to take responsibility for the management of the health services, including personal social services. A structure of Area General Managers should be established which would be responsible to the Executive Authority.

4. The Chief Executive of the Executive Authority should be appointed by the Authority on a fixed-term contract.

5. The functions of every existing executive board should be examined to establish whether they could be undertaken by the Health Services Executive Authority or whether they should continue to be provided by a separate agency.

6. In each area there should be a Health Council which would represent local interests by influencing the formation of policy and by monitoring the adequacy and quality of the services available to meet local needs. These Health Councils should also have power to delay the implementation by Area General Managers of certain decisions with which they do not agree, in order to appeal to the Executive Authority. This power should be confined to matters concerning the quality and availability of services.

7. Professional and other staff input on executive matters should be provided through formal consultative arrangements at regional level, involving management, professional associations and trade unions. There should also be a channel for representing the views of voluntary organisations.

8. Council members should be nominated by Local Authorities.

9. 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.

10. The Executive Authority should be free to rearrange its operational boundaries if necessary to increase the effectiveness or efficiency of the services, in which case the Health Council boundaries should also change.

11. The Executive Authority should experiment with different structures for the division of responsibilities below the level of Area General Manager.

12. All service providers whether hospitals, homes, agencies or individuals,should have explicitly-stated roles, objectives and service

requirements. Voluntary agencies should be funded by reference to an agreed level and type of service.

13. The Health Services Executive Authority should be free to contract services from the private sector where this would be cost-effective. Contracts should be on the basis of competitive tendering for the provision of an agreed level and type of service as the need arises.

14. The Health Services Executive Authority should make an explicit delegation to the Area General Manager of responsibility to deliver services in accordance with its directives. Specified statutory functions of Chief Executive Officers of health boards should be transferred to Area General Managers. It 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.

15. Priority should be given to the development of management training programmes.

16. All disciplines should be entitled and encouraged to compete for management posts.

17. It should not be necessary to increase the total number of administrative and managerial staff employed in the health services as a whole under the proposed new structure. 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.

18. An independent Appeals Officer for the health and personal social services should be appointed in each functional area.

19. A Performance Audit Unit should be established to assist the Minister in assessing the effectiveness of the health services in meeting the specified service requirements. Its reports should be published.

CHAPTER TEN

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

INTRODUCTION

10.1 Choices in healthcare cannot be avoided, since the demand for services will always outstrip the available resources. Choices are now being made, at national level and at local level, by politicians, administrators and healthcare professionals. Their choices determine what services will be available, to whom, and the manner of their delivery.

10.2 Those who have to make decisions need full information on health needs and the costs and outcomes of treatments

— to plan services and allocate resources;

— to make choices in the delivery of services;

— to measure performance of services on the basis of quality and efficiency.

This information and evaluation function is most important, but is underdeveloped in the present system. This chapter describes the type of information which is needed and gives general directions as to how it should be used.

10.3 The decision-making process must not be dominated by purely economic analysis or costings to the exclusion of other considerations. It is not possible to derive a neat formula to calculate an ideal allocation of resources which will have an optimal effect on the health of the population. Views on the importance of different kinds of healthcare can change, and political judgements on the relative priorities accorded to various health and other social services may vary. Good information is, however, essential for policy-makers who

take decisions, and also for the managers and professionals who make judgements on how to implement these to best effect. All decisions should, to the greatest possible extent, be based on information which is accurate and sufficient.

10.4 The three broad categories of research work which have an important, complementary role in this process are:

— *epidemiology,* which is concerned with obtaining information about the distribution and determinants of disease and injury in given populations;

— *clinical,* or *biomedical research,* concerned with developing and assessing treatments; and

— *health services research,* concerned with evaluating the effectiveness and efficiency of the delivery of health services.

Although these categories are defined in terms of healthcare, similar research is also needed on the extent and causes of social needs and the effectiveness of the personal social services in meeting them.

10.5 An urgent priority of the Health Services Executive Authority and its Area Management will be an assessment of the needs and capacity of the health services. The development of the information and evaluation techniques which we describe in this chapter should greatly facilitate this process. The cost-effectiveness of services and their capacity at every level to provide an acceptably high quality of treatment within a reasonable timescale should be a point of particular focus. Capacity should be assessed both in terms of the human resources of doctors, nurses and all other personnel and in terms of physical resources such as beds, theatres and community care facilities. The assessment should include specific recommendations to enable the Authority to provide services at an acceptable level commensurate with existing needs. These recommendations should include issues such as the number and level of consultants and the length of waiting period considered acceptable for different procedures and treatments. These issues are discussed in greater detail in the relevant chapters of the report which deal with individual services. The results of the assessment should be presented to the Minister for Health and the Government. It should then form the basis for the allocation of Exchequer resources to the health service and this resource allocation should be made public.

IDENTIFYING SERVICE NEEDS

10.6 It is difficult to plan services without accurate information on the extent, nature and distribution of needs. This information must then be linked both to the services currently available and the manner in which they are used. In later chapters on the various services, however, we note deficiencies in the availability of such information. The Department of Health's consultative statement acknowledged that the formal measurement of health needs on a wide scale would "be an innovation in the Irish health care system ... it will call for new skills in collecting, analysing and interpreting health data and in devising policy measures to address particular health problems".[1]

10.7 In the absence of such measurement, the allocation of resources is inevitably determined more by the requirements of the structures that are already in place than by the health needs of the population.

10.8 It is not difficult to collect information. Indeed, most data required for the measurement of service needs are already being routinely collected by public agencies[2] or by health and social service professionals in the course of their work. The difficulty lies in drawing together this information and using it effectively. Progress has been made with the development in the North Western Health Board of the Community Care Information System, which is intended to be applicable to other regions also. In addition to aiding the operation and management of services, this system enables data to be analysed on the basis of any required breakdown by geographic area, population subgroup or service. This form of detailed analysis could be helpful in matching services to needs. Pilot work carried out in the Eastern Health Board on an Epidemiological Information System suggests[3] that health needs vary widely within relatively small areas and that health services are much less effective in some areas than others. These variations may cancel out and pass unnoticed if data are analysed at too aggregated a level. Detailed epidemiological analysis of needs may also help to identify causal factors and thus highlight the scope for preventive measures.

10.9 Epidemiological information on hospital in-patient services is at present collected through the Hospital In-Patient Enquiry, conducted by the Health Research Board. This survey covers patients

---

[1]Department of Health: *Health — The Wider Dimensions* (Stationery Office, 1986): p. 36

[2]Such as the Central Statistics Office, Department of Health, General Medical Services (Payments) Board and the Health Research Board.

[3]Z. Johnson: *The Epidemiological Information System* (forthcoming paper).

of most acute public hospitals and includes information on, for example, diagnosis, area of residence and length of stay. Confidentiality is maintained in respect of the patient's identity. However, the Enquiry falls short of being a comprehensive source of information on in-patient services. In planning the availability of hospital services, account must be taken of the extent to which national and local requirements are already being met by private hospitals. However, private hospitals are not covered by the Enquiry and detailed information on the use of their services is not available. It has also been submitted to us that the Enquiry does not in any case operate satisfactorily, even in public hospitals, as returns are often inadequately completed, either through lack of commitment, poor training, or insufficient resources.

10.10 **Information systems must therefore be developed for health and personal social services in each region which**

- **include comprehensive population registers with demographic and health profiles and data on mortality and morbidity;**
- **give detailed information on the usage of community, out-patient and in-patient services, including those provided by private hospitals;[4] and**
- **link into a national network of epidemiological information as well as providing a basis for local decision-making.**

ESTIMATING SERVICE COSTS

10.11 If resources are to be allocated and used efficiently, it is essential that the costs of specific activities are known with some degree of accuracy. There are, however, major deficiencies in the information available in this field. Chapter Twelve discusses this problem in detail in relation to hospital services and describes the current research into output-related costings. There is a need for marked improvement also in the information available on the costs of individual services outside the hospital. Since alternative forms of care are available to meet many health and personal social service

[4]This implies that private hospitals would be required to furnish detailed epidemiological data. Since eligibility for other forms of public health service is more limited than that for access to public hospitals, it would not be necessary to monitor in such detail the private use of, for example, general practitioners as a prerequisite for planning and organising the public service. However, in evaluating the equity and efficiency of the overall health services, it would be valuable to carry out research from time to time on, for example, comparative utilisation rates, prescribing rates etc. as between the public and private sectors. The 1980 research in A. Dale Tussing: *Irish Medical Care Resources: An Economic Analysis* (ESRI, 1985) provides the only basis for such comparative analysis at present.

needs, it is essential, in assessing the appropriate care for specific cases, to have accurate data on the relative costs of the alternative approaches. As the National Economic and Social Council has recently noted:

> "It is popularly argued that community care is 'cheaper' or that in the 'long run' it is 'better value', yet no detailed, specific analyses have been undertaken of the costs of care for different client groups and care settings".[5]

10.12 **Each health service manager should have to ensure that the cost per unit of services for which he or she is responsible is quantified on a continuing basis.** This may be relatively complex in the case of acute hospital services but appropriate systems are being developed to meet this requirement. Allocating the overall costs of community and long-term care services as between units of service should not give rise to particular difficulties.

MEASURING OUTCOMES

10.13 The third category of information needed to inform choices for appropriate healthcare involves evaluating the effectiveness of specific treatments and of ways in which services can be delivered to meet patient-needs most effectively.

10.14 Clinical research examines the effectiveness of medical interventions in preventing, curing or alleviating illness or injury. The results are, in general, transferable across country boundaries. A small country such as Ireland will inevitably draw heavily on the findings of international research. Irish clinical researchers do, of course, have important contributions to make to advancing scientific knowledge in their own fields; they can also examine whether local epidemiological factors affect the validity of particular international findings in Irish conditions.

10.15 The relatively new and developing discipline of health services research provides greater scope for work specific to Irish conditions, as it analyses the effectiveness of the healthcare system rather than of individual procedures. For example, community-based treatment of acute illness may be evaluated in terms of the reductions in hospital usage and other institutional care which it makes possible; the relative effectiveness of alternative forms of hospital care — e.g.

---

[5]National Economic and Social Council: *Community Care Services: An Overview* (NESC No. 84, October 1987) Council's Comments: page 13.

in-patient care, day care, out-patient care — for specific conditions may be compared; and the effectiveness of immunisation and screening programmes can be studied in terms of the local epidemiology of the diseases at which they are targeted. Studies which compared the effects of different approaches to service delivery in Northern Ireland and the Republic of Ireland would be of particular value because of the similarity, in epidemiological terms, of the two populations. The organisation of health services research is discussed later in the chapter; it is a multi-disciplinary activity, with a role for healthcare professionals, administrators and researchers such as epidemiologists and economists.

10.16 International health services research has tried to establish a more accurate and refined measure of assessing the effectiveness of healthcare. It was recognised that crude measures such as whether a life was saved, or the number of years added to life, took insufficient account of differences in the quality of life as a result of medical intervention. An attempt, albeit controversial, to come to terms with this problem can be found in the development over the last decade of the concept of the *quality-adjusted life year* (QALY). This tries to take account both of additional life years and their quality in terms of factors such as physical mobility, freedom from pain and the capacity to engage in normal daily life. (An illustration of the potential use of the QALY concept is included as Appendix 10A.) As techniques such as this are developed and refined in the international field, they can be assessed and used, if appropriate, to improve the analysis of the effectiveness of the Irish health services.

10.17 **Information on the effectiveness of specific services and methods of service delivery, drawing on international and local research, as appropriate, should be an important part of health service planning.**

CHOICES IN THE PLANNING OF SERVICES AND THE ALLOCATION OF RESOURCES

10.18 Ultimately all choices which are to be made in the area of healthcare must be based on and reflect the ethos of our society. It is desirable that, when taking any decision in this area, policy makers can clearly distinguish the ethical ground from the economic. In particular, decisions on the planning of services can be influenced by a better understanding of the trade-offs and sacrifices implicit in any option. The three forms of information described in the previous sections — the identification of service needs, the accurate estimation of service costs in detail and the measurement of service outcomes

to the greatest extent possible — can be combined to clarify the choices facing policy-makers.

10.19 The choices concerned — such as how much funding should be allocated to the health services as a whole and to each region, the services to be given priority and whether particular technologies should be introduced — are, of course, fundamental. In deciding on the types and levels of service which are to be funded, policy-makers set the parameters within which general practitioners, consultants and other healthcare professionals must exercise their choices in relation to the care needed by individual patients. It is therefore essential, in the interests both of the quality and the acceptability of the choices made, that these disciplines should be involved in the process of evaluating programmes and procedures and in recommending choices to the policy-makers. In many countries, multi-disciplinary teams are now applying to these questions the techniques of economic appraisal, in association with the results of clinical and epidemiological research, as an aid to health services policy-making.[6]

10.20 The paragraphs which follow describe the application of information and evaluation to the key policy issues. The organisation of the information collection and the multi-disciplinary evaluation work is discussed later in the chapter.

The level of funding

10.21 In the past, annual decisions on the total level of funding for the public health services have been based on trade-offs between the competing resource demands of health and other public agencies and the expenditure constraints of macroeconomic policy. Given adequate information on activity-related costs, it would be possible to take decisions on overall funding on the basis of policy options which set out the impact on specific services of any changes in the resources available. Chapter Twelve illustrates this approach in respect of hospital services. In preparing each year's allocations, the costs of maintaining existing levels of hospital services in terms of access criteria and waiting-times, the cost of specific improvements, and the impact on these service levels of any reduction in funding would all be known. A similar approach could be adopted for all services.

10.22 **It should thus be the responsibility of the Health Services Executive Authority to provide the Minister for Health with details of**

[6]Appendix 10B lists a number of references which provide a methodological guide to the area and document the relevant studies.

— **the funding required to maintain the current level of services, eligibility criteria and charges; and**

— **the costs or savings associated with any changes in services, eligibility criteria or charges which had been suggested by the Minister or put forward by the Authority itself for his consideration.**

The Minister, in drawing up policy options to be costed by the Authority, would of course be influenced by the prevailing macroeconomic constraints.

Which services should be given priority?

10.23 Decisions on the services to be given priority in the allocation of resources would be helped by having better information on service needs, and by the analysis of each service's return in terms of health benefits for a given expenditure, as illustrated in Appendix 10A. It is sometimes argued that such analysis is futile or misguided on the grounds that human life or health cannot be valued in material terms and that it is objectionable to suggest that any form of treatment which would prolong life or reduce suffering is in some way "poor value". These arguments ignore the reality that prolonging life, improving health and reducing suffering are *implicitly* valued every time that resource-using decisions are taken in the health services. The purpose of the proposed approach is to improve the quality of decision-making by making *explicit* such valuations of life, health and suffering as are already contained in the subjective judgements of healthcare decision-makers. These may be well-intentioned in specific cases but are often in fact at variance with the ethos in which society understands itself to be grounded.

10.24 **The Health Services Executive Authority should provide the Minister for Health with relevant information and evaluation which would be taken into account, along with the views of public representatives and professional and consumer interests, in deciding priorities.**

How should the regional allocation of funds be decided?

10.25 The system of allocating resources on a geographic basis in Ireland is officially acknowledged to owe more to history than to any scientific methodology,[7] since annual allocations are based largely on incremental changes on the previous year's figures. The allocations

[7]Department of Health: *op cit:* p. 39.

to health boards do not, in any case, reflect all expenditure on health services for residents of their areas because of the separate funding of voluntary hospitals and other agencies. Under the present system, it is not possible to assess whether the geographic distribution of resources reflects the relative needs of different areas.

10.26 The information described earlier would make possible a much more equitable and efficient geographic allocation of funding. The health and social services budget for each area, which would cover all publicly-funded services, could take account of differences in the nature and extent of local needs. There are several factors which may combine to produce patterns of need which differ widely from one region to another. These include the size of the local population, together with its distribution density, and the dependency ratio associated with its age structure. There may be other factors such as regional variations in morbidity which must be taken into account as well as the proportion of the population covered by Category I eligibility. The allocation of funds to each area could also take account of the role of privately-funded services in meeting some needs and also differences in cost factors which may exist due to local conditions. There could also be an adjustment for "cross-boundary flows" i.e. where patients living in one area require treatment which is provided in another area.

10.27 **The Health Services Executive Authority would have an overall budget for the provision of a specified service requirement. It would be its responsibility to determine the allocation of resources to each of its Area General Managers to ensure that this service requirement was met in all regions.**

Should new, high-cost technologies be introduced?

10.28 Difficult choices arise in relation to whether new high-cost technologies should be introduced. Drummond[8] has pointed out that new health technologies have spread widely through the healthcare systems of most countries without systematic evaluation of their costs and benefits. However, the resource implications of these trends have led to a questioning of the justification for much of the technology which has been introduced, and detailed appraisals of their costs and benefits are now becoming commonplace.

10.29 **The Health Services Executive Authority should have these studies adapted to Irish data on service needs, costs,**

[8]M.F. Drummond (ed): *Economic Appraisal of Health Technology in the European Community* (EC Commission Health Services Research Series No. 2, Oxford University Press, 1987): p. 3.

population distribution and other relevant factors. It might well be shown that, due to the small size of Ireland and the proximity of expensive, high-technology services in the United Kingdom and elsewhere, the most cost-effective way to make certain procedures available would be to arrange for the patients concerned to have access to services abroad.

At which groups should certain programmes be targeted?

10.30 **Specific programmes could be made more effective if detailed epidemiological data were used to identify particular groups in the population at whom they should be directed.** This has particular relevance to preventive services such as immunisation, screening and child health examinations, and also to the organisation of personal social services. The availability of population registers would help the implementation of the targeting approach.

What are the long-term manpower needs of the services?

10.31 Manpower planning involves analysing trends in manpower supply and demand, identifying factors causing imbalances and devising policies to correct them. Because of the nature of the health services, the education and training of healthcare professionals is a major factor in determining the way in which the supply of manpower responds to changes in demand. Healthcare professionals, educated mainly at the expense of the community at large through taxation, account for about 45 per cent of the overall cost of the health services. In view of their high cost, it is essential that manpower resources are deployed in the most effective way possible. We received a number of submissions which drew attention to the absence of a coordinated approach to manpower planning in the Irish health services.

10.32 There will be major changes in the future patterns of manpower requirements as demographic patterns alter; as technology and drugs develop; as approaches to patient care evolve; as new medical problems arise to take the place of those which have been contained; as other forms of healing are accepted; and as individuals and communities come to review their responsibility for environmental health and preventative medicine. These and other issues will affect the human resources required to deliver an adequate health service. **It should be a function of the Health Services Executive Authority to identify existing imbalances and the likely effect on manpower requirements of technology development and changing approaches to patient care**. This information would

be central to the development of education policy in medical and related fields. In particular, several factors must be taken into account and reviewed:

(a) the effectiveness of the widely disparate methods of training of the various professions;

(b) the degree to which inter-disciplinary flexibility is encouraged;

(c) the inclusion of appropriate training to enable healthcare professionals cope with the management side of healthcare delivery; and

(d) exploring the possibility of cooperating internationally on the provision and funding of medical professional training.

Implementation of policy would be the responsibility of the education authorities.

CHOICES IN THE DELIVERY OF SERVICES

10.33 The previous section discussed the choice of which services should be provided so as to make best use of the limited resources available. It was pointed out that this process would set the parameters within which doctors, other professionals and managers would in turn have to make choices about how the services should be provided. These decision-makers also need assistance to ensure that the resources available to them are used in the most efficient way possible.

What treatment should be provided?

10.34 Many of the choices which must be made concern *the appropriate treatment in individual cases* — should a patient be admitted to hospital or treated as an out-patient or by the general practitioner; what drug therapy should be prescribed? The ultimate responsibility for such clinical decisions must always be that of the doctor concerned with the case. However, in our discussions with doctors we were conscious of their awareness that, since resources are scarce, they also have a responsibility to ensure that they are used efficiently. As one commentator has pointed out:

> "Unless doctors can demonstrate that they are acting efficiently, they may be acting unethically. To provide healthcare inefficiently is to deprive potential patients of care from which they could benefit. Such behaviour is unethical ..."[9]

---

[9]A. Maynard: *Is it Ethical to be Cost-Effective?* (Paper presented to Irish Matrons' Association, May 1988).

10.35 To ensure that they are providing treatment efficiently, doctors need information on the costs and effectiveness of alternative therapies. **The most efficient way to make this information available to them would be to use it as a basis for drawing up protocols for the delivery of appropriate care.** For example, conditions appropriate to treatment by the general practitioner or at different levels of hospital care could be identified, as could levels of dependency at which community care or different forms of institutional care were indicated; drug protocols for application both in general practice and hospitals could also be drawn up.

10.36 The involvement of the medical profession in formulating all such protocols would, of course, be essential. It would also be important to recognise the doctor's right to deviate from the protocol on the basis of clinical judgement in the treatment of an individual patient. However, this in turn points to the need for professional review procedures to consider the cases of doctors whose prescribing or treatment patterns are markedly different from those which would be expected under the relevant protocols. This issue of performance measurement is discussed later in the chapter.

How should services be organised?

10.37 Other choices which must be made relate to *the organisation of services* — for example, which combination of residential care and community care will best meet the needs of the dependent elderly population of a given area? Since the question is one of how best to deliver a specified level of service, the formal evaluation of differences in outcome will not arise in the same way as it does when choices are being made as to which services should be provided. However, qualitative differences between approaches to service provision cannot be ignored. For example, in comparing alternative forms of care, the welfare of the patient (such as the psychological benefits of retaining one's independence through community-based rather than institutional care) must inform the decision-making process albeit in a subjective, unquantifiable way.

10.38 **The evaluation of the most cost-effective way of providing a given service should be carried out by those responsible for its management.** It follows that this evaluation would in general be carried out by local managers, taking account of local needs, costs and other relevant factors. However, health services research at a central level, as discussed in paragraph 10.15, would provide an important starting-point, just as the proposed protocols would provide guidance for doctors in deciding on appropriate care. The techniques involved are those of economic

appraisal but sophisticated technical expertise is not required to put them into practice. While, as discussed further in Appendix 10B, there are some potential pitfalls, these could be avoided by the design of standard evaluation procedures and the organisation of short courses to familiarise health managers with their application.[10]

10.39 Considerable data on service activity and costs will be collated at the central level, both as a contribution to policy-making and, as discussed below, for the purpose of monitoring service quality and efficiency. **Arising from the analysis of this data, information on differences in factors which affect cost-effectiveness could be collated centrally and circulated to local managers as an aid to increased efficiency**. These factors might include, for example, variations in length of hospital stay for specific procedures, the utilisation of ancillary services and the range and prices of supplies.

MEASURING PERFORMANCE AND QUALITY

10.40 Under the proposed management approach, the role of managers would change greatly. They would no longer be concerned with controlling matters of detail but rather would act as the monitors of a contractual arrangement in the sense that they would establish whether the performance targets were achieved.

10.41 The measurement of performance in the medical area presents obvious difficulties. The time and money spent on a particular patient to achieve a given degree of recovery may represent inefficiency or a poor quality of treatment, or, on the contrary, it may reflect an unusually difficult case. It is not possible to devise exact, measurable performance criteria which would take such factors into account. However, an approximate assessment can be made by establishing broad norms from aggregate figures. Persistent departures from the established pattern would serve as an indication of unusually good or poor performance.

10.42 The analysis of aggregate patterns of costs, lengths of hospital stay, prescribing rates and other relevant measures will thus provide a framework within which performance can be monitored but will give no more than an approximate evaluation of individual units and professionals. A qualitative review in addition to the purely statistical analysis is also needed. The statistical analysis would then help to

[10]The Institute of Public Administration has organised a number of such courses for health services personnel in recent years.

identify anomalies and unexpected trends which could be examined in more depth with those directly involved.

10.43 This latter process of performance evaluation and discussion with those concerned, which can be termed *professional audit,* cannot be dealt with by managers alone. It must also involve those who have the qualifications and experience to make the necessary judgements and who will be accepted as such by those being assessed. **The Executive Authority would thus require the services of qualified and experienced clinicians and other healthcare professionals. This requirement could be met by the establishment, in cooperation with the professional associations, of a peer review mechanism or by the employment of the necessary expertise by the Authority.**

10.44 Any organisation involved in the delivery of services must be concerned with the consumer perception of the quality of services provided. The views of consumer groups and other interests would be channelled to the Health Services Executive Authority by the Health Councils. The Councils would also have an advisory relationship with Area General Managers. However, these processes would tend to highlight areas of dissatisfaction rather than satisfaction. **The Authority should therefore be responsible for regular analysis of the quality of its service, which should be published.**

ORGANISATION OF INFORMATION COLLECTION AND EVALUATION

10.45 The work which has been described in this chapter can be divided into three categories:

— compiling and evaluating information as an integral part of the day-to-day management of local services;

— coordination and assessment of this information, and the provision of technical support to local evaluation, as part of the central management of the health services; and

— research and evaluation in areas such as priorities for resource allocation, technology appraisal and the development of service protocols.

10.46 **Each Area General Manager should be responsible for ensuring that local needs are identified, that information systems are maintained on local epidemiology and the usage of services, and that unit costs for the various services are**

quantified. He or she should also be responsible for adapting modes of service delivery to suit local needs and circumstances. The National Economic and Social Council[11] has pointed out that the need for continued evaluation and adaptation is particularly marked in community care, where client reaction is very important. For example, families who are caring for handicapped children or adults can give essential feedback on the effectiveness of the services which cater for their needs.

10.47 **The Health Services Executive Authority should be responsible for the development of information systems and evaluation procedures; collating and circulating information on innovations and efficiency improvements which may prove transferable to other areas; and the maintenance of a national network of epidemiological information.**

10.48 While the subject-matter of the first two categories might be termed *management information*, the third category covers areas closer to the common perception of *research*. As a result, there is a danger that their importance may be seen as less immediate and even peripheral to the policy-making process. This would be a serious mistake. We have argued in this chapter — and it is a central theme of our entire report — that such work must play an important role in guiding the choice of priorities and the allocation of resources within the health services. This role is more likely to be effective if the organisation of the necessary research and evaluation is the direct responsibility of those involved in planning health services rather than that of a separate research agency.

10.49 The promotion and grant-aiding of clinical research and health services research is at present the responsibility of the Health Research Board. Clinical research is largely carried out in academic institutions and their associated hospitals,[12] much of it funded by private and corporate donations. Relatively little health services research has been carried out in Ireland to date. The Health Research Board is also concerned with epidemiological research at a national level and carries out ongoing surveys such as the Hospital In-Patients Enquiry and the Psychiatric In-Patient Reporting Scheme.

10.50 **We recommend that the Health Services Executive Authority should take over full responsibility for the**

[11]National Economic and Social Council: *op cit*, p. 12.

[12]Considerable clinical research is of course carried out independently by the pharmaceutical and other medical industries.

coordination of epidemiological research, the allocation of grant-aid to clinical research and the organisation of health services research and evaluation. In all areas of research, the Authority would be guided by priorities given to it by the Minister for Health. This would ensure that the limited resources which are available for health research would be channelled into areas most likely to produce the greatest benefits for the health services as a whole. Other smaller fields of more personal specialised interest, although worthy of academic attention, can be of lesser relative importance to society at large which ends up paying, in some final form, for such projects. Whether it would be desirable for the Health Services Executive Authority to take over the functions of the Health Research Board or to leave it as a separate agency would be a matter for the Authority to decide in accordance with the recommendation contained in paragraph 9.54.

10.51 The relevant *epidemiological research* would be closely related to the information and evaluation needed for the day-to-day management of services. *Clinical research* would continue to be carried out in academic institutions and hospitals, and the role of the Executive Authority would be to allocate funding in line with the priority research needs of the public health service. The responsibilities of the Authority in relation to *health services research* would include setting the agenda, monitoring international findings, organising research directly and commissioning it from other agencies.

10.52 Clinical research can have implications for healthcare costs and treatments; developments in treating chronic illnesses, for example, could have a considerable effect on long-term care needs. There must therefore be adequate liaison between the Ministers for Health and Education, the Health Services Executive Authority and bodies engaged in research.

10.53 The multi-disciplinary nature of health services research has already been stressed; doctors, other healthcare professionals, administrators and researchers such as epidemiologists and economists must be involved. *This should be reflected in the range of personnel employed by the Executive Authority to organise the relevant research.*

10.54 Academic bodies in other countries have provided vehicles for multi-disciplinary collaboration by establishing health services research departments within medical or economic faculties. **We recommend that a multi-disciplinary Department of Health Services Research should be established within an Irish University**. Such a department could carry out research

commissioned by the Executive Authority. It might also, as discussed in the previous chapter, be a suitable location for the proposed Performance Audit Unit.

10.55 The academic institutions also have a role to play in helping those who provide services to make the best use of the limited resources available. **We recommend that some element of training in the relevant management skills and a general appreciation of the principles of efficiency in healthcare should be included in the undergraduate and postgraduate education of doctors and other healthcare professionals.** There is a general acceptance that traditional medical training is greatly deficient in this area, although we are aware of recent initiatives to improve it.

RECOMMENDATIONS

10.56 We have made the following recommendations in this chapter:

1. Information systems should be developed for health and personal social services in each region which would

   — include comprehensive population registers with demographic and health profiles and data on mortality and morbidity;

   — give detailed information on the usage of community, out-patient and in-patient services, including those provided by private hospitals; and

   — link into a national network of epidemiological information as well as providing a basis for local decision-making.

2. Each health service manager should have to ensure that the cost per unit of services for which he or she is responsible is quantified on a continuing basis.

3. Information on the effectiveness of specific services and methods of service delivery, drawing on international and local research, as appropriate, should be regarded as an important part of health service planning.

4. The Health Services Executive Authority should provide the Minister for Health each year with details of

   — the funding required to maintain the current level of services, eligibility criteria and charges; and

— the costs or savings associated with any changes in services, eligibility criteria or charges which had been suggested by the Minister or put forward by the Authority itself for his consideration.

5. The Executive Authority should provide the Minister with relevant information and evaluation on service needs and effectiveness which would be taken into account, along with the views of public representatives and professional and consumer interests, in deciding priorities.

6. The Executive Authority, which would have an overall budget for the provision of a specified service requirement, should determine the allocation of resources to each of its Area General Managers to ensure that this service requirement was met in all regions.

7. The Executive Authority should have international cost-benefit analyses of new health technologies adapted to Irish data on service needs, costs, population distribution and other relevant factors, in making decisions on whether they should be introduced.

8. Detailed epidemiological data should be used to identify particular groups in the population so as to make specific programmes more effective.

9. The Executive Authority should provide information on long-term manpower requirements to influence education policy.

10. Information on the costs and effectiveness of alternative therapies should be used for drawing up, with the involvement of the medical profession, protocols for the delivery of appropriate care.

11. The evaluation of the most cost-effective way of providing a given service should be carried out by those responsible for its management.

12. Information on differences in factors which affect cost-effectiveness should be collated centrally and circulated to local managers as an aid to increased efficiency.

13. For the purposes of performance evaluation, the Executive Authority should obtain the services of qualified and experienced clinicians and other healthcare professionals, either by the establishment (in cooperation with the professional associations) of a peer review mechanism or by the direct employment of the necessary expertise.

14. The Executive Authority should be responsible for regular analysis of the quality of its service, which should be published.

15. The Executive Authority should take over full responsibility for the coordination of epidemiological research, the allocation of grant-aid to clinical research and the organisation of health services research.

16. The Executive Authority should adopt a multi-disciplinary approach to the organisation of health services research.

17. A multi-disciplinary Department of Health Services Research should be established within an Irish University.

18. Some element of training in the relevant management skills and a general appreciation of the principles of efficiency in healthcare should be included in the undergraduate and postgraduate education of doctors and other healthcare professionals.

APPENDIX 10A

COST-EFFECTIVENESS AND THE QUALITY OF LIFE

The concept of the Quality Adjusted Life Year (QALY) has been developed over the past ten years as a measure of the outcome of procedures in terms of the quality of life as well as the duration of life. When combined with cost data, the measure can be used to give some indication of the comparative return, in terms of health benefits, for expenditure on different procedures.

A detailed discussion and application of the QALY concept may be found in Williams[1] from which an illustration of its potential use has been abstracted for Table 10A. This presents estimates based on U.K. data for 1983-84 of the cost per quality-adjusted life year of a number of treatments. These estimates show that, on the basis of the cost and outcome data used, considerably greater benefits in terms of quality-adjusted life years can be obtained for a given expenditure on hip replacements, insertion of cardiac pacemakers and valve replacements than for similar expenditure on kidney transplants, heart transplants and certain forms of coronary artery bypass. Hospital haemodialysis for kidney patients is particularly expensive in terms of the benefits received.

Health economists acknowledge that measurements of the quality of life are crude, particularly at this early stage in the development of the approach, but argue that they, nonetheless, provide a more substantial basis for debate on the allocation of resources than do the competing, subjective arguments of doctors, patients and other interest groups in the various fields.[2] Table 10A does not imply that heart transplants and hospital haemodialysis should not take place; it does, however, imply that there is reason to believe that if the allocation of resources to these treatments is at the expense of, for example, hip replacements, the net benefit to society from expenditure on health services will be less than it could otherwise have been. Such conclusions should at least be taken into account in the decision-making process.

---

[1]Alan Williams: *Economics of Coronary Artery Bypass Grafting:* (British Medical Journal, Vol. 291, pp. 326-329, 3 August 1985)

[2]A. Maynard: *Logic in medicine: an economic perspective* (British Medical Journal, Vol. 295, p. 1540, 12 December 1987)

TABLE 10A

COST PER QALY OF CERTAIN PROCEDURES (U.K., 1983-4)

	Cost per QALY (£)
Pacemaker implantation for heart block	700
Hip replacement	750
Valve replacement for aortic stenosis	900
Coronary artery bypass grafts for:	
Severe angina with left main vessel disease	1,040
Severe angina with triple vessel disease	1,270
Moderate angina with left main vessel disease	1,330
Severe angina with double vessel disease	2,280
Moderate angina with triple vessel disease	2,400
Mild angina with left main vessel disease	2,520
Kidney transplant	3,000
Heart transplant	5,000
Hospital haemodialysis	14,000

Source: Derived from Williams (op cit)

Gudex[3] describes a joint project between the University of York and the North Western Regional Health Authority, England, in which the QALY was combined with cost data to provide a criterion for use in determining resource allocation. The paper reports that the NWRHA found the cost/QALY data to be a useful adjunct to their decision-making, and that the Authority would require details of both resource inputs and of health outcome to be included in subsequent bids for resource allocation for the development of specialties. Gudex concludes:

> "Assumptions and estimates are necessary at present to fill the gaps in knowledge of benefits and costs. However, the final cost/QALY figures show such variations in magnitude that even a crude calculation could give an idea of cost-effectiveness. It is suggested that such data should be used in conjunction with information presently available, to form a more reliable basis on which to make funding decisions".[4]

A substantial body of literature on the measurement of QALY's is now available.[5]

---

[3]C. Gudex: *QALY's and their Use by the Health Service* (University of York Centre for Health Economics, Discussion Paper No. 20: 1986).

[4]*ibid:* p. 15

[5]See for example G. Torrance: *Measurement of health state utilities for economic appraisal: a review* (Journal of Health Economics, Vol. 5, pp. 1-30, 1986); C. Gudex and P. Kind: *The QALY Toolkit* (University of York Centre for Health Economics, Discussion Paper 38, 1988); and P. Kind: *The Design and Construction of Quality of Life Measures* (University of York Centre for Health Economics, Discussion Paper 43, 1988).

APPENDIX 10B

ECONOMIC APPRAISAL IN HEALTHCARE

Economic appraisal in healthcare is concerned with comparing the relative efficiency of alternative strategies as an aid to decision-making. For example, it compares alternative approaches to providing a particular treatment or service to identify which yields the required benefit at least cost; and it compares the benefits for a given expenditure on various treatments or services to help in the allocation of scarce resources between them.

An economic appraisal of a service or treatment must identify, measure and value the relevant costs. If there are any differences in the "benefits", or qualitative outcome, of the services or treatments which are being compared, these too must be identified, measured and valued to the greatest extent possible. Consequently, an economic appraisal is usually heavily dependent on the medical and other technical appraisals which will have yielded the relevant data on outcomes.

It is not necessary to be a professional economist to carry out an economic appraisal. However, there are pitfalls for those without an adequate appreciation of the underlying principles. For example, data may be readily available on the average daily cost of various forms of long-term care; these costs will include overheads which may remain if the number of patients is reduced. They cannot therefore be counted as an automatic saving as a result of transferring patients to alternative forms of care. It is essential to ensure that comparisons are made only between the *marginal costs* associated with alternative choices.

The involvement of a professional economist in the design of evaluation procedures is therefore advisable; and it would clearly be worthwhile for health service managers to acquire some understanding of the key principles through, for example, short training courses.

A number of methodological guides to the area for non-economists have been published. These include:

M.F. Drummond, G.L. Stoddart and G.W. Torrance: *Methods for the Economic Evaluation of Health Care Programmes* (Oxford University Press, 1987);

M.F. Drummond: *Principles of Economic Appraisal in Health Care* (Oxford University Press, 1980); and

G.H. Mooney, E.M. Russell and R.D. Weir: *Choices for Health Care* (MacMillan Press, 1980).

A selection of published studies in this area are examined critically in:

M.F. Drummond: *Studies in Economic Appraisal in Health Care* (Oxford University Press, 1981); and

M.F. Drummond, A. Ludbrook, K. Lowson and A. Steele: *Studies in Economic Appraisal in Health Care, Vol. 2* (Oxford University Press, 1986).

Much of the recent international research, particularly in the area of evaluating high-cost technology, is documented in M.F. Drummond (ed): *Economic Appraisal of Health Technology in the European Community* (EC Commission Health Services Research Series No. 2, Oxford University Press, 1987).

PART FOUR

THE SERVICES

CHAPTER ELEVEN

GENERAL PRACTITIONER SERVICES

INTRODUCTION

11.1 The general practitioner is usually the patient's first point of contact with the health services and therefore plays a key role in influencing the utilisation and cost of the services as a whole. In this chapter, the Commission discusses the organisation and funding of general practitioner services and the effect of these arrangements on the efficiency of the health service as a whole. While the main focus of discussion is on the service for Category I patients, many of the issues are equally important for self-funded general practitioner care.

11.2 During the course of our work, a new contract for doctors participating in the General Medical Services scheme was introduced which altered the method of payment and other conditions of work. Appendix 11A outlines its principal features. Since the new arrangements were implemented very recently it is not yet possible to evaluate their practical effect. The chapter deals with both the former and the new arrangements.

THE PRESENT SYSTEM

11.3 There are about 1,800 practising general practitioners in Ireland, of whom some 1,500 participate in the choice-of-doctor scheme under the General Medical Service, which provides free general practitioner services and prescribed medicines to the 37 per cent of the population with Category I eligibility. Chapter Three described how the dispensary system for providing these services to low-income groups was replaced in 1972 by the General Medical Service scheme which gave those unable to pay the cost of medical care a choice of doctor. This was designed to eliminate the distinction between private and public patients on the basis of the service provided to them. The system of paying general practitioners was altered in 1989 under an agreement between the Department of Health and the Irish Medical Organisation.

11.4 Prior to March, 1989, doctors participating in the GMS scheme were paid on a fee-per-item of service basis by health boards, through the GMS (Payments) Board. A small number of former District Medical Officers opted to be paid by salary rather than fees. Under the new agreement, doctors are paid largely on the basis of capitation, weighted by reference to demographic and geographic factors, with fees for a number of specified procedures. Former District Medical Officers have retained their right to opt for a salary.

11.5 In addition to services provided under the GMS scheme, health boards also pay fees under the Domiciliary Maternity Service to a number of general practitioners who provide ante-natal and post-natal care for expectant mothers in Categories I and II free of charge, as well as medical care for their infants up to the age of six weeks.

NOTE: The tables in this chapter relate to when the former fee-per-service system was in place. As described in the text, the method of payment under the GMS scheme has since been altered.

TABLE 11.1

PAYMENTS TO G.P.s UNDER PUBLIC SCHEMES, 1987

	£m
Fees to doctors under GMS Scheme	38.996
Salaries and allowances to doctors under GMS Scheme	3.218
Fees to doctors under Domiciliary Maternity Service	1.960
TOTAL	44.174

Sources: Report of the GMS (Payments) Board, 1987.
Revised Estimates for Public Services, 1988.

11.6 Table 11.1 provides details of payments to general practitioners under the GMS and Domiciliary Maternity schemes, amounting to £44 million in 1987. However, as shown in Table 11.2, payments to doctors account only for one-third of the cost of the General Medical Service, the bulk of its expenditure arising from the supply of prescribed medicines. Table 11.3 shows that in 1987 doctors participating in the GMS earned, on average, £32 per patient on their panel.

11.7 Free general practitioner services are confined to Category I patients, with the exception of the Domiciliary Maternity Service which is also available to those in Category II. The majority of the population, i.e. Categories II and III, obtain their general practitioner

TABLE 11.2

COST OF GMS SCHEME, 1987

	£m
Fees to Doctors	39.00
Salaries and Allowances to Doctors	3.22
Ingredient Cost of Medicines	63.92
Fees to Pharmacists	17.57
VAT	2.14
Administration (GMS Payments Board)	1.59
TOTAL	127.44

Source: Report of the GMS (Payments) Board, 1987.

Note: The above figures do not take account of changes in the value of advance payments to pharmacists — see Chapter Fifteen.

services privately, on a fee-paying basis. Most general practitioners have a mixed public/private practice with the balance determined by the proportion of medical card holders (i.e. Category I patients) in the local population.

11.8 The Voluntary Health Insurance Board includes recoupment of the cost of general practitioner services in the out-patients benefit which attaches to its standard plans. However, the out-patient benefit as a whole is subject to a threshold (at present £105 for an individual and £170 for a family); expenditure below this amount over any one year is not covered. There is also an upper limit to the out-patient benefit, ranging from £1,000 to £1,400 depending on the plan held. The Revenue Commissioners operate a scheme of tax relief for

TABLE 11.3

COST OF GMS SCHEME PER PATIENT, 1987

	£
Fees to Doctors	29.39
Doctors' salaries and allowances*	2.41
Total payments to doctors	31.80
Total cost of medicines	62.47
Administration*	1.19
TOTAL	95.46

Source: Report of the GMS (Payments) Board, 1987

* Derived from Report, based on average of start-year and end-year number of medical card holders.

TABLE 11.4

ANNUAL VISITING AND PRESCRIBING RATES (GMS)

	Visiting Rate per Patient on Panel			Number of items prescribed per Patient on Panel*
	Surgery	Domiciliary	Total	
1973	4.09	1.18	5.27	9.20
1975	4.33	1.15	5.48	10.13
1977	4.26	1.08	5.34	10.16
1979	4.43	1.16	5.59	10.79
1981	4.82	1.21	6.03	11.93
1983	4.76	1.16	5.92	9.29
1985	5.20	1.16	6.36	10.15
1986	5.30	1.14	6.44	10.49
1987	5.40	1.09	6.49	n.a.

Source: Reports of GMS (Payments) Board

*Note: The reduction from 1983 onwards reflects the exclusion from free supply under the GMS of a number of items as and from 1982. This column excludes items dispensed directly by doctors in certain rural areas. As the arrangement was discontinued for a time during 1987, it is not possible to calculate a comparable figure for that year.

unreimbursed medical expenses; again a threshold (of £50 for an individual and £100 for a family) applies. While all eligible expenditure may be accumulated in arriving at these thresholds, in practice the great majority of non-medical card holders do not qualify for recoupment of their expenditure on general practitioners' fees.

11.9 The amount spent on direct payments to general practitioners gives little indication of their importance in determining the overall cost of the health services. Tussing[1] estimated, on the basis of his 1980 household survey, that general practitioners instigate, directly or indirectly, 72 per cent of hospital expenditure, 65 per cent of expenditure on specialists, and 98 per cent of the cost of prescription medicines.

11.10 The pattern of utilisation of general practitioner services by GMS patients is shown in Table 11.4. This illustrates a steady rate of increase in visiting rates since the introduction of the scheme; the average rate per person on a GMS panel in 1987 was almost 6.5 visits per year. Data for 1987 from the recent ESRI survey[2] on

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

[2]Nolan, B. et al, *Health Service Utilisation in Ireland: Results from the ESRI Survey* (ESRI, unpublished, February 1989).

health service utilisation record visiting rates to general practitioners by Categories II and III of 2.5 and 1.8 per annum respectively, or 2.4 for fee-paying patients overall. Tussing's household survey, relating to 1980, recorded visiting rates of 2.5 per annum for non-medical card holders, as compared to 6.1 for medical card holders. The latter might, of course, be expected to use general practitioner services more frequently than the rest of the population since this group contains a disproportionate number of the elderly, the chronically ill and those on low incomes. Table 11.4 also shows that the prescribing rate for GMS patients has been rising steadily, although there was an interruption in this trend in 1982 because of the removal of a large number of items from the list of medicines which could be supplied under the scheme.

EVALUATION

11.11 We now consider the provision of general practice in Ireland by reference both to the former and present contracts for doctors participating in the General Medical Services Scheme. A number of issues considered in the sections that follow, such as the development, organisation and funding of general practice, are of relevance to services for private patients as well as to those in Category I.

11.12 The aims put forward for the proposed choice-of-doctor scheme in the 1966 White Paper[3] related mainly to considerations of equity: the provision of a choice of doctor for medical card holders similar to that available to the rest of the population, and the removal of a distinction between the standards of treatment of public and private patients. The Report of the GMS Working Party[4] concludes that these objectives have been met; the submissions and other evidence available to us give no indication of any dissatisfaction in this regard.

11.13 When we turn to the objective of providing comprehensive and cost-effective general practitioner services, our concern is not alone with the level and cost of these specific services but also with their impact on the efficiency of the health services as a whole. This implies that general practitioner services should be organised, funded and coordinated with other services in such a way as to ensure that each patient receives appropriate care in the most cost-effective setting, and that doctors, hospitals and medicines are not used wastefully.

---

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

[4] *Report of the Working Party on the General Medical Service:* (Stationery Office, 1984).

11.14 Taking the GMS maximum panel size of 2,000 as a guideline, and allowing for the apparently lower need of the Category II and Category III population for medical care, there are clearly more than enough general practitioners to provide a comprehensive service for the Irish population. However, a number of features of the arrangements which applied up to 1989 impeded the provision of an efficient, cost-effective service for eligible patients.

Paying the Doctor

11.15 The most important factor in this regard was the method by which general practitioners were remunerated. The Irish College of General Practitioners criticised the fee-per-item system prior to its replacement on the grounds that "the G.P.'s income depends solely on the number of face-to-face consultations which can be fitted into each day. It medicalises minor illness and induces unhealthy doctor dependence in the patient."[5]

11.16 There is some evidence that the fee-per-item system influenced the rate of utilisation of services. However, data on utilisation rates must be interpreted with care, since the proportion of the population covered by the GMS scheme has different social, economic and demographic characteristics from the rest of the population. Tussing's findings, referred to above, suggested that medical card holders had a visitation rate almost two-and-a-half times that of the rest of the population. The recent ESRI survey[6] reaches a similar conclusion.

11.17 Tussing carried out a detailed analysis of his survey data on utilisation, and found that return visits varied positively with the ratio of general practitioners to population and negatively with area per capita income and ratio of medical card holders to the population. He argued that this suggested that the individual general practitioner, when faced with a lower than average level of demand, generated additional demand through recommending return visits.[7] The data presented in Table 11.5 appear to support this argument, since they show that the proportion of doctors with relatively high GMS visiting rates tends to be considerably greater among doctors with smaller panel sizes.

11.18 The problem of unnecessary consultations was exacerbated by an unnecessary level of prescribing since, as discussed later, there

---

[5]Irish College of General Practitioners: *The Future Organisation of General Practice in Ireland — A Discussion Document* (ICGP, 1986): page 34.

[6]Nolan, B. et al, *op. cit.*

[7]*op cit:* chapter six.

TABLE 11.5

PROPORTION OF DOCTORS WITH ANNUAL AVERAGE GMS VISITING RATE OF 8 OR OVER (1987)

GMS Panel Size	Proportion of Doctors
100 — 499	16.23%
500 — 1499	8.40%
Over 1500	5.24%

Source: Derived from Report of GMS (Payments) Board, 1987: Table 11.

is an observed relationship between the two. While the GMS (Payments) Board verified the accuracy and reasonableness of claims under the old system (including prescriptions), only those claims patterns which were substantially higher than average were, in general, subject to investigation. Thus, the monitoring process could not judge whether the average rates themselves reflected a general degree of excessive consultations and prescribing.

11.19 Under the new system of payment, participating doctors receive a capitation payment in respect of each panel patient, weighted by reference to demographic characteristics (age and sex) and geographic factors (distance of the doctor's principal place of practice from the patient's home). In addition, fees are paid for a number of specified procedures. Since the new scheme has been put in place very recently, it is too early to evaluate its effects. However, *the Commission believes that the revised remuneration system offers a number of potentially important advantages. In particular, we hope that the incentive towards over-visiting will be removed and that the GMS Working Party's preference for fewer but less hurried consultations will be facilitated.*

11.20 Capitation systems, however, carry the potential disadvantage of under-visiting, since the doctor's payment in respect of each eligible patient is fixed irrespective of the number of consultations (other than for the fees for special procedures under the new contract). There is also the possibility that doctors will have little incentive to limit referral to hospitals; in-patient admission may be an attractive route to general practitioners wishing to limit their time commitment per case. Such a problem would be particularly worrying in the context of efforts to cater for psychiatrically ill and mentally handicapped patients in the community. **We would emphasise, therefore, the importance of monitoring the operation of the scheme to ensure that the change to a largely**

capitation-based system does not lead to inadequate or poorly targeted services.

11.21 The new contract does not require the collection of as much information by the GMS (Payments) Board on matters such as number of consultations as applied under the former system. Details of the incidence and type of work performed by general practitioners are important both for monitoring the new payment system and developing an epidemiological profile of the population as a whole. Accordingly, **the Commission recommends that general practitioners should regularly supply broad epidemiological data on their complete caseload (i.e. both medical card and private patients) to the Health Services Executive Authority or other central agency designated by the Authority, such as the GMS (Payments) Board.**

11.22 The success of the new contract in achieving a more cost-effective service depends on the continuation of the observed relationship between the number of consultations and rate of prescribing. The Irish College of General Practitioners states that practice-activity analysis of antibiotic prescribing has shown that once a patient consults a doctor, the likelihood that a prescription will be written is fairly constant; thus, the level of prescribing is determined above all by the patients' initial decision to consult.[8] Table 11.4 shows that the rise in visiting rates over time has been accompanied by a rise in prescribing rates, subject to an interruption in the trend in 1982 when a wide range of over-the-counter preparations were excluded from free supply under the scheme.

11.23 There is, indeed, evidence to suggest that there may have been considerable over-prescribing of medicines under the former GMS arrangements. Tussing's survey found that Category I patients had a significantly higher level of pharmaceutical consumption than other patients, even after allowing for differences in age, sex, social group and even for general practitioner utilisation.[9] In prescribing for a Category II or III patient, the doctor must take into account that the patient has to pay the full cost of the medicine, although he may be recouped some or all of the cost at a later stage. The difference in prescribing rates suggests that the doctor gives more careful consideration to the cost-effectiveness of the medicine concerned in such cases. While we discuss the question of medicines in more detail in Chapter Fifteen, it is relevant at this point to note that the organisation and funding of general practitioner services

[8] *op cit:* chapter five
[9] *op cit:* chapter seven

would appear to have had considerable influence on expenditure in this area. The GMS Working Party concluded that:

> "We are convinced that doctors can and should provide a service to patients which is less reliant on drugs than at present".[10]

11.24 The anticipated reduction in the level of unnecessary prescribing would be a major achievement of the new payment mechanism, given that drugs account for two-thirds of the cost of the GMS scheme. This would be complemented by the Drugs and Therapeutic Committee for general practice which we recommend in Chapter Fifteen. It will also, we believe, be assisted by the proposed National Drugs Formulary drawn up recently by a group representing the Department of Health and the Irish Medical Organisation. The Formulary, consisting of a broad list of drugs and medicines selected for their cost-effectiveness, is not mandatory on general practitioners, but those participating in the GMS undertake, through their contract, to co-operate in its operation (see Appendix 11A). Adherence to it by general practitioners would be of considerable value in achieving a more cost-effective pattern of prescribing.

11.25 Two other factors which may influence prescribing patterns must also be addressed if an appropriate reduction is to be achieved. These relate to patient expectations that a consultation with a doctor should be accompanied by a prescription, and to the sales and promotional activities of the pharmaceutical industry. Both issues are considered in Chapter Fifteen.

The Development of General Practice

11.26 The GMS Working Party argued for a more comprehensive style of general practice which would reduce the incidence of referral to specialists and of hospital admissions:

> "With appropriate support and adequate time for diagnosis, the general practitioner is capable of successfully treating the vast majority of patients. Referral to specialists should therefore be an exceptional decision on the part of the general practitioner. Advances in therapeutics and analysis of the cost-effectiveness of alternative modes of treatment have resulted in widespread acceptance of the general practitioner's capacity to treat

[10] *op cit:* pp. 117-118.

conditions which might formerly have been referred to a specialist".[11]

11.27 To date, however, the development of general practice has been impeded by a number of factors. Firstly, the former arrangements for paying GPs did not encourage investment in ancillary staff, surgeries or equipment since all such costs[12] had to be met from the doctor's gross fee for service. The Working Party on the GMS reported[13] that general practitioners considered that the development of general practice was being discouraged because doctors who invested in improved facilities and staff had, as a result, lower net earnings than colleagues who provided minimal services and standards.

11.28 A second factor inhibiting the development of general practice has been the predominance of single-handed practices; investment in facilities and ancillary staff is clearly more feasible for a partnership or group practice since the costs can be shared. The partnership or group practice also provides the opportunity for consultations on diagnoses; the single-handed practitioner is isolated in this respect and a higher rate of referral is likely.

11.29 Thirdly, general practitioners have poor access to investigative facilities in hospitals and must often refer their patients to hospital consultants in order to have tests carried out. The GMS Working Party pointed out[14] that this can result in the ongoing management of conditions being assumed by hospital staff which might be more appropriate to the general practitioner. This lack of access to investigative facilities is part of the reason for the level of referral to specialists and of hospital admissions which, while not established empirically, is widely suggested to be unnecessarily high.

11.30 Fourthly, relationships between general practice and other community-based services, and with hospital services, are inadequately developed. It is clear that the general practitioner has a potentially important role within an integrated, comprehensive

---

[11] *op. cit:* page 62.

[12] There is a very limited scheme of capital grants from health boards towards the cost of new premises or the improvement of existing premises. The amounts payable would account for only a small part of the cost of building a surgery and are subject to availability of health board funds. Grants of 25 per cent to a maximum of £2,680 are payable for single-handed practices; for partnerships the figures are 37.5 per cent and £3,940 respectively; for groups of three 50 per cent to a maximum of £5,360 is payable, increasing by £1,340 for each additional doctor. Expenditure on the scheme has averaged about £20,000 per annum in recent years.

[13] *op. cit:* chapter one.

[14] *op. cit:* chapter three.

service which would reduce the need for hospitalisation in many cases. However, this is hindered at present by problems of co-ordinating services provided directly by health boards such as public health nurses, and with the hospital services themselves. The general practitioners' primary role within the system should relate to medical cases, with scope for referral of social cases to the appropriate social services.

11.31 The development of general practice must continue to take account of the personal relationship between patient and doctor. The Commission recognises that patients often attach considerable importance to seeing the same doctor at each visit, and believes that this preference should be respected wherever possible. This is of particular relevance to group practices, many of which are already organised on this basis.

ORGANISATION AND FUNDING

11.32 We now examine how the organisation and funding of general practice might be improved to help the achievement of a more efficient, cost-effective system.

(i) Practice Organisation and Facilities

11.33 The GMS Working Party[15] found that only about 30 per cent of Irish general practitioners are in partnership or group practice, and recommended that adequate assistance towards the provision of premises and support services should be forthcoming where the requirements for effective group practice were met. They defined group practice as three or more doctors who arrange to practice from one principal centre sharing support systems, including records, and providing comprehensive availability to all of their patients. In circumstances, particularly in rural areas, where it was not possible to form groups of three or more, they also recommended assistance towards the costs of premises and support.

11.34 We agree that the grouping of doctors in larger and better-equipped practices is essential if general practice is to develop in such a way as to increase the efficiency of the health services. The former GMS fee-for-service was intended to cover both the doctor's professional input and his expenses, but the fee was a global one and no account was taken of the level of expenses incurred. Thus, under the previous arrangements, doctors who invested in their

[15] *op. cit:* chapter three.

premises, equipment, support staff and in their own further training did so at their own expense, since the provision of a higher-quality service attracted the same fee. The offset of expenses against taxable income was, of course, available; but the doctor who incurred such expenses nonetheless suffered a reduction in net income.

11.35 Associated with the new agreement (although not part of the contract) is a commitment by the Department of Health to allocate £3 million per annum for the next three years towards the costs in general practice of employing practice nurses and secretarial support. Grants of up to £10,000 for nurses and up to £6,000 for secretaries are to be provided, based on the number of panel patients involved. While the amount allocated is intended to cover only a portion of such costs, the Commission believes that it offers potential to promote greater efficiency in general practice and to reduce the time that doctors must spend on ancillary tasks.

(ii) Access to Hospital-Based Facilities

11.36 There are significant disadvantages in arrangements under which hospital-based services such as laboratory tests, x-rays and physiotherapy are freely available if ordered by a hospital doctor but not if the referral is from a general practitioner. This reinforces the tendency towards specialist consultation and use of other hospital services in cases where general practitioner care would be more appropriate.

11.37 **We endorse the recommendation of the GMS Working Party[16] that uniform arrangements for access by general practitioners to hospital-based diagnostic facilities should be implemented.** There should be close cooperation between the relevant hospital departments and the general practitioners in their catchment area. The Working Party pointed out that the danger of excessive and inappropriate use of facilities would have to be avoided by specifying criteria to be used by the doctor in determining whether a particular investigation should be requested. There would therefore have to be an emphasis on the identification of appropriate investigative facilities to which general practitioners should have access.

11.38 The access of general practitioners to services such as physiotherapy and occupational therapy, many of which are hospital-based is also poorly developed at present. Despite the importance of

[16] *op. cit.:* chapter three

these services in helping patients who might otherwise require in-patient treatment, doctors experience difficulty in referring patients to appropriate facilities. We discuss these services in detail in Chapter Fourteen.

(iii) Integration with Other Community Services

11.39 General practitioners can often work in considerable isolation from other community care personnel such as nurses and social workers. Some difficulty in integrating the services is inevitable because, unlike the other personnel, general practitioners are independent contractors rather than direct employees of the health services. However, lack of integration hinders the development of a comprehensive community-based alternative to institutionalisation of the infirm elderly and other groups in need of special care. This is of particular relevance to chiropody, speech therapy and other paramedical services.

11.40 It is likely also that the isolation of the general practitioner from other personnel leads to the "medicalisation" of many problems which are social in nature. The organisation of community services around the general practitioner might not resolve this problem, as the medical emphasis would be retained. **There is, however, a need for greater cooperation and communication between the general practitioner and those involved in the organisation and delivery of community services in general.** We have discussed our preferred approach to the provision of these services in Chapter Fourteen.

(iv) Funding of Special Procedures

11.41 We have noted earlier that there are many conditions which are usually treated in hospital but which could be dealt with by a well-equipped general practice. The treatment involved may require, in varying degrees, specialised equipment, specialised training and a greater amount of the doctor's time than is the case with routine consultations. Such procedures could not be specifically encouraged under a pure capitation system. **The Commission therefore supports the concept of funding certain special items of service on a fee-per-item basis so as to promote their provision where possible by the general practitioner rather than in hospital. It is important, however, that the services funded in this way are carefully selected for their likely effect on hospital referral rates and that the list is reviewed periodically. Care must be taken to guard against the indiscriminate growth of a lengthy list of fee-per-item**

procedures over time which would diminish the potential value of the new capitation-based system.

11.42 A working party has been established to identify procedures that should be funded separately and has already made interim recommendations in this regard. We would expect that, while these funding arrangements apply only to eligible patients, general practitioners will also find it practical to provide the special procedures to private patients, thereby promoting the delivery of services in the most cost-effective and efficient manner possible.

THE NEW GMS CONTRACT

11.43 The Commission has already pointed to the potential benefits of the new agreement between the Department of Health and the Irish Medical Organisation. We believe that the revised arrangements for dealing with eligible patients offer the potential of helping to achieve the new style of general practice envisaged by the GMS Working Party. We note that the new contract is more flexible than its predecessor since it is subject to periodic review, and any changes agreed upon can be readily implemented. **The present agreement should therefore be regarded as an interim arrangement to which changes may be made in light of experience rather than as an unalterable final version.**

11.44 We would emphasise, moreover, that **the quality of service provided under the new capitation-based system must be monitored carefully to ensure that the needs of eligible patients are properly served.** We have also stressed that the funding of special procedures on a fee-per-item basis, while desirable, should be reviewed periodically to guard against any indiscriminate growth of services funded in this manner.

ELIGIBILITY FOR FREE SERVICES

11.45 As detailed in paragraphs 11.3 — 11.8, medical card holders receive general practitioner services free of charge; Category II patients must pay, except for services provided under the Domiciliary Maternity Scheme; Category III patients must pay for all services; and the available VHI cover is quite limited. The GMS scheme covers about 37 per cent of the population at present.

11.46 The Irish system is thus quite different from many other found in Europe and elsewhere, in which general practitioner services are provided either free or with substantial subsidy to all or most of

the population, either through taxation funding or through a compulsory social insurance scheme.

11.47 It has been argued that Ireland should move to, or towards, a universal free general practitioner service. Two main reasons have been advanced in support of this argument. Firstly, it is held that the charge for general practitioner services may work against the efforts to direct patients away from the use of hospital services where primary care would be more appropriate. Secondly, it is contended that those in the present Category II and Category III may, because of the charge, wait too long before seeing a doctor. This may result in higher costs to the health services in the long run for want of adequate preventive care or early detection of illness.

11.48 We can make a crude estimate of the potential cost to the Exchequer (and equivalent saving to those who must currently pay their general practitioner) if free services were extended to all. Tussing's survey indicated that private expenditure on general practitioners' fees was about £20 million in 1980.[17] If this expenditure has grown in line with the rate of inflation, it would amount to about £40 million in 1989, somewhat under £20 per person without a medical card. This gives an indication of the likely cost of extending cover to all, although the actual cost would of course depend on the arrangements arrived at in relation to the remuneration of doctors. Proponents of universal entitlement to free general practitioner services argue that long-run savings in the cost of other health services would ensue as a consequence.

11.49 The principal point at issue is the effect on the incentives facing both patients and doctors. It is most unlikely that the extension of full eligibility under the former fee-per-service system could have been contemplated, as both patients and doctors would have had every incentive to over-use the services. However, even if cover were extended on the basis of capitation payments to doctors, there would still be no disincentive to trivial and unwarranted utilisation. As already seen, increased utilisation of the services would be likely to result also in increased prescribing of medicines. It may also be argued that the current charge for a general practitioner visit is not so high as to act as a real deterrent to the great majority of patients in genuine need of care, and that it acts as a useful barrier to frivolous demands on the service.

11.50 Another argument is that it is desirable for people to take some degree of responsibility for their own health, and that this

[17] *op cit:* chapter five

concept includes paying for routine medical care when it is within their means to do so. It is suggested that there would be general support for this approach among those who must currently pay their general practitioner, as there is no evidence of any widespread dissatisfaction or demand for change.

11.51 There might be a case for the provision of universal free general practitioner care if it were based on the concept of clinical budgeting, under which the practice would receive an annual pre-payment for each patient, out of which it would undertake to provide or arrange for the provision of all necessary care, including hospital services and medicines. This approach is similar to that underlying the Health Maintenance Organisations which have become common in the United States. The practice would have every incentive to economise, since it would retain any profit and carry any loss, but excessive economising that might affect the quality of care would cause the patients to go elsewhere.

11.52 In principle, such an approach could realise the full benefits of free general practitioner services. The patient faces no price barrier to preventive or necessary care, and the onus is on the doctor to educate those patients with a tendency towards frivolous use. The doctor faces a finely balanced set of incentives to provide neither too much nor too little onward referral and prescribing, since he is responsible for the full cost but must also seek to retain his patients.

11.53 The approach, however, relies crucially on conditions which may not exist in Ireland. There are very few centres of population which could support a number of group practices large enough to provide the spread of risks needed to make such a scheme viable. If the consumer does not have a choice of practices, the competitive aspect, which is an essential safeguard against the provision of an inadequate service, is missing. Because of these restrictions, it is unlikely that the HMO-type approach would present a realistic option for Ireland in the immediate future. Appendix 6A has already discussed the significant shortcomings of HMOs in the Irish context.

11.54 In Chapter Six the Commission recommended that the lowest income group should remain eligible for all necessary health services free of charge, and that the entire population should have entitlement to a core group of publicly-funded services, comprising specified acute hospital care, long-term care and personal social services. A principle underlying these recommendations has been that necessary health services should be available to all at a price they can afford.

11.55 The Commission does not believe that liability for the fees of general practitioners places an undue burden on persons outside Category I. We received no evidence from submissions to us or from other sources that this was the case; we noted in Chapter Seven that Chief Executive Officers may, in any event, grant a medical card on grounds of hardship to those who would not otherwise be eligible for free general practitioner services.

11.56 In addition, we have been influenced by the arguments above regarding the incentives facing doctors and patients. In the absence of a mechanism to make general practitioners financially responsible for the costs of their patients, we believe that the provision of universal free general practitioner services would be likely to lead to increased inefficiency. **In all the circumstances, the Commission recommends that persons outside Category I should continue to meet their general practitioner costs themselves.**

Reservation by Mr. P. Flynn

I disagree with the recommendation contained in paragraph 11.56 that only medical card holders should be entitled to a publicly-funded general practitioner service. Many middle and low-income families outside of the General Medical Services scheme are deterred by **price** *from utilising general practitioner services which they need. Such an inequitable situation can only be improved by the introduction of a free general practitioner service for all the population. The higher cost of this form of primary care would be more than offset by a corresponding reduction in the utilisation of hospital services. Indeed, a situation where one hundred per cent of the population would be entitled to Core Services largely free while, at the same time, less than 40 per cent would be entitled to an additional general practitioner service without charge, is quite clearly a complete contradiction of a stated desired policy of emphasis on primary health care to which General Practice is central.*

Domiciliary Maternity Scheme

11.57 At present the Domiciliary Maternity Scheme, described earlier, provides certain general practitioner services free of charge to the 85 per cent of the population in the existing Categories I and II, leaving only those in Category III with responsibility for meeting these costs themselves. Since the Commission's proposals involve just two categories of eligibility, the question arises whether the scheme should be confined to the lowest income group or applied to the whole population.

11.58 We regard the Domiciliary Maternity Scheme as an important element in preventive care for mothers and infants, which might be used less if a charge was imposed on those currently eligible for it. Although maternity care is largely provided in acute hospitals, attendance as an out-patient for ante- and post-natal care is not a practical proposition for many mothers. The maximum saving to the State of requiring the present Category III to pay for free GP care during pregnancy would be less than £1 million. **We recommend that the Domiciliary Maternity Scheme should be part of the core service available to the entire population.**

11.59 Although we have concluded that the State's direct responsibility for the provision of general practitioner services should continue to be limited to the low-income group, it is important nonetheless to recognise the extent to which the State should have an interest and an involvement in the organisation of general practice as a whole. Since private patients of general practitioners go on to use public hospital services, and obtain assistance from the State towards the cost of prescribed medicines, it is very much in the interests of the State to ensure that the objectives set out earlier are met in relation to the general practitioners' private as well as GMS practice. This concern is reflected in the earlier discussion of the organisation and funding of general practice.

User Charges

11.60 Although the absence of a charge to patients for consultations under the GMS may provide an incentive to unwarranted use of the service, we would not favour introducing one. The principle that services should be free to those of low incomes is an important one. Even a token charge could, in some cases, deter patients from seeking necessary care. Nor should a situation develop where patients feel it incumbent upon them to pay their general practitioner for services to which they are entitled free of charge. Under the new capitation-based approach, we would expect doctors to educate patients on the appropriate use of GP services; we have recommended in Chapter Sixteen that this should also be an objective of health education programmes and we would again emphasise the role of the general practitioner in relation to the areas of health promotion and education. The tendency by many patients to over-visit the general practitioner could also be remedied by closer cooperation between the doctor and community personnel such as nurses and social workers.

RECOMMENDATIONS

11.61 In this chapter we have made the following recommendations:

1. General practitioner care should continue to be paid for by those who can afford to do so. Free general practitioner care should be limited to persons in Category I and to persons outside this group only on hardship grounds, as at present.

2. There should be no user charges of any sort for general practitioner care in respect of Category I patients.

3. All persons should have entitlement to the Domiciliary Maternity Scheme as a core service.

4. The operation of the revised arrangements for paying general practitioners in the General Medical Service should be monitored over time to guard against inadequate or poorly targeted services.

5. Services funded on a fee-per-item basis should be carefully selected for their likely effect on hospital referral rates and should be reviewed periodically. Care must be taken to guard against the indiscrimate growth of such procedures which would diminish the potential value of the new capitation-based system.

6. General practitioners should regularly supply broad epidemiological data on their complete caseload (i.e. both medical card and private patients) to the Health Services Executive Authority or other central agency designated by the Authority, such as the GMS (Payments) Board.

7. Uniform arrangements for access by general practitioners to hospital-based diagnostic facilities should be implemented.

8. There should be greater co-operation and communication between the general practitioner and those involved in the organisation and delivery of community services in general.

APPENDIX 11A

MAIN FEATURES OF CONTRACT FOR DOCTORS PARTICIPATING IN THE GENERAL MEDICAL SERVICES SCHEME

The following is an outline of some of the main elements of the contract implemented, in the case of most participating doctors, in March and April, 1989. The contract itself should be consulted for detailed information.

1. Conditions of Contract

— Specified provisions regarding the duties of a participating doctor including the requirement that:

"The medical practitioner shall provide for eligible persons, on behalf of the relevant Health Board, all proper and necessary treatment of a kind usually undertaken by a general practitioner and not requiring special skill or experience of a degree or kind which general practitioners cannot reasonably be expected to possess. This will include such preventive and developmental services as are currently provided or may be developed in the new style of practice which this agreement facilitates, some of which servicies may be included on the list of special items of service for which specific payments shall be made" ....

"The medical practitioner shall:

* accept clinical responsibility for persons on his list who need medical treatment and treat them or, when the clinical condition is such that it is appropriate to transfer them to appropriate consultant care, do so and accept clinical responsibility for them on becoming aware of their discharge from consultant care.
* use the most efficient and economic forms of treatment or care consistent with the needs of his patients.

* ensure that no discrimination or differentiation is exercised as between the treatment of eligible and private patients within the practice and take reasonable steps to ensure that no such discrimination is perceived" ....

— *Paragraph 11.*

— Procedures for prescribing and dispensing, including the requirement that:

... "In arrangements for prescribing or dispensing drugs, medicines or appliances, the medical practitioner shall have due regard to the need for economy but shall have primary regard for the interests of the patients. The medical practitioner shall have regard to recommendations on the prescribing of drugs, medicines and appliances which may be issued jointly by the Minister and the Irish Medical Organisation following agreement between these parties. The medical practitioner shall co-operate in a manner agreed between the Irish Medical Organisation and the Minister for Health in the operation of the National Drugs Formulary issued by the Minister for Health with the agreement of the Irish Medical Organisation"

— *Paragraph 18*

— Procedures for investigation of complaints against participating medical practitioners and for suspension of their agreement pending investigation, if necessary, by a Complaints Officer appointed by the Minister for Health with the agreement of the Irish Medical Organisation. Provision for appeal by medical practitioners against termination of contract or other disciplinary action to a GMS Tribunal established for that purpose.

— Provision for a three-yearly review of the agreement. Any alterations agreed between the Minister for Health and the Irish Medical Organisation shall have effect "following the issue of a statement of such agreed changes by the Minister". Both sides may give twelve months notice of termination of the agreement at any time after 1 February, 1991.

2. Payment of Doctors

(i) Capitation fee per patient calculated as the sum of (a) Demographic Factor and (b) Geographic Factor.

Age	Demographic		Geographic			
	Male	Female	3—5 miles	5—7 miles	7—10 miles	10 + miles
	£	£	£	£	£	£
Under 5	24.42	23.83	1.30	3.22	5.11	7.46
6—15	12.32	12.48	0.54	1.33	2.10	3.06
16—44	18.11	29.59	0.69	1.72	2.73	3.98
45—64	36.14	39.71	1.68	4.15	6.59	9.61
65+	38.07	42.48	4.67	11.57	18.37	26.79

(ii) Supplementary out-of-hours payment of £1.20 per patient, to encourage greater use of rosters and rotas.

(iii) Out-of-hours payments for consultations necessarily carried out between 10pm and 8am, and requested after 8pm, other than in the course of routine surgery arrangements. Subject to third-party verification of the time that the consultation took place.

Up to 3 miles	**£15.00**
3 — 5 miles	**£20.00**
5 — 7 miles	**£22.50**
7 — 10 miles	**£25.00**
Over 10 miles	**£30.00**

An additional payment of £11.70 is payable where more than one patient is seen in the course of such a consultation.

(iv) Specified additional fees in respect of temporary residents, EC residents, emergencies and rural dispensing.

(v) Specified additional payments ranging £10 to £25 for special items of service. The appropriate list of special services is currently the subject of a separate review.

(vi) Fee of £10 for second medical opinion in certain circumstances.

3. Other Conditions of Contract

(i) Superannuation scheme to be administered by the Irish Medical Organisation funded by health board contribution equivalent to 10 per cent of total capitation fees and 5 per cent deducted from the capitation payments due to medical practitioners and paid into the scheme on their behalf.

(ii) Provisions for annual leave, sick leave, maternity leave and study leave as follows:

— *Annual Leave* : Payment of £400 per week for employment of locum (or direct provision of locum by health board). Number of weeks covered is determined by the doctor's panel size as follows:

Panel Size	Number of Weeks Covered
1500 +	5
1000 – 1499	4
500 – 999	3
100 – 499	2

— *Sick Leave* : Supplement of £60 per day (Monday-Friday) paid to GP providing cover for a sick GP for the first seven days; locum fees of £400 per week thereafter for up to 26 weeks and £200 per week for a further 26 weeks where the sick doctor has at least 700 panel patients. For those with 100-700 panel patients, payments equivalent to capitation earnings during the first week and subsequent 26 weeks; half of this amount for a further 26 weeks. Where the medical practitioner is unable to obtain a locum the health board assumes responsibility for providing services to patients.

— *Maternity Leave* : Fourteen weeks maternity leave (and additional weeks on grounds analogous to those in the Maternity Protection of Employment Act, 1981) for doctors with at least 500 panel patients. The same arrangements apply for locum cover as those for sick leave.

— *Study Leave* : One week per annum for doctors with at least 100 panel patients; the same locum arrangements apply as for maternity and sick leave.

CHAPTER TWELVE

GENERAL HOSPITAL SERVICES

INTRODUCTION

12.1 This chapter describes and evaluates the existing provision of general hospital services,[1] and sets out the policy changes which would be required to ensure equitable access to a comprehensive and cost-effective service. The justification and scope for the use of patient charges as a source of funding are examined. The chapter then discusses the administration of hospital services and the basis for determining the appropriate allocation of Exchequer funding to each public hospital. Finally, the role of private hospitals is considered.

12.2 Our concern in this chapter is with acute hospitals. In general, the term "acute hospital" is used to distinguish those hospitals providing medical and surgical treatment of relatively short duration from those providing long-term care. All, except district hospitals, are consultant-staffed. District hospitals are classified as "acute" where the average length of stay is less than 30 days. Issues relating to long-term care are discussed in Chapters Seventeen to Nineteen.

DESCRIPTION OF THE PRESENT SYSTEM

12.3 The numbers and activity levels of the different categories of acute general hospitals are set out in Table 12.1 for 1987, the most recent year for which detailed statistics are available. There have been some hospital closures in the intervening period.

12.4 The evolution of hospital services was described in Chapter Two. Three categories of hospital can be distinguished on the basis of ownership and funding:

(i) Health board hospitals are owned and funded by the health boards which, in turn, receive their funding annually from the

[1]Hospital services are classified as "general" and "special". Special hospital services (i.e. for the mentally ill and mentally handicapped) are discussed in Chapter Nineteen.

Department of Health. The allocation of available funds between the hospitals in an area is determined by the relevant health board;

(ii) Voluntary public hospitals receive annual funding directly from the Department of Health, acting as agent for the health boards, and this accounts for almost all of their income. Some are owned and operated by religious orders, others are incorporated by charter or statute and work under boards which, in many instances, are appointed by the Minister for Health;

(iii) Private hospitals are owned and managed privately and receive no direct funding from the State.

12.5 Some of the categories in Table 12.1 require definition. County Hospitals[2] have consultant-staffed units for general medicine, general surgery, obstetrics and gynaecology. They usually also have children's wards. Regional Hospitals have a wider range of specialised units. District Hospitals are staffed on a part-time basis by general practitioners, for medical and minor surgical treatment. Some also provide an obstetric service. Table 12.1 excludes long-stay district hospitals, where the average duration of stay exceeds 30 days. Among public voluntary hospitals, the General Teaching Hospitals are in Dublin and Cork and offer treatment in major specialties. Non-Teaching Hospitals offer treatment in a wide range of specialties. Cottage hospitals provide services somewhat akin to those of district hospitals. The other categories are self-explanatory.

12.6 Each publicly-funded hospital has a designated official role and the Department of Health, with Comhairle na nOspideal, determines its specialities and its consultant staffing. There are three levels of service: first, those provided in the vast majority of general hospitals to cater for the immediate catchment area; second, those which, because of their complexity and requirements, are provided on a regional basis; and third, some highly specialised services which are provided for the whole population in a small number of national centres.

12.7 Table 12.2 details estimated public expenditure under the General Hospitals Programme for 1987, excluding expenditure on health board long-stay hospitals and contributions to patients in private hospitals and homes. Table 12.2 includes, as a deduction from gross expenditure, hospitals' receipts from maintenance charges. These relate to charges for private and semi-private accommodation,

[2]The term "County Hospital", while used in the official statistics, is now a misnomer as most provide services for a number of counties. They are now commonly called "General Hospitals".

TABLE 12.1
ACUTE HOSPITAL STATISTICS, 1987

Health Board Hospitals	Number of hospitals	Number of beds	Patients discharged	Average duration of stay (days)
Regional	10	2,775	112,493	7.5
County	22	3,131	137,352	6.4
District (short-stay only)	18	696	8,543	21.2
Fever	1	150	3,008	12.8
Orthopaedic	3	309	6,121	12.1
TOTAL	54	7,061	267,517	7.5
Public Voluntary Hospitals				
General (Teaching)	14	3,587	117,917	8.3
General (Non-Teaching)	6	865	35,400	6.8
Maternity	4	764	42,151	4.7
Paediatric	3	584	27,644	5.0
Cancer	3	232	4,982	11.8
Eye and Ear	2	196	6,594	4.6
Orthopaedic	4	418	4,185	30.4
Cottage	2	67	846	24.8
TOTAL	38	6,713	239,719	7.5
ALL ACUTE PUBLIC HOSPITALS	92	13,774	507,236	7.5
PRIVATE HOSPITALS*	18	1,817	53,192	7.6

Sources: Hospital In-Patient Statistics (1987): (Department of Health) (Public Hospitals)

Conference of Major Religious Superiors (Private Hospitals) and from a number of individual private hospitals.

* Excludes one for-profit private hospital. Average duration of stay excludes two private hospitals.

and also to certain circumstances in which the full estimated cost of providing treatment is chargeable to the patient.[3] There is no published data on expenditure on private hospital services.

12.8 Table 12.3 provides estimates of the average cost of different categories of hospital, on the basis of weekly cost per occupied bed and total cost per discharged patient. These estimates are based on hospitals' total expenditure, and, as these include the cost of out-patient services, the real cost of providing in-patient services is overstated.[4] Similar estimates are available for individual hospitals, but their use for comparison purposes requires caution. The

[3]This arises mainly where treatment is required as a result of a road traffic accident in respect of which the patient is entitled to compensation from a third party for damages including medical costs, as discussed in Chapter Seven.

[4]However, it should be noted that the accounts of public hospitals include no provision for depreciation.

TABLE 12.2
EXPENDITURE ON ACUTE GENERAL HOSPITALS, 1987

		£m
	Regional Hospitals	151.8
	Public Voluntary Hospitals	259.7
	County Hospitals	125.1
	District Hospitals	26.0
	Ambulance Services	17.5
	Current Expenditure	580.1
Less	Income from Maintenance Charges	38.4
	Net Current Expenditure	541.7
Add	Capital Expenditure	45.6
	Total Net Expenditure	587.3

Source: Department of Health

difference in case-mix between hospitals will greatly influence costs, and, as no two hospitals have an identical case-mix, the average cost figures may not reflect the relative efficiency of individual hospitals.

12.9 Table 12.4 shows the growth in the utilisation of public hospital services over time. The possible causes of this growth have been discussed in detail in Chapter Four. The increase in patient throughput has been accompanied, and facilitated, by a reduction in the average length of a hospital stay.

12.10 Projections of growth in the demand for hospital services in the coming years have been published on the basis of demographic projections and historic patterns of usage by age-group. One such

TABLE 12.3
ESTIMATED AVERAGE COSTS OF HOSPITAL STAYS, 1987

	Average Weekly Cost per Occupied Bed (£)	Average Cost per Discharged Patient (£)
Voluntary Teaching	1,139	1,036
Voluntary Non-Teaching	676	755
Regional	981	944
County	785	750
District Short-Stay	314	786

Source: Department of Health

TABLE 12.4

PUBLIC HOSPITAL ACTIVITY INDICATORS

	1962	1970	1980	1986	1987
Patients discharged from acute public hospitals (excluding district hospitals)	248,648	341,064	521,080	549,464	498,693
Average duration of stay in days (excluding district hospitals)	18.1	12.8	8.6	7.3	7.0
Patients discharged from district hospitals (short-stay and long-stay)	30,030	27,252	22,618	16,641	13,311
Number of out-patient attendances	n.a.	n.a.	1,460,198	1,621,032	1,529,969
Number of new attendances	n.a.	n.a.	336,781	367,374	339,855

Notes: District hospital data for earlier years is not readily classifiable into long-stay and short-stay.

Out-patient data was not collected before 1980. The figures refer to consultant-staffed out-patient clinics. A new attendance is defined as a patient who has not attended a clinic for the particular specialty in the year prior to this attendance.

Source: Department of Health

projection[5] shows an increase of 3 per cent between 1986 and 1996, and a further 3.5 per cent between 1996 and 2011. This excludes maternity hospitals, where the forecasted sharp decline in the birth rate will have a dramatic effect. However, these projections are of little practical relevance because changes in healthcare policy and developments in medical technology will have far greater impact than demographic factors on the patterns of hospital use.

12.11 All public hospital services are provided free of charge to medical card holders i.e. Category I. Those in Category II are entitled to accommodation, ancillary services and consultant care, subject only to a charge of £10 per day, to a maximum of £100 in a year, while Category III patients have similar entitlements except that they are liable for consultants' fees. A patient in Category I or II who exercises choice of consultant is also liable for consultants' fees. The question of consultants' services is discussed in more detail in Chapter Thirteen. Any patient opting for private or semi-private accommodation is liable for a maintenance charge, the present

[5]O. Keegan & C. McCarthy: *Ireland's Changing Population Structure* (DKM Economic Consultants, September 1987)

TABLE 12.5

PUBLIC HOSPITAL MAINTENANCE CHARGES

CHARGE PER DAY, WITH EFFECT FROM 1 JANUARY 1988

	Private Room	Bed in Semi-Private Ward
Regional or Teaching Hospital	£96.00	£70.00
County or Non-Teaching Hospital	£73.00	£55.00
District Hospital	£36.00	£27.50

NOTE: 1. The £10 per day charge, which applies to *all* accommodation for the first 10 days in any period of twelve months, is additional to the above charges.

2. The 1988 rates were not increased in 1989.

Source: Department of Health

structure of which is detailed in Table 12.5. It is estimated[6] that private and semi-private beds accounted for 20 per cent of all beds in public hospitals in 1986, although their definition is not fixed and may vary within an individual hospital over time.

12.12 Admission to acute public hospital services, in non-emergency cases, is normally through a consultant-staffed out-patient clinic to which a patient has been referred by a GP. A patient who is being treated privately by a consultant in a public hospital will normally seek private accommodation which will be arranged for him by that consultant in accordance with the arrangement the consultant has with the hospital for the use of its private accommodation. If such a private patient seeks public accommodation, his consultant will admit him acting in the capacity of his public appointment and in accordance with his professional assessment of the patient's medical needs.

12.13 Private hospitals charge their patients for maintenance and for all ancillary services. There is no public control over the level of charge, although the Voluntary Health Insurance Board negotiate charges for services provided to their members.

EVALUATION OF THE PRESENT SYSTEM

12.14 We now look at the extent to which the present provision of general hospital services is equitable and efficient. As discussed in

[6]M. Wiley: *The Public/Private Mix on Health Care in Ireland* (Paper delivered to Conference on Health Policy, Beaumont, October 1987).

Chapter Five, we define equity in terms of ensuring equal access to and utilisation of necessary services for patients with similar needs, regardless of differences in their ability to pay. We define efficiency in terms of planning and providing services to make the most cost-effective use of the available resources.

12.15 There is a public perception that private care, whether in a public or private hospital, carries with it faster access to treatment and higher-quality care — the latter being represented by a greater degree of personal attention from the consultant rather than from more junior medical staff. This perception would partly explain the substantial take-up of voluntary insurance by those with full eligibility for public hospital services — the VHI have told us that 32 per cent of those in Category II are members of their Plans. It would also explain the willingness to pay public hospital charges of up to £70 per day for semi-private accommodation which in the more modern hospitals is barely distinguishable from that in the public ward. Our discussions with those involved with various aspects of the services have left us in no doubt that the public perception is an accurate one, and that, in some cases, speedy access to necessary treatment is determined by ability to pay rather than by medical need. While this disparity is most marked where it concerns access to the same public hospital, the issue of faster access to treatment through the use of private hospitals is also important because this form of care is subsidised by public funds through the training in the public sector of their medical and nursing staff.

12.16 We believe that access to any publicly funded or subsidised hospital service, and the level at which care is provided, should be determined solely on the basis of objective medical criteria. Having said this, we recognise that an unmet demand for public hospital services, which is manifested in long waiting lists for many procedures, inevitably creates an environment in which many will seek to bypass the queue. This raises the question of whether the widely apparent dissatisfaction with the availability of public hospital services is because the necessary facilities have not been provided, or because they are in place but are being operated inefficiently.

12.17 The existence of waiting-lists does not, in itself, imply that the available service is less than adequate. To ensure immediate admission to hospital in all cases where non-urgent treatment was required, it would be necessary to carry permanent spare capacity and this would be wasteful of scarce resources. However, we are aware that for certain procedures the waiting-time is extremely long, to the extent that there is no certainty that the required treatment

will be available at all. This clearly indicates a system which is either inadequately-geared or else inefficiently operated.

12.18 International comparisons are of limited use in assessing the adequacy or otherwise of the provision of hospital beds because definitions, health care delivery systems, morbidity patterns and demographic factors differ considerably. Comparisons between Ireland and the United Kingdom may have some validity because these differences are less marked. Raftery[7] showed that the provision of acute beds was substantially higher in Ireland than in England, Wales or Scotland even after allowing for differences in relative morbidity levels. However, it must be noted that there has been a substantial reduction in the provision of acute beds here since this study was carried out.

12.19 The present level of acute hospital bed provision in Ireland is based on planning guidelines in the form of bed-population ratios. These were developed in the mid-1970s, although they have been updated from time to time. The approach involved estimating the expected numbers of patients for each specialty, largely based on existing patterns of patient demand. The consequent bed requirement was estimated on the basis of the lengths of stay in those hospitals with the best rates of patient turnover. The ratios used involve the recommended provision of 3.67 acute beds per 1,000 population, equivalent to about 13,000 beds to meet the needs of the present population.

12.20 The data which are published in respect of acute hospital beds include a number of beds which are staffed at non-consultant level and which are non-acute in the strict sense. These include beds in Cottage Hospitals, some beds in District Hospitals, some longer-stay beds in rehabilitation units and a proportion of the beds in private hospitals. Thus, although Table 12.1 shows a total of over 15,000 beds for 1987, the total number of acute consultant-staffed beds available in public and private hospitals at the end of 1987 was somewhat less than this when allowance is made for the above exclusions. We understand that the closure of a number of hospitals in 1987 and 1988 reduced the supply of beds to around 13,000. Temporary ward closures would have reduced this figure further.

12.21 We do not believe that the current planning guidelines on bed-population ratios are a useful yardstick on which to decide the future availability of hospital services. They were developed in the

---

[7]James Raftery: *Health Services: The Implications of Demographic Change* (National Economic and Social Council — No. 73, November 1983): Chapter Four.

mid-1970s and, although subject to some modification since then, they reflect the assumptions and usage patterns of that time. Since that time, the potential of general practitioner services to deal with acute illness, and the scope for reducing hospitalisation through the development and improvement of other community services have been widely recognised. This is reflected in current health policy which is aimed at shifting the emphasis on treatment in an institutional environment to community care in appropriate cases. The success of this policy is to some extent measurable in a reduction in the acute bed/population ratio. Furthermore, the calculation of bed-number guidelines on the basis of existing patterns of usage inevitably perpetuates any existing inefficiencies.

12.22 We do not argue simply that the recommended guidelines for bed numbers need considerable revision; we are satisfied that the nature of hospital care is changing to such an extent that bed numbers alone no longer determine the extent of services which can be provided. The rapid development of diagnostic procedures and methods of treatment is reducing the need for surgery and also the requirement for in-patient accommodation. This development, and other efficiency improvements, have allowed hospitals to treat significantly more patients without corresponding increases in bed numbers. Indeed, it was reported[8] that many hospitals maintained, or even increased, their activity levels in 1987, although a significant proportion of their beds had been temporarily closed.

12.23 There is considerable evidence that the available hospital beds have been used inappropriately or inefficiently. This arises in a number of ways:

(a) a study[9] of one acute general hospital found that at least 40 per cent of short-stay patients, accounting for almost 18 per cent of all patients, could have been treated without requiring admission to an acute care ward;

(b) submissions have been made to us that a significant proportion of acute care beds are occupied by long-stay patients who would receive appropriate care at much lower cost in a non-acute facility;

(c) an analysis[10] of in-patient data for a number of hospitals suggests that durations of stay for a range of procedures are longer than would seem necessary;

---

[8]J. O'Dwyer: *Whither The Acute Hospital System?* (Paper delivered to Conference on Health Policy, Beaumont, October, 1987).

[9]R.A. Hamill: *An Analysis of Short-Stay Hospital Cases* (Irish Medical Journal, December 1982).

[10]Z. Johnson & H. Johnson: *Irish Health Care — The Future* (April 1986).

(d) inappropriate use of hospital casualty departments rather than general practitioner services leads to unnecessary admission to hospital and further investigation. An article[11] by the consultant surgeon in the Accident and Emergency department of one large hospital argues that the hospital doctor, mindful of the risk of litigation and having neither vast experience nor the opportunity of domiciliary visiting, tends to adopt the safe course of admitting the patient and requesting multiple investigations. The extent of such admissions is, he argues, so great that very little capacity remains for dealing with patients on waiting-lists for non-emergency procedures. This view was also expressed to us in several submissions;

(e) the efficient use of the facilities provided to serve populations in different parts of the country may be hampered by the freedom of patients to obtain treatment in public hospitals of their choice. It has been submitted to us, for example, that there is a substantial amount of referral of patients to Dublin hospitals for routine procedures which are available in local hospitals. To the extent that this pattern exists, it would clearly tend to result in excess demand pressure on some hospitals and under-utilisation of the facilities provided elsewhere; and

(f) the absence of a properly integrated community care infrastructure has hampered the implementation of the policy of moving towards community care. It has been submitted to us that the lack of public health nurses, day-care centres and general support facilities continues to result in the unnecessary admission to hospital of certain types of patient who could be treated equally successfully, and more cheaply, in the community.

12.24 It is clear from the foregoing that the emphasis in the planning and delivery of hospital services has been almost entirely on the *provision of inputs* — beds, equipment and personnel — with little emphasis on ensuring their efficient use. Services must be defined in terms of the medical needs which they seek to meet, the criteria on which they will be delivered and the waiting periods which are acceptable. Only then can an assessment be made of the inputs required to provide them efficiently. The above evidence suggests some over-provision of services, although it must be noted that it pre-dates the recent reductions in bed numbers. However, in the absence of the required definition of service needs, criteria and waiting periods, we cannot quantify the extent to which there may be over-provision or, indeed, under-provision.

---

[11]L. Vella: *The Cut-Backs viewed from the front-line* (Irish Medical Journal, December 1987).

EQUITABLE ACCESS TO AN EFFICIENT SERVICE

12.25 The Commission has recommended in Chapter Six that core health services should be funded publicly through general taxation, allowing for modest charges in certain circumstances. The entire population would be eligible for these core services. Obviously, as hospital services, both in-patient and out-patient, would form the most important component of these services, the basis on which people avail of them and are admitted to hospital has important consequences for the equity and efficiency of the system as a whole.

(i) Equity

12.26 The Commission regards improvement in the equity of access to services, in the context of available resources, as being of paramount importance. One of the main areas within the publicly funded health services in which this issue arises is the provision of acute hospital services. We would like to affirm our belief that the primary protection of the patient's right to obtain equitable access to any health service must be grounded in the ethics of the medical profession. We have no reason to think that there has been a diminution in recent times in the high degree of commitment of doctors to the principles of equity, but we are of the opinion that there are features of the present system which militate against the proper operation of these principles and which, in the present climate of financial stringency, have tended to promote the perception of access to the public acute hospital system as being seriously inequitable.

12.27 The demand for healthcare will always exceed the capacity of the available resources to meet it, and some form of rationing is therefore inevitable. The rationing system at present in place in acute hospitals is based to some extent on ability to pay and, indeed, to some extent on arbitrary criteria, such as accidents of geography or timing, or indeed even personal persistence. It is inequitable that patients in medically similar circumstances do not have equal access to services. As a result, unnecessary frustration and suffering is caused to those on long waiting-lists.

12.28 **To overcome this problem, we recommend the introduction of an objective system of assessment for access to publicly-funded hospital services. This would relate to all planned admissions, whether to public or private accommodation, and would result in a *common waiting list* from which cases would be taken in order of medically established priority rather than the type of accommodation**

sought. It would require the publication on a regular basis of criteria for hospital admission and of maximum waiting-periods for access to specific non-emergency procedures. This would involve stating the circumstances in which hospital admission is generally inappropriate, such as conditions for which effective treatment is available at lower cost in the primary care sector. Factors such as the social situation of the patient and the quality of the back-up care available to him outside the hospital would have to be taken into account, however, in the operation of the criteria. The approach would also require decisions to be made explicit concerning the circumstances in which the availability of certain procedures was not guaranteed.

12.29 The development of common admissions criteria would require the involvement and cooperation of the medical profession, with care taken to demonstrate the overall benefit to doctors and patients of guaranteed access for necessary services within a specified period. It is essential that the working of a common admissions policy be properly reviewed to monitor its effective operation. The Commission considers that it would be impractical to do this on a case by case basis given the individual clinical responsibility of the admitting doctor for his patient. However, *we envisage that such monitoring would be done by reference to the overall balance between public and private patients admitted over a period* and between each of the different specialties practised in a hospital. We consider that this monitoring is most appropriately carried out by the medical professionals themselves at local level. Such a system based on peer review is the most practicable since it involves those responsible for admissions.

12.30 The facilities necessary to meet the guarantee of access would, of course, have to be made available. It would thus be the responsibility of the Health Services Executive Authority to ensure that the services were generally available and appropriately distributed so as to honour the guarantee of access. The existence of private hospital facilities should be taken into account in planning the provision of public facilities in order to avoid wasteful duplication. It would be the responsibility of local management to ensure that those entitled to services received them within the specified period, either by providing them directly or by arranging for their provision elsewhere.

12.31 **Under the recommended approach, admission to public hospitals would be governed by universal criteria, regardless of the patient's status as public or private, and irrespective of the type of accommodation chosen.** The

traditional practice of allocating a fixed amount of private accommodation to individual consultants or specialties, which is still in operation in many hospitals, would cease. The existence in the hospital of a fixed number of private or semi-private beds, as opposed to public ward beds, should not determine the choice of patients to be admitted. Private and semi-private accommodation should be regarded as an amenity for which charges should be levied equal to the cost of providing it when it is possible to offer patients this choice of accommodation. However, if public ward accommodation has been fully taken up, a patient with priority on the basis of the specified criteria who has sought a public ward bed should be admitted to whatever level of accommodation is available as if it were a public ward bed. Over time, this will lead hospital managements to ensure that the mix of accommodation levels which they provide is broadly matched to the demands of their patients.

12.32 The range of services which could be provided, and the duration of the waiting-periods, would still be determined by the resources available. However, the cost implications of any proposals to alter services, admission criteria and waiting-times would have to be identified. This information would enable the policy options available to the Government in relation to hospital services to be clearly costed. In preparing each year's allocations, the cost of maintaining the existing level of hospital service in terms of the access criteria and waiting-times, the cost of specific improvements and the impact on these service levels of any reduction in funding would all be known.

12.33 The research and analysis which would be required to develop this approach would be the function of the Health Services Executive Authority, as discussed in Chapter Ten.

12.34 Individual aspects of the present problem of access to public hospital facilities are also of concern. It has been suggested, for example, that for those major hospitals providing an Accident and Emergency service, the introduction of such a common admissions policy, although desirable, would, in their present circumstances, be impractical. This is because of the highly disruptive effect such Accident and Emergency admissions can have on the normal schedule of planned admissions, which are often just as critical as casualty cases. These can force the cancellation of clinics and operations in order to cope with a once- or twice-weekly influx of emergency cases. Beds are often occupied by casualty cases for two or three days leaving no opportunity for scheduled activity before the next 'on call' day. This is obviously a very difficult area which must receive the early attention of the new Health Services Executive

Authority to see how it can be improved.[12] It has been suggested to us that the answer may lie in the designation of full-time casualty-oriented hospitals, perhaps two in Dublin and one each in the major cities, as operate in the United Kingdom, providing an initial reception, diagnosis and, as appropriate, treatment or referral to a general or specialist hospital of casualties. While this would not reduce the total number of casualty cases, it could serve to reduce the extreme pressure placed at intervals on some acute hospitals.

12.35 The problem of over-referral of cases from outside Dublin to the Dublin Voluntary Hospitals has also been brought to our attention. While the concentration of major national centres of specialist treatment in Dublin is obviously understandable given the country's population distribution, it is undesirable that unnecessary referral to Dublin should result in the underutilisation of local facilities in other parts of the country. This is another area of immediate concern which must be addressed by the incoming Health Services Executive Authority. Clearly, a balance must be achieved between genuine cases which cannot be served locally and other patients whose needs could be met within their own area. We discuss this issue further later in the chapter.

Reservation by Mr. P. Teahon

Equity of access to public health services would be significantly improved if the VHI premia for services in public hospitals were payable by way of ***addition*** *to general taxation which funds the public health service to which everyone is entitled. All patients would therefore have the same starting point in terms of entry to hospital services while some could, if they chose, pay extra for semi-private or private treatment in public hospitals. VHI premia for private hospital treatment should be funded separately and in full.*

(ii) Efficiency

12.36 To plan the hospital services required to meet the demand arising under the specified access criteria, the Executive Authority would have to ensure the efficient use of the available services. This would involve

— reducing unnecessary hospitalisation;

— providing hospital care at the appropriate level; and

[12]Since this was written, the Department of Health has reorganised the provision of Accident and Emergency services in the Dublin acute hospitals in response to these problems.

— preventing the wasteful use of hospital resources.

12.37 Hospital admissions can be categorised as planned and unplanned. As discussed earlier, *planned* admissions should be governed by uniform criteria which would rule out hospitalisation in cases where appropriate, less expensive treatment was otherwise available (taking into account all relevant aspects of the individual case). The same principle holds in relation to *unplanned* or emergency admissions, but its implementation is far more difficult because of the need to take immediate decisions.

12.38 The level of unplanned admissions to hospitals is widely regarded as a prime source of wasteful use of hospital resources. A pattern of self-referral to Accident and Emergency Departments rather than to the general practitioner has gradually developed. It has also been suggested that some general practitioners refer patients to Accident and Emergency Departments to by-pass delays in the normal process of referral for consultant investigation. It appears clear that these practices in turn lead to unnecessary admissions for observation and investigation. In addition to the development of consistent admissions policies for application in Accident and Emergency Departments, *there is also a case for experimenting with the staffing of these Departments by general practitioners, who would have wider experience than non-consultant hospital doctors of the range of conditions for which admission is unnecessary*. The use of charges to counteract abuses of emergency services is discussed later in this chapter.

12.39 Within the hospital, there are different arrangements for the provision of services. The alternatives to the standard form of in-patient care include treatment in five-day wards, admission as a day-patient and attendance as an out-patient. Because of the labour-intensive nature of hospital care, the potential cost savings from a greater use of these alternatives are large. For example, treatment on a day-care basis reduces from three to one the number of shifts of staff required. The introduction in the United States of hospital funding approaches based on case-mix rather than length of stay has led to a rapid move to the provision of surgery on an out-patient or day ward basis, and there would seem to be potential for a similar move in Ireland, not only for surgical procedures but also for many diagnostic and treatment services which are now provided on an in-patient basis.

12.40 It follows that the cost-effective use of hospital services requires not alone an admissions policy governing access to the hospital, but also the operation of criteria to ensure that treatment

is provided at the least level of complexity appropriate to the case, and also to ensure that patients are not kept in hospital longer than necessary. These would be important concerns of the research work recommended in Chapter Ten in relation to the determination of the required level of services.

12.41 We discuss later in this chapter the question of the funding of hospitals, and how to use the funding system so that care is provided cost-effectively. This involves providing care in the appropriate setting and preventing waste of resources. While the development of expensive, high-technology procedures has been blamed for much of the escalation of hospital costs, it is a consistent finding of international research[13] that a far greater impact is made by the collective cost of the repeated use of conventional diagnostic and therapeutic procedures which individually cost relatively little. Many submissions to us focussed on areas of specific interest to their authors, and argued that there was, for example, considerable waste of radiology and pathology investigations; unnecessary referral for paramedical treatment; abuse of emergency on-call procedures for these services; and a lack of concern for economy when choosing between alternative equipment and consumables. We do not propose to deal in detail with the wide range of potential cost savings and efficiency improvements which may be available to hospitals. Rather we would argue that a funding and budgeting approach is required which would give hospital personnel every incentive to seek these out. We return to this issue later in the chapter.

CHARGES FOR HOSPITAL SERVICES

12.42 Three main issues arise in relation to hospital charges. The first concerns charging for the use of public hospital facilities and accommodation by private patients of consultants. The second relates to the use of *regulatory* charges to deter patients from making unnecessary use of expensive hospital services. Thirdly, the question of imposing major *cost-sharing* charges on certain higher income groups, which would necessitate private insurance, has been addressed by the Commission in Chapter Six, but the introduction of such charges was not recommended for the reasons stated there.

(i) Charges for private accommodation

12.43 The Commission has accepted in Chapter Five that the individual should have access to self-funded medical treatment if he

[13]See, for example: T. Moloney and D. Rogers: *Medical Technology: a different view of the contentious debate over cost* (New England Journal of Medicine: Vol. 301, No. 26, 1979); and Groot, Lacronique and Stocking: *Report of the Second Phase of the Study of Medical Technology* (Directorate-General V of the EC, 1983).

so desires. However, as we have argued in Chapter Seven, an individual who wishes to have private treatment should be required to make his choice for this treatment explicit. If he chooses the private route he removes himself completely from the public system and becomes liable for the full cost of services. Where private treatment is provided in a public hospital, it is logical that the full cost of making treatment, facilities and accommodation available should be recovered from a private patient. We have argued earlier that charges for private accommodation have been generally perceived as payment for quicker access and a higher quality of care rather than solely for a distinct standard of accommodation. We have recommended that admission to hospital and the level of care provided should not be related in any way to one's status as a public or private patient. We see no need for the central fixing of a uniform charge for the private use of facilities and for private accommodation in similar categories of hospital, as at present, regardless of the relative extent to which standards of accommodation differ within individual hospitals. **We recommend that hospital managements should tailor their charges for private accommodation to recover the cost of providing it, and should determine the quantity and quality of such accommodation on the basis of the demand for it at that price.**

(ii) Charges as a deterrent to unnecessary utilisation

12.44 The standard charge of £10 per in-patient day or new out-patient visit, introduced in 1987, applies to all patients except medical card holders and in respect of certain specified conditions. The charge does not reflect the economic cost of providing the service, although it does make some small contribution to the funding of hospitals. It may also provide a disincentive to unnecessary utilisation, to the extent that this is within the patient's control. The obvious application of the latter objective relates to the use of hospital casualty services in preference to attending the general practitioner. We understand that the charge has had a significant impact on this tendency.

12.45 A recent OECD survey[14] reports that there appears to be a strong feeling in several European countries that the introduction of cost-sharing results in an initial drop in utilisation, but that this is not sustained. Much of the behavioural information on cost-sharing comes from the Rand Health Insurance Experiment in the United States, a major long-term study under which families were enrolled in one of several health plans which differed in the extent and nature

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

of cost-sharing. An analysis[15] of the results of the experiment shows that those individuals facing cost-sharing used fewer services. As might be expected, however, this experience was most marked in relation to the use of hospital emergency department services for less serious conditions. In most cases, cost-sharing relative to free care did not negatively affect health status. The provision of free care to poor adults (the lowest 20 per cent in the income distribution) did yield health status benefits for chronic problems that are relatively inexpensive to diagnose and remedy such as high blood pressure, myopia and dental care. Those with higher incomes did not receive clinically significant benefits from the availability of free services rather than under cost-sharing. The authors of the analysis infer that programmes targeted at the specific problems mentioned would be much more cost-effective in achieving these gains in health status than would free care for all services.

12.46 We accept that patient charges are justified to deter unnecessary use of services where that choice is within the patient's control. **We agree, therefore, with the imposition of a charge for out-patient services, so that there is no incentive to use hospital out-patient services where recourse to a general practitioner would be appropriate. However, we believe that the availability of insurance cover for such charges defeats its purpose.**

12.47 The issues are somewhat different in relation to regulatory charges for in-patient services. In-patient admission to hospital should not be at the discretion of the patient; we have recommended a strict admissions policy which should ensure that only patients who are in genuine need of in-patient care should receive it. *If an in-patient charge is to be justified, therefore, it must be on the grounds that patients should contribute to the cost of services rather than to deter unnecessary admissions.* This brings us to the question of the appropriate level of contribution from those patients who can afford to pay.

(iii) Charges as a contribution to the cost of the service

12.48 The present £10 daily charge described above is limited to £100 over any twelve-month period for in-patient services. The Commission believes that a charge of this nature does not expose patients to severe financial hardship; medical card holders and those receiving treatment for certain conditions are exempt, and the charge

[15]Manning et al: *Health Insurance and the Demand for Medical Care: Evidence from a Randomised Experiment* (American Economic Review, June 1987).

can be applied with discretion in circumstances where hardship might arise. A charge of this magnitude can be justified on the basis that it goes some way towards reducing the cost to taxpayers of services provided to the individual patient, particularly in relation to "hotel" costs such as food and bed-linen, as distinct from medical or nursing care. However, any such charge should not be so complex or administratively expensive as to reduce greatly its net revenue.

12.49 There may be scope for raising this charge somewhat above the present level, but the scope is limited by the danger of causing significant hardship to many patients at the lower end of the income range liable for the charge. This could result in a high level of non-payment, which would be inequitable to those who did pay, and could also deter patients from availing of necessary treatment. It would be a matter of judgement as to the level of charge which could be applied without causing such consequences. However, the full cost of providing hospital treatment for the duration of a patient's stay averages over £1,000 per patient in the larger hospitals and over £750 in the smaller ones, although these figures include some costs which are not attributable to in-patient care. It would not be realistic to make non-medical card holders liable for such major charges unless they had insurance cover to meet them.

12.50 We have already rejected in Chapter Six the concept of funding the health services through private health insurance. It would be completely contrary to our recommendation for a publicly funded health service to introduce a major element of cost-sharing for in-patient services which would require insurance, given the major problems for equity and compliance which we believe are associated with the insurance model. **We therefore believe that any modest cost-sharing charges for in-patient services should be on the same scale as those for out-patient services, as at present, with exclusions for groups for whom such charges could prove a hardship, including medical card holders. The charges should be subject to a yearly maximum, and should be framed in a way that avoids undue complexity and administrative cost.**

ADMINISTRATION

12.51 The separate administration of health board hospitals and voluntary hospitals has been the subject of debate for many years. The 1968 Fitzgerald Report[16] argued that the independent status of

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

voluntary hospitals, in the absence of effective machinery for coordination, had caused excessive duplication of services. However, it also held that characteristics of their independence, including their adaptability and the participation of their medical staff in hospital policy, were of considerable value and should be retained. The report therefore recommended the creation of three regional hospital boards to coordinate all public hospital services. While these boards would assume ownership of the local authority hospitals, voluntary hospitals would remain under independent ownership and management and would enter into contractual arrangements with the regional boards for their participation in a planned hospital service.

12.52 Three regional hospital boards were provided for in the Health Act, 1970. They were not intended to own or manage hospitals; the newly-established health boards would take over the local authority hospitals while the voluntary hospitals would remain independent. However, it was envisaged that each regional hospital board would

> "exercise its coordinating function mainly through a continuing review of general organisation and development of hospital services in its region, through examination of proposals by hospital authorities for development in their hospitals, through critical examination of hospital budgets and by generally promoting efficiency in hospitals."[17]

12.53 It was also intended that the boards would be authorised to appoint consultant medical staff to provide services in their regions. Such arrangements were to be made "in close conformity"[18] with the decisions of Comhairle na nOspidéal, which was established under the Health Act, 1970 to regulate, at the national level, the number and type of consultant appointments and thus the development of specialised facilities in public hospitals.

12.54 Although provided for in the 1970 legislation, the proposed role for regional hospital boards was not in fact implemented. Consequently, the Department of Health became closely involved in the organisation and management of voluntary hospitals, which it was funding directly, while responsibility for organising, managing and funding the other public hospitals remained with the health boards.

12.55 The need for a greater coordination of hospital services has not diminished, but **we would not recommend the establishment**

---

[17] *Health Act, 1970: Explanatory Memorandum* (Stationery Office, 1970): paragraph 32
[18] *Idem:* paragraph 33

of a national or regional hospital board for this purpose. There is now widespread recognition 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 particular catchment area. In the absence of this, there are practical difficulties in the coordination of hospital services with community-based services in the most efficient and effective manner. This problem is particularly marked in the Eastern Health Board area, where most hospital services are provided by the voluntary sector. However, it also affects other health boards, including those without voluntary hospitals in their areas, because of the direct access of patients to voluntary hospitals elsewhere regardless of the facilities available in their own areas.

12.56 We discussed the appropriate administrative structures for the health services in general in Chapter Nine, and concluded that the Health Services Executive Authority, through its Area General Managers, should be responsible for ensuring that the populations of each region had access to all necessary services. The definition of necessary services, and the criteria for and conditions of access to them, would be specified by the Minister for Health. This does not, however, imply that the ownership and management of voluntary hospitals must be taken over by the Executive Authority; they can remain free to manage themselves and to provide agreed services to the Authority. However, the place of each hospital within the overall system must be made clear, and the arrangements for access to hospitals changed so as to enable each hospital to carry out its designated role.

12.57 **We recommend the designation of specific roles and catchment areas for all public hospitals.** Hospitals with regional or national specialties would have separate catchment areas in relation to each of these. It would be the responsibility of the Executive Authority to designate these roles and catchment areas. **Publicly-funded treatment should normally be available to patients only in hospitals designated to provide the services required for the region in question.** A patient opting for treatment in a different hospital would forego his entitlement to public funding. Special arrangements would, however, apply to emergency admissions, and also to patients living close to hospitals which were nonetheless outside the boundaries of their region. As discussed earlier, a balance would also have to be achieved between services which could be provided locally and, as in the case of national specialties, those available only in a limited number of centres.

12.58 This approach need not imply the complete restriction of patient choice of hospital, as catchment areas could overlap. For example, patients could have freedom of choice as between hospitals in their own area for local specialties; they might also have a limited choice as between designated hospitals outside their own region for regional or national specialties which were not available locally. However, there would be formal agreements between the Executive Authority and the hospitals which would govern the criteria for admission of a patient requiring these services. A monitoring process would be required to ensure that these criteria were observed.

12.59 There would be many advantages in this approach. Area General Managers, operating admissions criteria agreed with the voluntary hospitals, could take full responsibility for ensuring the provision of appropriate care to the populations of their areas without requiring these hospitals to surrender their independent status. Imbalances in the usage of hospital facilities as a result of the complete freedom of patient choice would be eliminated. Unnecessary duplication in the provision of regional or national specialties would be avoided and the effective management of each hospital would be aided by the availability of a clear statement of its role and the criteria under which it was expected to execute it.

12.60 In the context of the administration of hospital services, it is appropriate to refer also to the question of the management function within hospitals. It is clear that the development of this function has lagged far behind the growth in the complexity and sophistication of hospital services. It has become a cliché at this stage to contrast the remuneration, training and support services available to hospital managers with those considered essential for managers responsible for equivalent budgets in industry and commerce; the comparison is no less valid for its repeated exposure. It is clear that the traditional approach to recruiting, paying and supporting hospital managers is no longer adequate, given the responsibilities they must fulfil if the modern hospital is to operate efficiently. The admission, treatment and discharge of a patient can be made subject to criteria, but are nonetheless ultimately determined by clinical decisions. The cooperation of clinical personnel in the management of resources is therefore crucial to ensuring that they are used efficiently. The hospital manager must have adequate technical knowledge and professional standing if this cooperation is to be secured. **We recommend the development of more professional and highly-skilled hospital management, on the basis of fixed-term contracts which would clearly specify their responsibility for the hospital's performance in terms of measurable**

criteria, and which would remunerate them appropriately for this responsibility.

LICENSING OF HOSPITALS

12.61 At present, there are few statutory controls over the establishment of hospitals. Private psychiatric and maternity hospitals and private nursing homes are subject to certain restrictions,[19] but the limitations over other hospitals are primarily financial. In the public sector, establishment and operation is, of course, dependent on the provision of funds from the Exchequer, while for private hospitals the scope for establishing or extending facilities is effectively determined by the willingness of the VHI to cover the services offered.

12.62 The Commission is anxious that the quality and standard of hospital services be monitored and maintained. For this reason, **we recommend that all public voluntary hospitals and private hospitals should be required to obtain a licence, renewable periodically, from the Health Services Executive Authority. The Executive Authority would not be required to license its own hospitals, but they would be subject to the same standards.** Licences should be granted only after the Authority has satisfied itself as to the quality and standards offered by a hospital, or, in the case of proposed new hospitals, the quality and standards that would be provided.

12.63 The system of licensing would offer the Executive Authority a more flexible tool for monitoring the quality of services provided. It would be open to it to withdraw a licence temporarily until a hospital demonstrated its ability to provide services to a required level.

12.64 Chapter Ten referred to the difficulty of obtaining comprehensive data from private hospitals on their activity levels. It should be a condition of licensing that private hospitals undertake to supply the Health Services Executive Authority with specified information in this regard.

---

[19]Maternity homes must be registered under the Registration of Maternity Homes Act, 1934, although non-profit homes may be exempted. Psychiatric hospitals must obtain a licence under the Mental Treatment Act, 1945. Private nursing homes must notify the local health board before establishment under the Health (Homes for Incapacitated Persons) Act, 1964 and are subject to health board inspection under the Homes for Incapacitated Persons Regulations, 1985. The Private Nursing Home Bill, 1989 provides for the licensing of such homes.

METHOD OF FUNDING

(i) Background

12.65 The traditional method of paying hospitals for their services in most countries, has been on the basis of a standard daily charge per patient. However, the development of medical technology in recent decades has meant that diagnostic and treatment costs now vary considerably from patient to patient, depending on the nature of the case. Consequently, a standard charge is unfair to those hospitals dealing with a more complex mix of cases. It also inhibits efficiency by providing an incentive to hospitals to keep their beds occupied, so as to maximise their income; it may also lead some hospitals to retain patients for longer than necessary, as the later stages of a hospital stay tend to be relatively less costly. A further disadvantage associated with funding by daily charges is its open-ended nature; control of total expenditure by the funding authorities is thus difficult.

12.66 As a result of these disadvantages, most countries have now moved away from a standard daily charge. Many, including Ireland and the United Kingdom, finance their public hospitals through the allocation of global budgets. This approach is effective in limiting overall expenditure, provided that the hospitals are not permitted to overrun their budgets; however, it still does not guarantee the efficient or equitable use of resources. In Ireland, the approach has been based on incremental budgeting, so that a hospital's allocation is, in general, based on its level of expenditure for the previous year, with adjustments made for inflationary factors, changes in service provision, and government policy on the overall level of expenditure. This approach has the obvious drawback that it sustains, over time, the cost differences between efficient hospitals and resource-wasting ones. To overcome this, it is necessary to develop a system of measuring the output of hospitals, and relating this to their budgets. In practice, this requires measuring activity in terms of the case-mix, and identifying the cost of each type of case.

(ii) Case-mix costing

12.67 The most widely-known approach to this problem is that based on Diagnosis-Related Groups (DRGs) which was developed originally in the United States and was gradually introduced as the basis of hospital funding under the Medicare programme in 1983. Payments for in-patient services are made on the basis of pre-determined rates calculated for almost five hundred classifications of diagnosis. The amount paid will differ from area to area, taking

account of local factors, but the relative weightings of the DRGs are constant until updated. The payment is paid per hospitalisation, rather than per day. It does not cover out-patient costs, capital costs and medical education costs; the hospitals continue to receive direct reimbursement for these. There is provision for special payments for cases meeting specified criteria as *outliers* i.e. abnormally long length of stay or extraordinarily high costs. The independent Prospective Payment Assessment Commission, which was established to monitor the operation of the system in the United States, has carried out a comprehensive review of approaches for improving the measurement of case-mix and concludes that "the DRG system is the most appropriate available measure".[20] The introduction of the system has seen significant reductions in lengths of stay for Medicare patients. The DRG classification system is now the subject of experimentation and research in about sixteen European countries,[21] including Ireland.

12.68 The Department of Health has told us that considerable progress has been made on this work in Ireland. It has proved possible to calculate a set of cost weightings, based on Diagnosis-Related Groups, through detailed analysis of the activity and costs of three large hospitals. The results of this exercise have been found to be consistent with those being produced for other countries. A detailed measurement of hospital activity is also being carried out in the larger acute hospitals, which together account for about two-thirds of acute hospital expenditure. In the short-term, it will be possible to relate this activity data to the case-mix cost weightings derived from the DRG research. This will give some indication of the extent to which the relative funds allocated to the hospitals at present reflect the differences in their activity levels and complexity of their case mix. It will thus provide a basis for bringing their budgets more into line with the output required of them.

12.69 **We recommend that the work on deriving case-mix based cost weightings should be extended to cover a wide range of acute hospitals.** While this will require the provision of adequate cost information systems to these hospitals, we believe that this is justified on a number of grounds:

(i) the pilot project, based on the activity and costs of three hospitals, has shown that valid results can be derived;

---

[20]Prospective Payment Assessment Commission: *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services* (April 1987): page 4.

[21]Miriam M. Wiley: *DRGs as a basis for Prospective Payment* (Health Policy, 9-1988: pp. 157-165).

(ii) the usefulness of the results, in the short-term, is limited to giving a broad indication as to whether individual hospitals are under-funded or over-funded in relation to the output they provide. More detailed use of the approach in determining hospitals' budgets would require that the cost weightings were based on data from a much wider range of acute hospitals;

(iii) if hospital managements are to ensure that an efficient and cost-effective service is being provided, it is essential that they should have information on the relationship between output and the cost of inputs in respect of their own hospitals; and

(iv) there is a perception, on the basis of differences in the overall expenditure levels of similar hospitals, that some are considerably more efficient than others in relation to the cost of specific procedures. The extension of the existing research to a greater number of hospitals would enable such differences in the standard costs of various types of activity to be identified.

(iii) Application to hospital funding

12.70 The results of this work could provide an equitable and efficient basis for the allocation of funds to public hospitals. **We recommend that hospitals should receive global budgets for the provision of an agreed service level as outlined earlier. However, the calculation of these budgets would be based, not on an incremental approach as at present, but on an assessment of the activity level implied by the hospital's agreed role and catchment area and the case-mix based cost of meeting this. The calculation of case-related weightings, and the standard cost levels to which they would be applied, should be based on the costs prevailing in the more efficient hospitals. Some elements of hospital expenditure, such as out-patients services, diagnostic and other services provided to general practitioners and the research and education functions of teaching hospitals would be separately calculated and funded.**

12.71 The effect of this approach would be to provide each hospital with adequate funding to meet its agreed service commitment, if the hospital was efficient in its use of resources. The onus would be on the hospital management to secure the necessary efficiencies. Continued failure of a hospital to meet its cost targets would require an examination of whether the calculation of the hospital's budget took insufficient account of legitimate factors affecting that hospital's costs, in which case appropriate adjustments should be made, or whether the management of the hospital was inadequate to achieve

the objectives for which it was accountable. On the other hand, hospitals achieving savings on the budgeted cost of activity would be free to carry forward the saving (or some portion of it) or to use it for the improvement of facilities within the hospital. There would thus be strong financial incentives to hospital managements and clinicians to ensure that potential efficiency savings were realised.

12.72 The involvement of the clinician is, of course, vital if resources are to be used efficiently, since the clinician bears ultimate responsibility for the main decisions — the admission, treatment and discharge of patients — which affect the use of resources. **We recommend that the hospital funding approach discussed above should be complemented by the use of clinical budgeting within hospitals.** This would involve clinicians, or clinical teams, being given budgets for the services for which they were responsible. The detailed costing approach which has been discussed above would provide the necessary data upon which to base this. Savings retained by the efficient hospital could be allocated to the budget-holders who had achieved them, for research, training, equipment or other desirable uses. All hospital personnel with resource-using responsibilities would thus have resource-management functions, with strong incentives to ensure efficiency and cost-effectiveness.

12.73 While we believe that the combination of case-mix based hospital funding and clinical budgeting within the hospital has the potential to bring about major improvements in the efficiency of the hospital services, it would rely heavily on the information, evaluation and performance measurement which we have discussed above and in Chapter Ten. The quality of the information on activity and costs is crucial to the effectiveness of the approach, and this must be maintained on a continuing basis. The estimation of the annual activity associated with each hospital's agreed role will be complex; it will be affected not only by the incidence of medical conditions but also by demographic factors, the admission criteria laid down and by patterns of usage of private hospitals.

12.74 It would be essential to monitor the quality of services provided by hospitals to ensure that savings were not achieved by providing an inferior service to patients, or by the preferential admission of those types of case where a hospital had a cost advantage. There would also be a need to support hospital managers in their dealings with clinicians by establishing procedures to examine patterns of high admission rates or long durations of stay. We discussed how this might be done in paragraph 10.43.

12.75 It was argued in a number of submissions which we received that the use of a single-year time-frame for allocations to hospitals makes forward planning extremely difficult. It was also claimed that the need to meet short-term budgetary constraints can mean that measures must be taken by the hospital which have uneconomic consequences in the longer-term. The approach to funding which we have outlined above clearly implies a greater degree of continuity in the year-to-year allocations of hospitals. Funding should be on the basis of rolling plans of perhaps three years' duration rather than single-year budgeting. We discussed the issue of multi-annual budgeting in Chapter Nine.

THE ROLE OF PRIVATE HOSPITALS

12.76 Table 12.1 includes information for 1987 on private acute hospitals with about 1,800 beds and a throughput of about 53,000 patients in that year. These figures represent just over 11 per cent of all acute beds and about 9 per cent of patients.

12.77 Most of the hospitals covered by the data are owned by religious orders and operate on a non-profit basis. They cater mainly for elective procedures, and, in general, do not deal with those of an extremely complex nature. The procedures are generally carried out on a part-time basis by consultants with attachments also to public hospitals.

12.78 There has been some significant development of the private hospital sector in recent years. Two large hospitals have opened, each equipped to carry out complex procedures requiring the use of sophisticated technology. There has also been some development of private hospitals, for less complex procedures, on a commercial basis, and there have been reported plans for further such development.

12.79 The development of private hospital facilities is perceived to have both advantages and disadvantages for the public health services and for the country as a whole. On the positive side, it increases the range and choice of services available, reduces the demand pressure on public hospital facilities and enables an increased proportion of healthcare needs to be met without recourse to public expenditure.

12.80 On the other hand, it is pointed out that there appears to be an immutable association between the provision of hospital beds and the admission of patients to fill them. Consequently, it is argued that the development of private hospitals will lead to an increased throughput of patients and thus increased national expenditure on healthcare, taking private expenditure into account, and that the

likelihood of wasteful expenditure, through unnecessary use of services, will increase as the supply of hospital beds increases. It has therefore been suggested by some that the development of private hospital facilities should be restricted.

12.81 The implications of the latter argument need careful examination. In our society, individuals have the right to spend their money on any lawful goods or services of their choice. There is therefore no basis for applying the cost-effectiveness criteria, which arise in relation to publicly-funded facilities, to the control of private hospital development. Those demanding a service, the cost of which they are willing and able to pay, should be free to avail of it. **For this reason, we do not recommend the restriction of the development of private hospital services, provided of course that satisfactory standards of patient care are ensured. To this end we have already recommended a licensing system which would include private hospitals. However, it is important also that public policies do not insulate private hospitals from the competitive forces which are required to provide an efficient balance between supply and demand.** This could arise, for instance, if consumers have little choice between voluntary health insurance policies, and cover is extended (and premia increased) as new hospitals came onstream. The question is also relevant to the discussion of tax relief on health insurance. We have discussed these issues in detail in Chapter Eight.

12.82 **The scope for the use of private hospital facilities as a cost-effective alternative should be taken into account in determining the appropriate provision of public facilities.** For example, we understand that there are long waiting-lists in the public sector for some orthopaedic and ophthalmic procedures. As an alternative to additional investment in order to meet this demand, it may be less expensive to reduce the backlog by contracting to have a number of procedures carried out by private hospitals. The Commission is not aware that there has been any significant cooperation between public and private sectors in this way in the past, but it could provide a cost-effective approach in certain circumstances and help to avoid unnecessary duplication of facilities.

RECOMMENDATIONS

12.83 The following recommendations have been made in this chapter:

1. An objective system of assessment should be introduced for access to publicly-funded hospital services, involving the regular

publication of criteria for hospital admission and maximum waiting-periods.

2. Admission to public hospitals should be governed by universal criteria, regardless of the patient's status as public or private and irrespective of the type of accommodation chosen.

3. Hospital managements should tailor their charges for private accommodation to recover the cost of providing it, and should determine the quantity and quality of such accommodation on the basis of the demand for it at that price.

4. We agree with the imposition of a regulatory charge for hospital out-patient services, so that there is no incentive to use these services where recourse to a general practitioner would be appropriate. The availability of insurance cover for this charge defeats its purpose.

5. Any modest cost-sharing charges for in-patient services should be on the same scale as those for out-patient services, as at present, with exclusions for groups for whom such charges could prove a hardship. The charges should be subject to a yearly maximum, and should be framed in a way that avoids undue complexity and administrative cost.

6. The establishment of a national or regional hospital board, as provided for in existing legislation, is not recommended.

7. Specific roles and catchment areas should be designated for all public hospitals.

8. Publicly-funded treatment should normally be available to patients only in hospitals designated to provide the services required for the regions in question.

9. More professional and highly-skilled hospital management should be developed, on the basis of fixed-term contracts which would clearly specify managers' responsibility for hospitals' performance in terms of measurable criteria, and which would remunerate them appropriately for this responsibility.

10. Research work on deriving cost breakdowns by case-mix should be extended to cover a wide range of hospitals.

11. Hospitals should receive global budgets for the provision of an agreed service level. The calculation of these budgets should be

based on an assessment of the activity level implied by the hospital's agreed role and catchment area, and the case-mix based cost of meeting this. The calculation of case-related weightings, and the standard cost levels to which they would be applied, should be based on the costs prevailing in the more efficient hospitals. Some elements of hospital expenditure, such as out-patients services, diagnostic and other services provided to general practitioners and the research and education functions of teaching hospitals would have to be separately calculated and funded.

12. This approach to funding hospitals should be complemented by the use of clinical budgeting within hospitals.

13. The development of private hospital facilities need not be restricted, provided that satisfactory standards of patient care are ensured; but public policies, including those related to voluntary insurance, should not insulate these hospitals from competitive forces.

14. In order to ensure the maintenance of required standards, public voluntary and private hospitals should be required to obtain a licence, renewable periodically, from the Health Services Executive Authority.

15. The scope for the use of private hospital facilities as a cost-effective alternative should be taken into account in determining the appropriate provision of public facilities.

CHAPTER THIRTEEN

CONSULTANT SERVICES

INTRODUCTION

13.1 A consultant is "a registered medical practitioner in hospital practice who, by reason of his training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and undertakes full responsibility for patients in his care without supervision in professional matters by any other person ..... the consultant may discharge this responsibility directly in a personal relationship with his patient, or, in the exercise of his professional judgement, he may delegate aspects of the patient's care to other appropriate staff, or he may exercise the responsibility concurrently with another doctor or doctors. Notwithstanding this, however, the unique position of the consultant in the hospital requires that he cannot shed the continuing responsibility for his patients so long as they remain in his care".[1] A consultant may also have various responsibilities in running a department, teaching, training and research.

13.2 Patients are referred to consultants by general practitioners, other consultants or through hospital accident and emergency departments. Consultants may also see self-referred private patients. This chapter describes and evaluates the present arrangements for the provision of consultants' services and discusses whether changes in these arrangements are required.

DESCRIPTION OF THE PRESENT SYSTEM

13.3 The appointment of consultant medical staff to public hospitals is regulated by Comhairle na nOspidéal. Table 13.1 details the number of consultants by specialty for selected years. The great majority are defined as "whole-time" i.e. with a scheduled

[1] *Working Party on a Common Contract and a Common Selection Procedure for Consultants: Interim Report* (September, 1978): Section 2.

commitment of 33 hours per week, although some consultants are employed on the basis of a part-time commitment. However, there is no restriction on the level of private practice which a consultant may undertake in addition to the public commitment, and many consultants maintain substantial private practices. A growing number of consultants are exclusively engaged in private practice. Table 13.2 shows that these represented almost 10 per cent of all consultants in 1988 as compared with 5 per cent in 1985.[2] It should be noted that appointments as private consultants are not regulated by Comhairle na nOspidéal or by any other agency.

TABLE 13.1.

CONSULTANTS WORKING IN THE PUBLIC HOSPITAL SERVICE

SPECIALITY	1975	1980	1986	1987	1988
Medicine	122	171	168	176	177
Psychiatry	154	155	178	174	174
Anaesthesia	115	128	142	142	144
Surgery	152*	145	135	128	135
Radiology	59	71	88	85	85
Obstetric/Gynaecology	81	92	85	81	83
Pathology	73	79	80	81	80
Paediatrics	25	40	49	50	50
Orthopaedics	(—*)	35	42	45	45
Ophthalmology	46	44	29	32	31
Ear, Nose and Throat	26	27	25	26	25
TOTAL	853	987	1,021	1,020	1,029

* Orthopaedics in 1975 included under Surgery.

Notes: Figures relate to 1 May and exclude consultants in exclusively private practice.

Source: Comhairle na nOspidéal

TABLE 13.2

TOTAL NUMBER OF CONSULTANTS

	1985	1986	1987	1988
Working in Public Hospital Sevice	1,011	1,021	1,020	1,029
Exclusively Private Practice	52	82	92	112
TOTAL	1,063	1,103	1,112	1,141

Source: Comhairle na nOspidéal

[2]These figures do not include consultants who have retired from public sector appointments and continue to be involved in private practice.

Public Patients

13.4 Persons with Category I or II eligibility are entitled to free consultant treatment in public hospitals, and consultants are remunerated by salary for providing this. The £10 charge for each in-patient day and for the first out-patient consultation, described in Chapter Twelve, should of course be noted. This is paid to the hospital, not to the consultant. As discussed later, a considerable proportion of those eligible for free consultant treatment forego this entitlement and become private patients of the consultant of their choice.

13.5 Consultants have regular out-patient clinics in hospitals at which those referred to them as public patients are seen. While the consultant has ultimate responsibility for each patient assigned to him, the investigation and treatment of patients on an out-patient or in-patient basis may be carried out by junior medical staff under his general supervision, with referral to the consultant of more difficult or complex cases. Table 13.3 shows that there are almost two non-consultant doctors for each consultant in public hospitals.

13.6 Consultants are paid for services to public patients under the terms of the Common Contract for Consultant Medical Staff which was introduced in 1981. Prior to its introduction, consultants were paid for services to public patients in a variety of ways:

— payment by salary was most commonly used in the case of health board appointments, where the consultants were usually permanent and pensionable; it applied in some cases in voluntary hospitals also, where it was usually confined to non-clinical consultants such as radiologists and pathologists;

— payments for sessions of fixed duration usually operated in the case of out-patient clinics, generally held in voluntary hospitals, and paid for by the health board; visiting consultants were sometimes engaged by health boards to hold clinics at their hospitals;

— most voluntary hospital consultants were remunerated for in-patient services by way of daily capitation rates.

Payments by session or capitation rate precluded benefits such as superannuation, paid sick leave or annual leave. Both the profession and the Minister for Health considered it desirable that the conditions of other consultants, particularly those with an almost full-time commitment, should, as far as possible, be brought into line with those in health board hospitals. Following earlier reviews, a Working

Party was set up in 1977 with representation from medical organisations, health boards, voluntary hospitals, the Department of Health and Comhairle na nOspidéal. It submitted an Interim Report[3] in 1978 which, following lengthy negotiations, formed the basis for the introduction from April 1981 of a Contract which, by 1983, had been accepted and implemented in all public hospitals.

13.7 The Common Contract provides for the payment to each consultant of an annual salary which is intended to take account of his continuing responsibility for his patients in addition to the scheduled commitment. The basic salary consists of two elements. The first is in respect of a 33-hour scheduled commitment, and the second (paid to all consultants whether or not extra hours are worked) is intended to compensate for 2 extra hours per day which may be required to complete work begun during the scheduled period. There are also payments for periods "on-call", and for emergency call-outs. The basis for remuneration under the Contract, and the current rates, are set out in detail in Appendix 13A. The Contract also allows for the recoupment of certain expenses and for the normal benefits attaching to permanent employment including superannuation, annual leave, sick leave and study leave.

13.8 The actual salary paid to each consultant includes a deduction, or "abatement", from a notional total salary, to take account of the estimated time spent treating private patients during their scheduled commitment. This is calculated on the basis that 15 per cent of the population are ineligible for free consultants' services, but the deduction varies from 10 per cent to 20 per cent to take account of factors specific to individual specialties or areas. The application of the abatement is detailed in Appendix 13A. Table 13.4 gives an estimated distribution of public hospital consultants by abatement rate.

13.9 The current annual cost of consultants' salaries under the Common Contract is estimated[4] to be £29m. This excludes on-call and call-out payments which could cost up to £6.1m more, depending on the number of consultants reaching the upper limit for these payments. The costs of recoupment of expenses, and the additional stipends attaching to academic appointments are not included in these estimates.

---

[3] *op. cit.*

[4] Secretariat estimate based on 1988 employment and on salary rates, from 1 January 1989, for scheduled commitment and 10 hour factor; taking account of proportions at each abatement rate, and of the proportion not in whole-time employment.

Private Patients

13.10 The fifteen per cent of the population with Category III eligibility are not entitled to treatment as public patients of a consultant. They may make private arrangements with the consultant of their choice, or may avail of the consultant assigned to them by the hospital, but in either case must pay the consultant directly. They are also liable for the fees of other consultants, such as radiologists, pathologists and anaesthetists with any involvement in their investigation or treatment.

13.11 Many of those eligible for free consultant care, particularly those in Category II, forego this entitlement and become private patients of the consultant of their choice. Some indication of the extent of this practice is given by the enrolment of over 30 per cent of the population in the Voluntary Health Insurance Board's schemes which include cover for consultants' fees. Over half of this enrolment is drawn from the Categories with eligibility for free consultant care. The private in-patient of a consultant is also liable for the fees of other consultants involved in his investigation or treatment, regardless of his category of eligibility.

TABLE 13.3.

NON-CONSULTANT HOSPITAL DOCTORS

	1975	1982	1984	1987	1988
Intern	314	360	368	343	314
House Officer	596	824	893	949	973
Registrar	300	442	563	576	556
TOTAL	1,210	1,626	1,824	1,868	1,843

Source: Postgraduate Medical and Dental Board (1975–1984); Department of Health (1987).

TABLE 13.4

DISTRIBUTION OF PUBLIC HOSPITAL CONSULTANTS BY ABATEMENT RATE UNDER COMMON CONTRACT, 1987

	%
10 per cent abatement	32
15 per cent abatement	28
20 per cent abatement	40
	100

Source: Secretariat estimates derived from Comhairle na nOspidéal data.

TABLE 13.5

PAYMENT BY VHI TO CONSULTANTS IN RESPECTS OF IN-PATIENT HOSPITAL TREATMENT

	£m
1984/5	20.8
1985/6	23.9
1986/7	25.4
1987/8	28.6
1988/9	31.3

Source: Department of Health.

13.12 Private patients' out-patient consultations usually take place in consultants' rooms, although some consultants see private patients on public hospital premises. In-patient treatment may be provided in public hospitals or private hospitals. Many public hospital consultants treat private patients in private hospitals; outside the scheduled commitment to public patients, the Common Contract places no restriction on the extent of private practice.[5]

13.13 Most private patients of consultants have insurance cover for semi-private or private accommodation and, if admitted to a public hospital, are provided with such accommodation if it is available. They thus become the private patients of the hospital as well as of the consultant, and are liable to pay a maintenance charge. The statutory entitlement of a consultant's private patient to public ward accommodation is not clear. Section 52 of the Health Act, 1970 requires in-patient services to be made available for persons with full eligibility and persons with limited eligibility. Section 55 states that in-patient services may be made available

> .... "for persons who do not establish entitlement to such services under Section 52 and (in private or semi-private accommodation) for persons who establish such entitlement but do not avail themselves of the services under that section ...."[6]

13.14 This section is open to the interpretation that patients who choose their own consultants are entitled only to private or semi-private accommodation i.e. the private patient of a consultant must

[5]Consultants holding academic appointments, however, are, to varying degrees, restricted as to the extent of their private practice by the terms of their contracts with the academic institutions concerned.

[6]*Health Act, 1970*: section 55.

also be regarded as the private patient of the hospital. However, as Category III patients have entitlement to all in-patient services, including public accommodation, except consultant services (which they therefore must provide for themselves privately), the concept of the private patient of a consultant always being obliged to occupy private accommodation is erroneous. Those who are entitled to consultant services under section 52 but who forego this entitlement in order to be the private patient of a consultant must, according to the above-mentioned interpretation, do so only in private accommodation. This is clearly an anomalous situation. We understand that this interpretation is not always applied in practice; indeed, the admissions procedures in many hospitals do not identify the private patients of consultants.

13.15 The Commission's proposals for the abolition of Category III would overcome this problem by establishing a universal entitlement to a full range of hospital services, including consultant treatment. Private patients under the new regime would then only be treated in private accommodation when in a public hospital.

13.16 Private patients pay their consultants on the basis of fee-per-item of service. There is no restriction on the fees which consultants may charge; however, the amount which the insured patient may recoup under the Voluntary Health Insurance Board's schemes is limited to a scale of maximum fees for each type of procedure. Reimbursement of fees for out-patient consultations is available to VHI members once the threshold for eligible out-patient expenses (including general practitioner services, drugs, etc.) has been exceeded; the threshold is, at present, £105 for an individual and £170 for a family in any year. This threshold does not apply to treatment in a day ward or day care facility, which is regarded as in-patient rather than out-patient care.

13.17 Table 13.5 shows the total amounts paid by the VHI Board to consultants in respect of in-patient hospital treatment in recent years. These figures significantly understate the total extent of consultants' private income, as they exclude payments by non-members of the VHI, by VHI members for amounts in excess of the maximum recoupable fee and all payments for out-patient consultations, as well as payments for legal and insurance cases.

EVALUATION OF THE PRESENT SYSTEM

Equity

13.18 The definition of equitable access to consultants' services needs careful consideration. The State employs consultants to provide

a free service to 85 per cent of the population, on the basis that it is appropriate for the remaining higher-income groups to make their own arrangements. However, many with entitlement to free consultant care choose to become private, fee-paying patients. It is clear therefore that there are perceived advantages in doing so. These would appear to be:

(i) the possibility of speedier access to in-patient treatment if it is required;

(ii) a shorter wait for appointments;

(iii) choice of consultant; and

(iv) a greater degree of personal attention from the consultant.

13.19 The previous chapter discussed in detail the issue of speed of access to in-patient treatment and recommended that publicly-funded hospital admissions should be from a common waiting list governed by universal criteria and maximum waiting-periods regardless of the patient's choice, if any, of consultant.

13.20 The other perceived advantages are related to the quality of the service provided by the consultants themselves. Since consultants initially see their public and private patients in separate out-patient clinics, the question of a common waiting-list does not arise and it is inevitable that there will be differences in waiting-periods. This would not, of itself, be inequitable provided that the differences were not so great as to cause unnecessary suffering or anxiety to public patients. Similarly, we would not regard it as inequitable that fee-paying patients should have personal attention from their chosen consultant, provided that the consequence was not a reduction in the standard of attention to which non-fee-paying patients are entitled. These latter advantages of personal attention and choice of consultant do not lend themselves to objective measurement. What is possible, however, is the more accurate quantification of the extent of private practice in public hospitals. At present the scheduled commitment of consultants to public patients is not monitored; private patients are not always identified separately by hospitals for the purposes of in-patient treatment; and information on waiting-periods for specialist consultation is not available.

13.21 An assessment can be made of the incentives offered to consultants by the combination of payment by salary for services to public patients and private practice on a fee-for-service basis. We have discussed these with many groups and individuals involved in the delivery of hospital services, including a number of consultants. Very many consultants, perhaps the great majority, may well fulfil

their responsibilities to public patients to (and often beyond) the extent envisaged in their contract; it is generally accepted, however, that, as a result of the incentive structure, some consultants do not.

13.22 We have been told that, in many cases, public patients must wait considerably longer for an appointment, and furthermore, that public clinics are organised so that patients may have to wait several hours on each occasion. It has been submitted to us that these factors encourage patients who can afford to do so to opt for private consultations. In relation to in-patient care, it has been alleged that concentration on private practice by some consultants results in an unnecessarily high level of delegation of treatment of public patients to junior medical staff. These patterns, to the extent that they occur, are clearly inequitable.

Efficiency

13.23 In considering the efficiency of the present arrangements, we are concerned with whether the incentives facing patients and consultants encourage or discourage the efficient use of consultants' services and of the health services in general. The incentive structures differ in respect of public and private patients.

13.24 Public patients incur no charge for consultants' services, apart from the £10 charge payable to the hospital for the first out-patient visit in respect of any condition. Medical card holders are exempt from this charge, as are a number of other categories of patient. Patients might therefore have little financial disincentive to make unnecessary visits to the services. However, access to the consultant requires referral from a general practitioner or from the hospital accident and emergency department, and this process should enable those who do not require specialist attention to be treated elsewhere.

13.25 Private patients have some disincentive to unnecessary visits to consultant out-patient clinics as they must meet the cost themselves. Those with Voluntary Health Insurance cover are, as described earlier, entitled to reimbursement only after a threshold has been reached. However, although VHI-insured patients do not always receive full reimbursement for consultants' fees for in-patient services, there is widespread ignorance of this fact which contributes to a misconception that VHI cover is comprehensive. Subjectively, therefore, like public patients, VHI members face little financial disincentive should the consultant offer them services which are not strictly necessary on medical grounds. The incentive structure facing the consultant is thus of crucial importance.

13.26 Consultants are paid on the basis of a fee per item of service in respect of their private patients. A recent survey of international research on healthcare delivery systems concludes that

> "the best documented area concerns the effect of payment by Fee-For-Service on supplier induced demand. Despite doubts about adequacy of data, most evidence tends to support the view that Fee-For-Service leads to 'induced' demands by patients (for fee-yielding services) on the recommendation of their doctors".[7]

The payment method for private patients is thus open to the criticism that it can unduly influence a decision, for example, on the priority to be given to an elective surgical procedure. To reduce this risk, insurers in some countries require some form of confirmation of the need for a procedure, such as a second opinion by an independent consultant, before approving it as eligible for funding. No such requirement operates in Ireland.

13.27 As discussed earlier, the payment of consultants by salary in respect of their public patients, and the demands of their private practice, may give them an incentive to make extensive use of junior medical staff as a substitute for their own services. It has been submitted to us that many consultants do not have the time to play as full a part in the day-to-day management of their departments or units as was envisaged when the Common Contract was being formulated. It has been suggested that, as a result, junior medical staff are in some cases left with effective responsibility for patients with inadequate consultant supervision. This can result in unnecessary acceptance of patients for admission, over-use of tests and other waste of scarce hospital resources.

13.28 It follows from the above that the equitable and efficient use of hospital services will be influenced to no small extent by the terms on which consultants' services are provided. These include the arrangements for private practice and the method of payment for public and private patients.

ARRANGEMENTS FOR PRIVATE PRACTICE

13.29 The question of how public and private practice should be structured to permit the most equitable and efficient provision of services is one of the most difficult which we have had to consider.

---

[7] A.J. Culyer, C. Donaldson and K. Gerard: *Financial Aspects of Health Services: Drawing on Experience* (Institute of Health Services Management, March 1988): page 64.

It involves two related issues — the extent to which consultants in full-time employment should be permitted private practice, and whether private practice should be located in or kept separate from the public hospital campus. Strong arguments have been put to us on each side of each of these issues. A particular problem in assessing the merits of the arguments is that some are based on predictions of the dynamic effects which any changes in the present arrangements would have on the whole healthcare system. In the absence of evidence of comparable experience, these predictions remain speculative.

13.30 *The case for restricting, or excluding, private practice on the part of consultants employed in the public service* rests on the incentive effects discussed earlier. Consultants are employed on a whole-time basis, and with the explicit acceptance of a continuing responsibility for the care of their public patients. They are also required to be fully involved in the management of their departments or units. It is argued that these responsibilities cannot be met in full if the consultant is simultaneously engaged in considerable private practice. *The main argument against such restriction* appears to be the view that talented consultants will not otherwise remain within the public hospital system because of the income available to them in the private sector.

13.31 *The arguments for the separation of private practice from public hospitals* also relate to the incentive effects discussed earlier. Firstly, it is argued that some consultants neglect their commitment to public patients in order to concentrate on their private patients. Secondly, it is suggested that it is difficult to operate an equitable admissions policy, based on medical criteria, when consultants have a financial interest in the admission of certain patients. Thirdly, it is claimed in relation to the services of other hospital personnel, that many consultants seek priority, or a greater degree of attention or treatment, for their private patients, and that this impedes the team approach which is necessary for the efficient functioning of a modern hospital. Fourthly, it is argued that a public perception of unfairness may undermine confidence in the public hospital system. This may cause patients of limited means to endure financial hardship by seeking private care, in the belief that public care is not adequate. Finally, it is argued that, as part of their training and development, consultants need the public sector to attain professional recognition and that a period of exclusive commitment to the public sector before engaging in any private work would actually improve the public sector by ensuring a flow of younger, more recently trained specialists in many fields.

13.32 *The main arguments for permitting private practice on public hospital campuses* are as follows. Firstly, private patients tend to require private or semi-private accommodation (although this is not a necessary condition of private practice), and this is an important source of hospital revenue. Secondly, if consultants are to be allowed have private practice at all, it is held that their commitment to public patients is more likely to be honoured if they see both sets of patient on the same campus, and that it is wasteful of a valuable resource if they spend much of their time in transit from one location to another. Thirdly, it has been argued to us that the separation of private practice from public hospitals would lead to the latter becoming a residual, poorer-quality service on the basis that the demands of the fee-paying patients tend to maintain high standards in both treatment and accommodation to the advantage of public patients. Finally, there are areas outside Dublin, Cork and Galway where the use of a consultant is cost-effective only in the context of both public and private practice and there are specialties where this also applies.

13.33 Summarising the arguments on these two related issues, it would appear that the impediments to equity and efficiency caused by the present incentives to public hospital consultants could be removed by their employment on exclusive contracts with no rights to private practice, but that the possible consequence of this would be a deterioration in the public hospital system as a result of the loss of talented consultants, of some of the more articulate patients, and of the revenue from private and semi-private accommodation.

13.34 Arguments can be put forward to conteract this pessimistic view. In particular, it cannot be assumed that exclusively private practice would have unlimited scope for absorbing further consultants and providing them with income substantially above that available in public employment — particularly if the extent of public subsidy to private practice was removed or reduced. In addition, the enhancement of a consultant's earning potential is often related to the prestige of a public appointment, particularly in teaching hospitals. However, the Commission has been impressed by the view that a public/private mix of patients in a hospital results in higher standards to the advantage of public patients, particularly as it provides the consultant with an incentive to remain in the hospital for longer than his scheduled public commitment. The major disadvantages of this system lie in the problems of faster admission of private patients, which we believe can be largely overcome by the common admissions policy put forward in Chapter Twelve, and in ensuring that the exclusive commitment of the consultant in respect of public patients is properly carried out. With regard to this latter

aspect, we feel that it is a matter which can be appropriately addressed in the context of a revision of the contractual arrangements under which consultant services are provided for public patients.

PAYING THE CONSULTANT

Public Patients

13.35 The current system of payment[8] under the Common Contract is described in detail in Appendix 13A. Its combination of a basic salary and special payments for "grey hours", on-call periods and emergency call-outs is administratively cumbersome and is also inappropriate to the type of employment to which it relates. Consultants are required to accept a continuing responsibility for their patients on a twenty-four hour daily basis. Other senior public servants have a similar open-ended responsibility for their work and are paid an all-in single salary to take account of whatever demands are made upon them.

13.36 **We recommend that the Health Services Executive Authority should be free to employ consultants on the basis of fixed-term contractual arrangements in which conditions of employment and remuneration would be tailored to the requirements of particular disciplines or positions, having regard, also, to the scope for private practice. Contracts would be made in respect of individual institutions and would specify certain core responsibilities for all consultant posts and, in addition, functions relevant to each individual post.** We envisage that this flexibility could be used to offer full-time or part-time contracts as appropriate, under which consultants' time commitment to public patients would be clearly specified and exclusive.

13.37 **We recommend that an agreed system of monitoring the public commitment in consultant practice should be introduced** which would combine elements of administrative control

[8]Shortly before the Commission concluded its work, the Government referred the remuneration of medical consultants and related matters to the Review Body on Higher Remuneration in the Public Sector. The Review Body's terms of reference are:

> "To examine and report upon the remuneration (salaries, fees and allowances) of consultant medical staff employed by health boards, public voluntary hospitals and other health agencies, and the terms and conditions (other than remuneration) which should attach to their discharge of health service requirements.
>
> The Review Body is requested when making its report to have regard to the state of the public finances and current Government pay policy."

aspect, we feel that it is a matter which can be appropriately addressed in the context of a revision of the contractual arrangements under which consultant services are provided for public patients.

PAYING THE CONSULTANT

Public Patients

13.35 The current system of payment[8] under the Common Contract is described in detail in Appendix 13A. Its combination of a basic salary and special payments for "grey hours", on-call periods and emergency call-outs is administratively cumbersome and is also inappropriate to the type of employment to which it relates. Consultants are required to accept a continuing responsibility for their patients on a twenty-four hour daily basis. Other senior public servants have a similar open-ended responsibility for their work and are paid an all-in single salary to take account of whatever demands are made upon them.

13.36 **We recommend that the Health Services Executive Authority should be free to employ consultants on the basis of fixed-term contractual arrangements in which conditions of employment and remuneration would be tailored to the requirements of particular disciplines or positions, having regard, also, to the scope for private practice. Contracts would be made in respect of individual institutions and would specify certain core responsibilities for all consultant posts and, in addition, functions relevant to each individual post.** We envisage that this flexibility could be used to offer full-time or part-time contracts as appropriate, under which consultants' time commitment to public patients would be clearly specified and exclusive.

13.37 **We recommend that an agreed system of monitoring the public commitment in consultant practice should be introduced** which would combine elements of administrative control

---

[8]Shortly before the Commission concluded its work, the Government referred the remuneration of medical consultants and related matters to the Review Body on Higher Remuneration in the Public Sector. The Review Body's terms of reference are:

> "To examine and report upon the remuneration (salaries, fees and allowances) of consultant medical staff employed by health boards, public voluntary hospitals and other health agencies, and the terms and conditions (other than remuneration) which should attach to their discharge of health service requirements.
>
> The Review Body is requested when making its report to have regard to the state of the public finances and current Government pay policy."

and peer review. Outside the public commitment, **the consultant should be free to engage in private practice in the hospital where he holds his main public appointment. Private practice at another hospital should only be undertaken with the agreement of the employing public hospital and to an extent compatible with the overall policies of the Health Services Executive Authority.**

13.38 The present system does not reflect the varying levels of responsibility attaching to different consultant posts, nor does it reward seniority. We believe that a career structure for consultants, with a number of payment elements to reflect the responsibilities of different types of post, would provide a performance incentive which would be all the more important in the context of the type of contract which we have recommended above.

13.39 Tables 13.1 and 13.3 show that the ratio of junior doctors to consultants has grown dramatically over the last twelve years. It has been argued to us that there are insufficient consultants to meet the needs of the health services; it has also been suggested that an intermediate post of consultant grade could be introduced at a salary somewhat below that currently paid to consultants. **In the context of our recommended approach to employing and remunerating consultants, we believe that there is a need for a comprehensive review of the medical manpower requirements of all public hospitals, with a particular emphasis on establishing a sufficiently broad grading structure for consultant level appointments.**

13.40 The present Common Contract stipulates that 15 per cent of the population be in Category III and therefore liable for consultant fees. Our earlier recommendation contained in Chapter Seven for the abolition of Category III should not therefore have any major implications for consultant salaries, because at present 30 per cent of the population holds voluntary health insurance. The future of health insurance is discussed in Appendix 20A.

Private Patients

13.41 As explained earlier, the fee-for-service method of payment gives the consultant no incentive to economise on his provision of services, particularly in respect of elective procedures. Quite apart from any danger to the patient, unnecessary treatment increases health expenditure and is thus reflected in the cost of health insurance. **We recommend that health insurers should devise ways of reducing the risk of unnecessary private expenditure.**

Various approaches, under the general title of "Managed Care", have been introduced elsewhere, particularly in the United States. They include, for example, agreed criteria for reimbursable procedures, the requirement to seek second opinions, and other forms of verification of the need for treatment. The feasibility of these or other approaches in Ireland should be examined.

13.42 Voluntary Health Insurance cover does not guarantee full reimbursement of consultants' fees — nor, indeed, could it be expected to, in the absence of agreement with the profession on the maximum level of fees chargeable, since an open-ended reimbursement system would have a built-in tendency to increase costs. Reimbursement is on the basis of a scale of fees for the various procedures. Consultants are not obliged to restrict their charge to the scale fee, although it is understood that many do so. Patients, particularly at a time of illness, are in no position to "shop around" and have little opportunity to question consultants' charges. We are aware of a growing concern in recent years that some charges are greatly in excess of the amounts reimbursable to patients. **We recommend that health insurers should seek to negotiate maximum chargeable fees with consultants. Insured members should be provided regularly with details of these maximum fees, of the extent of cover available towards them, and of those consultants who have agreed to abide by them.** Patients' choice of consultant need not be restricted to those who have agreed maximum fees. However, in making this choice, patients would be able to take account of information, not available to them at present, on the unreimbursable cost of alternative choices.

13.43 In this context we welcome a recent announcement by the Voluntary Health Insurance Board of its intention to provide a higher level of cover in respect of treatments by consultants who are prepared to accept the insured amount in full settlement of their fees. We would like to see this practice become as widespread as possible.

RECOMMENDATIONS

13.44 In this chapter we have made the following recommendations:

1. There should continue to be a mix of public and private consultant practice in public hospitals subject to the recommendations below.

2. The Health Services Executive Authority should be free to employ consultants on the basis of fixed-term contractual

arrangements in which conditions of employment and remuneration would be tailored to the requirements of particular disciplines or positions, having regard also to the scope for private practice. Contracts should be made in respect of individual institutions and should specify certain core responsibilities for all consultant posts as well as functions relevant to each individual post.

3. An agreed system of monitoring the public commitment in consultant practice should be introduced which would combine elements of administrative control and peer review.

4. Consultants should be free to engage in private practice in the hospital where they hold their main public appointment. Private practice at another hospital should be undertaken only with the agreement of the employing public hospital and only to an extent compatible with the overall policies of the Health Services Executive Authority.

5. There should a comprehensive review of the medical manpower requirements of all public hospitals, with a particular emphasis on establishing a sufficiently broad grading structure for consultant level appointments.

6. Health insurers should devise ways of reducing the risk of unnecessary private expenditure.

7. Health insurers should seek to negotiate maximum chargeable fees with consultants. Insured members should be provided regularly with details of these maximum fees, of the extent of cover available towards them, and of those consultants who have agreed to abide by them.

APPENDIX 13A

COMMON CONTRACT FOR CONSULTANT MEDICAL STAFF

Explanation of remuneration basis and list of rates effective from 1 January 1989

There are four elements in each consultant's remuneration under the Common Contract. These are as follows:

"A" Factor: this element reflects the consultant's contracted service element in respect of his patients and his continuing responsibility for them. It is calculated on the basis of a 33-hour scheduled commitment per week. The majority of consultants are contracted to this schedule. Some consultants are employed on the basis of a lesser scheduled commitment and are paid a pro-rata amount under this heading.

The notional salary is reduced by abatements of 10, 15 or 20 per cent, depending on the specialty and location, to take account of the proportion of the scheduled commitment which is likely to be taken up by patients liable to pay consultants' fees.

	Annual rate (33-hour commitment)
10% abatement: for consultant geriatricians; for consultant psychiatrists holding appointments based in district mental hospitals or institutions for the mentally handicapped; and for all other consultants in the Midland, Western and North Western Health Board areas.	£23,356
15% abatement: for all other consultants in the Southern, Mid Western, North Eastern and South Eastern Health Board areas.	£22,059
20% abatement: for all other consultants in the Eastern Health Board area.	£20,761

Payment for 10 "Grey Hours": this element is in respect of extra time and work in excess of the scheduled commitment arising within

two hours of the end of that commitment on each weekday. The rate is £7,863 per annum; this amount is fully payable whether the scheduled commitment is whole-time or part-time.

"B" Factor: this element is in respect of periods during which a consultant is specifically rostered to be "on-call" i.e. available for immediate attendance at the hospital. The rate is £29.14 per 24-hour period or a proportionate sum for any greater or lesser period. The annual amount payable to any one individual is subject to an upper limit of £2,980 in any one calendar year.

"C" Factor: this element reflects specific instances where a consultant attends at the hospital for emergency duties arising from unscheduled work for eligible patients. The rate is £29.80 per call-out to each patient; £39.73 if the call-out takes place after, or extends beyond midnight; and £19.84 extra per hour or part hour beyond the first hour, measured from leaving home until return. The annual amount payable to any one individual is subject to an upper limit of £2,980 in any one calendar year.

The total annual payments, where on-call and call-out payment limits are reached, are thus as set out in the following Table.

	10% abatement	15% abatement	20% abatement
	(£)	(£)	(£)
Scheduled Commitment	23,356	22,059	20,761
10 hour period	7,863	7,863	7,863
Total Salary	31,219	29,922	28,624
Maximum value of "B" and "C" Factors	5,960	5,960	5,960
TOTAL	37,179	35,882	34,584

Expenses

The Contract also provides for payments in respect of car availability, medical insurance and telephone rental.

Academic Appointments

Consultants who also hold academic appointments receive enhanced salary payments. The rates are:

Professor Consultant:	£15,484
Lecturer Consultant:	£6,968

A Professor Consultant in the Eastern Health Board area thus receives £44,108 per year, comprising £28,624 hospital salary and £15,484 University stipend, in addition to "B" and "C" factor payments as set out in the above Table, where these arise.

For consultants attached to University College Dublin, the allocation of total remuneration between hospital salary and college salary is different to that set out above, but the total is unchanged.

CHAPTER FOURTEEN

OTHER MEDICAL AND ASSOCIATED SERVICES

INTRODUCTION

14.1 This chapter considers a number of medical and associated services other than those provided in the hospital in-patient setting or by the general practitioner. These include dental, ophthalmic and aural services, community or out-patient paramedical services and home nursing. The role of "alternative medicine" is also discussed briefly.

14.2 Certain closely-related issues are dealt with in other chapters. The role of community nurses in preventive care is discussed in Chapter Sixteen; their role and that of paramedical staff in the continuing care of the chronically ill, the elderly and the handicapped is discussed in Chapter Seventeen. Our particular concern in this chapter, in relation to both paramedical and nursing services, is with their role in maintaining patients' health, reducing the need for in-patient treatment and enabling patients to be discharged from hospital more quickly.

DENTAL, OPHTHALMIC AND AURAL SERVICES

14.3 It is convenient to discuss dental, ophthalmic and aural services together in this section because certain categories of patient are entitled to them under the Pay-Related Social Insurance Scheme.

Description

14.4 Health boards are required, under section 67 of the Health Act, 1970 to make dental, ophthalmic and aural treatment and appliances available without charge to persons in Category I and their dependants, and also to pre-school and national school children referred from child health examinations.

— *Dental services* are provided by about 250 salaried dentists employed by the health boards. Due to lengthy waiting lists for

public dental services, an ad hoc scheme was introduced in 1979 under which health boards could pay private practitioners to treat eligible patients. However, by 1988 this arrangement had been discontinued in all but two health boards apparently because of budgetary constraints.

— Under the *Community Ophthalmic Scheme*, health boards employ part-time ophthalmologists to provide sight-testing services, examine eye defects, and, where necessary, to prescribe spectacles or to refer patients to specialists. Health boards also contract with private opticians to provide similar services under the Sight Testing Scheme. Eligible persons may choose between the two schemes, although the dispensing of spectacles is by private opticians in either case. Opticians are paid a fee per item of service.

— Children are screened for *hearing defects* at pre-school and school health examinations, usually by public health nurses with specialised training. The National Rehabilitation Board's Audiology Service provides audiometry tests for eligible adults referred by health boards and supplies and repairs hearing aids for children and eligible adults.

14.5 Workers paying the full rate of PRSI, and their spouses, are eligible for Treatment Benefits, administered by the Department of Social Welfare and provided by private practitioners paid on a fee-for-service basis. However, dental benefits are not in practice available to most spouses.[1]

— Basic dental treatment such as fillings, scalings and extractions is provided free of charge by private dentists on the Department's panel. The provision of dentures and treatment for certain gum conditions is subsidised — the patient pays a portion of the fee to the dentist.

— Sight-testing by an ophthalmic surgeon, doctor or optician on the Department's panel is available without charge. The cost of certain spectacles is fully reimbursable while more expensive pairs are partially covered. Up to half the cost of contact lenses is also payable when required for medical reasons, subject to a maximum refund of £200.

— Half of the cost of the supply or repair of hearing aids is also available under the Scheme, subject to a maximum refund of £200.

---

[1]Treatment Benefits were extended to all spouses of insured workers in October 1987; expectant and nursing wives were already covered. However, by January, 1989 only one-quarter of dentists on the Department of Social Welfare's Panel had agreed to operate the extension, leaving many spouses without effective cover.

TABLE 14.1

PUBLICLY FUNDED NON-HOSPITAL DENTAL TREATMENT

	Health Boards	Dept. of Social Welfare	Total
	£m	£m	£m
1979	5.75	3.12	8.87
1980	8.50	4.60	13.10
1981	9.15	5.80	14.95
1982	10.50	7.12	17.62
1983	11.50	9.35	20.85
1984	12.00	10.30	22.30
1985	12.50	11.20	23.70
1986	12.92	12.20	25.12
1987	13.29	12.35	25.64

Source: Department of Health and Department of Social Welfare

14.6 It is understood that some employers, in both the public and private sectors, operate dental treatment benefit schemes for their employees.

14.7 Persons ineligible for dental services under the health board, Social Welfare or employer-funded schemes, and those who are unable to obtain treatment to which they are entitled under these schemes (or who choose not to do so), must meet the full cost of dental treatment provided by private practitioners. Routine treatment is not covered by VHI plans, although certain orosurgical operations are. The scheme of tax relief for unreimbursed medical expenses also excludes routine dental treatment but includes certain other procedures. Routine ophthalmic care, or the provision of spectacles, contact lenses or hearing-aids, are not covered under the VHI's plans. The scheme of tax relief for unreimbursed medical expenses also excludes routine ophthalmic care, spectacles and contact lenses but does cover audiometry tests and hearing aids.

14.8 The following is an approximate breakdown of the total population in terms of eligibility for the above schemes:

Health Board Services *(Category I; also pre-school and national school children)*	1.9 million
Social Welfare and employer-funded schemes *(excluding about 0.4 million also eligible for health board services)*	1.0 million
Ineligible	0.6 million
	3.5 million

However, as services are not available to all those eligible for either the health board services or (in relation to spouses of insured workers) the Department of Social Welfare scheme, the number depending in practice on private dentists is likely to be substantially greater than the figure of 0.6 million above.

14.9 Table 14.1 shows that public expenditure on dental treatment under health board schemes and the PRSI dental benefit amounted to almost £26 million in 1987. A recent study[2] has suggested that private expenditure is of the order of £52 million per annum, or two-thirds of all expenditure on dental treatment. This compares with Tussing's estimate[3] for 1980, based on a household budget survey, of private expenditure of £14 million, amounting to half of all expenditure on dental treatment in that year.

14.10 Table 14.2 shows public expenditure on community ophthalmic and aural services to have been almost £9 million in 1987. Recent estimates for private expenditure are not available. However, the data collected in 1980 by Tussing would suggest that private expenditure accounted for at least two-thirds of all ophthalmic and aural expenditure in that year.

14.11 Tables 14.3 and 14.4 provide indicators of the usage of the health board and PRSI schemes.

Evaluation

14.12 Two major areas of concern are apparent in the provision of these services. The first is the wholly inadequate level of service available in the health board system. The second is the unsatisfactory mix between means-tested health board services and the insurance-related scheme of Treatment Benefits.

(i) Provision

14.13 It is clear that the current arrangements for providing *dental services* do not satisfy the criteria of either equity or comprehensiveness. Health board services cater for a relatively small proportion of those statutorily entitled to them. Certain categories, including pre-school and national school children, expectant and

---

[2]Coopers and Lybrand: *Oral Health Care Manpower 1986-2006 (May 1987): Section 6*

[3]A. Dale Tussing: *Irish Medical Care Resources: An Economic Analysis* (ESRI, 1985): Chapter 5. Tussing's study showed private expenditure on eyeglasses in 1980 to have been over £7 million. Taking account of expenditure on hearing aids, professional fees, etc., it is likely that total private expenditure was at least twice the £4.3 million public expenditure on ophthalmic and aural services in that year.

TABLE 14.2

PUBLICLY FUNDED COMMUNITY OPHTHALMIC AND AURAL SERVICES

	Health Boards	Dept. of Social Welfare	NRB Audiology Service[1]	Total
	£m	£m	£m	£m
1979	1.90	0.80	0.37	3.07
1980	2.70	1.08	0.56	4.34
1981	2.85	1.50	0.71	5.06
1982	3.75	1.67	0.66	6.08
1983	4.22	2.00	0.66	6.88
1984	4.35	2.72	0.83	7.90
1985	4.63	2.74	0.97	8.34
1986	4.78	2.91	0.91	8.60
1987	4.85	2.83	0.99	8.67

[1] Includes overhead cost. The basis for calculating expenditure changed slightly in 1982; consequently there is some discontinuity in the series.

Source: Department of Health; Department of Social Welfare; National Rehabilitation Board.

nursing mothers and the handicapped, are accorded priority; the great majority of persons with Category I eligibility are effectively without public dental care other than for emergencies. At the same time, a sizeable part of the population, many in more favourable economic circumstances than those depending on the health board system, receive treatment through the Department of Social Welfare's dental Treatment Benefits scheme.

TABLE 14.3

USAGE OF PUBLICLY-FUNDED DENTAL SERVICES

	Numbers treated by health board dentists[1]			Number of claims under PRSI Dental Benefit ('000)
	Children ('000)	Adults ('000)	Total ('000)	
1970	179	34	213	150 (1970/71)
1975	240	62	302	196
1980	301	62	363	225
1983	296	56	352	279
1986	323	61	384	309
1987	319	61	380	308

[1] Excludes treatment of eligible patients by private dentists under "ad hoc" scheme.

Source: Department of Health and Department of Social Welfare.

TABLE 14.4

USAGE OF PUBLICLY-FUNDED OPHTHALMIC AND AURAL SERVICES

	Community Ophthalmic Service & Sight-Testing Scheme		Community Aural Services		PRSI Scheme – Number of claims	
	Persons Examined	Spectacles Provided	Persons Examined	Hearing Aids Provided	Optical Benefit	Supply of Hearing Aids and Contact Lenses
1983	140,055	87,900	231,445	3,099	75,394	974
1985	123,198	61,364	208,987	3,156	89,005	1,215
1987	122,787*	73,980	201,288**	2,146**	92,030	1,288

* Excluding adults in Cork and Galway examined in hospitals.
** Some of the data relate to 1985 and 1986.

Source: Department of Health and Department of Social Welfare

14.14 A recent report[4] on the health board service concluded that health boards were failing in their statutory obligation to provide dental treatment for eligible adults. It also found that the curtailment of routine services for adults and the consequent large increase in demand for emergency services (referred to below) was hampering the development, and in some areas, the maintenance of dental services for children.

14.15 Pressure on the health board dental service has increased steadily in recent years. While the data in Table 14.3 indicate that the numbers treated by salaried public dentists have remained relatively constant since 1980, a growing proportion of services for adults has been confined to emergency cases — from 31 per cent in 1983 to 63 per cent by 1987. In addition, the numbers treated under the ad hoc scheme (not included in the Table) fell from a peak of 32,000 in 1983 to just over 6,000 in 1987.[5]

14.16 The inadequate level of health board service may well be exacerbated in future by the likely increase in patient demand for dental services. While demand in Ireland for the services is relatively low by international standards, it may be expected to grow significantly in future years as awareness of the importance of dental care increases. This will pose additional challenges to the service,

[4] *Report of Working Group Appointed to Review the Delivery of Dental Services* (Department of Health, June 1988).
[5] *Idem*

although the emphasis may be on preventive rather than restorative care.

14.17 The ratio of dentists to eligible patients in the health board service is considerably lower, at 1:6,344[6] than that in the Department of Social Welfare Scheme (1:2,000) or in the population at large (1:3,000).[7] Furthermore, the duties of health board dentists may include oral health education, supervising the flouridation of water supplies, and travelling to clinics in outlying towns. The hours available for the treatment of eligible patients may thus compare even less favourably with those for the population as a whole than would be suggested by the above ratios.

14.18 The shortfalls in provision may also affect the cost-effectiveness of the health board service. For example, while pre-school and national school children are given priority for treatment under health board schemes, it has been argued in various reports[8] and in submissions made to us that the benefits of this treatment may subsequently be lost because services are not available during adolescence. Indeed, the recent report on the health board dental service[9] argued that it would be desirable to extend eligibility for the service up to the age of sixteen years when resources permit.

14.19 There is a general shortage of information on which to base an assessment of the cost-effectiveness of the public dental service. It has been established[10] that there has been a dramatic decline in the prevalence of dental caries among children as a result of water flouridation. While this has reduced the need for restorative treatment, there has been a shift towards more elaborate forms of treatment, in particular in the area of orthodontics. The 1986 report of the survey on children's dental health[11] pointed out that the nature and extent of the need for orthodontic treatment is difficult to estimate, and considerable further work is necessary in designing estimation methods. The report also pointed to the almost complete absence of any data on adult dental health status.

14.20 Inadequacies in services for public patients are not confined to the public dental system, however. There are considerable deficiencies in ophthalmic and aural services also which have been

---

[6] *Op cit.* The ratio excludes those also eligible under the Dental Treatment Benefits Scheme.
[7] Department of Health estimates based on whole-time equivalents.
[8] For example: *Report of a Working Party on Dental Services* (Stationery Office, 1979); and *Children's Dental Health in Ireland 1984* (Stationery Office, 1986).
[9] *Report of Working Group Appointed to Review the Delivery of Dental Services*: op. cit.
[10] *Op. cit.*
[11] *Idem.*

giving cause for increasing concern. There are lengthy waiting lists for eye-testing in some health board areas, both under the Community Ophthalmic Scheme and the Sight Testing Scheme described earlier. Similar deficiencies arise in the case of health board aural services.

14.21 In summary, therefore, the shortfall in health board dental, ophthalmic and aural services is a serious inadequacy in the present health system which must be addressed as a matter of priority. Among the means of doing so are the Commission's proposals regarding the existing Treatment Benefits Scheme, the use of dental auxiliaries and the scope for delivering certain ophthalmic and aural services at a lower level of complexity.

(ii) Treatment Benefits Scheme

14.22 Treatment benefits, including various hospital, medical and surgical appliance costs, were carried forward from the approved health insurance societies of the early twentieth century into the National Health Insurance Society of 1933, the functions of which were transferred in 1950 to the Minister for Social Welfare. In 1954, the various hospital and medical provisions were removed from the range of treatment benefits and made available under the Health Acts. The Commission on Social Welfare[12] was unable to ascertain why the remaining treatment benefits were not similarly transferred at that time. They concluded that it was inappropriate that treatment benefits, which are essentially related to healthcare, should be provided for under a social insurance system which provides cover primarily for income maintenance.

14.23 Both the Department of Health and the Department of Social Welfare confirmed to the Commission on Social Welfare in 1986 that the takeover by the former of responsibility for the scheme was part of the long-term policy of both Departments. The Department of Health reiterated this policy in a letter to the Commission on Health Funding in 1988. The Commission on Social Welfare recommended that this transfer of functions should take place.

Discussion

14.24 Any reorganisation of public dental, ophthalmic and aural services must take account of the needs of both medical card holders and insured workers; reforms in either scheme cannot be made in isolation from the other and the overall emphasis must be on improving the availability of services to the lowest income group.

---

[12] *Report of the Commission on Social Welfare* (Stationery Office, 1986): Chapter 19.

14.25 The 1988 report on health board dental services[13] recommended that health boards should establish a scheme similar to the ad hoc scheme described earlier to cater for routine treatment for eligible adults. For children it proposed a structured school-based service concentrating on first and sixth classes. The report also emphasised the need for a national strategy for the delivery of dental services to ensure availability of an equal standard of service, and recommended that the Department of Health should develop national guidelines for implementing a systematic approach to delivery.

14.26 In relation to the Treatment Benefits Scheme, there are three possible courses of action:

(i) to retain the existing Scheme, with the Benefits remaining as an element of the Social Insurance Fund under the administration of the Department of Social Welfare;

(ii) to abolish the Scheme and transfer the resources saved to an upgraded service under the Health Acts; or

(iii) to amalgamate the health board and Treatment Benefits Scheme in some form.

14.27 It can be argued that the present arrangements (option (i) above) have important practical advantages. Firstly, the Department of Social Welfare has succeeded over time in negotiating very favourable rates for the provision of treatment (particularly dental care) to a large proportion of the population. It might be contended that the overall cost of such care, including payments by the State and the patient, could therefore rise substantially if the arrangements were changed. A second argument, though less compelling, is that those paying PRSI contributions place a high value on dental, ophthalmic and aural benefits, even though their cost amounts to less than 1.5 per cent of the total expenditure of the Social Insurance Fund.

14.28 However, the Commission believes that preserving the existing system in its present form is undesirable since it retains the present inequity of providing varying levels of service based on different conditions of eligibility with little regard for the less well-off. Neither is there an obvious rationale for operating two parallel public schemes by separate bodies for the same set of services.

14.29 A strong case can be made for the second option, that of abolishing the Treatment Benefits Scheme and using the resources

[13] *op cit.*

thus saved to upgrade the health board dental service. Unlike the first option, this approach could, if properly organised, ensure equitable access to a publicly funded dental, ophthalmic and aural service.

14.30 In considering this option, it should be recalled that the Social Insurance Fund is not self-financing: the government subvention amounted to about 30 per cent in 1987. Consequently, the State is subsidising, through the Treatment Benefits Scheme, routine care for insured workers, regardless of their means, which it is unable to provide to many on low-incomes in spite of their statutory entitlements. It can be argued that the available resources would be better directed towards providing an adequate service for those least able to provide for their own needs. Assistance towards the cost of necessary, expensive treatment could still be made available to other groups.

14.31 A third approach, favoured by the Commission on Social Welfare, would be to transfer the administration of Treatment Benefits to the Department of Health. A simple transfer, retaining the Scheme's present source of funding and basis for determining eligibility, would present considerable problems in the context of a health service funded from general taxation. It would be very difficult to provide an integrated dental, ophthalmic and aural service with insurance-based, unrestricted cover for some patients and tax-funded, means-tested cover for others. A continued role for the Department of Social Welfare in the Scheme would also appear inevitable because of the involvement of the Social Insurance Fund, which would thus add to administrative complexity.

14.32 In considering the merits of each of the three approaches outlined above, the Commission has borne in mind the fundamental principle, stated in Chapter Six, that health services should be available on the basis of need and not ability to pay. Given the widely accepted inadequacies in the ophthalmic, aural and, particularly, dental services available to persons in Category I, set against a background in which many better-off PRSI contributors can obtain similar services with relative ease under the Treatment Benefits Scheme, the Commission is of the opinion that the delivery of these publicly subsidised services should be restructured.

14.33 **We therefore recommend that the resources of the Treatment Benefits Scheme be channelled into providing an improved service for those persons entitled to health board dental, ophthalmic and aural services who, we believe, represent the most appropriate target group given the total**

level of resources available. Inevitably this approach will have implications for PRSI contributors who benefit from the present arrangements, but the principle of equity demands that the anomalies inherent in the existing schemes must be addressed.

14.34 In deciding what dental, ophthalmic and aural services should be provided and to whom, the same principles should be applied as those discussed in this report in relation to other services. These require that account is taken of scientific evaluation of need and the cost-effectiveness of alternative approaches to meeting it. Criteria for access to services should be uniform in all areas. The choice of whether to provide services directly or by arrangements with private practitioners should be a matter for determination at local level.

Dental Auxiliaries

14.35 The question of whether the most cost-effective use is being made of the available dentists has arisen in the context of the debate, both internationally and in Ireland, on the potential role of dental auxiliaries. While auxiliary staff such as dental surgery assistants and dental technicians are employed in Ireland, it is illegal at present for non-dentists to provide any form of dental treatment directly to a patient. However, the Dentists Act, 1985 empowers the Dental Council to establish, with the Minister's approval, classes of auxiliary dental workers and the Minister may also direct the Council to establish such categories.

14.36 Forms of dental auxiliaries have evolved in other countries, such as

— *dental hygienists:* for health education, hygiene instruction, application of flouride solutions and fissure sealants, and cleaning and polishing of teeth;

— *dental therapists:* for routine fillings, minor injections and extraction of infant teeth; and

— *denturists:* for supplying dentures directly to the public.[14]

14.37 A number of international studies[15] have concluded that the use of such personnel increases the productivity of the dental services to a considerable extent, and some recent Irish reports have recommended the introduction of certain categories of auxiliary.

---

[14]It is reported (Coopers and Lybrand: *op cit:* p. 19) that some dental technicians do in fact supply dentures directly to the public in breach of the existing law.

[15]The relevant literature is reviewed in Miriam M. Wiley: *The Irish Dental Care Delivery System: Utilisation, Financing and Policy Options for the Future* (Doctoral dissertation submitted to Brendeis University, 1984): Chapter III.

14.38 For example, the 1979 Working Party[16] recommended the introduction of dental hygienists who would work to the prescription of a dentist. It also recommended the use of a demonstration study to establish the feasibility of employing dental therapists in the public dental service to carry out prescribed procedures and treatments for children and adolescents in regions where there was a marked shortage of dentists. This recommendation was not implemented.

14.39 The Coopers and Lybrand study[17] indicated that there would be some demand by dentists for the services of dental hygienists. The Restrictive Practices Commission recommended[18] in 1982 that the general prohibition on the performance of dentistry by non-dentists should be qualified to allow for the provision of dentures in certain circumstances, but the proposal has not since been implemented.

14.40 Most recently the Dental Council received the Minister's approval to the establishment of a pilot project introducing a new class of dental auxiliary for such duties as scaling and polishing, applying fissure sealants and providing dental advice. The 1988 report on health board dental services[19] recommended that the health boards should play a major role in the project and that they should engage the services of these auxiliaries to carry out the full allowed range of procedures.

14.41 It appears that there remains considerable opposition among the dental profession to the introduction of dental auxiliaries in Ireland. Having considered the matter carefully, however, the Commission feels that the use of auxiliaries could play a major role in improving the availability of dental services and would help achieve a more cost-effective use of the scarce resources available. Information from abroad clearly indicates that the use of auxiliaries would improve productivity without loss of quality in patient care.

14.42 **Accordingly, we strongly recommend that the use of dental auxiliaries for preventive care and minor procedures should be permitted and encouraged. We believe that it would increase the time available to qualified dentists for more complex work, and thus reduce the present shortfall in services.**

---

[16] *Report of a Working Party on Dental Services: op cit:* Chapter 6.
[17] Coopers and Lybrand: *op cit:* p. 19.
[18] Restrictive Practices Commission: *Report of Enquiry into the Statutory Restrictions on the Provision of Dental Prostheses* (Stationery Office, 1982).
[19] *Report of Working Group Appointed to Review the Delivery of Dental Services: op cit.*

Provision of Ophthalmic and Aural services

14.43 The Commission has formed the view that certain ophthalmic and aural services could, as in the case of certain dental services, be provided safely and more cost-effectively by less-qualified personnel than is regarded as necessary at present. In particular, there may be a case for relaxing the requirement that the supply of spectacles be limited to qualified dispensing opticians, as is the practice in other countries. In relation to aural services, it appears equally clear that certain procedures, such as the insertion of grommets, could more efficiently be performed by general practitioners. At present there is a lengthy waiting list in some areas due to the practice of confining the procedure to consultants at hospital level.

Charges for Dental, Ophthalmic and Aural Services

14.44 The Commission is of the view that there is scope for charges in the case of certain dental, ophthalmic and aural services for those who can afford them. The recent report on health board dental services,[20] for example, favoured charges for orthodontic treatment provided to the children of non medical card holders. Indeed, it also recommended reasonable charges for medical card holders for dentures and orthodontic treatment (other than for children with cleft lip and palate) if the law were changed at some future date to permit such charges to Category I for specific services.

14.45 **We recommend that, as in the case of other services below, guidelines should be established at national level on the applicability and amount of charges for dental, ophthalmic and aural services.**

COMMUNITY AND OUT-PATIENT PARAMEDICAL SERVICES

Description

14.46 The provision of paramedical services such as physiotherapy, occupational therapy, speech therapy and chiropody in the community or to out-patients in hospitals can help to reduce the demand for in-patient services.

14.47 *Physiotherapy* involves the treatment of injury and disease by physical means, following diagnosis and referral by a doctor. The

[20] *Report of Working Group Appointed to Review Delivery of Dental Services: op. cit.*

work of the physiotherapist includes assessing and providing the appropriate treatment, and giving advice to patients on, for example, exercises to assist rehabilitation and maintain mobility. The great majority of publicly-employed physiotherapists work in hospitals; there is a limited community-based service, and there is also a number of private practitioners. VHI out-patient benefits include limited cover for private physiotherapy arising out of accident or illness, when provided by a Chartered Physiotherapist.

14.48 *Occupational therapy* is provided to patients temporarily or permanently disabled by physical or mental illness, or mental handicap. Its objective is to assist the rehabilitation of the individual through purposeful activity. The occupational therapist also advises on, and assesses the need for, housing modifications, wheelchairs and other aids to independence. Occupational therapists work in hospitals, training centres and schools as well as in the community; they receive referrals from a wide range of sources, including hospitals, general practitioners, public health nurses, social workers and voluntary organisations.

14.49 *Speech therapy* is concerned with the diagnosis and treatment of communication disorders in speech, voice, language and fluency, which may arise from autism, handicap or emotional disturbance, or from incidents such as strokes or road traffic accidents. Under the Community Care programme persons in need of speech therapy are generally seen at out-patient clinics. Community-based services are limited and mostly focus upon pre-school and school children.

14.50 *Chiropodists* examine and treat foot conditions and refer cases for medical or surgical attention as appropriate. Chiropody can be of particular importance in maintaining the mobility of elderly patients. Most chiropodists are in private practice. Health boards employ some on a full-time basis and others on a part-time sessional basis to provide services in hospitals, day centres and in the community. In Dublin, the Eastern Health Board contracts with private practitioners on a fee per capita basis. Most publicly-funded chiropody services are concentrated on medical card holders aged over sixty-five.

14.51 It is not possible to quantify in detail the availability of paramedical services in the community but the available information indicates that there is a significant variation between regions. Table 14.5 details the distribution of paramedical staff (by whole-time equivalents per one hundred thousand population) employed by health boards in the community and in hospitals. A number of such staff, though based in hospitals or health board headquarters, provide

TABLE 14.5

HEALTH BOARD PARAMEDICAL STAFF, 1987

(Number[1] per 100,000 population)

	Physiotherapists	Occupational Therapists	Speech Therapists	Chiropodists
Eastern	2.15	2.18	1.77	0.23
Midland	8.54	2.40	3.74	0.94
Mid Western	4.93	1.71	2.85	0.57
North Eastern	6.36	3.97	1.98	0.19
North Western	13.91	12.22	6.30	0.94
South Eastern	7.06	0.60	2.96	0.20
Southern	7.63	2.57	1.58	0.71
Western	8.76	2.33	4.02	1.11

Note: [1]Whole-time equivalents

Source: Derived from data supplied by Department of Health.

services to the community but it is not possible to estimate the extent of such provision. Neither is it possible to take account of community-based services provided by voluntary organisations as the relevant data is not available.

Evaluation

14.52 Paramedical services do not at present measure well against the criteria of comprehensiveness and equity. Their availability appears to depend more on arrangements that have developed over time rather than on any planned response to objectively determined needs. Thus, patients with similar needs have access to very different levels of service, depending largely on the health board area in which they live.

14.53 In particular, domiciliary and other community-based services are available in some areas, while in other areas, they are mostly available only in hospitals. In certain cases, such as physiotherapy for urban communities, a hospital-based service may well be the most cost-effective method of delivery for most patients, provided that there is reasonable access on an out-patient basis. However, it has been argued to the Commission that the access of out-patients to hospital physiotherapy services is extremely restricted because of the in-patient workload of the relevant staff.

14.54 A factor contributing to the widely varying levels of service is the absence of national guidelines and of uniform national criteria for eligibility for the services.

14.55 It is clear that there is no systematic monitoring and evaluation of these services at a central level. No individual section of the Department of Health appears to have overall responsibility for them. There is a general lack of compilation and coordination of the information required to assess the cost-effectiveness of the services. For example, existing information is inadequate on the costs of individual services, the needs which they are intended to meet and the reductions in in-patient treatment and other institutional care which they make possible.

Discussion

14.56 The planning of community paramedical services should be part of the overall determination of the appropriate forms of care. For instance, we were informed by medical and paramedical staff in one community care area in which a full-time community physiotherapist was employed that this service shortened the stay in hospital of post-operative patients and avoided hospitalisation of others. **It is essential that studies be carried out to quantify the relative cost-effectiveness of the various paramedical services and alternative methods of delivering them.**

14.57 **The general decision-making process, as discussed in Chapter Ten, would involve using the results of such studies and information on the extent of service needs to determine national guidelines on service levels and eligibility criteria. It would then be a matter for local managers to 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.**

14.58 It appears probable that an objective evaluation of the required provision of paramedical services will indicate the need for additional services to be provided in the interest of the overall cost-effectiveness of the health services. While this would require additional resources to be devoted to these services, there may be scope for user charges for certain patients depending on their ability to pay. **We recommend the establishment of national guidelines on the applicability and amount of such charges.**

HOME NURSING

Description

14.59 Our concern in this section is with medical services (i.e. prescribed by a doctor) which are provided by nurses in the patients' homes. Other aspects of the work of Public Health Nurses are discussed in later chapters.

14.60 There is an increasing tendency to discharge acute hospital patients quickly, allowing much of their recuperation to take place at home. There is also an increasing emphasis on care in the home for terminally-ill patients and those with long-term conditions who would formerly have remained in hospital.

14.61 The Health Act, 1970 obliges health boards to provide home nursing services without charge to medical card holders and their dependants, and to such other groups as the Minister for Health decides. These services are provided by Public Health Nurses, who are general nurses with additional qualifications in community health. Much of their workload relates to the elderly and the handicapped, the special needs of whom are discussed in Chapters Seventeen to Nineteen. Public Health Nurses also have a major involvement in child health examinations and other preventive care, as discussed in Chapter Sixteen. Home nursing for acute and chronic illnesses is provided to medical card holders, and to other patients as resources permit.

14.62 There were 1,230 Public Health Nurses, excluding supervisory grades, in 1987. Table 14.6 shows their distribution among health boards. The total cost of the Community Nursing Service in 1987 was £21 million. It is not possible to identify the proportions of these staffing and expenditure figures which relate to the preventive and curative aspects of the nurses' work.

14.63 Home nursing care is also available privately. The Voluntary Health Insurance Board's out-patient benefit provides cover, subject to a limit of £15 per day for 42 days in any subscription year, when the nursing care has been certified as essential for medical reasons.

Evaluation

14.64 The operation of the Community Nursing Service was reviewed in both the 1975 Survey of Workload[21] and the 1980

[21] *Survey of Workload of Public Health Nurses: Report of a Working Party* (Stationery Office, 1975)

TABLE 14.6

DISTRIBUTION OF PUBLIC HEALTH NURSES, 1987

Health Board	Public Health Nurses[1] (Whole time equivalent)	Per 100,000 population
Eastern	384.9	31.2
Midland	84.0	40.4
Mid Western	106.5	33.8
North Eastern	106.7	34.2
North Western	98.8	46.4
South Eastern	144.5	37.5
Southern	154.4	28.8
Western	150.6	43.2
Total	1230.4	34.7

Note: [1] Excluding Superintendents and Senior Public Health Nurses.

Source: Derived from Department of Health data.

Report of the Working Party on General Nursing.[22] The former estimated that the desirable ratio of Public Health Nurses to population for a comprehensive nursing service was 1:2,616. On this basis, the present required staffing would be 1,350. The 1980 report argued that there was a serious shortfall in the number of public health nurses in preventive and curative services; there were in fact 1,122 at the time. Both sets of findings suggest that the present staffing is inadequate, given the growing workload — the number of elderly people being cared for in the community is increasing, particularly those aged 75 or over who require considerable attention, and the trend towards early discharge of patients from acute hospitals places particular pressure on the service because of their need for quite intensive nursing care. Table 14.6 shows also that there are significant differences in the nurse/population ratios of the various health boards.

14.65 The Institute of Community Health Nursing has submitted to us that services to non-medical card holders, and routine visiting of the elderly and other supportive care, have had to be curtailed because of the size of the nurses' workloads. Restrictions on the availability of home nursing must inevitably place strain on patients and on those taking care of them at home, and increase the likelihood of admission or readmission to hospital.

[22] *Report of Working Party on General Nursing* (Stationery Office, 1980)

Discussion

14.66. The Home Nursing Service is of key importance in developing alternatives to in-patient care. **We recommend an urgent review of its role and workload, to define the appropriate level of home nursing services which should be available to those with specific medical (as distinct from social) needs.** Since the 1975 review, there has been a growth in the categories of specialised nursing. It is therefore important to ensure that the appropriate level of services is determined in the context of national guidelines on service levels and on the categories of nurse required.

14.67 **It should then be a matter for local management to decide how the necessary services can best be provided.** There are several options. For instance, the 1980 Report on General Nursing[23] recommended the introduction of general nurses, without public health qualifications, especially for a home nursing service. This recommendation was not implemented. There is some opposition among public health nurses to the redeployment of general nurses to the community on the grounds that their approach and training may not be suitable. In our view, however, nurses are an important, skilled resource to be used in the most effective manner possible. There is undoubtedly scope for the redeployment of general nurses, given appropriate training, to augment the home nursing service.

14.68 It is likely that there are many qualified nurses, whether or not in full-time employment, who would be prepared to provide part-time home nursing services as and when they were needed in their own neighbourhoods. A recent report has recommended[24] that an on-call list of general nurses in each area should be established. These would be available as required to provide intensive home nursing to discharged hospital patients and to patients whose admission to hospital could thus be avoided. This is of particular importance, given the increasing tendency of families to take care of their sick relatives at home in these circumstances.

14.69 A particular drawback of the present public home nursing service is that it is largely confined to normal working hours. Little progress has been made towards implementing the recommendation of the Working Party on General Nursing[25] that a 24-hour community

---

[23] *ibid*

[24] *Report of the Working Party on Health and Welfare Services for the Elderly* (Stationery Office, 1988): para. 6.30.

[25] *op. cit.*

service be provided. The use of local general nurses on a part-time basis would be an ideal solution to the problem of providing after-hours care which may be particularly needed by patients discharged early from hospital.

14.70 An expansion of home nursing would not necessarily involve *net* additional costs. Account must be taken of the potential savings in hospital costs and also of the scope for some contribution towards the cost of the service from those patients in a position to pay. **It would be appropriate to levy a charge for home nursing on those patients who would be liable for hospital charges, although the level of charge should not be such as to provide an incentive to seek hospital admission. As with other possible charges for community services, there should be uniform guidelines on its applicability and level.**

"ALTERNATIVE MEDICINE"

14.71 A wide range of treatments outside the bounds of orthodox medicine is available from various practitioners. Some, such as herbalism and bone-setting, are based on traditional skills and folklore; others, such as osteopathy, homeopathy and chiropractic are based on alternative theories of the origin of disease which have not, however, been subjected to scientific validation. Certain treatments, notably acupuncture, are also offered by some orthodox medical practitioners.

14.72 "Alternative medicine" undoubtedly attracts considerable public interest and, although the extent cannot be quantified, substantial consumer expenditure. Unless a treatment has been scientifically proven to be of benefit, it could not be regarded as cost-effective in terms of the criteria which must be applied to public expenditure. However, healthcare, in the broadest sense, is a consumer good; the consumer is free to spend his money as he sees fit, and may well obtain subjective benefits as a result. Restrictions on the practice of "alternative medicine" should only arise, therefore, if it is necessary to protect the consumer from dangerous treatment or from misrepresentation.

14.73 We have argued in Chapter Eight that voluntary insurance should complement the publicly-funded health services by providing cover for such additional services as consumers wish to pay for. The question of whether any forms of "alternative medicine" should be covered under voluntary insurance is thus a question for insurers to determine on the basis of balancing consumer demands with the need to maintain premia at a competitive level.

14.74 We have argued that the allocation of the scarce resources of the public health services should be based on objective evaluation of the cost-effectiveness of alternative forms of care in meeting the priority needs of the community, rather than on the satisfaction of individual demands for preferred treatments. If any "alternative" treatments were found to perform better against objective criteria of efficacy and cost-effectiveness than the more orthodox forms of care for patients with particular conditions, it would then be appropriate to ensure that they were available to those patients. There are many historical precedents for the absorption into medical orthodoxy of treatments previously considered outside its bounds. However, "alternative" treatments which have not been scientifically validated and do not meet the criteria which we have discussed must remain outside the scope of the public health services.

RECOMMENDATIONS

14.75 We have made the following recommendations in this chapter:

1. The resources of the Treatment Benefits Scheme should be channelled into providing an improved service for persons entitled to health board dental, ophthalmic and aural services who represent the most appropriate target group given the total level of resources available.

2. The use of dental auxiliaries for preventive care and minor procedures should be permitted and encouraged as it would increase the time available to qualified dentists for more complex work, and thus reduce the present shortfall in services.

3. Formal studies should be carried out to quantify the relative cost-effectiveness of the various paramedical services and alternative methods of delivering them.

4. National guidelines on service levels and eligibility criteria should be set for community and out-patient paramedical services. 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.

5. National guidelines should be set on the applicability and amount of charges for public dental, ophthalmic and aural services and for paramedical services.

6. An urgent review of the role and workload of the Home Nursing Service should be carried out to define the appropriate level of services to be available to those with specific medical needs. It should then be a matter for local management to decide how the necessary services can best be provided.

7. A charge for home nursing should be payable by those patients who would be liable for hospital charges, although the level of charge should not be so great as to provide an incentive to seek hospital admission. There should be uniform guidelines on its applicability and level.

CHAPTER FIFTEEN

DRUGS AND OTHER MEDICAL SUPPLIES

INTRODUCTION

15.1 The Irish health services spend almost £200 million per annum on drugs and other medical goods. This expenditure includes the cost of goods supplied to patients through pharmacists; subsidies towards private purchases of drugs; and the cost of medical supplies for hospitals and health boards. Many of the submissions to the Commission argued strongly that this area of expenditure offered scope for considerable savings. This chapter describes and evaluates the arrangements for procuring and supplying these goods, and examines possible approaches to increased efficiency and reduced cost.

DESCRIPTION OF THE PRESENT ARRANGEMENTS

The General Medical Service Scheme

15.2 Prior to the introduction of the General Medical Service Scheme in 1972, the health authorities employed pharmacists in the cities and in some of the larger towns to compound and dispense medicines and drugs at dispensaries. In smaller towns and rural areas, medicines and drugs were dispensed by the district medical officers. Supplies were purchased in bulk through contracts arranged by the Combined Purchasing Section of the Department of Local Government. In proposing the Choice-of-Doctor scheme to replace the dispensary system, the Government argued[1] that it would be preferable if those covered by the Scheme were entitled to get their drugs, medicines and appliances through the same channels as the doctors' private patients, i.e. the retail chemists, or the doctors themselves in areas where there were no chemists. The Health Act, 1970 made provision for the introduction of a scheme on the lines proposed and, following negotiations with the medical and pharmaceutical organisations, it was brought into operation in 1972.

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

TABLE 15.1

FEES IN THE GENERAL MEDICAL SERVICE FOR PHARMACISTS

(Revised at 1 January, 1989)

Basic Fee	133.48p
Extemporaneous Preparations	266.94p
Urgent Fee and Late Fee	368.97p
Midnight to 8.am.	760.48p

Note: An element of the fee is intended to compensate for containers, obsolescent stock, etc. For example, the basic fee of 133.47p comprises a fee of 110.35p and an allowance of 23.12p.

Source: Department of Health

15.3 Goods supplied under the Scheme are provided through retail pharmacies. In addition to prescribed drugs and medicines, these include other items for patients with special needs such as medical foods, dressings, incontinence wear, needles and syringes. In most cases, the doctor gives the patient a prescription on a GMS prescription form; the prescription can be filled, without charge to the patient, at any pharmacy participating in the Scheme. The number of pharmacies in the Scheme at end-1987 was 1,108, out of an estimated 1,200 retail pharmacies in the country. In rural areas, where a doctor has a centre of practice three miles or more from the nearest retail pharmacy in the Scheme, patients are entitled to have their prescriptions dispensed by the doctor. The doctor is paid a dispensing fee; the medicines are obtained by him through a stock order given to a retail pharmacy participating in the Scheme. There were 295 dispensing doctors, catering for 124,900 GMS patients, at the end of 1987.

15.4 Retail chemists are paid monthly by the General Medical Service (Payments) Board for services provided under the Scheme. For prescriptions supplied directly to patients, they receive the ingredient cost, at trade price, and a dispensing fee. The schedule of fees is set out in Table 15.1. For stock orders supplied to dispensing doctors, chemists receive the trade price and a further 25 per cent by way of fee. Participating chemists also receive advance payments, reviewed annually, against the cost of holding stocks.

15.5 Tables 15.2 and 15.3 detail the growth in the volume and cost of prescriptions since the introduction of the Scheme. The drop in the number of items prescribed in 1983 followed the exclusion of a

TABLE 15.2

GROWTH IN VOLUME OF PRESCRIPTIONS UNDER GMS SCHEME
(excluding prescriptions dispensed by doctors)

	Number of Prescription Forms (million)	Number of Items (million)	Number of Items per Patient*
1973	3.72	7.39	9.20
1975	4.61	9.60	10.13
1977	5.14	10.55	10.16
1979	5.30	11.04	10.79
1981	5.75	12.27	11.93
1983	5.69	10.66	9.29
1985	6.23	11.82	10.15
1986	6.44	12.39	10.49
1987	6.84	13.32	n.a.

Note: Data relates only to prescriptions supplied by pharmacies.

* This figure is based on the total number of eligible patients, excluding those for whom doctors dispense directly. A comparable figure for 1987 is not available due to the discontinuation of direct dispensing by doctors for a time during that year.

Source: Annual Reports of GMS (Payments) Board.

wide range of preparations from supply under the scheme. Table 15.4 details the principal components of drugs-related expenditure under the GMS Scheme in 1987.

Long-Term Illness and Drugs Refund Schemes

15.6 Prior to the introduction of the General Medical Service Scheme, health authorities could also provide, free of charge, drugs for non-eligible persons where the private purchase of the drugs would involve undue hardship. These arrangements were replaced by the Long-Term Illness Scheme and the Drugs Refund Scheme, introduced in 1971 and 1972 respectively.

15.7 The Long-Term Illness Scheme provides, without charge, drugs, medicines and other medical requisites for the treatment of Category II or III patients with certain scheduled long-term illnesses and disabilities. Persons suffering from one of the scheduled conditions are registered with health boards and receive a booklet containing dockets which are exchanged in pharmacies for the required items. The pharmacist is reimbursed by the health board on the basis of the ingredient cost, with a 50 per cent mark-up, a

TABLE 15.3

GROWTH IN COST OF PRESCRIPTIONS UNDER GMS SCHEME

	Total Cost of Prescriptions (£m)	Total Cost of Stock Orders (£m)	Overall Cost (£m)	Cost per Eligible Patient (£)
1973	7.13	1.12	8.24	8.67
1975	13.26	1.90	15.16	13.53
1977	19.66	2.54	22.20	18.18
1979	28.04	3.32	31.37	25.60
1981	45.42	4.81	50.22	41.19
1983	54.34	5.72	60.06	45.35
1985	66.93	6.41	73.34	55.85
1986	72.92	6.62	79.54	59.98
1987	79.81	3.83	83.64	62.47

Note: The first column represents the cost of prescriptions supplied by pharmacies; the second is the cost of prescriptions dispensed by doctors. (The cost of the latter fell in 1987 due to the discontinuation of the scheme for a period during that year). Costs quoted include pharmacists' fees and VAT. Cost per eligible patient is based on total number of medical card holders.

Source: Annual Reports of GMS (Payments) Board.

further 10 per cent for broken bulk, a dispensing fee of 60p and a container fee if one is supplied. This represents the standard retail mark-up and dispensing fee in the pharmacy trade.

15.8 Just over 44,000 patients availed of the Long-Term Illness Scheme in 1987. Table 15.5 provides a breakdown by condition of the numbers availing of the Scheme in 1985, 1986 and 1987. Estimated expenditure under the Scheme was £8.8 million in 1986 and £8.5 million in 1987.

15.9 Under the Drugs Refund Scheme, persons with Category II or III eligibility who incur expenditure of more than £28 on

TABLE 15.4

GMS DRUGS-RELATED EXPENDITURE: BREAKDOWN OF OVERALL COST, 1987

	(£m)
Ingredient Cost of Medicines	63.92
Pharmacy Fees	17.58
VAT	2.14
TOTAL	83.64

Source: GMS (Payments) Board Report, 1987

TABLE 15.5

PERSONS AVAILING OF LONG-TERM ILLNESS SCHEME, 1985–1987

Condition	Number of Patients		
	1985	1986	1987
Diabetes	18,586	18,722	20,325
Epilepsy	12,401	11,895	13,925
Mental Handicap	2,662	2,666	2,873
Parkinsonism	1,395	1,441	1,499
Spina Bifida/Hydrocephalus	1,017	1,066	1,131
Multiple Sclerosis	1,007	1,044	1,136
Cerebral Palsy	887	903	980
Cystic Fibrosis	698	704	873
Acute Leukaemia	378	383	440
Phenylketonuria (P.K.U.)	299	309	336
Muscular Dystrophies	211	258	262
Haemophilia	195	191	197
Mental Illness (under 16 only)	155	146	141
Total	39,891	39,728	44,118

Source: Department of Health.

prescribed medical requisites for use in any calendar month are entitled to a refund from the health board[2] of the amount in excess of £28. There were over 225,000 claims in 1987; many patients would, of course, have submitted claims in more than one month. Estimated expenditure under the Scheme was £9.4 million in 1986 and £10.5 million in 1987.

Other Expenditure

15.10 Patients in public hospitals receive all necessary drugs, medicines and other requisites free of charge; the cost is borne from the hospital's budget. Community Care personnel also use medical supplies in the treatment of patients, and supply certain aids and appliances directly to them.

15.11 Table 15.6 summarises total public expenditure on medical goods in 1987. In addition to expenditure on the specific schemes

[2]In February, 1989, the Minister for Health announced his intention to change the payment mechanism for certain categories of patient under the Scheme. Patients will continue to be responsible for the first £28 of expenditure on prescribed drugs in any month, but those registered with their health board as requiring ongoing expensive medication (for example, due to chronic illness) will not be required to pay the pharmacist more than £28 in any month. In such cases the health board will now refund the pharmacist rather than the patient. The existing arrangements will continue for patients whose expenditure exceeds £28 per month less frequently.

described earlier, almost £100 million was spent on medical supplies for hospitals and Community Care — including £41.6 million on drugs and medicines and £60.9 million on non-pharmaceutical medical and surgical supplies. The latter category includes sterile goods, needles and syringes, X-ray films, laboratory chemicals and patient aids and appliances.

TABLE 15.6

ESTIMATED PUBLIC EXPENDITURE ON MEDICAL GOODS, 1987

	(£m)
GMS Scheme (including pharmacists' fees)	83.6
Drugs Refund & Long-Term Illness Schemes	19.0
Other Expenditure on Drugs and Medicines	35.3
Total drugs and medicines	137.9
Other medical supplies	60.9
TOTAL PUBLIC EXPENDITURE	198.8

Source: Department of Health.

Supplying The Health Services

15.12 There is a substantial pharmaceutical industry in Ireland but it is largely involved in producing and exporting intermediate and bulk products for parent or associated companies abroad. It is understood that about 95 per cent of the medicines consumed in Ireland are imported from abroad, the remainder being accounted for by products of indigenous manufacturers and, to a small extent, finished products of the multinational companies based here. Of the 95 per cent of medicines which are imported, over 80 per cent originate in the United Kingdom.

15.13 Prior to 1972, as health authorities were purchasing medicines in bulk for direct supply to eligible patients, it was possible to operate a limited list of available products and to purchase these by competitive tendering at national level. Since 1972, agreements have operated between the Department of Health and the Federation of Irish Chemical Industries (formerly the Pharmaceutical and Allied Industries Association) which represents the majority of pharmaceutical manufacturers and distributors. The earlier agreements provided for price uniformity, volume discounts to hospitals and rebates to the General Medical Service for all products supplied under the GMS Scheme, but did not govern the level of prices.

15.14 Following a review[3] of the supply arrangements which recommended that prices should be tied to a fixed relationship with those in the UK (as the principal country of origin), a new form of agreement was reached with the Federation of Irish Chemical Industries in 1983. In addition to providing for hospital discounts and rebates to the GMS, the agreement placed limits on the amount by which the Irish trade price of drugs and medicines could exceed the trade price obtaining in the UK. The agreement was revised in 1986 and again in 1987. The principal terms of the current agreement which came into effect on 1 August, 1987 are as follows:

(i) each manufacturer's or importer's average price to wholesalers, weighted in accordance with his supply of products to the General Medical Service, may not exceed the equivalent UK price by more than 4 per cent, after currency differentials. The price of any individual item may not exceed the UK price by more than 10 per cent. When account is taken of wholesalers' margins, the effect of these terms is to restrict the average trade price (i.e. the price at which goods are supplied to retail pharmacies and hospitals) to a maximum of 107.06 per cent of the UK trade price, and the trade price of any item to a maximum of 113.2 per cent of the UK equivalent;

(ii) each manufacturer/importer must refund to the GMS (Payments) Board 5 per cent of the value of his products dispensed under the Scheme;

(iii) hospitals and health boards receive a discount of 15 per cent of the trade price on orders over £100 in value where orders are placed with the manufacturer/importer or his agent;

(iv) where clear comparison with UK prices is not possible, special arrangements are to be agreed between the manufacturer/importer and the Department of Health;

(v) for the duration of the agreement, the scope of the Department of Health to remove products from the list of those reimbursable under the GMS Scheme is limited, and restrictions may not be placed on the freedom of doctors to prescribe the medicines of their choice or on the requirement that pharmacists dispense the products prescribed;

(vi) all health boards and hospitals are bound by the terms of the Agreement, and no other arrangements for the supply of medicines, such as tender or contract purchasing arrangements,

---

[3]Trident Management Consultants: *Report on the Review of Arrangements for the Supply of Drugs and Medicines* (Stationery Office, 1980)

are permitted. They are, however, free to accept better terms if offered by suppliers.

15.15 While the terms of the agreement relate to the trade price of drugs and medicines, they also effectively determine the maximum retail price to private purchasers since the retail mark-up in the pharmacy trade is a standard 50 per cent. Under the Drugs Refund Scheme, health boards are entitled to refuse to refund any amount which exceeds this standard mark-up.

15.16 The supply of non-pharmaceutical medical goods to the health services is not governed by any agreement with the trade. Distributors are free to set prices but many hospitals and health boards obtain substantial discounts through competitive tendering or direct negotiation. Purchasing procedures, however, vary considerably and studies have shown significant variations in the prices paid for comparable purchases.

EVALUATION OF THE PRESENT ARRANGEMENTS

15.17 There are four main areas of criticism of the present arrangements:

(i) the extent and range of drugs prescribed;

(ii) the price of drugs;

(iii) specific aspects of the schemes for providing or subsidising drugs; and

(iv) the efficiency of non-pharmaceutical purchasing.

Prescribing patterns

15.18 It was noted in Chapter Eleven that there is evidence to suggest that there may be considerable over-prescribing of medicines under the GMS Scheme. The GMS Working Party[4] pointed out that the high level of drug consumption in most Western countries is a cause of concern not alone because of cost, but also because of the risk of iatrogenic disease (i.e. induced by medical treatment), particularly due to interactions among drugs, and the risk of physical or psychological dependence. The Irish College of General Practitioners has stated that general practitioners "vary so enormously

[4] *Report of the Working Party on the General Medical Service* (Stationery Office, 1984): chapter five.

in their prescribing habits as to suggest that some prescribing is likely to be excessive, inappropriate or inadequate".[5]

15.19 We have discussed in Chapter Eleven the possible influence of the method of remunerating general practitioners on their style of practice. Prescribing patterns may also be influenced by patient expectations. It has been submitted to us that most patients expect to receive a prescription when they visit a doctor, and that this suggests a gap in the coverage of health education. It has also been submitted to us that a doctor's tendency to prescribe for most patients presenting to him may be influenced, albeit subconsciously, by the promotional expenditure of the pharmaceutical industry, which employs about 340 sales representatives[6], and extensively supports medical journals, research and educational work and social activities related to the medical profession.

15.20 The range of prescribing also presents a problem. The patent life of new pharmaceutical products is relatively short and the majority of the most commonly prescribed drugs under the General Medical Service are in fact off-patent. It is therefore open to manufacturers other than the original developer of such a drug to produce an identical formulation for sale under a different brand-name or in generic (i.e. unbranded) form. There may be considerable price variations between different products with the same formulation. Generic products tend to be the least expensive as there are no promotional overheads. Doctors in the GMS are encouraged to prescribe generically (i.e. without specifying a brand name) where possible by the regular circulation of comparative drug costs, including those of generics, by the GMS (Payments) Board. The Board also distributes to doctors, free of charge, the *Drugs and Therapeutic Bulletin* which provides relevant information on the alternative preparations available. However, it is universally accepted that promotional activity has a marked influence on the brand prescribed, and there is thus very considerable prescribing of products for which greatly cheaper substitutes are available. The Department of Health is precluded from going beyond the exhortation of doctors in order to counteract this, since the terms of its agreement with the Federation of Irish Chemical Industries specifically rule out

— any restriction on doctors' rights to prescribe medicines of their choice;

---

[5]Irish College of General Practitioners: *The Future Organisation of General Practice* (ICGP, 1986) para. 8.6.

[6]Estimate confirmed in discussions with representatives of Federation of Irish Chemical Industries.

— allowing pharmacists to dispense substitute products for those prescribed; or

— reducing the range of drugs available under the GMS Scheme.

15.21 The problem of choice between a number of similar drugs at markedly different prices also arises in the hospital setting. Some hospitals have sought to overcome this through Drugs and Therapeutic Committees, consisting of medical, pharmaceutical and administrative personnel, which draw up limited lists of products for use in the hospital.

Drug prices

15.22 Table 15.7, which is based on a survey carried out for the EC Directorate General for Consumer Protection in 1988, shows that drug prices in Ireland are among the highest in the EC and are, on average, approximately fifty to one hundred per cent higher than in the five Member States with the lowest costs. It must be noted, however, that these price comparisons take no account of the 5 per cent rebate to the Government for GMS sales.

15.23 The agreement with the pharmaceutical industry relates Irish prices to those in the United Kingdom. However, the latter prices are themselves among the highest in Europe. Differing government policies towards the drugs industry are important in explaining this pattern. Prices in the UK are governed by an agreement which is designed to allow a good return to the British pharmaceutical industry for research and development expenditure. In contrast, other countries have for some time operated severe restrictions on drug prices. Industry sources have confirmed to us that this has driven pharmaceutical companies to raise their prices elsewhere in order to maintain their overall profit margins. We might conclude, therefore, that Irish prices include a premium to reward the industry for research and development expenditure (although research and development carried out in Ireland is negligible) and a further premium to compensate the industry for tight price controls elsewhere.

Specific Aspects of the Schemes

15.24 Until 1982, *medical card holders* were entitled to virtually any medical product under the GMS Scheme, provided that it had been prescribed by a doctor. In 1982 around 900 products were removed from availability under the Scheme. These were mostly over-the-counter (i.e. non-prescription) items; they included, for example,

TABLE 15.7

SURVEY OF AVERAGE RETAIL DRUG PRICES IN EC COUNTRIES, 1988

Cost of sample of 125 branded medicines

	IR£	Index
Portugal	752.18	100
France	840.54	111
Spain	844.92	112
Greece	871.56	115
Italy	960.00	127
Belgium	1,046.00	139
Luxembourg	1,172.42	155
Britain	1,359.00	180
Ireland	**1,453.00**	**193**
Holland	1,615.50	214
Denmark	1,740.00	231
Germany	1,800.15	239

Source: Survey carried out by European Organisation of Consumers' Associations (BEUC) in January, 1989, as quoted in *Consumer Choice* (Consumers Association of Ireland) May, 1989. The survey included the 125 branded medicines which were to be found in the top 25 of sales value or top 10 of sales volume in any of the countries concerned.

mild painkillers, antacids, tonics and a wide range of preparations for minor conditions. Further exclusions, additions and restorations to the list of reimbursable products have since been made. The purpose of the exclusions is to restrict expenditure under the Scheme to preparations of significant therapeutic value and to discourage patients from visiting their general practitioner solely to obtain prescriptions for over-the-counter products. It has been submitted to us by representatives of both pharmacists and general practitioners that the exclusion of certain items has led to pressure on the doctor to prescribe more expensive and less appropriate alternatives because they are free to the patient.

15.25 Some form of assistance towards the cost of necessary drugs for *non-medical card holders* can be justified on the basis that it eases the financial burden on persons availing of community rather than hospital-based care and that, for certain conditions, the cost involved can be extremely high. However, each of the existing schemes has drawbacks. In both cases, recipients benefit without reference to their ability to pay and indeed may obtain items which have been removed from the list of goods available to medical card holders.

15.26 The Drugs Refund Scheme is particularly open-ended since the cost of all prescribed medical requisites in excess of £28 per

month is reimbursed. Once the threshold has been reached there is no incentive to the patient to keep costs down by, for example, asking for the generic preparation to be prescribed. It has also been submitted to us that there are abuses of the Scheme, through combining prescriptions for a number of months, or even for a number of individuals and families, in order to exceed the threshold. It has also been suggested that refunds may sometimes be made on the basis of chemists' receipts which do not in fact relate to the purchase of medical prescriptions.

15.27 The Long-Term Illness Scheme is intended to provide for the supply of items specific to the patient's designated condition. However, the range of items which may be supplied in respect of each condition has not been laid down. It has been submitted to us that the prescription for supply under the Scheme of items not relevant to the designated condition is common. The pharmacist's mark-up to full retail price under the Scheme is also open to criticism. Representatives of the pharmacists have argued to us that the profitability of the supply of goods under the Long-Term Illness Scheme was an accepted element in their negotiations on the introduction of the General Medical Service Scheme; they have also indicated, however, that the profession would be prepared to negotiate a lesser mark-up for some product ranges.

Non-pharmaceutical purchasing

15.28 An extensive study[7] of the procedures for purchasing non-pharmaceutical medical supplies for hospitals and community care was carried out on behalf of the Department of Health in 1985 and 1986. The study revealed substantial variations in the type and quality of procedures used; these were reflected in marked variations in the prices paid for equivalent or identical products. The study concluded that the development of the purchasing function in most health agencies in terms of staffing, training, storage facilities and information systems, was far from adequate. We received a number of submissions which referred to the scope for efficiency improvements in this area.

CONTROLLING VOLUME, RANGE AND PRICE

15.29 The cost-containment policies of most countries' health services have focussed on pharmaceuticals in particular, because of the high level of expenditure and the perceived scope for savings.

---

[7]Trident Management Consultants: *Purchasing of Medical and Surgical Consumables and Appliances* (Unpublished Study for the Department of Health, 1986)

The various approaches have included measures aimed at reducing the total level of consumption, reducing the range of products by excluding those for which less expensive substitutes are available and reducing prices either by agreement with suppliers or through statutory controls. In Ireland, attempts to reduce the volume and range of prescribing have (with the exception of the 1982/3 de-listing of minor preparations from supply under the GMS) been limited to providing doctors with relevant information and exhortations towards more economic prescribing. Any formal restrictions are specifically excluded under the terms of the agreement with the Federation of Irish Chemical Industries.

15.30 The agreements with the industry have had some advantages for the health services. They provide a simple but effective control on the upper limit of prices, which is an essential requirement where patients' needs are being provided through the pharmacy trade rather than directly by health boards. Even in relation to purchasing by health boards and hospitals, the evidence in other areas of purchasing is that the function has been very poorly developed in many agencies and it may well be the case that expenditure on drugs would have been considerably greater in the absence of the agreements. The first agreement to include price limits, in 1983, resulted in a significant drop in the average trade price, and the Department of Health has estimated that the consequent savings to the health services on the cost of drugs were £12 million per year.

15.31 However, there are also some disadvantages in the type of agreement which has operated:

— the linking of Irish prices to those in the United Kingdom may not be to our advantage because of the variation in average prices across the European Community and the increasing scope for obtaining supplies from lower-cost markets;

— health boards and hospitals have become more conscious of the potential for efficient purchasing and the funding mechanisms which we have recommended will increase this further. However, the agreement with the pharmaceutical industry specifically rules out procedures such as competitive tendering or contract purchasing; better terms than those stated in the Agreement can be obtained only when freely offered by suppliers; and

— the agreement restricts the scope of the government, as the principal funder, to determine the range of products used.

15.32 The Department of Health has recently given twelve months notice to renegotiate the present agreement. The agreement is

terminable on 31 July, 1990. **We recommend that a different approach to controlling expenditure on drugs should now be introduced.** We outline our approach in the following paragraphs.

The volume and range of prescribing

15.33 Chapter Eleven discussed the development of a more comprehensive and cost-effective general practice, the benefits of which would include a lesser reliance on prescribing. The Commission anticipates that the change in the payment method for doctors in the GMS scheme from a fee-per-item to a mainly capitation system will contribute to a lower prescribing rate and, in turn, savings in drug costs. An immediate measure which would help to reduce reliance on prescribing would be the establishment of therapeutic guidelines for general practice similar to those drawn up for hospital practice by the Drugs and Therapeutic Committees in some hospitals. The GMS Working Party[8] noted that a number of studies elsewhere had shown significant changes in prescribing habits to have been effected by general practitioners who had been encouraged to review their own prescribing patterns and had been given supporting information on the alternatives available; experience elsewhere also suggested that treatment guidelines would be most effective if general practitioners were themselves involved in their preparation and active endorsement. The Irish College of General Practitioners have similarly concluded that

> "the real reforms of prescribing must address the crude variation between individual prescribers, the appropriateness of individual prescriptions and their duration and the problems of polypharmacy .... (i.e. multi-item prescribing) .... these questions can only be answered by their review by general practitioners as part of their work."[9]

15.34 **We recommend the establishment of a Drugs and Therapeutic Committee for general practice,** to involve general practitioners themselves in the evaluation of prescribing patterns and the development of therapeutic guidelines.

15.35 As mentioned earlier, some hospitals have Drugs and Therapeutic Committees which draw up limited lists of products, but these are not widespread. It is clear that hospital prescribing patterns have an important influence on trainee doctors and ultimately on the approach to prescribing in general practice. **The Commission**

---

[8] *op cit*: chapter 5
[9] *op cit*: paragraph 8.3

recommends, therefore, that hospitals should be encouraged to establish Drugs and Therapeutic Committees and that they should be closely related to the Committee proposed above for general practice.

15.36 The same set of drug protocols should apply across all forms of care, whether in acute or psychiatric hospitals, or in general practice. All Drugs and Therapeutic Committees should work within the parameters of general protocols established at national level. This latter task should be a matter for the Health Services Executive Authority using appropriate expert advice. Paragraphs 10.34-10.36 discussed the issue of drawing up nationally applicable protocols for the delivery of appropriate care.

15.37 The "limited list" approach has been implemented in a number of countries. Under this system doctors and pharmacists are supplied with a listing, regularly updated, of all products which the health services will pay for under the terms of its schemes. Where a number of equivalent products are available, including, for example, generic versions of branded items, the list may exclude the more expensive choices. The doctor is not prevented from prescribing these; the patient, however, may have to pay the excess cost over that of the product included on the list.

15.38 It is essential that any limited list is based on rigorous scientific evaluation of the products involved. An important argument which has been made against the reliance on generic drugs is that different versions of the same formulation may not be biologically equivalent and may produce different therapeutic responses in certain cases. The GMS Working Party[10] pointed out that the establishment of equivalence among generic versions of drugs would require extensive clinical assessment in excess of the current requirements for the issue of a product authorisation. It would also be essential to have procedures for assuring the quality of the listed products on an ongoing basis. Finally, the involvement of doctors and pharmacists in the development and maintenance of a limited list would also be essential to ensure that any potential difficulties in its operation were identified and resolved, and to help secure cooperation on the part of both professions.

15.39 **Subject to these safeguards, we recommend the introduction of a limited list of pharmaceutical products.** We discuss later the application of this to the arrangements for supplying or subsidising patients' requirements.

---

[10] *op cit*: chapter five

15.40 The limited list should be subject to continuous review. The criteria for inclusion, in the case of existing products, should include safety, efficacy and cost-effectiveness. Choice between comparable products need not be excluded, but a product would not be listed where it was markedly more expensive than equivalent substitutes. The inclusion of new products should be based on an assessment of their therapeutic benefits, over and above existing products, in relation to any additional cost involved. It is understood that some manufacturers develop "new" products, which are minor modifications of products whose patent life has expired, to maintain a marketing advantage over generic versions of the original preparation.

15.41 There is a need also to educate the general public on the role of drugs in the treatment of routine illness and to reduce the general expectation of a prescription for every ailment. **The Commission recommends that this should be given particular attention in the development of health education programmes.**

Drug Prices

15.42 We have recommended the establishment of a Health Services Executive Authority to take responsibility for the management of the health services. Ensuring that drugs and other medical supplies are purchased in the most efficient way is a good example of the type of function best undertaken by a central executive with appropriate expertise. The Executive Authority could determine whether local or central negotiation is appropriate in individual cases. Negotiations at national level are likely to be most efficient for many items and trade prices for the supply, through retail pharmacists, of prescriptions under the unified statutory scheme proposed below would have to be the same throughout the country. However, the Executive Authority might well establish that certain purchases are best negotiated by individual hospitals and units, or regional groups of units, to take advantage of local market conditions.

15.43 Central negotiation need not, of course, imply central purchasing and distribution. There is at present a fast and efficient distribution network, with several deliveries a week to the most remote rural pharmacist. The overhead costs of this service are shared with the cosmetic and veterinary products of the same distributors and it would be costly and inefficient to duplicate it. Where central negotiation takes place, it would relate to the terms on which specific products would be included on the limited list discussed above. Agreement could be reached on trade prices which would be binding for specified periods. The limited list circulated

to pharmacists and doctors would specify the products which could be supplied under the new statutory scheme and the trade price which had been agreed.

15.44 The basic system of distributing drugs to patients through the retail pharmacy trade would remain unchanged. However, the health services would have considerably more control over the range and cost of products and would benefit from competition among suppliers where the scope for such competition exists. This scope is obviously greatest in relation to off-patent drugs where there are a number of equivalent products; only those available at the lower range of prices (all safety and efficacy requirements having been met) might be included on the limited list.

15.45 There is a danger that suppliers of certain patented products, for which there are no substitutes and which are often among the most costly requirements, might raise their prices in the absence of the present industry-wide agreement. This would, however, provide scope for other parties to tender lower prices on the basis of *parallel importing*. This involves purchasing products in other countries, where they are available more cheaply, and importing them for sale in competition with the local distributor. The marked differences in prices across Member States has led to an expansion of parallel importing in the European Community. In Ireland, Regulations were introduced in 1984 to allow for the granting of Parallel Product Authorisations. There is an obvious requirement that the quality of supplies imported under such authorisations should be strictly monitored. If this requirement is met, the scope for parallel importing provides some safeguard against over-pricing of patented products.

PATIENT ENTITLEMENTS — NEW PROPOSALS

15.46 If it is accepted that the proposed constraints on the range and price of drugs would result in a more cost-effective service to medical card holders, then the same constraints should also apply to non-medical card holders obtaining state assistance towards the costs of their requirements. There are also a number of anomalies in the existing schemes for the latter group, as discussed earlier; and it is likely that overall administrative costs are increased by the co-existence of a system for reimbursing pharmacists for drugs provided to certain patients (under the GMS scheme) with a system for reimbursing other patients directly (under the Drugs Refund Scheme).

15.47 A single, integrated scheme could prove more satisfactory on all the above grounds, while maintaining the principle that those in

a position to contribute towards the cost of their requirements should do so. Such a scheme might be structured as follows:

(i) only those products included on the limited list are covered;

(ii) prescribed products on the limited list are supplied by pharmacists to medical card holders, and their cost and dispensing fee reimbursed to the pharmacist under arrangements similar to the present ones;

(iii) non-medical card holders may obtain prescribed products on the limited list *at a subsidised price* by presenting a special prescription form. The difference between the subsidised price and the appropriate retail price is reimbursed to the pharmacist on submission of the prescription form. The administration of the reimbursement is carried out in parallel with that for supplies to medical card-holders;

(iv) the "appropriate retail price" is determined by the trade price specified on the limited list and a retail mark-up negotiated with the pharmaceutical profession. The level of mark-up might differ in respect of certain categories of product;

(v) the level of subsidy varies from product to product depending on factors such as therapeutic benefit, cost, and whether frequent repeat prescriptions would be required; and

(vi) safeguards are built into the design and method of use of the different prescription forms for medical card and non-medical card holders to limit the possibility of any abuse arising out of the two methods of reimbursement under the integrated scheme.

15.48 The above approach would have a number of important advantages:

(i) the open-ended nature of the existing schemes for non-medical card holders would be removed and all patients receiving State assistance towards their requirements would be subject to the same restrictions on the products available;

(ii) administrative effort would be greatly reduced as all reimbursements would be handled through a single mechanism — claims by individual patients would no longer arise;

(iii) the use of subsidies to reduce the net price of individual items to the patient rather than to reimburse gross expenditure provides virtually unlimited scope for targeting the available resources. For example, a nil or negligible subsidy might apply to minor, low-cost items but a major subsidy might be applied to expensive preparations which are effective in preventing the need for hospitalisation of patients; and

(iv) although the proposed restrictions on the range and prices of products would save the health services a considerable amount of money, the changes in the manner in which subsidies for medication are paid would not leave patients worse off in medical or financial terms. The safeguards built into the compilation of the limited list would ensure high medical standards. Medical card holders would still receive their requirements free of charge, while the rates and distribution of subsidies to others could be designed to ensure that the average cost incurred by non-medical card holders, without reimbursement, was no greater than under the present arrangements. As a further safeguard, there could be a discretionary scheme to give special assistance in cases where, despite the subsidies, hardship arose because of the need for a number of drugs over a short period of time.

15.49 The Commission also considered a slightly different approach under which State assistance would be directed at individual patients rather than specific drugs. The scheme would still be an integrated one to replace the existing arrangements, and would also operate under a limited list, with State funding for drugs based on the price of the lowest-cost alternative on the list. However, instead of purchasing drugs at subsidised prices, patients would recoup expenditure above a stated threshold. A special scheme could operate for those with long-term needs; as in the case of the scheme announced by the Minister for Health in February, 1989 (see footnote 2), patients registered as in need of on-going expensive medication would not pay the pharmacist more than the monthly threshold. The pharmacist would recoup the balance from the public system.

15.50 This alternative approach would have some advantages but, on balance, the Commission favours the first option above. The system of subsidising drugs would be less complex for patients since they would know their net costs immediately, receiving any subsidy at the point of purchase, whereas under the second scheme they would have to reclaim expenditure already incurred. The first option would also offer less administrative complication since the public system would deal with about 1,100 pharmacists rather than a huge volume of claims from individual patients.

15.51 **The Commission therefore recommends a single integrated scheme which would supply prescribed drugs, through pharmacists, on the basis of a limited list, to medical card holders free of charge, and to other patients at subsidised prices — the rates of subsidy to vary according to factors**

such as the therapeutic benefit, cost and frequency of repeat prescriptions associated with specific products.

15.52 **The Commission does not recommend the imposition of prescription charges on medical card holders** because of the need to ensure that access to any form of treatment is not restricted by ability to pay and the danger that even nominal charges might act as a deterrent to obtaining necessary medicines. As prescriptions are written by the doctor, not the patient, we do not see prescription charges as a useful deterrent to unnecessary consumption of medicines.

CONCLUSION

15.53 The recommendations made in this chapter have two objectives: to increase the efficiency of the arrangements for supplying or subsidising patient requirements, and to reduce the overall cost of doing so by influencing the volume, range and price of the products supplied. It has been argued that the pursuit of the latter objective may have an adverse effect on industrial development. Multinational pharmaceutical companies play an important part in the Irish economy. It has been suggested by representatives of the industry that, although the size of the Irish market is small in comparison to the total turnover of the companies concerned, they may be less inclined to invest in Ireland, or even to continue their present level of manufacturing here, if government policies operate to reduce the profitability of sales to the Irish market. In a wider context, it is also argued that a good return on research and development is essential for the continued development of the pharmaceutical industry in the European Community as a whole.

15.54 While we draw attention to these arguments, our concern is with the fair and efficient operation of the Irish health services. Aids and incentives to investment, to employment and research and to development are best provided directly and explicitly through the relevant industrial development agencies. We believe that the cost of drugs and other medical supplies to the Irish health services is considerably higher than it need be, and can be reduced.

RECOMMENDATIONS

15.55 We have made the following recommendations in this chapter:

1. There should be a Drugs and Therapeutic Committee for general practice to involve general practitioners in the evaluation of

prescribing patterns and the development of therapeutic guidelines. Hospitals should be encouraged to establish Drugs and Therapeutic Committees which should be closely related to the new Committee for general practice.

2. Subject to specified safeguards, a *limited list* of pharmaceutical products for supply under a new unified State scheme should be introduced.

3. Health education programmes should deal with the role of drugs in the treatment of routine illness.

4. The Health Services Executive Authority should negotiate the trade prices of products on the limited list for supply under State schemes. For other purchases, it should negotiate centrally or allow local negotiations, to exploit market conditions in each case.

5. 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 other patients at subsidised prices — the rates of subsidy to vary according to factors such as the therapeutic benefit, cost and frequency of repeat prescription associated with specific products.

6. Prescription charges should not be imposed on medical card holders.

CHAPTER SIXTEEN

PROMOTING AND PROTECTING HEALTH

INTRODUCTION

16.1 This chapter deals with the services which are specifically geared towards preventing illness and promoting health. They are categorised in terms of the four approaches described below. There are, of course, preventive aspects to all areas of healthcare and our discussion of the various services in other chapters takes these into account.

16.2 The World Health Organisation has in recent years advocated a greater emphasis on preventive approaches to healthcare and this has been reflected in health policy developments in most industrialised countries. Many preventive measures are, of course, of long standing; we can identify four broad strands in the development of the role of public authorities in promoting the health of their populations:

(i) the major improvements in mortality and morbidity rates between the mid-nineteenth and mid-twentieth centuries were attributable to a large extent to scientific advances in identifying the causes of disease, which pointed in particular to the need for improving sanitation, housing and nutrition;

(ii) during the twentieth century, preventive medical services directed at the entire community such as vaccination, child health examinations and screening for specific disorders were introduced;

(iii) in more recent years, there has been a growing emphasis on the concept of individual responsibility for health through behaviour and lifestyle, with public policy directed towards influencing these through health education;

(iv) finally, the recognition that the individual's choice of a healthy lifestyle can be supported or impeded by the actions of government, industry and other groups in society, has led to an emphasis on seeking to influence the orientation of all policies and activities which directly or indirectly affect health.

w

REGULATORY AND ENVIRONMENTAL FUNCTIONS

16.3 Preventive health services were developed in conjunction with environmental protection by the local sanitary services in the nineteenth century. When the Department of Local Government and Public Health was divided in 1947, the Department of Health became responsible for services related to personal health and the Department of Local Government (later the Department of the Environment) for those related to the environment. The latter services, which are of major importance to public health, are thus outside the control of the Department of Health, although the medical officers of the health boards advise the local authorities on medical aspects of these and other services. The estimated public expenditure on water and sewerage services and environmental protection exceeded £400 million in 1987[1].

16.4 The Department of Health or its agencies are directly responsible for a number of regulatory and environmental functions intended to promote health and prevent illness. These include:

(i) a range of public health measures carried out by health boards through the health inspectorate and aimed at preventing the spread of infectious disease;

(ii) controls on the safety, quality and efficacy of drugs and medicines through a system of product authorisations operated by the Department of Health and the National Drugs Advisory Board;

(iii) controls on the promotion of tobacco products;

(iv) controls over drugs liable to be abused; and

(v) the flouridation of water supplies by the health boards.

The total cost of these activities was about £7 million in 1987. Their benefits accrue to society as a whole rather than to identified individuals. **For this reason, general taxation is the appropriate source of their funding and we recommend no change in this arrangement.**

IMMUNISATION, SCREENING AND CHILD HEALTH EXAMINATIONS

16.5 We are concerned in this section with medical services which are provided to the community at large, or to specific groups, to

[1] *Summary of Public Expenditure Programmes* (Stationery Office) 1987

prevent the occurrence or spread of disease, or to detect disease at an early stage when prompt treatment may affect the outcome. These services include the prevention of infectious diseases through immunisation, child health examinations and screening for specific disorders. Equity and efficiency in their provision demands that adequate information be available to ensure the appropriate targeting of the programmes and to enable their effectiveness to be assessed.

16.6 Chapter Ten discussed the general information needs of the health services. These include accurate population registers and comprehensive epidemiological data, collated through computerised records. This would enable health services personnel at local level to identify people requiring services, and policy planners at central level to evaluate the effectiveness of the services provided. These requirements are particularly relevant to the immunisation and screening programmes.

(i) Immunisation

16.7 Immunisation is available against diphtheria, tetanus, pertussis (whooping cough), polio, tuberculosis, rubella and measles. Influenza vaccination is available for groups particularly at risk of complications. Vaccination schemes are operated by the health boards and routine vaccination of children is available. The total expenditure on the programme to prevent infectious diseases was almost £6 million in 1987.

16.8 Immunisation programmes are of proven value. The vaccines are effective, the risks small and the benefits considerable. It is considered inappropriate to make vaccination mandatory, however, because of the slight risks involved. We understand that the rates of vaccination against many illnesses are lower than would be considered desirable. A number of reasons for this have been suggested to us, including public complacency due to the decline in the incidence and severity of the diseases, the division of responsibility between general practitioners and local clinics and inadequate systems of records to identify those children who have not been vaccinated.

16.9 **We recommend that comprehensive record systems should be used to ensure the required coverage of immunisation programmes.** Ongoing epidemiological assessment at national level would provide a basis for the withdrawal of specific schemes, or their restriction to high-risk groups, and the introduction of new schemes as appropriate. Health services managers at local level would be responsible for determining the appropriate use of general practitioners and local clinics in each area for this work so

as to ensure the most effective and efficient service. **Immunisation under these programmes should be available free of charge to those in the target groups,** regardless of category of eligibility for other health services, since preventing the spread of infectious disease is to the benefit of society as a whole.

(ii) Screening

16.10 Screening includes specific tests for the presence of diseases such as breast or cervical cancer, or conditions such as high blood pressure and sight disorders, on the basis that early diagnosis and treatment may be more beneficial than after symptoms have appeared. We cannot estimate the total expenditure on screening as it is not identified separately in the costs of the various relevant services. Many of the submissions made to us, however, have argued for a greater emphasis to be placed on this area of preventive medicine.

16.11 The relative effectiveness of many types of screening is the subject of current scientific debate. For example, those opposed to widespread screening for breast and cervical cancer argue that it is not proven that early diagnosis provides any enhanced possibility of cure. Furthermore, these diseases occur infrequently, so that screening of a large population is likely to result in few cases diagnosed, at high average cost, and also in a significant number of false positives[2] relative to true cases identified, leading to unnecessary anxiety and even surgery. Those on the other side of the debate, however, argue that the more recent evidence tends to support the view that early treatment of pre-symptomatic cancer may modify the natural course of the disease and that the effectiveness of screening can be greatly increased by targeting it towards high-risk groups.

16.12 The Commission's view, in this as in all areas of the health services, is that the available resources should be allocated so as to achieve the most benefit in terms of saving lives and improving the quality of life. We cannot adjudicate on a scientific debate which is, in any case, ongoing. It appears clear, however, that screening is least likely to be efficient and effective if it is indiscriminate and untargeted. The available evidence suggests that those most likely to avail of the services are those at lowest risk.

16.13 Screening programmes should therefore be designed and operated on the basis of an approach similar to that which we have recommended for immunisation services. **They should be based**

[2]A false positive arises where a test incorrectly indicates the presence of disease. All tests have some degree of error.

on comprehensive record systems and epidemiological assessment and should be subject to continuing evaluation in the light of their own results and the most recent available evidence. They should be directed specifically at those groups identified as at high risk and the information systems should be used to ensure the widest possible coverage of such groups. The research, design and evaluation work should be carried out at national level, although the targeting of programmes should take account of local epidemiology. Health services managers should be responsible for achieving the desired coverage of target groups in their areas by providing the services directly or by arranging for their provision by general practitioners, opticians etc. As with immunisation services, **we recommend that those in the target group for a specific programme should receive that service free of charge, regardless of category of eligibility.**

(iii) Child Health Examinations

16.14 There is a number of stages in the preventive care of infants and children. Ante-natal and post-natal care of mothers and infants is available through hospitals and also from general practitioners under the Domiciliary Maternity Scheme which is discussed in Chapter Eleven. Our concern at this point is with the child health examinations which are carried out by public health nurses, in addition to their domiciliary nursing work, and by area medical officers employed by health boards. Pre-school services involve developmental paediatric examination at the approximate ages of 6, 12 and 24 months; school health services include a comprehensive health examination for children entering school, selective examination of school-going children, examination on request by parent, teacher or nurse and annual vision testing and selective audiometric testing by the public health nurse. The total expenditure on these services was almost £7 million in 1987.

16.15 The early identification of treatable defects is of such immense importance that the child health services must be organised as effectively as possible. We have received a number of submissions which suggest that this is not the case at present. On the one hand, it is argued to us that the services provided in schools are being curtailed or withdrawn in some areas because of financial and manpower restrictions, and that the effect of this is to deny certain children the only medical examination which they are likely to receive. On the other hand, it is also argued to us that the school examinations waste medical manpower by using doctors for routine examinations that could be carried out by nurses; that defects found are mostly trivial or have previously been noted; and that the follow-

up is poor. It is also argued that the developmental paediatric examinations could usefully be replaced by a single, comprehensive developmental examination which would identify any important defects.

16.16 **We recommend a reappraisal and reorganisation of the child health services.** The case for a single, comprehensive developmental examination should be examined. Coverage should be extended to all children through the use of computerised records. Subsequent school examinations could in general concentrate on vision and hearing and be carried out by public health nurses with referral to area medical officers. Provision for referral of children with educational or other problems could continue. Such a reorganisation would enable area medical officers to concentrate on the areas of greatest need, where comprehensive medical examinations could continue.

16.17 **We do not recommend the imposition of a charge for these child health examinations because of the need to ensure the appropriate coverage.**

(iv) Source of Funding

16.18 While immunisation, screening and child health examinations confer benefits on those who receive them, we have argued that it would be inappropriate to impose charges on those at whom they are directed. **The prevention of disease, and the early identification of treatable illness or defects in children, can result in long-run savings for the health services and should therefore be funded from general taxation.**

HEALTH EDUCATION

16.19 The Department of Health and its agencies are responsible for developing and carrying out health education programmes and also for providing assistance to the many voluntary bodies which undertake programmes specific to their own locality or field of interest. These functions were carried out largely by the Health Education Bureau, but in 1987 the Bureau was abolished and its functions assigned to a Health Promotion Unit within the Department of Health. Expenditure on health education was £2.3 million in 1987, of which £2 million was funded from the proceeds of the National Lottery.

16.20 Those submissions to us which discussed the issue were mostly supportive of the recent orientation of policy towards the

encouragement of health-promoting individual behaviour. Many called for more resources to be devoted to the area. Some, however, have argued to us that much of the enthusiasm for health education is misplaced, on the basis that the causes of major illnesses are not known with certainty and that many of the prescriptions for changes in diet and lifestyle may be entirely ineffective in reducing their incidence.

16.21 There is a danger in over-stating the influence on health of factors within the control of the individual. This may lead to an insufficient degree of attention being paid to environmental and other factors within the control of the community as a whole which may be of equal or greater importance. It may also lead to long-term disillusionment with the recommended behavioural patterns if they do not lead to the reductions in illness which people had been led to expect.

16.22 While unrealistic expectations should not be fostered, we accept the need to persuade individuals to modify their lifestyles in terms of the more obvious risk factors. The principal difficulty, we believe, is to ensure that the resources devoted to this area are effectively used. As with any kind of advertising, the evaluation of effectiveness is very difficult. The main purpose of health education is to obtain benefits in terms of reduced morbidity or mortality, but it will be many years before these are quantifiable, if at all.

16.23 Much of the international evaluation of health education programmes measures effectiveness solely in terms of absorption of the message by the target group. There is also a need for evaluation techniques which can assess the impact of programmes on behaviour and, over time, on morbidity and mortality. **We recommend that all health education programmes should have specific goals relating to short-term behavioural change and long-term health indicator targets.[3] A substantial portion of the resources available for health education should be devoted to evaluation of programmes and the refinement of evaluation techniques.**

16.24 Illness has been found to be considerably more common in low-income areas. The primary causes of this pattern are undoubtedly poverty and environmental factors outside the individual's control. Studies have also shown, however, that positive health-promoting

[3]The recent Kilkenny Health Project, a community health programme aiming to modify the environment and behaviour of a defined population in order to reduce risk factors for coronary heart disease, is an example of a preventive programme which specified its targets and the timescale within which they were to be achieved.

behaviour is less frequent in low-income areas. It may well be very difficult for low-income groups to act upon much of the advice given in health education campaigns. **We recommend particular concentration on devising and targeting programmes suited to the needs of low-income groups.**

16.25 The effects of alcohol and tobacco on health, and their cost implications for the health services, are well known. The Commission believes that health education has a particularly important role to play in highlighting these effects and in encouraging the healthier lifestyles that would result from reduced consumption of such products.

16.26 Our concern throughout this report is to ensure that the health services are organised in such a way that the available resources are used effectively and efficiently. Other chapters have discussed how the unnecessary use of specific services might best be discouraged. **Health education could make an important contribution by increasing public awareness of the appropriate use of medical services. We recommend that this should be given emphasis in the design of campaigns.**

16.27 Increased resources are not a prerequisite of improved health education. The role of voluntary organisations is of proven importance, given direction and support. Professional groups within the health services also have much to contribute. The Report of the Working Party on the General Medical Service[4] pointed out that the advice and ability of the general practitioner are widely respected by patients and that these are valuable assets in the effort to prevent common diseases. Public health nurses can play an important part in the dissemination of health education in the community and in schools. The Irish Pharmaceutical Union, in its submission to us, has offered the facilities of pharmacies for the distribution of health education materials.

16.28 **Responsibility for health education, as an executive function, should be assigned to the Health Services Executive Authority.** The Authority's epidemiological data and research would be of value in the design, targeting and evaluation of programmes. While funding from general taxation is appropriate, it is clearly in the interests of health insurers also to sponsor health education programmes, and we are aware that the Voluntary Health Insurance Board has already done so.

---

[4] *Report of the Working Party on the General Medical Service* (Stationery Office) 1984.

HEALTH PROMOTION

16.29 The health of the community is affected, positively or adversely, by public policies in other sectors. These include, for example, industrial and labour policies which may affect environmental and occupational health, and agricultural policies which may influence health through diet and nutrition. In many cases the objectives of these policies may conflict with the objective of minimising health risks. A number of bodies have, in recent years, argued for a greater co-ordination of public policy to ensure that a national rather than sectoral perspective is taken. The National Economic and Social Council argued that "it should not be the task of social policies to repair the damage that has been caused by other policies: rather the aim should be to prevent the latter policies causing social damage".[5] The National Planning Board recommended that the Department of Health should "act as initiator and coordinator of a broadly-based preventive strategy".[6]

16.30 The Health Promotion Group, established by the Health Education Bureau, recommended that the Minister for Health should have statutory responsibility for health promotion, and should have the assistance of a Health Promotion Council bringing together expertise and experience from the different public and private interests whose activities affect health.[7] The Department of Health proposed the establishment of a Cabinet Sub-Committee on Health Policy "to address the clear need for effective co-ordination of public policies which impact on human health", and also the establishment of an appropriate mechanism for co-ordination at local level in which the health boards would have a lead role.[8]

16.31 During 1987 the Government established a cabinet committee to coordinate health promotion policies, under the chairmanship of the Minister for Health, an Advisory Council on Health Promotion, and a Health Promotion Unit within the Department of Health. We assume that these decisions imply that the assessment of the health implications of public policies, and general aspects of health promotion, will become a major concern of the Department of Health. **We support this re-orientation of the Department's role,** which would be facilitated by the transfer of executive functions which we recommend in this report.

---

[5]National Economic and Social Council: *Social Planning in Ireland: Its Purpose and Organisational Requirements* (NESC No. 68) 1983

[6]National Planning Board: *Proposals for Plan 1984-87* (Stationery Office) 1984

[7]*Promoting Health Through Public Policy* (Health Education Bureau) 1987

[8]*Health — The Wider Dimensions* (Department of Health Consultative Statement) 1986.

RECOMMENDATIONS

16.32 We have made the following recommendations in relation to the areas discussed in this chapter.

1. General taxation is the appropriate source of funding for the regulatory and environmental functions of the Department of Health and its agencies, and for immunisation, screening and child health examination programmes provided by the public health services.

2. Comprehensive record systems should be used to ensure the required coverage of immunisation programmes. Immunisation under these programmes should be available free of charge to those in the target groups regardless of category of eligibility.

3. Screening programmes should be based on comprehensive record systems and epidemiological assessment and should be subject to continuing evaluation. They should be directed specifically at high-risk groups, to whom the services should be available free of charge.

4. The child health services should be reappraised and reorganised. No charge should be made for child health examinations.

5. All health education programmes should have specific goals, related to short-term behavioural change and long-term health indicator targets. A substantial portion of the resources available for health education should be devoted to evaluation of programmes and the refinement of evaluation techniques.

6. There should be particular concentration on devising and targeting health education programmes suited to the needs of low-income groups.

7. There should also be an emphasis in health education programmes on increasing public awareness of the appropriate use of medical services.

8. Responsibility for health education, as an executive function, should be assigned to the Health Services Executive Authority.

9. We support the reorientation of the role of the Department of Health towards the assessment of the health implications of public policies and general aspects of health promotion.

CHAPTER SEVENTEEN

WELFARE AND CONTINUING CARE SERVICES: GENERAL ISSUES

INTRODUCTION

17.1 Earlier chapters have discussed the services which cater for the medical needs of the population in general. Particular groups also need other forms of help and care as a result of disability, infirmity or social circumstances. Table 17.1 shows that the Department of Health and its agencies are responsible for a wide range of services to meet these needs, ranging from personal social services provided in the community to long-term residential care. The estimated total expenditure of around £500 million in 1987 should be regarded as an indicator of scale rather than a precise costing for the reasons set out in the footnote to the Table.

17.2 Public policy in other areas, such as housing and social welfare, is also concerned with the special needs of these groups. We regard our terms of reference as excluding detailed consideration of public expenditure outside of the health programme, but the question of coordination of the various services must be examined.

17.3 The welfare and continuing care services comprise those which are needed in the main by patients or clients on a continual or long-term basis. They may have both a social and a medical dimension in varying proportions. Chapters Eighteen and Nineteen deal with a number of broad groupings of these services: those for the elderly, mothers and children, the disabled, the long-term psychiatrically ill and health board income support schemes. This chapter discusses some general issues common to all of these services i.e.

— the assessment and provision of the appropriate form of care;
— eligibility for services and the role of charges;
— the administration and coordination of services; and
— the role of voluntary organisations.

Some detailed issues specific to individual services are discussed in Chapters Eighteen and Nineteen.

TABLE 17.1.
PUBLIC EXPENTITURE ON
WELFARE AND CONTINUING CARE SERVICES

Service	Expenditure 1987 (£m)	
COMMUNITY SOCIAL SERVICES		18.0
Home Helps	6.5	
Meals on Wheels	1.6	
Grant to Voluntary Welfare Agencies	9.9	
COMMUNITY NURSING SERVICES[1]		21.2
RESIDENTIAL CARE OF THE ELDERLY		82.9
Welfare Homes[2]	7.8	
Long-Stay Hospitals[2]	60.1	
Contribution to Patients in Private Homes	15.0	
MOTHER AND CHILD SERVICES		11.6
Milk for Mothers and Children	1.0	
Pre-School Support Services	0.5	
Boarding-Out of Children	2.7	
Payment for Children in Residential Homes	6.7	
Adoption Services	0.6	
Family Planning	0.1	
CASH GRANTS AND ALLOWANCES		65.3
Income Maintenance	59.3	
Other	6.0	
MENTAL HANDICAP SERVICES		113.5
Care in Special Homes	77.3	
Care in Psychiatric Hospitals	28.6	
Care in Day Centres	7.6	
PHYSICAL HANDICAP SERVICES		19.3
Assessment and Care	16.0	
Rehabilitation Service (relates to mental handicap also)	3.3	
PSYCHIATRIC SERVICES[1]		158.2
TOTAL NON-CAPITAL		490.0
CAPITAL EXPENDITURE		10.0
Community Welfare Programme	0.9	
Psychiatric Services	4.9	
Services for the Handicapped	4.2	
TOTAL EXPENDITURE		500.0

Source: Estimates for Public Services (1988).

1 It is not possible to disaggregate the costs of all Programmes into acute and longer-term services. Elements of the expenditure shown for community nursing and psychiatric care relate to acute treatment, while some of the costs of meeting needs which are non-acute in nature are taken into account under expenditure headings other than those included in the Table.

2 Gross expenditure before deduction of income from patients' contributions.

17.4 The provision of care in the most appropriate setting, taking into account the welfare of the patient and the cost-effectiveness of the service, has been a major issue in healthcare for some considerable time. The need has been recognised, particularly in relation to long-term care, to reduce the emphasis on institutional services by strengthening those in the community. This does not imply that there is no role for hospitals and other institutions in the provision of non-acute care. It is accepted that the institutional setting will continue to be the most appropriate, on grounds of both patients' welfare and cost-effectiveness, for those with certain levels of dependency. Those cared for in the community will also have a continuing need for access to out-patients' services and, in some cases, residential care from time to time to allow for family circumstances. The delivery of appropriate care thus involves *complementary* roles for institutional and community-based services.

17.5 It has been submitted to us that, because of inadequate community-based services, there are, at present, elderly people in hospital, often in acute beds, where this is unnecessary on medical grounds; handicapped people in homes and psychiatric hospitals who would achieve more of their potential if given the opportunity of leading a more "normal" and independent life; and children in residential care who would develop better in a family environment. Although these deficiencies are widely recognised, the solution to them is not simply the expansion of certain services at the expense of, or in addition to, other existing ones. The essential first stage is to have adequate assessment and evaluation procedures, at both the aggregate level and for each individual case, to determine exactly what form of care is appropriate. The second stage of the solution is to ensure the availability, when and where required, of the most appropriate services.

Assessment

17.6 If appropriate care is to be provided, it is clearly necessary first of all to establish what form it will take in different circumstances. This requires continuous evaluation of the possible responses to different needs, these needs having been ranked according to levels of dependency, and social and other circumstances. The appropriate response in each case will be determined by the relative costs and impact on the patient's welfare of the alternative approaches.

17.7 We are aware of some recent examples of the type of analysis which is required. Research carried out on behalf of the Department

of Health[1] shows that mentally handicapped persons with low levels of dependency can be cared for at a lower cost through the use of day centres and small hostels than in the traditional setting, and that the capital costs involved in providing these services would be recouped quickly from reduced running costs. Residential care for the more severely handicapped would continue to be necessary on the grounds of both welfare and cost-effectiveness. The National Council for the Aged has told us of its current involvement with the Economic and Social Research Institute in a comparative study of the costs of caring for elderly persons in the community and in institutions.

17.8 **We recommend that the evaluation of the relative costs and the effects on patient welfare of alternative forms of care for different client groups should be an ongoing, integral part of the planning of services.** The organisation of research and evaluation in the health services has been discussed in detail in Chapter Ten.

17.9 The assessment procedures at the level of the individual case are also of crucial importance. Uniform procedures are required in the interests of equity and efficiency. *The criteria which have been used to determine the appropriate forms of care at a national level, such as dependency and social circumstances, should also be used in individual cases to ensure that the appropriate response matches each category of need. However, those carrying out the assessments must be given some degree of flexibility to take account of factors in individual cases which may make it desirable to depart from the formal criteria.* It is clear that in some cases single, rather than regular, assessments would be most appropriate where the condition of the patient or client will clearly not change. The frequency with which eligibility for allowances or other services is reviewed should therefore relate to the nature of the condition and the likelihood that it will alter.

Provision

17.10 Once the appropriate form of care has been determined, the services must be in place to provide it. If inadequate support services are available in the community, heavy burdens may be placed on patients and family carers and residential care may become necessary when it could have been avoided. In recent years, a number of reports have examined the various welfare and continuing care

[1]D. Brennan: *Cost-Effectiveness Study of the Mental Handicap Services* (unpublished, 1987).

services.[2] All have concluded that the community-based support services need to be strengthened. Some examples of the apparent underdevelopment of these services are outlined in the following paragraphs.

17.11 *Community nursing* is a key service in maintaining the elderly and other groups in the community rather than in institutional care. As discussed in Chapters Fourteen and Sixteen, the present workload also includes home nursing of acute patients, child health examinations and health education. The definition of the workload appears to be such that routine visiting of the elderly and other groups requiring long-term supportive care is greatly restricted.

17.12 *Community social workers* have a role in the care and protection of children at risk and in difficult family circumstances; in the care of discharged psychiatric patients; in assisting families to care for handicapped members; in the care of the elderly in the community; and in the special needs of particularly deprived groups. The demand for their services appears in recent years to have grown well beyond their capacity to meet it, so that their role at present is limited to crisis intervention, almost exclusively in the area of childcare and family casework. Certain voluntary organisations for the mentally, sensorially and physically handicapped employ social workers, so that services are available to these groups in some areas but not in others. The general unavailability of services to the elderly and the mentally ill may result in the "medicalisation" of social problems and in increased general practitioner, drug and hospital costs as a result.

17.13 The *home help service* is geared towards the needs of the elderly but could also be effective in relation to families caring for the handicapped and for families in difficult social circumstances where children may be at risk. While the Health Act, 1970 *empowers* health boards to provide the service, it does not *oblige* them to do so. Some boards employ home helps directly while most give grants to voluntary bodies to organise the service. At present, it appears that home helps are available to no more than a small proportion of elderly people living alone, and are virtually unavailable outside that group.

---

[2]National Economic and Social Council: *Major Issues in Planning Services for Mentally and Physically Handicapped Persons* (NESC No. 50, 1980); *Green Paper on Services for Disabled People: Towards a Full Life* (Stationery Office, 1984); *Report of a Study Group on the Development of the Psychiatric Services: Planning for the Future* (Stationery Office, 1984); *Report of the Committee on Social Work* (Department of Health, 1985); National Economic and Social Council: *Community Care Services: An Overview* (NESC No. 84, 1987); *Report of the Working Party on Health and Welfare Services for the Elderly* (Stationery Office, 1988).

17.14 *A meals service* can be important in maintaining the independence of a relatively immobile person. They are provided almost entirely by voluntary groups who are grant-aided by health boards. They are generally available only in urban areas where voluntary groups are active, although in some cases elsewhere health boards arrange for the provision of meals by neighbours.

17.15 *Day centres* help to ease the burden on caring relatives while making a range of non-medical services available to their clients. They are thus of considerable value in the care of the elderly, the handicapped and children with family difficulties. However, there is no legal obligation on health boards to provide them; the majority of centres are operated by voluntary bodies with grants from health boards. The development of the service appears to be uneven and generally inadequate.

17.16 There have been a number of recent developments which would also help to support family carers and thus avoid the need to substitute for them. Some institutions offer short-term residential care in *relief beds*, to provide breaks for family carers or when short-term crises arise. There have also been successful experiments with temporary *boarding-out* schemes for mentally handicapped children, to provide holiday breaks for their own families. Another successful experiment involved the use of *care attendants* to provide assistance for handicapped persons at a level between the support provided by community nurses and by home helps.[3]

17.17 In principle, the case for strengthening these various support services appears to be universally accepted. In practice, there appears to be little development; the reasons are likely to include the overall financial constraints, the discretionary nature of many of the services (in the sense that health boards are not obliged to provide them) and the more visible needs of the acute services. However, failure to develop adequate support services is likely to prove a false economy in the long-run. As the National Planning Board has pointed out:

> "It would be foolish to build a strategy of community care on the assumption that existing levels of informal care will continue to be available without taking steps to facilitate and support its provision. It is unlikely that informal care of elderly and other relatives will be forthcoming in future without some minimum guaranteed access to support services in the community, such

[3]These schemes are described in detail in National Economic and Social Council (1987): *op cit.* Chapter 5.

as more extensive home-nursing, social work and home help services".[4]

17.18 The general approach to the planning and provision of services which we have recommended throughout our report is clearly of particular importance in this area. **Decisions on what services should be provided, and to whom, should be taken at national level on the basis of objective assessment of needs and the appropriate response to them within the overall resource constraint. They should then be implemented on the basis of uniform criteria in all areas.** Flexibility at local level should enable services to be targeted on the needs of particular client groups. This flexibility should not, as at present, result in marked variations from area to area in the level of service available to those with similar needs and in similar circumstances.

Transition Funding

17.19 Although care in the community may be established as more appropriate than institutional care for a particular category of patient, a practical obstacle may arise at local level because, in the short-term, additional expenditure is needed to bring about a shift from one form of care to the other. The transfer of patients from one setting to another must be phased; many may have become institutionalised to the extent that they are not suitable for transfer. A period of parallel operation is thus required, during which community services are building up but the overhead costs of the institutional services remain. There may also be capital costs associated with the development of the community services.

17.20 At present, health boards receive a global allocation for the provision of the services for which they are responsible. Any additional services which are required in the short-term to permit a shift from institutional to community-based care must be found from within the existing allocation. This can present a serious obstacle to the implementation of the desired policy at local level.

17.21 It has been submitted to us that there is a case for "transition funding" in certain circumstances to overcome such obstacles. It is argued that this would reinforce the commitment to community-based services and give health agencies a financial incentive to develop the required services in their areas, whereas there may at present be a financial disincentive. We see merit in this argument,

[4]National Planning Board: *Proposals for Plan 1984-87* (Stationery Office, 1984) pp. 313-314.

but it should be a matter for the Executive Authority itself to decide how to distribute its resources to achieve the required objectives.

ELIGIBILITY AND CHARGES

17.22 Health boards are legally obliged to provide hospital services, and the entire population has a legal entitlement to avail of them. However, there is no legal obligation on health boards to provide many of the community-based services which may keep patients out of acute hospitals or long-term residential care, and consequently no legal entitlement to avail of them. This results in variations in the provision of these services from area to area and in the criteria for access to them. This situation is clearly not cost-effective; nor is it equitable that those with objectively similar needs have different access to services depending on factors such as where they happen to live.

17.23 We have recommended that services should be provided on the basis of uniform criteria in all areas. This would require the establishment of formal eligibility criteria. However, there is also an important role for the assessment of the extent of dependency and the social circumstances of the recipient by field personnel such as community nurses and social workers, so that some element of discretion would be required in individual cases. The general question of assessment of eligibility for the various health services has been discussed in detail in Chapter Seven.

17.24 In addition to the question of *uniformity* of eligibility criteria, it is also important to consider the *extent* of eligibility. Some of the services under discussion are aimed at the welfare of groups who are clearly unable to provide for their own needs, such as the severely disabled or families in difficult circumstances. Recipients are predominantly in low-income groups. Many of the services, however, are of potential value to those in various income groups. **Since such services help to keep in the community those for whom residential care might otherwise be necessary, it would seem preferable to have wide eligibility for them, with contributions to their cost from those in a position to pay, rather than to have greatly restricted eligibility.**

17.25 There is considerable scope for contributions from recipients to the costs of certain services, where they have the means to make them. For example, those in long-term care who have pensions already pay a charge for their maintenance. The Health Act, 1970 provides that charges may be levied in respect of home help services, and it is understood that arrangements vary from board to board.

Voluntary organisations providing meals-on-wheels services usually charge a small fee to the beneficiary. We have already recommended in Chapter Fourteen that it would be appropriate to make a charge for home nursing provided to those patients who would be liable for hospital charges.

17.26 **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 in all areas on the basis of uniform guidelines, which would provide for the exercise of discretion in the levying of charges in individual cases where hardship would otherwise result.**

ADMINISTRATION AND COORDINATION

17.27 Under the organisational structure which has operated since their inception in 1971, the work of each health board is divided into three broad programmes covering Community Care Services, General Hospital Services and Special Hospital Services. The services for the client-groups with which we are concerned in this chapter are mostly provided under the Community Care Programme, but cut across all three. Institutional services (and indeed many community-based services) for the mentally ill or mentally handicapped are organised under the Special Hospitals Programme, while residential or day hospital care for the elderly is provided under the General Hospital Programme in many health boards. There has been some development of the concept of providing all services for specific client-groups under one administrative structure. For example, the North Western and Midland Health Boards have made district coordinators responsible for all services for the elderly.

17.28 Each health board is divided into a number of Community Care areas, of which there are 32 in all with an average population of a little over 100,000. The Medical Officer of Health for the area also serves as Director of Community Care. The expectation behind the creation of the post of Director of Community Care/Medical Officer of Health was to emphasise the commitment to plan and deliver a comprehensive range of services through multi-disciplinary teams. However, there is widespread acceptance that the proposed multi-disciplinary approach has not fulfilled these expectations. Recent reviews of the delivery of community care services by

Inbucon Management Consultants,[5] on behalf of the Department of Health, and by the National Economic and Social Council,[6] both highlighted a number of organisational barriers to the effective operation of the approach, which have also been raised in submissions made to us by various individuals and organisations. These problems include

— a medical orientation in the management of the Community Care teams, to the extent that the effectiveness of the non-medical personnel is hampered;

— difficulties and tensions in the working relationships within teams, associated with a lack of clear objectives, clarification of team members' roles and opportunities for team members to contribute to planning and management decisions concerning the services which they deliver;

— a disinclination of some professionals to take direction from professionals in other disciplines; and

— inadequate coordination between the services provided under different programmes.

17.29 We argued in Chapter Nine for experimentation with different approaches to the division of responsibility for the delivery of services at local level. It is clear that the concept of the Community Care team approach needs to be replaced, but the best approach will only emerge when alternatives have been tested and, indeed, varying approaches may be best suited to different areas. **Under any effective approach, however, the roles, objectives and accountability of all personnel must be clearly defined and problems of coordination between services must be removed. The approach must also allow for effective coordination and channels of communication between case-workers and general practitioners.**

17.30 Health and welfare services provide only part of the range of assistance needed by dependent people. Housing, transport and income maintenance services, for example, are also of great importance. The level of coordination between those providing these services varies considerably. Cooperation between health boards and local authorities, and voluntary organisations where relevant, has resulted in substantial improvements for the elderly in some areas, but in other areas little progress has been made. **Again, an effective**

[5]Inbucon Management Consultants: *Community Care Review Report for Department of Health* (1982, unpublished).

[6]National Economic and Social Council (1987): *op. cit.*

management approach must provide for proper coordination of all necessary services for the patients and client-groups concerned.

THE ROLE OF VOLUNTARY ORGANISATIONS

17.31 There are many hundreds of voluntary organisations providing welfare and continuing care services in Ireland. They range from large, national associations to small, community-based self-help groups; some employ considerable numbers of full-time professional and support staff, while others rely largely or wholly on volunteers. Public funding for their activities is made available under section 65 of the Health Act, 1953, which allows the funding of organisations providing services "similar or ancillary" to those provided by the statutory bodies, and under section 26 of the Health Act, 1970, which allows health boards to arrange for services to be carried out on their behalf. Some of the larger organisations are funded directly by the Department of Health, while grants to others are allocated independently by each health board, at its discretion. Many voluntary organisations also raise considerable funds themselves, although we cannot estimate the total amount involved.

17.32 The role of voluntary organisations is immensely important. They reflect and stimulate the community spirit and humanitarianism of very many people outside of the formal health services, and in so doing they make available considerable additional resources, both human and financial. They can also identify and meet needs quickly because of their closeness to the client-group which they serve; indeed, many services which are now provided or funded by the State were originally developed independently by such organisations.

17.33 However, there is no formal framework or procedural guidelines for the relationship between statutory and voluntary bodies so as to ensure their complementarity. While the relevant legislation permits the funding of services "similar or ancillary" to statutory ones, this has never been defined and is interpreted quite differently by various health boards. The discretionary nature of the funding, on a year-to-year basis, creates difficulties for voluntary organisations in planning their services, particularly if the employment of staff is involved. On the other hand, difficulties also arise for health board officials in seeking to coordinate the activities of voluntary bodies with the statutory services, because reporting relationships and standards of accountability appropriate to the provision of public funding have not been laid down.

17.34 The Inbucon review[7] identified an insufficient understanding and appreciation of each other's contribution on the parts of those in the statutory and voluntary sectors, which inevitably militates against effective cooperation, particularly in the field. Cooperation among voluntary organisations themselves was also found to be inadequate; Social Service Councils, which were set up in the 1970s to provide local coordination of voluntary activities, had only limited success. These are practical consequences of the absence of any framework under which each agency's role and relationship to the others could be made clear.

17.35 A further drawback to the present approach is a lack of comprehensiveness. Health boards arrange for voluntary organisations to take responsibility for the provision of certain services in their regions but some areas, or categories of client-group, may be unprovided for because of gaps in the service provision by the voluntary bodies.

17.36 It is clear therefore that an approach is needed which will ensure that all publicly-funded agencies, whether statutory or voluntary, work together in the most efficient and effective way, without jeopardising the independence and flexibility which are the voluntary organisations' most important attributes.

17.37 Under the recommended approach to the management and provision of services which we set out in Chapter Nine, uniform guidelines would apply in all areas as to the appropriate level of services to meet specific needs. **Those responsible for the management of services in each region should, with the involvement of the voluntary organisations, determine the services required to meet these guidelines both in respect of the needs in their area and the most effective provision of these services, through the use of the available voluntary and statutory services. The grant-aid to each voluntary organisation in each area should be related to the provision of a specific agreed level and type of service; the inter-relationship in the field between statutory and voluntary workers (and between voluntary workers of different organisations) should be clearly set out; and there should be an agreed basis for the evaluation of each agency's contribution.**

17.38 While the funding of voluntary organisations in relation to services in each region would thus be the responsibility of the area

[7]Inbucon Management Consultants: *op. cit.*

management, the Health Services Executive Authority would deal with those organisations in relation to national activities such as research and education. They would also contribute to the development and ongoing review of policies by the Minister for Health and his Department.

17.39 Both the National Planning Board[8] and the National Economic and Social Council[9] have argued that public funding of voluntary organisations should be on the basis of medium-term contracts for the provision of specific services for periods of three to five years. The approach outlined above effectively implies a contractual relationship, since funding would be on the basis of clear agreement on the services to be provided in return. We agree that the annual funding cycle and the associated uncertainty about continuity is detrimental to the planning of services. **We recommend that agreements with voluntary organisations should be on the basis of medium-term contracts, subject to continuing evaluation of the level and quality of service provided.**

RECOMMENDATIONS

17.40 The following recommendations have been made in this chapter:

1. The evaluation of the relative costs and the effects on patient welfare of alternative forms of care for different client groups should be an ongoing, integral part of the planning of services.

2. Decisions on what services should be provided, and to whom, should be taken at national level on the basis of objective assessment of needs and the appropriate response to them within the overall resource constraint. They should then be implemented on the basis of uniform criteria in all areas.

3. The criteria which have been used in determining the appropriate forms of care at an aggregate level, such as dependency and social circumstances, should also be those used in individual cases to ensure that the appropriate response is matched to each category of need. However, those carrying out the assessments must be given some degree of flexibility to take account of factors specific to individual cases which may make it desirable to depart from the formal criteria.

---

[8]National Planning Board: *op. cit.*
[9]National Economic and Social Council (1987): *op. cit.*

4. 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 national level. They should be implemented in all areas on the basis of uniform guidelines which would provide for the exercise of discretion in the levying of charges in individual cases where hardship would otherwise result.

5. Responsibility for the management and delivery of services at local level should be such that the roles, objectives and accountability of all personnel are clearly defined and that there is effective coordination between all relevant services.

6. The grant-aid to voluntary organisations in each region should be related to the provision of a specified agreed level and type of service; the inter-relationship in the field between statutory and voluntary workers should be clearly set out; and there should be an agreed basis for the evaluation of each agency's contribution. Agreements with voluntary organisations should be on the basis of medium-term contracts, subject to continuing evaluation of the level and quality of service provided.

CHAPTER EIGHTEEN

SERVICES FOR THE ELDERLY

INTRODUCTION

18.1 In Chapter Seventeen we discussed the general principles which should govern the assessment of need for welfare and continuing care services and the way in which they should be administered and co-ordinated. In this chapter we apply these principles to services for the elderly in particular. We discuss existing and probable future demand, the provision of certain services, the scope for partial funding of public services by those who use them and the role of the private sector.

18.2 The gross public expenditure on long-term residential care for the elderly, as detailed in Table 17.1, was almost £83m in 1987. When account is taken of the cost of home help and meals on wheels services, and some element of the expenditure on grants to voluntary welfare agencies, community nursing and psychiatric services, it is estimated that annual public expenditure on the welfare and continuing care of the elderly, excluding acute hospital, general practitioner and medicine costs, is in excess of £100 million. There is also substantial private expenditure by voluntary groups concerned with the welfare of the elderly, by elderly persons on their own healthcare and on payments to private nursing homes.

18.3 The health and welfare needs of the elderly[1] vary almost as widely as those of the population as a whole. While utilisation of medical services by the elderly in general is naturally greater than the average for the population as a whole, the majority of those over 65 are not dependent on welfare or continuing care services. The level of dependency does increase considerably, however, at more advanced ages.[2]

18.4 Table 18.1 provides data for selected years, on patients resident in long-stay geriatric units, including welfare homes and

[1]The 1986 Census showed that 384,000 people, 10.8 per cent of the total population, were aged 65 years or more.

[2]144,000, or 4.1 per cent of the population, were 75 years or over in 1986.

TABLE 18.1

LONG STAY GERIATRIC UNITS, SELECTED YEARS

	1980				1983				1986			
	Health Board Geriatric Hospitals/ Homes	Health Board Welfare Homes	Private Nursing Homes	Total	Health Board Geriatric Hospitals/ Homes	Health Board Welfare Homes	Private Nursing Homes	Total	Health Board Geriatric Hospitals/ Homes	Health Board Welfare Homes	Private Nursing Homes	Total
Number of Beds	7,541	1,185	4,700	13,426	7,586	1,451	5,668	14,705	7,302	1,509	6,422	15,233
Number of Patients Resident on 31 December	7,095	1,127	4,518	12,740	7,063	1,389	5,104	13,556	6,804	1,436	5,980	14,220
Age Distribution (%)												
— Under 65	12.0	8.2	3.5	8.6	9.5	6.9	4.6	9.5	8.7	7.0	3.8	6.5
— 65 — 74	27.1	26.4	14.3	22.5	25.7	25.1	20.0	23.5	25.1	23.0	15.9	21.0
— 75 and Over	60.4	62.8	71.0	64.4	64.8	68.0	67.0	65.9	66.3	70.0	76.0	70.7
— Not Stated	0.6	2.6	11.2	4.5	0.0	0.0	8.4	3.2	0.0	0.0	4.3	1.8
Distribution by Cause of Need for Care (%)												
— Social	17.2	68.4	17.5	21.9	15.8	65.2	18.7	21.9	16.3	64.7	41.3	31.7
— Acute Illness	5.5	0.2	2.5	3.9	4.8	0.7	3.6	3.9	3.5	18.2	3.4	3.3
— Chronic Illness	55.6	14.5	34.0	44.3	64.0	20.4	36.4	49.1	64.1	1.9	36.1	47.7
— Terminal	2.5	0.6	2.5	2.3	3.5	1.6	3.2	3.2	4.2	0.8	2.9	3.3
— Mental Handicap	4.2	1.2	1.4	3.0	3.7	1.7	1.9	2.8	3.1	2.3	1.0	2.1
— Chronic Psychiatric	3.8	8.1	2.3	3.6	5.5	8.5	6.0	6.0	5.8	10.2	4.9	5.8
— Other or Not Stated	11.1	7.0	39.8	21.0	2.8	1.9	30.4	13.1	3.0	1.8	10.6	6.0

Source: Long Stay Geriatric Unit Statistics, Department of Health 1980, 1983, 1986

TABLE 18.2

POPULATION PROJECTIONS ('000)

NCA projections	1991	1996	2001	2006	2011	Actual 1986 population
Over 65	388	387	386	397		384
Over 75	150	155	158	159	–	144
Over 80	70	76	78	81		68
DKM projections						
Over 65	392	395	387	390	414	
CSO projections						
Over 65	394	395	395	405	437	

SOURCES: National Council for the Aged: Housing of the Elderly in Ireland (1985).

DKM Economic Consultants: Ireland's Changing Population Structure (1987).

Central Statistics Office: Population and Labour Force Projections 1991-2021 (1988).

Actual 1986 population data: Census of Population

nursing homes. The number involved has risen from 12,740 in 1980 to 14,220 in 1986. Some private nursing homes do not respond to the Department of Health survey on which this data is based, but it is understood that about 95 per cent of all long-stay geriatric beds are covered. This suggests that there are in all about 15,000 patients in such accommodation. There are also about 3,600 elderly persons in psychiatric hospitals for more than one year.[3] There is also at any given time an unspecified number of elderly patients in acute hospital beds, not on medical grounds but because neither suitable accommodation nor adequate support services in the community are available. The average number of elderly patients receiving long-term residential care could thus be about 20,000. In addition, it is estimated[4] that there are some 66,000 elderly persons in the community who require some level of care, and that 50,000 of these are looked after by members of their households.

18.5 While the number of people aged 65 or more will increase to a moderate extent over the next twenty years,[5] the numbers reaching advanced old age will grow more rapidly. Table 18.2 details the

[3]Estimate supplied by Department of Health.

[4]National Council for the Aged: Quoted in submission to Commission on Health Funding.

[5]The DKM and CSO studies predict that those over 65 will represent about 11.6% of the population in 2006. However, by 2021 the CSO predicts an increase to 16%.

results of three recent sets of demographic projections. The projections published by the National Council for the Aged pre-date the 1986 Census; those of DKM Economic Consultants are based on preliminary 1986 Census data, and on the medium range of a number of assumptions about emigration. The CSO study uses the final results of the 1986 Census, based on its own assumptions regarding emigration and fertility.

18.6 The relatively sharp increase in the numbers aged 75 and over will have a significant impact on the demand for geriatric services; as shown in Table 18.1, this age-group uses the most long-stay geriatric beds. On the basis of existing utilisation patterns, DKM Economic Consultants estimate that their projections imply a 7 per cent growth in the demand for geriatric services between 1986 and 1996, with an unchanged level of demand between 1996 and 2011. However, the regional distribution of this growth will be very uneven. The National Council for the Aged includes in its projections a county breakdown which forecasts, for example, a growth of 28 per cent in the numbers aged 75 or over in the Eastern Health Board area between 1986 and 2006. Pressure on services in particular areas will thus be even greater than the national projections would indicate.

SUPPLYING THE APPROPRIATE LONG-TERM CARE

18.7 Chapter Seventeen discussed the *principles* that should apply both in assessing the appropriate form of long-term care required in individual circumstances and in providing that care. Chapter Nine described the responsibility of the Health Services Executive Authority and its Area General Managers in planning and delivering services. In this section we consider issues of particular relevance to the *provision* of services for the elderly.

18.8 The proper co-ordination of services is important to everyone using them, but has a special impact on people who cannot easily travel or fend for themselves. The National Economic and Social Council study[6] concludes that services for the elderly are at present dependent on isolated action from diverse sources, and the recent report of the Working Party on Health and Welfare Services for the Elderly[7] also points to the tendency of service providers, both statutory and voluntary, to work independently of one another. It

[6]National Economic and Social Council: *Community Care Services: An Overview* (NESC No. 84, 1987).

[7]*The Years Ahead ... A Policy for the Elderly: Report of the Working Party on Health and Welfare Services for the Elderly* (Stationery Office, 1988). Described throughout this chapter as "the Working Party".

recommends that the co-ordination of services for the elderly should be assigned to a liaison nurse for each "district" (a sub-division of the present community care area) and that health boards should appoint a Co-ordinator of Services for the Elderly in each community care area. This is one example of how the varied experimental approaches to local management structures that we have recommended in paragraph 9.70. might be implemented.

18.9 A crucial element in the future provision of services for the elderly is the development of adequate support services for those who can remain in the community. We have already referred to the shortfalls in this area in Chapter Seventeen and also to the value and cost-effectiveness of home helps, the provision of meals services, day centres and other facilities which assist independent living. The absence of these services gives rise to unnecessary admissions to institutions, delays in discharges from acute hospitals and hardship for many elderly people who are badly in need of care. Table 18.1 shows that about one-third of those in long-stay geriatric beds have been admitted for social rather than medical reasons i.e. their inability to continue living independently in the community. The Working Party report discusses the importance of these and other community oriented services and suggests the steps necessary for their expansion and development.

18.10 Some elderly people will, of course, continue to need a form of extended care that cannot be provided in the community. The Working Party has recommended that a number of the institutions currently providing this care, such as geriatric hospitals and homes, long-stay district hospitals and welfare homes be developed as *community hospitals*. These would provide assessment and rehabilitation services for elderly persons, convalescent care, day hospital and/or day care services, advice and respite care to support caring relatives, and facilities for nursing highly dependent or terminally-ill elderly patients who can no longer be cared for at home. The community hospital concept deliberately blurs the distinction between "community" and "institutional" services and illustrates the continuum of care that should exist between the two.

18.11 The Working Party report also emphasises the importance of assessing the need for care and determining its most appropriate form:

> "It is critical to the success of extended care facilities that before admission every elderly patient has been assessed as in need of these facilities by professional staff. In those parts of the country where assessment prior to admission to long-term

care is routine .... much more effective use is being made of the long-stay beds than in those areas where admission is still from waiting lists".

This is strongly in keeping with the principles which we set out in Chapter Seventeen regarding the need for assessment and provision of appropriate care.

CHARGES FOR SERVICES

18.12 The legislation which empowers health boards to charge for long-term residential care distinguishes two categories of service:

(i) *Institutional Assistance* is defined in the Health Act, 1953 as shelter and maintenance in a county home or similar institution. Charges may be imposed on all persons with personal means, with effect from the date of admission. While the 1965 Regulations providing for such charges (and not subsequently updated) allow residents a personal income of up to £1 per week, health boards in practice allow around £9 or £10, representing about 25 per cent of pensions, and retain the balance.

(ii) *Institutional Services* are defined in the Health Act, 1947 as including maintenance, diagnosis, advice and treatment and the supply of appliances, medicines, etc. The Health Act, 1970 provides for charges to persons receiving "In-Patient Services", defined as "institutional services provided for persons while maintained in a hospital, convalescent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto". The 1970 Act allows charges to be made for these services, but specifically excludes those with full eligibility i.e. those entitled to a medical card. Unlike institutional assistance, charges may be levied only where the patient has no dependants and has been in care for thirty days (or a total of thirty days in any twelve-month period).[8] Prior to December, 1987 the period was ninety days. In practice, the same level of charges as those for institutional assistance applies i.e. about 75 per cent of pensions are retained in the form of a charge for in-patient services and patients keep the remainder.

18.13 The distinction between the two categories of service gives rise to confusion and differences of interpretation. The intention appears to be to distinguish between non-medical and medical

[8]In addition, a daily charge of £10 for the first 10 days of in-patient services was introduced in 1987, but medical card holders are exempted.

services. However, it is not always possible to categorise a patient as receiving one or the other; elderly patients receiving care and maintenance will also tend to require some level of medical attention. It is understood that, in practice, charges are levied from the date of admission if patients are identified as potentially long-stay at time of admission to geriatric, psychiatric or long-stay institutions and that these charges apply to all those with personal means, regardless of category of eligibility.

18.14 **We recommend that the law should be revised to specify clearly the circumstances in which charges are payable and to standardise the amount of personal allowable income above which the charges would be levied.**

18.15 Most of the elderly in health board long-stay institutions have limited means and there is unlikely to be room for any significant increase in income from this source over and above the present level of contribution. However, in the context of the general trend towards more substantial contributory-type pension schemes, there could be a higher proportion of the elderly in the future with significant financial resources capable of making some contribution to the cost of services. We have discussed the scope for charges for certain community support services in Chapter Seventeen.

PRIVATE PROVISION OF LONG-TERM CARE

18.16 Table 18.1 provides data on about 6,000 patients resident in private nursing homes; data for a small number of homes is not available. Private nursing homes operate under a registration system with minimum standards set down and monitored by the health boards. There are two categories: those approved by the Minister for Health for the provision of services on behalf of health boards, and others. The essential difference between the categories is that, under section 54 of the Health Act, 1970, patients who avail of approved nursing homes are entitled to a daily capitation payment on their behalf. Of the 5,980 patients included in Table 18.1 in 1986, 2,924 were resident in approved nursing homes and 3,056 in other private nursing homes. The daily rate of subsidy for patients in approved homes is, from 1 July, 1989, £6.78.[9] The non-approval of a home does not imply any deficiency in its operation. To control the total cost of the subsidy to those availing of such care, no new homes have been approved by health boards under section 54 for capitation payments since 1980, but the Eastern Health Board makes

[9]The estimate of £15m in Table 17.1 for the cost of contributions to patients in private homes includes subventions paid for short-term stays.

capitation payments under different arrangements. During this time, the number of private nursing homes has increased significantly.

18.17 The existence of a significant private nursing home sector may yield a number of benefits:

(i) elderly patients who are in a position to make their own arrangements benefit from a wider choice;

(ii) small homes, run by owner-managers and with flexible staffing arrangements, may have substantially lower overheads and running costs than public sector facilities; and

(iii) the public health services benefit from capital savings and increased flexibility because their need to provide residential places is reduced.

18.18 The principle of subsidisation of elderly patients in private nursing homes is, we believe, justifiable. Unlike the general public hospital services, publicly-provided long-term residential care for the elderly is not intended to meet the needs of the elderly population as a whole. The existence of the subsidy enables those with some private means to avail of nursing home care and is therefore cost-effective as it relieves the State of the greater expenditure which would be required if it had to provide additional public facilities.

18.19 However, we feel that the present arrangements for the subsidisation of these patients are neither equitable nor efficient. Health boards are required to pay a subsidy on behalf of any person who has secured a place in an approved home; those unable to obtain one of the limited number of such places are excluded from benefit. This is a highly arbitrary rationing device, particularly since there are no approved homes in certain areas and all homes opened since 1980 are excluded. It would be preferable to pay the subsidy on the basis of medical and social need, rather than on the patient's good fortune in obtaining a place in one home rather than another.

18.20 The Working Party recommended that section 54 of the Health Act, 1970 be amended to enable health boards to subvent the care of eligible elderly patients, after specified assessment procedures, in nursing homes licensed by the boards and to enable boards to vary the level of subvention according to individual needs. **We would agree with this recommendation. All registered private nursing homes should be approved for the provision of services on behalf of the Health Services Executive Authority, subject to regular inspection and monitoring of standards. However, a subsidy should be paid only in respect**

of patients who have been assessed as in need of residential care and there should be scope for varying the level of subsidy to take account of the degree of financial and medical dependence of the patient.

18.21 In addition to the payment of subsidies for those who opt for private care, health boards may also arrange directly for the use of places in private nursing homes, where sufficient accommodation is not available in health board institutions for those in need of places. While this will be more costly to the health board than the payment of a subsidy, it may still prove more cost-effective than the provision of additional accommodation. **We recommend that, in organising and coordinating services for the elderly in each area, full account should be taken of the scope for cost-effective utilisation of private nursing homes.**

18.22 Some elderly people are in relatively good health but because of infirmity are not able to lead a completely independent life. For these, it is obvious that even nursing home care may be unnecessarily illness-oriented; all they require is accommodation and non-medical assistance in daily living. In some cases, this could be provided for in homes without a substantial medical component or, on a smaller scale, in the homes of private individuals. At present, however, legislation governing private nursing homes requires the employment of nursing staff regardless of whether residents need medical care. While this is important in the case of elderly people needing such attention, it should not operate to hinder the provision of homes catering for non-medical cases. **The Commission recommends that the legislation governing private nursing homes should be sufficiently flexible to allow private nursing homes to operate without full-time nursing staff where they cater solely for persons not in need of regular medical attention.**

18.23 There is considerable international debate on the future financing of long-term care. The demand for such care is growing rapidly in most countries because of the ageing of their populations and also because changing social structures reduce the provision of family care. Private insurance arrangements, under which individuals would choose to pay over the course of their working lives for nursing care needed in their advanced old age, are feasible but may prove difficult to market because of the long time-horizon. There is also scope for arrangements under which the elderly owner of a house could draw on its capital value while retaining lifetime ownership.

18.24 The proportion of Ireland's population accounted for by the elderly will not increase substantially for some time. The opportunity should be taken, therefore, to study the experience of those countries at present coping with this type of demographic imbalance and the measures which they are adopting to deal with the consequent financing problems.

18.25 It has been suggested to us that, by increasing the level of research aimed at postponing the onset of certain types of diseases affecting the elderly, it may be possible to prolong the time before which the long-term care associated with such conditions is needed. In this way the individual would retain independence for a longer time while the costs of such research would be more than offset by savings in the provision of long-term care.

RECOMMENDATIONS

18.26 We have made the following recommendations in Chapter Eighteen:

1. Services for the elderly should be provided on the basis of the general principles set out in Chapter Seventeen regarding the assessment and provision of appropriate care. The recommendations of the Working Party on Health and Welfare Services for the Elderly regarding the need for greater co-ordination of services and for the development of community support and residential services should be judged in this context.

2. The law in relation to residential accommodation should be revised to specify clearly the circumstances in which charges are payable and to standardise the element of personal income which is allowed to patients before a charge is made.

3. All registered private nursing homes should be approved for the provision of services on behalf of the Health Services Executive Authority, subject to regular inspection and monitoring of standards. However, a subsidy should be paid only in respect of patients who have been assessed as in need of residential care, and there should be scope for varying the level of subsidy to take account of the degree of financial and medical dependence of the patient.

4. In organising and coordinating services for the elderly in each area, full account should be taken of the scope for cost-effective utilisation of private nursing homes.

5. Legislation governing private nursing homes should be sufficiently flexible to allow private nursing homes to operate without full-time nursing staff where they cater solely for persons not in need of regular medical attention.

CHAPTER NINETEEN

OTHER WELFARE AND CONTINUING CARE SERVICES

INTRODUCTION

19.1 Chapter Seventeen discussed issues relevant to a range of welfare and continuing care services and Chapter Eighteen focused on services for the elderly. This chapter is concerned with the special needs of mothers and children and services for the disabled and the mentally ill. Many of the points made in the previous two chapters are again relevant. Individual service needs are not covered in great detail; instead, some major issues are examined to see how they should be dealt with to achieve an equitable, comprehensive and cost-effective service. Again, the principles in Chapter Seventeen regarding the assessment and provision of appropriate care are fundamental.

SERVICES FOR MOTHERS AND CHILDREN

19.2 As in the case of all the other groups discussed, mothers and their young children absorb a proportion of acute healthcare expenditure. In addition, however, the special problems associated with low-income and disadvantaged families have long been recognised. These include the consequences of broken or inadequate families, single parents unable to cope and abused or neglected children. Some of these problems are covered by welfare services under the health system. They are considered in the paragraphs below.

Expenditure and Trends

19.3 Services for mothers and children are designed to support families in difficulty and to provide appropriate alternative care for children when it cannot be given by the family. Table 17.1 details direct expenditure by the Department of Health and the health boards of almost £12 million in 1987 in this area. In addition, a

considerable element of the grant-aid of almost £10 million to voluntary welfare agencies relates to family support and child care services. The health boards' social work services, which cost about £5 million, are also largely concerned with family problems. Thus, while we cannot arrive at a precise estimate, the overall annual cost of services for mothers and children may exceed £20 million. Further expenditure is incurred by voluntary agencies, financed by their own fund-raising.

19.4 Table 19.1 illustrates the growing demands on child care services and the increasing emphasis on foster care; the total number of children in care rose from under 2,500 to just over 2,700 between 1983 and 1987 of which the majority were fostered. In addition, 7,263 children were catered for in pre-school services assisted by health boards in 1987.[1] The demands on community support services for families in difficulty have been growing rapidly in recent years as a result of high levels of unemployment, the rising proportion of one-parent families, and a large increase in the number of child abuse cases reported.

TABLE 19.1

CHILDREN IN CARE, SELECTED YEARS

	1983	1984	1987
Fostered children (through health boards)	1,267	1,258	1,824
Children maintained in Residential Homes	1,186	1,105	882
Total	2,453	2,363	2,706

Source: Department of Health

Provision of Services

19.5 A major review of child care services was carried out by a Task Force[2] between 1974 and 1980. The Task Force highlighted many of the organisational deficiencies which we have already discussed in relation to welfare and continuing care services in general. These include insufficient coordination of services at national and local level; discrepancies in the extent to which needs were being met in different sections of the population; recourse to institutional care where the provision of support services to family

[1]Information supplied by Department of Health
[2]*Task Force on Child Care Services: Final Report* (Stationery Office, 1980)

care would have been preferable; and a general absence of data on which to base an assessment of the level of service required.

19.6 Many of the problems identified by the Task Force remain. While co-ordination at national level has been made easier by the transfer of responsibility for the various child care services to the Minister for Health and the numbers in institutional care have declined substantially, the recent National Economic and Social Council review[3] still concluded that progress in remedying the inadequacies identified by the Task Force has been slow.

19.7 Deficiencies have been identified in services for families in difficulty such as day care, creches and playgroups. While foster care has long been seen as preferable to placement in a residential home (other than in cases requiring special care or control) the service is still under-developed. The numbers in foster care have increased in recent years but both the Task Force and the National Economic and Social Council have emphasised the need for additional resources for the recruitment and preparation of foster parents and the provision of appropriate support services to them. Submissions to us have also stressed the value of placing a greater emphasis on a preventive approach through, for example, the development of community based self-help programmes and wider access to local classes on preparation for parenthood.

19.8 Many of the deficiencies outlined in the paragraphs above are closely related to the general issues discussed in Chapter Seventeen. As in the case of other groups, **we recommend that the development of services for children and families in difficulty should be based on a consistent approach to assessment and evaluation of need and the provision, when and where required, of those services judged most appropriate.**

Funding

19.9 Since the great majority of services for children and families at risk is directed at low income groups, we believe that the scope for funding of these services by the recipients is extremely limited. However, **we recommend that a contribution to the cost of services such as day care should be required, depending on income, on the basis of the principles discussed in paragraphs 17.22 to 17.26.**

---

[3]National Economic and Social Council: *Community Care Services: An Overview (NESC No. 84, 1987)*

19.10 An issue of importance to child care services in recent years has been the role of residential homes, most of which are operated by voluntary organisations. A small number are owned and operated by health boards. The homes have been funded directly by health boards on the basis of agreed budgets since 1984; this replaced an unsatisfactory capitation system. It has been submitted to us that some homes are over-selective in accepting placements, making it difficult to find accommodation for the more difficult cases. On the other hand, some of the voluntary organisations involved have submitted to us that they could not cope with children who would seriously disrupt the running of the home and cause strain to those already cared for there.

19.11 It would therefore seem that the relationship between the homes and their funders should be changed. Both parties should negotiate to supply care for the children who need it; the homes would become more accountable for the services they provide and the funders would make reasonably long-term contracts to ensure cover for difficult as well as easier cases. **We therefore recommend that Area General Managers should enter into formal contractual agreements with homes to ensure that the required range of care is available in each area. The homes would then be funded on the basis of an agreed level and type of service as described in paragraph 17.37.**

SERVICES FOR THE DISABLED

19.12 A Green Paper on Services for the Disabled[4] described the broad objective of services for those with physical, mental or sensorial handicap as being

> "to equip them to realise their full potential and to participate to the greatest extent possible in the life of the community."

Current policy emphasises the development of community-based alternatives to institutional care, reflecting the relatively recent recognition that the needs of all but the most severely disabled can more effectively be met in a less institutional setting.

Expenditure and Trends

19.13 The total expenditure under the Health Vote on welfare and continuing care services for the disabled exceeds £200 million per

[4] *Towards a Full Life: Green Paper on Services for Disabled People* (Stationery Office, 1984).

annum. As detailed for 1987 in Table 17.1, this includes £65 million on cash grants and allowances (which are discussed in a later section of this chapter); £113 million on the care of the mentally handicapped; £16 million in relation to the physically handicapped, £3 million on rehabilitation services and £4 million on capital expenditure. An element of the cost of community nursing and other community social services must also be taken into account. Many of these services are provided by voluntary agencies, with financial support from health boards or directly from the Department of Health. Expenditure in relation to the disabled is also incurred by other Government Departments, particularly Social Welfare, Environment and Education.

19.14 Spending on services for the handicapped has grown more rapidly than health expenditure in general. Table 4.4 indicates that it rose from 7.6 per cent of Department of Health gross expenditure in 1976, to 10.1 per cent in 1987. The main area of growth over this period was expenditure on care in special homes for the mentally handicapped, which increased by almost 150 per cent in real terms between those years. This growth reflects both an increased provision of facilities and an increased reliance on State funding by the voluntary agencies who developed and operate the services.

TABLE 19.2

EXTENT OF MENTAL HANDICAP, 1981.

Age	Degree of Handicap			Total
	Moderate	Severe	Profound	
0 — 14	2,204	850	242	3,296
15 — 34	3,622	1,637	494	5,753
35 — 54	1,559	612	97	2,268
55 and over	715	248	24	987
	8,100	3,347	857	12,304

SOURCE: Census of Mental Handicap, 1981.

Note: (1) The Census also identified 9,443 border-line or mildly mentally handicapped cases and 1,232 were returned with an unspecified degree of handicap.

(2) Data has incomplete coverage of children under 5.

TABLE 19.3

PLACING OF MENTALLY HANDICAPPED, 1985

	Degree of Handicap				
	Mild	Moderate	Severe	Profound	Total
Psychiatric Hospitals	578	737	560	156	2,031
Special Residential Centres	633	2,161	1,738	567	5,099
Hostels and Supervised Lodgings	285	355	121	12	773
Day Care Units	1,093	1,882	848	139	3,962
Total	2,589	5,135	3,267	874	11,865

Source: Department of Health

19.15 The value of available data on the extent of mental handicap in Ireland is variable. While the 1981 Census of Mental Handicap provides details of the extent of mental handicap classified by degree of severity (as summarised in Table 19.2) little information is available regarding the medical assessment of individuals, additional disabilities or other factors about their condition which would be relevant to the planning of services. Comparative statistics give an indication, however, of some general trends; the numbers of severely and profoundly mentally handicapped have been falling, while the incidence of moderate mental handicap and numbers of mentally handicapped overall, have been rising. Statistics indicate declines in younger age groups due, it is felt, to improved preventive measures, but numbers in middle age groups are expected to grow because of increased life expectancy.

19.16 Table 19.3 provides data on the numbers catered for by services for the mentally handicapped. The National Economic and Social Council's projections,[5] based on the 1981 Census of Population, suggested an increase of about 5 per cent in the demand for services between 1986 and 1991, whereas more recent projections[6] based on the 1986 Census suggest a fall of 1.5 per cent in demand between 1986 and 1996 and by almost 8 per cent between 1996 and 2011.

19.17 Data regarding the incidence and degree of physical disability is poor; while a physical handicap record system was initiated in 1983, progress towards completing it has been relatively slow. A similar record system for the mentally handicapped was established in 1979 and the emphasis at present is on building up information from community care area level.

---

[5]National Economic and Social Council: *Health Services: The Implications of Demographic Change (NESC No. 73, 1984)*

[6]DKM Economic Consultants: *Ireland's Changing Population Structure (1987)*

Provision of Services

19.18 The general issues discussed in Chapter Seventeen are, again, relevant to the provision of services for the disabled. Support services in the community are argued to be inadequate; there are marked variations in the availability of social workers and rehabilitation personnel, the majority of those working in the area being employed by voluntary organisations; and the community nursing and home help services are not geared to meeting the needs of the disabled.

19.19 A range of deficiencies in the provision of services for the disabled have been identified by various studies. In the case of residential care, the Green Paper[7] has referred to a need for a relatively small number of additional places for the physically disabled. Some progress has since been made in improving the quality of homes but the number of places has not increased significantly.

19.20 A related issue of concern is the placement of both physically and mentally handicapped persons in settings not best suited to their disability. We referred in Chapter Seventeen to a recent study[8] which suggests that the majority of mentally handicapped persons resident in psychiatric hospitals (1,600 out of 2,000) are suitable for transfer to community hospitals and residential centres and that about 1,900 of those in special residential centres require only hostel accommodation or, in some cases, day care. In addition, a number of physically disabled persons are unsuitably placed in psychiatric and orthopaedic hospitals, geriatric hospitals and homes, and centres for the mentally handicapped.

19.21 The mismatch between available residential facilities and actual needs illustrates the importance of assessment and provision of appropriate care. It also demonstrates how our recommendation in paragraph 17.8, regarding the evaluation of the effects on patient welfare of alternative forms of care and their relative costs, might be implemented. For example, the study summarised in Table 19.4 suggests that the transfer of suitable patients to less institutionalised settings could be cost-effective, and, at the same time, improve the well-being of the people concerned.

19.22 Further examples of the need for assessment and provision of appropriate services arise in the areas of day care and rehabilitation

---

[7]Green Paper: *op cit.*
[8]D. Brennan: *Cost-Effectiveness Study of the Mental Handicap Services* (Unpublished, 1987).

facilities. The National Economic and Social Council[9] noted a particular shortfall in day care places for the physically handicapped and suggested that they could be provided in conjunction with existing facilities such as community workshops and residential centres. This is in line with our emphasis on identifying the most appropriate and cost-effective approach to delivery of services.

TABLE 19.4

AVERAGE COST OF MENTAL HANDICAP FACILITIES, 1985

Degree of Handicap	Annual Cost per Person (£)		
	Hostels	Mental Handicap Centres	Psychiatric Hospitals
Mild	4,600	8,300	12,500
Moderate	9,200	10,500	12,500
Severe	17,800	16,500	19,000

Source: D. Brennan: *op cit.*

19.23 The Green Paper[10] recognised a shortage of places for sheltered employment in the country's rehabilitation services. The fact that grant-aid from the European Social Fund[11] is available only in respect of training for open employment may well have contributed to this problem. This again highlights the need to ensure that services are planned on the basis of the appropriate response to measured needs.

19.24 We have discussed the difficulty of co-ordinating services in Chapter Seventeen. This problem is particularly acute in the case of services for the disabled due to the number of agencies involved and the absence of an overall framework for planning and delivery. As we have recommended in paragraph 17.37, the management of services in each region and the definition of a clear inter-relationship between voluntary and statutory agencies (and within both) are essential to the achievement of effective co-ordination.

Funding

19.25 Services for the disabled are funded in disparate ways; some voluntary organisations are funded directly by the Department of

[9]National Economic and Social Council: *Major Issues in Planning Services for Mentally and Physically Handicapped Persons* (NESC No. 50, 1980) and NESC No. 84: *op cit.*

[10]Green Paper: *op cit.*

[11]Details of grants from the European Social Fund are in Table 4.1.

Health, some by health boards and others by a combination of both. Other services, such as psychiatric care, are provided directly by health boards in their own institutions. The direct funding of certain agencies by the Department of Health is, in some cases, due to a long-standing relationship pre-dating the establishment of health boards and, in other cases, because the service provided is nationwide or cuts across a number of health board boundaries.

19.26 Allocations are not normally related to the numbers and levels of handicap of those served; often they are based merely on a global budget which is adjusted incrementally. It has been claimed[12] that costs per patient in centres catering for similar clients vary widely and that some inefficient spenders have excess resources while their more efficient counterparts cope with chronic deficiencies.

19.27 **We recommend that appropriate costs per place for particular levels of handicap and type of care setting should be established, and agencies providing care funded accordingly by the Executive Authority through its local management structure. As recommended in paragraph 17.37, each voluntary agency should be funded on the basis of an agreed level and type of service.**

19.28 Organisations which are funded directly by the Department of Health have made it clear that they would be reluctant to see a change in this arrangement, because of the degree of inconsistency which they associate with health board funding. However, the approach which we have recommended would relate funding to the provision of a specific agreed level and type of service, on the basis of uniform national guidelines which would be developed in consultation with the Area General Managers of the Health Services Executive Authority and voluntary organisations. This would preserve the desirable features of the present funding arrangement which have been identified to us by the organisations concerned, namely consistency and continuity of funding, a level of internal autonomy and the involvement of the organisations in planning at national level.

THE PSYCHIATRIC SERVICES

19.29 A major review of psychiatric services was carried out by a Study Group between 1981 and 1984. Its report[13] laid down

[12]D. Brennan: *op cit.*

[13]*The Psychiatric Services — Planning for the Future: Report of a Study Group on the Development of the Psychiatric Services* (Stationery Office, 1984)

guidelines for future development, as far as possible in a community setting, with the emphasis and resources switching from large psychiatric hospitals to a range of alternative services based in the community and in acute general hospitals.

Expenditure and Trends

19.30 Table 17.1 shows that public expenditure under the psychiatric services programme (which excludes the cost of caring for mentally handicapped patients in psychiatric hospitals) exceeded £160 million in 1987, including some capital expenditure. Information is not available on expenditure in private hospitals. Data is also unavailable on private practice by psychiatric consultants in public hospitals, although we understand that its extent is quite limited.

19.31 In-patient treatment is provided in health board psychiatric hospitals, acute units attached to general hospitals and a small number of private psychiatric hospitals. Table 19.5 details admissions to and discharges from psychiatric hospitals and units in 1984. Most discharges were of patients in care for less than a year; the 1981 census of patients[14] showed that seventy-five per cent of available places were occupied by long-stay patients with the remainder catering for a high turnover of short-stay cases. Over 9,000 patients were resident for more than a year, of which the Department of Health estimates that three-quarters were there for over five years.

19.32 The main components of the community services, operated by each health board psychiatric hospital in its catchment area, are out-patient clinics, hostels and day facilities. Out-patient clinics are widespread in all health board areas and there were over 160,000 out-patient attendances (almost 9,000 of these being first attendances by new patients) at public psychiatric hospitals in 1985. However, there is considerable variation between hospitals in the extent to which hostels and day facilities have been set up.

Provision of Services

19.33 Statutory entitlements for psychiatric services are the same as for acute hospital care but VHI cover is limited to a total aggregate period of 91 days in the case of hospital maintenance and treatment for alcoholism and substance abuse (subject to reinstatement after five years in certain circumstances). This is significant because, as can be seen from Table 19.5, 25 per cent of all psychiatric

[14]Medico-Social Research Board: *Irish Psychiatric Hospitals and Units Census 1981.*

admissions and 40 per cent of those to private psychiatric hospitals, relate to alcohol abuse and alcoholic psychoses.

19.34 A distinction must be made between psychiatric services which cater for chronically ill patients requiring long-term care and those which provide treatment for once-off or recurring short-term conditions. There is, of course, a degree of overlap between the two. We believe that the approach to long-term psychiatric care should be in accordance with the principles set out in Chapter Seventeen. This involves the provision of residential care where necessary, in the appropriate setting, and of the necessary support services to those who can be cared for in the community.[15] In particular, we again emphasise, in the case of both short-term and long-term care, the importance of assessment and evaluation procedures in determining the appropriate form of care in each case, and in the planning and provision of such care.

19.35 As in the case of other client groups, we stress the importance of ensuring that community support services are in place for the psychiatric patients discharged from institutions. The discharge of patients to inadequate care, as has occurred in some countries, is an abdication of society's responsibility to the most vulnerable of its members, creates fear and distrust in the population generally and leads to additional costs for other public services. Again, the importance of assessing and providing appropriate care arises; it has been suggested to us, for example, that the shift to community services may, if not monitored, include a greater concentration of care on those with minor psychiatric problems to the detriment of the chronically ill. This underlines the need for adequate links between institutional and non-institutional services which would be made possible under the Commission's management proposals in Chapter Nine.

Funding

19.36 The Study Group[16] estimated that the implementation of their recommendations would cost in the region of £50 million in capital expenditure over a 10-15 year period, with a continuation of existing levels of non-capital expenditure. The age and condition of the existing psychiatric hospitals were found, in general, to be such that the expenditure required for their restructuring and replacement

[15]This approach is consistent with that recommended by the Study Group (*Planning for the Future* op. cit.).

[16]*Planning for the Future: op. cit.*

TABLE 19.5

ADMISSIONS TO PSYCHIATRIC HOSPITALS AND UNITS, 1986

Diagnosis	Health Board Psychiatric Hospitals	General Hospital Psychiatric Units	Private Psychiatric Hospitals	All Admissions
Organic Psychoses	913	136	171	1,220
Schizophrenia	4,597	1,005	508	6,110
Other and Unspecified Psychoses	81	45	1	127
Depressive Disorders	5,346	1,612	1,529	8,487
Mania	1,336	553	362	2,251
Neuroses	897	240	158	1,295
Personality Disorders	970	159	79	1,208
Alcohol Abuse and Alcohol Psychoses	4,734	815	1,583	7,132
Drug Dependence	164	70	19	253
Mental Handicap	440	47	9	496
Unspecified	679	48	86	813
ALL DIAGNOSES	20,157	4,730	4,505	29,392

Source: Aileen O'Hare and Dermot Walsh: *Activities of Irish Psychiatric Hospitals and Units 1986* (Health Research Board, 1989).

Note: (1) Coverage is complete with the exception of two general hospital psychiatric units.

(2) Of all discharges during 1986 (28,650) 97 per cent were of patients in hospital for less than one year.

if the Group's recommendations were not implemented would in fact be greater than this amount. The Study Group argued that investing on such a scale in psychiatric hospitals would be entirely inappropriate on medical grounds.

19.37 The recommended capital expenditure would involve the development of new community-based psychiatric facilities, including the provision of high support hostels for new long-stay patients. We understand that planning is proceeding in each health board area on the implementation of these recommendations, under the overall guidance of a Development Team including administrative and professional personnel.

19.38 While the Study Group identified sources such as the sale of land owned by psychiatric hospitals as a possible source of the capital funding required, the main proportion will have to come from public expenditure. The Study Group's conclusion that the restructured services can be operated without any increased revenue requirement depends crucially on the efficient transfer of staff and other resources from the psychiatric hospitals to the community services.

19.39 We discussed the scope for charges in relation to long-term care of the elderly in Chapter Eighteen; similar considerations apply to the long-term care of psychiatric patients with a source of income.

CASH GRANTS AND ALLOWANCES

Income Maintenance and Other Allowances

19.40 In Chapter Nine we considered but rejected the argument that all health and social welfare functions should be the responsibility of a single Department. We now consider the question of income maintenance as it affects the Department of Health and the health boards. The broad division of welfare functions between the Departments of Social Welfare and Health rests on the distinction between income maintenance services and personal social services. The Department of Health is, however, responsible for a number of cash grants and allowances, costing a total of £65.3 million in 1987, as detailed in Table 19.6.

19.41 The Commission on Social Welfare[17] recommended that three schemes intended to provide income maintenance: Disabled Person's Maintenance Allowance, Blind Welfare Allowance and Infectious Diseases Maintenance Allowance, should be transferred to the Department of Social Welfare in order to provide an integrated structure for all income support schemes. The Green Paper on Services for the Disabled[18] had previously criticised the administration of their income maintenance functions by the health boards and concluded that the centralisation of these functions within the Department of Social Welfare would be administratively desirable and advantageous to the claimant.

19.42 The Commission on Social Welfare also recommended that the cash allowances which served a community care objective rather than providing income maintenance should continue to be

---

[17] *Report of the Commission on Social Welfare* (Stationery Office, 1986).
[18] Green Paper: *op. cit.*

administered by the Department of Health and health boards. These schemes include the Domiciliary Care Allowance, Motorised Transport Grant and Mobility Allowance.[19] In the case of the latter, the Commission argued that the eligibility conditions were unnecessarily restrictive and that the scheme should be extended to include those who, because of their disability, are unable to avail of public transport.

19.43 **We support the recommendations of the Commission on Social Welfare in respect of these three schemes.** The proposals represent a logical division between standard income maintenance functions and those concerned primarily with community care objectives. **The Department of Health should therefore retain responsibility for policy related to the schemes while the Health Services Executive Authority should be responsible for their administration.**

Training Allowances

19.44 The report of the Commission on Social Welfare also recommended that the Disabled Person's Rehabilitation Allowance, payable to certain persons receiving training for open employment in community workshops and special training centres, should remain the responsibility of the Department of Health. After the publication of that report, the Minister for Health established a Working Group on Uniform Training Allowances for the Handicapped to enquire into the introduction of a uniform allowance for all disabled persons receiving training for *open employment*. Such an allowance would replace the various rates and types of payment made in different circumstances at present such as Unemployment Benefit, Unemployment Assistance, Disability Benefit and Disabled Person's Maintenance Allowance.

19.45 There is also a variety of allowances and rates of payment for persons in workshops providing *sheltered employment*. Payments vary between and within units, depending on the State allowance (if any) for which the individual is eligible. Because of the varying levels of activity and output in these centres, it would be very difficult to justify the application of similar conditions as apply to open employment. However, **we consider that payments for sheltered employment should be as equitable and consistent as possible throughout the country.**

---

[19]Domiciliary Care Allowance is intended to assist parents caring for handicapped children at home rather than placing them in residential care; Motorised Transport Grant contributes towards the cost of adapted motor vehicles for disabled people; Mobility Allowance is intended to assist in the travel expenses of those unable to walk.

Supplementary Welfare Allowance

19.46 The Supplementary Welfare Allowance, which is the income support scheme of last resort, is administered by the health boards from Department of Social Welfare funds. The work is carried out by Community Welfare Officers, who are also responsible for investigating and reviewing eligibility for medical cards and health board allowances. The Commission on Social Welfare found serious divergences between and within health boards in the interpretation by Community Welfare Officers of the discretionary aspects of the scheme. It argued that the scheme should be integrated fully into the Department of Social Welfare, including the transfer of Community Welfare Officers to the direct employment of that Department. It recognised that liaison between Community Welfare Officers and members of other professions such as social workers or public health nurses would be necessary, but the report did not consider that this required them to be employed by the same agency.

TABLE 19.6

CASH GRANTS AND ALLOWANCES

	EXPENDITURE 1987 (£m)
INCOME MAINTENANCE	
Disabled Person's Maintenance Allowance	56.150
Disabled Person's Rehabilitation Allowance	1.530
Blind Welfare Allowance	1.050
Infectious Diseases Maintenance Allowance	0.545
	59.275
OTHER	
Domiciliary Care Allowance for Handicapped Children	5.490
Mobility Allowance for Disabled Persons	0.380
Grants for Motorised Transport for the Disabled	0.071
Maternity Cash Grant	0.070
	6.011
TOTAL	65.286

Source: Department of Health

19.47 **We agree that the administration of the Supplementary Welfare Allowance and the employment of Community Welfare Officers should be the responsibility of the Department of Social Welfare.** We realise, however, that Community Welfare Officers perform other health-related functions such as assessing means for Category I eligibility and that they act

as assessors, in some health board areas, for the other income maintenance schemes discussed in this chapter. When they become employed by the Department of Social Welfare, it will be necessary to devise an alternative system for assessing means for medical card applicants. We also feel that the advantages of personal contact exercised by Community Welfare Officers, and the flexibility of approach shown by health board officials in the operation of the Supplementary Welfare Allowance and other income maintenance schemes, should continue to be shown to vulnerable client groups when the operation of these schemes is transferred to the Department of Social Welfare.

RECOMMENDATIONS

19.48 We have made the following recommendations in this chapter:

1. The development of services for mothers and children, the disabled and the mentally ill should be based on a consistent approach to assessment and evaluation of need, and the provision, when and where required, of those services judged most appropriate.

2. A contribution towards the cost of certain services such as day care should be required, depending on income, using the principles discussed in paragraphs 17.22 to 17.26.

3. Area General Managers should enter into formal contractual agreements with organisations providing residential care for children to ensure that the required range of care is available in each area. Homes should then be funded on the basis of an agreed level and type of service.

4. Agencies providing care for the disabled should be funded by the Health Services Executive Authority on the basis of appropriate costs per place for particular levels of handicap and type of care setting.

5. We endorse the recommendations of the Commission on Social Welfare that responsibility for the Disabled Person's Maintenance Allowance, Blind Welfare Allowance and Infectious Diseases Maintenance Allowance should be transferred to the Department of Social Welfare, which should also take over responsibility for the administration of the Supplementary Welfare Allowance and the employment of Community Welfare Officers.

6. Payments for sheltered employment should be as equitable and consistent as possible throughout the country.

PART FIVE

CONCLUSION

CHAPTER TWENTY

IMPLEMENTATION AND FINANCIAL IMPLICATIONS OF COMMISSION'S PROPOSALS

INTRODUCTION

20.1 In this concluding chapter of our report, the Commission reviews its major recommendations for the funding, organisation and delivery of the health services. The first part of the chapter distinguishes recommendations which can be implemented relatively easily, in the context of existing legislation, from those proposing major structural reforms in the administrative organisation of the health services, which will require new legislation. We also examine, in the second part of the chapter, the possible financial implications, insofar as they can be accurately assessed, of recommendations which involve savings or extra expenditure.

RECOMMENDATIONS OF THE COMMISSION WHICH WILL REQUIRE CHANGES IN LEGISLATION

Core Services

20.2 At the heart of the Commission's proposals for a revised structure for the delivery and organisation of the Irish health services is the extension of Core Services to the entire population and the establishment of a new administrative model centred on the Health Services Executive Authority to deliver these. The abolition of the existing Category III which we have recommended could be effected relatively easily by Ministerial Order under the 1970 Health Act. It is obvious, however, that the scope of the other changes which we propose would warrant the preparation of a new Health Act to give a full expression to all the recommendations which we have made. It must be remembered that the 1970 Health Act is nearly twenty years old and was designed for conditions of eligibility which no longer apply.

20.3 A new Health Act would establish universal eligibility for Core Services. Furthermore, while the precise extent of what constituted these Core Services would remain a decision for Government, we feel that it would be appropriate for the new Health Act to make a broad statement of the types of service which should be provided on a universal basis. In addition, the new Health Act would have to make provision for the establishment of a category to cover the lowest income group who, in addition to Core Services, would also be entitled to certain other services, principally the GMS-style general practitioner service. It is also important that the broad parameters of legislative control over the eligibility criteria for each of these two new categories should be established within the new Health Act.

Administration

20.4 The other main function of a new Health Act would be to establish the administrative framework and model within which the health services would be organised and delivered. The Health Services Executive Authority would be set up under this Act, together with the Area General Management infrastructure and the Health Councils. It is essential that the nature of the relationship between the Minister for Health and the Health Services Executive Authority be clearly defined in this new legislation. It is also important that the role of the Health Services Executive Authority, as the agency primarily responsible for the delivery of health services in accordance with government policy, be made explicit.

20.5 Our recommendations concerning the capacity of the Health Services Executive Authority to hold a multi-annual budget and to allow some variation in its expenditure from the given annual budget must be enshrined in the new Health Act. The new Health Act should also make provision for the absorption of other executive agencies by the Executive Authority as appropriate.

20.6 Our recommendations regarding the establishment and role of the Health Councils and the nature of their relationship with the Health Services Executive Authority would also need to be covered by the new Health Act. We believe that it is essential that the purely political and non-executive role of the Health Councils should be emphasised in the new legislation. The new Health Act would also provide Health Councils with powers to delay the implementation of certain decisions of the Executive Authority. The Act would also cover the nomination of members of the Health Councils from the local authorities.

Tax Relief on Insurance Premia and Unreimbursed Medical Expenses

20.7 We have recommended that tax relief on insurance premia and unreimbursed medical expenses should be phased out. The manner in which this should be done has been described in Chapter Eight. This will obviously require legislation.

Health Contributions

20.8 We have recommended that the health contribution be abolished forthwith. The health contribution is levied under the Health Contributions Act, 1971 and regulations made thereunder. We recommend that this legislation should be repealed. Provision for the continued collection of health contribution arrears should be made.

Court Awards

20.9 We have recommended that in the case where damages are awarded arising out of accidental injuries, a 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 any damages awarded directly to the health services concerned. The implementation of this recommendation will require a legislative basis. This could possibly be done in the new Health Act.

Licensing of Private Hospitals

20.10 We have recommended that all private hospitals be licensed by the Minister for Health. Legislation exists to regulate the operation of private nursing homes. This should be reviewed to see whether it could be revised or expanded to cover the case of private hospitals or whether the enactment of new legislation is necessary.

Hospital Services

20.11 In establishing acute hospital services as part of the Core Services, to which all the population would be entitled, the new Health Act should carefully distinguish between services which are being provided as part of the Core Services and the capacity of a public hospital to offer private accommodation. Under the Health Act, 1970 there is a confusion as to whether the public patient of a consultant can occupy private accommodation and conversely whether the private patient of a consultant can occupy public accommodation. It is essential that this issue be addressed by the new Health Act

and that those patients who wish to avail of private consultant services can do so only in private accommodation. The ability of a hospital management to set its own scale of charges for providing private accommodation should be covered by the new Health Act.

20.12 The basis on which certain voluntary hospitals would provide services on behalf of the Health Services Executive Authority should be made explicit in the new Health Act. This is particularly important in regard to the funding which such voluntary hospitals will receive and the level of service provision which will be expected from them.

Drugs

20.13 Our major recommendation concerning drugs is for the establishment of a single integrated scheme to supply prescribed drugs through pharmacists, on the basis of a limited list, to medical card holders free of charge and to other patients at subsidised prices. The rates of subsidy would vary according to factors such as therapeutic benefit, cost and frequency of repeat prescription associated with specific products. We believe that this scheme should be introduced at an early stage. It will require legislation; the statutory basis for the existing drugs refund scheme is contained in section 59 of the 1970 Health Act. There may be some constraint on the timing of the introduction of the new scheme due to the agreement negotiated by the Department with the Federation of Irish Chemical Industries. However, when this expires, the scheme which we have recommended should be introduced as soon as possible thereafter.

Dental, Ophthalmic and Aural Services

20.14 We have recommended that the Department of Social Welfare Treatment Benefits Scheme be subsumed into the services provided by the Executive Authority. This will require legislation.

Charges for Certain Services

20.15 A number of our recommendations envisage the levying of charges, albeit modest, for certain services. These include possible charges for home nursing, for dental, ophthalmic and aural services, for meals services and the present hospital out-patient charges. In addition, there could be charges, as at present, for the "hotel accommodation" element contained in certain forms of long-term care. It is essential that a uniform basis for levying these charges be clearly established in the new Health Act. This legislation should

furthermore clarify and standardise the conditions for payment and collection of outstanding arrears.

Income Maintenance Schemes

20.16 The recommendation that the administration of the Disabled Person's Maintenance Allowance, Blind Welfare Allowance and Infectious Diseases Maintenance Allowance should be transferred to the Department of Social Welfare will require legislation to give it effect. In addition, our recommendation that Community Welfare Officers who primarily administer the Supplementary Welfare Allowance should be transferred to the Department of Social Welfare may also require some legislative basis.

RECOMMENDATIONS WHICH WILL NOT REQUIRE LEGISLATION

20.17 Many of the recommendations which we have made in this report will not necessitate legislation. This is because these changes can be implemented under existing legislation or because of their nature they are administrative changes or changes in operational practice. It is not our intention to list every single recommendation which we have made which can be implemented without legislation. Rather, we will establish broad policy areas and point to the major recommendations which can be given effect without the attendant difficulties of preparing legislation. The timescale for the implementation of such recommendations is, in some cases, problematic. Certain recommendations can be put into effect relatively quickly. Others are contingent on the establishment of the Health Services Executive Authority and associated administrative model. It remains for the Minister for Health and the Government to decide which of our recommendations, other than our main proposals for a revised administrative structure, should be implemented sooner rather than later.

Eligibility

20.18 Our recommendations for the establishment of standard guidelines for medical card eligibility and for other services can be implemented without any legislation. This would require agreement from the Chief Executive Officers of the health boards who at present have statutory authority for determining eligibility. Similarly, the criteria for imposing the modest charges which we have envisaged in certain service areas can also be standardised without difficulty. We have also called for an urgent review of the income distribution of medical card holders. This should be done as soon as possible.

Tendering Out for Services

20.19 Our proposals for allowing the Health Services Executive Authority to tender out certain services, if it believes these can be provided by outside agencies on a more competitive basis, should be examined now to see the extent of the scope for their implementation.

Consultative Bodies

20.20 We have recommended that channels of consultation through formal consultative bodies for the different professions at local level should form part of the new administrative structure. In order that these might be in place when the Health Services Executive Authority is established, moves should now be made to create such channels of communication.

Management Development

20.21 We have made proposals to improve the quality of management personnel within the health services. We have specifically recommended that management development programmes be promoted. There is no reason why this should not be done in advance of the establishment of the Executive Authority.

Performance Audit Unit

20.22 We have recommended the setting up within the new administrative structure of a Performance Audit Unit. This is related to our recommendations concerning health services research. We have not made a specific recommendation as to the basis on which the Audit Unit should be established. It could be set up more or less formally by legislation or as an advisory function to the Department and later the Executive Authority.

Information and Evaluation

20.23 We have made many recommendations in Chapter Ten regarding the establishment and utilisation of proper information and evaluation systems. We have encouraged the development of health services research and have recommended the establishment of a Department of Health Services Research in one of the universities. The lack of adequate information and evaluation within the health services is a major problem and, as will be seen in the following section on financial implications of our recommendations, is a major cause of the lack of accurate costings which could provide a much more objective basis on which to make policy decisions.

20.24 In view of the importance which we attach to information systems and evaluation programmes which will contribute to the development of realistic policies within the health services, **we believe that our recommendations contained in Chapter Ten should be implemented as soon as possible.** While many of these recommendations refer to the Executive Authority developing information strategies, there is no reason why the existing Health Research Board should not begin to develop these initiatives in the areas of costings, treatment evaluation, case-mix funding, market research, the development of epidemiological data and the evaluation of clinical research. Indeed it has already done so in certain areas. Some of the functions relating to costings and case mix are already being developed in the Department of Health. We believe that the funding of these research areas should immediately be given priority in view of the importance which we attach to the entire health services research function within the new administration and delivery model which we have recommended.

Hospital Services

20.25 We recommend in Chapter Twelve that the basis of admission to acute public hospitals should be that of objective assessment against, where necessary, published criteria. This should lead to the establishment of a common waiting list for public and private accommodation. **We would like to see this development brought about as soon as possible and, in any event, certainly not later than the abolition of Category III.** The definition of the roles to be played by the various acute hospitals within the new administrative structure can be developed pending the establishment of the Executive Authority. Moves towards establishing more professional and highly-skilled hospital management should be made immediately. In particular, flexibility to employ managers on fixed-term contracts should be introduced without delay.

20.26 We are aware that the Department of Health is developing a pilot project of providing some hospitals with overall budgets based on case-mix. To extend this system to all hospitals as our recommendations have envisaged would clearly be impractical until the information function, to which we have referred earlier, is improved. This example highlights the extent to which the implementation of many of our reforms cannot be brought about until adequate information and evaluation is available to policy-makers.

Other Medical Services

20.27 We have recommended that the relative cost-effectiveness of the various paramedical services and alternative methods of delivering them should be examined. We have similarly argued that certain functions in the dental services can be performed by dental auxiliaries. In other services it may be appropriate to have certain procedures delivered by general practitioners rather than in a hospital setting. We have also called for the establishment of national guidelines on eligibility for non-acute hospital services and on the level of service provision so that a uniform standard may apply throughout the country. This similarly should apply in the case of charges for public dental, ophthalmic and aural services and for other paramedical services. There is no reason why these recommendations should not also be implemented immediately.

20.28 We have called for an urgent review of home nursing services. This should be implemented without delay so that the needs of those who require these services can be determined and an appropriate response made to meet these needs.

Drugs

20.29 We have recommended that drugs and therapeutic committees should be established in hospitals and that these should be closely related to the new general practitioner GMS drugs committee. We are aware that some hospitals already possess such drugs and therapeutic committees. The establishment of such committees in hospitals which do not already have them and the development of close links with the general practitioner committee should be encouraged as soon as possible.

Health Promotion and Health Education

20.30 All of the recommendations which we make in Chapter Sixteen can be implemented without recourse to legislation. In particular, the introduction of a records system for immunisation and screening programmes should be introduced at an early date. We have recommended that the child health services be re-appraised and we believe that this should be done as soon as possible. We realise that the implementation of health education programmes is a continuing function of the Health Promotion Unit of the Department of Health but we feel that it is necessary to refine the evaluation techniques whereby these programmes are assessed. Moves in this direction should be made before the establishment of the Executive

Authority which will take over responsibility eventually for health education insofar as it is an executive function.

20.31 We have also recommended that existing health education programmes should place an emphasis on increasing public awareness of the appropriate use of medical services. We consider that this is important and that a programme to give effect to this policy should be introduced as soon as possible.

Welfare and Continuing Care Services

20.32 One of the main recommendations common to each of Chapters Seventeen, Eighteen and Nineteen is that uniform criteria for the assessment and evaluation of service needs should form the basis for the development of policy regarding service provision. We have recommended that the criteria which have been used in determining the appropriate forms of care at national level should also be used in individual cases to ensure that the appropriate response is matched to each category of need. Most of the recommendations contained in these three chapters are based on this principle. In addition, the evaluation of the relative costs and benefits on patient welfare of alternative forms of care for different client groups should be an ongoing and integral part of the planning of services. Both of these main recommendations and the other recommendations which flow from them can be implemented immediately. However, the full benefits of a coordinated and planned approach to the delivery of all continuing care services can be achieved only under the integrated management structure which we have proposed in terms of the Executive Authority. This, however, is not to say that our recommendations in this area should remain untouched until the establishment of the Executive Authority. Many recommendations, on the contrary, are capable of being implemented immediately. In particular, health boards which effectively pre-figure the proposed Area General Management structure, should enter into formal and contractual arrangements with voluntary organisations providing residential care for children and for the elderly to ensure that the required range of care is available in each area. These services should be funded on the basis of an agreed level and type of service.

Payments for sheltered employment

20.33 We have recommended that payments in workshops and other units providing sheltered employment for those who will not be capable of taking their place in open employment should be equitable and consistent throughout the country. We believe this recommendation should be implemented immediately.

FINANCIAL IMPLICATIONS OF THE COMMISSION'S RECOMMENDATIONS

Financial Gains from the Reformed Administrative Structure

20.34 The main thesis of our report is that efficiency and equity in the organisation and delivery of the health services can only be achieved by a two-fold policy of reform. The first part of this is the overhauling of the administrative structure and the creation of the Health Services Executive Authority to organise the delivery of the health services in a purely executive way. The second part of our reform strategy is the development of major information and evaluation systems to provide decision-makers with a firm basis for making choices between conflicting policy objectives and allowing them to predict the consequences of such policies with a greater degree of insight and accuracy than is at present possible.

20.35 The financial implications of the introduction of our recommendations, and the establishment both of the new administrative model based on the Health Services Executive Authority and the placing of a new degree of emphasis on the role of information and evaluation within the health services, cannot be accurately assessed. Obviously, we believe that these changes will produce a more efficient service. The establishment of the Health Services Executive Authority together with a clear definition of the roles of each of the component parts of the healthcare system, will lead to a rationalisation in the use of all resources and facilities. This, in turn, should lead to the elimination of wasteful duplication of facilities and institutions, structural inefficiencies and lack of the cost-effective use of resources occasioned by confusion over the roles played by constituent elements in the healthcare system. By way of example, we would point to our recommendations in regard to the acute hospital structure. We have recommended that each acute hospital should have a designated role both at local level and regional level and, if warranted, at national level. The funding of hospitals would reflect the role expected of them and, in turn, hospitals would be expected to provide a level of service commensurate with the funding provided for them.

20.36 The main reason why it is so difficult to assess the financial implications of many of the Commission's recommendations is because there is a major shortage of accurate information regarding the costs of services related to their output. There are similarly major gaps in knowledge of the relative cost-effectiveness of various types of treatment and of certain approaches to healthcare such as the use of institutional or community-based facilities. In the earlier part of this chapter we have called for the urgent implementation of policies which will lead to the development of the information and evaluation functions within the health services. Only when this is done will it be possible to assess policy options and decide upon the most cost-effective ways to meet service needs and the most efficient way to deploy resources within the health services.

20.37 It is obvious that the development of information and evaluation systems and techniques will require an outlay, particularly on data systems and information technology. Already the Department of Health is engaged in a major programme of computerisation in the health boards and we envisage that the recommendations which we have made can form an extension of the existing programme of information technology development. Obviously, if this programme is to be accelerated to give effect to our recommendations, it will be necessary to make available further expenditure. While it is not possible to quantify exact costs, we stress that it is only by developing such information technology that greater savings can be achieved in the provision of services.

20.38 An example of the use of information and evaluation techniques can be found in basing the funding of acute hospitals on a case-mix rather than overall global budgeting as at present. Otherwise, funding requirements will become increasingly out of touch with the necessities of service provision.

20.39 We have also advocated the tendering out of certain services, in particular acute hospital services, on the basis that the introduction of a certain element of competition into the delivery of services will result in improved efficiency and performance. Again, it is not possible to quantify exactly the extent of the savings which such a policy would achieve, but the Commission believes that the introduction of this policy would result in major efficiency savings and a generally more business-like approach to the running of what, in many cases, are very large institutions with budgets of many millions of pounds.

20.40 The main potentially cost-creating recommendation in the Commission's report is that of extending Core Services cover to all of the population. It is very difficult to assess the financial impact of this proposal because already some 30 per cent of the population, mainly in the upper income group, have elected to provide for themselves with voluntary health insurance cover for private treatment. Of crucial importance, therefore, in trying to form any assessment about the likely cost of full eligibility for the entire population for, say, hospital services, is the necessity of coming to some opinion about the likely level of insurance cover in the future.

20.41 Firstly, the recommendation of the Commission concerning the establishment of a common waiting list and admissions policy in publicly-funded hospitals would serve to eliminate the perceived advantage of queue-jumping as a private patient. Secondly, the abolition of tax relief on health insurance premia, even if phased out gradually, would be likely to have an effect on the numbers opting for health insurance, as its real cost would increase. Thirdly, there is the unknown quantity of the effects of the integration of the EC Internal Market after 1992 which again could create a very different climate in the health insurance market in this country in the future, particularly in relation to the continuation of 'community-rating'.

20.42 We have outlined the factors which influence the proportion of the population holding voluntary health insurance in an appendix to this chapter. This also discusses possible future developments in the health insurance market and attempts to illustrate the extent and scale of any likely impact on the public services following a reduction in the numbers of people holding voluntary health insurance.

20.43 Most of the extra costs associated with the introduction of Core Services, which might materialise following a reduction in the numbers holding health insurance, would be offset by the savings achieved in the reduction and elimination over time of tax relief on health insurance premia and unreimbursed medical expenses. The extra costs would be concentrated in the acute hospital sector, although the extension of a domiciliary maternity service to the entire population would also be a cost-increasing policy. At present, Categories I and II are entitled to benefits under this scheme. These represent approximately 85 per cent of the population. The extension of the domiciliary maternity scheme to include the existing Category III would probably cost in the region of £1 million.

Withdrawal of Tax Relief on Health Insurance Premia

20.44 The Commission has recommended that income tax relief on health insurance premia and unreimbursed medical expenses be phased out for the reasons stated in Chapter Eight. The cost to the Exchequer of providing this relief is estimated at approximately £44m. Obviously, this amount could be saved and become available to the Exchequer for other health-related purposes if this form of tax relief was removed at a stroke. (There would, of course, be a time lag as the relief is given on a preceding year basis). However, this would have very disruptive effects, particularly on VHI, as many subscribers would cancel policies in response to a rise in the real cost of premia. These implications are discussed in the appendix to this chapter, but the Commission wishes to emphasise here that it envisages the gradual removal of tax relief in a way which will ensure that no major disruption occurs and that the transition of those who will do so from private health insurance to public entitlement is made as soon as possible. The completion of the Single Market at the end of 1992 may have a radical effect on the Irish health insurance market. The Commission feels that tax relief on premia can be used as a policy instrument in the meantime to prepare the market for the eventual conditions which may obtain post-1992. We therefore have not made specific recommendations about the precise way in which the relief should be withdrawn or the rate at which it should be phased out. We feel that a flexible approach to this issue should be adopted. Depending on the reduction in demand observed in relation to effective price increases, caused by the part-removal of relief, we believe that the complete phasing out of tax relief should be tailored to the pattern that emerges so that any change takes place as smoothly as possible.

Abolition of the Health Contribution

20.45 As stated in Chapter Six, the Health Contribution is not paid into a separate fund but is generally perceived as a part of general taxation. It does not confer an entitlement to any benefit. There have been serious inequities resulting from differences in the level of collection obtaining in the PAYE sector, where this contribution is deducted from salary at source, and that found in the self-employed sector where the collection rate is low. We have therefore agreed with the recommendation of the Commission on Taxation that the Health Contribution be abolished. This is not to say that the Commission holds that the Department of Health should forego some £113 million (1989 estimate) in Health Contribution revenue. Rather this amount should be made good by the Exchequer, and Income Tax in turn adjusted so that this burden is spread more

equitably between all Income Tax payers. Whether this integration of the Health Contribution with Income Tax takes place in the context of the long-awaited reform of the taxation system is obviously a matter for Government. However, its implementation would, in the opinion of the Commission, be easier to achieve in a context of overall tax reform.

20.46 We do not therefore envisage that any extra cost to the Exchequer would arise from the abolition of the Health Contribution.

Consultants

20.47 We have recommended that a new flexibility be used in the making of contracts with consultants in respect of their public patients. We are aware that our recommendations for the abolition of Category III carry implications as far as the consultant Common Contract is concerned. We have already mentioned that the scope for private practice in individual disciplines should be taken into consideration in determining consultant remuneration. We are aware that, at present, the consultant contract is under review but we do not wish to make any pre-emptive statement concerning the specific level of remuneration which should be paid to consultants. In the context of abolishing Category III, some extra consultant costs may arise from a decline after 1992 in the numbers holding insurance. These costs could, however, be absorbed by the more flexible approach which we have recommended in the use of part-time contracts in employing consultants and by the introduction of a more career-type structure of remuneration for consultants based on incremental salary scales.

Dental, Ophthalmic and Aural Services

20.48 We have recommended that the Department of Social Welfare Treatment Benefits Scheme be absorbed into similar schemes administered by the Health Services Executive Authority. We, however, do not envisage that this recommendation should involve extra expenditure. The funds which will be saved through the abolition of the Treatment Benefits Scheme should be re-directed to the Health Services Executive Authority and specifically towards the improvement of dental, ophthalmic and aural schemes, particularly directed at Category I patients.

20.49 We have recommended that, where appropriate, greater use should be made of paramedical personnel and dental auxiliaries in the provision of certain types of services at present provided by more highly-qualified medical personnel. While, in some cases, the

employment of such paramedical personnel will involve an extra cost, in the longer term this will lead to the provision of an improved service being provided in a more cost-effective manner.

Drugs

20.50 All of our recommendations concerning a limited list, the establishment of therapeutic committees in hospitals, improved central negotiation and the introduction of a single integrated scheme for the provision of subsidised drugs should result in savings in drugs expenditure. In addition, the move to a capitation basis for the GMS general practitioner services should result in lower visiting rates which, in turn, will be reflected in lower levels of prescribing. This should again effect savings in drugs expenditure.

Health Promotion and Health Education

20.51 It is difficult to assess the financial impact of programmes for health promotion and health education. Obviously, our recommendations for improvements in this area may require slightly greater expenditure. However, since our recommendations include the assessment and evaluation of such programmes, we hope that, in future, expenditure is directed on health education and health promotion projects which are likely to show a significant return in terms of reducing illness and improving health, thus creating savings in the long term.

Welfare and Continuing Care Services

20.52 The main thrust of our recommendations concerning the welfare and continuing care services is that these services at present are not provided on the basis of uniform assessment of need against clearly established criteria. We cannot be certain, therefore, of whether the type of service being provided at the moment is exactly what is needed in any of the areas covered by the description "long-term care". Before it is possible to decide whether the level of resource input into this area is adequate, it is necessary to have a complete picture of the requirements of the services against which to evaluate the present level of service provision. Only when an evaluation has been made will the true picture of need emerge. It will then be possible to determine the most cost-effective ways of meeting service requirements for the various client groups, such as the elderly, the disabled, the handicapped and the psychiatrically ill. The level of funding required to give an adequate service for these groups can only be properly assessed in this context.

20.53 A number of our recommendations in Chapters Seventeen to Nineteen are concerned with establishing criteria for the assessment of need at national level which will be reflected in the assessment of individual cases. Also, we have argued that the Health Services Executive Authority must agree a level of service provision from the many voluntary agencies working in the area of long-term and continuing care. In turn, the funding by the Executive Authority of these agencies must reflect in a planned and systematic way the targets and policy objectives set out for service provision. We believe that the effects of these recommendations and the implementation of such policies can only result in a more efficient system which will provide improved continuing care for the many client groups depending on publicly-funded services.

20.54 We have recommended that national guidelines and criteria be established for the levying of certain types of long-term accommodation charges based on the individual's ability to pay. At present, such types of charge exist, although their coordination and the basis on which they are levied is, in many cases, confused and inconsistent. We do not anticipate that such charges would provide a significantly larger source of income than at present. The object of our recommendations is to rationalise them so that they can be levied in the most equitable way possible.

20.55 We do not anticipate that any major costs will arise from the transfer of the various income support schemes at present administered under the aegis of the health boards to the Department of Social Welfare. We have, however, noted that it may be necessary to replace certain Community Welfare Officers who, in addition to administering these income maintenance schemes, also assess means for medical card eligibility. It would be necessary that some type of community-oriented local officials of the Health Services Executive Authority be employed to maintain a liaison with those in the lower income and other high-risk groups in relation to health services generally.

APPENDIX 20A

THE FUTURE OF HEALTH INSURANCE

1 As part of its recommendations on the funding of the health services, the Commission has recommended that Core Services, including hospital services, be made available to all the population. Under the present system of eligibility, 85 per cent of the population are entitled to maintenance in a public hospital and to free consultant services. The remaining 15 per cent, while being eligible for maintenance in public hospitals, must provide and pay for their own consultant services. Voluntary Health Insurance premia are at present tax-relieved to encourage and facilitate this group to take out health insurance.

2 Under the proposed core services approach, *all* the population would be covered for public hospital services, both maintenance and treatment. It remains to consider whether the extension of this cover to the top 15 per cent will result in a significant extra cost to the public health services.

THE IMPORTANCE OF INSURANCE

3 In the present circumstances the extension of full eligibility to those in Category III would not necessarily add, of itself, to the costs of existing services. Since 30 per cent of the population has voluntary health insurance for hospital services and most of these are concentrated in the upper income groups, the abolition of Category III would not have an appreciable cost effect in the present circumstances. However, the important factor here is the number of persons who have health insurance. At present, insured persons obtain private hospital services in one of two ways:

(a) maintenance in private hospitals for which they pay an economic cost determined by those institutions; or

(b) maintenance in private accommodation in public hospitals.

The charges for (b) are set by the State at a level which in many cases approaches the true economic cost of providing those services.

In addition, such persons pay for private consultant treatment, normally through insurance.

4 Given that only 15 per cent of the population needs to insure against consultant fees, the fact that 30 per cent of the population have elected to do so suggests a desire for a higher level of service than is provided by the public system. There are four main reasons why people elect to take out private health insurance:

(i) there is the perceived advantage of beating the public queue and receiving attention in hospital quicker than might be the case for a public patient;

(ii) there is the advantage of freedom of choice of consultant and personal attention. Often, in fact, the freedom of choice is exercised by the GP who decides which consultant a patient will see but, nevertheless, some regard it as an important advantage;

(iii) there is the advantage of privacy and convenience in the type of private accommodation provided by health insurance; and

(iv) the cost of health insurance for taxpayers is reduced substantially by tax relief on health insurance premia.

REDUCTION IN NUMBERS INSURED

5 As mentioned above, any change in the cost to the Exchequer following the introduction of the Core Services model depends crucially on the proportion of the population which would be covered by health insurance. There are three factors which would serve to reduce the demand for health insurance:

— Firstly, an improved public service with an *admissions policy* designed to address the problem of queue-jumping would serve to reduce the necessity, in the eyes of some people, for health insurance. If the speed of admission to a public hospital is not determined by the type of hospital accommodation desired, then the advantage conferred by health insurance of getting treatment faster than public patients would be removed. Consequently, this would tend to reduce the demand for insurance.

— Secondly, the Commission has recommended the *abolition of tax relief* on health insurance premia. The net effect of abolishing tax relief will be to increase the cost of health insurance premia. The relative price elasticity of demand for health insurance remains largely one of speculation. The available evidence based on VHI premium increases over the

last number of years suggests that the demand is relatively inelastic. However, there is little doubt that a major increase in insurance premia could result in a considerable drop in the numbers holding health insurance.

— Thirdly, the Commission has accepted that under the integration of *the EC Internal Market post-1992,* it is unlikely that Ireland would be able to preserve its requirement for community-rating in the area of health insurance. This will tend to make health insurance more costly for the elderly and those with long-term or chronic disorders. Given that a large proportion of those insured under VHI at present fall into these categories, it is likely that overall their demand for non-community-rated health insurance would be diminished.

6 These three factors could combine to create a climate in which the demand for health insurance is likely to be reduced. The first two stem from recommendations of the Commission and are designed to improve equity; the third is an external development which the Commission accepts is likely. Against this, it can be argued that a de-regulation of the health insurance market following 1992 will make competitive insurance cheaper and therefore more appealing to a wider range of people. In particular, the likelihood of employers purchasing cover as a benefit-in-kind for their employees can be expected to increase demand for health insurance in the working population.

7 However, competitive health insurance companies will prefer to insure only the young and healthy, leaving the older age groups and those with chronic illnesses to obtain their services from the State. (In the longer run, of course, policies might be introduced by insurers which would be based on a spread of risk over a lifetime). Will this increased number of persons falling back on public services result in increased costs to the State and, if so, to what degree?

8 In the following paragraphs we consider the order of magnitude of extra costs arising from a decrease of one-third in the number of persons covered by health insurance. The Commission believes that this represents the most likely future development for the reasons explained below. The main costs for the public health services arising from a fall in the numbers insured will obviously come in the acute hospital area but there are also implications for the psychiatric services.

COST OF TREATING MORE PUBLIC PATIENTS

9 The Acute Public Hospital system has the physical capacity to absorb a sizeable increase in the number of persons demanding in-

patient services under public entitlement. However, in order to do this, all or part of the existing private accommodation in public hospitals would have to be converted into public accommodation. This could, in turn, lead to the disappearance of private practice from the public hospital system with the resulting disadvantages discussed in Chapter Eight.

10 The Commission believes that the most likely outcome of the changes described in paragraph 5 above will be a significant drop, possibly as much as one-third, in the numbers holding health insurance. This view is based on an assessment carried out for the VHI by consultants retained by them. It does not take into consideration the extra people who might be attracted into insurance by cheaper policies offering more restricted cover, which might become available in a competitive private insurance market operating experience-rated premia. However, the Commission feels that the potential for further expansion of the Irish health insurance market is limited. Conditions have been favourable for many years and although policies for younger and healthier members are higher because of community-rating, there is no doubt that the tax relief incentive to insure has been generous by any standard, especially to those paying high tax rates.

11 The revenue which the State obtains from private accommodation in its own hospitals at the moment amounts to over £35 million. If the number of those with private health insurance was reduced by one-third, the State would theoretically be capable of absorbing the extra demand for public treatment in public hospitals. This is based on the assumption that the decrease in the numbers insured would be concentrated among the higher risk groups who tend to use public rather than private hospitals. We make the assumption therefore that this high-risk group accounts for at least 50 per cent of VHI bed-days. At present, over half of the bed-days of VHI members are spent in public hospitals, of which 60 per cent are in private accommodation. If VHI membership fell by one-third, and if those leaving consisted mainly of higher risks who tend to use public rather than private hospitals, it would be necessary to convert private to public accommodation in public hospitals to cater for them. The extra cost to the public system would be the loss of revenue from private accommodation and the cost of providing additional public consultant services. However, the wholesale conversion of private to public accommodation could have serious repercussions for the advantageous system of having a public/private mix on the campuses of public hospitals and could effectively lead to many of those seeking private treatment having to obtain it in private hospitals. The cost of the foregone revenue from private

accommodation (about £35 million) could be covered by savings from abolishing tax relief, at present about £44m. The extra cost of public consultant services is discussed below. In the longer term, public hospitals could restore the existing public/private balance by creating additional private accommodation. The cost of providing this would be recouped by its inclusion in the charges levied for its use.

12 Obviously, it cannot be assumed that a fall of one-third in VHI membership would have no adverse effects on the private hospital sector and it is possible that there may be a decline in the demand for private hospital services. However, against this, it can be argued that the contraction of private practice in public hospitals and the requirement that private patients in them pay the full economic cost will tend to improve the competitive situation of private hospitals in terms of ease of access to private medicine and in terms of costs. In this context, it must also be remembered that private hospitals are not entirely dependent on insured patients. The recent ESRI survey[1] on utilisation of health services found that 17 per cent of patients in private hospitals had no insurance cover.

CONSULTANTS

13 A major problem with any reduction in the numbers holding health insurance is, of course, the consultants who are at present obtaining over £31m from private health insurance for private treatment. If the numbers insured were to be considerably reduced, it would mean that this source of consultants' income would be curtailed. In order to extend consultant services to the 15 per cent at present in Category III, the State would have either to employ additional consultants or obtain an increased public commitment from the present complement of consultant staff. However, any revised remuneration arrangements clearly could not fully compensate for loss of income from private practice.

14 In this context, it should be noted that even a fall of half the insured population would leave 15 per cent of the total population still in a position to pay their consultant. The requirement that 15 per cent do so is a condition of the present consultant Common Contract.

15 The effect on consultant incomes of a likely reduction in the numbers holding health insurance seems to have been overlooked by

---

[1]Nolan, B. et al: *Health Service Utilisation in Ireland: Results from the ESRI Survey* (ESRI, unpublished, February, 1989).

those arguing for a liberalisation of the health insurance market and the introduction of competition. In the absence of community-rating, there is likely to be a considerable fall in the number of people requiring private insurance and, therefore, such a liberalisation will lead eventually to a smaller fund being available for division among consultants. The only ways in which consultants could maintain their incomes from private practice would be through an expansion of elective procedures being performed on relatively healthier and younger insured people or by charging higher fees for their services. Either would be a most undesirable development.

CONCLUSION

16 It should be stressed that it is not possible to give *accurate* estimates of additional costs which would fall on the public hospital service based on a change in the proportion of the population covered by health insurance. This is because

(i) the costs of treating individual patients for specific conditions are not known;

(ii) the relative complexity of case-mix treated in public and private hospitals is not known;

(iii) the relative price elasticity of demand for health insurance is not known accurately;

(iv) the relative health needs of those who would leave health insurance following price increases is not known; and

(v) the proposed new structure of the health services will bring about a more efficient allocation of resources in public hospitals as a result of which the marginal cost of treating extra patients should be considerably reduced.

Signed:

Miriam Hederman O'Brien (Chairman)

Sr. Gemma Byrne*

Phil Flynn*

Noel Fox*

Camilla Hannon

Cormac Macnamara*

Colm McCarthy*

Dermot McCarthy*

Dan McGing*

Donal O Shea*

Joseph Robins

Paddy Teahon*

Tom O'Mahony, Secretary

Paul Kelly, Secretary

Fergal Lynch, Assistant Secretary

* Subject to reservations; see pages 89, 94, 140, 221, 241, 396 and 398.

Reservation by Dr. Cormac Macnamara

While accepting and endorsing many of the important recommendations of the Commission, there are a number of key recommendations in Chapters Six, Seven, Eight, Nine, Twelve and Thirteen with which I am in fundamental disagreement.

The Irish health services are at present primarily tax-funded. The recommendation in 6.70 that this method of funding be retained to cover an expanded core services model must mean increased expectation and demand, which can only be met through higher taxation. It must also greatly aggravate the dilemma facing both present and future governments, namely reconciling the twin demands of expanded health care and lower taxation.

The core services model (7.16), the requirement that those opting for private care meet the full cost of their treatment (even when this is provided in a public hospital) and the phasing out of tax relief on insurance premia (8.55) will combine to ensure the demise or near demise of the VHI as clearly only the wealthiest will in future be in a position to meet the requisite premia. In real terms, then, the forseeable consequences of these proposals will be not just significantly increased costs to be met from the public purse through increased taxation but also reduced access to services for the overwhelming majority of those at present covered by the VHI.

The arrangements proposed for private practice in Chapters Seven, Twelve and Thirteen are likely to prove unworkable in practice or fail to deliver on expectations or both, while the recommendation that the existing statutory functions of the CEO be delegated to the Area Managers (9.75) can only needlessly weaken the power and influence of the Executive Authority.

In Ireland, as elsewhere, we are attempting to meet ever-increasing health care demands from finite resources. The clamour for more and better health services stems partly from the greater expectations of a more sophisticated society at a time of rapid scientific and technological advances, but also, and to a considerable degree, represents a consumer response to what has amounted to an aggressive and all too successful marketing campaign by vested interests — health professionals, pharmaceutical companies, politicians, et al. All too often it seems that

only Government parsimony stands between us and our health utopia! There is an almost universal ignorance of and/or disinterest in the practical reality that better health care will often mean increased expenditure which can only be met through taxation, health insurance, health contributions or borrowing.

While the way we manage the money we spend is clearly vital, how that money is raised can have an important bearing on public awareness, expectation and ultimately demand. To continue to fund health care almost exclusively through general taxation will do little to raise individual consciousness. Health contributions, earmarked taxation or insurance contributions covering at least a significant part of health care expenditure could have a useful role in raising public consciousness as to the cost of health care and would also temper the enthusiasm of those who, for their own reasons, might seek to stimulate expectations and demand.

Much of the present anxiety and unrest centres around access to services, where there is a clear perception that those in a position to meet private fees have ready access while other eligible patients must face unreasonable delays. Inequities are often represented as stemming from the different methods by which doctors are paid for their public and private work. If this is the case, and the present arrangements would appear at least to facilitate and/or encourage such a trend, then, given the relative size of doctors' overall remuneration in the context of the health budget, it should surely be possible to finalise alternative arrangements which will favour equity of access, such as a combination of salary/fees for all patients or whole-time appointments to include an additional element for private patients. These and other options should be explored. Equity of access will never be easy to achieve but it is difficult to see how designating "private beds" in public hospitals for the exclusive use of patients capable of meeting the full economic cost can contribute towards that objective.

An insurance based system of funding for a significant proportion of health expenditure, with the State meeting the premia of the lower paid from general taxation and doctors employed on a mixed salary/fee basis or on whole-time contracts, would mean that all patients would approach the system and the doctor on an equal footing. The VHI could be restructured to facilitate such a scheme which would be sufficiently flexible also to accommodate those willing to make top-up payments to cover treatments in hospitals other than public hospitals.

Subject to the foregoing, I accept and endorse the other recommendations of the Commission.

Reservation by Mr. Colm McCarthy

The central recommendations of the Commission are that eligibility for core services should be extended to the upper income groups currently enjoying only a partial entitlement, and that the system should continue to be largely funded by central Government taxation.

In recent years, central Government has met about 80% of total health spending. Around one third of the remainder goes through the VHI, and VHI premiums attract tax relief, so there is a further element of state subsidisation through this channel.

Direct expenditure on health services by households has been around 12% of the total in recent years, excluding their spending on health insurance.

In 1989, total state spending, current and capital, on health will be £1,326m. The number of households in the country is, conveniently, almost exactly one million. It follows that each household is paying, on average, £1,326 each year in taxes, or about £25 per week, for state-financed health services.

An unavoidable feature of any publicly provided service that is predominantly funded by general taxation is that the public at large will be unaware of its cost, will perceive it (accurately) as free, or nearly so, at the point of provision, and will clamour for increased services.

In Ireland, we have witnessed a substantial increase in public spending on health care, in real terms and as a % of GNP, in recent decades. But the attempts of the last few years to moderate the burden on the Exchequer have provoked widespread public disquiet and pressure on politicians to expand the health budget.

The international comparisons considered in Chapter 4 of the report suggest that health expenditure in Ireland is relatively high given the country's level of economic development and the low proportion of elderly people in the population.

A system of financing which relies so heavily on central Government taxation is more likely to produce this result than one which relies on other methods of finance.

In Ireland, the trend towards greater health expenditure has been accompanied by an increasing reliance on central Government taxation. In 1960, one-third of spending was direct household expenditure, versus only 12% now, and an element of the public portion came from local taxation, since abolished.

Tax-financed health expenditure fulfils a number of functions. It ensures that low income groups have access to health services which they could not otherwise afford and this is the principal purpose of the system. But it also redistributes risk, and can be seen as a kind of compulsory insurance scheme, where each taxpayer is levied involuntarily but is protected against costs of illness which can be catastrophically, and unpredictably, high. The redistributive function is incapable of being financed other than through taxation of some kind, but the insurance function need not involve the tax system at all.

Thus the extent to which the health services need to be tax-financed depends on how much redistribution you want to do. If expenditure per person is uniform across income groups, and for basic services that should be roughly the case, the system need be no more than 50% tax-financed if the entire bottom half of the income distribution get these services free of charge.

The current Irish system goes well beyond that, with all citizens entitled to at least some tax-financed services. It follows that the current Irish pattern of health service finance cannot be justified by appeal to concerns about redistribution.

A system where the middle and upper income groups had to rely to a greater extent than at present on private health insurance can only increase the redistributive impact of the system. The objection that health insurance costs would be burdensome even for better-off families is often made, but you either want to redistribute or you do not. The prospective burden of increased insurance costs must in any event be weighed against the existing burden of taxes.

The attractions of a lesser reliance on central Government finance go beyond increasing the effectiveness of redistribution. The existing system is prone to difficulties with expenditure control, and any alternative which strengthened public perception of costs is likely to make a greater contribution to the attainment of value for money.

This problem is acute in the case of health services and is a recurring theme in economic writings on the subject. The producers of health services have every opportunity to induce increased demand, and consumers who pay nothing or only a small portion of costs have little incentive to resist the inducements. An insurance-based system runs the same risk but the perception of costs can only be heightened.

There are other sources of finance which could contribute, including local taxation. The elimination of local household property taxes has had the effect of turning local bodies who deliver various public services into lobbyists for increases in central Government expenditure. Such increases no longer have any local taxation consequences. Should Government at any stage consider the reintroduction of local taxes on the household sector, there is a case for reverting also to an element of local funding of the health services.

Two other questions discussed in the Commission's report are the health contribution and the issue of the form which insurance might take.

The health contribution, currently 1.25% of income up to a ceiling of £16,000, is expected to yield £113m in 1989. This constitutes about 8.5% of the total cost of health services to the State. For every £1 which the typical worker pays as health contribution, he or she is paying over £10 in other taxes to support the health services.

Since there is an income ceiling, the health contribution is a regressive tax. There is a good case for its abolition.

Health insurance in Ireland is dominated by the VHI whose premiums enjoy tax relief. The premiums are not related to claims experience, so the VHI engates in cross-subsidisation amongst its members at any point in time. But over the life-cycle, the cross-subsidisation is less serious. Ultimately, all insurers subsidise those who claim out of the pockets of those who do not. The existing system is a form of community rating, and I believe that this should be retained.

The health insurance market should be expanded, through the restriction of entitlements for middle and upper income groups to free health services.

For all those not entitled to core services free of charge, it appears to me that insurance would have to be compulsory. The State is most unlikely to actually refuse basic healthcare to those who have been so improvident as not to insure themselves. If entitlements are narrowed, so that an increased portion of the population needs to insure, there will always be those who will take the short view, particularly under

community rating. If the State is compassionate and will not refuse to treat uninsured people who become ill, it has a third-party exposure. It is precisely the prevalence of third-party exposure which has resulted in car insurance being compulsory.

The expansion of the market should help the VHI, which has had a difficult underwriting experience recently, but it is difficult to argue that is should enjoy any State protection of a monopoly position in the longer term.

If insurance is to be compulsory, the compulsion should extend only to core services. People would be free to insure for additional services if they so wished.

The tax relief currently extended to VHI premiums is regressive and its abolition has been proposed. There may be merit in retaining tax relief if entitlements to free services are to be withdrawn for better-off groups, but it should be available only for the cost of core services insurance.

Measure along the lines would reduce the proportion of health service costs being met from central taxation. I believe that expenditure control will be increasingly difficult unless this is done.

Finally, the Commission's report contains numerous proposals dealing with the supply side of the health industry, the most important of which is the dismantling of the existing Health Board system. I support these proposals, but I am concerned that they will be insufficient on their own unless central Government's contribution to the funding of the health services is reduced.

APPENDICES TO REPORT

Appendix I: List of Submissions

Appendix II: Other Organisations which assisted the Commission

Appendix III: Experts invited by the Commission to Ireland

APPENDIX I: List of Submissions

The following organisations and individuals made written submissions to the Commission. An asterisk denotes those who also presented their views orally.

Organisations

Association of Hospital Accountants*
Association of Optometrists
Association of Physical Scientists in Medicine
Blood Transfusion Service Board
Catholic Private Healthcare Association
Centre Care (Dublin Diocesan Social Service Centre)
Cheshire Foundation in Ireland
Confederation of Irish Industry
Community Nurses, Little Sisters of the Assumption, Cork
Coombe Hospital and Rotunda Hospital (Joint Submission)
Council for Social Welfare*
Council for the Status of Women
Daughters of Charity of St. Vincent de Paul, Navan Road*
Dr. Barnardo's*
Dental Council*
Eastern Health Board*
Federated Workers' Union of Ireland
Federation of Voluntary Bodies providing Services to People with Mental Handicap
Headway Ireland
Hospitaller Order of St. John of God
Institute of Community Health Nursing* (Two submissions)
Intensive Care Society of Ireland
Irish Association of Social Workers*
Irish College of General Practitioners*
Irish Countrywomen's Association
Irish Family Planning Association
Irish Medical and Surgical Trade Association*
Irish Medical Organisation*
Irish National Teachers Organisation
Irish Nurses' Organisation*

Irish Pharmaceutical Union*
Irish Private Nursing Homes Association
Irish Society for the Prevention of Cruelty to Children
Irish Society of Chartered Physiotherapists*
Irish Society of Medical Officers of Health
Labour Social Services Group
Local Government and Public Services Union
Mater Hospital
Midland Health Board
Mid Western Health Board
Medical Laboratory Technologists' Association*
National Association for the Mentally Handicapped of Ireland*
National Association of Hospital Chaplains
National Council for the Aged*
National Economic and Social Council
National Medical Rehabilitation Centre
Postgraduate Medical and Dental Board
Psychological Society of Ireland
Rehabilitation Institute*
Roscommon County Hospital Action Committee
Royal College of Physicians of Ireland*
Royal College of Physicians of Ireland (Board of the Faculty of Community Medicine)
Royal College of Surgeons in Ireland*
St. John's Hospital, Limerick
St. Joseph's Association for the Mentally Handicapped*
St. Michael's House
St. Vincent's Hospital, Elm Park
Sinn Fein
Southern Health Board
South Infirmary, Cork
Trinity College Dublin (School of Dental Science) (Two submissions)
Union of Professional and Technical Civil Servants
Voluntary Health Insurance Board
Workers' Party

Individuals

Ad hoc group of consultants, Mater Hospital
Mr. Richard Bruton T.D.
Fr. Frank Buckley
Senator John Connor
Mr. Denis Dudley
Mr. W.P. Dunbar
Ms. Estelle Feldman

Mr. Liam Gormley
Ms. Margaret Headon
Dr. Mary Henry
Professor D.I.D. Howie
Dr. Mary Joyce-Leader
Councillor Kathleen Lynch
Professor James McCormick
Dr. P.A. McLoughlin
Mrs. Kathleen Marshall
Ms. Mairéad Moore
Ms. Maura Moynihan
Mr. B. St. John Murphy
Mr. Michael J. Murphy
Dr. E.H. O'Flynn
Professor Denis M. O'Mullane
Ms. Catherine O'Rourke
Mr. Eamon O'Shea
Councillor Jack Roche
Mr. H.T. Rowan and Mr. M.A. Fanning
Senator Brendan Ryan
Ms. Mary Smith

APPENDIX II: Other Organisations which Assisted the Commission

In addition to those who made submissions, the following official bodies assisted the Commission in various ways, such as providing information, offering advice or joining in discussion.

1. IRELAND

Government Agencies

— Central Statistics Office
— Department of Finance
— Department of Foreign Affairs
— Department of Health
— Department of Industry and Commerce
— Department of Social Welfare
— Director of Consumer Affairs
— Health Education Bureau
— National Economic and Social Council
— Revenue Commissioners

Other Bodies

— Economic and Social Research Institute
— Embassy of the Netherlands
— Federation of Irish Chemical Industries
— Irish Insurance Federation
— Irish National Council on Alcoholism

2. UNITED KINGDOM

— Department of Health and Social Services
— King's Fund College
— King's Fund Institute
— Institute of Health Services Management
— NHS Management Board

3. **UNITED STATES**

— Brookings Institution
— Congress Budget Office
— Federal Bureau of Health and Human Resources
— Urban Institute
— World Bank

4. **BELGIUM**

— European Commission
— Ministry of Economic Affairs, Belgium

APPENDIX III: Experts invited by the Commission to Ireland

— Dr. David Green, Institute of Economic Affairs, London
— Professor Rüud Lapré, Erasmus University, Rotterdam
— Dr. Jean-Pierre Poullier, Organisation of Economic Co-operation and Development, Paris
— Mr. Martin Teilman, Deputy Permanent Secretary, Ministry of Health, Denmark.