
CHARGING FOR PUBLIC HEALTH SERVICES IN IRELAND: WHY AND HOW?

Brian Nolan



No. 19
CHARGING FOR PUBLIC HEALTH SERVICES IN IRELAND
Brian Nolan
November, 1993

THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

COUNCIL

- * TOMÁS F. Ó COFAIGH, *President of the Institute.*
- * EUGENE McCARTHY, *Chairman of the Council.*
KEVIN BONNER, *Secretary, Department of Enterprise and Employment.*
VANI K. BOROOAH, *Professor, Department of Applied Economics and Human Resource Management, University of Ulster at Jordanstown.*
JAMES CAWLEY, *Managing Partner, Cawley & Company, Solicitors.*
LIAM CONNELLAN, *Vice-President, Royal Dublin Society.*
- * SEAN CROMIEN, *Secretary, Department of Finance.*
WILLIAM B. DILLON, *Chief Executive, Amdahl Ireland Limited.*
- * MARGARET DOWNES, *Deputy Governor, Bank of Ireland.*
- * MAURICE F. DOYLE, *Governor, Central Bank of Ireland.*
DERMOT EGAN, *Deputy Chief Executive, AIB Group.*
- * CONNELL FANNING, *Professor, Department of Economics, University College, Cork.*
IAN GRAHAM, *Consultant Cardiologist, The Charlemont Clinic, Dublin.*
GRAHAM GUDGIN, *Director, Northern Ireland Economic Research Centre.*
JOSEPH HARFORD, *Chief Executive, Yamanouchi Ireland Company Limited.*
JOHN HURLEY, *Secretary, Department of Health*
- * KIERAN A. KENNEDY, *Director of the Institute.*
PATRICK LYNCH, *Chairman of the Institute, 1983-1988.*
JOSEPH MORAN, *Chief Executive, Electricity Supply Board.*
DONAL MURPHY, *Director, Central Statistics Office.*
- * DERMOT F. McALEESE, *Whately Professor of Political Economy, Trinity College, Dublin.*
EDWARD F. McCUMISKEY, *Secretary, Department of Social Welfare.*
FERGUS McGOVERN, *Chief Executive, Telecom Eireann.*
- * DONAL NEVIN, *former General Secretary, Irish Congress of Trade Unions.*
JOYCE O'CONNOR, *Director, The National College of Industrial Relations.*
PATRICK O'REILLY, *Chief Executive, EBS Building Society.*
- * W.G.H. QUIGLEY, *Chairman, Ulster Bank Limited.*
- * NOEL SHEEHY, *Professor, Department of Psychology, Queen's University of Belfast.*
MICHAEL J. SOMERS, *Chief Executive, National Treasury Management Agency.*
REV. CONOR K. WARD, *Social Science Research Centre, University College, Dublin.*
T.K. WHITAKER, *President of the Institute 1971-1987.*
- * PADRAIC A. WHITE, *Director, Dresdner International Finance plc.*

* Members of Executive Committee

CHARGING FOR PUBLIC HEALTH
SERVICES IN IRELAND:
WHY AND HOW?

*Copies of this paper may be obtained from The Economic and Social Research Institute (Limited Company
No. 18269). Registered Office: 4 Burlington Road, Dublin 4.*

Price IR£8.00

(Special rate for students IR£4.00)

Brian Nolan is a Research Professor with The Economic and Social Research Institute. The paper has been accepted for publication by the Institute which is not responsible for either the content or the views expressed therein.

*CHARGING FOR PUBLIC HEALTH SERVICES
IN IRELAND:
WHY AND HOW?*

Brian Nolan

©THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE
DUBLIN 1993

ISBN 0 7070 0147 1

Acknowledgements

Valuable comments on earlier drafts were received from the Director of the Institute Kieran Kennedy and from ESRI colleagues Tim Callan, Barry Merriman, Robert O'Connor, and Colm O'Reardon. Thanks are also due to Tom O'Mahony of the Department of Health for providing data and to Stephen Birch and Greg Stoddart (McMaster) for supplying references and studies on the topic. Mary McElhone prepared the manuscript for publication with her usual efficiency.

<i>CONTENTS</i>		<i>Page</i>
	<i>Acknowledgements</i>	iv
	<i>General Summary</i>	vii
<i>Chapter</i>		
1	<i>INTRODUCTION</i>	1
2	<i>THE STRUCTURE OF HEALTH CHARGES</i>	3
	2.1 Introduction	3
	2.2 The Structure of Health Charges in Ireland	3
	2.3 The Role of Health Charges Elsewhere	8
	2.4 Conclusions	11
3	<i>CHARGING FOR HEALTH</i>	13
	3.1 Introduction	13
	3.2 Charging for Health – The Debate	13
	3.3 Charges, Cost Control and Resources	15
	3.4 Charges and Efficiency	18
	3.5 Charges and Equity	21
	3.6 Conclusions	24
4	<i>HEALTH EXPENDITURE AND FINANCING IN IRELAND</i>	25
	4.1 Introduction	25
	4.2 Expenditure on Health Care	25
	4.3 The Financing of Expenditure on Health	31
	4.4 Implications	33
5	<i>HEALTH CHARGES AND EFFICIENCY IN IRELAND</i>	36
	5.1 Introduction	36
	5.2 Charges and Efficiency in Use of Health Services	36
	5.3 Charges and Efficiency in Provision of Health Services	39
	5.4 Charges and Efficiency: Conclusions	40

<i>Chapter</i>		<i>Page</i>
6	HEALTH CHARGES AND EQUITY IN IRELAND	43
	6.1 Introduction	43
	6.2 Equity and Health Care	43
	6.3 Charges, Equity and Access	45
	6.4 Charges, Equity and Utilisation	47
	6.5 Charges and Equity in Financing	50
	6.6 Conclusions	52
7	HEALTH CHARGES IN IRELAND: CONCLUSIONS	53
	<i>References</i>	58

LIST OF TABLES

<i>Table</i>		<i>Page</i>
4.1	Health Expenditure as a Percentage of GDP in OECD Countries, 1960-1991	26
4.2	Health Expenditure Per Capita in US\$ in OECD Countries, 1960-1991	29

GENERAL SUMMARY

The role of user charges for public health services has been hotly debated internationally in the last decade, in both developing and developed countries. In Ireland, out-patient services and in-patient care in public wards of public hospitals were provided free of charge to most of the population up to 1987. In that year, without little or no prior discussion or debate, charges for out-patient services and a per-night charge for in-patients in public hospitals were introduced, applying to all those who did not qualify for a medical card on the basis of a means test.

These charges were increased in early 1993, and the reaction was such that the Minister for Health set up a review body to examine how they should be structured, to report before the 1994 Budget. People who have medical card cover are also entitled to free General Practitioner services and prescription medicines, and the question of whether some charge for those services should be imposed has also been raised on occasion (though this is not being addressed by the review body).

An examination of the rationale for policy on user charges in the Irish public health services is therefore overdue. This paper considers the arguments as they apply in an Irish context, and assesses the current structure of charges in that light.

The need to be clear about what user charges are intended to accomplish is highlighted. Is the primary objective to control costs and restrain health expenditure, discourage unnecessary utilisation, promote efficiency, enhance equity, or simply raise revenue? The paper looks at each of these possible objectives, and having assessed the arguments and the available evidence concludes that the case for charges is for the most part a weak one.

As far as controlling the growth of health expenditures is concerned, charges are a blunt weapon, likely to deter not only "unnecessary" but also "necessary" care (which are often difficult to distinguish even with hindsight). Total expenditure on health as a proportion of GDP has been successfully restrained in the Irish case during the late 1980s and early 1990s. This has been brought about through Exchequer control over public spending, particularly hospital budgets. The impact this has had on accessibility and quality of services is not clear, but simply in terms of restraining the growth in overall health spending Ireland has been particularly successful. Measures to control expenditure growth with least impact on the benefits from health care may be best directed at providers and administrators rather than patients.

Charges can provide an incentive for people to use the health services more sensibly, in particular to follow the appropriate referral systems rather

than by-passing primary care to use hospital-based services. The current structure of charges in Ireland is unlikely to be effective in providing such an incentive, since those liable to charges still pay substantially more for a GP consultation than for out-patient services, and those with medical card cover do not pay for either. If penalising those who go straight to hospital is a central objective, then a by-pass fee applying only to those who have not been appropriately referred (other than genuine emergencies) would suffice. Charges as currently constituted in Ireland are also unlikely to discourage use of costly-to-provide hospital in-patient care. In-patient charges will be covered by insurance in many cases, and there is also an annual maximum payment, so the patient will very often not have to pay for an additional night. Greater use of co-payments in insurance (where the insured person bears some of the cost) would be required to give an incentive to patients to minimise hospital stays, but evidence from elsewhere suggests this is not very effective anyway: decisions about length of stay and choice of in-patient versus out-patient care are mostly in the hands of the providers and administrators rather than patients.

Proponents of charges also argue that they can improve the incentives facing those providing and delivering health care. Since the revenue raised by public hospital charges currently goes to the Department of Health, the resources available to providers and hospitals are not directly affected and little or no impact on their behaviour is to be expected. While allowing hospitals to retain some of the revenue raised could alter their incentives, this would not necessarily be in the direction desired – for example, it could encourage maximisation of throughput without regard to quality of care. Incentives for providers can be altered by changing the way remuneration and hospital budget-setting are structured, whether charges are in place or not.

From an equity perspective, access to health care is generally regarded as a basic right, and the notion that care should be *distributed* primarily on the basis of need rather than ability to pay is widely held. Charges may act as a barrier to access to care for the poor, and exempting the poor from charges via means-testing, as is currently the practice in Ireland, can create other problems by contributing to unemployment and poverty traps. Even where the poor are exempt, charges increase the importance of ability to pay as opposed to need in determining access to care throughout the rest of the distribution. Focusing on equity in financing, the view that health care should be *financed* primarily on the basis of ability to pay is also widely held. Charges are probably a regressive way of financing health care even when the poor are

exempt, and expanding their role is likely to move the financing of health care in Ireland, which is currently mildly progressive, in the direction of less progressivity.

Ireland is not in the position of many developing countries, which appear to have little realistic alternative to user charges if resources for the health sector are to be mobilised. Here other sources of finance are available, and the case for an enhanced role for health charges cannot simply rest on the assertion that they are necessary to raise revenue. Instead, the costs and benefits associated with alternative sources of financing public health services have to be assessed. The alternatives include raising additional revenue from taxation, diverting additional resources to health from other areas of government spending, or improving the way the money currently being devoted to health care is spent. While there are distortions and welfare losses associated with taxation or social insurance, charges also have costs in that some "necessary" utilisation of health services will be discouraged, and sick people will bear a larger share of the burden of financing. In this context it is worth highlighting evidence from Ireland and other countries which suggests that there is significant scope for improvement in the way the health care system is structured and managed and the way the resources devoted to health care are spent. User charges can in some sense be seen as a "soft option", alleviating the need to address how to get better value for money in the public health services.

The paper thus concludes that on efficiency grounds there may be a case for a charge on "inappropriate" use of hospital out-patient services by those who by-pass the GP and are not genuine emergencies, although non-financial factors such as GP availability which may influence this choice also need to be considered. Charges on users of out-patient services who have been appropriately referred, and on in-patients, cannot be justified on this basis: they are best seen simply as a means of raising revenue, which must be assessed against the alternatives. The Exchequer currently forgoes about £45 million per year in income tax through the relief granted on health insurance premia. Since the extension of entitlement to public hospital care to the entire population with the abolition of Entitlement Category III in 1991, the original justification for this relief – namely the limited public entitlements of this group – no longer holds. While this remains in place, it is particularly difficult to accept the argument that user charges are the best or only way to increase the resources available to the public health services.

Chapter 1

INTRODUCTION

A central objective of health policy internationally is to promote access to care for all those who need it. In many countries, developed or developing, this objective has been pursued by ensuring that health services are provided free of charge or at heavily subsidised prices at point of use for some or all of the population. In recent years there has been a great deal of debate about the effectiveness of such a pricing policy for health services, and the issue of whether or how best to charge for these services has become a "live" one for policy makers. In a developing country context, this debate has been strongly influenced by the forthright views expressed by the World Bank that health services should not, in general, be provided free, and that efficiency and equity would both be enhanced by charges. In developed countries wrestling with the problem of controlling the growth of expenditure on health, the question of charging for services is now being actively considered even where this would mark a radical shift, as in Canada. Where charges are already in place, changes in their level and structure are often among the options recently implemented or being actively considered.

In Ireland, out-patient services and in-patient care in (public wards of) public hospitals were provided free to most of the population for many years, up to 1987. Only the 15 per cent or so of the population towards the top of the income distribution had to pay for these services up to that date. In 1987, charges for out-patient services and a per-night charge for in-patients in public hospitals were introduced, applying to all those not in Entitlement Category I, that is those who did not qualify for a medical card on the basis of a means test. These charges were increased in early 1993, and the reaction was such that the Minister for Health set up a review body to examine how they should be structured. People who do have medical card cover are entitled not only to free hospital care but also free General Practitioner services and prescription medicines. As public expenditure on providing these services, particularly the drugs element, continues to rise relatively rapidly, the issue of whether some charge should be imposed for GP visits and/or drugs has also been raised on occasion – though this is not being considered by the Minister's review group. Finally, very substantial increases have been implemented in recent years in charges for private accommodation in public hospitals, most of the impact being on those insured by the Voluntary Health Insurance Board, and questions about how

much farther this should be pursued also have to be addressed. The basis and rationale for policy towards charging for public health services therefore merits re-examination in Ireland, as in many other countries.

The objective of this paper is to assess the options facing policy-makers in this area, in the light of the general arguments, experience and debates elsewhere, and the specifics of the Irish situation. In Chapter 2, the current system of charges for public health services in Ireland is described and put in the context of pricing policies in the health area followed by other OECD countries. Chapter 3 sets out the general arguments advanced for and against charging for health services, and the factors which must be considered in designing a system of health charges. Chapter 4 looks at recent trends in health expenditure and the contribution of charges to health financing in Ireland compared with elsewhere, and assesses how this affects the case for charges. Chapter 5 focuses on the argument that charges can promote economic efficiency, and discusses whether charges as currently structured in Ireland are likely to enhance efficiency. Chapter 6 deals with equity issues, looking at the distributional impact of charges within the broader perspective of equity in the financing and delivery of health services. Chapter 7 summarises the main conclusions.

Chapter 2

THE STRUCTURE OF HEALTH CHARGES

2.1 Introduction

This chapter first describes the way in which charges are levied on users of health services in Ireland. It then places current Irish practice in comparative context by looking at the role which charges play in the health systems of some other OECD countries, as well as recent trends in OECD and other countries in this regard. The major issues relating to charges which need to be addressed are then set out.

2.2 The Structure of Health Charges in Ireland

Entitlements to free or subsidised health care in Ireland depend on income.¹ The system of entitlement currently in operation distinguishes two categories: those in Category I, who have what is commonly termed "medical card" cover, and those in Category II, who do not. Families with incomes below a specified ceiling qualify for a medical card and are entitled to free General Practitioner (GP) care and prescription medicines, free out-patient services in public hospitals, and free in-patient care in public wards of those hospitals. (Most Irish hospitals are "public" in this sense, in that they are financed almost entirely by the state, although they may be owned and run by religious orders/charitable trusts, etc., or by regional Health Boards²). Those who do not meet this means test, on the other hand, generally have to pay the full cost of GP care and prescription medicines³, and since 1987 they also have to pay charges for out-patient services in public hospitals and in-patient stays in public wards of those hospitals. Public hospitals also have semi-private and private accommodation: those occupying semi-private or private beds have to pay for that accommodation, whether they are in Category I or not. (Those obtaining care in private hospitals have to pay for that care irrespective of income.)

¹ A full description of the Irish system of health care entitlements and delivery is given in Nolan (1991) Chapter 2.

² A detailed description of the hospital sector and the Health Board/Voluntary/private hospital mix is given in Report of the Commission on Health Funding 1987, Chapter 12.

³ There are, however, several State schemes, operated through the Health Boards, whereby high or prolonged expenditure on prescription medicines over specified ceilings is covered or reimbursed.

The way these charges for public health services are currently structured is as follows:

- (1) Those outside Category I using out-patient clinics of public hospitals are charged £6 per visit, with a maximum payment per person of £42 in any 12-month period;
- (2) Those outside Category I spending time as in-patients in public wards of public hospitals are charged £20 per night, with a maximum payment of £200 in any 12-month period;
- (3) All those opting for private accommodation in a public hospital pay additional charges. These are currently £132 per night for a private bed or £104 for a semi-private one in major public hospitals, with lower charges for smaller hospitals.

The level and structure of these public hospital out-patient and in-patient charges has also been altered somewhat since they were introduced in 1987. At that time, the out-patient charge was £10 for the first visit with a specific condition, with subsequent visits for that condition not subject to charge, whereas now a lower charge is payable but for each visit. The in-patient charge was introduced at £10 per night, with a maximum of £100 in any year.

To understand the role of these public health service charges, it is necessary to discuss the way they evolved and the relationship between public and private provision and financing of health care in Ireland. Those without medical card cover have always had to pay privately for GP care and prescription medicines. The GPs who provide this care and the pharmacists providing the medicines are independent professionals who also cater for those with medical cards, for whom they are paid by the General Medical Service (GMS) Payment Board on behalf of the Department of Health. Since 1989 GPs are reimbursed for their GMS patients on a capitation basis, rather than the fee-for-service system which operated until then: other patients continue to pay a fee for each visit. Up to 1987, though, out-patient services in public hospitals and in-patient care in public wards of those hospitals were provided free of charge not only to those with medical card cover but also to a majority of the remainder of the population.

A three-category entitlement system was in operation at that time, those without medical card cover being divided into Categories II and III, again on the basis of an income ceiling. Those in Category III, who were above a specified income ceiling and comprised about 15 per cent of the population, had much more limited entitlements than those in what was then the

intermediate Category II.⁴ Up to 1987, people in Category II had the same entitlements to free out-patient and in-patient care in public hospitals as those with medical card cover. Thus, about 85 per cent of the population were entitled to free public hospital care. The remaining 15 per cent were entitled to free maintenance but were liable for medical consultants' fees in the public health services. So that those without full public cover could insure against these costs, the Voluntary Health Insurance Board had been set up in 1957 by the state as a monopoly non-profit provider of health insurance, and most people in Category III did have VHI cover. This also covered the costs of private accommodation in public hospitals or care in private hospitals and allowed choice of consultant, and a significant proportion of those in Category II also paid for health insurance despite their entitlement to free care in public wards of public hospitals.

The introduction of charges for public hospital services (other than those for private accommodation) in 1987 was therefore a marked departure from the policy which had obtained up to that date, whereby these services were provided free of charge at point of use to most of the population. The distinction between those with medical card cover and those without was greatly reinforced: having applied only to whether one was entitled to free GP care and associated drugs, the differentiation now extended to entitlement to free care in public hospitals. The entitlement structure was subsequently altered in 1991. Category III was abolished and those who had been in that category were now entitled to full public hospital care in a public ward – subject only to the new charges – rather than maintenance only. The present structure, then, distinguishes simply between those in Category I, who receive GP care and public hospital care free of charge, and the remainder of the population, who pay privately for GP care and are liable for the charges for public hospital care. Currently, just over one-third of the population are in Category I, with medical card cover, so the charges are payable by almost two-thirds of the population.

The role of health insurance remains an important one, both narrowly with respect to charges and more broadly. It was suggested at the time

⁴ See Nolan (1991) Chapter 2 for a full description of the pre-1991 entitlement system. It is worth noting that those in Category III versus Category II were distinguished on the basis of an individual earnings ceiling (whereas the means test for Category I status relates to family income and takes family size into account). As a result, membership of Category III did not correspond exactly with position in the income distribution, and the 15 per cent in that category were not all in the top 15 per cent in terms of unadjusted or equivalent household disposable income (see Nolan, 1991, pp. 47-49).

Category III was abolished that this might reduce the demand for health insurance substantially, since that group could now avail of care in public wards of public hospitals (subject only to the per-night charges). However, as analysed in Nolan (1991), the limited entitlements of Category III did not in fact appear to be the major element in the demand for health insurance. Many of those on middle and higher incomes appeared to be willing to pay for health insurance primarily in order to be sure of speedy access to hospital care, and the study concluded that the abolition of Category III, taken alone, was unlikely to have much impact on the demand for health insurance.⁵ As yet the evidence suggests no significant effect on the numbers with VHI cover: about one-third of the population are currently covered by VHI, with a small increase between 1991 and 1992.⁶ Their coverage varies depending on the plan chosen and the premium paid, but all the standard plans include cover for the public hospital in-patient charges.⁷ The out-patient charges in public hospitals are also included under the standard plans but will only be reimbursed when total expenditure in the year on out-patient care (including GP visits but not prescription medicines) exceeds a ceiling, currently £105 for an individual or £170 for a family, when the excess over those amounts will be covered.

At the time the statutory public hospital charges were introduced in 1987, and in response to concerns about the financial burden they might impose, the VHI at the Minister for Health's urging introduced new policies which allowed people to buy cover for these charges only. Although the annual premia are low, by 1992 only about 105,000 people had cover for the statutory charges only, which is about 5 per cent of those liable for the charges and 10 per cent of those liable and without VHI cover under the standard plans already.⁸

In assessing the impact of the public hospital charges, then, the role of insurance must be noted. The per-night in-patient charges will generally be

⁵ See Nolan (1991) Chapters 10, 11 and 14.

⁶ The numbers insured under the main VHI plans rose from 1,165,624 at end-February 1991 to 1,193,965 at end-February 1992 (VHI *Annual Reports* 1991, 1992).

⁷ That is, if the hospital night in question is covered, so is the statutory per-night public charge.

⁸ Initially, there were two such plans - Plan P, which covered the statutory in-patient and out-patient charges, and Plan T, which allowed people in Entitlement Category III to buy cover for public consultant fees as well as the statutory charges. Membership of these two plans was 124,000 in 1991, when the abolition of Category III and extension of public eligibility for consultants fees to the whole population made Plan T unnecessary. Some of those enrolled under Plan T then joined the main plans, and membership of Plan P was 105,140 at end-February 1992 (VHI *Annual Reports* 1991, 1992).

paid directly by the VHI for about one-third of the population, and another third will be exempt because they are in Category I, so these charges will be paid at point of use by only about 1 in 3 of the population. The out-patient charges, on the other hand, will be paid at point of use by all those without medical card cover, and even where the individual has VHI these charges will very often not be reimbursed.

The main role of health insurance, though, remains the coverage of the costs of obtaining "private" hospital in-patient care: that is, care from a consultant of one's choice either in public hospitals – generally though not always in private or semi-private accommodation – or in private hospitals. The level of the charge made for a private or semi-private bed in public hospitals is therefore an important element in the cost of obtaining private in-patient care in these hospitals. There has always been a charge for this amenity, set by the Department of Health and applying uniformly across all public hospitals, but for many years it was relatively low. Over the past decade or so, however, the level has been raised very substantially. From 1980 to 1993, the charge for a private bed in major public hospitals has risen from £12 to £132 per night, and that for a semi-private one has risen from £9 to £104. While these charges rose eleven-fold, over this period consumer prices rose by only 125 per cent, so this represented a very substantial increase in real terms. This has a direct impact on the VHI and has contributed to a sharp rise in premia, which increased in nominal terms by a factor of 3 between 1980 and 1993.

As the discussion has made clear, the charges for public health services must be seen in the wider perspective of the role of charges at point of use and out-of-pocket expenditure in the financing of the health services. "Out-of-pocket" expenditure here refers to those payments by households for health services (whether public or private) which are not subsequently reimbursed by an insurer. In Ireland, out-of-pocket expenditure for health care principally goes on:

- (1) GP care and prescription medicines for those not in Entitlement Category I;
- (2) public hospital out-patient and in-patient charges for those not in Entitlement Category I and without VHI cover for these charges;
- (3) "private" hospital treatment (in public or private hospitals) to the extent that this is not covered by the VHI;
- (4) long-term nursing home care for the elderly not covered by VHI or Health Boards.

Such out-of-pocket expenditure accounts for about 15 per cent of current health spending in the Irish case⁹. (As far as the charges for public health services are concerned, it is worth emphasising that only the element not covered by the VHI will count as out-of-pocket expenditure in this sense.)

Having set out the role which charges for health services now play in the Irish system, the remainder of this chapter puts this in a comparative context, looking at the structure of charges facing users of the health services and the importance of out-of-pocket expenditure as a source of financing in some other OECD countries.

2.3 The Role of Health Charges Elsewhere

Health systems in OECD countries vary greatly in terms of institutional structures, the public/private mix in financing and in delivery, and the role of social and private insurance, and it is not our objective here to describe these structures in detail. Instead, we concentrate on the charges which face users of the health services at the point of use, and the role which out-of-pocket payments play in financing, in a number of these countries.

Perhaps the simplest system in structural terms is one in which charges play a relatively minor role, namely the UK. Everyone is entitled to free GP and hospital care under the National Health Service (NHS). There is a flat-rate charge for prescriptions (which was Stg.£3.05 in 1990), though many patients are exempt for a variety of reasons. There are also charges for dental and ophthalmic care under the NHS. A relatively small private medical care sector provides for choice of doctor, speedier access to hospital, and private hospital accommodation for those who are willing to pay, often covered by private health insurance. Out-of-pocket payments account for only about 10 per cent of all expenditures on health, and private insurance for only about 5 per cent, the remainder being financed out of general taxation or social insurance contributions. Major changes in the organisational structure of the NHS have been implemented in recent years which are intended to promote autonomy and efficiency of the component parts, but no changes have been made in the way the service is financed. Health care (mostly) free at point of use remains a central tenet of the NHS.

The health financing structures in other EC member states tend to be much more complex, often based on a mix of cover by the state, non-profit sickness funds and private insurance, as well as out-of-pocket payments. In Belgium and France, for example, patients generally have to pay a

⁹ See Nolan (1993a).

proportion of the cost of GP visits and prescription medicines, the remainder being covered (directly or by reimbursing the patient) by health insurance funds or, less frequently, private insurers. In both cases, the patient generally pays 25 per cent of the doctor's fee, with the long-term ill exempt in France while widows, the disabled and old age pensioners below an income ceiling pay lower fees in Belgium.¹⁰ For hospital in-patient stays, in France there is a small per day charge, currently FF60 or about £7 per day. In Belgium, there is a co-payment of a proportion of the fees for the specialist and diagnostic tests as well as a daily charge of BF221 or about £3.50. In Belgium, reforms aimed at controlling health care expenditure in the late 1980s/early 1990s have concentrated on the implementation of global budgets for various sectors, with little emphasis on increasing cost-sharing by patients. In France, by contrast, the extent of cost-sharing has been rising through increased co-payments and other channels, though the impact has been cushioned by supplementary insurance for some. Out-of-pocket payments cover about 17 per cent of total health care expenditure in France and about 12 per cent in Belgium.¹¹

In the former West Germany, most of the population is insured on a compulsory or voluntary basis by sickness funds. Under the statutory insurance system, patients pay a prescription charge of DM3 and a per-day hospital charge of DM10 for the first 14 days, with ceilings on total charges and exemptions for children and those on low incomes. These were introduced only in the early 1980s, when they were set at DM2 and DM 5 respectively, and were raised in 1991 as part of cost-containment policy packages. Out-of-pocket expenditure accounted for about 11 per cent of health expenditure.

The system of health financing in The Netherlands is currently in flux, with a radical reform being implemented following the broad outline of the recommendations of the Dekker Commission which reported in 1987. Prior to the reforms, the whole population was voluntarily or compulsorily insured for acute health care costs, a majority with sickness funds and the remainder with private insurers. The sickness funds generally covered the entire cost of GP visits and prescription medicines as well as specialist care, whereas people with private insurance could choose to carry some of the risk themselves. Out-of-pocket payments accounted for about 11 per cent of health care expenditure. While the Dekker Commission and the modified version of its

¹⁰ In both countries patients pay a proportion of the cost of drugs.

¹¹ See Hurst, 1992, pp. 32, 47.

recommendations actually being implemented emphasise the importance of competition and consumer choice, direct charges are not given an enhanced role: the basic insurance package continues to cover most health care. Rather, it is the choice of insurer by the consumer which is seen as the key competitive lever, and the concentration is on enhancing competition in the insurance market and among providers of health care. Rising costs will have their impact on the consumer mainly through the flat-rate element of the total insurance premium which they pay – the remaining risk-related element effectively being paid by the state – rather than through increased costs at the time when care is needed.

In Denmark central and local tax revenues finance publicly-provided health care and those receiving GP and hospital care do not face a charge, though there are co-payments for prescription drugs. In Switzerland, those with only basic sickness fund cover pay 10 per cent of the cost of ambulatory care. In these countries, out-of-pocket payments account for about 16-18 per cent of total health care spending. In Spain the figure is slightly higher, but in Portugal, with a less developed public health system, out-of-pocket payments account for close to 40 per cent of health spending.¹²

This is even higher than the level seen in the USA, which is strikingly different among the richer OECD countries in the extent to which health care is financed out-of-pocket. In the US case, this expenditure is largely in the form of co-payments for primary and in-patient care by those with private insurance and those covered by Medicare, the national scheme for the elderly, as well as spending by those without insurance. Rapidly rising health spending in the US during the 1970s and 1980s was attributed by some to the fact that consumers with insurance did not bear much of the direct cost, and the response has been to increase the proportion borne by the consumer through more extensive use of deductibles, co-insurance and co-payments. (A deductible is a fixed amount which the consumer must pay before the insurer pays the excess, and co-insurance and co-payment involve the consumer paying a specified proportion of the cost or a specified amount for a particular service with the insurer paying the rest.) As we will see in the next chapter, though, health care spending in the US has continued to grow rapidly. More fundamental reforms are now being considered, with the extension of health insurance to the entire population and the control of costs as central aims.

¹² Wagstaff, van Doorslaer, *et al.* (1992) p. 369.

Canada presents an interesting and oft-quoted contrast to the USA. There, health services charges were abolished in 1972, under the health insurance system which is operated by the provinces but under conditions mandated at federal level. GP and hospital care has been free at point of use, and the emphasis in terms of cost control has been on using the bargaining power of the provinces as monopoly purchasers of health care services from providers. For many years this appeared successful in keeping down the rate of growth in health spending, though more recently the record has been more mixed. As a consequence of this and other concerns, the whole issue of the role of charges in the health services has re-emerged as a topic of debate, with some provincial governments pressing for their use.

In some though by no means all the OECD countries we have discussed the reaction of policy-makers to rapidly increasing health expenditures included giving a greater role to charges. With the possible exception of the USA, though, this was not seen as the main plank in the packages of health services reform measures introduced in the various countries during the 1980s and early 1990s. In reforms being implemented in many developing countries around the same time, however, charging "consumers" of health services was given great prominence.

2.4 Conclusions

Looking at the financing of health care in comparative perspective, Ireland is not an outlier among OECD countries in the extent of reliance on out-of-pocket payments. The UK is at one extreme with only 10 per cent of health spending coming from this source and the USA and Portugal are at the other with 30 per cent or more, but at 15 per cent the percentage for Ireland is similar to countries such as France and Denmark.

Likewise, the increased role of charges for users of the public health services in the 1980s and 1990s does not mark Ireland out as exceptional. Some, though by no means all, of the other OECD countries we considered responded to the growth in health expenditure by increasing charges at the point of use, primarily to discourage "unnecessary" utilisation. Many developing countries, urged on by international organisations such as the World Bank, have also moved to introduce or increase charges for health services.

This does not necessarily mean that the case for charging for health services is a convincing one at a general level, of course, nor that charges are an appropriate response in the specific circumstances of Ireland. Moving a

stage further, even if one accepted that charges were appropriate it would still be necessary to ask whether the structure of charges adopted in the Irish case was likely to promote the desired objectives. In the next chapter we examine the rationale behind charging for health services and the case against doing so at a general level. In the following three chapters we go on to look at how the balance of arguments weighs up in Irish circumstances, and how the structure of charges currently in place can be assessed in the light of these arguments.

Chapter 3

CHARGING FOR HEALTH

3.1 Introduction

Having described the role which charges currently play in the health services in Ireland and some other OECD countries, we now discuss the general arguments for and against charging for health services and the factors to be taken into account in designing a structure of charges. In Section 3.2 the general shape of the debate on charging for health care is outlined, while subsequent sections concentrate on specific aspects, namely resources and cost containment, efficiency, and equity.

3.2 Charging for Health Care – The Debate

Whether and how to charge users of health care has been a particularly contentious issue for policy debate in developed and developing countries over the past decade or so. In developed countries, much of the pressure for reform of health care systems has reflected a concern about restraining expenditure levels, with health spending as a proportion of GDP on a sustained upward trend in many countries. In the developing world, although the costs of health care inputs were also generally rising, the concern tended to be more about the scarcity of resources for health care given pressure on public finances and, particularly in Africa, poor macroeconomic performance. The case for introducing charges for users of health services or increasing the level and widening the scope of such charges has focused in the industrialised countries primarily on making consumers more cost-conscious and thereby discouraging “unnecessary” utilisation, whereas in developing countries the emphasis has been more on charges as a source of revenue.

In both cases, proponents have also argued that charges help to promote efficiency, while opponents have concentrated mostly on the implications for the poor and for equity. The efficiency arguments for charging users flow from the belief that prices not only act as a disincentive to “frivolous” use, they can also help to promote use of the appropriate level of care and send the right signals to providers and planners. Patients are faced with a financial incentive to act as diligent consumers, searching for the “best buy” and thereby promoting competition among providers and insurers. These arguments are often put within the more general framework which emphasises the inefficiencies associated with organisations not subject to the

discipline of the market – though usually acknowledging the particular features on both supply and demand sides which make the market for health care different from other commodities.

Those who argue against charges, on the other hand, while often disputing the cost control/resources and efficiency arguments, emphasise the potential impact of charges on the poor. They generally take as their point of departure the value judgement that health care should be available to all and that need rather than means should have primacy, so the distribution of health care should not be left up to the market. Charging for health care from this perspective is most likely to discourage utilisation by the poor, and providing care free of charge at point of use is the only way to ensure it is available to all. The counter-argument put by those in favour of charges is that the poor do not in fact “capture” most of the benefits from services provided free of charge to everyone, and can be exempted from charges, so that equity can actually be improved by charging non-poor users.

While some of the arguments have general applicability and are familiar from wider debates about the role of the state versus the market, health care differs from other commodities in ways that are central to understanding the debate about charging for care. The key distinguishing features of health care in this context may be briefly described as follows:

- (1) Uncertainty about the incidence of illness and the associated costs calls for sharing of risk across the population via some form of public or private insurance.
- (2) Consumers do not have sufficient knowledge on which to base independent rational decisions about the nature of their health problems and the care required. They are heavily dependent on expert advice from those providing the care, who are therefore in a position to exert a major influence on demand.
- (3) Market failure is also inherent on the supply side, with restrictions on entry and on competition between providers, and third-party payers (the state, non-profit and for-profit insurers) play a dominant role in financing health care. In combination with the weak position of the consumer, this means that the standard market model with consumer sovereignty and many competing sellers does not apply.
- (4) Health care is also widely regarded as “different” from other commodities in ethical or normative terms. Access to health care for those who need it is seen as a basic entitlement, and ensuring

that everyone has that access is prominent among the stated goals of health policy in many countries. Going further, the notion that health care ought to be distributed according to need rather than ability to pay appears to command widespread support among health professionals and the public at large (Wagstaff, van Doorslaer, *et al.*, 1992a) though precisely how this is to be interpreted can be disputed. It is not necessary for present purposes to delve into the philosophical issues involved or the distinctions which can be drawn between access to and receipt of care. It is sufficient to note that health care is regarded in a different light to other commodities, and that there are particularly strong views about how it should be distributed and the role played by ability to pay.

The fact that health care has these distinguishing characteristics is common ground: where those arguing for and against a major role for charges part company is on the implications for how the market for health care can and should operate. Against this background, having identified the main themes in the debate about charging for health care, we now look at each in more detail, starting with cost control and revenue generation.

3.3 Charges, Cost Control and Resources

Expenditure on health care as a percentage of GDP in OECD countries increased from an average of about 4 per cent in 1960 to over 7 per cent by the mid-1980s. In some countries that growth was even more pronounced, with the share of GDP going on health spending more than doubling in both Ireland and the USA over that period, from 4 per cent to over 8 per cent in the Irish case and from 5 per cent to over 10 per cent in the US. (These expenditure trends are discussed in more detail in Chapter 4 below.) Controlling the growth in health spending became an increasing priority in many OECD countries, and this led *inter alia* to scrutiny of the role of prices and of insurance. In the USA, in particular, many economists diagnosed "over-insurance" as an important part of the problem. Because of insurance – whether from private insurers or the state-provided Medicare for the elderly and Medicaid for the poor – patients frequently bore little of the direct cost of the health care they actually received. While they had to pay indirectly through insurance premia or taxes when health costs went up, this was not sufficient to make them ration their own utilisation.

More "cost sharing" would discourage "unnecessary" or "frivolous" use of

services and limit the growth in expenditure, it was argued. In the US, this cost sharing generally took the form of greater use of co-payments and deductibles in health insurance, both by private insurers and in Medicare, so that patients faced a direct financial incentive to minimise their use of services. Other OECD countries have also been seeking to limit the growth in health spending, though (as documented in Chapter 4) the problem they face has not been as severe as in the USA. With cover against health care risks generally provided by social insurance funds or directly by the state, the use of co-payments/charges has been extended in a number of countries and in others moves in that direction are under active consideration, as we saw in Chapter 2. Private health insurers elsewhere also generally followed the US lead.

Controlling the growth in health care expenditure primarily through focusing on consumer behaviour faces two main difficulties, however. Both relate to the structure of the "market" for health care and the weak position in which the patient will inevitably be as a consumer, because of what are generally referred to as "informational asymmetries". Patients are not able to form an independent judgement of what their health care needs are, they must rely on professional advice. As a result, providers of health care play a crucial role in forming the views of patients on what they should be demanding. The first implication is that incentives facing providers and insurers may therefore be more important than those facing consumers in terms of influencing expenditure levels. The second is that if people do respond to financial incentives and reduce their utilisation of health services, there is no way to be sure that it will be "frivolous" or unnecessary utilisation which is forgone. That judgement can only be made *ex post*, on the basis of a professional assessment, and patients may not be good judges *ex ante*. In the light of these factors, cost-control policy may be more effective and have lower costs in terms of health outcomes if targeted towards providers and insurers rather than consumers of health care. This is reflected, for example, in efforts to control expenditure on prescription medicines principally through influencing the prescribing behaviour of doctors.

We look in the next chapter at the extent to which different OECD countries have been able to control the growth in health spending, in order to assess the case for charges on that basis. As well as influencing demand, charges are, of course, a means of raising revenue. Most OECD countries rely primarily on tax revenue or social insurance contributions (whether to a central National Insurance Fund or to sickness funds) for financing health

care, the USA being exceptional in the importance of private insurance. With public budgets under strain throughout the 1980s and many countries seeking to reduce their tax burdens, "cost sharing" in health, education and other areas could be one way of shifting part of the burden and easing these pressures. Whether reducing taxes by increasing such charges improves the situation or has a largely cosmetic or even negative impact depends on behavioural responses and distributional effects. Reducing the tax burden would in itself be expected to reduce distortions, and people are likely to respond differently to charges than to taxes, but these responses may themselves have costs in terms of policy objectives. For example, charging for primary education or primary health care may make it more difficult to ensure that people make use of these services so that targets for education and health outcomes are more difficult to reach. There will also be distributional implications, first in that those on low incomes may be most likely to reduce their utilisation, and secondly in that the distributional pattern of payments associated with charges will itself differ from that associated with taxes. Both are discussed when we come to consider equity in depth below.

In developing countries, cost control has not been the main concern for proponents of charges. Rather, user charges have been seen as offering a way of mobilising more resources in aggregate for health care and education (while promoting efficiency and improving equity). Many developing countries have attempted to provide health care and education fee of charge, while others have had only nominal fees for users or have not been assiduous in collection. However, in the 1980s and into the 1990s the pressures on public spending in the face of slow economic growth and record budget deficits have become intense. As a result, alternative sources of financing for social services have been sought, and attempts to raise significant revenue through user charges have become much more common in both health and education. The World Bank, which has played an important role in advocating the use of charges in the social sectors, set out its recommended agenda for reform of the financing of health services in developing countries in 1987. User charges were central to this agenda, and were seen as offering a way to increase the resources available for government spending on health, particularly for the provision of usually underfunded but highly cost-effective primary health care. The policy has been or is being taken up by many developing countries, partly as a result of pressure from the Bank and other donors, with varied success so far in terms of raising revenue. The key

difference between developed countries and many developing countries in this context, however, lies in the capacity to raise revenue through the tax system. While there may be distortions and welfare costs associated with taxation, OECD countries do not face such pressing limits on their capacity to raise revenue for public spending via taxes.

From a resources point of view, then, the context in which the debate about charging for health takes place in developing countries is quite different to developed countries, where constraining rather than expanding the total resources devoted to health care is a key objective. However, in both developed and developing countries proponents place much of their emphasis on the potential of charges to improve efficiency, where very much the same arguments are used in either setting. It is to these efficiency-based arguments that we now turn.

3.4 Charges and Efficiency

Where services are provided free of charge, consumers face no direct financial incentive to limit their consumption, and allocation methods other than price have to be used to determine who gets what service and when. The absence of a direct financial penalty for consumption may lead to "unnecessary" use of the health services, although there will often be other costs associated with use, such as travel, time costs and perhaps loss of earnings. As we have seen, the main difficulty with using price to discourage such utilisation is that there can be no presumption that it will be the unnecessary visits which are discouraged. Defining what is "unnecessary" utilisation is itself problematic.¹³ Experts and officials have difficulty defining in advance, and sometimes even after the event, what is medically necessary, so it is unreasonable to expect patients to be good judges. The large-scale controlled experiment carried out by the RAND Corporation in the USA suggested that user charges were about as likely to deter patients from using what was judged to be necessary as unnecessary services (Lohr, *et al.*, 1986). Simply from the point of view of efficiency and controlling health costs, discouraging early treatment may mean that the care ultimately needed ends up being more costly to provide. With "ordinary" commodities the consumer can make a rational informed choice to reduce consumption in the face of

¹³ Care which has some medical benefit but not sufficient to outweigh the costs can be considered "unnecessary", but assessing that benefit - certainly *ex ante* - is often difficult, and deciding whether it is then "worth" the cost is a matter for political and ethical judgements rather than self-evident (see Stoddart *et al.*, 1993).

increased price, posing no problem for public policy. In the case of health care, though,

- (a) the consumer may not be in a good position *ex ante* to assess the value of a visit to the doctor, and
- (b) improving the health status of the population in a cost-effective way is an objective of public policy.

Promoting the use of appropriate health services, particularly primary and preventive care, has therefore become an important part of health policy, and this is the context in which "pricing policy" – user charges – have to be seen.

There are a number of ways, other than discouraging "unnecessary" utilisation, in which it is suggested that charges could contribute to improving efficiency, through the signals and incentives they can give to both consumers and providers or planners. One of the most important is the role charges could play in redirecting demand and resource allocation away from high-cost hospital-based care, particularly in-patient care, to lower cost and often more appropriate primary care. Where no fees are charged, a patient will have no incentive to use the service that is less costly to provide – the GP rather than the hospital out-patient department, for example. Most health budgets are dominated by the costs of running hospitals, and countries are trying to redirect resources towards primary care, with an associated shift in emphasis towards preventive rather than curative services. A structure of charges which reflects the relative costs of providing different types of services will signal patients to ration their use of expensive resources – as the World Bank put it: "Consumers will be more sensible in their demand for services".¹⁴ Particular emphasis is placed on the potential to encourage the proper use of referral systems. Charges can give patients an incentive to seek care first at the lowest level – the health centre or GP – rather than going straight to hospital, as frequently happens where both are free of charge. They can also provide an incentive for patients to spend as little time as possible as an in-patient, for example, helping to promote the use of day-surgery.

Whether charges actually do help to produce the desired redirection of demand towards primary care depends on how they are structured, and equally importantly whether the patient or a third party ends up paying them. The structure of charges in place in many countries does *not* in fact

¹⁴ World Bank (1987) p. 26.

provide a disincentive to bypassing the primary level, or the difference in the level of the fee is not sufficient to outweigh what are seen to be other advantages of going straight to hospital, such as availability or quality of care provided. Further, it can often be the case that insurance offsets the incentives built into the structure of charges. It is common, for example, for patients to have to pay for out-patient costs themselves (or to be covered by insurance only above a relatively high deductible), but to be covered fully for in-patient care. Further, it is generally overlooked in presenting the case for charges along these lines that use of the referral system could be promoted simply by charges levied only on those who bypass the primary level. Neither charges at primary level itself, nor at hospital level for those who are referred upwards from primary level, would be required to produce the desired incentive. Those arguing in favour of charges also emphasise the role of prices as an efficient method of allocation. Where services are provided free of charge, there has to be some alternative method for allocation of the service, and, where demand exceeds supply, for rationing. Proponents see price as a more efficient mechanism for allocation than, for example, queuing. Critics of free health services such as those in the UK and Canada thus highlight the existence of queues for doctors or out-patient clinics and sometimes lengthy waiting lists for particular types of hospital in-patient treatment. Leaving aside for the moment the obvious equity implications of allocating health care using price, the assumption that this will be more efficient than alternative mechanisms depends on what one means by efficient and what it is that one is seeking to maximise. If, for example, the aim is to produce the greatest impact on ill-health possible with the resources available, then efficiency would involve allocating care first to those who can benefit most. A queuing procedure which ranked people on the basis of condition and severity and allowed those who could benefit most to receive care first would then be more efficient than allocation using price and ability to pay. This is not to say that queues and hospital waiting lists actually operate in that way and achieve that objective: again, though, it is far from self-evident that prices would be a more efficient allocation mechanism in this sense.

On the supply side, it is also argued that providers will be more responsive to the concerns and needs of patients where the latter are paying for the service. The revenue raised via charges can also be used to give providers or administrators an incentive to provide good care. Whether fees

can actually produce these effects clearly depends on what happens to the revenue. If charges for users of public health services are simply passed on to the central administration or to the Exchequer, then neither providers themselves, nor administrators at hospital or facility level, will be directly affected by their imposition. It may be that patients will themselves be more assertive and demanding if they are paying, but this is a rather tenuous basis for a supply-side response. Providers and administrators may be expected to respond rather more if at least some of the revenue raised goes to improving either their own remuneration or working conditions, or the service they can provide. Precisely how this is structured is crucial. It can be, for example, that the incentive created for providers or hospitals is to maximise numbers treated rather than improve quality of care or reduce costs. A great deal of the effort to control health spending in OECD countries has concentrated on designing reimbursement mechanisms for providers which build in the "right" incentives, focusing mostly on the relationship with third-party payers (including the state) rather than the patient. It is not clear that expanding the role of charges is a necessary part of this process, while it is certainly not a sufficient one in that – depending on how the revenue is distributed – charges could leave these incentives unchanged or even worsen them from an efficiency and cost control point of view.

3.5 Charges and Equity

Resistance to the adoption or expansion of charges for users of public health services has been so pronounced primarily because of concerns about their equity effects. The debate has generated so much heat because many people hold very strong views about the importance of health care being available to those who need it. The main concern is that charges will act as a barrier to access for those on low incomes, so that some people who need care will be forced to do without. A related but broader issue is whether, even if everyone had access to "adequate" health care, those with more resources should be in a position to obtain speedier treatment or better quality care. Finally, financing health care through charges is regarded by some people as less fair than financing through taxation, where an individual's or family's contribution can be related to ability to pay.

While demand for health care is generally found to be relatively price-inelastic, the fact that user fees can discourage utilisation by the poor is acknowledged as a serious problem by those who advocate them. The usual

response is that the poor can be charged lower fees or exempted entirely. Thus the World Bank, for example, in arguing for charges emphasizes the need to safeguard the poor, and suggests that differential fees and/or exemptions be used. Distinguishing the poor in administering charges poses major difficulties in developing countries, much greater than in developed ones where means-testing is already widespread. While there can be administrative problems, in developed countries it is the impact of means-testing on incentives which has become a major issue in recent years. A great deal of attention has been paid to the possibility that where social security cash transfers and perhaps also assistance with housing or other needs are targeted on a means-tested basis, the incentive to take up employment or to work harder can be eroded, leading to unemployment and poverty "traps". Introducing charges for health services (or education) together with means-based exemptions will exacerbate these problems, whereas much of the effort in reforming tax and social security systems currently is directed towards improving work incentives.

More broadly, equity concerns about access to health care and the distribution of care do not concentrate simply on the position of the poor. The notion that health care is a basic right that should be available free of charge to all has been quite a widely-held one – indeed some countries have it enshrined in their constitutions. The related idea that health care should be available on the basis of need rather than ability to pay is also commonly found in policy statements, etc. Whether that necessarily entails providing services free of charge can be disputed, but it is in some senses even more demanding: from this perspective it would be regarded as inequitable if the rich got much speedier access to care or much better care than the rest of the population, even if care were available to everyone free of charge. Without wishing to get embroiled in debates about precisely what policy-makers actually mean when they talk in terms of care being available to all on the basis of need, the fact that this is a fundamental objective of health policy forms a central part of the background against which the role of user charges is debated.

Those advocating the use of charges in developing countries argue that they would in fact help to improve equity, since a great deal of the benefit from free services actually goes to the non-poor. This is particularly the case where much of public health spending goes on hospitals from which the urban population, generally better off than those in rural areas, get most of

the benefit. Even in a developed country context, it is argued that the well-off capture much of the benefit from free services and that charging the non-poor would allow better targeting of public spending towards the poor. These arguments are familiar from long-running debates about whether social security transfers should be better targeted on the poor and, if so, whether this is best accomplished by means-testing. While more equitably distributed than in many developing countries, a good deal of the benefit from public health spending in OECD countries does go to middle income groups (as discussed in more detail in Chapter 6 below). Even apart from the incentive problems created by means-testing itself which have already been mentioned, though, it may be questioned whether charging the non-poor is the most effective way to re-target public expenditure. If the objective is to encourage the rich to use private health care instead of public services, the result may be to promote a two-tier system. As already noted, this might be considered inequitable even if the rich pay fully for the better care they receive, and the side-effect may be to erode public support for the public system, where standards may suffer without the "sharp elbows of the middle classes" to keep up the pressure for a good and well-resourced service. If the objective is simply to raise resources for health spending from the non-poor via charges while keeping them within the public system, then at least in a developed country context there are alternative revenue sources which may be preferred from an equity point of view.

The other concern from an equity point of view of shifting some of the financing of health care from taxes to charges is precisely that the distribution of payments may be more regressive. Precisely how the distribution of charges compares with taxation depends on the structure of the charges, who uses the service in question, and what the tax alternative is. Flat-rate charges on services used by people throughout the income distribution (even with exemptions for the poor) will generally be regressive, while income taxes or pay-related social insurance contributions will generally be progressive. Other taxes will not, though, and charges on services used mostly by the rich may turn out to be progressive. The distributional effects of shifting from taxes to charges therefore depends on precisely what is involved in a particular case. Once again, the view that health care should be available on the basis of need but financed on the basis of ability to pay is a widely-held one often reflected in policy statements, and the role of charges has to be seen in that light.

3.6 Conclusions

This chapter has outlined the issues and arguments which have featured in the debate about the role of user charges in the health services. Those arguing for an expanded role for charges point to ways in which they can contribute to controlling health expenditures, mobilising resources for health, promoting efficiency and improving equity. Opponents see charges as ineffective in controlling expenditure and promoting efficiency, and likely to raise resources in an inequitable way while reducing the access of the poor to health services. Adjudicating between these arguments at a general level would be an over-ambitious task, and in any case reaching a judgement may often depend on the specifics of the setting involved. The rest of this paper concentrates on assessing the use of health services charges in Ireland, using the framework in which the arguments have been presented in this chapter. Thus, Chapter 4 discusses expenditure control and resources mobilisation, Chapter 5 deals with efficiency, and Chapter 6 discusses equity aspects of health services charges in Ireland.

Chapter 4

HEALTH EXPENDITURE AND FINANCING IN IRELAND

4.1 Introduction

In this chapter the level of expenditure on health services in Ireland and the financing of that expenditure are examined, and the role of charges assessed from a financing and expenditure containment perspective. Section 4.2 looks at the evolution of the overall level of expenditure on health care and of private versus public expenditure. Section 4.3 deals with the financing of expenditure on health, including the contribution currently made by charges for health care in financing public spending.

4.2 Expenditure on Health Care

It is now possible to analyse Ireland's health expenditure in comparative context, thanks to the work done in recent years at the OECD in constructing a database on health spending and health systems for 24 member countries. In this database, health spending is measured using National Accounts conventions in order to promote cross-country comparability.¹⁵ Using this source we see that in 1980, expenditure on health care in Ireland came to 9.2 per cent of Gross Domestic Product (GDP). As Table 4.1 shows, this was among the highest percentages going on health in the OECD countries at that time, and was well above the average for these countries, which was 7.0 per cent. Indeed, the Irish figure was identical to that for the USA, now viewed as the archetypal "high-spending" country in the health care context. Health spending had grown relatively rapidly in Ireland during the 1960s and particularly the 1970s, rising from 4 per cent of GDP in 1960 to 5.6 per cent in 1970 and then accelerating to reach 8 per cent by 1975 and 9.2 per cent by 1980.¹⁶

¹⁵ For that reason, the figures presented by the OECD are not identical to those given in the Department of Health's annual Health Statistics, which follows the Commission on Health Funding in using departmental expenditure rather than National Accounts figures. The differences between the two and their reconciliation are discussed in Nolan (1991, Chapter 2).

¹⁶ The most recent figures published by the OECD show a higher level of health expenditure in Ireland from 1980 on than did earlier versions, on which the discussion of Ireland's relative position in Nolan (1991, Chapter 2) relied. This reflects recent revisions to the Irish National Accounts estimates by the Central Statistics Office.

Table 4.1: *Health Expenditure As a Percentage of GDP in OECD Countries, 1960-1991*

<i>Country</i>	<i>1960</i>	<i>1970</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1991</i>
Australia	4.9	5.7	7.3	7.7	8.2	8.6
Austria	4.4	5.5	7.9	8.1	8.3	8.4
Belgium	3.4	4.1	6.7	7.4	7.6	7.9
Canada	5.5	7.1	7.4	8.5	9.5	10.1
Denmark	3.6	6.1	6.8	6.3	6.3	6.5
Finland	4.2	5.7	6.5	7.2	7.8	8.9
France	4.2	5.8	7.6	8.5	8.8	9.1
Germany	4.8	5.9	8.4	8.7	8.3	8.5
Greece	2.9	4.0	4.3	4.9	5.4	5.2
Iceland	3.5	5.2	6.5	7.1	8.3	8.4
Ireland	4.0	5.6	9.2	8.2	7.0	7.3
Italy	3.6	5.2	6.9	7.0	8.1	8.3
Japan	2.9	4.4	6.4	6.5	6.5	6.6
Luxembourg	..	4.1	6.8	6.8	7.2	7.2
Netherlands	3.9	6.0	8.0	8.0	8.2	8.3
New Zealand	4.3	5.2	7.2	6.6	7.2	7.6
Norway	3.3	5.0	6.6	6.4	7.4	7.6
Portugal	..	3.1	5.9	7.0	6.7	6.8
Spain	1.5	3.7	5.6	5.7	6.6	6.7
Sweden	4.7	7.2	9.4	8.8	8.6	8.6
Switzerland	3.3	5.2	7.3	7.6	7.8	7.9
Turkey	..	..	4.0	2.8	4.0	4.0
UK	3.9	4.5	5.8	6.0	6.2	6.6
United States	5.3	7.4	9.2	10.5	12.4	13.4
Average	..	..	7.0	7.2	7.6	7.8

Source: OECD (1993) Vol. I, Table 4.1.1, p. 108 and Vol. II, Table A1.2.4, p. 34.

As Table 4.1 also shows, a remarkable turn-around took place between 1980 and 1990 in the evolution of Ireland's health spending, which is particularly striking in comparative terms. By 1990, Irish health spending had fallen to only 7 per cent of GDP. This was now considerably lower than the average for the OECD countries, which had risen to 7.6 per cent. Indeed, Ireland was one of only four OECD countries which saw health spending decline as a percentage of GDP over the decade, and the fall in the Irish case was by far the largest. The USA, by contrast, which started the decade with the same relatively high level of health spending (as a percentage of GDP) as Ireland, saw a continued climb to over 12 per cent by 1990, by far the highest level in the OECD. While most other OECD countries were much more successful than the US in curbing the growth of health spending as a percentage of GDP in the 1980s, Ireland is unique in the extent to which growth was actually reversed.¹⁷ In 1991 Irish health spending rose to 7.3 per cent of GDP, but remained substantially below the average for the 24 countries.

Although the population grew relatively slowly, health spending per capita therefore rose a good deal less in Ireland than in most other OECD countries in the 1980s. Table 4.2 shows health spending per capita in each country, converted to a common basis (using purchasing power parities rather than exchange rates). In 1980, health spending per capita in Ireland was 78 per cent of the average for the OECD countries. On the basis of a simple cross-section equation relating per capita health spending to per capita GDP estimated for the 24 countries for that year, Ireland's actual health spending was about one-third higher than would be predicted. By 1990, Irish health spending per capita had fallen to 66 per cent of the OECD average and was fourth-lowest of the countries covered, corresponding to Ireland's rank by GDP per capita. Health spending per head in Ireland was now only slightly above the level which would be predicted for a country with

¹⁷ For comparative purposes, the level of health spending is most often expressed as a percentage of GDP, the practice adopted here and in earlier OECD analyses. The most recent OECD publication (1993, Chapter 1) focuses on health expenditure as a percentage of total domestic expenditure (TDE), on the grounds that using an expenditure aggregate in both numerator and denominator increases consistency. For Ireland, health as a percentage of TDE was 8.1 per cent in 1980 and 7.6 per cent in 1990, so the decline is less pronounced than when GDP is used. However, over the decade Ireland still moved from well above average to below average in the proportion of spending going on health.

that GDP.¹⁸ In 1991, the Irish figure was 70 per cent of the OECD average, still close to that “expected” simply on the basis of GDP per capita.

An analysis of trends in health expenditure in the 24 countries from 1980 to 1990 presented in OECD (1993) decomposes the observed changes into price and volume components. This reveals that in Ireland over that period, prices continued to increase more rapidly in the health sector than elsewhere in the economy, as was the case in most of the other countries. However there was volume growth in the health sector – what the OECD study terms “health care benefits volume growth” – in all the other countries, but in Ireland there was a fall in volume.¹⁹ Many of the other countries saw the *rate* of growth in volume decline in the 1980s compared with the 1960s and particularly the 1970s, but none saw a fall in volume. This analysis is dependent on the quality of the measures of price changes (since volume change is determined residually) and available indices for price trends in health care are of variable quality and coverage, but the general pattern is probably reliable. This finding for Ireland is by no means unambiguously “good news” – from the point of view of the consumer of health care restraining total expenditure via price rather than volume of care would of course be preferable. This highlights the limitations of an exclusive focus on restraining expenditure growth, since this may be achieved only at the cost of a decline in the quantity and/or quality of services. Simply from the point of view of controlling total expenditure growth, however, Ireland’s experience in the 1980s stands out.

¹⁸ The estimated equation is given in Schieber, Poullicier and Greenwald (1992) p. 6. The actual level of health spending per capita in Ireland in 1990 was 3.5 per cent above that predicted by the equation for that year. From OECD (1993, Chapter 1) it can be seen that similar conclusions apply when the analysis is carried out using total domestic expenditure rather than GDP as the independent variable.

¹⁹ See OECD (1993 I, Table 2, p. 23).

Table 4.2: *Health Expenditure Per Capita in US\$ in OECD Countries, 1960-1991*

<i>Country</i>	<i>1960</i>	<i>1970</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1991</i>
Australia	99	207	663	998	1310	1407
Austria	69	163	683	984	1383	1448
Belgium	55	128	571	879	1242	1377
Canada	109	253	743	1244	1811	1915
Denmark	70	212	582	807	1051	1151
Finland	57	164	517	855	1291	1426
France	75	203	698	1083	1528	1650
Germany	98	216	811	1175	1522	1659
Greece	16	58	184	282	400	404
Iceland	53	137	581	889	1379	1447
Ireland	38	97	449	572	748	845
Italy	51	153	571	814	1296	1408
Japan	27	127	517	792	1175	1267
Luxembourg	..	154	632	930	1392	1494
Netherlands	74	207	696	931	1286	1360
New Zealand	94	180	562	747	970	1050
Norway	49	134	549	846	1193	1305
Portugal	..	46	238	398	554	624
Spain	14	82	325	452	774	848
Sweden	94	271	855	1150	1455	1443
Switzerland	96	268	839	1224	1640	1713
Turkey	..	..	64	66	133	142
UK	79	147	458	685	985	1043
United States	143	346	1063	1711	2600	2867
Average	..	..	577	855	1124	1213

Source: OECD (1993) vol. II, Table A2.1.2, p. 67.

Breaking down total Irish health expenditure into public and private elements using the OECD figures, these show contrasting trends in the relationship between the two over the decades from 1960. In the 1960s, public health expenditure grew a good deal more rapidly than private expenditure. In the 1970s, both grew at almost exactly the same pace. In the 1980s, private health spending grew a good deal more rapidly. While the public element has been dominant throughout, then, the private share has fluctuated somewhat, falling from about one-quarter in 1960 to 18 per cent in 1970, and rising from that level in 1980 back up to about one-quarter in 1990 and 1991. At three-quarters of the total, the share of public health spending in Ireland was then very close to the average for the 24 OECD countries.²⁰

This comparative analysis of Ireland's health spending points to some important conclusions in considering the structure of financing and the role of health charges. Controlling the growth of health expenditure has posed major challenges across all the OECD countries in recent decades, but some countries have been more successful than others in this respect. While the relationships are complex, the way health spending is financed is clearly a crucial factor. Assessing the performance of the Irish system simply in terms of its ability to control the growth of expenditure, one would have to conclude from the experience of the 1980s that this objective was achieved. Indeed, in comparative terms the size of the fall in health spending as a proportion of GDP makes Ireland exceptionally successful in these terms. The scope of charges for public health services was significantly widened in the 1980s, as described in Chapter 2, but this does not appear to have played a major role in curbing expenditure. Rather, that success can be attributed primarily to central government control of the Exchequer allocation to health through the budgetary process, and the dominance of that source in

²⁰ Care must be exercised with data on this public/private distinction. In constructing the Irish National Accounts figures, expenditure on prescription medicines under the General Medical Service for those covered by medical cards is counted as *private* health spending, although the individuals involved do not pay (the GMS (Payments) Board reimburses pharmacists directly), because the individual does have the freedom to choose *where* to make the purchase. If other countries follow this National Accounting convention then the cross-country comparisons using OECD figures are on a consistent basis. However, the Commission on Health Funding and the Department of Health have adopted what would appear the more obvious procedure and classify this expenditure as public rather than private. On that basis, *Health Statistics 1991* shows private health spending increasing from about 17 per cent of total current health spending in 1980 to 23 per cent in 1990, falling again to 21.6 per cent in 1991. The OECD figures show private spending at 25 per cent of total health spending in 1990 and 24 per cent in 1991.

total health expenditure. Using budgetary rather than National Accounts classifications, current government health expenditure fell from 7.3 per cent of GNP in 1980 to 5.9 per cent in 1989, with much of the decline registered in the years 1987-89. The key element was spending on general hospitals, which accounts for about half of current government health services expenditure, and which fell in real terms²¹ by 7 per cent between 1980 and 1986 and by a further 9 per cent between 1986 and 1989 (see Callan and Nolan 1992). This was associated with a sharp decline in the number of hospital beds and a smaller fall in the number of in-patients treated as the average length of stay also fell. Expenditure on psychiatric hospitals fell in *nominal* terms between 1986 and 1989, and was the other area most affected. By contrast, expenditure on the "demand-driven" General Medical Service, providing free GP care and prescription medicines to those with medical card cover, grew relatively rapidly, particularly between 1986 and 1989. While the charges introduced in 1987 could have had some impact on demand, it is supply-side factors which appear to dominate public hospital spending. The fact that the central Exchequer was able to exert control over the budgetary allocation to public hospitals thus appears to have been the key element in restraining public health spending.

The implications of these trends for the use of charges to control utilisation and expenditure will be taken up after the current structure of financing and the contribution of charges has been described.

4.3 The Financing of Expenditure on Health

Public expenditure on health services in Ireland is financed predominantly out of general tax revenues. The precise breakdown of financing sources depends on how public health spending is itself defined and measured. As discussed in Nolan (1991), the coverage of the series on health expenditure published by the Department of Health and in the Estimates of Receipts and Expenditures differs from the National Accounts.²² In particular, some cash transfers administered by the Department of Health are included in the departmental figures but excluded in the National Accounts. Further, the figures for the breakdown of sources of finance published by the Department of Health refer to expenditure *net* of income from charges and other income accruing.²³

²¹ Here the general government expenditure deflator is used.

²² The differences in definition between the series are described in Nolan (1991) Chapter 2, pp. 23-27.

²³ See, for example, Health Statistics 1991, Table J2.

Excluding cash transfer schemes administered by the Department of Health but not properly health spending, and focusing on *gross* current expenditure, the sources of financing of public health spending in 1991 are (estimated) as follows:

	%
Exchequer	81.4
Health contributions, etc.	8.8
Receipts under EC regulations	2.5
Charges and other income	7.3

The Exchequer – that is, revenue raised through general taxation – clearly dominates, accounting for over 80 per cent of public health spending. Health contributions, raised through the health levy which operates alongside the system of social insurance contributions, account for about 9 per cent. Charges for health services – including those for maintenance in private or semi-private accommodation in public hospitals – are a relatively minor source of finance. Taken together with some other sources of income for the Department of Health such as deductions from pay for emoluments and superannuation, canteen and other receipts, and investment income they accounted for about 7 per cent of total current public health spending in 1991. Charges for private and semi-private accommodation make up about 40 per cent of that figure, so charges for public hospital services *per se* and the other sources mentioned come to only about 4.5 per cent.

As the discussion in Chapter 2 emphasised, these charges for public health services are sometimes paid out-of-pocket and sometimes covered by health insurance. Looking at all out-of-pocket payments by households for health services (whether public or private) which are not subsequently reimbursed by an insurer, we saw that these account for about 15 per cent of total (public plus private) current health spending in the Irish case²⁴. As well as the public hospital charges not covered by insurance, this includes GP care and prescription medicines for those not in Entitlement Category I, treatment in private hospitals, and long-term nursing home care, where these are not covered by the VHI.

²⁴ See Nolan (1993a).

4.4 Implications

We have seen that charges for public health services currently make only a small contribution to financing public health spending in Ireland. From the point of view of mobilising resources for health, then, public health charges at their current levels play a very minor role. To become an important source of revenue, they would have to be substantially raised and extended in scope. From a resources perspective, alternatives exist which spread the burden of financing much more widely – most obviously, either general taxation or the health contribution which operates alongside the system of social insurance contributions. There are, of course, costs associated with raising revenue from those sources, and these have to be taken into account in weighing up the costs and benefits of alternative modes of financing. However, Ireland, like other OECD countries, is far from the situation of many developing countries where the revenue-raising capacity of the tax or social insurance (where it exists) systems are in doubt. The case for an enhanced role for health charges in Ireland cannot rely simply on the need to raise resources: there must be clear advantages over the alternative sources of financing.

One of the main advantages posited for health charges in developed countries, however, is that they discourage “unnecessary” utilisation of health services and thereby contribute to controlling the growth of health expenditure. This can be assessed in the light of this chapter’s analysis of health expenditure and financing. Controlling the growth of health expenditure has posed major challenges in OECD countries in recent decades. The analysis of trends in Ireland’s health spending compared with other OECD countries has shown that, since the early 1980s, the Irish system has been exceptionally successful simply in terms of its ability to control the growth of expenditure as a percentage of national income. That success can be attributed primarily to central government control of the Exchequer allocation to health through the budgetary process, and the dominance of that source in total health expenditure. As the UK experience has shown, where the Exchequer is the dominant source of financing and tight central control can be exercised over the budgetary allocation to health, charges are not a *sine qua non* for expenditure control. Conversely the experience of the USA has shown that even the extensive and increasing use of co-payments for consumers is not in itself sufficient to restrain the growth of health care spending as a proportion of national income. (Health spending might have grown even more rapidly in the USA without an expansion in charges: the

point being made is that charges are neither a necessary nor a sufficient condition for restraining expenditure growth.) Controlling expenditure growth is clearly a very limited goal, and success could be at the expense of the availability and quality of health care, so a much broader perspective and above all an emphasis on obtaining the maximum benefit from what is spent on health is required. Given the technological, demographic and other pressures on health spending, though, controlling total expenditure will remain an important objective.

While Exchequer control over public health spending has been the key to success in restraining the growth in health expenditure in Ireland, it is noteworthy that public health spending on prescription medicines for people with medical card cover continued to grow rapidly in the late 1980s and early 1990s: precisely the area where departmental expenditure was determined by the extent of utilisation rather than the other way around. Measures to control this growth have focused on the behaviour of doctors rather than patients. First the reimbursement system for GPs treating medical card patients was changed from a fee-for-service to a capitation basis, and subsequently strenuous efforts have been made to persuade doctors to alter prescribing habits, increasingly by offering them financial incentives to do so. The introduction of drug charges for medical card patients has also been proposed on occasion, though it is not clear if it has been seriously considered as a policy option. Given that low income households are involved, such a charge would presumably not reflect the full cost but could take the form of either a flat-rate fee per prescription item or a proportion of the cost, the latter being more appropriate from the point of view of encouraging patients to use less costly drugs. However, apart from concerns about equity, experience elsewhere suggests that this would be unlikely in itself to have the desired impact on prescribing and drugs expenditure.²⁵

Because of the nature of health care and the market for health services, prices may be a particularly ineffective way to constrain demand. Consumers rely on professionals to advise them about the care they "need", and can often pass on charges to third-party payers. Where charges cannot be passed on and do discourage utilisation, the short-term saving may be associated with higher costs in the longer term for the health care system, as some people delay seeking care and need more expensive treatment when they finally do so.

²⁵ See, for example, Birch (1991).

It is perhaps for these reasons that some advocates of user charges for health are now concentrating even more than heretofore on the ways in which charges can contribute to improving efficiency, rather than resources mobilisation or expenditure control. We go on in the next chapter to consider these efficiency arguments as they apply in the Irish case.

Chapter 5

HEALTH CHARGES AND EFFICIENCY IN IRELAND

5.1 Introduction

This chapter considers the way charges for public health services operate in Ireland from the point of view of promoting efficiency. This involves assessing their structure to see whether it is likely to produce the efficiency gains seen by advocates of charges as a key potential contribution. We deal first with efficiency from the point of view of promoting use of the appropriate type and level of care, and then with the impact on health services providers.

5.2 Charges and Efficiency in Use of Health Services

As set out in detail in Chapter 3, it is suggested by proponents that – in addition to discouraging “unnecessary” utilisation – charges can make a major contribution to efficiency by promoting use of the appropriate level and type of care. Where care is free of charge, it is argued, all too often people seek care first not at the primary level but at hospital out-patient and casualty departments. Scarce and costly resources are therefore taken up attending cases many of which could be dealt with much less expensively by GPs. Further, there is no incentive to economise on scarce resources in availing of in-patient care, since the patient does not have to bear any of the cost. What is now seen as the over-emphasis on hospital care and insufficient attention to primary and preventive care built into modern health care systems is thereby reinforced. Charges, appropriately structured, could change the incentives facing patients so that they have an incentive to go to hospital only if referred, and to minimise time spent as an in-patient.

It is noteworthy that Tussing (1985), writing about the Irish health services in the early 1980s before the impetus for charges had gathered momentum internationally, highlighted the financial incentives facing patients at that time which promoted the inappropriate use of care. Those with medical card cover, who were entitled to free GP and hospital care, had no incentive to use the former rather than the latter, but these were not his main concern. Instead, he emphasised the fact that the rest of the population had to pay for GP care but were entitled to free public hospital out-patient services. They therefore had a significant incentive to go straight to hospital level, bypassing the GP and the referral system. Furthermore, those in

Entitlement Category II and those with VHI cover had virtually complete cover from the state or the VHI for hospital in-patient care. He saw these financial incentives as playing an important part in promoting inefficiency in the use of services, and recommended that they be altered.

This analysis formed part of the backdrop to the 1987 decision to introduce charges for users of public hospital out-patient and in-patient facilities who did not have medical card cover. However, the policy adopted differed in important respects from that recommended by Tussing. He argued that the balance of user costs between GP and hospital-based care for those not entitled to medical card cover needed to be altered, but this was to be done not only by charging for hospital-based care but by making GP care available free of charge to the entire population. In the event, there was no attempt to reduce the cost of GP care for those outside Category I: policy concentrated entirely on introducing charges for hospital out-patient and in-patient care.

Given the level of the charge for out-patient care, this has not in fact been sufficient to eliminate the financial incentive to use hospital out-patient and emergency departments rather than the GP as first point of contact. The charge for an out-patient visit was initially £10 for the first visit with a particular condition and no charge for subsequent visits with that condition, and is now simply £6 for each visit. For a visit to the GP, those without medical cards currently pay between £15-20 depending on the area and the doctor. There is thus still a substantial gap between the price of these two options for someone seeking health care. There may often be longer waiting times and perhaps higher travel costs associated with the hospital-based option, but these may not outweigh the significant difference in the basic price in favour of going straight to hospital. While evidence on the extent to which people actually do bypass the GP is limited, this phenomenon has been seen as a problem for a number of years and continues to attract attention.²⁶ While bringing about some alteration in the balance of financial incentives, charges as currently structured have not provided a solution. Not only is there a substantial remaining differential in price in favour of going straight to hospital, but the patient who does go to the GP first and is then referred

²⁶ For example, it was seen as a problem by GPs surveyed by the Dublin Hospital Initiative Group, appointed by the Minister for Health to examine the operation of Dublin hospitals (see Third Report, 1991, p. 90) and has been discussed regularly between GPs and the Department of Health in reviews of the GMS scheme. While apparently most common in accident and emergency, it appears that some people do also attend out-patient clinics without a referral letter from their GP.

on will have to pay at both stages. The total cost could then be as much as £25 instead of the £6 out-patient charge. User charges in Ireland so far are therefore likely to have had limited success in promoting the use of the referral system, one of the main channels through which they are seen as (potentially) promoting efficiency.

As far as making people conscious of the cost of hospital in-patient care is concerned, the charges currently in place are also likely to have limited impact. They do not apply to those who have medical card cover and, for the most part, will be covered by the VHI for those with health insurance.²⁷ As a result, they will impact directly on less than one-third of the population. In addition, there is an annual maximum payment of £200, so that even for that one-third the charge will often not apply to the "marginal night" in hospital. The charges as structured are therefore unlikely to have had a major impact on incentives: while hospital stays have been falling significantly in length in recent years, this is once again primarily a supply-side rather than a demand-led phenomenon. The pressures on hospitals facing tighter budgetary allocations appear to have been the main force behind falling length of stay, with the relatively low per-night charges playing at most a minor role. (As far as insured patients are concerned there are powerful incentives to prolong in-patient stays rather than switch to home nursing, since the VHI will generally cover the cost of the former but not the latter.)

While efficiency considerations have loomed large in the research and policy literature and undoubtedly played a part in the decision to introduce charges for public health services in the Irish case, policy has not been consistent in this regard. A deep-seated ambiguity is revealed by the fact that, in the face of the reaction to the introduction of charges, the Minister of Health encouraged the VHI to set up special low-cost health insurance schemes which would cover these charges. This is, of course, understandable from the point of view of concern about equity and ability to pay, but – to the extent that people buy that insurance – comprehensively undermines the impact of the charges on the incentives facing patients, and thus one of the main efficiency arguments made for charges in the first place.

²⁷ This is the case for the in-patient charge but not generally for the out-patient one, since only those who spend over the annual deductible *or* have the special policy designed to cover all the charges will be reimbursed for the latter.

5.3 Charges and Efficiency in Provision of Health Services

As well as changing the incentives facing patients, proponents argue that charges can help to improve efficiency in the delivery of health services by altering the incentives for those providing the care – primarily doctors and administrators. Where charges are levied and the remuneration of the individual provider depends on the amount collected, there is a direct incentive to attract and treat more patients. This link between charges and reimbursement could be made simply by allowing the provider keep a proportion of the revenue raised, or through bonuses or other mechanisms. Where the revenue collected does not affect the remuneration of the individual provider but some or all is retained in the hospital or health centre, there will still be an incentive to maximise revenue from charges so the proceeds can be ploughed back into improvements in the facility in terms of staffing, equipment and working conditions. To the extent that those delivering health care derive satisfaction not only from their own remuneration and working conditions but also from the quality of the service they can provide, they will also be motivated to raise revenue through charges in order to be able to improve that quality. Apart altogether from improving efficiency, those working in the health services may need to see some results from raising revenue through charges if they are to be motivated to collect it in the first place.

For these reasons, advocates of charges tend to emphasise the importance of retention of some or all of the revenue raised through fees at the point where they are collected. The nature of the incentives to providers produced by charges and retention need to be analysed carefully, though. The incentive may be to maximise throughput rather than quality of care, for example. A doctor or hospital levying charges per patient and keeping some or all of the revenue will maximise their financial return (at least in the short run) by treating as many patients as possible and minimising the time given to each. Where a hospital keeps some of the revenue from per-night charges, on the other hand, the incentive may be to lengthen patient stays since the treatment cost per patient usually then falls. Where there is a charge for prescription medicines, the incentive may effectively work to promote over-prescribing rather than efficiency. For these reasons, given the power of providers in influencing patients' decisions, payment on the basis of fee-per-service has long been regarded with suspicion by many in the health area. Indeed, these concerns led to the reimbursement system for doctors treating Category I patients in Ireland being altered recently from fee-per-service to

(principally) a capitation basis. The incentives to providers are of central importance in influencing both the quality of care and the rate of expansion of health spending. Where the objective is to maximise the benefits from health spending while controlling the growth in that spending, depending on the nature of the link charges can in fact affect provider incentives adversely. Once again, the special nature of both the commodity and the objective in the case of health care need to be kept to the forefront.

These considerations with respect to provider incentives and charges are somewhat academic in the Irish context at present, though, since there is in fact no link between providers and the charges for public health services. All the revenue raised from these charges goes to the Department of Health, none is retained at the hospital where they are collected, and neither the funds available to the hospital nor the position of those providing the service is directly affected. While the total funds available to the Department of Health may be increased (if there is not an offsetting reduction in the Exchequer allocation), the impact this has on the budget of a particular hospital is so small and indirect that it is not likely to affect incentives.

5.4 Charges and Efficiency: Conclusions

As they are currently structured, charges for users of public health services in Ireland are unlikely to yield the efficiency gains which proponents see as one of their central justifications. Since they apply only to those without medical card cover, over one-third of the population – who are relatively intensive users of the health services – are unaffected. For the rest of the population the cost of seeking GP care is still significantly higher than the charge for a hospital out-patient visit, so there is still an incentive to bypass the referral system and go straight to hospital. The public hospital in-patient charge will often be covered by health insurance, and even where the patient pays the charge it is unlikely to have a major impact on marginal decisions about the length of hospital stays, where the patient often has relatively little say anyway. Since providers and hospitals do not retain any of the revenue raised through charges, the incentives facing them are unaffected.

If the current levels and structure of charges are unlikely to yield major efficiency gains, one option is clearly to increase their levels, widen their scope, and restructure them very substantially. To promote the use of the appropriate level of care, this could involve, for example, raising out-patient charges for those outside Category I so that they exceed the cost of a GP visit, which would represent about a three-fold increase. Consideration would also

have to be given to introducing some charges for those with medical card cover, since otherwise a substantial proportion of utilisation would not be affected. If GP care remained free of charge for this group, a lower out-patient charge than for the rest of the population would still provide an incentive to use the GP instead. Some charge for prescription medicines for the Category I population, already discussed in Chapter 4, would also have to be considered. To provide an incentive to minimise the number and length of hospital stays, the per-night charge could be raised significantly, the annual maximum annual payment could be abolished, and insurance cover for the charges for those with VHI could be reduced (by the use of co-payments, i.e., the patient pays a proportion of the charge) or eliminated. Hospitals could be allowed to keep some or all of the revenue raised.

First of all, the result would be a very substantial increase in the importance of out-of-pocket payments, and in the cost of health care for those who spend time in hospital. The objections to such a course from an equity point of view, to be discussed in the next chapter, are such that it is unlikely to be considered an attractive option. Even from an efficiency perspective, though, experience elsewhere does not suggest that this is a particularly productive route to take. Other means may be available to promote the same objectives more directly and effectively, involving either a reduced but reoriented role for charges or by other mechanisms entirely.

To promote the use of the referral system, for example, a simple by-pass charge, applying only to those who go straight to hospital and are not considered emergency cases, could suffice. Those who are referred by their GP or need out-patient care after an in-patient stay would not pay the fee. The charge would have to be substantial to outweigh the cost of a GP visit, of the order of £20 or more: an alternative would be for hospitals simply to refer such patients back to the GP without treatment. (All this presupposes the availability of the GP even at unsociable hours, without which trying to promote the use of the referral system is problematic as an aim in the first place.) Incentives to limit the length of hospital stays where appropriate, and encourage day surgery rather than in-patient stays, may be better directed at providers and hospitals than patients. While linking rewards/budgets to revenue from charges is one way to affect incentives for providers and hospitals, such incentives can equally well be altered without charges. For example, GPs in the UK are now rewarded for reaching targets for the proportion of their patients immunised or screened, although the patient faces no charge. Similarly, hospital budgetary allocation procedures can be designed to reward efficiency, however defined, with little or no reference to

the initial source of the funding.

Improving efficiency in the delivery of health services in order to meet growing demands while controlling health spending is the central challenge facing health care systems in the developed world. Because of the nature of health care and the particular features of the market for that commodity, having users pay for the service at the point of delivery is not likely to have the impact on efficiency that it would in other markets. If promoting efficiency in use and provision of health services is a central aim of charges for public health services in Ireland, the design of the current structure of charges fails to adequately reflect that objective. Any restructuring will also have to take equity considerations into account, however, and it is to these that we turn in the next chapter.

Chapter 6

HEALTH CHARGES AND EQUITY IN IRELAND

6.1 Introduction

Whatever about the merits of introducing or expanding charges for public health services from an efficiency and expenditure containment point of view, the resistance to charges has been driven primarily by concerns about equity. In this chapter we consider the nature of those concerns, and assess the current role and structure of charges in Ireland, and different directions for reform, from an equity perspective. We begin in Section 6.2 with a discussion of why and how health care is widely regarded as different from other commodities from an equity point of view, and the implications for assessing the fairness or otherwise of financing and delivery systems. Section 6.3 deals with the potential for charges to act as a barrier to access to health care for the poor, and the issues which arise if the poor are to be exempted. Section 6.4 looks at the broader question of how charges might affect the distribution of access to and use of health services throughout the distribution. Section 6.5 turns to equity in the financing of health care and how charges relate to other sources of financing from this point of view. Finally, the conclusions are brought together.

6.2 Equity and Health Care

In a market economy, the distribution of goods and services among individuals and households is determined primarily by the distribution of purchasing power – the distribution of income and wealth. Governments wishing to alter the distribution of consumption can use the tax and social welfare systems to alter the way in which command over resources is distributed. Income transfer safety-nets are designed to provide for a basic level of consumption of, for example, food or clothing. However, governments in such economies also intervene directly in altering the distribution of certain goods and services, and the most prominent of these are health care and education. This partly reflects the fact that markets for these commodities will not operate in the way that other markets do, for a variety of reasons, so that intervention can be justified on efficiency grounds.²⁸ Probably the more important reason, though, is that these

²⁸ See, for example, Barr's (1987) analysis of the reasons why markets for health care and education – unlike housing – fail to conform even approximately to the conditions required for competitive markets to operate efficiently. As far as health care is concerned, the central factors are the reliance of consumers on providers for guidance about appropriate care, the uncertainty about the incidence of illness and the need for pooling of risks, and the limited competition between suppliers.

particular commodities are distinctive in terms of public attitudes as regards equity.

Precisely how they are distinctive, what public attitudes are in this respect, is debatable and much debated. As far as health care is concerned, McLachlan and Maynard, for example, conclude that "equity, like beauty, is in the eye of the beholder" (1982, p. 520). This seems to overstate the extent of divergence in views, though. Judging from public policy statements, a commitment to the notion that all citizens should have access to health care is very widely shared, in developing and developed countries. In many countries, though, this is taken further: it is seen as a goal that access to and receipt of health care should depend on need, rather than on ability to pay (Wagstaff, van Doorslaer, *et al.*, 1992). In the Irish case, the discussion document *Health the Wider Dimensions* issued by the Department of Health in 1986 stated that equity "is taken to relate to the distribution of available health services over the population on the basis of need" (p. 18). The Commission on Health Funding, in its 1989 report, took as a starting-point the definition of equity in terms of ensuring "equal access to and utilisation of [necessary] services for patients with similar needs, regardless of their geographical location or ability to pay" (p. 66). Presenting the aim in terms of equality of access to "necessary" or "adequate" health care recognises that some limits inevitably have to be placed on the services included.

Even if these broad goals are widely accepted, there undoubtedly exist significant differences in interpretation,²⁹ and different people would wish to see the implications followed through in policy terms to differing degrees. This reflects, *inter alia*, the fact that there may be a conflict with other societal goals. For example, ensuring that health care was distributed purely on the basis of need rather than ability to pay might involve restrictions on the freedom of the rich to use their resources to buy better health care than the rest of the population. A balance therefore has to be struck, with the Commission on Health Funding, for example, concluding that it would not be acceptable to deny people recourse to private health care if they wished to pay for it (but that there should be no public subsidy). At a minimum, though, there does appear to be quite widespread support for the notion that need rather than ability to pay should be the major influence on the distribution of health care, and a corresponding unease with income-based

²⁹ For example, the recent exchange between Culyer, Van Doorslaer and Wagstaff (1992a,b) and Mooney, Donaldson and Gerard (1991,1992) focuses on whether equality of access or equality of use of services is the aim commonly implied by policy statements.

differences in speed of access to, or quality of, care.

As far as financing is concerned, public attitudes towards health care as reflected in official policy statements also clearly see it as different from other commodities for which payment is simply related to consumption. The most common formulation is that contributions towards the funding of health care should be based on ability to pay rather than use. Van Doorslaer, Wagstaff and Rutten (1993), for example, document that this is the case in policy statements for 8 out of the 9 European countries covered in the study. Again, Ireland fits neatly into the general pattern. *Health The Wider Dimensions* stated that people should be asked to contribute to the cost of health services on the basis of their financial means. The Commission on Health Funding also stated that payment should be according to means. Again, there is scope for divergence in interpretation and for disagreement about whether a particular distributional outcome is "fair" in these terms.

6.3 Charges, Equity, and Access

Charging for health care gives rise to concerns from an equity perspective first and foremost because charges may act as a barrier to access for the poor. While the demand for health care appears to be relatively price-inelastic, the evidence is that price is an important determinant of utilisation of medical care and that introducing or increasing charges, in itself, will reduce utilisation.³⁰ There is also some evidence that low-income households are most likely to be discouraged – the poor are more price-sensitive than the rich.³¹ (Even where care is available free of charge, time and travel costs and perhaps also loss of earnings will be associated with obtaining care.) Charges will discourage some of those who would use free health services, unless the quality or availability of the service improves markedly when charges are imposed or increased. In a developing country context, the argument is often advanced that charges can provide the basis for such an improvement, and that demand may actually then increase rather than fall when charges are introduced because, for example, health facilities will be able to purchase medicines. In the OECD countries, though, where health services are at a

³⁰ This is certainly the case in developed countries, for which see, for example, Manning *et al.* (1984), Colle and Grossman (1978), van de Ven (1983) and Mooney (1989). For developing countries the position is less clear. Some studies have failed to find significant price effects on demand for health care (see, for example, Heller 1982, Akin, *et al.*, 1986), but other such as Gertler and van der Gaag (1990) do find price to be an important determinant and conclude that model mis-specification is the main reason why other studies did not do so.

³¹ See, for example, Newhouse, Manning and Morris (1981), Gertler and van der Gaag (1990).

much more advanced stage and other sources of financing are available, it is hard to see charges having such an impact on services that utilisation would not be discouraged.

Estimating the likely impact of charges *per se* on demand in the Irish case is problematic. The most comprehensive estimates of the relationship between price and demand for health care, from the USA, are drawn from an ambitious and expensive controlled randomised experiment conducted by the Rand Corporation over a five-year period and involving over 20,000 individuals (Manning, *et al.*, 1984). In the Irish case, we can only look at how utilisation varies across different individuals and households at a particular point in time, using cross-section data from the ESRI 1987 Survey of Income Distribution, Poverty and Use of State Services or the CSO's Household Budget Surveys. While there is some variation in price across these households, the nature of this variation makes it difficult to distinguish the influence of price from other factors likely to affect demand. This is because prices differ (for the most part) only between households with and without insurance and between those entitled to free public health care and those who have to pay for some services. Thus, Nolan (1991, 1993b) analysed the GP visiting behaviour of the ESRI 1987 sample and found that even when factors such as age, sex, location, and health status were taken into account there was a significant difference between those who had to pay for care and those who did not – those with medical card cover and thus free care had more visits. However, not all this difference can be attributed to the impact of price on demand, for two reasons. The first is that there may be other differences between those with/without medical card cover which have not been included in the model but would affect the demand for care – perhaps most importantly, the indicators of health status included may not adequately reflect the greater ill-health experienced by those on low incomes. Secondly, as Tussing emphasised, the fact that (up to 1989) GPs treating medical card patients were paid on a fee-per-service basis but patients did not have to pay could have contributed to some inducement of demand by providers. While Tussing's results and the analysis of the 1987 survey both suggest that price has a role in influencing demand for care, they do not permit a confident prediction of the magnitude of the effects.

It is not disputed, though, that charges do generally discourage utilisation and that the poor must be protected. The usual approach of those advocating charges is that the poor can be exempted. However, the impact on incentives of targeting the poor via means-testing has become a major

issue in recent years, both in the research literature and in public policy debates. Where social security cash transfers and perhaps also assistance with housing or other needs are targeted on a means-tested basis, the incentive to take up employment or to work harder can be eroded, leading to unemployment and poverty "traps". Having charges for health services with means-based exemptions will exacerbate these problems, whereas much of the effort in reforming tax and social security systems currently is directed towards improving work incentives. In the Irish case, the fact that the unemployed or those in work with incomes low enough to entitle them to free GP care and prescription medicines will lose this entitlement if they return to work or increase their earnings has been seen as an important contributor to such "traps". Some estimates of replacement rates for illustrative household types, intended to show the relationship between net income when in and out of work, have included a tentative figure for the value of these medical card entitlements, based on family size and the likely number of GP visits and prescriptions in a year and what these would cost if the income ceiling is exceeded and medical card cover lost. The impact on labour supply behaviour has not been reliably estimated and the overall significance of these traps, for example for the level or composition of unemployment, is unclear. What is clear, is that increasing the role of charges for health while exempting the poor contributes to worsening these traps, and would probably be of greatest significance for those with large numbers of dependent children.

This is the approach which has in fact been adopted with the public hospital charges introduced here in 1987. These apply only to people without medical card cover, thus widening the gap in entitlements between those in Category I and the rest of the population. With the subsequent abolition of Category III, the entitlement structure now simply distinguishes those with medical card cover, who are entitled to full free public health care, and the remainder of the population, who have to pay for GP care, prescription medicines, and the "new" charges for public hospital out-patient and in-patient care. Any further expansion in the role of charges while relying on exemption to protect the poor will add to the significance of this means-tested entitlement and further exacerbate the problems created.

6.4 Charges, Equity, and Utilisation

Apart from the problem of access to health care for the poor, the broader question of how charges might affect the distribution of access to

and use of health services throughout the distribution is also of relevance from an equity perspective. We have seen that the view that "need" rather than ability to pay should be the main determinant of access to and use of health care appears to be a widely-held one. Against that background, even if the poor were exempted, charging for care could be seen as increasing the importance of ability to pay throughout the rest of the distribution. Proponents of charges, on the other hand, argue that the middle and upper income groups often "capture" most of the benefit from free services, and that charges can improve equity by making them pay, thus providing resources which can be used to improve services for the poor.

In developing countries, it is certainly often the case that the relatively well-off benefit disproportionately from public health services, because most public spending usually goes on services in urban rather rural areas. In the OECD countries, though, the more common pattern is that the benefits from public health spending tend to be much more evenly spread throughout the income distribution (see, for example, Saunders and Klau, 1985). While those in the bottom half of the distribution generally benefit most from public health spending, that is where the elderly, who are the most intensive users of health services, are predominantly located. In the Irish case, studies which have allocated the "benefit" from public spending on health services among households on the basis of utilisation patterns and the cost of providing different types of care show very much this type of distribution. Rottman and Reidy (1988) used the 1980 Household Budget Survey and Nolan (1991) used the 1987 ESRI survey for this purpose. Nolan used reported utilisation for each individual, whereas Rottman and Reidy had to rely on averages for each age/sex group.) Ranking households on the basis of equivalent disposable income, Nolan (1991) found that about 30 per cent of allocated public health spending went to the bottom 20 per cent of households, two-thirds went to the bottom half of the distribution, and only 7 per cent went to the top 20 per cent.³² While expenditure on GP care and prescription medicines for Category I is the most concentrated in the bottom half, two-thirds of public hospital spending also goes to that part of the distribution and it dominates the total.

In Ireland, as in other OECD countries, it is not then the case that most of the benefit from public health spending is "captured" by the well-off. Nor is it the case, that the benefits are entirely concentrated at the bottom of the distribution. This is by design rather than by accident: public hospital care is

³² See Nolan (1991), Table 12.4, p. 169.

intended to be available to all and is in fact used by people throughout the distribution. (In the upper income deciles a large proportion pay to have in-patient care in private or semi-private accommodation in public hospitals but still benefit to some extent from public spending, though that benefit is difficult to quantify precisely.) In the UK, similarly, studies have shown that public expenditure on the National Health Service goes on people throughout the distribution but with the bottom half receiving more than half the benefit. This is consistent with the notion that the objective of public spending on health is much broader than simply ensuring access to services for the poor: by making services available to everyone irrespective of income, the NHS aims to promote access and use on the basis of need rather than ability to pay. To the extent that they act as a barrier to access which diminishes in importance as income rises, charges (even exempting the poor) such as those now operating in Irish public hospitals increase the importance of income *vis-à-vis* need as a determinant of use. Their significance in this regard depends on how much of a barrier they constitute at current levels, which is difficult to assess with the information available: the most recent household survey with information on utilisation was carried out before or just as the charges were being introduced, so it is not possible to use such data to assess how utilisation patterns have been affected.

Concerns about equity in the distribution of health care relate not only to how public spending on health is distributed, but to the overall use of health services, whether publicly or privately financed or delivered. Here less information is available internationally, but the recent cross-country study by van Doorslaer, Wagstaff and Rutten (1993) has tried to assess the extent to which income influences the use of health services in various OECD countries. This study took as point of departure that equity in this context implies that those in equal need of health care should be treated the same, irrespective of income. Based on household samples for each country and applying a common methodology, the relationship between the value of health care received (in terms of imputed expenditure), "need" as proxied by age, sex and indicators of health status, and income was examined. The results tentatively suggested that there was in this sense inequity favouring the better-off in a number of the countries studied, including the USA, the UK and Spain. Ireland was included in this study, with results fully reported in Nolan (1993a), and no pronounced inequity in delivery of health care was found. The indicators of health status available were crude and limited, particularly in the Irish case. However, the study does suggest that on a cross-country basis there is no simple one-to-one correspondence between a

country's financing or delivery system and the degree of inequity in delivery. This is best illustrated by the fact that some inequity was found in the UK, where public cover is universal and comprehensive, as well as in the USA where the private sector is so important. Looking at an individual country and predicting the impact of an increased role for charges, though, it is once again difficult to see how the result can be anything other than an increase in the importance of income as opposed to need as a determinant of use.

6.5 Charges and Equity in Financing

So far we have been concerned in this chapter with equity in access to and use of health services. Many people have strong views not only about access and use, but also about fairness in the financing of health care, and charges also give rise to concerns from that perspective. Compared with alternative sources of revenue, they are seen as likely to be regressive. If one starts from the premise that health care ought to be financed on the basis of ability to pay, then this is an undesirable feature of charges irrespective of their impact on utilisation.

Studies which have attempted to assess the degree of equity in the finance of health care across countries and across different sources of revenue have taken this premise as their point of reference. For example Hurst (1985) compared US, Canadian and British systems of health financing, and Gottschalk, Haveman and Wolfe (1989) compared US, British and Dutch systems from this standpoint. The most comprehensive such study is again the recent one by van Doorslaer, Wagstaff and Rutten (1993), covering 10 OECD countries including Ireland. This found that, using standard assumptions about incidence, taxes are typically a progressive means of raising revenue, with direct taxes generally progressive and indirect taxes regressive – consistent with the usual picture provided by studies of taxation and distribution. Social insurance, by contrast, is usually a regressive method of raising revenue, often because contributions are subject to a ceiling. In countries where it plays a major role, private health insurance is also regressive, indeed usually even more so. Where private insurance plays only a subsidiary role and is taken out mainly by the better-off, as in the UK, The Netherlands and Ireland, it is currently progressive: however, to the extent that further expansion can only come about as a result of persons in the middle and lower income groups also taking out insurance, such expansion would make it less progressive. Out-of-pocket payments were generally found to be a regressive form of health care finance. Indeed in predominantly tax-

financed systems, these payments are generally the only regressive element in the financing system, apart from indirect taxes.

The results for the different sources of health financing in Ireland (again fully reported in Nolan 1993a) are quite consistent with this general pattern. Direct taxes were found to be quite progressive, indirect taxes regressive, and total taxes marginally progressive. Social insurance contributions, in this instance the Health Levy element, were mildly progressive, because although there was a ceiling above which no further contributions were levied, very little was paid by the bottom two (equivalent) income deciles because they contained very few earners. (The income ceiling for the Health Levy element was abolished in 1991 so it currently applies to all earnings, which would imply a greater degree of progressivity.) Health insurance is progressive, as already noted, because it is mostly taken out by upper and middle income households, and out-of-pocket payments are regressive. Weighting each source by its importance in the overall financing of health care, the structure as a whole (in 1987) was found to be slightly progressive but close to proportional.

The cross-country comparative data for OECD countries lead van Doorslaer, Wagstaff, *et al.*, to conclude that a greater emphasis on out-of-pocket payments in these countries is likely to make health care financing less progressive or more regressive. In the Irish case, these payments are currently regressive and this conclusion applies. This is the case even though here, as in some of the other countries in the study, those on low incomes are accorded special treatment. In the Irish case, those qualifying for a medical card do not have to pay for GP care or prescription medicines, which make up a significant element in out-of-pocket expenses for the remainder of the population. None the less, on balance these payments over the distribution as a whole are regressive, on the basis of conventional summary progressivity indices. Simply exempting the poor is not sufficient to make these payments a progressive source of financing.

There is no simple correspondence between out-of-pocket payments and charges for public health services, since the former include payments for private care and the latter may be partly covered by insurance. However, in the Irish case, it is probable that charges for public health services as currently structured are regressive. They apply to about two-thirds of the population and are flat-rate rather than income-related, and those in the middle of the income distribution are more intensive users of public health services and are therefore more likely to be subject to the charges than those

towards the top. While health insurance is currently progressive, expanding its role in covering these charges does not offer a way around their regressivity, since, as already noted, any such expansion will be into the middle and lower income groups and will simply make insurance less progressive. Not all the alternatives are necessarily more progressive – for example, increasing indirect taxation – but certainly compared with direct taxation, or even increasing social insurance contributions, expanding the role of charges is likely to move the Irish system of health financing towards less progressivity.

6.6 Conclusions

Health care is generally seen as different to other commodities in terms of equity. Health care is regarded as a right, and the notion that it should be distributed primarily on the basis of need and financed primarily on the basis of ability to pay is widely held. This has implications for the role of charges for public health services, in terms of their impact on utilisation and on the progressivity of health care financing. Charges may act as a barrier to access to care for the poor, and exempting the poor from charges via means-testing, as is currently the practice in Ireland, can create other problems by contributing to unemployment and poverty traps. Even where the poor are exempt, charges increase the importance of ability to pay as opposed to need in determining access to care. Out-of-pocket payments are generally a regressive means of financing health care, and expanding their role is likely to move the financing of health care in Ireland, which is currently mildly progressive, in the direction of less progressivity. The same is probably true of charges for public health services as they are currently structured in Ireland, whether covered by health insurance or paid out-of-pocket.

Chapter 7

HEALTH CHARGES IN IRELAND: CONCLUSIONS

In Ireland, out-patient services and in-patient care in (public wards of) public hospitals were provided free to most of the population up to 1987. In that year charges for out-patient services and a per-night charge for in-patients in public hospitals were introduced, applying to all those who did not qualify for a medical card on the basis of a means test. These charges were increased in early 1993, and the reaction was such that the Minister for Health set up a review body to examine how they should be structured. People who do have medical card cover are also entitled to free General Practitioner services and prescription medicines. As public expenditure on providing these services, particularly the drugs element, continues to rise relatively rapidly, the question of whether some charge should be imposed there has also been raised on occasion. Issues which arise in setting the level of charges for private accommodation in public hospitals – which have been increased dramatically in recent years – also need to be addressed. The basis and rationale for policy towards charging for public health services therefore need to be examined in Ireland, as in many other countries, and that has been the aim of this paper.

Proponents of health services charges argue that they can mobilise resources for health, discourage unnecessary utilisation and thereby help to control costs, promote efficiency, and enhance equity. This paper has examined these arguments as they apply in an Irish context, and assessed the current structure of charges in that light. Without repeating the discussion in any detail, it is worth drawing out the central conclusions from that analysis in this final chapter.

- (1) Whereas some developing countries do indeed appear to have little realistic alternative to user charges, other sources of health financing which spread the burden much more widely (taxation or social insurance) are available in a country like Ireland. While there may be distortions and welfare costs associated with these sources, charges also have costs. The case for an enhanced role for health charges in Ireland cannot rely simply on the need to raise resources: instead, the costs and benefits of alternative sources of financing have to be assessed.
- (2) Charges are a blunt weapon for controlling the growth of health expenditures, likely to deter not only “unnecessary” but also

"necessary" care. Aggregate expenditure on health as a proportion of GDP has been successfully restrained in the Irish case primarily by Exchequer control over public spending, particularly hospital budgets, though the impact on accessibility and quality of services is not clear. Measures to control expenditure growth with least impact on the benefits from health care may be better directed at providers and administrators rather than patients.

- (3) Charges can provide an incentive for people to use the health services more sensibly, in particular to follow the appropriate referral systems. The current structure of charges in Ireland is unlikely to be effective in doing so, though, since those liable to out-patient charges still pay substantially more for a GP consultation, and those with medical card cover do not pay for either. If penalising those who go straight to hospital is a central objective, then a by-pass fee which does not apply to those who are referred on by the GP would give the appropriate incentive;
- (4) Charges as currently constituted in Ireland are unlikely to discourage use of (costly to provide) hospital in-patient care, since very often they will be covered by insurance and there is, in any case, an annual maximum payment, so the patient will very often not face a charge for the "marginal night". Greater use of co-payments in insurance would be required to give the appropriate incentive to patients, but evidence from elsewhere suggests this is not very effective anyway: decisions about length of stay and choice of in-patient versus out-patient care are more in the hands of the providers and administrators than patients.
- (5) Since revenue raised by charges goes directly to the Department of Health and does not directly affect the resources available to providers and hospitals, they do not provide incentives for cost control or greater productivity. While retention of some of the revenue raised can alter the incentives for providers and hospitals, this would not necessarily be in the direction desired. These incentives can be altered by changing the way remuneration and hospital budget-setting are structured, whether charges are in place or not.
- (6) From an equity perspective, health care is generally regarded as a right, and the notion that it should be distributed primarily on the basis of need rather than ability to pay is widely held. Charges may

act as a barrier to access to care for the poor, and exempting the poor from charges via means-testing, as is currently the practice in Ireland, can create other problems by contributing to unemployment and poverty traps. Even where the poor are exempt, charges increase the importance of ability to pay as opposed to need in determining access to care.

- (7) The view that health care should be financed primarily on the basis of ability to pay is also widely held. Charges are probably a regressive way of financing health care even when the poor are exempt, and expanding their role is likely to move the financing of health care in Ireland, which is currently mildly progressive, in the direction of less progressivity.

The persistence with which user charges for public health services have been proposed in Canada, despite repeated rejection by policy-makers and the general public, leads Stoddart *et al.* (1993) to term them "zombies" which refuse to remain buried. In Ireland, by contrast, the case for charges has not been properly debated but they were introduced anyway. On examination of the arguments and an assessment of the available evidence, the case for charges proves to be for the most part a weak one. This highlights the need for clarity about what user charges in the Irish health services are actually meant to accomplish. Is the primary objective to control costs, discourage unnecessary utilisation, promote efficiency, enhance equity or simply raise revenue? Since charges are ineffective and unnecessary for controlling costs and as likely to discourage "necessary" as "unnecessary" use (which are often difficult to distinguish even with hindsight), the case on cost control or efficiency grounds is unconvincing. Most public hospital in-patient care depends on the decisions of doctors rather than patients and in-patient charges are often covered by insurance and leave incentives to patients unaffected anyway, so they cannot be justified on efficiency grounds. Discouraging "inappropriate" use of hospital out-patient services instead of GP care could be achieved simply by charging those who by-pass the GP and are not "genuine emergencies", rather than all users. From an equity perspective, financing public health care via taxation (or social insurance) means that, in broad terms, those on higher incomes pay a larger share than others. With user fees, by contrast, the sick pay a larger share than others, and this remains true even when "the poor" are exempted.

The key issue remaining, then, is whether user charges are justified simply as a means of raising revenue for the public health services. The

argument can certainly be made that charges provide additional resources and allow services to be improved. What has to be considered, though, is the costs involved and the alternatives. The costs are that some "necessary" utilisation of services will be discouraged, and sick people will bear a larger share of the burden of financing. The alternatives include raising additional revenue from taxation, diverting additional resources to health from other areas of government spending, or improving the way the money currently being devoted to health care is spent. There are costs associated with increased taxation, and decisions about the level of taxation and the appropriate balance of public spending between different areas are political choices. However, it is worth highlighting evidence from Ireland and other countries which suggests that there is significant scope for improvement in the way the health care system is structured and managed and the way the resources devoted to health care are spent.³³ User charges can in some sense be seen as a "soft option", postponing the need to address how to get better value for money in the public health services.

The point of departure for any assessment of current user charges for public health services in Ireland must therefore be that the basis and justification for such charges need to be re-examined. Here it has been argued that there is a case on efficiency grounds only for a charge on "inappropriate" use of hospital out-patient services by those who by-pass the GP and are not genuine emergencies, although non-financial factors such as GP availability which may influence this choice also need to be considered. Charges on users of out-patient services who have been appropriately referred, and in-patients, are simply a means of raising revenue which must be assessed against the alternatives. Even if the need for the revenue provided by charges is accepted, there is an alternative source, still within the health area, which would yield considerably more while improving equity and removing distortions. The Exchequer currently forgoes about £45 million per year in income tax through the relief granted on health insurance premia. This subsidises those with insurance, mostly the better-off, in obtaining private health care. (Callan (1991) shows how the benefits are concentrated in the upper parts of the income distribution.) Since the extension of entitlement to public hospital care to the entire population with the abolition of Entitlement Category III in 1991, the original justification for this relief – namely the limited public entitlements of this group – no longer holds. Indeed, it was on this basis that the Report of the Commission on Health

³³ See for example Stoddart, *et al.* (1993); Report of the Commission on Health Funding (1987).

Funding (1987) recommended that the tax relief be phased out once the entitlement structure had been altered. The Commission on Taxation (1982) also recommended that the relief be abolished as part of the broadening of the tax base and removal of tax-induced distortions to incentives. While this remains in place, it is particularly difficult to accept the argument that user charges are the best or only way to increase the resources available to the public health services.

REFERENCES

- AKIN, J., D. GUILKEY, C. GRIFFIN and B. POPKIN, 1986. "The Demand for Adult Outpatient Services in the Bicol Region of the Philippines", *Social Science and Medicine*, Vol. 22, No. 3, pp. 321-328.
- BARR, N., 1987. *The Economics of the Welfare State*, London: Weidenfeld and Nicholson.
- BECK, R., 1974. "The effects of Co-payments on the Poor", *Journal of Human Resources*, Vol. 9, pp. 129-142.
- BIRCH, S., 1991. "Charging for Health Care: Evidence on the Utilisation of NHS Prescribed Drugs", *Social Science and Medicine*, Vol. 33, No. 6, pp. 681-687.
- CALLAN, T., 1991. *Income Tax and Welfare Reforms: Microsimulation Modelling and Analysis*, General Research Series Paper No. 154, Dublin: The Economic and Social Research Institute.
- CALLAN, T. and B. NOLAN, 1992. "Distributional Aspects of Ireland's Fiscal Stabilisation", *The Economic and Social Review*, Vol. 23, No. 3, pp. 319-342.
- COLLE, A.D. and M. GROSSMAN, 1978. "Determinants of Paediatric Care Utilisation", *Journal of Human Resources*, Vol. 13 (Supplement), pp. 115-158.
- COMMISSION ON HEALTH FUNDING, 1987. *Report*, Dublin: Stationery Office.
- COMMISSION ON TAXATION, 1982. *Direct Taxation: First Report*, Dublin: Stationery Office.
- CULYER, A.J., E. VAN DOORSLAER and A. WAGSTAFF, 1992a. "Comment on 'Utilisation as a measure of equity by Mooney, Hall, Donaldson and Gerard'", *Journal of Health Economics*, Vol. 11, pp. 93-98.

- CULYER, A.J., E. VAN DOORSLAER and A. WAGSTAFF, 1992b. "Access, Utilisation and Equity: A Further Comment", *Journal of Health Economics*, Vol. 11, pp. 207-210.
- DEPARTMENT OF HEALTH, 1986. *Health The Wider Dimensions*, Dublin: Stationery Office.
- DEPARTMENT OF HEALTH, 1991. *Health Statistics*, Dublin: Stationery Office.
- DUBLIN HOSPITAL INITIATIVE GROUP, 1991. *Third Report*, Dublin: Department of Health.
- GERTLER, P. and J. VAN DER GAAG, 1990. *The Willingness to Pay for Medical Care: Evidence from Two Developing Countries*, Baltimore: World Bank and Johns Hopkins.
- GOTTSCHALK, P., B. WOLFE and R. HAVEMAN, 1989. "Health Care Financing in the USA, UK and Netherlands: Distributional Consequences", in *Changes in Revenue Structures*, Proceedings of the 42nd Congress of the International Institute of Public Finance, Athens, pp. 351-373.
- HELLER, P., 1982. "A Model of the Demand for Medical and Health Services in Peninsular Malaysia", *Social Science and Medicine*, Vol. 16, No. 3, pp. 267-284.
- HURST, J., 1985. *Financing Health Services in the United States, Canada and Britain*, London: King Edward's Hospital Fund.
- HURST, J., 1992. *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries*, Paris: OECD.
- LOHR, K.N., R.H. BROOK, C.J. KAMBERG, *et al.*, 1986. "Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis- and Service-specific Analyses of a Randomized Controlled Trial", *Medical Care*, Vol. 25 (Supplement), pp. 531-538.

- MANNING, W., *et al.*, 1984. "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services", *New England Journal of Medicine*, Vol. 310, pp. 1505-1510.
- McLACHLAN, G. and A. MAYNARD, 1982. "The Public/Private Mix in Health Care: The Emerging Lessons", in G. McLachlan and A. Maynard (eds.) *The Public/Private Mix in Health Care: The Relevance and Effects of Change*, London: Nuffield Hospitals Trust.
- MOONEY, G., J. HALL, C. DONALDSON and K. GERARD, 1991. "Utilisation as a Measure of Equity: Weighing Heat?", *Journal of Health Economics*, Vol. 10.
- MOONEY, G., J. HALL, C. DONALDSON and K. GERARD, 1992. "Reweighing Heat: Response to Culyer, van Doorslaer and Wagstaff", *Journal of Health Economics*, Vol. 11, pp. 199-205.
- NEWHOUSE, J.P., W. MANNING, C. MORRIS, *et al.*, 1981. "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance", *New England Journal of Medicine*, Vol. 305, pp. 1501-1507.
- NEWHOUSE, J.P. and C. PHELPS, 1974. "Price and Income Elasticities for Medical Care Services", in M. Perlman (ed.) *The Economics of Health and Medical Care*, London: Macmillan.
- NOLAN, B., 1991. *The Utilisation and Financing of Health Services in Ireland*, General Research Series Paper 155, Dublin: The Economic and Social Research Institute.
- NOLAN, B., 1993a. "Ireland", in E. van Doorslaer, A. Wagstaff and F. Rutten (eds.), *Equity in the Finance and Delivery of Health Care: An International Perspective*, Oxford: Oxford University Press.
- NOLAN, B., 1993b. "Economic Incentives, Health Status and Health Services Utilisation", *Journal of Health Economics*, Vol. 11, pp. 151-169.
- OECD, 1993. *OECD Health Systems: Facts and Trends 1960-1991*, Vols. I and II, Health Policy Studies No. 3, Paris: OECD.

- ROTTMAN, D. and M. REIDY, 1988. *Redistribution Through State Social Expenditure in the Republic of Ireland, 1973-1980*, Dublin: National Economic and Social Council. Report No. 85.
- SAUNDERS, P. and F. KLAU, 1985. *The Role of the Public Sector*, OECD Economic Studies Special Issue, Paris: OECD.
- SCHIEBER, G., J.-P. POULLIER and L. GREENWALD, 1992. "U.S. Health Expenditure Performance: An International Comparison and Data Update", *Health Care Financing Review*, Vol. 13, No. 4, pp. 1-15.
- STODDART, G.L., M. BARER, R.G. EVANS and V. BHATIA, 1993. *Why Not User Charges? The Real Issues*, Ontario: Premier's Council on Health, Well-Being and Social Justice.
- TUSSING, A.D., 1985. *Irish Medical Care Resources: An Economic Analysis*, General Research Series Paper No. 126, Dublin: The Economic and Social Research Institute.
- VAN DE VEN, W.P.M.M., 1983. "Effects of Cost-Sharing in Health Care", *Effective Health Care*, Vol. 1, No. 1, pp. 47-58.
- VAN DOORSLAER, E., A. WAGSTAFF and F. RUTTEN, 1993. *Equity in the Finance and Delivery of Health Care: an International Perspective*, Oxford: Oxford University Press.
- VOLUNTARY HEALTH INSURANCE BOARD, various years. *Annual Report and Accounts*, Dublin: VHI.
- WAGSTAFF, A., E. VAN DOORSLAER, *et al.*, 1992. "Equity in the Finance of Health Care: Some International Comparisons", *Journal of Health Economics*, Vol. 11, pp. 361-387.
- WORLD BANK, 1987. *Financing Health Services in Developing Countries: An Agenda for Reform*, Washington D.C.: The World Bank.

THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

RECENT PUBLICATIONS BY STAFF MEMBERS

(All reports are published by the Institute except where otherwise stated)

General Research Series

Unemployment, Poverty and Psychological Distress (1991, C.T. Whelan and D.F. Hannan, S. Creighton, Paper 150, IR£12.00).

Domestic Electricity Demand (1991, S. Scott, Paper 151, IR£8.00).

Education, Employment and Training in the Youth Labour Market (1991, R. Breen, Paper 152, IR£12.00).

The Quality of their Education: School Leavers' Views of Educational Objectives and Outcomes (1991, D.F. Hannan and S. Shortall, Paper 153, IR£15.00).

Income Tax and Welfare Reforms: Microsimulation Modelling and Analysis (1991, Tim Callan, Paper 154, IR£10.00).

The Utilisation and Financing of Health Services in Ireland (1991, Brian Nolan, Paper 155, IR£13.00).

Review of the Irish Aquaculture Sector and Recommendations for its Development (1992, R. O'Connor, B.J. Whelan, J.A. Crutchfield with A.J. O'Sullivan, Paper 156, IR£15.00).

Care Provision and Cost Measurement: Dependent Elderly People at Home and In Geriatric Hospitals (1992, J. Blackwell, E. O'Shea, G. Moane, P. Murray, Paper 157, IR£15.00).

Intersectoral Financial Flows in Ireland (1992, Patrick Honohan, Paper No. 158, IR£7.00).

Low Pay in Ireland (1993, Brian Nolan, Paper No. 159, IR£12.00).

Alcohol Use in Ireland: Some Economic and Social Implications (1993, Denis Conniffe and Daniel McCoy, Paper 160, IR£12.00).

Broadsheet Series

An Overview of Civil Service Computerisation, 1960-1990 (1992, Robert Pye, Paper 26, IR£10.00).

The Pilot Programme for Integrated Rural Development 1988-90 (1992, Eoin O'Malley, Paper 27, IR£10.00).

Family Problems - Substitute Care: Children in Care and Their Families (1993, Kathleen O'Higgins, Paper 28, IR£10.00).

Lone Parents in the Republic of Ireland: Enumeration, Description and Implications for Social Security (1993, A. McCashin, Paper 29, IR£10.00).

Policy Research Series

Property Tax: Principles and Policy Options (1991, Tim Callan, Paper 12, IR£7.00).

The Role of the Structural Funds: Analysis of Consequences for Ireland in the Context of 1992 (1992, John Bradley, J. Fitz Gerald, I. Kearney, G. Boyle, R. Breen, S. Shortall, J. Durkan, A. Reynolds-Feighan, E. O'Malley, Paper 13, IR£10.00).

The Economic Effects of Carbon Taxes (1992, John Fitz Gerald and Daniel McCoy (eds.), Paper 14, IR£8.00).

European Community Lending and the Structural Funds (1992, Patrick Honohan, Paper 15, IR£7.00).

Integration, Federalism and Cohesion in the European Community: Lessons from Canada (1993, J. Frank Strain, Paper 16, IR£8.00).

Ireland and Europe: Challenges for a New Century (1993, Rory O'Donnell, Paper 17, IR£8.00).

An Examination of Irish Currency Policy (1993, Patrick Honohan, Paper 18, IR£8.00).

Charging for Public Health Services in Ireland: Why and How? (1993, Brian Nolan, Paper 19, IR £8.00).

Medium-Term Review

Medium-Term Review: 1991-1996 (1991, J. Bradley, J. Fitz Gerald, D. McCoy, No. 4, IR£25.00).

A COMPLETE LIST OF PUBLICATIONS IS AVAILABLE FROM THE INSTITUTE