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EFFICIENCY AND CONTROL OF IRISH MEDICAL CARE EXPENDITURES

by

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My paper this morning arises from my forthcoming ESRI Research Report on Irish medical Care Utilisation and Expenditures. I am happy to be able to preview some of that paper's implications with you; I must confess that I would be happier still were I presenting the final published paper rather than a preview. The substance of the work is complete, and the editorial work is in its final stages. It is our hope to have a publication available within a few months.

My topic is efficiency and the control of expenditures in the Irish medical care system. As economic incentives are crucial in this matter, I will review both patient and provider incentives, and proposed changes in these. In the process, I will comment on the recent Report of the Working Party on the General Medical Service (1984). I will then review and assess four main models which have been or might be proposed as the basis for a restructured Irish system.

The principal problem facing the Irish medical care system today is control of expenditures. Utilisation levels, resources applied to each unit of utilisation, and prices or costs of resources have been rising at explosive, unsustainable rates.

There is a sense, however, in which the problem is more accurately described as one of economic inefficiency, rather than of inflation or costs per se. Had the rise in costs been accompanied by widely perceived improvements in the range, reach, extent, and quality of medical care, comparable for example to those which occurred when most infectious diseases were conquered in developed countries, there would be substantially less concern. But the cost increases have occurred with no corresponding gains. Moreover, the most rapid increases in outlays appear not to have occurred in the medical care areas most in need of expansion -- preventive care, primary care, community care -- but in the sectors which seem already to absorb too many resources -- especially hospitals.

In other words, it is fair to say that the marginal contribution of medical care expenditures to human welfare in Ireland may now be less than the marginal contribution of other expenditures; and it is almost certain that the marginal contribution of medical care expenditures in Ireland is non-uniform across the system. There is no mechanism in Ireland which assures an efficient outcome, and existing mechanisms are often perverse to that goal.

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Changes are required. The main objectives of these should be to bring increased efficiency and rationality. This means:

1. Reducing or eliminating uneconomic utilisation; and
2. Shifting to lower cost forms of utilisation. Note that the former goal is expressed in terms of uneconomic, and not unnecessary, utilisation. The notion that there is a dichotomy between "necessary" and "unnecessary" utilisation is based on a simplistic and excessively mechanical interpretation, both of medicine and of economics. Much excessive utilisation of medical care may be of some medical value; but that does not make it worth its cost. The same resources, devoted to medical care elsewhere in the system, might yield significantly more medical value; and it is possible that the same resources shifted outside of medical care, to nutrition, education, highway safety, etc., might yield significantly more social return. The second goal entails, among other things, a shift from costly in-patient hospital care to out-patient care (i.e., a reduction in admitting rates); a shift, within out-patient care, from hospital-based and specialist care to community-based primary care, especially by general practitioners; and a shift, within primary care, from physician to non-physician care; and a shift from treatment to prevention; wherever such shifts are appropriate.

A. The Incentive Structure

The heart of the problem lies in the incentive structure facing consumers (the demand side) and providers (the supply side). The main incentive problem is that those who make resource-using decisions concerning medical care -- patients and providers -- frequently do not individually bear the economic costs of those decisions. Hence they are not led systematically to compare the probable benefits of medical care services with their social costs. This incentives problem has a demand side and a supply side.

The demand side refers to the influence of price and other terms on patient demand for medical care. There is a nearly universal tendency for people to deal with the unpredictability of their medical care needs by arranging for some kind of health insurance, either public or private, and either compulsory or voluntary. In this context, the provision of free or subsidised medical care by government or through government financing should simply be considered as compulsory, public insurance. By bringing down the point-of-purchase price of medical care services, in many cases to nothing, insurance increases the demand for those services. This problem is referred to as that of "moral hazard," which is defined as the general tendency of insurance to increase the likelihood of a contingency insured against, in this case medical care utilisation.
It is to be emphasised that the tendency to over-use medical care services because of reduced (or nil) point-of-purchase prices is not the result of government per se. It is a universal phenomenon that arises in wholly private, market-based medical care systems as well as in wholly public, national health services. It is a characteristic of medical care, not of socialism.

A solution commonly offered to moral hazard is some form of cost-sharing, under which the patient pays at the point of use some part of the cost of providing the care, service, or product. Cost-sharing is often attractive to policy-makers because it can achieve other objectives than combating moral hazard. It can help hard-pressed health services in raising revenue, a far from unimportant property, in this age of fiscal crisis. It can also, it is asserted, help make patients and physicians more cost-conscious, by reminding them that medical care resources are not free. In addition, it can help in asserting social priorities among types of medical care services, an advantage to be discussed later.

In spite of the attractions of cost-sharing, there is a large body of opinion which is either sceptical of the alleged gains or is opposed to general application of the technique. This point of view is based primarily on two considerations. First, physicians make most utilisation decisions. My estimate is that Irish general practitioners influence, directly or indirectly, two-thirds of Irish medical care expenditures, public and private. Consultants and other doctors influence much of the rest. Cost-sharing can do little but punish the patient for a physician's lack of cost consciousness. While physicians who act as "agents" of their patients (Feldstein, 1974) may take into account patient cost in making utilisation decisions, imposing costs on patients would be an indirect, inefficient, unsatisfactory and unfair way of attempting to change the behaviour of physicians acting as agents in this sense. Second, the single area where cost-sharing might have most influence on utilisation is in the patient-initiated first physician contact, for a suspected illness, or for preventative care. Within that area, the greatest impact would be on initial contacts by lower income persons. "Nothing should be done which would discourage people from early access to professional services ... Attempts to exempt the poor from cost-sharing are never wholly successful and insofar as they are successful they further stigmatise the poor" (World Health Organization, 1979). There may be important places for cost-sharing within a medical care system, as will be noted presently; but as a general technique for limiting utilisation it is liable to have the undesirable effect of limiting mainly the types of care which we least want to limit, viz., self-initiated primary care.

In addition to the general problem of moral hazard, we find on the demand side another important genus of problem, where a system imposes fees or charges in a manner that does not correspond with social priorities or costs. In many instances, the structure
of prices in the Irish system is such as to encourage utilisation of the higher-cost resources rather than the lower-cost ones. There are instances in which the Irish incentive system encourages in-patient hospital care over out-patient care, specialist care over GP care, and physician care over non-physician care. Subsidies to private care and, indirectly, to VHI, have encouraged over expansion of both, which makes national medical care costs higher than they should be. One useful contribution of cost-sharing could be to shift utilisation from high-cost and/or low-priority uses to their opposites. For example, if it is desirable to encourage the expansion of primary care relative to secondary, that objective might be achieved by reducing the price of GP services, for the portion of the population who currently must pay, while imposing charges, perhaps nominal, flat-rate fees, on out-patient specialist care, for the same population.

The supply side refers to the influence of remuneration techniques and other incentives on resource-using medical care utilisation decisions made by providers. It is generally conceded in health economics that supply side incentives are significantly more crucial than demand side incentives in influencing utilisation. Two arenas dominate the discussion: physician remuneration; and hospital budgeting or reimbursement.

Physician remuneration has been a central concern of my study. My general conclusion, supported both by theory and by considerable statistical evidence, is that the fee-for-service method of physician remuneration in general use in Ireland not only fails to make physicians cost-conscious but on the contrary provides them with incentives for utilisation beyond levels which are efficient and economical. Modification of the fee-for-service system is at the heart of any serious effort to control costs and bring economic rationality to the Irish medical care system.

The main alternative to fee-for-service is capitation, under which physicians are paid according to the number of patients they have, rather than the number of times they see them, or the number of services they provide. There is considerable evidence on a world-wide basis that capitation reduces utilisation, and further that it reduces pharmaceutical prescribing rates as well.

In the Irish context, one difficulty (in addition to possible physician opposition) confronts any attempt to apply capitation to general practitioner care. Capitation is not applicable to physician services purchased for a fee at the point of use. Hence as the Irish medical care services are organised at present, it could apply only to Category I care (those covered by Medical Cards), and not to Category II and III care. Some observers, including the Working Party on the General Medical Service, have expressed fears that if physicians were to be paid on a capitation basis for Category I patients and on a fee basis for Category II and III patients, that would create (or perpetuate)
two classes of care. GPs, it is alleged, would spend less time with lower income, Category I patients, because consultations with them would bring in no cash income.

It should be noted that similar allegations are made concerning the present system, under which the G.M.S. (Payments) Board pays GPs for services to Category I patients at fee levels considerably below those prevailing for private patients. Capitation might, however, aggravate this effect, particularly where physicians have unmet income targets. To combat this effect, it would be necessary that patients on whose behalf capitation payments might be made be able to change GPs easily, thus bringing market forces into play. Patients who felt they were not adequately cared for could then deny their doctors their own and their family members' annual capitation fees, which might be a serious penalty.

The only certain way to insure one class of GP care is to pay GPs in the same way for all patients. There are strong arguments for the application of capitation remuneration to the whole population, and not merely to persons covered by Medical Cards. Not only would such a technique avoid the tendency of capitation remuneration to create two classes of care, but it would extend the desirable incentive effect of the reform to the whole population. There are two ways in which capitation remuneration could be extended to patients in Categories II and III. One would be to extend free GP care to the entire population. There are other arguments for this change, to be discussed in my report. But it is not necessary to provide free GP care in order to adopt capitation remuneration. The second technique would be for private patients themselves to pay GPs on an annual, pre-paid basis, instead of on the present fee-for-consultation arrangement. Not only would such a reform alter provider incentives in a decidedly favourable direction, but it would shift demand incentives in favour of primary care, an objective which is desirable in its own right.

The Working Party on the General Medical Service, in its recent Report (1984), recommended a modified fee-for-service method of remunerating GPs who treat Category I patients. The Working Party were clearly concerned with the effect of fee-for-service of raising consulting rates beyond the level of need, as documented in my study. They recognised that capitation remuneration would correct this tendency, and could at the same time improve GPs' practice styles, by "relieving doctors of the pressure to see patients at frequent and thus necessarily brief, consultations."

However, in the end they were convinced of the argument that capitation would generate excessive referrals, and that it might make GPs less responsive to Category I patients than to fee-paying private patients. In the latter connection, it should be noted that the Working Party, unlike my study, had to assume the non-GMS portion of the medical care system would remain
unchanged, as their terms of reference were limited to the General Medical Service. In the former connection, it should be noted that though the Working Party cited studies from countries using capitation remuneration showing that a significant proportion of GP referrals were deemed unnecessary, they offered no evidence that unnecessary referrals are any less in fee-for-service systems. My study indicates, on the contrary, the referrals in the Irish fee-for-service system appear to exceed those in the British capitation system.

The Working Party's proposed modification of fee-for-service remuneration is intended to reduce over-consulting and its correlate, over-prescribing. Doctors would, as now, be paid a standard fee for each visit, but only until a monthly visiting norm was reached. The norm would be based on national patterns, adjusted for the age of each doctor's patients and his or her referral rates. Beyond the visiting norm, doctors would be paid at a reduced rate, with the fee continuing to decline as the number of visits increased, though fees would always remain positive.

The Working Party are to be complimented on their ingenious scheme. As GPs and the organised medical profession were well represented on the Working Party, the modified fee-for-service proposal may be taken to be a compromise among conflicting interests, and it ought on that account to have a good chance of adoption. Depending, of course, on the visiting norms and fee schedules adopted, it has the potential to reduce consulting rates where they are high and excessive.¹

However, the proposed scheme has two important flaws which would significantly reduce its effect in controlling excessive consulting rates. First, it would affect only those GPs whose visiting rates exceeded national averages or norms, and it could hence do nothing about those averages or norms themselves, i.e., about a general tendency towards high consulting rates in a fee-for-service system. Second, and more worrying, it would do nothing to discourage demand stimulation by GPs whose consulting rates were below the pre-established norms. The reason this is a special concern is that my study has found, among other things, that GPs in areas with high ratios of GPs to population order significantly more return visits for their patients than GPs in areas with low ratios of GPs to population (Tussing, 1983).

The point is this: if medical care markets operated like conventional product and service markets, a high ratio of GPs to population would reduce each doctor's visiting rates and hence his or her income. The tendency of doctors in such areas to order more return visits can be seen as compensating for this tendency. The Working Party's proposal would offer no disencouragement to this behaviour, so long as the doctor's visiting rate remained, as it commonly would, below the adjusted national norm.
It would appear that this difficulty could be overcome by relating each doctor's norm to his or her panel size, and I urge that this correction be included in the modified fee-for-service scheme. Doctors in areas of high doctor-to-population ratios would presumably have smaller panels and lower norms to trigger the reduced rates. Unfortunately, however, this would not entirely solve the problem. My research also indicates that factors associated with low demand for physicians' services -- low regional per capita income, on the one hand, and a high ratio to population of persons covered by Medical Cards, on the other -- are also associated with higher return visits ordered by physicians. In other words, GPs appear to compensate for reduced demand, as well as increased supply, in ordering further return visits by patients. Hence in general doctors who order excessive return visits are those with lower-than-average visiting rates, and the proposed modified fee-for-service scheme, even when adjusted for panel size, would provide no disincentive to this behaviour.

I turn now to incentives facing hospitals. Methods by which hospitals are budgeted or reimbursed are as important as, or more important than, the ways in which physicians are remunerated. Hospitals are the main resource users in the Irish medical care system; and while physicians determine the extent of patient use of hospitals, they have less control over the per day or per case cost of that care.

Simplifying considerably, there are four ways in which hospitals' incomes can be determined: (1) Retrospective reimbursement of costs. Hospitals are paid, either by patients or by third party payors, according to activity and costs. For example, the state can pay hospitals on a patient-day basis, adjusted perhaps for severity of case mix. This is the rough equivalent of paying physicians on a fee-for-service basis. It assures hospitals that whatever costs they incur will be reimbursed, and thus provides them with no motive to economise. It encourages resource-utilising, rather than resource-saving, decisions; (2) Prospective budgeting on an individual hospital basis. Hospitals receive annual budgets from the state or other third party payors. They have an opportunity to explain and defend their budgets, and to use whatever political strength and/or negotiating skill they possess. While prospective budgeting is generally thought to be superior, on economic grounds, to retrospective reimbursement, when it takes the form of review on an individual hospital basis, it may provide virtually the same result: whatever costs are incurred are reimbursed, and incentives to economise are lacking.

The other two techniques provide for no negotiation between payor and hospital, and are hence impersonal, arms'-length techniques. (3) Prospective budgeting on a per capita basis. Hospitals receive budgets according to the size of the populations to be served, as adjusted, perhaps, for age composition, other structural properties bearing on potential hospital use, and possibly differences in each area's morbidity patterns from the national average. In short, hospitals are paid according to formulae. Variants of such
a system are used in centralized systems and national health services. They encourage efficient resource utilisation by hospitals by imposing on them, in effect, the full costs of all resource use. Any unneeded expenditure adds to hospital costs without adding to revenues; any economy reduces costs without reducing revenues. Because this method can provide very different income amounts from those provided under either of the first two methods, a transition from these to formulae-based budgeting needs to be gradual. (4) Diagnosis-related groups. The final method reimburses hospitals on the basis of activity, but on a case basis, rather than a costs-incurred, or patient-day, basis. In the U.S., where this method is to be used to reimburse hospitals for care of the aged under a social security system, hospitals will be paid an amount equal to the average per case cost of all hospitals, adjusted for case diagnosis (under 437 separate diagnosis related groups, or DRGs). Like the formula system, this one separates hospitals' resource-using decisions from factors influencing their incomes, and hence rewards them for economies and penalises them for inefficiency.

The Department of Health makes its budget decisions affecting hospitals on an ad hoc basis in ways which are, to the analyst, obscure. It is difficult to evaluate the present technique precisely because its incentive and allocational implications are not obvious without further research. Other scholars are strongly urged to take up this subject, which is the most important single item on the Irish health economics research agenda. The present system appears to resemble the second model, above; arms'-length methods, such as the third and fourth above, would be likely to provide far stronger incentives for efficient utilisation. Any change to such methods would have to be very gradual, and would probably have to be linked to further decentralisation of administrative decision-making.

In addition to altering the incentive structure on the demand and supply sides, authorities can seek to control medical care costs by two additional techniques.

The first is the imposition of firm cash limits on annual expenditures. Cash limits are easiest to impose where the system is centralised, as under a national health service. They are hardest to impose where the system is decentralised, market and insurance-based. In Ireland, cash limits could be applied even within currently government-financed aspects of medical care only if the current method of GP remuneration were modified.

The second is by adoption of medical audit and peer review. Medical audit is normally conducted by a third party payor (the state or the VHI), and involves review, by physicians, of services provided or ordered by physicians, to determine whether they are medically necessary, efficacious, and cost-effective. Peer review is normally based in hospitals (where it is often called bed
utilisation review, though more than bed use is at issue) and in medical societies. It, too, involves evaluation of services provided or ordered by physicians.

B. Models for Reform

Let me briefly review and assess four alternative models which have been or might be offered for a fundamental re-structuring of the Irish medical care system: the insurance model; the incremental growth model; the competitive prepaid group plan model; and the national health service model.

1. The insurance model. A number of years ago, an Irish Medical Association Working Party, consisting of four prominent specialist consultants, developed a discussion document on the feasibility of a "compulsory specialist and hospital insurance scheme" as an alternative to the present system (Mulcahy, et al., 1975). While the proposed scheme does not seem to have been strongly advanced in recent years, it does provide a worked-out example of an insurance-centred scheme, similar to some found in Western Europe, designed by Irish physicians for the Irish situation.

The heart of the proposal is that everyone in the state would have the same health insurance cover, along the lines of the present Voluntary Health insurance system, but no longer voluntary. Everyone would be a private patient of consultant specialists and in hospital. The state would pay a differential subsidy, according to individual or family income, toward the premium. Distinctions among patients would disappear. This is attractive because, at present, public and private patients receive different care, to the disadvantage of the former.

Another attractive feature of the proposed insurance model is that it calls for medical audit, cost-benefit analysis, and peer review. At present the last of these is rare and limited in its application in Ireland, and the first two are wholly absent. Their purpose in the present proposal is to assure that costly, time-consuming, and sometimes possibly hazardous medical and surgical procedures are medically necessary and useful, are efficacious, and are the most cost-effective treatments available. The VHI have stated that medical audit is useful mainly to deal with fraud, which they believe to be rare in Ireland (Joint Committee on State-Sponsored Bodies, 1980). However, that is a limited view of medical audit, and this part of the Working Party scheme should not be dismissed without careful investigation.

What seems appropriate is a research project, examining the range of treatments in Ireland for the same diagnosis, including lengths of hospital stays, to determine whether indeed no need apart from fraud exists for this kind of review.
In spite of these two attractive features, the insurance model is in general an unconstructive suggestion. It does nothing, really, to deal with the sources of either cost inflation or irrational allocation in Irish medical care. The present incentive structure is retained: physicians are remunerated on a fee-for-service basis, and indeed this is extended into areas where it does not now exist. On the basis of experience elsewhere, one might predict an increase in utilisation, especially of surgery and other in-patient procedures, as a consequence of a shift to the insurance model. Similarly, there is no change in patient incentives. Moral hazard, which is a problem in market-type medical care systems where care is free or nominally priced at the point of purchase, would persist.

Later, a modified version of Working Party's insurance proposal will be suggested, which will deal with some of these incentive objections.

2. The incremental growth model. A second model would aim the Irish medical care system toward the goal of a system with all services free at the point of use, as an ultimate goal; and would move toward that goal incrementally, by providing free, one by one, services heretofore charged for. This is the policy of the Irish Congress of Trade Unions (Cassells, 1980).

Congress has recently established as its "first priority" a "free hospital service for the entire population," which, it states, "could be achieved by the abolition of the income limit for limited (Category II) eligibility ..." (ibid.).

For a number of years, Congress has been on record as advocating a national comprehensive health service which is free for all at the point of use. Their approach has been to press for incremental changes which, bit by bit, move the health services toward that long-run goal. Within the structure of incremental change, Congress has chosen to concentrate on the income limit for Category II. Since the mid-1970s, the approach has been to seek increases in the upper-income limit for eligibility. In 1980, Congress adopted the position that there should be no upper-income limit, i.e., that Category III should be abolished, and Category II eligibility should be extended to all (other than those covered under the more liberal Category I). The major difference between the present Categories II and III concerns consultant specialist services, which are available free to those covered under the former, but not to those under the latter. Hence the main effect of the ICTU proposal would be to extend free consultant services to the approximately 15 per cent of the population not entitled to these at the present.

This proposal also has some attractive features. It moves the health services in the direction of comprehensive care, free
to all. At present, all persons, whatever their incomes, have a right to free hospital care; and those in Categories I and II have free consultant services while in hospital. Thus the proposal would close the last gap in coverage of expensive hospital care for all in Ireland. It would make it unnecessary for anyone to buy Voluntary Health Insurance cover, though of course those wishing private as opposed to public care would still do so. Since the large majority of people in Category III might be expected to continue to prefer private care, and not to avail of the new service, the proposal need not be expensive to administer. Its symbolic significance in progress toward a wholly free system would be considerable.

Nonetheless, the disadvantages of this approach outweigh its advantages. Like the IMA Working Party proposal, it envisions no fundamental change in the incentive structure of the Irish medical care system.8

There are distributional objections to the proposal. The essence of the proposal is to shift services already provided from the private, fee category to the public, free category. Thus public funds for medical care are used in a way that results in no net increase in resources for medical care. To the extent that persons in Category III avail of these services, the money they save on medical care is released for other purposes -- holidays, automobiles, recreation, and other private goods. When it is recalled that those in Category III are (approximately) the top 15 per cent of the income distribution, it will be seen that the proposal involves an effective upward redistribution of disposable income.

If Ireland is ever to move from a multi-tiered system in which some benefits are means-tested, to a system in which basic care is free to all, then just exactly this type of upward redistribution of income will be necessary at some point in time. Its regressive redistributional consequences can be neutralised, however, by financing such expansion out of savings arising out of cutting back on the many and substantial subsidies to private care found in the Irish system, such as services and facilities provided to consultants for their private patients, tax allowances for VHI, and others.

3. The competitive pre-paid group plan model. Prepaid group plans (PPGPs) operate in the private sector. They are organisations established for the purpose of providing comprehensive medical care to their clients. PPGPs either employ doctors or they are associations of doctors. Depending on their size and method of organisation, they may also employ other health professionals and ancillary personnel. They usually own and operate x-ray and pathology facilities. Some even own their own hospitals, or are owned by hospitals, which amounts to the same thing. For a set annual prepaid fee, comparable to an insurance premium, PPGPs undertake to provide for all of a patient's medical care
needs. Services they do not themselves provide are purchased by them for their patients.

The best-known and most common type of PPGP in the United States, where this form of arrangement was first begun and where it enrolls about 10 per cent of the population, is the Health Maintenance Organisation, or HMO. HMOs are private businesses, owned by doctors, engaged in the corporate practice of medicine. Other PPGPs are owned differently, but most other features are similar.

Two characteristics of HMOs and other PPGPs stand out: they have an incentive to keep their clients healthy. And they have an incentive to use resources efficiently.

PPGPs emphasise preventive care and periodic, routine examinations. It is in their economic interest to avoid delay in diagnosing illness, as delay may require more, and more expensive treatment.

When PPGP patients are seen by a primary care physician, that physician may prescribe medicines, or refer the patient to a specialist, or order x-rays or tests, or send the patient to the hospital, just as in any ordinary pattern of organisation. But when the doctor does so, the cost is borne by the PPGP. Indeed, as most HMOs are organised, the cost is covered from a budgeted fund for that physician. Thus the PPGP and, usually, the physician herself or himself, bear a cost when resource-using decisions are made.

In the United States, the experience with PPGPs, and in particular HMOs, has been consistently very good, according to evaluation studies. Cost savings are in the range of 20-33 per cent, and are concentrated in hospitalisation. Though HMO clients have similar characteristics to others, in terms of age, sex, education, occupation, etc., they lose fewer work days because of ill health. Consumer satisfaction, according to surveys, is high. In the U.S., HMOs operate in a very competitive, market type environment.

It is worth noting that American HMOs realise their savings entirely from the effects of altered provider incentives. There are no co-payments whatever; one's premium covers everything. This should create considerable moral hazard, especially by comparison with private insurance, which in the U.S. inevitably involves co-payment. Even though point-of-use prices are lower in HMOs than elsewhere, so is utilization, so moral hazard is evidently not an important factor. This is evidence for the proposition that provider incentives are vastly more important than consumer incentives in the quest for economy and rationality in the provision of medical care.
Competing "Consumer Choice Health Plans," or CCHPs, a type of PPGP, are the central reform proposed for the U.S. by conservative Stanford University economist Alain Enthoven (1979). Enthoven has sufficient faith in the market that he proposes only that enrolment in a CCHP be made available as an option to all consumers, as an alternative to private insurance and fee-for-service care. He is confident that the economic superiority of CCHPs would readily be established through competition. An Irish equivalent of this proposal would call for the creation of health plans which, like HMOs, CCHPs, and other PPGPs, would guarantee to provide all needed care, in exchange for a predetermined advance capitation payment. Persons in Category I could choose to enrol with such a health plan, as an alternative to care as now provided; the Health Board would pay the capitation fee in full, and would have no other responsibility to the patient (other than perhaps, monitoring the quality of care provided by the plan). Persons in Categories II and III would have partial payments made in their behalf by the state, and would pay the balance themselves as an alternative to purchasing VHI cover.

I am pleased to note that the Working Party on the GMS propose "agreed experiments in alternative methods of payment with particular reference to the operation of comprehensive clinical budgets by general practitioners ...." though their recommendation appears to fall short of a pre-paid group plan.

A more thoroughgoing restructuring would substitute such plans for all existing care, for all patients. Such a scheme would amount in effect to a modification of the IMA Working Party proposal, above. It would achieve most of that plan's advantages, and specifically it would remove the differences which now exist between care of public and private patients; and it would do so while avoiding most of that plan's disadvantages, and specifically its uneconomic incentive patterns. The result would be a voucher type of medical care system, one in which (a) the annual cost could be determined in advance, as based on the prepaid fee levels; and (b) the incentive structure would be revised, to provide a strong incentive in favour of resource savings.

Who would organise PPGPs? Groups of physicians, for private gain; hospitals; voluntary organisations; employers; possibly the VHI; or even Health Boards themselves. Plans could be organised by private, public, or non-profit voluntary bodies. Presumably, the state would have to control capitation fee levels, and keep an eye on the quality of care.

PPGPs are attractive in particular to those who favour market-type, or capitalistic arrangements, the private practice of medicine, and decentralisation. In the conventional practice of medicine, as found in Ireland today, and in many other
countries, the market yields distorted, inefficient, and uneconomic results. PPGPs can revive the market and restore to it the potential for efficiency.

4. The National Health Service Model. There is some loose talk which equates a "national health service" with the provision of all care free to the user at the time of use. The meaning of national health service is rather more precise. As usually employed in the relevant literature, it refers to a centralised, non-market system in which resource-using decisions are made administratively at the macro level, and made, as now, by physicians, through referral, prescribing, etc., at the micro level. Primary care physicians are paid on a capitation basis. Other physicians (for example, specialists and junior hospital doctors) may be paid by capitation, or they may be salaried, a situation which already prevails in Ireland, with respect to public patients. All services are provided on a free or heavily-subsidised basis to patients, and the market is not used at all to ration care or resources.

In the NHS model, there is an opportunity to apply effective cash limits, as was discussed above. Because in such a centralised system it is possible to determine total medical care spending in advance, and as well to determine its regional and functional allocation, it is possible to limit spending, and its growth, to any level. This is not possible under decentralised models, such as the present Irish scheme, the insurance model, or the incremental growth model. (It would be possible, however, in the PPGP model.)

To summarise then, the most salient characteristics of the NHS model are: (a) free or heavily subsidised care to all members of the population; (b) effective cash limits; and (c) an incentive structure which does not encourage excessive utilisation.

Britain of course uses a version of the NHS model, and indeed is in effect the originator of the model. And Britain stands out in international comparisons as one of the very few countries whose medical care expenditures have not exploded in recent years. It is one of the crowning ironies of this subject area that the British "National Health," put in place by socialists committed to equity, has become the most effective device, due to its centralisation, for controlling cost expenditure on medical care. However, the British have had to ration certain kinds of care to achieve this result.

C. Conclusions

The Irish medical care system stands today at a cross-roads. It has grown and evolved to its present size and structure largely out of incremental changes. The economic incentive structure
implicit in it, which looms so large today, was not always foremost when past decisions were made. While the system is fundamentally sound, it is often not cost-conscious. Instead of continuing to evolve, as in the past, on an incremental basis, the entire system should be reviewed, as a single, coherent, integrated system.

This is not to say that the system should no longer evolve, step by step. Rather, it is to say that that evolution should be guided by a strong concept, or vision, of the system toward which it is heading.

One reason is that when reforms are made in one confined sector of the system, those reforms are necessarily constrained by the structure of the rest of the system. This is the lesson, in part, of the useful but necessarily limited proposals of the Working Party on the GMS.

There are a number of proposed reforms on the table. I hope that providers and the public will debate these in the coming months. I have my own agenda of specific proposals which I hope soon to add to the discussion. In all my policy-oriented research, my main hope has always been to stimulate debate and to make sure that all parts of the community are heard from; I hope that I have been able to make a small contribution to that end this morning.
FOOTNOTES

1 It is possible that, faced with a reduced fee for excess consultations, a GP with income needs might encourage more rather than less additional consultations. That is, the income effect may more than offset the substitution effect. The Working Party implicitly denies this prospect, and I suspect they are right.

2 It is not clear whether the Working Party intend that norms be defined on a per-practice or a per-patient basis. Indeed, the proposal is somewhat ill-defined: "The norm for visits, both domiciliary and surgery, would be established taking into account the experience of the Scheme to date and regard would be had to the differential needs of patients on the basis of age and taking account of the referral rates to secondary care. The standard fees would be payable on a monthly basis in respect of all visits up to the level of the norm for visits for each practice, each practice norm reflecting the composition of the panel" (p. 141). The norm appears to be expressed in per-practice terms; the nature of the adjustments for age structure and referral patterns is not spelt out.

3 In addition, the interaction between the ratio of physicians to population and the ratio of public patients to population was found to be significantly related to physician return visit behaviour.

4 "Outliers," cases which deviate significantly from the norms, will be reimbursed at cost. Separate norms will be established for urban and rural hospitals. Several years are allowed for transition.

5 It is important to emphasise that the procedure is not obscure because of any disposition of the Department of Health to make it so, or to withhold from the public or researchers vital information concerning the procedures or the outcomes. Instead, the procedures are ad hoc and are inherently difficult to model without specific research into the statistical determinants of budgetary allocations.

6 Cost-effectiveness analysis compares the costs of alternative ways of achieving similar results, or compares results for identical cost. True cost-benefit studies are not appropriate in the area of health and medical care, because there is no acceptable measure of "benefit" comparable with cost.
It is assumed, however, that the authors have in mind cost-effectiveness rather than cost-benefit analysis.

First, a reduction in the private use of specialist services involves a marginal shift from fee-for-service to salary remuneration. Second, it increases slightly the moral hazard inherent in the system, to the extent that services once charged for, to uninsured persons in Category III, are now provided free. Uninsured persons in Category III are few, however. These two incentive changes are in opposite directions, and as each is small, the net change is still smaller, and of uncertain direction. The third incentive change inherent in the incremental growth model is a change in the relative costs of primary care from GPs and hospital care, both in- and out-patient. This is a rather more serious consequence than the two just cited. Persons in Category III would join those in Category II in finding it cheaper to use hospital services than GP care, thus encouraging a further shift away from community care and toward hospital care.

Luft (1978) reviews approximately 50 evaluation studies of FPGPs in the preceding two decades and finds cost savings ranging from 10 to 40 per cent, attributable in the main to hospital utilisation 25 to 45 per cent lower for similar populations using conventional fee-for-service care. See also Enthoven (1979).

Italy has also adopted a national health service in recent years, for the purpose of rationalising and controlling expenditures. One important feature of the changeover is a shift from fee-for-service to capitation remuneration of primary care GPs. The changeover provides an example of a natural experiment, because we have an opportunity to observe utilisation differences arising out of different systems, where the population served and the physician population are essentially unchanged. In areas where the change from fee-for-service to capitation has taken place, consulting rates have fallen (Abel-Smith and Maynard, 1978).
REFERENCES


