The Financing of Healthcare in Ireland

By Joe Durkan*

[It is an interesting aspect of the current debate with regard to healthcare in developed countries that the discussion starts with the finance of healthcare. What makes it interesting is that, with the exception of the US, healthcare is predominantly financed by government through a combination of a specific social welfare contribution and general taxation. There is some private financing through private insurance, but tax benefits for insurance and the universality attaching to most public systems effectively means that the government is financing health expenditure. In almost no other area of Government expenditure would we be considering the question of financing, as financing is simply a function of taxation. The question of financing healthcare is thus a deeper one than simply that of financing and owes its origin to the rapid growth of expenditure on healthcare over the past 30 years, and the realisation that as population ages, claims on resources will increase over the next 30 years. The finance of healthcare is in fact a topic which is not really about finance, but about the means that can be used to control expenditure to ensure that taxes do not have to be raised. This paper examines the causes of the growth in healthcare expenditure in Ireland and, within the framework developed there, discusses measures designed to control expenditure.]

Increasing Healthcare Expenditure

Health expenditure has increased throughout the developed world in real terms and as a proportion of GNP since the 1960s. Healthcare expenditure is believed to be highly income elastic, though the econometric studies on which this conclusion lies are subject to some controversy, particularly as much of the expenditure has been undertaken by the government. Ireland has been no different than other developed countries, in that the share of health expenditure in GNP has increased over the past 35 years. The share has not grown smoothly, in fact it peaked in 1980, and then declined throughout much of the 1980s. In the most recent period the share has risen as public health expenditure rose following the correction of the public finances. In 1991 total expenditure on health, both public and private, was estimated at just under £2 billion, or 7.8 per cent of GNP. Table 1 (Page 25) shows the relative importance of health expenditure for Ireland, UK and US. While the share relative to the UK is high, absolute levels of expenditure per head are significantly higher in the UK. The Irish share is atypically high, given income levels, for reasons discussed later.

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TABLE 1

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<td>US</td>
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It is also worth noting that public expenditure dominates health expenditure. Table 2 below illustrates this, with the US as a clear outlier. Even this low share in the US is itself a significant element of Government expenditure, hence the proposals to reform healthcare expenditure in the US.

TABLE 2

<table>
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<th>Public Health Expenditure as a % Total Health Expenditure 1991</th>
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<td>Ireland</td>
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Causes of Increasing Expenditure on Health

Public expenditure on health in Ireland is heavily influenced by the state of the public finances and the perception of the extent of the budget constraint facing the Government. As a general rule, Governments have sought to contain health expenditure when budget deficits were considered extreme, while when the budget constraint has appeared to have been relaxed, expenditure has expanded.

Demonstration Effects

There was a significant increase of the relative importance of health expenditure in the 1970s. In the background was an attempt to emulate the UK National Health Service, then seen as the model for Western societies, and an attempt to raise the level of absolute expenditure, which was low, and of service. Policy makers were consistent across a whole range of social policy issues - the level of social welfare entitlement both for unemployment and pensions were also targeted at UK levels, and of course in many areas wage rates were only marginally below UK wage rates. The demonstration effect was a major factor in the increase in expenditure, so much so that as the UK NHS deteriorated it became widely believed that the level of service was better in Ireland than in the UK.
Medical Development and Medical Inflation

Generally, we tend to consider technological development as cost reducing or capacity expanding, i.e. we either reduce the costs of producing a particular product or develop new products which widen consumer choice. In healthcare, technological development has been associated with increased costs and in some cases only marginal improvements in services/outcomes.

For some illnesses new drug products have replaced long standing products and new products are much more expensive. The same applies to equipment. What generates this is the obligation derived from medical ethics to provide the 'best' treatment on ethical grounds. Best treatment is equated with the latest technology. This explains the level of technology associated with the final days of life for many who die in hospital. There is a great deal of expenditure, but it is not clear that the benefits are commensurate, and the development of the hospice movement bears witness to the fact that this technology does not satisfy the basic needs of those terminally ill. Voluntary bodies add to problems by raising finance for equipment which then requires higher current expenditure in the future. There is also duplication of equipment throughout the system.

Health service inflation (i.e. changes in input costs of pay and prices for goods and services) has tended to outstrip general inflation and also public sector inflation.

Principal - Agent problem

Typically the principal-agent problem is seen as deriving from an asymmetry of information between patient and medical practitioner. However, there are many other forms in which this problem arises, e.g. between the Department of Health and those it funds, between the Department of Finance and the Department of Health and, of course, between the departments and government.

The ability of one tier to hide activities from other tiers of Government is well known (e.g. the flu epidemic of several years ago which 'cost' £35 million, the borrowing of £100 million undertaken by Health Boards which required a special one-off payment through the Exchequer). The acquisition of the information necessary to judge programmes and expenditure is possible, though costly. However, it exposes agencies of Government to regulatory capture. This is a serious problem for policy makers. The situation in Ireland is complicated by the dual role of hospital consultants, i.e. as public employees but public employees who can determine the
time-frame for treatment of some patients, within both a public and private environment, within the terms of their contract.

**Financing Methods**

Although budgeting for acute hospitals has recently been reformed, the previous practice of block grant budgeting acted to increase the level of expenditure. Hospitals were effectively free to provide extra services at the margin - services that required increased funding for their maintenance. At the individual level where healthcare is 'free' at the point of delivery there will be greater utilisation of services, most especially for trivial complaints. There may also be a moral hazard problem since people are possibly less careful than if they were paying directly for services. Financing methods only look at inputs not outcomes. There is no incentive to increase throughput by improved practices, e.g. by filling beds.

**Population**

The increase in population over the past 30 years has clearly caused an increase in the provision of healthcare services. The rise in the number of births up to the early 1980s increased claims on maternity hospitals, whilst the ageing of the population will have serious effects on expenditure in the long-run - the more so since this is at present unfunded.

**Methods to Control Health Expenditure**

There is a wide selection of methods adopted by different societies to control healthcare expenditure. None seem to be without problems.

**Drug Budgets**

A drug budget sets limits on the value of drugs prescribed by a GP to public patients. Those who stay within limits are rewarded by bonus payments. This creates an incentive for the GP to stay within the budget set. It matters how the GP sets out to achieve this - perhaps by using generics rather than the new expensive drugs or by simply reducing prescriptions where drugs are not necessary. There is an alternative, which is to pass the patient onto some other agent, for instance into the hospital system. Experience in the US indicates that control systems in healthcare tend to cause shifting to uncontrolled activities where there is genuine illness. There is no published economic analysis of the effect of drug budgets in the Irish system and the data are not published which would allow the necessary analysis.

**Capping**

The VHI introduced capping of expenditures by hospitals as part of its emergency measures to contain expenditure following the sudden
deterioration in its financial position in the late 1980s. What was initially a
temporary measure is now a control mechanism and has been extended
from hospitals to consultants.

Capping works by limiting the amount the VHI will pay each hospital
during the year. Once a hospital has reached its limit, in a pure capping
situation, then it cannot attract private insured patients, or if it does, it
cannot reclaim costs. The VHI has introduced some flexibility into the pure
system by a variant of marginal cost pricing.

The difficulty with capping is that it limits the expansion of the most
efficient, does not penalise the most inefficient, creates an incentive for
hospitals not to treat ‘costly’ conditions - forcing the people elsewhere in
the system, or delaying treatment - and makes it difficult for new entrants
to gain access to the market.

Overall, capping is essentially what the UK NHS did for most of its history,
but recent developments are attempting to apply more directly market-
based solutions.

**NHS - Fundholding**

It is somewhat ironic that at a time when the US is tantalising itself with an
administrative approach (which looks like an NHS type) to the problem of
the size of healthcare expenditure (one-seventh of total output), that the UK
is moving to market-based solutions. The most obvious manifestation of
this is the new fundholding practice. A certain number of large NHS
practices were invited to become fundholders. Fundholding practices
receive a budget from regional health authorities. With this budget they
must cover their own costs but they can also purchase a range of services
from hospitals, and other providers of health services.

Fundholders are expected to treat revenues as commercial revenues and to
purchase inputs on behalf of patients. They have the possibility of
generating surpluses which ultimately can benefit the practice holders.
There is an incentive to turn away high risk patients. There have been
some well-documented cases recently which make this a serious concern
and the problem will worsen as fundholding spreads, as is intended.

The principal-agent problem is not resolved by fundholding. In fact it may
be exacerbated, as there seems to be little attention to outcome for
patients. In a totally free market system, providers of medical services have
an incentive to get patients to buy what they sell, in fundholding the
incentive is to get patients not to use services. In neither case is the
outcome, compared to alternatives, considered.
Fundholding is unlikely to develop in Ireland. There are very few large practices in Ireland - a characteristic that is worth further research - and without multi-doctor large practices it is unlikely that individual doctors will develop the necessary knowledge on costs and available services in supporting activities. In the UK, this knowledge is being acquired by professional management newly hired by fundholders, but the fundholding practice needs a reasonable size to be able to hire management.

**Activity Based Costing**

A characteristic of the Irish hospital system is the difficulty of obtaining cost of treatment data. Since hospitals operate to fixed budgets derived from the public purse, the main emphasis has been on minimising the price of inputs of materials rather than minimising the cost of activities. Acute hospitals are introducing systems to record activity-based costings, and these will provide data which will allow comparison between hospitals and hopefully shifts in resources to reflect relative costs. The base data remain suspect and much still needs to be done in this area.

**Conclusion**

Healthcare illustrates a variety of economic problems deriving from the principal-agent relationship. This is complicated by the episodic random nature of illness at an individual level which necessitates some form of insurance - whether private or the public provision of healthcare services.

The private insurance model is a financing model and does not correct the principal-agent problem. It suffers from the fact that both the providers of healthcare services and the beneficiaries do not appear to be constrained by costs (US).

The public provision of Healthcare transforms the principal-agent problem, but government's activity on behalf of citizens has not been successful in the past in countering the basic cause, and the consequence, of the principal-agent problem, and beneficiaries are not obviously constrained by costs.

This suggests two routes to go in attempting to deal with this problem. The first is where the government, acting as principal, attempts to provide itself with the information necessary to evaluate the claims of providers of services. This is what the old UK NHS tried to do, and was reasonably successful for a long time in providing first rate services at relatively low cost. This system is difficult to monitor. Recent revelations about regional differences in services, and the nature of some services, indicate that the
problems of the NHS may have had more to do with the nature of bureaucracy, than with serious underfunding.

The second approach is with Health Maintenance Organisations (HMO). The essence of the HMO is competition between providers of services for patients, in terms of costs and quality of services, and cost minimisation at service level to derive and increase profitability. The HMO model has the added advantage that it is in the interest of the HMO to provide information to the member in regard to the state of health, and preventative measures that are necessary. HMOs, however, have not attracted a significant amount of attention, even in the market systems. The equity question must additionally be addressed, though this is not an insurmountable problem.

There will always be a reluctance to fundamentally alter systems, whether in health or elsewhere. Change will inevitably adversely affect some people, and they will be vocal in protecting their interests. This is particularly so in the case of providers of services, who tend to be well organised, though it is not so for those in receipt of services, who lack an effective lobby defending their interests. In the face of this and because governments will not readily give up control in health, the correct strategy is for government to get more heavily involved in the evaluation of expenditure. This should be done at the centre, given the problem identified with different tiers of government, and the different tiers where the principal-agent problem arises. There is another reason for this, viz. that decentralised decision-making does not allow government to choose between expenditure on different programmes at the margin. Self-evaluation of programmes by departments encourages increasing expenditure. Crude measures of control by setting budgets, avoids choice between departments and programmes. Of course, if one could incentivise government departments, while maintaining or improving outcomes, this would be optimal. Without this, greater controls are needed.