Creating Two Levels of Healthcare

Claire Finn
Research Fellow, UCD School of Public Health and Population Science
Claire.Finn@ucd.ie

Niamh Hardiman
UCD School of Politics and International Relations
Niamh.Hardiman@ucd.ie

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Introduction

The system of health care provision in Ireland came to a crossroads in the early 21st century. Problems of capacity constraints reached a critical level during the years of rapid economic growth and population expansion of the 1990s and 2000s. Provision of both primary and acute health care was no longer adequate to the needs of a growing population whose expectations were also rising. The challenge seemed especially daunting in the hospital sector, where overcrowding in Accident and Emergency units was a persistent phenomenon, and where waiting lists for surgical procedures were a very visible measure of the mismatch between need and availability of services.

How best to manage these problems became not just a matter of levels of public funding, but also involved consideration of the role of the private sector, and the management of the complex interrelationships between public and private sectors. Public spending on health care provision grew at unprecedented rates during the late 1990s and early 2000s. Policy documents published during the 1990s reiterated support for the public system, providing equitable access to and quality healthcare for all. Yet at the same time government was offering new incentives and supports to private sector initiatives in healthcare provision. Ireland appeared to be at a critical juncture in the governance of health care, between intensifying public provision on the one hand, and increasing its reliance on the private sector on the other.

In this paper we examine some of the implications of this dual system, with particular reference to the acute hospital sector. First we assess the rationale for a combination of public and private funding in health care, and outline the main features of the Irish system. Second, we suggest that the insurance system as it currently works creates inequitable
access not only to hospital care for surgical procedures, which are the most visible and most potentially expensive kinds of treatment people may need, but also to most consultant care. We examine the profiles of those with and without private insurance and consider the implications of Ireland’s model of healthcare provision for each of these groups. Third, we consider how best to explain the evolution and persistence of the current system. We suggest that the nature of consultants’ contracts is intimately bound up with the continuity of the two-tier system. However, we also note that there are broader structural explanations for the perpetuation of this system, to do with both funding and governance systems in health care provision. Finally, we suggest that the uneasy dual-track policy pursued to date cannot long be sustained. Alongside a public commitment to improving the quality of the public sector, there is a growing trend toward reliance on capacity provision by the private sector. Yet this resolution of current tensions seems to be evolving by default and in ways that are not consistent with other health care policy commitments.

**Perspectives on public and private health care**

Health care has become one of the most important areas of public policy in modern states. Citizens expect to have access to affordable treatment appropriate to their condition, and where this does not exist, there is generally an expectation that this is a problem and that a policy intervention is appropriate. Many of the wealthier OECD countries combine a public and a private sector in acute health care, though the mechanisms for funding and delivery vary considerably. The demand for health care is highly elastic and the costs rise with technological innovation. In theory it would be possible to spend not just a significant proportion of national income on health care but the whole national income. However as Barr notes, ‘if we spent nothing on health, some people would die unnecessarily from trivial complaints; if we spent the whole national income on health care there would be no food and we would all die of starvation’ (Barr, 1998, p279.). Thus the resources available for
healthcare are finite. Like education, healthcare is an example of a publicly provided private good where the marginal cost of an additional another user is substantial, and once the resource has been used it cannot be used elsewhere. This is the opposite to ‘public goods’ - like clean air, for example –is available to all and one person’s use does not preclude its use by others. But these sorts of goods have come to be provided to a significant extent by the public purse. There are both efficiency and equity arguments for providing a good such as healthcare publicly. Healthcare is associated with numerous market failures and government intervention is often considered necessary to correct these problems. For some, health care is a merit good, and as such something that it is believed should be available to all regardless of ability to pay, thus ensuring that access to essential medical attention is not debarred by reason of inadequate means, nonetheless this, as with all equity-related decision-making by a society, is a normative judgment. In addition, redistribution from the better-off to the less well-off through a benefit-in-kind (such a public healthcare) rather than a cash transfer, ensures that resources are spent for the purposes intended (Barr 1998).

Nevertheless, some powerful arguments have been put forward in support of supporting for private funding in healthcare provision. Chief among these is that it reduces the burden on the public sector and thereby improves both access to the public sector and the quality of the service it can offer (Besley & Coate 1991). Indeed, redistributive benefits can even be shown to occur, under certain conditions, where a private alternative exists. If the quality of the public sector is kept at a level that induces those who are better off to leave the public sector and seek private treatment, this will free up space in the public sector for those who remain (Besley & Coate 1991). Patients with low waiting costs will choose public treatment. They may be better off with waiting time than without, because waiting time
induces patients with high waiting costs to choose private treatment, thereby reducing the cost of public health care that everyone pays for (Hoel & Saether 2003). So the existence of a private sector frees up resources, thereby helping to reduce waiting lists in the public sector; and it offers choice by allowing those who are willing to pay to seek treatment elsewhere. But these assumptions only hold if public and private sectors are strictly alternative paths of treatment. And the argument applies only to the question of aggregate costs, not to issues of equitable access based on medical need. As we shall see, both these issues turn out to be problematic in the Irish case, and the coexistence of public and private medicine creates problems on both grounds.

**Variations in the organization of the public-private mix**

The nature and extent of the role of private funding varies greatly across the OECD, but in most western European countries, government plays a key role in healthcare provision, and free or subsidised health care is available to a significant majority of citizens. Health care at a certain quality level is provided and paid for through public funds, though the relative balance of tax and social insurance funding may vary. However despite the availability of this public health care, in most countries citizens also have the right to choose or alternate between varying combinations of public and private health care, if they wish to do so. The decision to purchase private care is often prompted by an individual’s desire to bypass perceived public sector inflexibilities and to access treatment with a quality level higher than that offered by the public system. While the particular combination of public and private in the Irish health care system is distinctive, the existence of a private alternative, offering a quality level higher than that of the public sector, is not unique. Many wealthy countries have analogous systems and even in systems with universal healthcare provision such as Britain and Sweden, there is some role for private insurance.
In Esping-Andersen’s well-known typology of welfare states, Ireland tends to cluster in the liberal or market-oriented welfare states (Esping-Andersen 1990; 1999). This model contrasts with the mainly Scandinavian Social Democratic welfare states with their high tax levels and wide reliance on universal entitlement schemes, and with the continental ‘Bismarckian’ welfare states, which rely heavily on payroll social insurance to fund generous welfare entitlements to those who qualify. In contrast, liberal welfare states tend to have more limited public welfare schemes, to target access according to means, and to encourage heavier reliance on private cover against risk. A simple typology of health system ‘regimes’ in national healthcare systems would be similar. One group might be characterised by universal coverage such as in Scandinavia or the UK, another by compulsory insurance systems with quasi public providers such as in Continental Europe, and yet another by extensive private cover such as the US. But while this provides a useful framework in which to categorise health care systems, in general the reality is far more complex. For example, quite apart from the creation of internal markets in service provision within the NHS, extensive national health care cover coexists with a growing private sector and approximately 15% of the population in the United Kingdom now hold private health insurance.

The OECD classifies the Irish system as a ‘duplicate’ system, that is one where insurance complements, supplements and duplicates that offered by the public system. However in these systems private health insurance typically provides a level of care, choice and speed of access above that offered by the public system (OECD 2004). Currently, along with Australia, Ireland has the largest duplicate market in the OECD, and approximately half the population in both countries hold private health insurance. In fact in Ireland, 70% of those
not qualifying for the free public care under the mean-tested medical card scheme opt for private health insurance (Finn & Harmon 2006)

The Irish system is characterized by a universal entitlement to public care, but deviates from this in a number of important ways. In line with its classification as a liberal welfare state it offers a means-tested entitlement to public care through which general practitioner services, public out- and in-patient hospital services, and prescribed medication, are all provided free of charge. Those who do not qualify for free medical care under a means test turn for their front-line primary care services to general practitioners who charge the user on a fee-per-visit basis. Prescribed medication is paid for by the user, to a relatively high maximum monthly amount compared with other European countries, the excess on which is paid for by the state. Public out- and in-patient hospital services are heavily subsidised by the state for those who are not eligible for medical cards, hence justifying Ireland’s classification as a ‘universal’ system. But as we shall see, this is not a universal system in the UK sense. This is not just only because charges in the public sector are subject to means-testing, and non-medical card holders can incur not-inconsequential user fees as they access medical care. It is also because the capacity of the health care system to provide access to appropriate medical care entails a strong reliance on private sector provision, and private insurance cover by a large proportion of the population. And the public and private systems in Ireland are closely bound with one another in ownership, management, care provision, and working practices.

The trends in eligibility for free public medical services on the one hand, and consumption of private health insurance on the other, throw up some explanatory puzzles. The proportion of the population eligible for medical cards (providing full free services for both
GP and hospital care) has fluctuated, but has in fact declined overall, as income thresholds failed to keep pace with rising living standards. The proportion of the population with medical cards stood at about 38% in 1977, and fluctuated only a little until 1987. By 2001 though, it had fallen to 31%. (Wren 2003, p.375). Some aspects of means-testing for medical card eligibility became less relevant as entitlement to free hospital care, for all but a fairly nominal nightly charge, was extended to the whole population in 1991. And access to free GP care was broadened to all those aged over 70 (albeit concluded in controversial terms) in 2001, and partial cover for primary care extended to more low-income families in 2004. Yet just as we see entitlement to both hospital and primary care expanding, the proportion of the population taking out private health insurance shows a marked increase. The proportion of the population with private health insurance was 18% in 1977, a figure that rose to about 30% in 1982. This had further grown to 35% in 1990, and continued to grow thereafter to 46% in 2001 (Wren 2003, p.375); the 2006 figure is about 50%. The reasons for the expansion of private health insurance, in parallel with the extension of public sector cover, need to be explored further.

The incentives to take out private health insurance can be traced to the long-standing government policy to continue to facilitate arrangements for private healthcare as a means of augmenting the resources and capacity available for acute sector health care (Department of Health and Children 1999). A central tenet of the argument supporting this policy is not just the cost-saving to the public system when patients seek treatment in the private sector (thereby forgoing their public entitlements and in theory, freeing up of resources in the public sector for those that remain) but also the transfer of direct revenue to the public system from the private, particularly via insurance payments (Finn & Harmon 2006). Indeed, government policy actively supports insurance take-up as a means of
delivering a high-quality service to all. Thus subsidies such as tax relief on private health
insurance are justified on the grounds that they ‘allow those with chronic health conditions
to benefit from insurance at a reasonable cost’ (Department of Health and Children 1999).

Private insurance in Ireland is said to facilitate equitable treatment because the cost of
insurance is governed by principles of community rating. This means that private health
insurance premiums are not weighted by the age or health status of the policy-holder. The
risk is thereby pooled across all policy holders, though because the scheme is voluntary,
‘risk-pooling’ does not have the society-wide reach of universal insurance schemes. The
private health insurance system in Ireland was established in 1957, provided by a state-
owned, non-profit, monopoly insurer, Voluntary Health Insurance (VHI). This was
designed to cater for the top 15% of earners who, at the time, were excluded from an
entitlement to free or subsidised public health services. It was set up principally to provide
cover for acute hospital care and typically covers all or most inpatient hospital expenses.
Private outpatient hospital appointments are paid by the user on a pay-per-visit basis, as
indeed are private GP services. There remains a high deductible on both these services, and
insurance makes a relatively low contribution to them. EU-mandated competition in the
health insurance market since the mid-1990s created a more diversified set of schemes. But
all were required (following a prolonged legal challenge) to maintain not only the principle
of community rating but also risk equalization across insurance providers. Private health
insurance cover in Ireland therefore continues to be strongly associated with acute hospital
inpatient care (albeit the development, in recent years, of insurance policies that make a
contribution to GP, outpatient and other primary care costs); and the bulk of the claims
discharged involve costs associated with surgical procedures requiring hospital stay.
Health insurance is subject to a regulatory system to monitor the rate of premium increase.
From 1987 on, sharp cuts were made in healthcare spending as part of the drive to curb public spending and to reduce high levels of public indebtedness. These cuts resulted in a net decline in the number of acute hospital beds, restrictions on appointment of additional personnel, especially consultants, and the imposition of new direct (but nominal) charges for hospital use. A Fianna Fáil minority government under the leadership of Charles Haughey undertook the initial cuts, and was supported in this by Fine Gael in opposition. In the rather more buoyant fiscal climate of the early 1990s, the Fianna Fail-Progressive Democrat coalition, again with Haughey as Taoiseach, changed the direction of some of these cuts by expanding free entitlement to hospital care to the top 15% of the income distribution who had previously not been entitled to free public care, creating a fully ‘universal’ system. However, the cuts to both capital and current spending in the health sector had bitten deep in to the capacity of the public system to deliver quality health care. As entitlement was extended and, we may presume, demands on the public sector grew, investments to improve or even restore the capacity of the public sector to deliver a high-quality service did not keep pace. This goes some way to explain the apparent paradox that the demand for private insurance went up in parallel with the extension of public sector entitlements.

Yet we must not assume any intention to roll back the welfare state, analogous to retrenchment policies then gathering momentum across continental Europe. Rather, a relatively under-developed healthcare system had suffered restrictions before a full high-quality public system had been put in place. Public spending on health care in fact subsequently increased under every combination of party in power. From 2000, spending on health care grew at unprecedented rates, much faster than other OECD countries. Yet
spending per capita on most indicators still lagged behind EU rates (Tussing & Wren 2006, ch.1). The legacy of the cutbacks and of the restrictions on infrastructural investments throughout the difficult years of the 1980s persisted in the form of capacity constraints throughout the system. Rapidly increasing public spending translated into much slower improvement in service delivery.

**Problems of sustaining a public-private mix**

We have already noted the arguments in favour of public policy support for a private sector health alternative; to reduce the burden on the public sector thereby enhancing quality and access for those that rely on it and to increase capacity in the health service overall. But there are two problems with this argument. The first is that the existence of a strong private sector may have the opposite effect – that it may result in draining resources from the public sector, thereby reducing public sector quality and restricting access (Besley et al 1999; Iversen 1997). The second is that, where the aim of public policy is social equity, the targeting of benefits toward the least well off, to achieve the best results in alleviating need, may actually be counter-productive, as it may in fact further intensify the flight into the private sector.

**Policy feedback and quality slippage**

This line of thinking suggests that for individuals to forgo public sector entitlements and pay for private sector treatment, whether out of pocket or for insurance, the public sector must be of a quality that is lower than the private alternative. From the point of view of equitable access to services, this could become problematic if the quality level is ‘too’ low and leads to significant desertion of the public sector.

Decision-making about the extent of investment in the public sector is primarily a matter for government policy. But governments respond to electoral pressures, and there is
a body of literature that suggests that private health sector users may be able to exercise disproportionate influence over the allocation of resources in health care provision (Blomquist & Christiansen 1999).

The argument works in two ways. Firstly, there is an indirect feedback effect into the demand for services, and secondly, there may be a more direct effect through the expression of preferences in voting behaviour and lobbying activity. The first explanation suggests that political commitment to service provision is shaped by patients’ patterns of use. Once an individual is privately insured they cease to be concerned about public sector waiting lists, which is generally taken as an indicator for public sector quality (Besley et al 1998; 1999). If the intensity of demand for public services can be alleviated by siphoning it off to the private sector, the pressure on policy-makers to improve public sector quality – measured in terms of waiting-list length and duration – thus may be diminished.

The second strand of explanation suggests that private sector use may be associated with different political attitudes about the role of the state in welfare provision; in particular, private users may favour a smaller role for the state (Propper & Burckhardt 1999). If attitudes are further affected by use, then an expansion of private healthcare may mean a further diminution in support for public provision and for the taxation required to fund it, as a consequence, ‘government may under-fund public services in areas with high private insurance coverage’ (Siciliani, 2003). Moreover, it may be that those who opt for private insurance are among the most affluent and articulate and are more successful at political lobbying than other groups. Since better public services and shorter waiting lists are not a priority for them, political pressure on these issues is reduced, and electoral and lobbying support for private sector alternatives is correspondingly strengthened. British research offers some support for these hypotheses. Besley and his co-authors, for example,
find that in their analysis of the relationship between public sector quality and demand for private health insurance in the UK

regions in which many are privately insured appear to put fewer resources into keeping waiting lists short

They conclude that:

From a public choice perspective, resource allocation is influenced by wilful political acts. If more individuals choose to opt out of certain NHS services by taking out private insurance this can affect the way in which resources are allocated (Besley, 1998, p.496).

They find this in a UK context despite the fact that compared to Ireland those with private insurance consist of considerably smaller proportion of the population and resource allocation in considerably less politicised. In fact in the UK, as noted by Propper, because many of those with private health users also make significant use of the public sector, for example for GP and prescription services, and because many services are in any case not available through the private sector, Accident and Emergency most notably, there remains considerable support for the NHS among these private users. However this support might not be so in the Irish case. As such then the argument pertaining to the relationship between patterns of use and the political articulation of policy preferences is summed nicely by Epple and Romano

On the one hand, the private alternative reduces the demand on the public system, thereby reducing costs, to the benefit of users of the public system. On the other hand, the loss of clientele to the private sector can be expected to reduce public support for a high quality public service, at least among those who do not use the public alternative. This is particularly true if those with the highest demand for quality are the first to opt out of the public system’ (Epple & Romano 1995, p.298).

These patterns however might not be as readily investigable in the Irish case. In Britain, public and private health sectors constitute two distinct sectors with separate organizational structure. But even at that, it has been estimated that only about 1% of total NHS
admissions in 2001 were through the private sector (National Economic and Social Forum 2002, p.38). In Ireland, in contrast, the interpenetration makes the distinction less stark and less immediately visible. But private insurance cover does offer the kind of choices which Besley, Propper and others have been concerned to investigate in the British case. So it is at least plausible that some comparability of findings might be anticipated in the Irish case.

The paradoxes of targeting

Targeting benefits and services through means testing is widely held to be the best way to achieve redistribution and to ensure that those in need receive most help. However, taking the above arguments one step further, a number of analyses of the welfare state have pointed out that governments may be able to build up electoral coalitions of support behind a universal model of provision not primarily by appealing to the altruism of the wealthiest, but by ensuring that every income-group sees benefits in the scheme for itself. Korpi and Palme suggest that ‘institutional structure affect the ways in which citizens come to define their interests and preferences’ (Korpi & Palme 1998, p.664). Welfare state institutions are shaped by different interest groups. Once these institutions are in place, they tend to influence the way citizens perceive their interests and the kinds of political alliances that are most appealing to them. Welfare state institutions themselves therefore have feedback effects on distributive processes. Universal care is undoubtedly more expensive to provide than targeted care. But paradoxically, electoral support for higher taxation and higher spending to build up public services is likely to be stronger where entitlements are universal and where everyone therefore has some grounds for believing that they are ‘all in the one boat’ (Rothstein 1998).

Although hospital care is in principle available to all in Ireland, a slight majority now invests in and avails of private health insurance against acute care needs. In addition,
The Irish health care system has many of the characteristics of a targeted system. The risk is, as Titmuss noted, that welfare for the poor is poor welfare (Titmuss 1976). As Levi notes, support from the middle class from a public sector is based on ‘contingent consent’ (Levi 1997), thus there must be an ability to offer benefits at a quality level where private solutions can be kept away. The huge demand for private insurance suggests that this is not happening in the Irish case, indeed one might also say the continuation of a policy that supports private insurance take-up suggests that government also believe quality levels are not at a high enough standard to maintain political support.

**Equity and access in a two-tier system**

One of the main difficulties with a dual system is that it creates two levels of health care according to insurance status and therefore ability to pay, that is, a two-tier system. For those procedures against which it is possible to insure, it is normal to find that separate waiting lists are maintained for public and private patients, therefore great discrepancies in waiting time depending on means rather than clinical need. This one of the most visible and aspects of inequitable treatment in the Irish healthcare system, and probably the issue that is most contentious. The evidence suggests that those who have private insurance are drawn disproportionately from among the more advantaged groups in society. And the reasons most often offered for having private insurance are strongly tilted toward ensuring access.

**Equity issues – profile of those with private insurance**

We now turn to consider the socio-economic and household characteristics of those who buy private health insurance, and their motivations for doing so.
If about half the population is insured, this may seem to be a strong endorsement of the private insurance system. If something close to a majority avails of it, it cannot be seen as a restricted good, or a benefit going only to the elite. However, recent work examining the impact of individual and household characteristics on the probability of insuring shows that the better educated, wealthier and healthier are more likely to insure. There is a clear disparity between those with and those without private health insurance across both income and education levels. Nearly 60% of those in the top income quartile are insured compared to 18% of those in the lowest quartile. Of those people with no qualifications or who only attended primary education, only 20% have health insurance. Among those with third-level education (which is a category that has expanded rapidly over the last 30 years, and accounts for up to half of those in the younger age categories), almost four-fifths (79%) are privately insured. Those with a third-level education have a 43% higher probability of having private health insurance to those with no qualifications or primary education only. Nor is it true that those with the strongest propensity to have private insurance are those with the greatest incidence of health needs. Only 26% of those with poor health are privately insured. Almost double this proportion (47%) of those with good health has private health insurance. The effect of poor health on propensity to insure is in fact negative – those with poor health status have a 10% less probability of being insured than those with good health (Finn & Harmon 2006; Harmon & Nolan 2001) And we can also show that health status itself is inversely related to income and education (Finn & Harmon 2006).

Irish public policy is aimed at promoting the take-up of private health insurance as a means of improving the supply and quality of healthcare. It does so through incentives such as community rating and tax reliefs. But it now seems that this is primarily successful at
encouraging take-up among people at the higher ends of the income and education distributions, and those who already enjoy better health (Layte & Nolan 2004).

The evidence suggests that a concern with quality is a significant motivator in the decision to insure. Survey evidence supports this: the majority of people citing quality issues as their motivation for purchasing private health insurance. Typically private health insurance buys an individual a higher standard of accommodation (private or semi-private) and hotel-style facilities (i.e. TV, phone, meal menus). The differences in quality of care and access are somewhat more contentious. This may vary across speciality – surgery in oncology, for example, has moved toward integrated care system. And it may vary across area of need – surgical procedures, for example, may be more open to dual waiting lists than is management of chronic conditions care of which is largely only available through the public sector. But access clearly looms large in people’s motivations for taking out private insurance. Chief among people’s concerns about public sector quality is not the standard of accommodation facilities once in hospital, but the ability to avoid queueing for outpatient appointments and for surgical procedures (Harmon & Nolan 2001; Watson & Williams 1996). No central record of waiting list statistics is kept anywhere in the Irish health system. Indeed the unrecorded time spent between referral from a general practitioner and an initial consultant appointment in the public sector often considerably exceeds the time spent between being recommended for a surgical procedure and admission to hospital (Wren 2003). The National Economic and Social Forum (NESF) found that following referral for a procedure, about a quarter of those without insurance, but no-one with private insurance, waited for more than one year for hospital-based treatment. (National Economic and Social Forum 2002, pp. 55-59). Furthermore, ‘going private’ whether through out-of-pocket payments or using private health insurance also ensures choice of consultant and
guaranteed treatment by a consultant rather than a member of the hospital doctors’ team, neither of which is true for public patients.

**Equity issues: cross-subsidies from public to private**

Take-up of private insurance is therefore skewed along lines of relative social advantage, which means that access to health care is differentially available depending on ability to pay. But in addition to this, the private system is so intricately bound up with the public system of health care provision in Ireland that private patients, or rather their insurers, do not pay anything like the full economic cost of their care. Those who are privately insured benefit not only from direct fiscal incentives, but also from cross-subsidies from the public sector to private medicine. As these are not distributed equally across the population, health care policy contributes to inequalities in access and quality of provision between public and private patients.

Tax relief for health insurance premia is a means of increasing the affordability of private treatment and expanding the range of treatments available to patients who would otherwise require treatment through the public system. The cost of tax relief on medical insurance premia and health expenses that was offset against income tax is reported by the Revenue Commissioners as €225m. in 2002 and €273m. in 2003 (Revenue Commissioners 2006, Table IT6). Total current health spending in 2002 was €8.2bn. (Wren 2003), of which rather less than half went to hospitals. Tax relief on health has been scaled back in line with the objective of broadening the tax base and reducing the use of fiscal instruments to achieve policy objectives, and health insurance relief is available only at the standard rate of 20%. But this still is a considerable benefit to those with private insurance, and a sizeable contribution from the public purse to private health treatment.
The ownership structure of Irish hospitals is complex, and meshes public and private in complex ways that derive from the origins of healthcare in Ireland as a mixture of religious charitable institutions on the one hand, and highly targeted, means-tested public care on the other. While some of the more recently established hospitals are owned and controlled by the public authorities (originally Regional Health Boards, now the Health Services Executive) under the auspices of the Department of Health and Children, others continue to have the status of ‘voluntary’ hospitals, owned and controlled by religious orders, though now almost entirely publicly funded. All of these hospitals treat both private and public patients. However, hospitals do not charge insurance companies the full economic costs of treatment of private patients in public hospitals. Nolan and Wiley, looking at areas of direct subsidy such as the difference between what the actual hotel cost of a private patient and that charged to the insurer, estimated in 2000 that the cost of the subsidy was about 50% of total actual costs (Nolan & Wiley 2000). In 2003, charges were raised by a very sizeable 67% to take account of medical inflation, but they still pay only in the region of half to 60% of total costs (Tussing & Wren 2006, p.139). In practice, considerable subsidies can be shown to flow from the taxpayer to private hospitals and patients (Brennan 2003, p.72). Furthermore, hospitals do not charge fees for use of public hospital equipment and premises when treating private patients. We may also note that the public system absorbs cost of professional training, public hospital development & indeed, accident and emergency costs.

Patients with private insurance can be treated in what are primarily ‘public’ hospitals because consultants’ contracts engage them for a specific number of hours’ commitment to public patients per week, on top of which they may engage in private practice (either on-site or off-site, depending on type of contract). Since most hospitals not only permit this but
rely on the income from private patients, this mixed system has flourished. Not more than 20% of bed capacity is meant to be occupied by patients admitted from consultants’ ‘private’ waiting lists. But Nolan and Wiley show while there is ‘substantial crossover of private patients to public beds’, the flow in the opposite direction is much smaller (Nolan & Wiley 2000). In practice it is acknowledged that this is very difficult to monitor or maintain the 20% limit to private patient admissions, as bed management is mainly managed by consultants themselves rather than by hospital managers. Besides, at any one time, considerably more of the patients in hospital are likely to be treated as private patients, since if they are admitted through Accident and Emergency, and have private insurance, it is in the hospital’s interests to admit them as ‘private’ patients and to seek reimbursement from the insurer. About two-thirds of all admissions to acute inpatient care come via Accident and Emergency rather than through scheduled elective surgery.

The existence of private for-profit hospitals adds extra capacity to the Irish healthcare system, as they account for some 12% of acute inpatient beds and elective surgery (Tussing & Wren 2006, p.98). These are concentrated in cities and especially in Dublin, and most belong to the existing ‘voluntary’ hospitals with mixed-use beds. But a new category of private hospital appeared to be favoured by the Fianna Fáil-Progressive Democrat coalition during the first decade of the 21st century, that is, for-profit private hospitals, located on the grounds of existing public or voluntary hospitals. The objective appeared to be to create more capacity using private capital, and remove treatment of private patients to this separate facility, thereby freeing up purely ‘public’ beds in the older hospital. However, the real costs of proceeding in this manner also need to be recognized. In the first instance, without radical change to consultant contracts and waiting-list management, such reforms would entrench and intensify two-tier provision. But in addition, the real cost to the
Exchequer is likely to be considerable. Tax reliefs to private hospitals have been estimated to amount to approximately 40% of the total costs of these facilities, without even considering the value of the land on which they are built (Tussing & Wren 2006, p.106).

Only those insured or willing to pay-out of pocket have access to the private hospital facilities. Thus the public money spent in support of these institutions is directed primarily towards the treatment of insured people, though access for some proportion of public sector patients is facilitated through public sector purchase arrangements in certain circumstances.

The final aspects of subsidization of the private sector by the public which we wish to note concerns the National Treatment Purchase Fund (NTPF). The Minister for Health and Children initiated the scheme in 2002 to alleviate the excessive waiting time of public patients for specific procedures. From a starting number of fewer than 2,000 patients in 2002, the Fund treated over 13,600 in 2004, and some 23,000 in total. Undoubtedly the scheme has been of immense benefit to its beneficiaries. But the logic of using public money to buy treatment in the private sector raises issues of equity and efficiency. At a time when government avows its commitment to improving the quality of public sector provision, additional expenditures are made to the private sector without any additional capacity being added to public resources. The NTPF spent over €40m. on direct patient care in 2004. The Comptroller and Auditor General found that some 44% of these procedures were carried out in a public hospital – and the majority of these were treated by the same consultant who had referred them from their own public patient lists to the NTPF (Office of the Comptroller and Auditor-General 2004, pp. 133-4). He also noted that the controls over excessive self-referral were weak, and that there seemed to be little standardization of the costs of procedures at that point, though these practices were
subsequently addressed (Office of the Comptroller and Auditor-General 2004, p.137). In effect the NTPF, while remedying some urgent treatment needs, worked by transferring public sector resources into the private sector to treat public sector patients.

In summary, this policy of subsidisation of the private sector through taxpayer money is justified by the argument that those who choose to be treated privately forgo their public sector entitlement for which they have already paid (through their tax bill). The case may be made that they are entitled to better quality treatment and access should they choose to pay more – analogous to paying for an upgrade on an airplane perhaps. But we have noted two principal counter-arguments. One of these is that access based on insurance status is inequitable on grounds of accessibility. If equitable access is the benchmark, it may be argued that health care is not like plane seats, and access ought to be organized on grounds of clinical need rather than ability to pay. The other is that the Irish system affects a considerable resource transfer in the form of a variety of subsidies from the public to the private sector. Looking at these issues in a broader perspective, we have also noted that the logic of having both a public and a private sector must be that the private sector provision is superior. Depending on the political conditions at work, it is possible that the incentives for policy-makers will be to permit the gap between private and public sector provision to widen rather than narrow.

**The two-tier system on the cusp of change**

The organisation of health care in Ireland, with its distinctive public-private mix, proves to be somewhat problematic when it comes to equitable access and indeed efficiency of resource allocation and utilization. Why then has this system been maintained? Various government policy documents reiterate the commitment of every major party to the improvement of the quality of public sector health care; major improvements in public
primary care and in the public acute care system; and a progressive drive to reduce the proportion of private to public hospital beds (Department of Health and Children 2001, pp.93-107).

Support for private sector provision is currently central to the delivery of services. We suggest here that the combination of public and private as practised to date is not likely to remain stable, especially in the context of planning for major improvements in service delivery. In a system that is already very complex, the role of the Minister for Health has often been thought of as a poisoned chalice, ‘Angola’, a territory riven by conflict between vested interests, and an institutional imbroglio in which any policy initiative is likely to make little headway. But we wish to suggest that a decisive shift in favour of a systematic improvement in the public sector would require a different policy approach from that which has been in place. It would appear that a tilt in favour of increasing the role of the private sector is implicitly under way in the first decade of the 21st century. Policy options are constrained by conflicts over consultants’ contracts, but also by the recognition of the vested interests of other stakeholders, not least those who hold private insurance. But in addition, the challenge of finding sufficient resources to fund an improved service is real and acute. And it is far from clear that government has appropriate instruments at its disposal through which significant policy change might be effected.

**Resource allocation in the political arena**

Studies of welfare economics seek to make policy recommendations from a resource allocation perspective, so that whether parties of the left or right are in power, decision-making should be made with social welfare maximisation at its root. However, other influences shape decision-making, and experts need not expect always to prevail. As Breyer and Schneider note,
In health economics…..there is a large gap between policy recommendations often made quite unanimously by academic experts and the measure eventually taken by political decision makers (Breyer & Schneider 1992, p.267).

Among the most urgent requirements for governments is the need to be re-elected. And increasingly competition for power takes place over the allegiances of a growing number of weakly aligned or non-aligned voters. It may even be argued that:

Policymaking is motivated not by the efficiency criteria of welfare theory, but rather by the desire to design policy which can obtain a majority in the voting process (Blomquist & Christiansen 1999, p.17).

The difficulties in restructuring hospital provision illustrate this very clearly in the Irish case. For example, the Hanly Report in 2003 recommended a thoroughgoing rationalization of acute hospital provision, concentrating expertise in a smaller number of high-quality hospitals, each serving a larger population base (Department of Health and Children 2003b). Barry Desmond, former Labour Party Minister for Health, once commented on the extreme difficulty in closing down hospitals because it stirs up local feelings so strongly. The Irish electoral system is particularly sensitive to local issues; if the major parties prove unresponsive, a well-established pattern is to elect a single-issue local representative to lobby on local hospital issues. A major gap always needs to be bridged between the withdrawal of benefits now and the delivery of improved services later.

Decision-making in the political arena may be influenced in a number of ways, through the electoral process and interest group pressure. Direct political lobbying may play a part, as may solicited activism; self-interested or entrenched bureaucratic interests are not unknown.

The Irish health care system provides powerful incentives for those who already benefit from the existence of private insurance to support its maintenance. We have already
noted that in spite of conflicts between consultants and government, the agenda of reform continued to build in a significant role for private practice. But patients also benefit from private insurance. In the absence of any clear pathway to a significantly better quality of provision in the public sector, it is quite likely that a large proportion of the electorate would remain favourable to continuing with the existing system of private insurance. The major political parties seemed content to work within the provisions of the existing system. The public-private divide continued to shape the alternatives under consideration.

Consultant contracts
The particular mix of public and private in Irish public hospitals is made possible because of the structure of specialist care provision in hospitals. Ireland has a ‘consultant-led’ service, not ‘consultant delivered’. It is generally acknowledged that there is a significant shortfall in the number of consultants relative to population size, compared with other developed countries: in Ireland, non-consultant hospital doctors (NCHD) outnumber consultants by about 2.3 to 1 (just under 2,000 consultants, and a little over 4,000 NCHD), and hospital service depends on these doctors working long hours in overtime (Tussing & Wren 2006, p.23). It is now government policy to implement the recommendations of the various consultancy reports that the health service be consultant-delivered, not consultant-led (Department of Health and Children 2003b). But the large number of additional consultants required to do this cannot be employed until difficulties over the nature of the consultant contract are resolved. This is a critical moment in Irish health policy, as the nature of consultant contracts shapes the pattern of service provision.

Consultants’ contracts requires them to offer 33 hours a week to the public sector, between running clinics, undertaking procedures, and ensuring administrative efficiency of their caseloads, but it does not specify the extent of their personal time commitment to public
patients. In practice, public patients are likely to be attended to by non-consultant hospital doctors whose salaries are also paid by from public health sector finances. This facilitates many specialists to concentrate on their private patients. It has proven all but impossible to introduce systems to monitor the use of consultants’ time. Until 1997, it was possible for consultants to have one of two types of contract: one which paid a salary but with some ‘abatement’ of the rate payable, and which permitted them to engage in private practice in addition to public employment; and another which permitted only work in the public sector on a salaried basis, and which paid a somewhat higher standard salary in recognition of private earnings forgone. The latter option – only held by 47 consultants in 2003 – was abolished in 1997 on the recommendation of a Review Body on Higher Remuneration in the public sector (Department of Health and Children 2003a, p.67). This further liberalized the consultant’s contract and expanded the scope of the public-private mix, while simultaneously providing some saving in public salary expenses. About three-fifths of consultants now have ‘Category 1’ contracts that permit them to treat private patients within the public hospital in which they are employed. Just over one-third of the consultants, mostly in Dublin and Cork, have ‘Category 2’ contracts that permit them to treat patients privately off-site as well as within their main place of work.

A particularly interesting point to note here is that the method of reimbursement is shown to have significant effects on the behaviour of medical professionals (Propper et al 200). Consultants are salaried employees for their public sector work. But they are paid on a fee per patient basis by their private patients. The public-private mix may therefore be seen to contribute directly to excessive waiting in Ireland (Tussing & Wren 2006, p.115). There is an opportunity cost to consultants of working in the public sector – that is, reimbursement in the private sector (Rickman & McGuire 1999) As two experts in this area have noted:
Public health systems have done little to alter the underlying incentives whereby those with the greatest control over the conditions of supply are rewarded rather than penalised for maintaining waiting lists. (Street & Duckett 1996).

The consultants’ contract came to be seen as a facilitator if not indeed a cause of many of the shortcomings in health care provision in Ireland. Yet at the time when it was negotiated, in 1979, it was an attempt to create some commonality in conditions of work for specialists who had previously worked under widely varying conditions. A two-tier career structure then obtained, in which some consultants were full-time salaried employees of the regional health boards, and others received no salary or pension from the state, but worked in the ‘voluntary’ hospital sector, earning fees from private patients, and gaining some recompense for treating non-fee-paying patients from the hospitals from the grants they received from the Department of Health (Barrington 1987, p. 107). But in the 1979 measures, several opportunities were missed – neither clinical accountability nor accountability for work-time was adequately built into the consultant contract.

The reforms of 1979 were themselves a belated attempt to address the issues that had been left unresolved in the earlier phase of health services reform. The late 1940s had seen a surge of reform initiatives in Ireland. It was far from unique in this, as a drive to reform health care provision was seen across Europe in aftermath of World War Two. Prior to this, two-tier health care provision was the norm, with private care provided by self-employed consultants for the wealthier, and a separate system of public care for the less well-off. Across Europe, governments sought to establish a single mode of provision of hospital treatment, with plans that bore a striking similarity to one another. Ireland was no different, and political parties shared broadly similar objectives. Fianna Fáil in 1947 was as committed to the same measures that failed so spectacularly in Noel Browne’s 1951 Mother and Child Bill, which would have provided free acute and primary medical care for
expectant mothers and for all children up to age 16, through bringing self-employed
doctors onto the public payroll.

While governments in many European countries favoured similar schemes, outcomes were
quite varied. This suggests that doctors do not necessarily hold a trump card in negotiations
with government. It may be the case that the institutional framework through which reform
is attempted can provide differential opportunities to offer resistance. In a study of the
outcomes of health reform initiatives in Sweden, Switzerland, and France, Ellen Immergut
argued that ‘veto points’ mattered more than pressure group power. Swedish consultants
were unable to prevail against a strong and unified majority government decision. In
Switzerland, in contrast, the outcome was the most favourable to private medicine, and
government was confined to providing subsidies for private insurance. A united medical
profession was able to use referendums in local regions to fragment public opinion and
weaken government’s ability to act (Immergut 1992, p.58). The conflict over health
reforms in Ireland in 1951, widely understood at the time as a stand-off between church
and state, has been reinterpreted as primarily a conflict between private medicine and
health policy reformers, in which doctors were able to mobilize a powerful veto player –
Catholic bishops, and specifically John Charles McQuaid of Dublin – on their behalf
(Barrington 1987, pp. ).

The net effect of government failure to introduce its preferred measures was a greatly
reduced government appetite for reform, and the introduction, as in Switzerland, of public
subsidies to private insurance, in the form of the 1957 Voluntary Health Insurance Act.
This was aimed at the 15% of the population outside the means-tested hospital access
introduced in 1953 (Barrington 2003, p.106). Growing volumes of public funding replaced
the charitable or sweepstake-based funding of the ‘voluntary’ hospitals. Yet these hospitals were not nationalized as their British counterparts had been. As the ‘public’ hospitals were upgraded, the need to rationalize conditions of work across the sectors grew more urgent. This resulted in introduction by a Fianna Fáil government of the 1979 ‘common contract’ in which the combination of public and private was entrenched.

Yet the anomalies of Ireland’s ‘mixed’ rather than ‘hybrid’ system grew over the decades that followed. Indeed, the Brennan Report concluded bluntly that ‘the opportunity to earn additional monies through private practice, combined with the ability to delegate public work to other staff, is not in the best interests of the Irish taxpayer’ (Department of Health and Children 2003a, p.66). This report argued that the only solution to the perverse incentives built into the system, from the point of view of a high-quality public health service, is the complete separation of public and private practice:

The existing arrangements for mixing public and private treatments are inherently unsatisfactory from a management and control perspective. They result in a conflict of interest for Consultants between meeting clinical obligations to public patients on the one hand and, on the other, the prioritisation, treatment and the use of publicly provided infrastructure and resources in public hospitals for private patients. They also raise issues of fair competition with private hospitals in that the resources used are not charged for fully. They severely limit the time the majority of clinicians have to pursue resource management. Ultimately, these issues can only be resolved fully by completely separating public and private practices. (Brennan 2003, p.71).

As Minister for Health, Mary Harney initiated a renegotiation of the contract of employment with consultants. But negotiations stalled principally over the nature of the conditions which it was proposed to set on the contracts of the large number of new appointees due to be recruited to the system. The Brennan Report recommended (R5.3, p.67) that ‘all new Consultant appointments, covering new posts and the replacement of existing Consultants, should be on the basis of contracting the Consultants to work
exclusively in the public sector’. Consultants sought to protect both existing members’ rights and the rights of new appointees to continue to practice privately.

Government views appeared to be mixed; the priority was to enforce greater accountability for use of time and resources on consultants’ practices. The strong recommendation to appoint only to public positions seemed unlikely to prevail. Moreover, if government were to follow this recommendation, it would conflict with the existing policy of offering tax incentives for the construction of new private hospitals, and facilitating construction of private facilities in the grounds of public hospitals. Not only was it highly unlikely that existing consultant contracts would become public-only in this context, but it seemed equally improbable that government was committed to recruiting new consultants on a public-only basis who would be unable to practice in these new facilities. The new hospitals would be deprived of staff, and the existing hospitals would be under enormous pressure to upgrade their diagnostic, surgical, treatment, and continuing care facilities.

**Capacity constraints and coordination challenges**

Planning for the future of the Irish health care system continued to be structured round the coexistence of public and private practice in consultant contracts, albeit on a new and more structured basis, implying a continuing role for private insurance alongside public provision. But while from a comparative perspective consultant contracts look like the crux of the matter, this would perhaps be misleading. The fact remains that the capacity of the public sector to deliver adequate services remained well below the level of actual demand in the system. And the health sector had long been characterized by fragmented management in unclear lines of accountability, such that overall system coordination presented major challenges.
Capacity constraints can be identified across a range of measures. Bed availability and bed occupancy is a highly visible indicator, and one that inflames popular feeling – severely ill people lying on trollies waiting for diagnosis, admission, treatment. Many reasons lie behind the problems of hospital bed availability, including issues such as the dearth of step-down facilities for long-term elderly patients, and the strong role of consultants in managing admission and discharge of patients. But behind all this lies an ongoing shortage of bed space, a legacy of the deep cuts in capital spending during the 1980s which was never adequately compensated for afterwards. Ireland’s rapidly increasing population, especially in the greater Dublin region, from the mid-1990s on, would only intensify demand on these depleted facilities (Tussing & Wren 2006, pp.182-90). Bed occupancy was regularly at or in excess of 100% of capacity, compared with international rates of closer to 85%.

Efficiency of bed space can be estimated in various ways of course, and beds are only one indicator, albeit a prominent and core one, of treatment capacity. Beyond this we may identify provisions such as operating theatre facilities, interdisciplinary care teams, patient management administrative supports, and support structures to facilitate ongoing patient care between hospital oversight and community-based delivery. On all these measures, Ireland’s public sector continued to lag severely. In this context, no government seriously contemplated altering the policy incentives that encouraged private sector providers to bring new hospital facilities onstream; and to staff these facilities, provision for continuing dual practice by consultants was all but inevitable.

Yet responsibility for driving and delivering change in health policy continued to be problematic Health services in Ireland, as in many other countries, had long been primarily
the concern of local government. Even as national funding too over – for example, the 1971 Health Act introduced a medical card scheme to provide means-tested access to GP services, thus abolishing the much-hated and discriminatory dispensary system – local accountability continued to play a large part in the administration of health services. The 1971 Act consolidated local services under a network of Regional Health Boards, which continued to have strong local authority representation on them. Opinion was divided on their merits though, even among the official reports on health service reform. Local accountability loomed large for the Brennan Report; the Prospectus Report was more concerned with avoiding local resistance to hospital rationalization as recommended by the Hanly Report, and consolidating central control over resources (Tussing & Wren 2006, pp. 298-300). The abolition of the health boards in 2004 and the creation of the Health Services Executive in 2005 represented a decisive move in the direction of centralization, to achieve greater coordinating capacity and therefore greater efficiency. However, the administrative problems generated significant new problems. Most significantly, the relationship between the Department of Health and Children on the one hand, and the Health Services Executive on the other, had not been fully specified at the time the legislation was enacted, and produced real uncertainty over domains of responsibility, initiative, and financial accountability (Tussing & Wren 2006, pp. 305-320). Spending control in a very large and diverse system was a real challenge; but opportunities to deliberate on resource allocation had been progressively reduced over time (Barrington 2003, p.116). Accountability within hospitals also remained severely under-defined. Indeed, weak financial controls within hospitals were specifically identified in the Brennan Report, which recommended that ‘where they do not already exist, chief executive officers in all hospitals should immediately establish an Executive Management Committee’, to agree the hospital Service
Plan, monitor performance against budget, agree corrective measures, and advise on policy matters (Brennan 2003, p.68).

Organizational reform of the Irish health system was thus pushed toward centralization of decision-making, though with a crucial lacuna in accountability and decision-making at the centre. This went against the trend in many other European societies, which had begun to experiment with decentralization, creation of internal markets, and fostering of competitive opportunities to try to achieve cost savings and efficiencies. A broad political and policy consensus appeared to exist in Ireland that market-based solutions in a small market would not be beneficial (Wiley 2000, p.922).

But the problem at the core of the system – the intermingling of public and private – was not centrally addressed by these structural changes. Where complex systems change, comparative analysis suggests that organized interests are likely to seek to ‘manoeuvre round them’ (Moran 1999, p.180). A trend toward more decentralized health service provision in Britain and Germany had not dismantled the privileged position and influence of the medical profession:

Closely integrated oligarchies dominated by professional and corporate interests, operating with a substantial degree of independence from the core institutions of the state, are being replaced: by looser, more open, more unstable networks; by networks in which professional and corporate elites still exercise great power but in a more contested environment than hitherto; and by an institutional setting in which the core institutions of the state exercise much tighter surveillance and control than hitherto. This is the sense in which to speak about the rise of the market and the retreat of the state is a great oversimplification. (Moran 1999, p.178).

**Conclusion**

Irish health care policy in the early 21st century was approaching a decisive point. Electoral pressures to reform and improve the many deficiencies in health services were strong. The quality of provision in the public sector needed to be improved significantly. All
governments pledged themselves to do this – to reduce waiting lists, reduce trolley-based waiting time for admission, make hospitals cleaner and safer places, and introduce the sort of evidence-based practice assessment that improved patient outcomes but that could only be delivered in a modernized health delivery system.

Key to doing all this was the employment of a great many more front-line medical personnel, which would involve increasing the role of consultants and redesigning the role of non-consultant hospital doctors. But the great majority of consultants already had private practice commitments; much of the delivery of services took place through private practice structures, whether in public or private hospitals, and a slight majority of the population was equipped with private insurance cover.

Under these conditions, successive governments seemed unable to decide where their priorities for health care reform lay. And while they spoke of their commitment to public sector quality, in effect private sector incentives were, if anything, strengthened. Ireland was no longer in the early or foundational stages of constructing a national integrated health service, as so many European countries were in the years following the end of World War Two. At that point, decisive policy changes were perhaps more easily undertaken. But reform of a developed health care system can be likened to rebuilding the ship while already at sea. A variety of problems in health sector governance have remained unresolved. At the heart of it lies the conundrum of the intermeshing of public and private. Some commentators, as we have noted, recommend a complete separation of the sectors. Quite how to do this, in a system that relies so heavily on the private sector to deliver central parts of its services, is unclear. How it might be initiated, and by whom, given the
complex relationships within the Health Services Executive, and between the HSE and the Department of Health and Children, is a puzzle.

Irish politicians claim to wish to strengthen public sector provision, yet have acted to strengthen private sector rewards and incentives. Some commentators have noted that if governments fail to take decisive action for long enough, inaction or indecision itself becomes a policy when it is pursued overtime in a fairly consistent way (Korpi & Palme 1998). It could be argued that the maintenance of the public-private mix in Irish health care is one such example.
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