REPORT

of the

COMMISSION

on

HEALTH FUNDING

September 1989

Summary

CHAPTER TWO

SUMMARY OF REPORT

INTRODUCTION

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

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

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

HEALTH EXPENDITURE

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

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

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

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

CHOICES IN HEALTHCARE

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

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

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

Comprehensiveness and Cost-Effectiveness

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

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

Equity

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

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

THE FRAMEWORK

Funding the Health Services

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

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

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

Public versus Private Funding

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

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

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

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

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

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

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

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

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

General versus Ear-marked Taxation

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

Other Sources of Funding

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

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

ELIGIBILITY FOR HEALTH SERVICES

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

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

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

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

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

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

User Charges

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

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

Other Issues relating to Eligibility

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

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

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

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

THE PUBLIC/PRIVATE MIX OF HEALTHCARE

The Role of Private Health Insurance

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

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

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

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

The Future of Private Health Insurance in Ireland

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

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

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

Tax Relief

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

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

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

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

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

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

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

Private Delivery of Health Services

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

ADMINISTRATION AND MANAGEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PRACTITIONER SERVICES

The new GMS Contract

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

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

Eligibility for GP services

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

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

Other issues

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

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

GENERAL HOSPITAL SERVICES

Roles and Funding

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

Access to public hospitals

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

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

User charges

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

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

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

Other Issues

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

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

CONSULTANT SERVICES

Private Practice in Public Hospitals

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

Remuneration and Conditions of Employment

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

Other Issues

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

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

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

OTHER MEDICAL AND ASSOCIATED SERVICES

Dental, Ophthalmic and Aural Services

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

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

Paramedical and Home Nursing Services

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

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

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

DRUGS AND OTHER MEDICAL SUPPLIES

Drug Prices

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

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

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

Entitlement to Drugs

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

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

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

Other Issues

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

PROMOTING AND PROTECTING HEALTH

Immunisation and Screening

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

Child Health Examinations

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

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

Health Education and Health Promotion

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

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

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

WELFARE AND CONTINUING CARE SERVICES

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

Assessment and Provision of Appropriate Services

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

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

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

User Charges

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

Administration and Coordination

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

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

Voluntary Organisations

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

Other Issues

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

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