

# RESOURCE ALLOCATION, FINANCING AND SUSTAINABILITY IN THE HEALTH SECTOR

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## Introduction

The focus on acute, episodic care in the conventional health-care model fails to provide adequately for changing health-care needs arising from increased longevity and increasing prevalence of chronic disease. Integrated care involves coherent and co-ordinated delivery of health-care services across a broad range of health and social care providers. A principal aim of integrated health care is to improve the patient's journey through the system by co-ordinating care among providers and by strengthening the role of primary care. Effective resource allocation mechanisms, supported by appropriate financing arrangements, have an important role to play in delivering integrated health care. In addition, more efficient use of scarce health-care resources is required, and can be influenced by the resource allocation and financing mechanisms. This article summarises research undertaken by the ESRI to provide evidence for the Expert Group on Resource Allocation and Financing in Health Care, which reported in July 2010 (Brick et al., 2010a, b; Ruane, 2010). The research:

- reviewed the theoretical and international empirical literature on resource allocation, financing and sustainability in health care (focusing on eight comparator countries – Australia, Canada, Germany, Netherlands, New Zealand, Sweden, UK, USA);
- evaluated current Irish systems of resource allocation and financing and issues associated with sustainability;
- proposed a framework for health-care entitlements and user fees that would support the delivery of integrated health care in Ireland.

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## Sustainability

It is important to provide an overview of trends in the overall level of resources available for health, and the drivers of increased health-care expenditure. Since 2000, Irish public health expenditure has more than doubled in real terms to reach a level of over €15bn in 2009. It accounted for almost 12 per cent of national income in 2009, up from 6.3 per cent in 2000. Health care accounted for about one in every four euros of total public expenditure throughout the last decade. Concerns about sustainability are not unique to Ireland; total per capita expenditure on health increased by an average of 6.4 per cent per annum across the EU-15, Australia, Canada, New Zealand and the US over the period 2000-2007.

Several studies have found that national income is the single most important driver of public health expenditure, with increases in income leading to proportionately equal increases in health expenditure. Other important factors include demographic change and an increasing burden of chronic disease, as well as supply-side factors such as rising medical prices, technological change, increasing capital stock and labour costs, the regulatory regime governing behaviour in the health sector and the incentive structure facing health-care providers are also important. In Ireland, while the size of the population increased by 17.7 per cent over the period 2000-2009, the share of the population aged over 65 years actually declined slightly over the period. The growth in national income was much more substantial, as was the change in both the overall price level and the change in health prices.

Particular concern over sustainability has arisen with regard to state expenditure on pharmaceuticals and payments to pharmacists. Approximately 85 per cent of total expenditure on pharmaceuticals in Ireland relates to state expenditure on pharmaceuticals and payments to pharmacists under the General Medical Service (GMS) Scheme and community drugs schemes (CDS). Expenditure on the GMS Scheme alone has increased from €831m in 2005 to €1.3bn in 2009 (195 per cent in real terms). The growth can be explained by a combination of increases in the price (e.g. newer, more expensive drugs) and volume (e.g. increase in eligibility) of drugs prescribed. Recent attempts to control this expenditure have focused largely on two particular measures, namely, attempting to secure better value for money via amendments to the pricing and reimbursement mechanisms on the GMS and CDS, and increasing the degree of cost sharing on the part of patients.

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## Resource Allocation

Internationally, the concept of population health need is being used to allocate health-care resources, in contrast to traditional methods driven by historic allocations to existing providers and facilities. In Ireland, resources are allocated largely on an historic funding basis, notwithstanding recent attempts to move to a more rational allocation of resources for some services (e.g. services for older persons).

Even when allocations are made on the basis of population health, the extent of ‘purchaser-provider split’ and methods of provider reimbursement can have important implications for the degree to which providers are financially incentivised to deliver appropriately integrated health care. One of the main advantages of segregating the purchasing and providing functions is the ability to employ financial incentives and monitoring tools to encourage providers to offer services more efficiently. While there is strict separation between the purchaser and provider in many aspects of Irish health care (e.g. between the HSE and GPs), other relationships are not characterised by such a split (e.g. the HSE owns and funds more than half of acute public hospitals).

Provider reimbursement can be activity-based (e.g. per number of patients/cases treated, treatment intensity or duration). This method could stimulate activity, but may be less effective at controlling costs than other reimbursement systems (such as global budgets or fixed salaries). The consensus which emerges from research is that no single payment mechanism can achieve all of the stated health-care objectives; rather, a mix of reimbursement types is required.

For the remuneration of GPs, most countries use a mixture of capitation and fee-for-service remuneration, with salary payments less common. Many countries are also now experimenting with pay-for-performance elements, whereby GPs face financial incentives for chronic disease management, appropriate prescribing, data collection, etc. The Irish system is unusual in that methods of GP remuneration depend on patient type; predominately capitation for medical card patients, and fee-for-service for private patients. The conflicting incentives on the part of GPs that arise from this distinction do not facilitate the delivery of integrated health care.

Casemix funding (prospective, activity-based payments) is now the preferred hospital reimbursement mechanism in six of the eight countries studied. Despite some common objectives for casemix funding, implementation varies considerably across countries, making it difficult to evaluate the system's impacts on activity, length of stay, quality and costs. For treating public patients, Irish public hospitals receive budgetary allocations, predominantly determined by historic factors. A subset of hospitals receives a retrospective budgetary adjustment for treatment complexity and relative performance. The planned move to prospective casemix funding should improve the transparency between payment and activity. Of some concern are potential perverse (and conflicting) incentives generated by the different mechanisms used to reimburse Irish public hospitals and their consultants for public and private patients (e.g. consultants in public hospitals receive a salary for treating public patients but a fee-for-service for private practice).

Crucial for integrated care is the alignment of financial incentives not only within, but also between, all sectors of the health-care system. Many international initiatives have sought to improve integration; however, these schemes generally fail to co-ordinate care across multiple conditions and lack formal evaluation. In Ireland, the HSE established the Integrated Services Directorate in 2009. While necessary, such organisational reforms are not sufficient for integration. Further development of primary care in particular is required, as well as financial incentives that are consistent across providers and patients.

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## Financing

Without resources, there is nothing to allocate. How resources are generated can affect the resource allocation process. In Europe, the main health care financing sources include public taxation, social health insurance, private health insurance and out-of-pocket payments. In Ireland, public taxes account for the largest proportion of health care financing (approximately 80 per cent) followed by out-of-pocket payments and private health insurance. Health systems are often grouped according to the dominant source of financing (e.g. tax-based systems). However, as the mix of health resource mechanisms is becoming more complex, it is more logical to assess the merits or otherwise of each individual mechanism separately.

Tax and social health insurance contributions both introduce separation between what people pay for health care, and what they receive. This allows the principles for collecting resources from individuals (e.g. according to ability to pay) to be separate from the principles determining how those resources are allocated (i.e. population health need). With social health insurance there is a clear, observable link between available health-care resources and health-care entitlements; although this transparency can be reduced where social health insurance is supplemented by tax-based resources. International evidence indicates that there are ways of introducing many of the desired features of social health insurance in a tax-based system. In the Irish context, policy-makers need to address problems of poor transparency around public tax-based resources, in particular the complications associated with public subsidisation of private health care activity.

Out-of-pocket payments are directly linked with the individual's use of the service. These payments are outside the public resource allocation process. International evidence indicates that user fees discourage both necessary and unnecessary utilisation, and have negative implications for equity and there is evidence of this in Ireland. The requirement for non medical cardholders, the majority of the population, to pay out-of-pocket for GP care is unique to Ireland compared with other developed countries. An inconsistent structure of user fees across community, primary and acute care means that non medical cardholders are not always directed to the most appropriate location for their care. These features interrupt the delivery of integrated health care. Incentives facing patients and providers need to be aligned so as to ensure that health problems are diagnosed at the earliest opportunity, that there is continuity of care for people with chronic conditions and that the most appropriate care takes place in the most appropriate location.

To support this process, a coherent framework of entitlements and user fees is proposed. Within the framework, a set of graduated subsidies are available for GP care, prescription medicines and other care for the whole population (people on lower incomes would receive higher levels of subsidy). Subsidisation of chronic conditions would also be streamlined to address existing inconsistencies (e.g. exclusion of certain critical conditions from the Long-Term Illness Scheme). The framework removes the large jumps in entitlement that are currently in place (e.g., where income increases above the GP Visit medical card eligibility threshold, the user fee for GP care increases from zero to the full private charge). The framework also introduces greater separation between payment for health care and people's risk of ill health by reducing the extent to which health care is paid for at the point of use.

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