	£
Under 66	72.00	62.00	103.50
66–79	77.50	67.00	115.00
80 and over	81.00	70.00	121.00

	£
Allowance per child under 16	12.00
Allowance for other dependants	13.50
Outgoings on house in excess of	12.00
Reasonable expenses necessarily incurred in travelling to work, in excess of	10.50

NOTE: THESE AMOUNTS ARE GUIDELINES ONLY AND ARE NOT LEGALLY BINDING (SEE TEXT)

Source: Department of Health

INADEQUACIES IN THE PRESENT ELIGIBILITY SYSTEM

7.11 The present eligibility structure, based on three categories, has been in place since 1979. Its advantage in determining Category II or Category III eligibility lies in its simplicity. The income limit is published annually and eligibility for Category II can be established without any formal assessment procedure, by producing as evidence of income the PRSI Form P60, or the Revenue Commissioners' Notice of Assessment.

7.12 As a result of the simplicity of this assessment system, however, certain anomalies are inevitable:

(i) provided that no family member exceeds the income limit, the entire family has Category II eligibility. Thus, in 1989-90, when the income limit is £16,000, a family with a total income of £31,000 comprising two salaries of £15,500 each is in Category II, whereas a family with a single income marginally above £16,000 is in Category III;

(ii) a spouse taking up employment, and thus increasing family income, can actually move from Category III to Category II. This occurs when the spouse of a person in Category III, who,

as a dependant, would also have been in Category III, takes up employment at an income below the limit, and is thus separately assessed as eligible for Category II;

(iii) a single person earning £15,500 is in Category II while a large family with a single income of £16,500 is in Category III.

7.13 These anomalies have led to a number of proposals that assessment of eligibility for Category II should be based upon total family income, with due allowance made for family size.[6] It would, for example, be possible to have separate income limits for single persons and married couples, with additional allowances for dependants. However, this would greatly increase the complexity of the system. Evidence of income such as the Form P60 could no longer be accepted to establish eligibility at the point of use of services, since it would give no indication of family income or family size. It would instead be necessary to issue annual certification in respect of all those entitled to Category II status (approximately half the population) based on applications which documented family income and size and which were subject to verification on a sample basis.

REVISED STRUCTURE OF ELIGIBILITY

7.14 Persons in Category III are at present eligible for all hospital services except consultant services, which they must provide for themselves. In practice, the vast majority of people in Category III insure themselves with the Voluntary Health Insurance Board against this liability. However, fee cover by the VHI is finite and recent increases in consultant fees in certain specialties have highlighted the fact that persons in Category III may find themselves in some cases liable for a substantial shortfall. The Commission considers that it is, in principle, undesirable that a person availing himself of an entitlement to *public services* should also be made liable for fee charges over which the State has no control. Furthermore, while persons in Category III may at present be able to obtain community-rated health insurance at a reasonable price, there is no guarantee that this will be the case in the future. Certain patients could then be left without either public entitlement or private insurance cover for consultant services.

7.15 It has also been pointed out to the Commission that a person in Category III, who is necessarily the private patient of a consultant,

[6]For example, see Tussing: *op cit*: p. 269; and National Planning Board: *Proposals for Plan 1984-1987* (Stationery Office, 1984) p. 315

or other private patient may, in availing himself of his right to non-consultant public hospital services, be admitted to a public bed earlier than a public patient with a similar condition. The Commission is not in a position to assess the extent of this practice but feels that it is one which should be addressed. The existence of Category III in effect institutionalises unequal access to public hospitals by requiring persons in this category to obtain private consultant services. The Commission feels that there is no valid reason why all who contribute to the public funding of health services should not be entitled to receive those services on the same basis.

7.16 Having taken account of these factors and the serious anomalies in assessment described earlier, **the Commission recommends that Category III should be abolished and that the eligibility structure for publicly-funded health services should consist of two categories: Category I for the lowest income group and Category II for the rest of the population.**

7.17 Unlike the situation obtaining under the present system of eligibility, however, **the Commission believes that patients using publicly funded medical services should be required to make an explicit choice between public and private care; they should not be able to combine the two forms of care** (for example, linking private consultant treatment with public ward accommodation). Chapter Twelve deals with the issue of consultant private practice in public hospitals.

7.18 This approach would offer a number of advantages. Firstly, it would distinguish clearly between public and private acute hospital care, requiring private patients to meet the full cost of treatment. At present, it is possible to benefit from public hospital facilities as the private patient of a consultant in public accommodation paying only the £10 daily charge (or no charge in the case of medical card holders) plus consultants' fees but receiving what is perceived as preferential treatment.

7.19 The second advantage of this system is that, since eligibility would be confined to two categories — those with medical cards and the remainder of the population with entitlement to a "core service" — the anomalies outlined earlier in the assessment for the existing Categories II and III would be eliminated. So too would the difficulty of devising a more equitable yet simple procedure for determining eligibility for Category III.

7.20 A third related advantage is that public hospitals could compete on the basis of price and quality of service for private

patients and the benefits of this competition would serve to improve the cost-effectiveness of the public service. Any danger of preferential access for patients in private accommodation would be counteracted by a common admissions policy for public and private patients in public hospitals and by the public funding system, which would relate each hospital's allocation to the level of service provided to public patients and ensure that sufficient resources were allocated to provide the appropriate services. Hospitals would therefore have to determine an appropriate mix between their complement of public and private beds. These issues are discussed in greater detail in Chapter Twelve.

THE SERVICES TO BE MADE AVAILABLE

7.21 Chapter Six recommended that all necessary health services be provided free of charge to those in the lowest income group, Category I. It also recommended that certain Core Services be made available for all of the population. In addition to these Core Services, there are other necessary services (mainly general practitioner and routine dental, ophthalmic and aural services) which do not involve major expense and which we envisage the majority of the population would continue to provide for themselves. These other necessary services would, however, be provided free for those in Category I as Additional Services extra to their entitlement to the universally available Core Services. While modest charges might be levied for Core Services on those outside Category I, those inside it would pay no charges. This two-tier system of eligibility which we are recommending, Core Services for Category II with Core and Additional Services for Category I, achieves the objectives we set ourselves in Chapter Six while at the same time removing the anomalies inherent in the present system.

Core Services

7.22 The decisions about what constitutes a Core Service and what constitutes an Additional Service are ultimately political ones to be made by government in the light of the dynamic interaction of population needs and available resources. At the present time we believe that the services provided to those in Category II adequately represent what we envisage in Core Services. These are

— In-patient hospital services (including acute, psychiatric and long-term care)

— Out-patient hospital clinic services, except routine dental, ophthalmic and aural services

— Subsidy of high or long-term drugs expenditure in accordance with the Commission's proposed integrated scheme (see Chapter Fifteen)

— Maternity care and infant welfare service

— Treatment of infectious diseases

— Child health examinations

— Services for children with long-term diseases and disabilities (such as mental handicap)

— Cervical smear screening

— Rehabilitation services for physically and mentally handicapped.

Additional Services

7.23 As well as being entitled to free Core Services, those in Category I would be entitled to free Additional Services. These would maintain the existing level of Category I entitlements. The Additional Services would be:

— General Practitioner Service

— Free drugs in accordance with Commission's proposed integrated scheme

— Dental, Ophthalmic and Aural services, including supply of appliances and hospital out-patient treatment

— Maternity cash grant.

In addition, we discuss in Chapters Fourteen, Seventeen, Eighteen and Nineteen a range of community-based services such as home nursing, paramedical services and personal social services which should be available to all who need them, on the criteria set out in those chapters. The scope for charges for each service is also discussed in the relevant chapters.

ASSESSING ELIGIBILITY FOR MEDICAL CARDS

7.24 The sections that follow examine issues relating to eligibility for health services, including assessment procedures, eligibility in specified circumstances and entitlements to discretionary services.

7.25 Applicants for medical cards are at present assessed by health boards on the basis of a means test carried out by community welfare officers. The means test takes account of actual income, number of dependants, household expenses and certain travel costs.

Factors not related to income, such as chronic illness, may also be considered, and a chief executive officer may grant a medical card to a person who would not qualify on means grounds.

7.26 The chief executive officers of the health boards agree income guidelines for assessing eligibility for Category I and these are updated periodically. They are informal and have no statutory force. The guidelines with effect from 1 January, 1989 are detailed in Table 7.4.

7.27 **The system for determining eligibility for medical cards should, to the greatest extent possible,**

- **— ensure that those in genuine need of medical cards receive them;**
- **— avoid awarding medical cards to those who are not in genuine need of them;**
- **— operate on the basis of broadly uniform criteria so that people in similar circumstances but living in different areas are treated in the same way.**

7.28 These requirements are important, not only in the interests of the equity and efficiency of the health service, but also because the medical card is a passport to other benefits. For example, neither the Youth Employment Levy nor the Health Contribution, totalling 2.25 per cent of gross income, are payable by employees holding medical cards — they must be paid instead by their employers — and families with medical cards are not required to pay for their children's school transport.

7.29 Before the establishment of the health boards, each county manager determined the eligibility criteria for medical cards in his area, and there was consequently a great deal of variation in the income limits applied. These converged to a considerable extent following the introduction of health boards in 1971, and guidelines for application in all areas came into force at the start of 1974. Since then, annual increases have been agreed by the Chief Executive Officers. The guidelines have thus evolved over a long period from the judgement of managers as to the income levels below which an individual could not be expected to provide medical services for himself or his dependants.

7.30 The income guidelines are not binding. Medical cards may be awarded to those exceeding the guidelines if they would not otherwise be able to meet their medical expenses and may be refused to those

with income below the guidelines who are considered to have adequate other means of providing for their own medical care. It has been suggested[7] that those below the limits should have a legal entitlement to full eligibility. However, this could result in the awarding of medical cards to those who, because of other circumstances, were not in genuine need of them. We have no evidence that medical cards have been refused under the present arrangements to persons below the income guidelines who were in genuine need of free medical care.

7.31 It would also be undesirable to remove the discretionary power of Chief Executive Officers (or Area General Managers in our proposed management structure) to award either medical cards or eligibility for specific free services in cases where the income guidelines are exceeded. This provision avoids "poverty traps" whereby a small increase in gross income could take an individual over the guidelines and worsen his net financial position as a result of the withdrawal of the medical card. It is also particularly important in cases where individuals are subject to high medical expenses which they would not be able to meet without undue hardship.

7.32 Because of these discretionary aspects, **the system of assessment for Category I eligibility should be subject to regular review to ensure that it operates in a similar fashion in different areas and that it is efficient in terms of awarding medical cards only to those who need them.** Such a review was carried out in 1983 by a working group representing the Department of Health and the health boards, which prepared a standard set of procedures for assessing and reviewing eligibility.[8]

7.33 During the course of our work the Economic and Social Research Institute was engaged in a large-scale national sample survey of income distribution and the usage of state services. Data collected in the course of this survey would enable a detailed analysis to be carried out of the income distribution of those with medical cards, and of factors indicating their need for free medical care where income guidelines were exceeded, such as chronic illness or heavy utilisation of health services. **We recommend that such an analysis should be carried out as a starting-point for a further review of the operation of the assessment procedures**

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[7]For example, in A. Dale Tussing: *Irish Medical Care Resources: An Economic Analysis* (Economic and Social Research Institute, 1985): p. 269.

[8]Department of Health: *Report on Standard Procedures for Medical Cards* (October 1983, unpublished).

and the need, if any, for improvements to ensure equity and efficiency in the awarding of Category I eligibility.

ELIGIBILITY IN SPECIAL CIRCUMSTANCES

Eligibility of Accident Victims

7.34 Road traffic accident victims who are entitled to receive damages or compensation for injuries arising from negligent driving are not eligible for public hospital services in the normal way. Under the Health (Amendment) Act, 1986 health boards[9] can charge for in-patient and out-patient services in such cases. Similar provisions have existed since 1933. The 1986 Act arose from a 1983 Supreme Court ruling that the provision then existing — the Health Services Regulations, 1971, article 6(3) — was ultra vires the Health Act, 1970.

7.35 The relevant legislation does not specify the charges payable but, in proposing it, the Minister for Health stated[10] that they would normally be the average daily cost per bed in the hospital concerned. The Minister estimated potential annual income from these charges to be £4 million at 1986 prices. The charges are determined as they arise but are payable only when compensation is awarded. If compensation is not awarded, the charges are waived; there is also provision for partial waiving of charges if a compensation award has been reduced due to contributory negligence or if the amount of damages paid would be insufficient to meet the charges.

7.36 These provisions are based on the principle that costs which arise as a result of negligent driving should be met by drivers rather than by taxpayers in general. To avoid causing hardship to any individual victim, the charges are payable only when compensation, which would take liability for charges into account, has been paid. Consequently, as drivers are legally obliged to have adequate insurance cover to compensate third parties injured as a result of their negligence, the provisions are in effect a levy on drivers in general through their motor insurance premia.

7.37 The present arrangements require health boards to pursue accident victims to settle their accounts when compensation is eventually paid. Furthermore, the arrangements only go part of the way towards satisfying the principle that taxpayers in general should

[9]Where services have been provided by a voluntary hospital, the relevant health board levies the charges on its behalf.

[10]*Senate Debates*: 23 April, 1986, col. 191-2.

not have to bear the costs of negligent driving, since charges are not payable if the accident victim does not receive compensation. This may be the case, for instance, if a victim's injuries were caused by his own negligent driving. It might also be considered anomalous that charges are levied on victims of motor accidents but not on victims of other forms of accident, such as in the workplace, where damages or compensation may also arise.

7.38 **We recommend that, in any case where damages are awarded arising out of accidental injuries (whether motor, industrial or other accident), the Court should take account of those costs which have fallen upon the public health services and should be empowered to award an appropriate share of the damages directly to the services concerned.**

Eligibility of Certain Foreign Nationals

7.39 Eligibility for health services is determined in the first instance by residence. Visitors to Ireland from other EC member states are treated for emergency procedures without charge, and those taking up residence here are granted Category I, II or III eligibility on the same basis as Irish citizens.[11] However, visitors from countries outside the EC have no entitlement to emergency services and may be charged for any treatment provided. Those deemed by the relevant health board to have made Ireland their normal place of residence are granted Category I, II or III eligibility as appropriate.

7.40 There are no statutory or uniform criteria for determining whether an individual is "normally resident" here. This may give rise to uncertainty, and to the application of different criteria by various health boards. **We recommend that a minimum period of residence should be specified as determining eligibility for services in the case of non-EC nationals.**

DISCRETIONARY SERVICES

7.41 The structure of eligibility and charges for most of the major health services are clearly specified in the Health Act, 1970 or under Ministerial Regulations made on foot of it. However, health boards have considerable discretion about some services, concerning whether and to whom they should be provided and what charges, if any, should apply. Some illustrations of these discretionary services are:

[11]In addition, recipients of social security pensions from other EC member states are automatically entitled to Category I eligibility.

— Section 61 of the Health Act, 1970, empowers but does not oblige health boards to provide services such as home helps, which would assist in the maintenance of a sick or infirm person at home. The Chief Executive Officer is given discretion to determine what charge, if any, should apply. The variability in the provision of such services is discussed in Chapter Seventeen.

— Community paramedical services, day care centres and meals on wheels are not specifically mentioned in the legislation, although they could be considered to come under the terms of section 61 inasmuch as they assist in the maintenance of a sick or infirm person in the home. In any event, health boards are not obliged to ensure their availability to any categories of patient and there are no guidelines as to charges. Again, the variations in access to services are described in later chapters.

— Section 57 of the Health Act, 1970 empowers but does not oblige health boards to provide ambulance services and gives discretion to the Chief Executive Officer as to whether a charge should be levied. In practice, all health boards provide an ambulance service. Charges, when levied, are on a uniform national scale, but there is considerable variation between health boards as to which categories of patient are required to pay.

— Certain services are discretionary in practice because resources do not permit the health boards to provide them to all those who are entitled to receive them under the terms of the legislation. This problem is particularly marked in the case of the dental services.

7.42 The absence of uniform eligibility criteria results in access to certain services being determined by the patient's good or bad fortune in relation to where he happens to live, or, in the words of the National Economic and Social Council,[12] by "rules of thumb" such as the concentration of home help services on the elderly. The eligibility pattern also inherently contradicts the stated objective of encouraging care in the community rather than in institutions where this is appropriate, since health boards are *obliged* to provide institutional care while the *discretionary* services are, by and large, those which would reduce the need for such care. The present position is thus neither equitable nor efficient.

7.43 Some element of discretion regarding the application of charges for services is clearly desirable to avoid hardship in specific

[12]National Economic and Social Council: *Community Care Services: An Overview* (NESC No. 84, October 1987): Council's Comments: p. 8.

cases. However, it is difficult to justify the lack of uniformity in relation to levels of charges and the categories of patient to which they should apply. Again, it is inequitable because similar patients in different localities are treated differently. It may also be inefficient in that it may imply that services are being provided free of charge to certain patients who would be able and willing to contribute towards their cost.

7.44 **The Commission recommends that the eligibility criteria for all services should be the same for all areas and applied in a uniform manner**. This is an essential element of the general approach to the administration of the health services which we discuss in Chapter Nine, under which the role of local health service managers is to ensure that the nationally-determined service requirements are met as comprehensively and as efficiently as possible. **The criteria for making charges, and the levels of charge, should also be uniform**. The specification of criteria and charges in Ministerial Regulations, which could be amended regularly as required, would provide flexibility to take account of developments in modes of service delivery and of variations in resource constraints from time to time.

7.45 Many factors are relevant in deciding what form of care is appropriate in any particular case. For example, in deciding whether a patient can continue to be cared for at home or requires admission to residential care, the professionals concerned will have to take account not alone of the extent of the illness or disability, but also of the degree of dependency of the patient and also of social factors such as the suitability of the patient's home and the ability of family or other carers to cope. **Within the system of uniform eligibility criteria, scope must remain for the exercise of discretion by fieldworkers to take account of factors peculiar to the individual case. Guidelines should be specified to assist in decisions where it is necessary to depart from the formal criteria.**

7.46 The implementation of formal eligibility criteria, as proposed, would give many patients a legal entitlement to certain services where none exists at present, and this could give rise to increased expenditure on those services. However, such expenditure must be seen in the context of the scope for savings in institutional care as a result of better support services in the community and the scope for partial financing of the services through the payment of charges by some categories of patient.

RECOMMENDATIONS

7.47 In this chapter we have made the following recommendations:

1. In keeping with the earlier recommendation that non-medical card holders should have entitlement to a core publicly funded health service, the present Category III should be abolished. The eligibility structure for the health services should consist of two categories: Category I for the lowest income group and Category II for the rest of the population.

2. Under the new eligibility structure, patients should be required to opt specifically for either public or private care and should not be permitted to combine them. Those choosing private treatment should bear the full cost.

3. The system for determining eligibility for medical cards should, to the greatest extent possible,

— ensure that those in genuine need of medical cards receive them;

— avoid awarding medical cards to those who are not in genuine need of them;

— operate on the basis of broadly uniform criteria so that people in similar circumstances but living in different areas are treated in the same way.

4. A detailed analysis should be carried out of the income distribution of medical card holders and of factors indicating their need for medical cards where the income guidelines are exceeded. This analysis should serve as a starting-point for a further review of the operation of assessment procedures and the need, if any, for improvements to ensure equity and efficiency in the awarding of Category I eligibility.

5. In any case where damages are awarded arising out of accidental injuries (whether motor, industrial or other accident), the Court should take account of those costs which have fallen upon the public health services and should be empowered to award an appropriate share of the damages directly to the services concerned.

6. A minimum period of residence should be specified as determining eligibility for services in the case of non-EC nationals.

7. Eligibility criteria for all services, including discretionary ones, should be the same for all areas and applied in a uniform manner. However, scope must remain for the exercise of discretion by fieldworkers to take account of factors peculiar to the individual

case. Guidelines should be specified to assist in decisions where it is necessary to depart from the formal criteria.

8. The criteria for making charges for discretionary services, and the levels of charge, should be uniform throughout the country.

APPENDIX 7A

THE EXISTING ENTITLEMENTS OF EACH ELIGIBILITY CATEGORY

CATEGORY I

Persons in Category I are entitled to a full range of public health services without charge:

— General practitioner services

— All in-patient hospital services in public wards;

— Specialist services in out-patient clinics;

— Prescribed drugs, medicines and medical and surgical appliances;

— Dental, ophthalmic and aural services, including the supply of prescribed dental, optical and aural appliances;

— Maternity care and infant welfare services; and

— Maternity cash grant.

CATEGORY II

Persons in Category II are entitled to:

— All in-patient hospital services in public wards, at a daily charge of £10, subject to certain exclusions and limits;

— Specialist services in out-patient clinics, excluding dental, ophthalmic and aural services. There is a charge of £10 for the first visit in respect of any specific condition, subject to certain exclusions and limits;

— Refund of expenditure in excess of £28 per month on drugs prescribed for use within the month for adults and their dependants;

— Prescribed drugs and other requisites for certain long-term illnesses, as discussed in Chapter Fifteen; and

— Maternity care and infant welfare service, including ante-natal family doctor services, and post-natal family doctor services for mother and child for the first six weeks after the birth.

CATEGORY III

Persons in Category III are eligible for services on the same basis as those in Category II, except that they are liable for hospital consultants' fees and are not entitled to the maternity care and infant welfare service.

UNIVERSAL ENTITLEMENTS

Certain services are available free of charge to all, irrespective of eligibility category. These include:

— Treatment for infectious diseases, including immunisation, diagnostic and hospital services;

— Certain child health services, including health examinations at national schools, and at clinics for children up to six years; specialist services for defects diagnosed at such examinations; and all hospital treatment in respect of dental, ophthalmic and aural conditions diagnosed at the examinations above;

— In-patient and out-patient services for children up to the age of sixteen years with specified long-term diseases and disabilities;

— Cervical smear screening (free to all women at health centres; free to medical card holders when attending their general practitioner); and

— Rehabilitation services, including vocational assessment and training for physically and mentally handicapped persons.

CHAPTER EIGHT

THE COMPLEMENTARY ROLES OF THE PUBLIC AND PRIVATE SECTORS

INTRODUCTION

8.1 The Commission has concluded that the Irish health services should be funded primarily from general taxation. However, it has been emphasised that this conclusion does not rule out a significant role for the private sector in both the funding and delivery of healthcare. The Commission's proposals regarding eligibility would guarantee a level of publicly-funded core services to all, in addition to which the lowest income group would be entitled to a free General Practitioner service. Hospital patients would have to make a choice between public and private care, and could not combine the two. These recommendations imply an important role for the private sector.

8.2 There has been considerable debate, in Ireland as in other countries, on the appropriate public/private mix in healthcare and on whether the two sectors can play complementary roles or must inevitably come into conflict. In Ireland, private insurance and private providers of services are integral parts of the healthcare system, with a close, complementary relationship with the public sector. Many people choose to supplement their statutory entitlements to health services by taking out voluntary insurance cover. The State pays a significant part of the cost through tax relief, while much of the income of the voluntary insurance scheme is, in turn, spent on the services of public hospitals. The State also pays private providers, such as general practitioners and pharmacists, for their services to certain categories of patient.

8.3 This chapter describes the present extent and nature of private *funding* for healthcare in Ireland, and examines how private insurance might best complement public funding. The chapter also briefly considers the role of the private sector in the *delivery* of services, an issue which is discussed in detail in the later chapters on the individual services.

8.4 It should be stated at the outset of this chapter that we envisage a continuation of the present system of allowing private practice in publicly-funded hospitals. The rationale for this is presented in Chapter Thirteen, which discusses consultant services. The problems which arise from the public/private mix in the acute hospital sector in relation to equity of access are discussed in Chapter Twelve together with our recommendations to improve the present situation.

PRIVATE FUNDING — THE PRESENT POSITION

8.5 The development of the structure of eligibility for the various health services was described in paragraphs 3.13 — 3.16. At present, all persons, other than medical card holders and their dependants, are liable to a range of charges, including

— all general practitioners' fees;

— the cost of drugs, subject to the assistance available under the Drugs Refund Scheme and the Long-Term Illness Scheme (see Chapter Fifteen);

— the fees of dentists, opticians and others except to the extent that the patient has cover under the PRSI Treatment Benefits Scheme (see Chapter Fourteen); and

— a charge of £10 for each day's maintenance in a public hospital, or out-patient visit, subject to a number of exclusions and limits.

8.6 In addition, patients in any category of eligibility can incur expenditure by opting for private or semi-private accommodation in a public hospital, attending a private hospital or choosing to become the private patient of a doctor, dentist or other healthcare professional.

8.7 Table 8.1. is based on the Commission's estimates of overall health expenditure, which are set out and discussed in detail in Chapter Four. The margin of error in the estimates, other than for VHI expenditure, may be significant. Nonetheless, it is clear that the relative importance of private expenditure fell significantly during the period of expansion of eligibility for public health services in the 1970s, but some reversal of this pattern is evident in more recent years.

The Voluntary Health Insurance Board

8.8 The Voluntary Health Insurance Board (VHI) is a state-sponsored corporation established under the Voluntary Health Insurance Act, 1957. It was set up at a time when about 15 per cent of the population were not entitled to free public hospital services

because of an income limit to eligibility. The primary purpose of VHI was therefore to provide cover for hospital charges to those groups liable to pay them. A secondary purpose was to enable any person who wished to avail himself of private healthcare to obtain insurance cover against its cost.

TABLE 8.1.

ESTIMATED PRIVATE HEALTH EXPENDITURE (£m)

	1960	1970	1975	1980	1983	1986	1987
VHI expenditure	0.3	2.8	8.7	30.9	81.3	117.4	150.1
Other non-household private expenditure	0.1	0.3	1.0	2.9	4.3	5.0	5.0
Household expenditure[1]	10.1	25.6	34.4	79.7	142.9	175.4	224.7
Gross private expenditure	10.5	28.7	44.1	113.5	228.5	297.8	379.8
Less Tax Relief	n.a.	n.a.	n.a.	6.5	20.3	39.1	43.8
Net private expenditure				107.0	208.2	258.7	336.0
As percentage of GNP							
Private Expenditure[2]	1.6	1.7	1.2	1.3	1.7	1.8	2.1
Public Expenditure	3.2	4.7	6.7	8.3	8.3	8.1	7.4

Note: [1] Net of health insurance or drug subsidy refunds.
[2] Before Tax Relief

Source: Derived from Tables 4.1, 4.2 and 4.3. See detailed explanation in paragraphs 4.9-4.14.

TABLE 8.2.

VHI MEMBERSHIP, SELECTED YEARS
(Figures relate to year ending February)

Year	Membership	Year	Membership
1972	478,382	1982	995,284
1975	524,525	1983	1,013,745
1978	645,165	1984	1,028,194
1979	697,346	1985	1,033,261
1980	843,309	1986	1,032,709
1981	935,804	1987	1,037,480
		1988	1,078,423*

*In addition, two new low-cost schemes covering charges in public wards and out-patient clinics only, had a total membership of 131,459.

Source: VHI Annual Reports

8.9 It is clear, however, that the provision of cover for private healthcare has now become the main function of VHI. Despite the introduction of universal eligibility for public hospital services in 1979, VHI membership continued to grow, as shown in Table 8.2. Furthermore, although Category III patients remained liable for consultants' fees under the new eligibility structure, a VHI Plan which provides relatively inexpensive cover against this liability alone has attracted few members in comparison to the Plans which include cover for semi-private and private accommodation in public and private hospitals.

8.10 Appendix 8A summarises the range of Plans offered by the VHI to its members.

Other non-household expenditure

8.11 As explained in Chapter Four, estimates of private expenditure other than through the VHI are quite tentative. The estimates in Table 8.1 for "other non-household private expenditure" are based on extrapolations of data compiled by Tussing for 1980.[1] They include expenditure under other health insurance schemes, and by employers who provide or finance their staff's medical care.

8.12 Under the terms of the Voluntary Health Insurance Act, 1957 it is illegal to offer health insurance without a licence from the Minister for Health. There are fourteen licenced health insurance schemes, other than VHI, in operation; with one minor exception, these are all "in-house" schemes which provide cover for a workplace or union membership and their dependants. The total membership of such schemes is understood to be about 50,000, the majority of whom are members of the ESB Staff Medical Provident Fund. Tax relief is available on premia.

8.13 In recent years Hospital Income Plans, or "Cash Benefit Plans", have been offered in the Irish market. These schemes developed in the United Kingdom as a response to the risk of loss of income during hospitalisation. They are characterised by low premia and, consequently, relatively poor ratios of benefits to premium because of administrative and marketing overheads. A recent study[2] estimated that in 1987 total premia in the U.K.

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[1]A. Dale Tussing: *Irish Medical Care Resources: An Economic Analysis* (ESRI, 1985): Chapter 5.

[2]George C. Orros: *The Potential Role of Private Health Insurance* (Institute of Health Services Management, April 1988): page 17.

amounted to £45 million, at an average premium of £50 per policy, while total claims amounted to £20 million. The study concluded that the demand for such cover in the U.K. was at best static and probably falling as a result of increasing affluence. Data are not available on the penetration of these schemes in the Irish market. As they do not purport to cover hospital maintenance or treatment costs, they are not regarded as coming within the scope of the Voluntary Health Insurance Act 1957, and tax relief is not available on premia.

Household expenditure

8.14 There is considerable private expenditure over and above that covered by health insurance. This includes expenditure on services outside the scope of insurance cover; expenditure below the threshold for cover or in excess of the cover provided; and expenditure by those without any cover.

8.15 The estimates for household expenditure in Table 8.1. are derived from Central Statistics Office extrapolations of Household Budget Survey data, adjusted to omit all refunds from health boards or health insurance. These estimates may be subject to a high margin of error.

THE ROLE OF PRIVATE INSURANCE

8.16 There is a widely-held perception that the role of private insurance is partly to ensure access, for those in a position to pay for it, to necessary treatment which would otherwise be available only after a very long waiting-period, if at all. Chapter Five discussed the criteria for evaluating the health services. It was argued that the criterion of equity requires that the access of patients to necessary services should be determined on the basis of need rather than ability to pay. The satisfaction of this criterion means not just that patients should have formal *entitlement* to the services but that the services should, in fact, be *available* in order to meet these entitlements. Arising from this requirement, our discussion of the various services throughout this report takes account of two important principles:

(i) services which have been evaluated as appropriate for provision within a comprehensive and cost-effective health service should be available within a reasonable period of time to all those assessed as in need of them;

(ii) while certain income groups may have to pay regulatory-type charges for such services, or may have to make their own

arrangements (such as for GP services), the costs should not be such as to prevent anyone in need of services from obtaining them.

8.17 **It follows from these principles that it should not be necessary, nor should it be perceived as such, to take out private insurance in order to secure access to necessary treatment.**

8.18 **The role of private insurance should therefore be**

(i) **to provide cover for those who wish to avail themselves of private healthcare; and**

(ii) **to provide cover for the costs for which certain income-groups are liable.** We have argued, however, that any charges for Core Services should not be so high as to make insurance against them inevitable.

8.19 Individuals may wish to avail themselves of private care for reasons of comfort or convenience, and for a greater choice of services. They may also wish to obtain treatment which is not available under the public health services, or to obtain necessary treatment more quickly. These latter aspects require some examination in the context of the criterion of equity.

8.20 It was argued in Chapter Five that choices must be made on the basis of objective criteria regarding the range of public health services to be provided so as to secure the greatest benefit from the available resources. It is therefore inevitable that certain treatments which are unavailable in the public sector will be available to those prepared to pay for them in the private sector. This could only be otherwise if the public sector were to offer an unlimited range of treatment, regardless of cost-effectiveness (which is clearly neither feasible nor desirable), or if the private sector were prohibited from offering treatment which was not available to public patients.

8.21 The Commission has argued in Chapter Five that it would not be in keeping with the political and social philosophy of our society to restrict access of individuals to self-funded medical care. It could, in any case, serve only to divert resources from the private healthcare sector in Ireland to that in other countries, since some of those in a position to pay for treatment would simply obtain it elsewhere. If this resulted in a diminished private healthcare sector in Ireland, it could reduce the scope for improving the services available to public patients through the use of private facilities in certain cases, as discussed later in this chapter.

8.22 Similar considerations apply to the question of speed of access to necessary care. It is, again, inevitable that those who can afford to go outside the public sector may be able to obtain certain treatment more quickly. The Commission would not regard this as inequitable *provided* that the public health services are available within a reasonable period of time to all those assessed as in need of them. This principle underlies our approach to the various services discussed in our report. Chapter Five has also argued that equity would require that the provision of treatment to those in a position to pay for it should not in any way operate to the disadvantage of those of lesser means, as could arise if, for example, private patients had priority in public hospital waiting-lists. The organisation of access to public hospital services is considered in more detail in Chapter Twelve.

8.23 **In summary, the Commission does not believe that it is inequitable that private insurance should enable individuals to obtain treatment which is otherwise unavailable, or to obtain treatment more quickly, *provided* that comprehensive and cost-effective public health services are available within a reasonable period of time to all those assessed as in need of them.** The question of whether such treatment should be subsidised through, for example, tax relief, is discussed later in the chapter.

8.24 The second element of the role of voluntary private insurance is to provide cover for certain non-discretionary healthcare expenses. These would include charges made for public health services provided to certain income groups (such as, at present, consultants' fees for Category III public patients and the £10 daily maintenance charge for public ward accommodation),[3] and the costs of services which are not available under the public system to these groups (such as general practitioners' fees).

8.25 It is likely that the provision of full cover for routine, recurring healthcare expenses could require premia to be set at an uncompetitive level. However, there is a range of devices available to insurers to keep premia at a marketable level by restricting benefits through, for example, non-coverage of expenses below a specified threshold or refund of expenses on a percentage basis rather than in full. It would be a matter for insurers to decide the appropriate balance of benefits and premium levels.

[3]A charge which is intended to deter unnecessary utilisation of a service (such as the £10 charge for attendance at a casualty department) is less suitable for inclusion in insurance cover. This issue is discussed in detail in Chapter Twelve.

COMPETITION BETWEEN PRIVATE INSURERS

8.26 As described earlier, there is an effective monopoly in the sale of private health insurance to the general public. A licence is required from the Minister for Health, and such licences have been issued only to schemes which are not regarded as being in competition in the open market with the Voluntary Health Insurance Board.

8.27 In Chapter Six we concluded that the Irish health services should be funded primarily from general taxation and that a funding system based on competitive private insurance for the population as a whole would have serious disadvantages. However, we did not rule out the use of insurance as a supplementary funder of services and, in the section above, we argued that it should provide cover for private healthcare costs and, possibly, public charges for which patients using the core service are liable.

8.28 The question then arises as to whether competition between insurers is desirable. The issue is complicated by the possible effects on health insurance of the EC Internal Market, but the arguments for and against competition may still be addressed.

8.29 The main argument in favour of allowing competition between insurers is based on the principle of consumer choice. However, we argued earlier that consumer preferences must take second place to objective evaluation in deciding the priorities of an equitable and efficient *public health service*. The appropriate role for private health insurance is then to *complement the public health service* by facilitating consumer preferences.

8.30 Insurers must seek a balance between consumer demands for an improved choice of private services and consumer resistance to increased premia. The mix of these preferences will, of course, differ greatly among consumers and it is therefore difficult for a single insurer to find a balance which will satisfy the range of preferences.[4]

8.31 This problem of achieving a balance between consumer preferences and willingness to pay is resolved for other goods and

[4]This problem is illustrated by a case which attracted public attention during the period in which we carried out our work. This concerned the proposed opening of a private hospital in Cork, to which the VHI was not prepared to extend cover on the grounds that there were already adequate private hospital facilities in that area to meet the needs of its members. It was argued that the provision of additional facilities could lead to unnecessary expenditure, and thus increase the premia for all VHI members. On the other hand, there appeared to be considerable public opposition to the VHI's decision in the Cork area, on the basis that members were being denied cover for the service of their choice.

services through the operation of competitive markets. Competing insurers for private healthcare could tailor alternative packages of benefits and premium levels to provide a range of responses to differing consumer preferences and, over time, market forces could lead to a greater representation of consumer choice.

8.32 Competition between insurers for private healthcare would also be expected to increase the emphasis on efficiency in that sector. Insurers could be expected to maintain the competitiveness of their premia by negotiating keen terms for the provision of services to their members, and by offering incentives to members to avoid wasteful use of services. For example, it is reported[5] that the introduction of general insurance companies to the private healthcare market in the United Kingdom since 1980, in competition with the long-established provident associations, has led to innovations such as non-smoker discounts, no-claims bonuses, discounts where the consumer pays a percentage or an initial amount of each claim, and, in one case, full cover for the use of approved preferred hospitals but only partial cover for the use of other hospitals.

8.33 It could also be argued, however, that in the absence of competition between insurers, a monopoly health insurance company could impose efficiency on the private healthcare sector by exercising its power as a monopsonist, i.e. the sole purchaser in the market. This would require the insurance company concerned to play a much more active role than has been done in the past in negotiating favourable terms with hospitals, consultants and other healthcare providers, and limiting its cover (or the full extent of its cover) to the services of those with whom agreement had been reached.

8.34 Chapter Six referred to an important and detrimental change which would result from the introduction of competing insurers to the Irish market for private healthcare: it would be extremely difficult to maintain the principle of community-rating, i.e. spreading risk evenly across all categories of patient irrespective of factors such as age-group or medical history. Community-rating is not required by law, but has been observed by the VHI with the approval of the Minister for Health. It could be required of any new entrants to the market; however, it would, as already stated, be extremely difficult to enforce community-rating in practice. Large employers may soon be in a position to purchase various forms of insurance by post from other EC member states, making the restriction of health insurance to community-rated schemes very difficult. Experience in the United

[5]Orros: *op cit:* p. 10.

States and the Netherlands suggests that community-rating cannot survive in a market which also offers experience-rated premia.[6]

8.35 The consequence of a move away from community-rating would be to increase greatly the cost of private health insurance for those in higher-risk categories, such as older age-groups, and thus increase the usage of public as opposed to private healthcare among those groups. It might also be argued that it would be unfair to long-standing members of the VHI since, under community-rating, one could be said to have paid in earlier years towards the cost of one's treatment in later years.

8.36 It has been noted that community-rating would be very difficult to sustain in the event of competing insurers entering the Irish market. However, it has not been possible to establish with certainty whether the Voluntary Health Insurance Board's effective monopoly will be sustainable after the removal of restrictions on the financial services sector on completion of the EC Internal Market. If it is not sustainable, then the question of choosing between a monopoly and competing insurers does not arise, and the future arrangements for funding public and private healthcare must be judged in this light.

8.37 The Commission has been offered a number of opinions and interpretations of the future position, some of which suggest that the monopoly is unsustainable and others which argue that it can remain. **Since the question cannot be answered with certainty at present, the Commission has concluded that it would be unwise to base its recommendations on an assumption that the VHI monopoly will be permitted to continue indefinitely.**

8.38 The Commission's proposal for publicly-regulated and tax-funded core services for the entire population is influenced by its paramount concern to protect the higher risk groups, such as the chronically ill and the elderly, in the context of a private health insurance system where community-rating may no longer be possible.

8.39 This is not to suggest, however, that the demise of community-rating is inevitable; on the contrary, every effort should be made to ensure its retention. In view of the significant social dimension contained in the Single European Act, a proposal by the Irish Government that health insurance should continue to be operated on the basis of community-rating could well meet with a positive

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[6]Alain C. Enthoven: *Theory and Practice of Managed Competition in Health Care Finance* (New York, 1988).

response from the European Community. **We therefore recommend that the Government should pursue this issue with the European Community as soon as possible.**

INCENTIVES TO PRIVATE FUNDING

Provision of Tax Relief

8.40 Payments to VHI or to other licenced insurers qualify for income tax relief. Since 1967, income tax relief has also been available in respect of certain unreimbursed medical expenses, exceeding £50 in one year for an individual or £100 for a family. Expenses relating to routine maternity care or routine dental and ophthalmic treatment are excluded from the latter relief. Claims for relief on unreimbursed medical expenses arise mainly in respect of geriatric patients ineligible for care in public facilities, and long-term illness patients who have been unable to obtain adequate insurance. The Revenue Commissioners have estimated the cost of income tax relief on medical insurance in the tax-year 1988-9 to be £41.8 million. Their most recent estimate of the cost of relief on unreimbursed medical expenses is £2.4 million for the calendar year 1987. Table 8.1. includes details of tax expenditure on these reliefs for selected years.

8.41 A number of recent reports have argued for the abolition or restriction of these reliefs:

— the Commission on Taxation[7] noted that, since tax relief on medical insurance was introduced, the provision of public health services had been extended; no-one was now liable for excessive medical costs; and the VHI's schemes were well-established. They therefore recommended the abolition of tax relief on medical insurance. In relation to tax relief on unreimbursed medical expenses, the Commission argued that the most appropriate way of helping people in the categories most reliant on this scheme was through direct expenditure, but recommended that the relief be retained for exceptional levels of expense until adequate provision for these groups could otherwise be made;

— the National Planning Board[8] recommended that income tax relief for medical insurance should be withdrawn in three phases over three years;

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[7] *First Report of the Commission on Taxation* (Stationery Office, 1982): Chapter 10.

[8] National Planning Board: *Proposals for Plan 1984-87* (Stationery Office, 1984): Chapter II.3

— the National Economic and Social Council[9] argued that the existence of tax allowances for private hospital insurance created a regressive dimension to the tax system and an inequitable dimension to health care accessibility. Curtailment of the allowance was therefore recommended;

— the Department of Health's consultative statement on health policy[10] argued that, while income tax relief on health insurance was defensible at the time that it was introduced in 1957, as it was then mainly taken out by people who had no entitlement to public hospital services, the justification for such relief now was questionable.

The Case for Retaining Tax Relief

8.42 The case for the retention of income tax relief has also been argued. The Voluntary Health Insurance Board's submission to us addressed the issue in detail; since it encompasses all of the major arguments normally presented in favour of tax relief, it is useful to quote it at length:

> "The point of substance in support of this tax relief is that by reducing the effective cost of insurance it encourages people to pay for their own health care, and thus generates revenues for the Department of Health directly and indirectly for the exchequer. Thus, of the £70 million paid to hospitals by the VHI in 1987, £23 million went straight to public hospitals. Of the £47 million which went to private hospitals, at least £10 million would have found its way back to the exchequer in the form of income tax payments on the 62% to 64% of private hospital costs which is represented by wages and salaries. It might be roughly estimated that about the same amount of money in income tax would be derived by the exchequer from the £25 million paid in fees to consultants. Likewise a proportion of the out-patient reimbursements by the VHI would accrue to the public health sector or to the exchequer. Finally, the £7 million which the VHI itself incurs in administering health insurance generates appreciable revenues to the exchequer in income and other forms of tax. In summary, the direct yield to the exchequer through tax payments and payments to public hospitals is unlikely to be less than £50 million — significantly greater than the nominal value of the relief.

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[9] National Economic and Social Council: *A Strategy for Development 1986-1990* (NESC No. 83, November 1986): p. 216.

[10] Department of Health: *Health — The Wider Dimensions* (1986): Chapter Three.

"However, the relief to the Department of Health and the exchequer is likely to be greater than this because in the absence of the VHI it is probable that almost all of the health care financed by the VHI would have to be provided by the Department of Health. Of the total of £110 million in claims paid out by the VHI in the tax year 1986/87, £70 million (as noted above) was for hospital accommodation and £14 million was for out-patient treatment. In addition, about half of the consultants' fees of about £25 million were paid by people in Category II. If the VHI did not exist, a total of about £96 million would have to be borne by the state under the existing structure of eligibility. Indeed, the financial burden would actually be somewhat higher if the Department's claim is accepted, that charges to VHI members in public hospitals understate the "true" cost. Moreover, there is some doubt whether the public sector could physically accommodate those VHI members now being admitted to independent hospitals, so that the ending of relief on health costs might also entail some capital expenditure on extending the capacity of public hospitals.

"Of course, the abolition of the tax relief on health insurance premiums would not completely eliminate private health insurance since there will always be those who will find the resources for private health care. Nevertheless, it is difficult to believe that increases in after-tax premiums of from 54% (in the case of a standard income tax payer) to 140% (in the case of a tax payer in the highest income tax bracket), unaccompanied by any improvement in coverage, would not substantially reduce the numbers providing for their own health care. Obviously it is difficult to make precise estimates of the elasticity of demand for health insurance with respect to the level of premiums. But it is certainly plausible to think that the decline in the number of subscribers resulting from such steep increases in premiums would exceed one third — the ratio of the value of the tax relief to total VHI reimbursements — and the point beyond which withdrawal of the concession would increase, rather than decrease net Government spending.

"On a more general level, by allowing tax relief, the state encourages self-reliance and bears the cost of treatment only to the extent of the marginal tax cost rather than the full cost. It would be inconsistent to accept the principle of the individual's right to make independent health care arrangements but through high taxation, to effectively deny the exercise of that right. If taxation levels would be reduced in the future, thereby releasing more personal spending power, the need for the tax allowances

would also be reduced. The recommendation relating to these allowances by the Commission on Taxation should be seen in the overall context of the Commission's recommendations which aimed at a simpler, but also a lower tax regime."[11]

Evaluating the Case for Retaining Tax Relief

8.43 There are a number of aspects to the arguments presented above. In considering them, it is essential to distinguish between three separate questions:

— is it appropriate that the State should give financial encouragement to avail of private healthcare?

— if such encouragement is appropriate, is tax relief on medical insurance or other medical expenses the most equitable and efficient way of providing it?

— if the principle of tax relief is questionable, would it nonetheless be undesirable to curtail it because of the likely practical consequences?

Financial Incentives to Use Private Healthcare

8.44 In relation to the *first* of these questions, it can be argued that the justification for financial assistance to those availing themselves of private healthcare depends on the nature of the care in question. The Commission has concluded earlier in this chapter that it is inevitable that treatments will be available in the private sector which are not readily available under the public system. We have argued that, in a society such as ours, the individual who chooses to fund his own access to private treatment must be free to do so. However, if the nature of the treatment is such that the State is unable or unwilling to fund its availability to the population in general through the public health services, it would be regressive and highly inequitable for the State to subsidise its availability to the private patient.

8.45 On the other hand, it can be contended that individuals who arrange to avail themselves of private healthcare facilities reduce the demand on public health services. This can have the two-fold advantage of reducing the level of expenditure required for the public services and improving their availability to those who rely on them. It can therefore be argued that it would be cost-effective for

[11]Voluntary Health Insurance Board: *Submission to Commission on Health Funding*, March 1988.

the State to offer incentives to patients to obtain privately treatment which they would otherwise seek from the public system.

8.46 However, the case for subsidising private health care must be judged in the context of the level of service provided by the public system. The State already contributes substantial funds from the Exchequer for the provision of a very wide range of services, and the Commission's proposals involve the provision of a core set of necessary health services to all. It is difficult, therefore, to justify extensive subsidisation of the private health sector if the State is already funding a core service itself. A case can be made for subsidies for emerging developmental services where the capacity of the public system is limited, but this would be exceptional and only for a specified period.

8.47 **Accordingly, the Commission does not favour subsidisation of private healthcare other than in exceptional circumstances, as outlined above, for emerging developmental services.** This is not the sole reason for the Commission's opposition to tax relief; other aspects of the issue must also be examined.

Use of Tax Relief to Encourage Private Healthcare

8.48 Even if the Commission's recommendation against subsidies to the private sector is not accepted, the question of whether tax relief is the most appropriate *method* of subsidisation (the *second* question posed earlier) must be addressed. The Commission believes that tax relief is neither an efficient nor equitable way of providing the required incentives. It is not practicable to restrict its benefits to such private healthcare as the Government wishes to encourage. Consequently the State contributes substantially to the cost of providing private patients with certain treatments which it has decided it will not, or cannot, provide for other groups, or subsidises the availability of treatment to private patients on criteria of medical need less rigorous than apply in the public sector. The present system of tax relief means that the allocation of about £44 million of public expenditure in the tax year 1988-9 was determined by the private choices of patients and their doctors; despite having responsibility for the allocation of the State's resources to healthcare, the Government could not exercise full control in this regard.

8.49 A further inequity occurs, as with all tax allowances, because the benefits differ between taxpayers and non-taxpayers, and between taxpayers on different marginal rates of tax. It may thus arise, for example, that a low-income member of VHI receives no State contribution towards the cost of his premium, while a high-income

member receives a subsidy of 56 per cent (the highest marginal rate of tax).

Practical Implications of Removing Tax Relief

8.50 The *third* question relates to the practical implications of any change in the present arrangements. The main argument presented by the VHI Board in favour of the present approach is that the withdrawal of tax relief would increase rather than decrease government spending. This argument assumes that

(i) the withdrawal of tax relief would very greatly reduce the numbers availing of health insurance;

(ii) revenue accrues to public hospitals and otherwise to the Exchequer which would not accrue in the absence of health insurance; and

(iii) the withdrawal of tax relief would increase pressure on public hospitals to the extent that capital expenditure could be required to extend their capacity.

We consider these issues below.

(i) Demand for Health Insurance

8.51 We discuss the likely impact of our main proposals, including the eventual withdrawal of tax relief, in Chapter Twenty. Some important points may be highlighted here. In particular, we believe that the effect on the demand for health insurance must be judged in light of the following considerations:

(a) the available evidence indicates that the price sensitivity of demand for health insurance is very low. Rising healthcare costs have led to substantial increases in VHI subscription rates during the 1980s. Table 8.3 shows that premia increased by 155 per cent between the start of 1981 and the start of 1987. After taking account of general inflation, the increase in real terms was over 38 per cent. Despite these increases, VHI membership rose by almost 11 per cent in the same period;

(b) it is likely that the price sensitivity of demand is particularly low among the higher-income groups upon whom the impact of the change would bear most heavily because of their high marginal tax rates;

(c) the withdrawal of tax relief could be introduced gradually over a number of years to avoid the negative impact of a sudden sharp rise in the net cost of VHI membership. The pace of removal

could be varied over a period in response to the size of any reduction in demand for health insurance. This would allow the change to take place smoothly;

(d) in view of the de-subsidisation, insurers would have a greater incentive to direct their coverage towards the most necessary forms of care. It would be open to the VHI, or to other insurers, to offer members the choice of a policy which concentrated on cover for cost-effective, necessary care rather than unlimited access to treatment on demand regardless of its cost-effectiveness. This would enable the gross, before-tax premium to be reduced for those availing themselves of such cover.

TABLE 8.3.

VHI MEMBERSHIP AND PREMIUM INCREASES IN RECENT YEARS

	Membership at end-February	Average Subscription Increase on 1 March	Real Increase, adjusted for consumer price inflation
1981	935,804	23.0%	2.2%
1982	995,284	41.5%	20.8%
1983	1,013,745	11.5%	0.9%
1984	1,028,194	13.5%	4.5%
1985	1,033,261	7.5%	2.0%
1986	1,032,709	8.0%	4.0%
1987	1,037,480	—	—
1988	1,078,423[1]	8.0%[2]	5.8%
		176.2%	46.1%

Source: VHI membership and subscription data derived from VHI Annual Reports. As subscription increases took effect from next renewal date after 1 March, and these are spread throughout the year, the CSO estimate for the annual rate of increase in the Consumer Price Index in each year has been used to derive an approximate estimate of the real rate of subscription increase.

[1] In addition, two low-cost plans introduced in May, 1987, covering public ward maintenance and out-patient charges had a total membership of 131,549 at end-February, 1988.

[2] With effect from 1 December, 1987.

(ii) Exchequer Benefits

8.52 The second element of the VHI Board's argument is that tax relief is costless to the Exchequer as it generates more revenue than

its cost, in the form of public hospital charges and tax payments by, for example, consultants and the staff of private hospitals. However, any form of health expenditure will generate substantial tax receipts as healthcare is extremely labour-intensive. There is therefore no special case to be made on those grounds for expenditure in the form of tax relief if it is less equitable and efficient than alternative forms.

(iii) Pressure on Public Hospitals

8.53 The third main argument of the VHI Board is that the withdrawal of tax relief would increase pressure on public hospitals. Paragraph 8.50 discusses a number of factors which are likely to temper any decline in demand for health insurance and, hence, demand for private care. In addition, the argument regarding pressure on public hospitals must be judged in the context of the Commission's objectives for the health services overall. Equity of access has been among the primary concerns in the Commission's deliberations and must on occasions take precedence over other considerations where choices have to be made between them. The present arrangements for subsidised health insurance have not helped to achieve equity due to the scope for speedier access to treatment by insured private patients. The establishment of a common waiting list for public hospitals (which the Commission recommends in Chapter Twelve) could be complemented by phasing out the present subsidies for private healthcare, ensuring that those wishing to avail themselves of private facilities do so without assistance from public funds.

8.54 In any event the implications for public hospitals of withdrawing tax relief must not be assessed in isolation from other important features of the Commission's proposals, such as the establishment of a common waiting list for public and private patients. The likely advent of competing insurers to the Irish market must also be taken into account. These factors also have implications for public hospital services and are examined in Chapter Twenty.

8.55 In conclusion, we have accepted the principle that the individual, in healthcare as in other goods and services, is entitled to spend his own money as he sees fit. However, this freedom does not extend to determining how public money should be spent without any involvement by the State in the decision. **The Commission recommends the phasing-out of income tax relief on health insurance and on unreimbursed medical expenses. The pace of phasing out should be adjusted over time, as necessary, in response to the pattern of demand for health insurance that emerges as tax relief is reduced.**

Reservation by Sr. G. Byrne, Mr. N. Fox, Mr. D. McGing and P. Teahon.

We do not agree with the above recommendation for the phasing out of income tax relief on health insurance. Ireland has a mixed economy and a large sector of the population has expressed a strong desire and has made independent arrangements for private healthcare, in addition to contributing to the public system. We accept the argument put forward by the VHI Board that the withdrawal of tax relief would very greatly reduce the numbers availing of health insurance by making it unaffordable. Additionally, we feel that a case should be made for the continuation of community-rating in health insurance in Ireland and that this should be pursued by the Government with the European Community.

PRIVATE DELIVERY OF SERVICES

8.56 The earlier sections of this chapter have discussed the role of private *funding* of healthcare as a complement to public funding. As most private funding relates to the private *delivery* of services, the earlier discussion has encompassed the question of the role of the private delivery of healthcare to those in a position to pay for it. In this section, we consider briefly the role of private providers in delivering services on behalf of the publicly-funded system. Later chapters on specific services deal in detail with the appropriate roles of the public and private sectors in their delivery, and the inter-relationships between them. This section introduces the issues in broad terms.

8.57 The best example of the existing use of private providers by the public health services is the General Medical Services Scheme under which independent general practitioners and pharmacists contract to supply services to public patients, usually in addition to their private work. There are less structured arrangements for the provision of services on behalf of health boards by voluntary organisations in various fields; there is also a scheme under which subsidies are payable for the care of geriatric patients in some private nursing homes. The use of private acute hospitals to provide services for public patients on a contractual basis has not been significant to date.

8.58 Chapter Nine sets out the Commission's recommendations for the administration of the health services, which would give the regional management of the proposed Health Services Executive Authority the comprehensive responsibility for ensuring the access of patients in their areas to necessary care. It must be stressed that this does not imply that local managers should directly provide every

service. They would enter into formal, contractual arrangements with, for example, other regions, voluntary agencies and private providers for the delivery of specified services wherever this was more cost-effective than providing the services themselves.

8.59 It is clear that this approach must be based on careful analysis of relative costs. There has been a general lack of analysis of the costs of individual health services in terms of units of output. In the absence of this kind of analysis, there has been a tendency to rely on crude indicators which may have little validity and be quite misleading. For example, the annual expenditure of a public hospital can be divided by the number of patient-days to yield an estimate of "daily cost per patient". These estimates have been compared with similar figures for private hospitals to support conclusions on their relative efficiency. Such comparisons ignore the fact that expenditure on an individual patient will depend to a great extent on the complexity of the treatment required, but crude average daily cost comparisons take no account of differences in case-load. The comparisons also ignore the inclusion of teaching costs, casualty services and other services to the community in the overall expenditure of a public hospital, so that the estimates over-state the true average cost of in-patient treatment; on the other hand, they also fail to take account of the fact that private hospitals, unlike public hospitals, must make provision for depreciation of assets and capital funding.

8.60 Chapter Twelve describes the current work to establish accurately the costs of treating specific conditions in public hospitals. The overall need in respect of all health services for accurate analysis of costs related to activity is discussed in Chapter Ten. With this type of information, managers can assess both the short-term and long-term relative cost-effectiveness of alternative approaches, and plan the delivery of services accordingly.

8.61 A particular advantage of giving managers flexibility in arranging for the delivery of services is that it provides scope for competition among the providers of services, which may lead to greater efficiency and lower costs. Competitive tendering is already widespread for the provision of medical supplies and non-clinical services to the health boards. The same approach could be extended to other areas. For example,

— tenders could be sought for carrying out a specified number of procedures such as hip replacements to reduce the waiting-list in an area or in place of any provision of the procedure by the public health services. It would be open to private hospitals,

voluntary hospitals and other public hospitals with adequate capacity to tender for the contract;

— tenders could be sought for the provision of services such as day-care to the elderly and the disabled;

— tenders could be sought for the provision of long-term care for geriatric patients;

— tenders could be sought for diagnostic testing and imaging services.

It would, of course, be of paramount importance to monitor on a continuous basis the quality of service being provided, and to have a mechanism for remedying any deficiencies which were found.

8.62 While the above discussion relates to competitive provision of specific and isolated services, such as a quantum of procedures or care for a specific group of patients, there may also be scope for introducing a degree of competition for a broader range of services. The provision of general hospital services for an area may be taken as an example. It has been argued that the scope for such competition will in practice be very limited. In the first place, many areas of the country have only one general hospital. Even where there is more than one hospital, it is argued that competition is not feasible since it would have very serious implications for a hospital which did not attract sufficient work in the short-term. It would remove all incentives to efficiency were such a hospital to receive funding to make up any losses as a result of failure to be competitive. However, it would be equally undesirable if short-term uncompetitiveness forced the closure of hospitals to the extent that the long-term availability of a choice of services was threatened.

8.63 The solution to these difficulties may lie in the concept of franchising the management of public hospitals. Under this approach, public hospitals would remain in place where they were needed, but their management and operation would be contracted out for specific periods on the basis of competitive tendering. The incentive to operate with maximum efficiency would thus be retained without jeopardising the continuing role of the hospital itself. This approach could have similar application to other services such as long-term care.

8.64 The general issues which have been introduced above are discussed in more detail in later chapters. For example, Chapter Twelve examines the scope for the use of private hospital facilities as a cost-effective alternative in determining the appropriate provision of public facilities; Chapter Seventeen discusses the appropriate

arrangements with voluntary organisations in relation to welfare services and services for the handicapped; Chapter Eighteen discusses the role of private nursing homes in meeting the need for geriatric care.

RECOMMENDATIONS

8.65 We have made the following recommendations in this chapter:

1. It should not be necessary, nor should it be perceived as necessary, to take out private insurance in order to secure access to necessary treatment. The role of private health insurance should therefore be

   (i) to provide cover for those who wish to avail themselves of private healthcare; and

   (ii) to provide cover for the costs of non Core Services for which certain income-groups are liable.

2. It is not inequitable that private insurance might enable individuals to obtain treatment which is otherwise unavailable, or to obtain treatment more quickly, *provided* that comprehensive and cost effective public health services are available within a reasonable period of time to all those assessed as in need of them.

3. It would be unwise to base future decisions regarding the healthcare system on the assumption that the present VHI monopoly will be permitted to continue indefinitely. However, the Government should pursue the issue of community-rating with the European Community as soon as possible.

4. Private healthcare should not be subsidised by the State other than in exceptional circumstances.

5. Income tax relief on health insurance and on unreimbursed medical expenses should be phased out. The pace of phasing out should be adjusted over time, as necessary, in response to the pattern of demand for health insurance that emerges as tax relief is reduced.

6. While local managers of the proposed Health Services Executive Authority should have comprehensive responsibility for ensuring access of patients in their areas to necessary care, this does not imply that every service must be provided directly by that area. The scope for competitive tendering and contractual arrangements with other regions, or with voluntary agencies and private providers, should also be examined.

APPENDIX 8A

SUMMARY OF VHI INSURANCE SCHEMES

The Voluntary Health Insurance Board offers insurance under a number of different Plans. These are described below. In each case, the premia quoted are the annual rates applying, on renewal of policy, in March 1989 to VHI members enrolled through "group schemes" i.e. whereby premia are collected by an employer or the members are part of an association. Premia for other members paying direct to VHI are about 10 per cent higher. The rates quoted are before tax relief.

Plan A: *Adult*: £76.44 *Child*: £25.31 (+ Fee Units — see below)

Plan A provides cover for *semi-private accommodation in public hospitals*; the £10 charge for public ward accommodation and public hospital out-patient and casualty charges; and out-patients expenses to a maximum of £1,000, excluding the first £170 per year for a family or £105 for an individual. Eligible expenses under the out-patients benefit are general practitioner fees, consultants' fees, doctors' fees for pre- and post-natal care (subject to a maximum of £40 admissible in the subscription year in which the birth takes place), radiology and pathology, physiotherapy occasioned by accident or illness, home nursing when certified as essential for medical reasons (subject to a limit of £15 per day for 42 days), specified medical and surgical appliances and emergency dental treatment arising from an accident.

Plan B: *Adult*: £120.60 *Child*: £44.83 (+ Fee Units — see below)

Plan B provides all the benefits of Plan A. In addition, it covers *private accommodation in public hospitals*; *semi-private accommodation and medical extras in most private hospitals*; and the maximum out-patients benefit is raised to £1,200.

Plan C: *Adult*: £206.16 *Child*: £82.65 (+ Fee Units — see below)

Plan C provides all the benefits of Plan B. In addition, it covers *private accommodation and medical extras in most private hospitals*; and the maximum out-patients benefit is raised to £1,400.

Plan D: *Adult*: £250.32 *Child*: £102.17 (+ Fee Units — see below)

Plan D provides all the benefits of Plan C. In addition, it covers *semi-private accommodation and medical extras in certain high-cost private hospitals.*

Plan E: *Adult*: £410.40 *Child*: £172.93 (+ Fee Units — see below)

Plan E provides all the benefits of Plan D. In addition, it covers *private accommodation and medical extras in certain high-cost private hospitals and hospitals in Northern Ireland.*

A patient who uses accommodation which is covered only by a higher level of Plan than that held, is entitled to proportionate reimbursement of the charges, on the basis of a specified scale. The proportionate reimbursement is increased for patients insured under Plans B and C who require certain specified treatment in the high-cost hospitals covered fully under Plans D and E.

Fee Units: Those insured under any of the above Plans must also take out cover against in-patient professional fees. Each "Fee Unit" provides cover, according to a scale of procedures, for surgeons' fees and anaesthetists' fees; and also for physicians' fees, specialist consultation fees, special nursing fees and other professional fees. VHI incorporates the cost of 28 Fee Units in the subscription rates which it quotes to the public. The maximum number of Fee Units available is 30. The costs are:

28 units:	*Adult*: £38.64	*Child*: £12.88
30 units:	*Adult*: £41.40	*Child*: £13.80

Plan P: *Adult*: £9.66 *Child*: £4.27

Plan P provides cover only for the £10 charge for public ward maintenance and public hospital out-patient and casualty charges.

Plan T: *Adult*: £48.30 *Child*: £17.15 (with 28 Fee Units)

Plan T provides the same benefits as Plan P; in addition, it provides cover against professional fees. This Plan has replaced the Public Ward Scheme, which was previously designed to offer cover against professional fees for Category III patients who did not require cover for semi-private or private accommodation. Category III patients are liable for consultants' fees even if they avail of their statutory entitlement to public ward accommodation.

CHAPTER NINE

ADMINISTRATION AND MANAGEMENT

INTRODUCTION

9.1 This chapter examines the present administrative structure of the health services, identifies a number of weaknesses which make effectiveness and efficiency more difficult to achieve, and proposes structural improvements which would rectify the problems.

DESCRIPTION OF THE PRESENT ADMINISTRATIVE STRUCTURE

9.2 Chapter Three described the evolution of the administrative structure from its nineteenth century origins to the present system of regional health boards. Figures 9A to 9D, which are reproduced from the Department of Health's 1986 Consultative Statement on health policy, present a broad outline of the existing structure which is described in the paragraphs which follow. It must be stressed that the relationships between the elements of the structure are not as clear-cut as those portrayed in the diagrams. Indeed, the evaluation of the present structure, contained in this chapter, will show that there are major deficiencies in the chain of accountability and control.

9.3 In Ireland, the executive powers of the State are exercised by, or on the authority of, the Government, in accordance with the laws enacted by the Oireachtas. The business of Government is assigned on a functional basis to Ministers who are individually and collectively responsible for its execution, except where the law provides otherwise. Ministers are supported in this work by their Departments. The Department of Health is thus concerned with

— formation of policy for consideration by the Minister and the Government;

— drawing up programmes for the implementation of agreed policy and allocating the available funding accordingly between the various health agencies;

— accounting for the expenditure of the voted funds;

— appraisal and review of the effectiveness of services;

— co-ordination of the international activities of the health services; and

— providing general support to the Minister in his ministerial and parliamentary functions.

9.4 A number of executive boards have been established to carry out work which is regarded as unsuited to local administration, such as the Health Research Board and the Blood Transfusion Service Board. The statutory responsibility for the regulation of the number and type of appointments of consultant medical staff and senior registrars in hospitals is vested in Comhairle na nOspideal, which also has an advisory function in relation to the organisation and operation of hospital services. There are also advisory boards such as the National Drugs Advisory Board and the National Council for the Aged, and professional registration bodies such as the Medical Council and the Dental Council.

9.5 The statutory responsibility for administering the services provided for in health legislation and by ministerial initiative is vested in eight regional health boards. Table 9.1 lists the area and population covered by each of the boards. The Health Act, 1970 stipulates that a majority of the members of each board must be appointed by the county councils and corporations in the board's functional area, and that the balance must comprise elected representatives of certain health professions and a small number of ministerial nominees.

TABLE 9.1.

THE REGIONAL HEALTH BOARDS

HEALTH BOARDS	COUNTIES	POPULATION (1986 CENSUS)
EASTERN	Dublin, Kildare, Wicklow	1,232,238
MIDLAND	Laois, Longford, Offaly, Westmeath	207,994
MID WESTERN	Clare, Limerick, Tipperary (North Riding)	315,435
NORTH EASTERN	Cavan, Louth, Meath, Monaghan	302,035
NORTH WESTERN	Donegal, Leitrim, Sligo	212,745
SOUTH EASTERN	Carlow, Kilkenny, Tipperary (South Riding), Waterford, Wexford	384,974
SOUTHERN	Cork, Kerry	536,894
WESTERN	Galway, Mayo, Roscommon	348,328

FIG.I

THE GENERAL STRUCTURE OF IRELAND'S HEALTH CARE SYSTEM

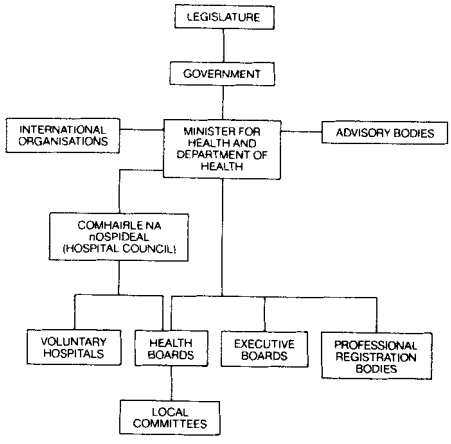


FIG.II

HEALTH BOARD AREAS AND POPULATION DENSITIES

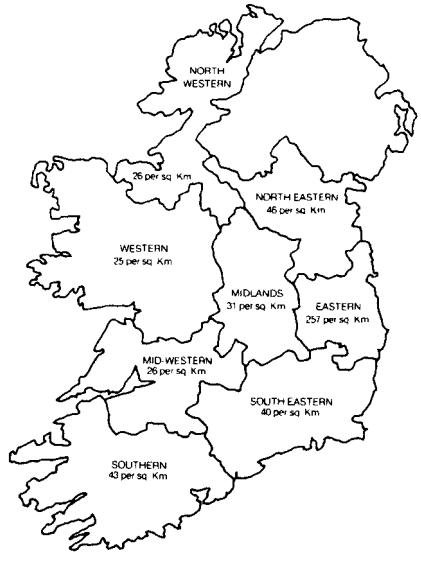


FIG.III

COMMUNITY CARE STRUCTURE

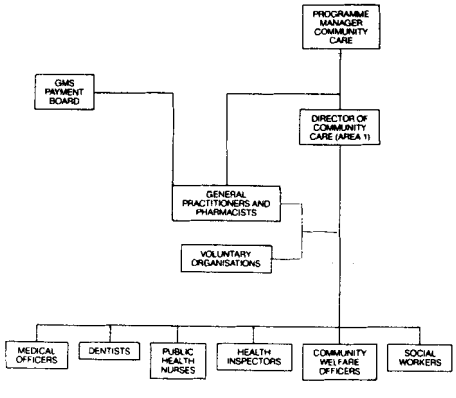
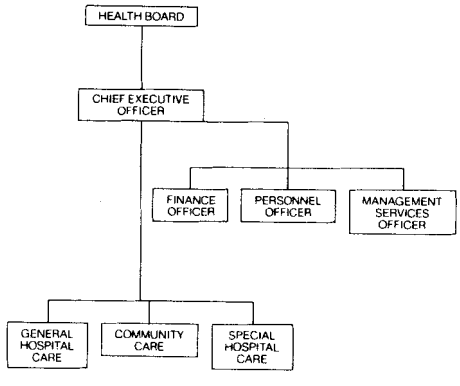


FIG.IV

HEALTH BOARD PROGRAMME STRUCTURE



Source: Department of Health: *Health–The Wider Dimensions* (1986)

Note: The comments in paragraph 9.2 should be noted. "Local Committees (Figure 9A) ceased to function in 1987"

9.6 The Health Act, 1970 empowers health boards to make arrangements with other bodies to provide public health services. In practice, many of the agencies which provide services have little or no reporting or funding relationship with the health boards. For example, almost all voluntary hospitals are funded directly by the Department of Health and are not directly accountable to any health board. Of the very many non-statutory agencies which provide services for the handicapped and other welfare services, some are funded directly by the Department of Health, others by the health boards and others by a combination of both.

9.7 Each health board is required under the Health Act, 1970 to have a Chief Executive Officer. Certain functions relating to personnel of the board and decisions on eligibility of individuals for services are reserved to the Chief Executive Officer. In addition, health boards have delegated management of the services on a considerable scale to their Chief Executive Officers, while retaining control of such matters as the approval of revenue budgets, the authorisation of capital schemes, the borrowing of money, the acquisition and disposal of land, and decisions on programmes for development or review of services.

9.8 It is difficult to describe the precise degree of autonomy enjoyed by the health boards because of the way the Minister and Department of Health determine priorities and because of their role in the management and financial control of the system. Boards cannot embark on major capital developments without the approval of the Department. Since April, 1987 the Department's approval is necessary for the filling of *any* vacant permanent post; previously, boards were subject to Department control of their overall staffing levels. The approval of Comhairle na nOspidéal is also needed for the replacement or creation of any medical consultant post. In allocating resources between programmes, boards may be constrained by guidelines laid down by the Minister and his Department, although the extent to which these guidelines are enforceable in practice is unclear.

9.9 The work of each health board is divided into three broad programmes, covering community care services, general hospital services and special hospital services i.e. those catering for the mentally ill and the mentally handicapped. In the larger boards there is a separate Programme Manager for each of these services; in the smaller boards one Programme Manager covers the general and special hospital programmes. Programme Managers report to the Chief Executive Officer.

9.10 The Health Act, 1970 also provided for the establishment of local advisory committees. There was generally one local committee in each county, the majority of the members being local councillors. The role of the committee was limited to the provision of advice to the health board and it had no decision-making powers. The local advisory committees ceased to function in 1987.

EVALUATION OF THE PRESENT STRUCTURE

9.11 The Commission considers that if an administrative structure is to carry out its functions properly in the efficient and cost-effective organisation of health services, then it must be designed to take account of the characteristics of healthcare delivery. This section examines the present structure and shows that it does not satisfy that requirement and as a result suffers from a number of weaknesses, viz.:

(i) it confuses political and executive functions, and therefore undermines both;

(ii) it fails to achieve a proper balance between national and local decision-making;

(iii) the decision-making process does not provide a sufficient role for information and evaluation;

(iv) accountability within the structure is inadequate;

(v) there is insufficient integration of related services; and

(vi) there is inadequate effective representation of the interests of individual patients and clients within the structure.

Confusion of political and executive functions

9.12 The representation of local, regional and national viewpoints in the planning of services and in reviewing their adequacy and quality is a *political* activity. The management of services in pursuit of objectives determined by the political process is an *executive* one. These functions are entirely different but in the present administrative structure they are intertwined, to the detriment of both.

9.13 It is a function of the political process to reflect society's concern that necessary health services are provided and, in the context of the total resources available, to decide on the type, quality and mix of services which should be made available to the public in general and to those groups with specific needs, as well as the manner in which they will be funded. While these decisions on the nature and shape of the health services will ultimately be taken at a

national level, there is also an important local dimension to the political function. This involves reviewing on behalf of constituents the manner in which services are delivered to meet defined standards and criteria, identifying deficiencies in these areas and putting this information into the political process.

9.14 The health services are characterised by their complexity, their very technical nature and the large variety of services provided. This complexity means that the efficient and effective realisation of the objectives formulated by the political process in terms of service requirements is best achieved by a separate executive function. Such a separation would enable the political process to concentrate on reviewing the performance of the health services against the criteria of perceived constituent needs and on formulating new health policies, as appropriate. The executive function, responsible for the provision and administration of services, would appraise their performance against the criteria of stated health policies and be free to make necessary management decisions to ensure such criteria were met.

9.15 The present administrative structure largely confuses the political and executive functions:

— the Minister for Health, whose primary role is clearly a political one, is also expected to deal not only with the opening and closing of hospitals, units and centres, but even with the most low-level executive work. He is often seen as personally accountable for the detailed circumstances of an individual hospital or centre, or even of an individual patient or client;

— the Department of Health, whose primary responsibility is to support the Minister in the formation of policy and the review of services, is very much involved in the day-to-day management of large areas of the services, despite the fact that the statutory responsibility for this function rests with the health boards. The Department deals directly with many individual hospitals, agencies and voluntary organisations, with executive boards, professional organisations and trade unions; it is involved with the management of capital schemes, the provision of specialised equipment and the development of information systems; it is involved in close supervision and control of the expenditure and recruitment of health agencies, and it must, on behalf of the Minister, be able to answer for the detailed circumstances of individual cases;

— the Department of Finance which is responsible for the overall control of Exchequer revenue and expenditure has become

increasingly involved in influencing executive decisions made at Department of Health and health board level. While this development is a consequence of the recent climate of financial stringency, it represents an undesirable and unnecessary confusion of authority and dilution of the accountability of those who are primarily responsible for the delivery of services;

— health boards, whose membership is mainly political, tend to concentrate on the details of executive work. The Chief Executive Officer's authority is derived mainly by delegation from the board. Although certain functions are reserved to the Chief Executive Officer, he can be directed by the board on most issues. The involvement of health boards in executive work has two important consequences. Firstly, they are unable to concentrate on the fundamental roles outlined earlier — that of representing their constituents' viewpoints in the overall formation of policy and that of monitoring the quality and adequacy of the services available. Secondly, it is inevitable that board members, who are either local politicians or representatives of medical and related professions, tend to be influenced by considerations other than the best delivery of the health services. These influences are quite legitimate in the political and representative process but may be greatly detrimental to the executive function;

— other agencies such as voluntary hospitals, certain homes for the mentally handicapped and voluntary organisations, because of the degree of autonomy which they possess, have in practice a major role in deciding the type, mix and quantity of services which they provide to the public. This derives in large measure from the unique position which they have within the Irish health services and which, in turn, is related to the historical development of those health services. Many voluntary hospitals and other agencies were established long before any public health service and the Commission recognises the invaluable role they have played in the life of the community. Nevertheless, in a modern health service their role must be defined afresh and the parameters of responsibilities in the delivery of services set out clearly. Such clarity is lacking in the present system. We discuss the question of accountability of voluntary agencies in receipt of public funds in greater detail later, but we draw attention to the issue of the nature of their role at this point as it provides an example of decisions which can be defined as political but which are taken at the moment by voluntary executive agencies.

Imbalance between national and local decision-making

9.16 The Commission believes that to provide an equitable and efficient health service, it is necessary to identify those decisions which are best taken at national (or central) level and those which are more appropriately taken at local (or operational) level, and to structure the decision-making process accordingly.

9.17 Certain decisions should be taken at national level because

— equity dictates that the same range and coverage of services be available throughout different parts of the State. To ensure this, the criteria for access to services must be uniform and these are best decided centrally;

— a system so complex and varied as the health services has a tendency towards imbalance between needs and availability at any one time, so that underused capacity in some services and delays in others may occur together. This can be countered by assigning overall responsibility for the long-term planning and coordination of services to a central unit with the relevant technical competence to manage large and complex systems;

— the development of health technology has meant that many procedures are best provided for the entire country in a small number of regional centres, in one national centre or, in certain cases, by negotiating the use of facilities outside the country. Decisions on where such services are to be provided must therefore be taken at national level to prevent wasteful duplication or unnecessary provision of facilities.

9.18 However, operational decisions on how to provide the nationally-determined level of service are best decentralised to the greatest extent possible, for a number of reasons:

— services will be more effective when they are tailored to meet local needs and to take advantage of local opportunities. A centralised management structure tends to be slow to respond to variations in local conditions, giving rise to a lack of flexibility which is commonly perceived as "bureaucratic inertia" or "red tape";

— variety in approaches to the delivery of services may lead to worthwhile innovations in some areas which can then be adopted in others; and

— local managements can monitor and take account of user response to and satisfaction with the services provided.

9.19 It follows that the broad planning of services is best carried out at national level, but that matters of detail should as far as possible be delegated to local level. This was recognised in the 1966 White Paper[1] which set out the framework of the present structure. It indicated that the Department of Health, freed of some of its detailed administrative work, should become orientated towards broad forward planning for the health services. This shift in emphasis did not in fact occur. In 1984, the National Planning Board[2] found that the Department was still absorbed in short-term administration (such as monitoring and controlling expenditure) of more than one hundred individual agencies, at the expense of the essential planning work necessary for the better management of the health services as a whole. The Department's role in this area has, if anything, increased further since the publication of the National Planning Board's report.

9.20 A consequence of the concentration on matters of detail at the national level is that many decisions which should be taken centrally are in fact left to those at the local level. The National Economic and Social Council's study of community care services[3] identified many service shortfalls which, it concluded, were due not only to limited resources but also to the absence, for many services, of national guidelines on desirable levels of service and of national statutory rules of eligibility for services. The report pointed out that this results in significant variation between health boards in the aspired level of service provision; people in objectively similar conditions have access to services in some parts of the country but not in others.

9.21 The present structure does not achieve the correct balance. There is inadequate central planning of services and a lack of national guidelines for health boards in respect of many services, yet there is, at the same time, pressure for the Department to be involved in the detailed management of services.

Absence of a role for evaluation

9.22 A particularly important characteristic of healthcare is the considerable degree of uncertainty about both what causes certain illnesses and the effectiveness of medical responses to them. If the

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[1] *White Paper: The Health Services and their Further Development* (Stationery Office, 1966): para. 132.

[2] National Planning Board: *Proposals for Plan 1984-1987* (Stationery Office, 1984): pp. 302-3.

[3] National Economic and Social Council: *Community Care Services: An Overview* (NESC No. 84, October 1987): p. 121.

health services are to use the available resources as effectively as possible, some form of central information and evaluation function is necessary. This involves drawing together information on health needs and the costs and outcomes of treatments, both as a basis for choice in planning and delivering services and also as an ongoing measure of quality and efficiency.

9.23 This crucial component is largely underdeveloped within the present structure. A functional unit, with the appropriate technical qualifications and resources, is needed to

— evaluate the needs which the health services are intended to address;

— plan, within the constraints of the policies and resources determined by the political process, services which will best meet these needs;

— examine the medium and long-term implications of developments in medical research and in the funding and delivery of health care; and

— monitor the performance of services in terms of both efficiency and quality.

9.24 While the formal role of the Department of Health embraces these matters and substantial work has been carried out by the Department, in association with health service managers and agencies such as the Health Research Board, there is a need to give a central role to this function with appropriate technical resources. The types of information and evaluation which would be required for this work are discussed in the next chapter. At this point, it is sufficient to draw attention to the absence of these components from the present structure. Where such a function should be located is discussed later in this chapter.

Inadequate accountability

9.25 The simple question "who is in charge?" cannot easily be answered for the Irish health services. The Minister is responsible to the Oireachtas for the effective and efficient use of resources; however, the accountability of those providing the services is less clearly defined. This question of accountability is one of the greatest importance in the context of the very high cost of the health services — some £1.2 billion in 1988 or 22 per cent of total Exchequer spending on non capital supply services.

9.26 Under section 14 of the Health Act, 1970 the Minister for Health may (and at present does) exercise control over the personnel

appointments of health boards. This control is very extensive and covers the number and types of grade in a given discipline, together with the qualifications required for each and appropriate job descriptions. In addition, and, most importantly, the Minister controls the number of personnel appointed to each grade and the applicable salary scales in each public sector health institution. Section 31 of the Health Act, 1970 limits the maximum expenditure of a health board to the sum specified by the Minister and prohibits the Chief Executive Officer from incurring expenditure by the board in contravention of this limit. Should a board refuse to agree a budget on the basis of the maximum expenditure sanctioned by the Minister — as may arise due to unwillingness to accept the implications for certain services — the CEO must then allocate the budget so as to remain within the limit. The CEO, however, has no statutory authority to cease specific services in order to ensure the most effective use of the available funds, and must therefore make the required savings through other means (such as across-the-board staff reductions) which may have a more detrimental effect on the overall level of service. The Minister could, under section 12 of the Health Act, 1970, remove a board from office, after a local public inquiry, if its duties were not being duly and effectively performed. As this is an extreme remedy, which has never been used, it does not in practice provide any effective accountability.

9.27 Although health boards have responsibility under the Health Acts for the provision of all health services, in practice about 50 per cent of acute hospital services are provided by voluntary hospitals, while most services for the disabled and the mentally handicapped are provided by voluntary homes and organisations. The statutory position implies that these services are carried out on behalf of the health boards, but in many cases the boards have no involvement in arranging for their provision, and have no direct relationship with the agencies concerned — the funding and supervision of the services are dealt with directly by the Department of Health.

9.28 These examples illustrate how the system of accountability as it operates in practice falls short of that prescribed by the statutory roles of its participants. However, the problem of inadequate accountability is also related to the absence of clear and detailed objectives for those providing services. Even if the Minister for Health had a practical way of exercising control over health boards, and health boards were directly responsible for funding and supervising all health agencies, it would still not be possible, under the present structure, to impose true accountability. True accountability requires those providing services to take explicit responsibility for the achievement of predetermined objectives. This

in turn requires further development of the central evaluation function within the structure to set the objectives and to monitor whether they are being achieved. As discussed earlier, this function is underdeveloped within the present structure. Without it, accountability can only be assessed in terms of staying within budgets, staffing levels, uniform procedures and statutory requirements. Such a form of accountability cannot ensure the effective and efficient delivery of services, nor can it take into account the quality of care provided.

Insufficient integration of related services

9.29 An important characteristic of healthcare is that patients may require more than one type of service at the same time. A feature of our system, which is also found in Northern Ireland but is not common elsewhere, is the wide jurisdiction of the Department of Health and the health boards. Because their responsibilities encompass hospital services, community care and personal social services, a potential basis exists for the integrated planning and delivery of services. In theory this should lead to a comprehensive service which would provide the most appropriate form of care in all cases of medical or social need, ease of transfer between in-patient and community services as necessary, recognising that the two forms of care are complementary and interdependent, and full coordination between the services provided by the various health and welfare agencies.

9.30 There is widespread acceptance that, in practice, there has been inadequate integration and coordination of services, due to a number of obstacles:

— the health boards are not responsible for the financial and administrative control of certain services;

— the programme structure adopted for the administration of health board services leads to competition for resources between programmes and little incentive for integrated planning of services across them; and

— there is no framework for incorporating voluntary organisations into planning the delivery of local services.

Inadequate Representation of Service Users

9.31 The health services are likely to be of great importance to all of us at some time in our lives. For the reasons discussed in Chapter Six, their funding should, in the main, be organised collectively

rather than in response to each individual's demands, and should be provided without charge, or at modest charge, at the time of use. A danger inherent in this collective approach is that the interests and preferences of the individual patient or client may receive less attention than would be the case if he or she were in the position of exercising full consumer choice as a purchaser of the service.

9.32 The present administrative structure is not particularly responsive to the views of service users on the adequacy or quality of the services which they receive. We have already pointed out that the health boards, which could have an important role in this area, are preoccupied with executive functions. The structure also fails to provide an appropriate mechanism under which individuals can seek a remedy if they feel their entitlements have not been met or that a less than adequate service has been provided. In the first place, the absence of specific criteria for access to many services may leave the individual without any basis for an appeal; in the second place, where an appeals procedure exists, as in relation to the non-award of medical cards, the case is reviewed by the authorities responsible for the original decision.

9.33 This is not to suggest that agencies are indifferent to patient opinion. Nor is it to suggest that there are no avenues through which grievances are pursued. For example, the Ombudsman's brief extends to the non-clinical aspects of the activities of health boards, while public representatives are frequently engaged in dealing with health agencies on behalf of constituents. However, the absence of a more positive orientation towards patient opinion may be reflected in the least satisfactory method of grievance resolution — the growing level of litigation.

9.34 The inevitable consequence of the absence of elements within the structure to represent consumer views and to investigate individual grievances is a perception that the services are run in the interests of those administering and delivering them rather than in the interests of those who receive them.

THE PROPOSED ADMINISTRATIVE STRUCTURE

9.35 It is clear from the above that some restructuring of the health services is essential. The submissions which the Commission received contained many suggested improvements and, in some cases, proposed alternative structures. We commissioned an analysis of possible structural mechanisms from the perspective of the organisational and managerial sciences. We also examined other

systems, and discussed possible approaches with healthcare providers, administrators and analysts at home and abroad.

9.36 A number of possible approaches were rejected because we felt they would retain rather than remove some of the weaknesses of the present structure.

9.37 It was put to us that in line with the general policy of devolving power to local authorities, a greater degree of autonomy could be given to the regional health boards in relation to the planning and delivery of health services. But, while this might increase responsiveness to local circumstances, it would retain the confusion between political and executive functions at local level which we have identified as a major weakness in the present system. In addition, the nature of this country as a relatively small geographic unit with a small population distributed in a low density pattern outside the capital, combined with a weak structure of local government, tends to strengthen arguments against devolving control to local centres. Furthermore, decentralised planning of services could lead to a proliferation of facilities which, while conferring prestige or yielding spin-off benefits to the local economy, would result in wasteful over-provision and duplication. Uncoordinated development could also mean that patients with similar needs might obtain or be denied access to the same service depending on where they happened to live. We concluded that this approach was likely to be detrimental to both efficiency and equity.

9.38 It was also submitted to us that the health boards should be abolished and the health services structured along the lines of a State corporation, with regionalised management but without a local representative element. We considered that this approach failed to allow for the importance of community participation in the planning and monitoring of health services, which, as discussed earlier, implies a legitimate and important role for the political function at the local level. There is a need, therefore, to redefine this role rather than to abolish it.

9.39 The option of a separate administrative structure for hospital services was also suggested. Regional Hospital Boards were indeed provided for in the Health Act, 1970 to coordinate and develop hospital services in each region. This proposed role was not in fact implemented. It is now recognised that a cost-effective health service, providing care at the least complex level appropriate to the particular case, requires the integration of responsibility for all levels of service within a catchment area, and a separate administrative structure for hospital services would prevent this.

9.40 The Commission has concluded that the administration of the health services can best be restructured by

— clearly defining the roles of the Minister and Department, the health boards and their Chief Executive Officers and the relationships between each;

— transferring responsibility for the overall management of health services to an executive authority;

— clearly defining the role to be played within the healthcare system by voluntary agencies and, in particular, the nature of their relationship with the local management in terms of coordinating objectives of service provision;

— enhancing the evaluation function within the planning and monitoring of services, including the capacity to carry out technical appraisals of service levels; and

— establishing an independent appeals mechanism for patients and clients.

9.41 The structure recommended by the Commission is outlined in diagramatic form in Figure 9E; its components are discussed in detail in the paragraphs which follow. If adopted, the proposal would remove the weaknesses of the present system discussed earlier. Healthcare would by no means be removed from the political arena. The political process would still be responsible for deciding policies, objectives and the extent and sources of funding, and also for the ongoing monitoring and review of the adequacy and quality of the service. However, there would be a clear separation of the political and executive functions. Executive control would rest with accountable managers, fully responsible for the efficient delivery of the required levels of service within the limits of the allocated budgets. Their responsibility would extend to all publicly-funded services, whether provided directly or by independent agencies or professionals on a contractual basis. There would be an appropriate balance between planning of services on the basis of objective evaluation at national level, and flexibility to adapt to local factors in influencing their delivery. Finally, the structure would provide greater responsiveness to the interests of the patient and client, both at the level of the individual case and in relation to the overall planning and delivery of services.

The Minister and Department

9.42 The Government, through the Minister for Health, would retain ultimate responsibility for the provision of health services in line with legislation passed by the Oireachtas. **In order that the Minister may be free to concentrate on his primary role of formulating health policy, the recommended structure is founded on the premise that the Minister and Department would no longer be directly involved in the management of individual services.**

9.43 The Minister for Health would be responsible for formulating policy for approval by the Government and for giving effect to it by securing the passage of legislation through the Oireachtas, by making regulations or issuing directives where empowered to do so by the existing legislation, and by securing the agreement of the Government and the Oireachtas to the allocation of appropriate funds to the health services. **The Commission recommends that the range and quality of services to be available to patients, and the eligibility criteria for access to them, should to the greatest extent possible be governed by legislation.** It would not be practical to require the Oireachtas to pass amending legislation each time that a change in these provisions was desirable. **We recommend therefore that the Health Acts should in general set out broad principles and empower the Minister to specify detailed provisions by regulations and directives.**

9.44 In formulating policy, the Minister for Health would be aware of national and international developments and would be concerned with choosing the appropriate responses to changes in health needs, technological developments and the political, economic and social environment. Account would be taken of the viewpoints represented by regional health councils, professional associations and consumer interests. The Minister would take decisions in the context of better information on the extent of health needs, the costs and effectiveness of services, and the level of funding required to meet any specific set of service requirements. Technical information supplied by the proposed Executive Authority would be of great importance in this regard.

9.45 Because of this political responsibility for the health of the population, the Minister should retain a special responsibility for the public health functions of immunisation, environmental health and the advancement of intersectoral action to promote health. The Minister's relationship with the Executive Authority would enable

him to issue specific instructions in circumstances where public health is at risk. He would also retain the ability to fulfil central functions deriving from international obligations, whether through the World Health Organisation or the European Community.

9.46 The Minister, with the approval of the Government, would be responsible for appointing the proposed Executive Authority. The Authority would be responsible to the Minister for fulfilling the service requirements set out in legislation and in ministerial regulations and directives, and for reporting progress to the Minister on its performance in meeting this objective. The Minister, in turn, would be empowered to seek such information from the Authority concerning its proceedings as he saw fit.

9.47 The role of the Department of Health would be to advise and support the Minister in policy review and formulation, national and international discussions, the preparation of legislation and overall funding estimates, and in his relations with the Executive Authority.

The Health Services Executive Authority

9.48 **The Commission recommends that a Health Services Executive Authority should be appointed by the Minister for Health, with the approval of the Government, to take responsibility for the management of the health services, including the personal social services currently administered by the health boards.** This Executive Authority should be set up on a statutory basis and should be independent of the Minister and Department of Health. It should have a small rather than large membership. The broad nature of its responsibility to organise the delivery of the health services, in the context of the overall health policies decided by Government, should be clearly stated in legislation. Within the framework of government policy, the Executive Authority should be free to decide how best to translate the objectives given to it in terms of service organisation and delivery.

9.49 As the Authority would be responsible for the operational and strategic control of a complex organisation with a budget in excess of a billion pounds, its members should be selected on the basis of criteria such as experience in the running of large-scale service organisations and an understanding of the nature and complexity of the health and personal social services. It is not envisaged that their appointment to the Authority should be on a full-time basis.

9.50 **The post of Chief Executive of the Executive Authority should be filled by someone of the highest calibre and the**

salary and other benefits should reflect this. He or she should be appointed by the Executive Authority itself rather than by the Minister and should have a fixed-term contract. The posts of Chief Executive and Chairman of the Authority should be separate.

9.51 **We recommend that a structure based on Area General Managers should be established which would be responsible to the Executive Authority.** The Executive Authority would be charged with translating the Government's policy decisions into operational goals which would enable the specified service requirement to be provided within the allocated budget. In line with these goals, it would determine local performance targets and the appropriate share of resources for its Area General Managers. These Managers would be designated by the Executive Authority to take responsibility for the delivery of services within a specified geographical area and would have considerable operational autonomy within the constraints mentioned above.

9.52 The Commission believes that the Executive Authority should be funded on the basis of a multi-annual budget in order to establish a continuity within which the rational and orderly planning of service provision can be facilitated. At present, services are hampered by the effects of annual budgeting resulting from the requirements of government accounting. Planning is rendered more difficult by uncertainties surrounding the future level of health service funding. The need to rationalise existing services within the constraints of a twelve-month financial framework leads to an unnecessary level of disruption in services when considered against the more gradual and less chaotic results which could be achieved over a longer timescale. **For these reasons, we recommend that the financial commitment given by the government to the Executive Authority should be a multi-annual budget for a minimum period of three years and that it should be "rolled forward" or adjusted annually so that the Executive Authority is in a position to plan the delivery of services effectively. Furthermore, we recommend that, in respect of the annual accounting period, the Executive Authority should have some discretion to vary, within an agreed percentage, its expenditure from the annual amounts contained in the overall three-year budget given to it by government.**

9.53 The Executive Authority should formally report each year to the Minister for Health and this report should be published. We envisage that, in addition to accounting in detail for the funds allocated to the Executive Authority by government, it should

contain a comprehensive statement of the way in which the Authority has responded to the needs articulated by the political process and more specifically in terms of publishing performance indicators for services provided. Such performance indicators should be based on the best analytical techniques available, as discussed in Chapter Ten, and would form the basis of government and, indeed, public appraisal of the performance of the Executive Authority.

9.54 The Executive Authority would also deal with those executive functions which are best organised at national level, including research and development, negotiations with professional organisations on operational issues, and liaison with the higher education authorities on long-term manpower policy. **The functions of every existing executive board (such as Comhairle na nOspideal, the National Rehabilitation Board and the Blood Transfusion Service Board) should be examined to establish whether they could best be undertaken by the Health Services Executive Authority or whether they should continue to be provided by a separate agency.**

9.55 The proposed separation of political and executive responsibilities can be illustrated by reference to the personnel function in the health services. Decisions concerning issues such as the overall number and types of staff employed would be the overall responsibility of the Executive Authority, but would be delegated where appropriate to regional managers or to individual agencies. However, all decisions would have to be taken within the limits set by government policies on public sector employment in general.

9.56 A key function of the Executive Authority should be that component which we have identified as underdeveloped within the present structure — i.e. generating information on health needs, service costs, outcomes and performance measures which are needed as a basis for

— choices in the planning and delivery of services;

— decisions (by government) on the overall level of funding for the health services and (by the Executive Authority) on its allocation to the various services and regions; and

— ensuring the effectiveness, efficiency and quality of the services.

Because of the importance of this function, and its inadequate development in the existing system, we devote the next chapter to describing the information and evaluation which are required and how they should be used.

The Health Councils

9.57 We have identified the confusion of political and executive roles as a major defect of the present organisational arrangements. This problem is most acute at the level of the health boards. We strongly favour the retention of a locally-based and managed service, operating flexibly within the policy and resource guidelines determined centrally. To achieve this in a manner compatible with the requirements of efficiency and effectiveness, **members of health boards would be freed of their involvement in the day-to-day management of services, but would instead concentrate on representing local interests by influencing the formation of policy and by monitoring the adequacy and quality of the services available to meet local needs. To underline this concentration on the representative function the boards should be known as Health Councils.** The change in role of these Health Councils could be achieved by the enactment of new legislation to redefine the existing relationship between the Health Board and the CEO (Health Council/Area General Manager) so that the executive functions are transferred to the Area General Manager while the political/consumer representational functions of the Health Council are retained and enhanced. The legislation must also define the relationship between the Executive Authority and the Area General Manager.

9.58 Each Council would have an advisory relationship with the relevant Area General Manager. The Council would provide the manager with important guidance on the local perception and acceptability of the options available to him in organising the delivery of services; it would therefore be in the Manager's interest to consult fully with the Council in arriving at decisions. The Council would also act as a channel for local views on the service being provided and would be entitled to make representations to this end. There would also be considerable scope for cooperation between the Council and Area Management on measures to encourage health promotion among the local community.

9.59 In recognition of the importance of the role of the Councils in representing the interests of consumers of healthcare, **the Commission recommends that Councils be given power to delay, for a maximum of three months on any one issue, the implementation by Area Management of major decisions with which they do not agree and to require Area Management to give a public justification for such decisions.** We envisage that a Health Council would be able to approach the Health Services Executive Authority in the intervening time to explain the basis of

its objections. The Executive Authority would then be bound to examine the objections, to consider such observations as interested parties wished to make and then to adjudicate on whether the Area Management's original decision be allowed to stand or be in some way modified or rescinded. This process could be appropriate to a public forum.

9.60 This three-month power of delay should be confined to matters concerning the quality and availability of services, and not to matters more appropriately dealt with as executive functions such as the deployment of staff, the formulation of budgets or the location of units.

9.61 Each Council would also publish a report regularly on whether services were being provided effectively and efficiently, on the level of satisfaction with the Area Management, and on the adequacy of services in response to local needs.

9.62 The membership of health boards at present comprises persons appointed by local authorities, representatives of medical and related professions and ministerial nominees. Given the proposed role of the new Councils in representing the views of consumers, we do not consider that it would be appropriate for members to serve on Councils as representatives of professions involved in the delivery of services. **Professional and other staff input on executive matters should be provided through formal consultative structures at regional level, involving management, professional associations and trade unions, using separate representative channels as appropriate.** There should also be a channel through which the views of voluntary organisations could be expressed. Associations and unions would also be entitled to make representations on policy issues to the Minister for Health.

9.63 The Commission feels that as the members of Local Authorities are the elected representatives of communities it is reasonable to draw on such bodies for the membership of the Health Councils. **The Commission recommends that Council members be nominated by Local Authorities.**

9.64 In order to ensure the most effective liaison between the political and executive functions at local level, it is important that the boundaries of Health Council constituencies should coincide with those of the local operational areas of the Health Services Executive Authority. The capacity of the Executive Authority to determine the operational areas of its Area General Management,

and the criteria which should apply in this determination, are dealt with in the next section of this chapter.

Management and Services

9.65 **The Commission recommends that the Minister for Health should give the Health Services Executive Authority the responsibility for ensuring that patients and clients have access to a specified level of service on the basis of eligibility criteria.** The Executive Authority should have complete freedom to determine the appropriate combination of services provided by its own facilities or contracted from voluntary hospitals and agencies, the private sector or, where necessary, outside the State, to meet its performance targets within its allocated budget. For instance, certain services may be best suited to provision by voluntary agencies; bottlenecks in waiting-lists for certain procedures may best be removed by the use of the private sector rather than by permanent additions to the public facilities; and it may be cost-effective to send patients abroad for certain procedures which are required infrequently because of the size of our population.

9.66 Some of these decisions would arise at the national level and would be taken by the Executive Authority itself. Those arising at the local level would be delegated to the Area General Managers, who would similarly be required to meet specified performance targets within their allocated budgets, but would have considerable flexibility in relation to how the required services were provided.

9.67 **The Executive Authority must have the freedom to rearrange its operational boundaries in the future if this is found necessary to increase the effectiveness or efficiency of the services, in which case the Health Council boundaries should also change.** It is important that these boundaries should coincide with those of the areas of responsibility of the Area General Managers, to ensure the most effective liaison between the political and executive functions at local level.

9.68 In structuring the areas of local management the following criteria should apply:

— Areas should be large enough to allow for efficient delivery of a reasonably comprehensive integrated range of services reflecting the norms for hospital catchments and service rationalisation.

— Areas should be small enough to allow factors such as local needs and population patterns to be reflected in the services.

is important that the capacity of the Executive Authority to delegate effectively to Area Management is clearly established in law so that, in relation to delegated matters, the Area General Manager and not the Executive Authority bears final legal responsibility. We believe that, by delegating certain functions to the Area General Manager, a framework will be created within which the danger of over-centralisation will be minimised, while, at the same time, the freedom and flexibility to implement the necessary reforms will be permitted.

9.76 Area General Managers, and those reporting to them, would have an entirely different accountability from that which exists in the administration of health services at present. The traditional concept of *administering* health budgets is based on uniform structures and procedures; individual accountability relates more to adherence to these than to the achievement of target levels of performance. By contrast, the concept of *managing* budgets requires individuals to take explicit responsibility for the achievement of predetermined objectives within the constraints of the available funds, but permits greater flexibility in relation to structures and procedures in order to do so.

9.77 The Commission feels that the poor quality of management in the health services is a problem which needs to be addressed urgently. The Department of Health has acknowledged that "the essential management structures and expertise in hospitals have, by and large, been neglected".[4] In the area of community care, the National Economic and Social Council has concluded that "a professional management ethos is apparently absent in the overall management of the services and in the operation of the sub-programmes".[5] An important reason for these deficiencies has undoubtedly been the lack of any emphasis on management training. **We recommend that the development of suitable management training programmes should be one of the priority tasks undertaken by the Health Services Executive Authority.**

9.78 **We recommend that all disciplines should be entitled and encouraged to compete for management posts in the proposed structure.** Doctors, nurses, paramedics and others with administrative or managerial experience within and outside the health services can all bring different insights and experience to bear on the job of running services effectively and efficiently, and the resultant cross-fertilisation can only benefit the overall management

[4]Department of Health: *Health — The Wider Dimensions* (1986): p. 33.
[5]*op cit*: p. 15.

of the services. The appointment of managers on secondment, especially from medical and other professional posts, could be a particularly useful way of attracting individuals who might have a significant short-term contribution to make, and who would themselves benefit from the managerial experience when they later returned to their original work. Senior medical staff, who otherwise might have no financial incentive, could also be recruited into management on a full or part-time contract basis for a fixed period. There is no doubt that the health services in general would benefit from such mobility of professional staff between managerial and vocational posts. A considerable degree of mobility between managerial posts would also be desirable, particularly to provide new and more challenging outlets to the better managers.

9.79 **It is important to stress that the Commission does not regard its proposals as necessitating any increase in the total number of administrative and managerial staff employed in the health services as a whole.** We have proposed that the control of matters of detail should be transferred away from the centre and, as much as possible, to the service providers themselves. This would remove much of the existing workload of the Department of Health and of local administrative staff. We have also suggested that the functions of many of the existing executive boards and agencies might be undertaken by the Executive Authority. Overall, the reorientation of health services management towards the planning and evaluation of services would involve a far more efficient use of the relevant staff. **It should also be stressed that the respective roles of the Department of Health, the Health Services Executive Authority, its Area Management and the Health Councils would be distinct and clearly defined by statute, to avoid any duplication of functions or any perception that the net effect was simply to "add another layer of bureaucracy" to the system.**

An Appeals System

9.80 In the absence of any independent appeals system within the health services, it is inevitable that people who feel that they have been denied their entitlements will channel their grievances through the political process. As a result, local and national politicians spend much of their time making representations about health and personal social services on behalf of individual constituents; much of the time of the Minister for Health is then taken up with answering them. Politicians are thus involved in detailed executive issues to the detriment of their more important role in policy formulation. This

also serves to encourage a perception that it is necessary to use political influence to obtain an entitlement.

9.81 As we have already noted, the Ombudsman can, of course, investigate complaints about the actions and decisions of health boards, but his role is intended to be that of a forum of last resort when normal appeals procedures have been exhausted.

9.82 We have recommended that the range and quality of services available to patients, and the eligibility criteria for access to them, should to the greatest extent possible be stated explicitly whether by way of legislation or by ministerial regulations and directives. **We recommend the appointment in each functional area of an independent Appeals Officer for health and personal social services to investigate complaints that these entitlements were not met in individual cases.**

The Performance Audit Unit

9.83 Since the Health Services Executive Authority would have full responsibility for the delivery of a specified range, level and quality of services within the constraints of its budget, it would be important to have an independent appraisal of its performance in meeting this requirement. This review is fundamentally a matter for the Minister and his Department. However, in addition to the expertise available within the Department, **there is a strong case for further technical resources such as would be found in a Performance Audit Unit whose role would be to assess the overall effectiveness of the health services in terms of meeting the specified requirements.** Its functions would be to monitor access to services and identify deficiencies in services to particular localities or groups. The Minister, and through him, the Performance Audit Unit, would have unrestricted access to the performance data of the Executive Authority, but there will be a need for independent enquiries and surveys of consumer perception of the availability and quality of services.

9.84 The Performance Audit Unit should be established by the Minister for Health, and its findings would obviously be essential to his own review of the performance of the Executive Authority. Its reports would be of considerable importance to health councils, professional associations and consumer interests, and should be published.

9.85 We envisage that the Performance Audit Unit would be small and not necessarily full-time. It might best be sited in a third-level

institution as part of a multi-disciplinary Department of Health Services Research. The need for such a Department is considered further in the chapter which follows.

THE BOUNDARIES OF THE HEALTH SERVICES

9.86 The responsibility of the health authorities for non-medical services such as personal social services and long-term care is much wider in Ireland than in most other countries, where these services are often the responsibility of local authorities or other agencies separate from the administration of healthcare.

9.87 We received a number of suggestions for re-drawing the boundaries of the health services. These ranged from the view that the administration of healthcare should be separated from that of the non-medical services, to the proposal that the Departments of Health and Social Welfare should be amalgamated to bring all health and welfare services under one administrative structure.

9.88 Personal social services and long-term care have a number of characteristics in common with the medical services. They require individual assessment of the needs of the client so that the appropriate response can be chosen. They also require flexibility in decision-making at local level. An administrative structure which is designed to take account of such characteristics of healthcare is thus well suited to the provision of these services also. The integration of the various services is also desirable because many personnel, including community nurses and paramedics, may be involved in providing both medical and non-medical care. Finally, the need for personal social services or long-term care will often arise as a result of illness or disability, so that close coordination with the medical services is required. Taking all of these factors into account, we would not be in favour of removing these services from the jurisdiction of the health services.

9.89 The amalgamation of the Departments of Health and Social Welfare was originally recommended by the Public Services Organisation Review Group — in the "Devlin Report" — in 1969.[6] The main argument advanced in favour of a merger was the need for effective coordination of both planning and resource allocation in relation to health and social welfare services. Since the publication of the Devlin Report, the responsibilities of the Department of Health in relation to welfare services have grown to a very great

[6] *Report of the Public Services Organisation Review Group* (Stationery Office, 1969): Chapter 29.

extent. The recommendations in our report would ensure that the planning and delivery of health and personal social services were fully integrated. The Department of Social Welfare is concerned essentially with income maintenance schemes, the administration of which has characteristics quite different from those described in the previous paragraph. Levels of payment and eligibility criteria are pre-determined and there is little need for decision-making except in relation to whether the eligibility criteria are met in a particular case. The system can be, and is, operated on the basis of a network of offices under a central executive. The appropriate administrative structures for the two types of service are so different that amalgamation of the functions at local level would clearly be undesirable. It is difficult to discern any potential benefit to be gained from an amalgamation at central level.[7]

9.90 There is, of course, a need for *coordination* at local level of the various health and related services with the income maintenance services of the Department of Social Welfare and with the other public services provided by local authorities such as water supply, sewage disposal, housing and environmental protection, all of which, by their very nature, have a significant impact on the health and welfare of individual communities. The initiation of appropriate arrangements for liaison and consultation between different agencies whose activities impinge on health should be a particular responsibility of each Area General Manager.

RECOMMENDATIONS

9.91 We have made the following recommendations in this chapter:

1. In order that he may be free to concentrate on his primary role of formulating health policy, the Minister for Health and his Department should no longer be directly involved in the management of individual services.

2. The range and quality of services available to patients and the eligibility criteria for access to them, should to the greatest extent possible be governed by legislation. Health legislation should in general set out broad principles and empower the Minister to specify detailed provisions by regulations and directives.

3. A Health Services Executive Authority should be appointed by the Minister for Health, with the approval of the Government,

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[7]Chapter Nineteen discusses the argument that certain income maintenance schemes which are at present administered by the Department of Health and the health boards should be transferred to the Department of Social Welfare.