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Creating Two Levels of Healthcare

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Abstract

The system of health care provision in Ireland came to a crossroads in the early 21st century. Problems of capacity constraints reached a critical level during the years of rapid economic growth and population expansion of the 1990s and 2000s. Provision of both primary and acute health care was no longer adequate to the needs of a growing population whose expectations were also rising. Public spending on health care provision grew at unprecedented rates during the late 1990s and early 2000s. Policy documents published during the 1990s reiterated support for the public system, providing equitable access to and quality healthcare for all. Yet at the same time government was offering new incentives and supports to private sector initiatives in healthcare provision. Ireland appeared to be at a critical juncture in the governance of health care, between intensifying public provision on the one hand, and increasing its reliance on the private sector on the other. This paper explores the rationale for private insurance in parallel with public provision, analyses the downsides for both equity and efficiency, and outlines how this pattern of provision evolved.

Introduction

In this chapter we examine some of the implications of this dual system, with particular reference to the acute hospital sector. First we outline the main features of the Irish system that differentiate it from other countries that have private as well as public health care. Second, we suggest that the insurance system developed in Ireland resulted in inequitable access to most consultant care and to hospital care for surgical procedures. Third, we consider how best to explain the evolution and persistence of the current system. We suggest that the nature of consultants' contracts is intimately bound up with the continuity of the two-tier system. Finally, we argue that the uneasy dual-track policy in fact entailed an unacknowledged bias toward growing reliance on private health care and a reinforcement of established inequities.

Perspectives on public and private health care

Health care has become one of the most important areas of public policy in modern states. Citizens expect to have access to affordable treatment appropriate to their condition, and where this does not exist, this is generally viewed as a problem where policy intervention is appropriate. Many of the wealthier OECD countries combine a public and a private sector in acute health care, though the mechanisms for funding and delivery vary considerably. There is no optimal amount any country might spend on healthcare. As Barr notes, somewhat facetiously perhaps, 'if we spent nothing on health, some people would die unnecessarily from trivial complaints; if we spent the whole national income on health care there would be no food and we would all die of starvation' (Barr, 1998, p279.).

Like education, healthcare is an example of a publicly provided private good, paid for to a large extent by the public purse, where the marginal cost of an additional another user is substantial, and once the resource has been used it cannot be used elsewhere. There are both efficiency and equity arguments for state intervention in the market for healthcare. Healthcare is associated with numerous market failures and government intervention is seen as necessary to correct these problems. But in addition, healthcare is an example of a merit good, which should be available to all regardless of ability to pay, so that access to essential medical attention is not debarred by reason of inadequate means. This, as with all equity-related decision-making by a society, is a normative judgment. Redistribution from the better-off to the less well-off through a benefit-in-kind (such a public healthcare) rather than a cash transfer, ensures that resources are spent for the purposes intended (Barr 1998).

Nevertheless, some powerful arguments have been put forward in favour of private provision and financing in healthcare. Chief among these is that it reduces the burden on the public sector and thereby improves both access to the public sector and the quality of the service it can offer (Besley and Coate 1991). Indeed, redistributive benefits can even be shown to occur, under certain conditions, where a private alternative exists. If the quality of the public sector is kept at a level that induces those who are better off to leave the public sector and seek private treatment, this will free up space in the public sector for those who remain (Besley and Coate 1991). Patients with low waiting costs will choose public treatment. Waiting time induces patients with high waiting costs to choose private treatment, thereby reducing the cost of public health care that everyone pays for (Hoel and Saether 2003). So the existence of a private sector may free up resources, thereby helping to reduce waiting lists in the public sector; and it may offer choice by allowing those who are willing to pay to seek treatment elsewhere. But these assumptions only hold if public and private sectors are strictly alternative paths of treatment. And it depends on the public sector being seen as the default option, catering to the great majority, and resourced to a level that maintains broad-based satisfaction with the system. As we shall see, all of these assumptions turn out to be problematic in the Irish case.

The nature and extent of the role of private funding varies greatly across the OECD, but in most western European countries, government plays a key role in healthcare provision, and free or subsidised health care is available to a significant majority of citizens. Health care at a certain quality level is provided and paid for through public funds, though the relative balance of tax and social insurance funding may vary. However despite the availability of this public health care, in most countries citizens also have the right to choose or alternate between varying combinations of public and private health care, if they wish to do so. The decision to purchase private care is often prompted by an individual's desire to bypass perceived public sector inflexibilities and to access treatment with a quality level higher than that offered by the public system.

Although Ireland spends rather less than the average amount on health care relative to GDP, Figure 1 below shows that total per capita spending on health was not unusually low compared with other OECD countries.¹

¹ Comparative data can be difficult to compare with confidence. Irish health spending appears lower than it really is because, unlike other countries, GDP was higher than GNP in Ireland during the 1990s and 2000s. And the Irish population had a lower rate of age dependency, which should keep demand lower than elsewhere. On the other hand, at least two of the seven categories of

Figure 1. Health expenditure per capita, US\$, public and private, 2007

While the particular combination of public and private in the Irish health care system is distinctive, the existence of a private alternative, offering a quality level higher than that of the public sector, is not unique. Many wealthy countries have some role for private insurance.

Countries tend to cluster in their funding patterns. Figure 2 shows that not only the mix of public and private in total health spending varies, but that within the public sector, the contribution of public social insurance as opposed to spending from general government revenues can vary a lot too. Almost 80 per cent of total spending on healthcare provision in Ireland comes from public sources and, like Britain and Sweden, this is mostly funded through general taxation (A Nolan 2008, p.302).

Figure 2. Composition of total health expenditure, 2007

Consistent with Esping-Andersen's well-known typology of welfare states, continental European countries are strongly insurance-based in their health funding, and Scandinavian countries fund their welfare spending from general revenues (Esping-Andersen 1990; Esping-Andersen, Gallie, Hemerijck and Myles 2002). The USA stands out in that, for a wealthy country, a much smaller proportion of total health spending is channelled through public provision.

The Irish 'duplicate' system

Delving further, the OECD classifies the Irish system as a 'duplicate' system, that is, one where insurance complements, supplements but also duplicates that offered by the public system. In duplicate systems, private health insurance typically provides a level of care, choice and speed of access above that offered by the public system (OECD 2004). Currently, along with Australia, Ireland has the largest duplicate market in the OECD. Approximately half the population in both countries holds private health insurance.

Irish health spending are 'social spending' in OECD terms: community care of elderly, and disability supports. Nolan, Anna. 2008. Health: Funding, Access and Efficiency. In *The Economy of Ireland: National and Sectoral Policy Issues*, edited by John W. O'Hagan, and Carol Newman. Dublin: Gill and Macmillan. , Tussing, A. Dale, and Maev-Ann Wren. 2006. *How Ireland Cares: The Case for Health Care Reform*. Dublin: New Island Press.

The Irish system features universal entitlement to public care, but there are important limits to this in practice. Public out- and in-patient hospital services are heavily subsidized by the state for those who are not eligible for medical cards, hence justifying Ireland's classification as a 'universal' system. Charges in the public sector are subject to means-testing, and non-medical card holders can incur significant user fees as they access medical care. But the capacity of the health care system to provide access to appropriate medical care entails a strong reliance on private sector provision. The trends in eligibility for free public medical services on the one hand, and consumption of private health insurance on the other, throw up some explanatory puzzles. The proportion of the population with medical cards stood at about 38 per cent in 1977, and varied only a little until 1987. By 2001 though, it had fallen to 31 per cent (Wren 2003, p.375), and was below 30 per cent in April 2008 (*Dáil Debates*, Vol. 654, 15 May 2008, Deputy Mary Harney, Written Answer 19025/08). But entitlement to free hospital care, subject to a nightly charge, was extended to the whole population in 1991. Access to free GP care was broadened to all those aged over 70 (albeit concluded on controversial terms) in 2001, though rescinded in 2008 with a return of a means-test as a result of budgetary pressures associated with the economic downturn. And partial cover for primary care (covering GP visits only) was extended to more low-income families in 2005.

Yet just as we see entitlement to both hospital and primary care expanding, the proportion of the population taking out private health insurance shows a marked increase. The proportion of the population with private health insurance was 18 per cent in 1977, a figure that rose to about 30 per cent in 1982. This had further grown to 25 per cent in 1990, and continued to grow thereafter to 46 per cent in 2001 (Wren 2003, p.375); the 2009 figure was about 52 per cent (Burke 2009, p.15; Thomas, Normand and Smith 2006). The reasons for the expansion of private health insurance, in parallel with the extension of public sector cover, need to be explored further.

The incentives to take out private health insurance can be traced to the long-standing government policy of facilitating arrangements for private healthcare as a means of augmenting the resources and capacity available for acute sector health care (Department of Health and Children 1999). A central tenet of the argument supporting this policy is not just the cost-saving to the public system when patients seek treatment in the private sector, thereby forgoing their public entitlements and in theory, freeing up of resources in the public sector for those that remain. A further consideration is that patients opting for private treatment often receive their treatment in public hospitals. This means that their insurance pays the public hospital as well the consultants for their treatment: public hospitals have an incentive to treat private patients (Finn and Harmon 2006).

Indeed, government policy actively supports insurance take-up as a means of boosting the hospitals' resource base.

Private insurance in Ireland is said to facilitate equitable treatment because the cost of insurance was governed from the outset by principles of community rating. Notwithstanding some qualifying conditions, and some recent complexities arising from the need to comply with EU competition requirements, private health insurance premiums were not weighted by individual characteristics such as age or health status of the policy-holder. The risk is thereby pooled across all policy holders, though because the scheme is voluntary, 'risk-pooling' does not have the society-wide reach of universal insurance schemes. The private health insurance system in Ireland was established in 1957, provided by a state-owned, non-profit, monopoly insurer, Voluntary Health Insurance (VHI). This was designed to cater for the top 15 per cent of earners who, at the time, were excluded from an entitlement to free or subsidised public health services. It was set up principally to provide cover for acute hospital care and typically covers all or most inpatient hospital expenses. Private outpatient hospital appointments are paid by the user on a pay-per-visit basis, on the same basis as private GP services. Insurance schemes make a relatively low contribution to them.

Private health insurance cover in Ireland therefore continued to be strongly associated with acute hospital inpatient care, and the bulk of the claims discharged involved costs associated with surgical procedures requiring hospital stay. Direct subsidies such as tax relief on private health insurance premia are justified on the grounds that they 'allow those with chronic health conditions to benefit from insurance at a reasonable cost' (Department of Health and Children 1999).

From 1987 on, sharp cuts were made in healthcare spending as part of the drive to curb public spending and to reduce high levels of public indebtedness. The investment deficits at this time resulted in lasting under-resourcing of the public sector in comparative terms, with a legacy of a lower ratio of beds to population, and lower numbers of specialist consultants in relation to population than other OECD countries. We must not assume any intention to roll back the welfare state, analogous to retrenchment policies then gathering momentum across continental Europe. Rather, a relatively under-developed healthcare system had suffered restrictions before a full high-quality public system had been put in place. Public spending on health care in fact subsequently increased under every combination of party in power. From 2000, spending on health care grew at unprecedented rates, much faster than other OECD countries. But spending per capita on most indicators still lagged behind EU rates (Tussing and Wren 2006, ch.1). The

legacy of the cutbacks and of the restrictions on infrastructural investments throughout the difficult years of the 1980s persisted in the form of capacity constraints throughout the system. Rapidly increasing public spending translated into much slower improvement in service delivery.

Problems of sustaining a public-private mix

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

Policy feedback and quality slippage

If individuals are to forgo public sector entitlements and pay for private sector treatment, whether out of pocket or through insurance schemes, the public sector must be of a quality that is lower than the private alternative. From the point of view of equitable access to services, this may be problematic. The quality of the public sector may be 'too' low, resulting in significantly worse experiences for those depending on public provision.

Among the considerations that weigh upon governments in the allocation of public spending, electoral pressures are always likely to loom large. Private health sector users may be able to exercise disproportionate influence over the allocation of resources in health care provision both directly through lobbying and voting behaviour, and indirectly by participating in or opting out of the public provisions on offer (Blomquist and Christiansen 1999). Once an individual is privately insured they cease to be concerned about public sector waiting lists, which is generally taken as an indicator for public sector quality (Besley, Hall and Preston 1998; Besley et al. 1999). If the intensity of demand for public services can be alleviated by siphoning it off to the private sector, the pressure on policy-makers to improve public sector quality – measured in terms of waiting-list length and duration – may be diminished. Moreover, private users may favour a smaller role for the state as a matter of principle (Propper and Burckhardt 1999). If attitudes are further affected by use, then an expansion of private healthcare may mean a further diminution in support for public provision and for the taxation required to fund it: 'Government may under-fund public services in areas with high private insurance coverage' (Siciliani and Hurst 2003). It may be that those who opt for private insurance are among the most affluent and articulate and are more

successful at political lobbying than other groups. Since better public services and shorter waiting lists are not a priority for them, political pressure on these issues is reduced, and electoral and lobbying support for private sector alternatives is correspondingly strengthened. British research offers some support for these hypotheses. Besley and his co-authors, for example, suggest that

regions in which many are privately insured appear to put fewer resources into keeping waiting lists short... From a public choice perspective, resource allocation is influenced by wilful political acts. If more individuals choose to opt out of certain NHS services by taking out private insurance this can affect the way in which resources are allocated (Besley et al. 1998, p.496).

In the British experience, investigators have found that patterns of use and the political articulation of policy preferences tend to go together:

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

These findings are not uncontested. Propper, for example, argues that many health service users in Britain tend to use both public and private in varying combinations, depending on circumstances and geographical location (Propper and Burckhardt 1999). Many services are in any case not normally available through the private sector – Accident and Emergency, most notably.

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

The paradoxes of targeting

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

Although hospital care is in principle available to all in Ireland, the Irish health care system has many of the characteristics of a targeted system. The risk is, as Titmuss noted, that welfare for the poor is poor welfare (Titmuss 1958). As Levi notes, support from the middle class from a public sector is based on 'contingent consent', whereby government must offer benefits at level of quality level that keeps voters broadly happy (Levi 1998, p.88). The rise in demand for private insurance suggests dissatisfaction with public provision in Ireland. But more seriously than that, survey evidence indicates much greater levels of dissatisfaction with health care provision in Ireland than in almost all other OECD countries. In a 2002 Eurobarometer survey reported in the OECD's Health Data Report for 2008, respondents in Finland, Belgium and France topped the poll in recording favourable verdicts on their national health care systems that were between two and three times greater than the negative ones. Only 20 per cent of Irish respondents reported judgments that were at all positive, and 72 per cent reported that their health care arrangements required 'fundamental changes' or needed to be 'completely rebuilt'. This level of dissatisfaction was topped only by Greece's 78 per cent and Portugal's 80 per cent (Source OECD 2008).

Equity issues in a two-tier system

The Irish dual system created two levels of health care according to insurance status and therefore ability to pay. For most procedures against which it is possible to insure, it is normal to find that separate waiting lists are maintained for public and private patients, resulting in variations in waiting time that depend on means rather than clinical need. This is one of the most visible aspects of inequitable treatment in the Irish healthcare system, and probably the issue that generates most resentment. Furthermore, instead of the public and private sectors each having their own funding stream, and contrary to the incentive systems facing hospitals to treat private patients in public hospitals, in fact the Irish acute care system is based on massive subsidies flowing from the public system to the private.

The profile of those with private insurance

We now turn to consider the socio-economic and household characteristics of those who buy private health insurance, and their motivations for doing so.

In Ireland, about 52 per cent of the population in 2008 had private insurance, 27 per cent had free access on grounds of low income; about 25 per cent had neither medical cards nor private insurance. 70 per cent of those not qualifying for the free public care under the mean-tested medical card scheme opted for private health insurance (Finn and Harmon 2006). And some with medical card entitlements still took out private insurance, generally on account of a chronic or acute health condition (Burke 2009, p.15). But recent work examining the impact of individual and household characteristics on the probability of buying private insurance shows that the better educated, wealthier and healthier are much more likely to insure themselves. There is a clear disparity between those with and those without private health insurance across both income and education levels. Nearly 60 per cent of those in the top income quartile are insured compared to 18 per cent of those in the lowest quartile. Of those people with no educational qualifications or who only attended primary education, only 20 per cent have health insurance. Among those with third-level education (which is a category that has expanded rapidly over the last 30 years, and accounts for up to half of those in the younger age categories), almost four-fifths (79 per cent) are privately insured. Those with a third-level education have a 43 per cent higher probability of having private health insurance compared with those with no qualifications or primary education only. Those with the strongest propensity to have private insurance are not those with the greatest incidence of current health needs. Only 26 per cent of those with poor health are privately insured. Of those with good health, almost double this proportion, 47 per cent, have

private health insurance. The effect of poor health on propensity to insure is in fact negative – those with poor health status have a 10 per cent less probability of being insured than those with good health (Finn and Harmon 2006; Harmon and Nolan 2001) And we can also show that health status itself is inversely related to income and education (Finn and Harmon 2006).

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

A majority of people cite a concern with quality as the most important consideration in their decision to insure. Typically private health insurance buys an individual a higher standard of accommodation (private or semi-private) and hotel-style facilities (i.e. TV, phone, meal menus). But access clearly looms largest in people's motivations for taking out private insurance. Chief among people's concerns about public sector quality is not the standard of accommodation facilities once in hospital, but the ability to avoid queueing for outpatient appointments and for surgical procedures (Harmon and Nolan 2001; Watson and Williams 1996).

Evidence about differential access is hard to come by. No central record of waiting list statistics is kept anywhere in the Irish health system, and the National Patient Treatment Register (NTPF) only provides information on waiting times for public patients for procedures in public hospitals. Indeed the time spent between referral from a general practitioner and an initial consultant appointment in the public sector often considerably exceeds the time spent between being recommended for a surgical procedure and admission to hospital (Wren 2003). The National Economic and Social Forum (NESF) found that following referral for a procedure, about a quarter of those without insurance, but no-one with private insurance, waited for more than one year for hospital-based treatment. (National Economic and Social Forum 2002, pp. 55-59). Furthermore, 'going private', whether through out-of-pocket payments or using private health insurance, also ensures choice of consultant and guaranteed treatment by a consultant rather than a member of the hospital doctors' team, neither of which is guaranteed for public patients.

Cross-subsidies from public to private

Take-up of private insurance is therefore skewed along lines of relative social advantage, which means that access to health care is differentially available depending on ability to pay. But in addition to this, the private system is so intricately bound up with the public system of health care

provision in Ireland, that private patients, or rather their insurers, do not pay anything like the full economic cost of their care. Those who are privately insured benefit not only from direct fiscal incentives, but also from cross-subsidies from the public sector to private medicine. As these are not distributed equally across the population, health care funding contributes to inequalities in access and quality of provision between public and private patients.

The cost of tax relief on medical insurance premia and health expenses that was offset against income tax is reported by the Revenue Commissioners as €225m. in 2002 and €273m. in 2003 (Revenue Commissioners 2006, Table IT6). Total current health spending in 2002 was €8.2bn, of which rather less than half went to hospitals (Wren 2003). Tax relief on health was scaled back over time in line with the objective of broadening the tax base and reducing the use of fiscal instruments to achieve policy objectives, and health insurance relief was made available only at the standard rate of 20 per cent. But this still would still be a considerable benefit to those with private insurance, and a sizeable contribution from the public purse to private health treatment.

The ownership structure of Irish hospitals is complex, and meshes public and private in complex ways that derive from the origins of healthcare in Ireland as a mixture of religious charitable institutions on the one hand, and highly targeted, means-tested public care on the other. Some of the more recently established hospitals are owned and controlled by the public authorities (originally Regional Health Boards, the Health Services Executive since 2005) under the auspices of the Department of Health and Children. Others continue to have the status of 'voluntary' hospitals, owned and controlled by religious orders, though now almost entirely publicly funded. All of these hospitals treat both private and public patients. However, hospitals do not charge insurance companies the full economic costs of treatment of private patients in public hospitals. Nolan and Wiley, looking at areas of direct subsidy such as the difference between the actual hotel cost of a private patient and that charged to the insurer, estimated in 2000 that insurance payments came to about 50 per cent of total actual costs (B Nolan and Wiley 2000). In 2003, charges were raised by a very sizeable 67 per cent to take account of medical inflation, but they still paid between half and 60 per cent of total costs (Tussing and Wren 2006, p.139). Furthermore, hospitals do not charge fees for use of public hospital equipment and premises when treating private patients. We may also note that the public system absorbs cost of professional training, public hospital development & indeed, accident and emergency costs. Considerable subsidies can be shown to flow from the taxpayer to private hospitals and private patients in public hospitals (Commission on Financial Management and Control Systems in the Health Service 2003, p.72).

Patients with private insurance can be treated in what are primarily public hospitals because consultants' contracts engage them for a specific number of hours' commitment to public patients per week, on top of which they may engage in private practice (either on-site or off-site, depending on type of contract). Since most hospitals not only permit this but rely on the income from private patients, this mixed system has flourished. Not more than 20 per cent of bed capacity is meant to be occupied by patients admitted from consultants' 'private' waiting lists. But Nolan and Wiley showed while there was 'substantial crossover of private patients to public beds', the flow in the opposite direction was much smaller (B Nolan and Wiley 2000). In practice it is acknowledged that this is very difficult to monitor or maintain the 20 per cent limit to private patient admissions, as bed management is mainly managed by consultants themselves rather than by hospital managers. Two-thirds of private beds were in public hospitals in 2007, and Dublin public hospitals had up to 40 per cent private patients (Burke 2009, pp.16, 118). And about two-thirds of all admissions to acute inpatient care come via Accident and Emergency rather than through scheduled elective surgery.

The development of a dedicated private for-profit hospital sector added extra capacity to the Irish healthcare system, and they accounted for some 12 per cent of acute inpatient beds and elective surgery in 2000 (Tussing and Wren 2006, p.98). There were two in 1988, and 18 in 2008 (Burke 2009, p.216). But a new category of private hospital appeared to be favoured by the Fianna Fáil-Progressive Democrat coalition during the first decade of the 21st century, that is, for-profit private hospitals, co-located on the grounds of existing public or voluntary hospitals. Eight were planned in 2008 (Burke 2009, pp.216-221), though public spending cutbacks postponed the implementation of the commitments. This ran counter to the planned rationalization of the hospital sector outlined in the Hanly Report. But in addition, there is a considerable hidden cost to the Exchequer. Tax reliefs to private hospitals have been estimated to amount to approximately 40 per cent of the total costs of these facilities, without even considering the value of the land on which they are built (Burke 2009, 207; Tussing and Wren 2006, p.106). Only those insured or willing to pay-out of pocket have access to private hospital facilities.

A final aspect of subsidization of the private sector by the public concerns the National Treatment Purchase Fund (NTPF). The Minister for Health and Children initiated the scheme in 2002 to alleviate excessive waiting time of public patients for specific procedures. From a starting number of fewer than 2,000 patients in 2002, the Fund had treated some 150,000 in total by 2009. Undoubtedly the scheme has been of immense benefit to its beneficiaries. But the logic of using public money to buy treatment in the private sector raises further issues of both equity and

efficiency. The NTPF spent over €40m. on direct patient care in 2004. The Comptroller and Auditor General found that some 44 per cent of these procedures were carried out in a public hospital – and the majority of these were treated by the same consultant who had referred them from their own public patient lists to the NTPF (Office of the Comptroller and Auditor-General 2004, pp. 133-4). He also noted that there seemed to be little standardization of the costs of procedures at that point, though these practices were subsequently addressed (Office of the Comptroller and Auditor-General 2004, p.137). In effect the NTPF, while remedying some urgent treatment needs, worked by transferring public sector resources into the private sector to treat public sector patients.

In summary, this policy of subsidisation of the private sector through taxpayer money is justified by the argument that those who choose to be treated privately forgo their public sector entitlement for which they have already paid (through their tax bill). The case may be made that they are entitled to better quality treatment and access should they choose to pay more – analogous to paying for an upgrade on an airplane perhaps. But we have noted two principal counter-arguments. One of these is that that access based on insurance status is inequitable. If equitable access is the benchmark, it may be argued that health care is not like plane seats, and access ought to be organized on grounds of clinical need rather than ability to pay. The other is that the Irish system effects a considerable resource transfer in the form of a variety of subsidies from the public to the private sector.

The evolution of the two-tier system

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

The process through which decisions are made can be complex. Breyer and Schneider note,

In health economics.....there is a large gap between policy recommendations often made quite unanimously by academic experts and the measure eventually taken by political decision makers (Breyer and Schneider 1992, p.267).

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

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

Private patients benefit from private insurance. In the absence of any clear pathway to a significantly better quality of provision in the public sector, it is quite likely that a large proportion of the electorate would favour continuing with the existing system of private insurance.

The particular mix of public and private in Irish public hospitals was made possible because of the structure of specialist care provision in hospitals, based on a 'consultant-led' service, not 'consultant delivered'. The contemporary system is the result of several phases of change and attempted change, firstly in the late 1940s, then in the late 1970s, and most recently in 2008.

Postwar reform initiatives

The late 1940s saw a surge of reform initiatives in Ireland, parallel to the drive to reform health care provision right across Europe in the aftermath of World War Two. Prior to this, two-tier health care provision had been the norm, with private care provided by self-employed consultants for the wealthier, and a separate system of public care for the less well-off. A change in public mood meant that governments sought to establish integrated schemes for hospital treatment and access to primary care, based on clinical need and equally available to all. Ireland was no different, and political parties shared broadly similar objectives. Fianna Fáil in 1947 was as committed to expanding free primary care as was Noel Browne, with the 1951 Mother and Child Bill. This would have provided free acute and primary medical care for expectant mothers and for all children up to age 16, through bringing self-employed doctors onto the public payroll.

Quite a variety of schemes were eventually introduced across Europe. Doctors do not necessarily hold a trump card in negotiations with government. In a study of the health reform initiatives in Sweden, Switzerland, and France, Ellen Immergut argued that institutional 'veto points' mattered more than pressure group power in shaping outcomes. Swedish consultants were unable to prevail against a strong and unified majority government decision. In Switzerland, in contrast, the outcome was the most favourable to private medicine, and government was confined to providing subsidies for private insurance. A united medical profession was able to use referendums in local regions to fragment public opinion and weaken government's ability to act (Immergut 1992, p.58).

The conflict over health reforms in Ireland in 1951, widely understood at the time as a stand-off between church and state, has been reinterpreted as primarily a conflict between private medicine and health policy reformers. Doctors were able to mobilize a powerful player – Catholic bishops, and specifically John Charles McQuaid of Dublin – on their behalf (Barrington 1987). These had ready access to the ear of government; and a weak and divided coalition was especially poorly equipped to hold a firm line against the expressly articulated preferences of the Catholic hierarchy (Inglis 1998; McCullagh 1998).

The net effect of governments' failure to introduce their preferred measures was a greatly reduced government appetite for reform, and the introduction, as in Switzerland, of public subsidies to private insurance, in the form of the 1957 Voluntary Health Insurance Act. This was aimed at the 15 per cent of the population outside the means-tested hospital access introduced in 1953 (Barrington 2003, p.106). Public funding replaced the charitable or sweepstake-based funding of the 'voluntary' hospitals. Yet these hospitals were not nationalized as their British counterparts had been.

The 1979 changes

As the 'public' hospitals were upgraded, the need to rationalize conditions of work across the sectors grew more urgent. This resulted in the introduction by a Fianna Fáil government of the 1979 'common contract' in which the combination of public and private was entrenched. This was an attempt to create some commonality in conditions of work for specialists who had previously worked under widely varying conditions. A two-tier career structure then obtained, in which some consultants were full-time salaried employees of the regional health boards, and others received no salary or pension from the state, but worked in the 'voluntary' hospital sector, earning fees from private patients, and gaining some recompense for treating non-fee-paying patients from the hospitals from the grants they received from the Department of Health (Barrington 1987, p. 107). But neither clinical accountability of consultants nor any coherent system for monitoring their work-time was adequately built into the consultant contract.

Between 1979 and 2008, consultants' contracts required them to offer 33 hours a week to the public sector, between running clinics, undertaking procedures, and ensuring administrative efficiency of their caseloads, but it did not specify the extent of their personal time commitment to public patients. In practice, public patients were likely to be attended to by non-consultant hospital doctors whose salaries are also paid by from public health sector finances. This facilitated many specialists to concentrate on their private patients. Until 1997, it was possible for

consultants to have one of two types of contract: one which paid a salary but with some 'abatement' of the rate payable, and which permitted them to engage in private practice in addition to public employment; and another which permitted only work in the public sector on a salaried basis, and which paid a somewhat higher standard salary in recognition of private earnings forgone. The latter option – only held by 47 consultants in 2003 – was abolished in 1997 on the recommendation of a Review Body on Higher Remuneration in the public sector (Commission on Financial Management and Control Systems in the Health Service 2003, p.66). This further liberalized the consultant's contract and expanded the scope of the public-private mix, while simultaneously providing some saving in public salary expenses. About three-fifths of consultants in 2008 had 'Category 1' contracts that permitted them to treat private patients within the public hospital in which they were employed. Just over one-third of the consultants, mostly in Dublin and Cork, had 'Category 2' contracts that permitted them to treat patients privately off-site as well as within their main place of work. The method of reimbursement thus entrenched is known to have significant effects on the behaviour of medical professionals (Propper, Croxson and Shearer 2002). Consultants are salaried employees for their public sector work. But they are paid on a fee per patient basis by their private patients. There is an opportunity cost to consultants of working in the public sector – that is, reimbursement in the private sector (Rickman and McGuire 1999, 54) As two experts in this area have noted:

Public health systems have done little to alter the underlying incentives whereby those with the greatest control over the conditions of supply are rewarded rather than penalised for maintaining waiting lists. (Street and Duckett 1996).

The public-private mix itself may therefore be seen to contribute directly to excessive waiting in Ireland (Tussing and Wren 2006, p.115).

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

The existing arrangements for mixing public and private treatments are inherently unsatisfactory from a management and control perspective. They result in a conflict of interest for Consultants between meeting clinical obligations to public patients on the one

hand and, on the other, the prioritisation, treatment and the use of publicly provided infrastructure and resources in public hospitals for private patients. They also raise issues of fair competition with private hospitals in that the resources used are not charged for fully. They severely limit the time the majority of clinicians have to pursue resource management. Ultimately, these issues can only be resolved fully by completely separating public and private practices. (Commission on Financial Management and Control Systems in the Health Service 2003, p.71).

Consultant contracts in the 2000s

It is generally acknowledged that there is a significant shortfall in the number of consultants relative to population size, compared with other developed countries. In Ireland in 2005, non-consultant hospital doctors (NCHD) outnumbered consultants by about 2.3 to 1 (just under 2,000 consultants, and a little over 4,000 NCHD), and hospital service depends on these doctors working long hours in overtime (Tussing and Wren 2006, p.23). Government policy adopted the recommendations of the various consultancy reports that the health service be consultant-delivered, not consultant-led. A new consultant contract was finally negotiated in 2008 as a precondition to hiring more consultants. This involved a commitment to work for 37 hours in the public system, in return for a significant increase in the remuneration package – making Irish consultants the best-paid in Europe by a considerable margin. The Brennan Report recommended that ‘all new Consultant appointments, covering new posts and the replacement of existing Consultants, should be on the basis of contracting the Consultants to work exclusively in the public sector’ (Commission on Financial Management and Control Systems in the Health Service 2003, p.67). But only about a quarter of consultants had signed up for the public-only option on offer this time. The rest remained free to develop their private practice. The new consultant contract ‘reinforces rather than deconstructs the two-tier system of hospital care’, resulting in a system in which Sara Burke has argued that ‘apartheid in Irish healthcare was official government health policy’ (Burke 2009, pp.117, 33).

Consultants sought to protect both existing members’ rights and the rights of new appointees to continue to practice privately.

The capacity of the public sector to deliver adequate services remained well below the level of actual demand in the system. And the health sector had long been characterized by fragmented management in unclear lines of accountability, such that overall system coordination presented major challenges. Capacity constraints can be identified across a range of measures. Bed

availability and extraordinarily high rates of bed occupancy are highly visible indicators that inflame popular feeling, especially when people see severely ill patients lying on trollies waiting for diagnosis, admission, and treatment (Tussing and Wren 2006, pp.182-90). Bed occupancy was regularly at or in excess of 100 per cent of capacity, compared with international norms closer to 85 per cent (Burke 2009, p.106).

The abolition of the regional health boards and the creation of the Health Services Executive (HSE) in 2005 represented a decisive move in the direction of centralization, with a view to achieving greater coordinating capacity and therefore greater efficiency. However, problems of managing the new structures generated significant new problems. Most significantly, the relationship between the Department of Health and Children on the one hand, and the Health Services Executive on the other, had not been fully specified at the time the legislation was enacted, and produced real uncertainty over domains of responsibility, initiative, and financial accountability (Tussing and Wren 2006, pp. 305-320). Spending control in a very large and diverse system was a real challenge. But opportunities to deliberate on resource allocation had been progressively reduced over time (Barrington 2003, p.116). Accountability within hospitals remained severely under-defined. Indeed, weak financial controls within hospitals were specifically identified as a problem in the Brennan Report, which recommended that 'where they do not already exist, chief executive officers in all hospitals should immediately establish an Executive Management Committee', to agree the hospital Service Plan, monitor performance against budget, agree corrective measures, and advise on policy matters (Commission on Financial Management and Control Systems in the Health Service 2003, p.68).

Organizational reform of the Irish health system was thus pushed toward centralization of decision-making, though with a crucial lacuna in accountability and decision-making at the centre. This went against the trend in many other European societies, which had begun to experiment with decentralization, creation of internal markets, and fostering of competitive opportunities to try to achieve cost savings and efficiencies. Michael Moran has argued that this is not inconsistent with continuing government oversight and management:

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

which to speak about the rise of the market and the retreat of the state is a great oversimplification. (Moran 1999, p.178).

A broad political and policy consensus appeared to exist in Ireland that market-based solutions in a small market would not be beneficial (Wiley 2000, p.922). Perhaps the real issue, though, is the weak political capacity displayed to date to manage organizational change effectively.

But the problem at the core of the system – the intermingling of public and private – was not centrally addressed by any of these structural changes. The consultant contract goes hand in hand with entrenched differentiated entitlements of those with and without private insurance. Nominal commitment to the public sector notwithstanding, successive governments presided over the expansion of a two-tier health care system.

Conclusion

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

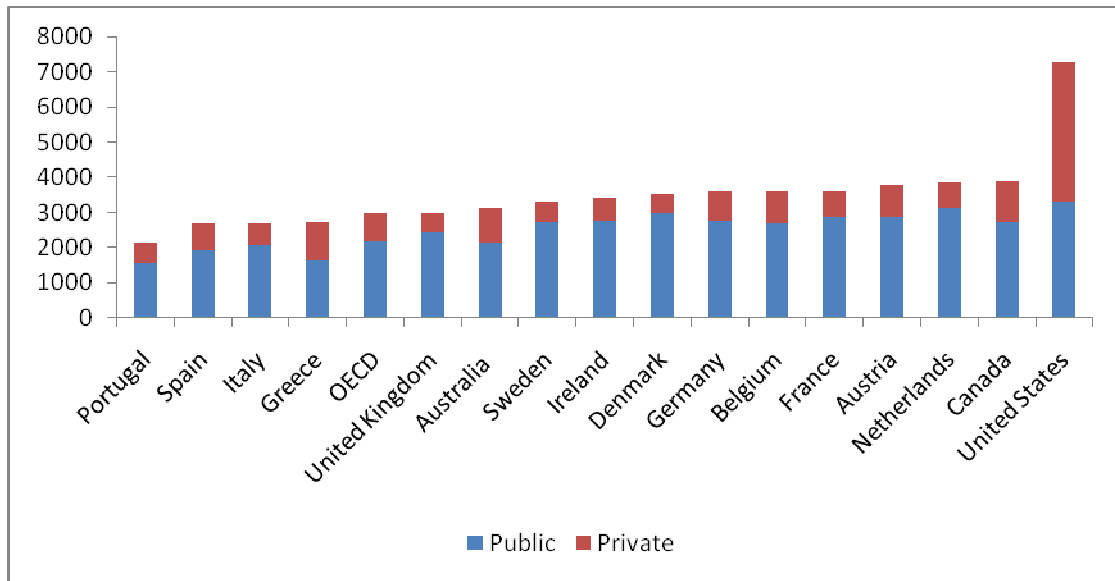
Key to doing all this was the employment of a great many more front-line medical personnel, which would involve increasing the role of consultants and redesigning the role of non-consultant hospital doctors. But the great majority of consultants already had private practice commitments. Much of the delivery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

Under these conditions, successive governments seemed unable to decide where their priorities for health care reform lay. And while they spoke of their commitment to public sector quality, in effect private sector incentives were, if anything, strengthened. Ireland was no longer in the early or foundational stages of constructing a national integrated health service, as so many European countries were in the years following the end of World War Two. At that point, decisive policy changes were perhaps more easily undertaken. But reform of a developed health care system can be likened to rebuilding the ship while already at sea. A variety of problems in health sector

governance have remained unresolved. At the heart of it lies the conundrum of the intermeshing of public and private. Some commentators, as we have noted, recommend a complete separation of the two. Quite how to do this, in a system that relies so heavily on the private sector to deliver central parts of its services, is unclear. How it might be initiated, and by whom, given the complex relationships within the Health Services Executive, and between the HSE and the Department of Health and Children, remained a puzzle.

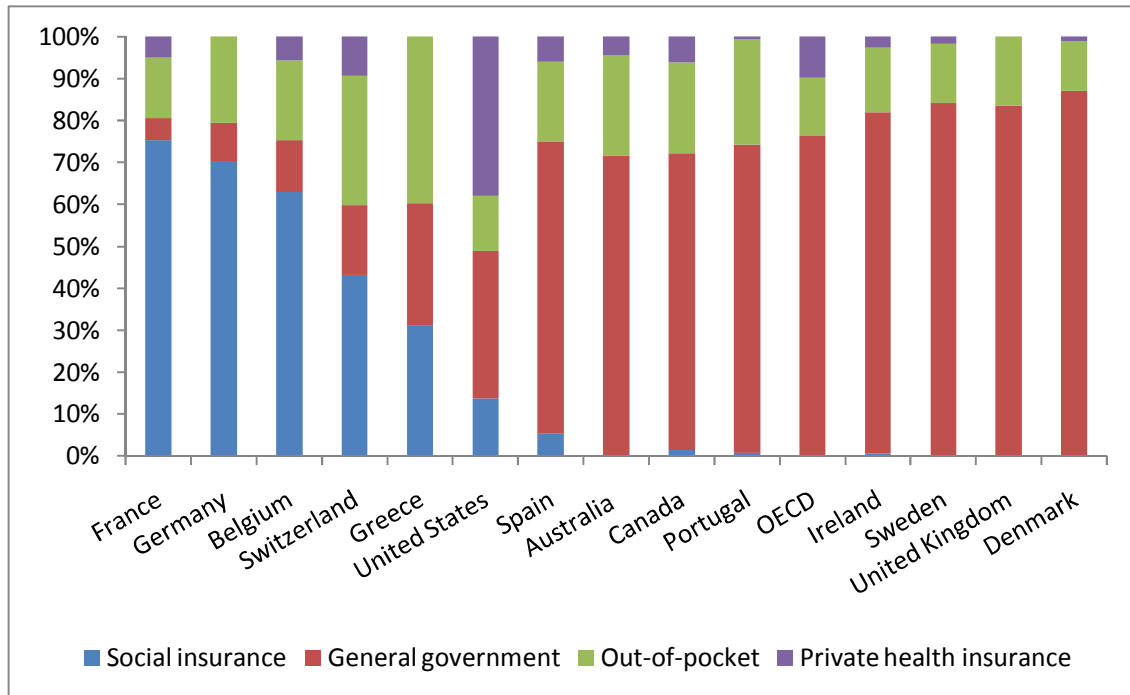
Irish politicians claimed to wish to strengthen public sector provision, yet acted to strengthen private sector rewards and incentives. But if governments fail to take decisive action for long enough, inaction or indecision itself becomes a policy when it is pursued overtime in a fairly consistent way (Korpi and Palme 1998). The public-private mix in Irish health care is a good example of policy evolution along unplanned lines, following contradictory imperatives, where non-decisions eventually become de facto decisions.

Figure 1. Health expenditure per capita, US\$, public and private, 2007



Source: OECD Health At A Glance 2009

Figure 2. Composition of total health expenditure, 2007



Source: OECD Health At A Glance 2009

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