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**The Health Funding Commission Report:  
A Critical Commentary**

by

**Moore McDowell**

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## INTRODUCTION

The Commission on the Funding of the Health System, established in June, 1987, reported to the Minister for Health in September, 1989. The report, including appendices and minority reservations, came to just over 400 pages. Based on its view of what constitutes an equitable, efficient and comprehensive healthcare system, it offered to the government a series of recommendations for reforms of both the administrative structures and the financing of the healthcare system.

The commission recommends the establishment of a unified, tax-financed and universal health system, leaving privately financed healthcare a marginal, voluntary and entirely financially freestanding role. Apart from "hotel" aspects of healthcare, it recommends that everyone should have the same right of access to healthcare, regardless of economic status. Priority of treatment is to be left to be decided by medical practitioner selection based on professional judgement of need. This is encapsulated in what has become known as the "common waiting list" recommendation. While access charges are retained in order to discourage frivolous use of scarce resources, the bulk of the proposed system's funding is to come from general rather than ear-marked taxation, and insurance is seen as being confined to meeting "hotel" costs or to meeting the full cost of treatment in freestanding private healthcare institutions.

The Commission recommends the dismantling of the present Health Boards, and their replacement by a single statutory health authority with regional management teams. It also recommends changes in the budgetary procedures affecting healthcare supply designed to enhance cost consciousness and increased economic efficiency in resource use.

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Consequent on these main changes, it makes a series of recommendations covering areas such as contracts and bases of remuneration in the health sector, health education, dental and aural/ophthalmic services, prescribed drugs and paramedical care.

The main recommendations in terms of the publicity afforded to them were the common waiting list, the marginalisation of health insurance as a source of funding, and the abolition of the existing Health Boards. As a result, this paper devotes most of its attention to these proposals. Being a short paper, it cannot be a full and definitive response to the report of the Commission on the Funding of the Health System, and is partial both in terms of the issues it discusses and in terms of its approach. It is a critical paper in that it takes the Commission to task over assertions or conclusions with which the author disagrees. This should not be taken to mean that there is little to praise in the Report. Far from this being the case, I find myself in considerable agreement with the Commission in several important areas. One example of this agreement, explicit in this paper, is with the need to simplify and slim down the administrative machinery of the state medical system. Others are related to such aspects of the Commission's conclusions as the inadequate economic safeguards against cost increases reflecting physician induced demand. It is also impossible to disagree with recommendations on the need to have user costs to dissuade frivolous use of inappropriate services.

The critical tone which dominates this paper reflects the fact that in my view the Commission can be accused of some methodological inconsistency and of having either failed to investigate aspects of the economics of the system which would have yielded interesting results, or reaching conclusions not based on the evidence.

As a general approach, the Commission appears to have treated in an unusually cursory fashion alternative models for organising health supply to the UK type NHS system which they recommend for adoption in Ireland. Their treatment of the possible role of a prop-

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erly articulated insurance system is brief and dismissive. They assume an ethical approach to equity which requires uniformity of outcome rather than minimum acceptable opportunity for all. This has major implications for their choice of structures for the system. Not everyone, however, agrees with this viewpoint, and a report of this type would have benefited from looking at the structural implications of alternative ethical starting points.

In the space available, I have chosen to concentrate attention on a limited number of aspects of the report. These are, in order, the basic ethical approach of the Commission, their diagnosis of the fundamental problems facing the system, the conceptual approach to the problem of health finance, the roles of private and public finance, finance and access, organisational reform and professional earnings.

#### HEALTHCARE EVALUATION: THE COMMISSION'S VIEW.

The confused approach of the Commission to the difficult problems at the core of resource allocation in the health sector is neatly encapsulated by the arguments it advances in ch.5, Criteria for Evaluating the Health Services. In line with most writing on health, the Commission notes that it is very difficult, conceptually as well as statistically, to measure the output of the health sector. In so far as the object of the sector's activities is to improve the "health" of the community, the problem is that (a) there is no simple and comprehensive way to measure the level of the community's "health", and (b) that even if narrow objectives such as longevity are used, it is difficult to measure the impact of healthcare on such objectives (1). It then goes on to note that, despite these problems, there is a rising demand for the services of an increasingly technological healthcare sector, to meet which in its entirety would be infinitely costly. To deal with this it is necessary to aim at efficiency in the allocation of available resources (para 5.7, p 61). "The

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evaluation of the provision and operation of individual services must therefore take account of their impact on the efficiency of the service as a whole" (para 5.9, p 62). The problem, of course, is that efficiency requires being able to measure units of output per unit of input, and if we cannot even agree on what the output is, it is not easy to see how any "objective" efficiency measures can be constructed.

Unable to go any further with the idea of efficiency in provision, the Commission tries to measure the performance of the system in terms of the dimension of access to it. The system should be "comprehensive" and "equitable". Just what is meant by comprehensive is not made clear: the report comes to the conclusion that it is not a fully objectively definable concept, but it seems to mean "covering as wide an area of medical care as is financially feasible and socially acceptable"; this could, of course, mean anything or nothing, and leaves the question of whether a system is or is not comprehensive to contemporary judgement rather than any objective yardstick. Equity is defined initially in terms of equality of access coupled to a fiscally progressive method of financing the services. Subjective elements are introduced by the backdoor: positive discrimination in favour of selected "disadvantaged" groups is included as compatible with equality of access (para 5.18, p 65).

#### THE PROBLEM: FUNDING OR ORGANISATION?

The Commission's approach to the question of the funding of the health services appears to be both confused and misleading. In the Summary Chapter (ch 2) of the report it states (para 2.45, p 15):

"The kernel of the Commission's conclusions is that the solution to the problem facing the Irish health service does not lie primarily in the system



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of funding but rather in the way that services are planned, organised and delivered".

Earlier (para 2.8, p6) the Commission gave its conclusion that:

"the level of funding which this country should spend on healthcare cannot be determined by reference to a fixed proportion of Gross Domestic Product or by reference to international comparison. The level of funding can only be decided in the context of the available resources and the priorities attached by Irish society to different objectives".

To the casual observer, and to anyone who experienced the wrath of the electorate last June, the first of these statements flies in the face of common sense. The political crisis over health arose directly from inadequate funding of the health services, admittedly given existing structures. The second statement, while emotionally plausible, is in economic terms nonsensical. For available resources and priorities one could reasonably substitute ability and willingness to pay (whether through taxes, insurance or direct charges) for the output of the healthcare sector. To suggest that the level of Irish GDP has little to do with either or both is unusual; to suggest that the level of Irish GDP relative to other countries is not a useful guideline to what can be afforded or is likely to be demanded is simply foolish. The Commission is in effect refusing to ask people to face up to the fact that the "priorities" may simply not be reconcilable with the means. To this extent it is conniving at maintaining the illusion of the possibility of an endless improvement in the quality of healthcare for all (2).

Despite these protestations, the Commission proceeds to devote three full chapters out of twenty, and a good proportion of the other chapters, to problems of funding. It fails, however, to place the funding problem at the forefront of its consideration. This seems to

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reflect an unwillingness or inability to approach the problems of the healthservice from an economic point of view. If this seems a little narrow as an approach to the problems of the healthcare sector, it might be well to remember that one definition of economics is that economics is the study of the problems arising from having to allocate means which are scarce between competing ends which are infinite.

In effect the Commission by this approach has tried to sidestep the difficult problem that the choice of funding procedure has a lot to do with the level of funds available, while the system of pricing is a major determinant of whether for any given funding availability the volume of resources available are capable of meeting the demands made upon them. In hiding behind its view that the main problem of efficiency facing the Irish health services lies in the organisation and administration of supply, the Commission is taking the easy way out.

It is almost certainly the case that given existing financial resources, a greater level of output could be obtained by reforms in the administration of the system. This, however, would be a once and for all improvement, which would merely postpone the day when the fundamental problems have to be faced. These are the introduction of economic and institutional changes designed to ensure that the resources society assigns to meeting health demands are sufficient to meet those demands, and to ensure that the level of output of health services equates the costs and benefits at the margin rather than being determined by the self interest of those whose incomes depend on the level and price of medical care.

How it could be maintained by the Commission that the level of funding was not central to the problems of the health services is very difficult to understand in the light of the statistics they themselves present just 30 pages further into the report. In the fourth chapter, which deals with expenditure, they make it clear (Table 4.1, p 43) that funding is



at the heart of the problem. Between 1983 and 1987, while GNP was roughly static and the population was still rising, if only marginally, the proportion of GNP devoted to non-capital health spending fell by 5.0% in real terms. This overall decline, which would have been serious enough as it was, reflected a fall in public spending of about 11% in real terms from 8.3% of GNP to 7.4%, while private spending rose by nearly a quarter, from 1.7% of GNP to 2.1%. The low base line figure for private spending meant that even when it increased more rapidly than at any time since the early 1960s it was not rising rapidly enough to offset the impact of public spending cuts.

#### THE APPROPRIATE LEVEL OF FUNDING

To argue that international comparisons are not helpful seems foolhardy when one examines the OECD data presented by the Commission in the same chapter on health spending in 21 OECD countries. It is true that there are problems in making cross-country comparisons, as the Commission points out, despite the efforts of the OECD to ensure comparability. These discrepancies are not, however, sufficient to explain the totally anomalous position of this country, with a reported level of health spending as a proportion of GDP approximately equal to that of Iceland, Australia, West Germany and Canada, countries with levels of GDP per cap. which were 80%, 50%, 80% and 95% respectively higher than Ireland's. Despite this, the Commission concludes (ch 4, p 50, para. 4.23) that

"the overall level of funding required for the Irish health services cannot be determined by reference to international comparison. On the contrary, we feel that the appropriate overall level of expenditure can only emerge in the context of the resources allocated to each of the services, having regard to

their relative cost effectiveness as influenced by their organisation, delivery and financing."

This conclusion, startling to any economist, is reached by the Commission having presented evidence available to them on the levels of health spending in 21 OECD countries relative to those countries' GDP per capita. It is clear from this evidence that Ireland is one of a group of statistical outliers with very high health spending per head relative to GDP. It would have been a useful exercise to investigate whether the data in the scatter diagram on p. 48 of the report and in the table on the following page offered any statistically significant explanatory relation between GDP and health spending. If it had, the question of the "appropriate" level of health spending by some objective criterion would have had to be faced squarely instead of hiding behind suggestions that sunny climates (para 4.20) or dependency ratios (para 4.19) are to be taken as significantly determining the level of spending that is "appropriate".

Such a simple econometric exercise could either have been undertaken by some members of the Commission themselves, or could have certainly been undertaken for them. Table 1 presents the results of using an Ordinary Least Squares estimation procedure on the data in ch 4 of the report to test the explanatory power of the proposition that the level of health spending across countries is a function of the level of GDP per capita.

90 ru p 20.

TABLE 1

TEST EQUATION :  $Y = a + bX + u$

where Y is Health Spending as a % of GDP, X is GDP per cap. and u is an error term.

VALUES OF THE COEFFICIENTS (t values in parentheses)

a = 3.515 (3.089)

b = .3173 (3.357)

R-squared (adj) = .339    Standard Error of the Estimate = 1.227

F = 11.272

This result suggests that the chosen (appropriate?) level of health spending as a proportion of GDP across the 21 OECD countries is significantly associated in a statistical sense with levels of GDP per head. Such a result is consistent with the view that the desired level of health spending is positively related to income, other things being equal.

Of course, other things are not in general equal, and it is clear from the test statistics that the variance in health spending as a proportion of GDP reflects other factors besides income per head. It means, however, that it is unacceptable simply to dismiss the question of the appropriate level of spending as being unrelated to experience elsewhere. The Commission should have been interested in investigating what explains the fact that Ireland is amongst the outliers. If Ireland showed a pattern of resource allocation to health consistent with income per head by OECD standards, health spending as a proportion of GDP in 1984 (the test year) would have come to about 6.25%; the actual figure was 8.0%

## PUBLIC AND PRIVATE FUNDING

The OECD data quoted in Ch 4 of the Commission's report are also very useful in the light they can throw on the question of the mix of public and private funding of the health services. There is considerable variation in the proportion in which the countries listed rely on state finance. The Commission does not investigate the possibility that the public-private mix is not simply random or, *ceteris paribus*, sociologically determined.

In Table 2 results are shown which are derived by regressing the ratio of total health spending to public health spending on GDP per capita and public health spending as a proportion of GDP.

TABLE 2

TEST EQUATION:  $Y = a + bX + cZ + u$ , where Y is total health spending divide by public health spending, X is GDP per cap., Z is public health spending as a percentage of GDP and u is an error term.

VALUES OF THE COEFFICIENTS ON X, Z (t statistics in parentheses).

a = 1.637 (5.803)

b = 0.045 (2.059)

c = -.152 (-2.919)

R-squared adj = .260      Standard Error of the Estimate = .248

F = 4.508

These results are of interest in terms of both the determination of the mix of spending on health but also because of what they imply for policy. The strong negative coefficient on public spending suggests that private and public spending are substitutes as means of arriving at the desired income determined level of overall health spending. If policy attempts to restrict private spending on health this suggests that EITHER total spending will have to fall OR political pressure will result in public spending increasing to make good the shortfall in actual spending below the desired level. Using a logarithmic variant of this procedure and regressing the ratio of private to public spending on health across OECD countries in order to get an estimate of the elasticity of the mix with respect to the ratio of public health spending to GDP yields a coefficient of -2.025 (t = -2.961) which implies that, at any given income level, a fall of 1% in the level of public spending on health as a percentage of GDP would result in a rise in the ratio of private to public spending of about 2%. Translated into representative figures, this says that at the unweighted mean health spending level for the 21 OECD countries of about 7.5% of GDP (made up of 6.0% public and 1.5% private) a reduction in public spending on health by 1% of GDP would result in an increase in private health spending equivalent to .5% of GDP.

How does Irish experience fit into this picture? From Table 4.1 of the Commission's report it emerges that public health spending in the Republic fell from 8.0% of GDP in 1980 to 6.7% in 1987, a drop of 16% as a percentage of GDP. The OECD results, if applied to Ireland, would predict an increase in private spending as a proportion of GDP by a little over a third. In fact, it rose from 1.2% of GDP to 1.9%, an increase of over 50%. Irish experience, then, suggests an even sharper response of private spending to a change in public spending than the OECD average since 1980. It has to be noted, however, that in the years from 1960 to 1980, when public health spending in Ireland rose from 3.3% of GDP to 8.0%, the fall in private spending, from 1.7% of GDP to 1.2% was less than would have been predicted by the apparent OECD relationship for the mid 1980s.

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This is consistent with a general relationship of the type outlined, but one which shifts slowly with the passage of time.

## PRIVATE AND PUBLIC FINANCE AND ACCESS TO HEALTHCARE

The aspect of the Commission's proposals which has received most publicity and in respect of which there has been most controversy is its recommendations on the relations between public and private healthcare in terms of both access and supply of service. This has concentrated on the role of private insurance finance of medical care and its implications for the terms and conditions of healthcare supply. It is very hard to untangle finance from supply, so to analyse the arguments and recommendations of the Commission it is easier to consider the efficiency and equity issues separately .

### EFFICIENCY: PRICING, COMPETITION AND REGULATION.

Under this heading one can look at the relative costs, both overall and in terms of treatment costs per unit under the two possible regimes. Medical care which is 100% tax or insurance financed tends to raise both demand and costs (3). On the demand side, the consumer now faces a low or zero cost of treatment. On the cost side, indemnity based finance and physician self interest combine to raise the unit costs of treatment above the level which would otherwise obtain. Further, a tax/insurance financed system with zero marginal costs to either patient or professional is bound to exhibit excess demand and queues unless the Government is willing to meet any expenditures required by patient or physician on demand. In so far as healthcare is not a public good, some exclusion device is necessary to allocate access; if prices are rejected we are forced to rely on queues or medical selection or a combination of the two. Medical selection is merely a

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way to disguise the queue implicit in excess demand at a zero price by allocating places in that queue and defining those refused a place out of the queue.

Hence, against a background of rising supply costs and income-induced demand, the question of market structures and institutions in both health provision and health finance assume crucial importance as determinants of the cost, quality and distribution of medical care.

The most recent attempt at an authoritative analysis of the scope for insurance financed medical care in Ireland appeared in an E.S.R.I. policy paper by Brian Nolan last autumn (4). The author concluded amongst other things that private insurance is unsuitable as the principal method of financing health-care on a national basis. The likely gaps in coverage that would emerge unacceptable political and social problems, or else would give rise to a level of free riding on the system that would threaten its financial viability. Whether this is the case or not, political considerations almost certainly rule out primary reliance on private insurance in Ireland. This does not mean, however, that the role of insurance finance should necessarily be reduced.

The evidence already cited suggests that if private insurance financed medical care does not expand as underlying demand, driven by GDP, rises publicly financed supply responding to political pressure and financed through taxation will have to fill the gap, at least in part. If the Government does not match the drop in private finance and unless costs per unit are lower under tax finance the quality of service must decline through congestion.

While insurance finance in principle is superior to tax finance in promoting economic efficiency in the health market, the margin of superiority is slim unless insurance markets are competitive.

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Competitive insurance markets have equity as well as efficiency implications. Faced with these, Irish governments have preferred to rely on regulation to control costs in the health sector, without, it seems, any great success.

Neither strategy is costless. Regulation uses resources directly, and induces resource use by those who are regulated. Competition, on the other hand, may raise problems of coverage gaps, and over supply through physician induced demand. The policy problem is to choose the less costly strategy and to reduce the costs associated with it.

The policy to date in Ireland has been to rely mainly on regulation. This has been done both by direct Government involvement in health-care supply and indirectly by using the V.H.I. to control spending, outputs and resource allocation in the health sector. Regulation as a means of social control has two major weaknesses: regulatory capture and regulation response. Both tend to raise rather than lower costs, and may outweigh any beneficial effects of regulation. Regulatory capture is the well established mechanism by which, given enough time, regulatory agencies end up implementing regulations which benefit the interests of those in the regulated industry rather than the interests of the general public.

Regulatory response refers to the consequences for outputs and costs induced by the self interest of the regulated firm or industry when the standard price/quality/advertising dimensions of competitive behaviour are partially or totally suppressed by regulation.

The steady rise in health supply costs over the last 20 years does not inspire confidence in the effectiveness of regulatory effectiveness as a mechanism to enhance efficiency in health-care supply in Ireland. The market structure of the health insurance system is a crucial factor in determining its effectiveness in controlling health costs. A monopoly sup-



plier of insurance to the public, especially a non profit one, has a relatively weak incentive to monitor and bargain with the suppliers of health-care (the hospitals and the health-care professionals), since higher costs of supply can be that much more easily or less painfully passed on to the public as premium increases. Competitive suppliers, especially for-profit ones, have a strong incentive to seek cost effective methods of achieving any given quantity and quality of health-care. In the U.S. and the U.K. this may be seen in the emergence of a system of "preferred suppliers". By this the insurance companies restrict cover to service supplied by producers with whom cost-efficient contracts have been agreed.

Competition in the insurance market is likely to produce efficiency seeking structural changes in the structure of both health insurance financing and health-care supply. In the area of insurance, experience in the U.S. suggests that large employers are likely to get more involved in the provision of health insurance, and through this to increase the number of financial methods of health insurance finance. Indirectly, they are likely to use their market power to bargain with insurers, which will produce corresponding gains in efficiency to be captured within the bargaining firms. Directly, there is evidence of large employers entering the health-care supply industry themselves, effectively taking on the role of insurers. This presumably reflects their superior monitoring ability where their own employees are concerned as well as the reduced incidence of moral hazard. Similar effects can be seen emerging on the health-care supply side of the market. The rise of pre-paid health-care plans, the so-called Health Maintenance Organisations, can be seen as a medical supply based response to the problems of moral hazard, adverse selection and physician-induced demand in a highly competitive environment. HMOs and the like effectively involve the suppliers of medical care screening and insuring the customer popula-

tion. They drastically reduce the incentive to doctors to prescribe unnecessarily; they encourage cost-reducing methods of treatment; their screening reduces frivolous customer demands; and all these are reflected in a lower level of premium levels which in structure resemble limited community rating.

It is hard to justify the conclusion that to shift from insurance finance to tax finance for any given level of service in volume terms is likely to produce a dividend in terms of increased efficiency of delivery of healthcare as measured by unit costs. The Commission seems to be placing its faith in the ability of a reformed administrative system to eliminate resource wastage. There is every reason to believe that it can achieve this in the existing public sector, but only as a once off improvement. Unless it restricts service, there is no reason to believe it can reduce the rate of increase of health costs in the future by this change. Certainly, no evidence is offered by the Commission to suggest that it can, and the evidence cited in this paper suggests that any cost advantage enjoyed by a centrally administered NHS type system is derived from supply restrictions.

At the same time, it is clear that the present VHI financed private sector is failing to control costs adequately, too. The case against the Commission's approach should not be treated as a justification of preserving the status quo.

#### ① EFFICIENCY: FUNDING AND THE COMMON WAITING LIST.


Central to the Commission's recommendations in the funding area is the proposal that a common waiting list be established for public and private patients. The basic rationale for this is equity, at least as defined by the Commission. Here we are concerned with the financial implications. This area is dealt with in ch 8 of the Report. The Commission correctly identifies the principal motive for insurance as the desire to secure treatment on demand, or at least on a priority basis. The evidence for this is plain: approximately

50% of the VHI subscribers are in Category II and are covered by public health provisions for virtually all hospital related costs. As public spending has fallen and waiting lists grew longer those in Category II who could afford to do so moved up to VHI cover to secure prioritised access.

The Commission recommends ending the tax sheltering of private health insurance while abolishing the distinction between Category II and Category III eligibility and establishing a common public and private waiting list. While the Commission is probably right in saying (ch 2 para 2.43, p 14) that the abolishing of tax relief on VHI subscriptions would have a relatively small impact on the demand for health insurance, its own analysis of the basis of the demand for insurance indicates that although it does not state this explicitly, the Commission clearly envisages a collapse in the health insurance market if a common waiting list is introduced. Indeed, when considering the possibility of a reduced demand for insurance with out tax relief, the Commission (ch 8 para 8.53 p139) nervously dismisses the consequences for the hospital system as a necessary price for increased equity in access to healthcare. Those consequences are obvious: at least 50% and possibly as much as 90% of the funding of the health service coming at present from the VHI would disappear. In the optimistic case total health funding would fall by a further 15%.

No matter what economies are achieved by the administrative reforms proposed by the Commission, a further cut of at least 15% in the finances of the system could only be described as catastrophic. Under these circumstances, it is hard to imagine that the Government would not feel itself politically obliged to make good the shortfall from tax revenues.

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EQUITY: PUBLIC FINANCE AND THE COMMON WAITING LIST. 

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In ch 12 the Commission makes its priorities clear:

"The Commission regards improvement in the equity of access to the services, in the context of the available resources, as being of paramount importance".

This lexicographic approach to policy has the blessing of simplicity. It avoids having to face equity/efficiency trade-offs. To be fair to the Commission, it qualifies its position a little in the course of the chapter, but the emphasis on giving priority to efficiency permeates the chapter.

The degree to which the proposals in the report can be claimed to be equitable is open to question. This can be looked at under the headings of equity in finance and equity in access. Where finance is concerned, it ought to be recognised that those in Category II who opt for VHI cover are in effect paying twice for expected treatment, first through their taxes, and then through their VHI subscriptions. The second payment is properly regarded as a payment for prioritisation in treatment. If two people of similar financial status can choose between paying or not paying for priority of treatment, and one chooses to do so, it is difficult to describe an outcome whereby the payer obtains priority as being in some sense inequitable. This will not, of course, prevent the non-payer from voicing his discontent when he is obliged to take his place in the queue.

Category III payers have no real option to taking out cover with the VHI. They are not covered for the cost of consultant services. On average they already pay a higher proportion of their incomes as tax than those in Category I or II, and can be regarded as bearing a higher proportion of the overall cost of tax-financed medical care while being

entitled to a lower level of benefit. In fiscal terms this is a progressive system of health funding.

If it were not for the question of priority access it would be hard to argue that the mixed system of tax and insurance finance adequately meets the generally accepted canons of social equity. It has to be accepted, however, that there are some amazing anomalies in the provisions affecting categorisation, especially as between Categories II and III which need to be put right.

This means that the equity issue really boils down to the question of access. The reality about the debate on funding is that it is, at the core, a debate about waiting lists. The Commission's proposals do not involve any substantial move to increase the overall funding of the health service. On the contrary: apart from the medium to long term efficiency gains on a once and for all basis which may result from the reorganisation of the administrative side of the service, the proposals are likely to reduce rather than increase the resource flow to the health sector. To the extent that this is the case, there will be no supply side increase in health output while on the demand side it is safe to predict that the demand for service will increase as the price to all consumers at the margin goes to zero. Even if demand remained unaffected, the main consequence of the common waiting list proposal would be to redistribute time in the queue. On average, waiting times for those who can expect to spend a greater than zero time queuing at the moment would fall by up to 25% to 30% (i.e. from 18 months to 13 to 14 months); those who at present can get treatment on demand (i.e., can expect a zero queue time) would have to wait the average length of time.

One final point about the common waiting list needs to be made. The report suggests that professional medical opinion on need and likely outcome of treatment would be the means whereby general guidelines on access priority would be interpreted. Whether doctors would

like to have their role as allocators of scarce resources between competing ends so extended must be a moot point. The Commission tacitly admits (ch 12 para 12.8 p 239) that a purely objective system of assessment for treatment under the common waiting list would not really be feasible:

"Factors such as the social situation of the patient...would have to be taken into account, however, in the operation of the criteria."

Unexceptionable, perhaps, but this suggestion opens a floodgate of personal judgements in deciding on whether or when to offer treatment. It further raises the question as to whether we really think there should be one common waiting list, or whether social or economic factors should play a role in allocating priority of treatment. Would we really ask the Taoiseach to wait the same length of time as a junior civil servant in his department for an operation to remove a condition which, while not life-threatening, impaired his efficient functioning? If we answer that the economic value of lost time by the patient to society should be taken into account, we are de facto talking about willingness and ability to pay.

#### ORGANISATIONAL REFORM OF THE PUBLIC HEALTH SERVICE

The overall thrust of the Commission's proposals for changes in this area is undoubtedly in the right direction. Without prejudice to the question of the relative roles of public and private supply and finance of healthcare, it is hard to argue against the view that (a) the present Health Board system is badly in need of change, and (b) that changes in the administrative and financial relations between the overall direction of healthcare in the public sector and those directly involved in supply could yield substantial dividends in terms of cost savings.

That a country with a population equivalent to that of greater Manchester should operate its publicly financed health services through eight separate health authorities is hard to justify. While some of the details of the proposed new unified structure are open to question, there can be no doubt that the general design of the system is a great improvement on present arrangements. In detail it is notable that some elements in the proposed system are based on a presumed implementation of the overall proposals for funding and for changing the public-private mix. Whether or not these are implemented, the main structures of the Commissions blueprint are worth putting in place anyway.

First, there should be a single, unified structure for the country as a whole. Competitive duplication of services by the existing authorities could then be reduced or eliminated. Secondly, the Commission calls for a well defined assignment of responsibility and clear allocation of decision making power to those with the best access to the information necessary for those decisions. Thirdly, the Commission recommends that specific and measurable performance criteria be laid down for administrators and suppliers of services. The fourth recommendation is for a system of rolling budgets to replace existing annual budgets. Fifthly, it calls for the widespread use of competitive tendering at as many levels as possible.

Similarly inspired reforms are suggested in ch 12 of the report for the financial relations between the Health Authority and the hospitals. The Commission clearly favours the introduction of case mix costing based on Diagnosis-Related Groups as the main format of public financing of the hospital sector.

Whether it is wise to introduce the degree of political "consultation" recommended by involving local and community representatives in decision making is a matter for judgement. Possibly in the context of the highly unified and centralised administrative structure envisaged by the Commission for the reformed health service such participation might be a

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necessary price to pay for political assent to the proposed reforms. Few observers would suggest that to offer substantial influence to these lower layers of the political system would be likely to enhance either the efficiency or the equity with which the service is delivered.

Given a decision to have a public sector in health, whether excluding a competing private sector or not, evidence from other countries suggests that a tightly controlled NHS type system which is the model underlying the Commission's proposals, has a better track record in containing the level of expenditure than less centralised state systems (5). This evidence is based on econometric analysis of 19 OECD countries for the year 1977. It indicates that the growth rate in health spending associated with rising GDP per head can be cut by between 20% and 25% relative to decentralised systems. The reason that expenditure growth is lower seems primarily to be the implementation of capacity restrictions (involving greater queuing) rather than through lower cost per unit of service. The same study finds that public provision, centralised or otherwise, tends to increase the level of expenditure on health per capita, although only marginally.

#### FUNDING REFORMS AND PROFESSIONAL EARNINGS

One issue to which the commission does not face up properly is the consequences of its proposed reforms for professional earnings. It is very sanguine about the continuation of privately financed medicine under conditions in which full historic or replacement cost charges are made for services. This is difficult to reconcile with the view it expresses that the main reason for insurance is to secure priority of treatment in non-life-threatening circumstances.





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While it might well be the case that virtually all privately financed medicine would disappear, let us assume that as much as half the present demand remained. According to the data from the VHI cited by the Commission, this would mean a drop of about IRL 15 million in VHI payments to health professionals. The question which has to be faced is whether in such an event the supply of skilled manpower to the system would remain unchanged in the medium to long term. In economics terminology, this is equivalent to asking how much of medical professional earnings is a "rent", a reward to shortages in supply, and how much represents the necessary price paid, whatever the mechanism, to secure the availability of manpower resources which can find alternative lucrative employment in other countries or occupations.

To the extent that the drop in income led to a contraction in the availability of skilled personnel the common waiting list could well end up longer rather than shorter than the selective one it is meant to replace.

### REFERENCES

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