NATIONAL ECONOMIC AND SOCIAL COUNCIL

Some Major Issues in Health Policy

No. 29

NATIONAL ECONOMIC AND SOCIAL COUNCIL

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NATIONAL ECONOMIC AND SOCIAL COUNCIL

Some Major Issues in Health Policy

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by

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PART 1

THE COUNCIL'S COMMENTS

Introduction[1]

1. Since its establishment in 1973, the Council has presented to the Government a number of reports on different aspects of social policy. The first of these — *An Approach to Social Policy* (NESC, No. 8, June 1975) — established the framework for thinking about social policy in the Irish context. The other reports generally fall into one of two categories. First, studies which analysed or tentatively explored areas of social policy, most of which had been neglected in the past; these reports included:

   Income Distribution: A Preliminary Report: No. 11, September 1975.
   Educational Expenditure in Ireland: No. 12, January 1976.
   Statistics for Social Policy: No. 17, September, 1976.
   Report on Housing Subsidies, No. 23, Autumn 1976.

   Paucity of data meant that some of these reports were necessarily tentative and exploratory. They did, however, cover some important aspects of policy and pointed the way for future policy and research.

2. Following the publication of the Council's *Population and Employment Projections* (Report No. 5, February 1975), the social policy committee of the Council embarked on a series of studies which form the second category of reports — those which examined the implications for social policy of the projected growth in population. To date, three reports in this category have been published, dealing with the implications for housing (Report 14, February 1976), education (Report 18, July 1976) and rural areas (Report 19, July 1976).

3. This report was originally planned as part of the series on the implications of the population projections. It soon became clear, however, that considerations other than the projected growth in population were more important in determining the future development of health policy and health services. The Council commissioned Mr. A. J. Culyer, of the Institute of Social and Economic Research, University of York, and Mr. A. K. Maynard of the Department of Economics and Related Studies, University of York, to examine some of the major issues in health policy in this country[1]. The study is set out in full in Part II of this Report, and summarised in paragraphs 4-12 below.

1. A draft of these comments was prepared by the Social Policy Committee and discussed and amended by the Council at its meeting on 18 November, 1976. The comments were drafted by Catherine Keehan of the Council's Secretariat.

Summary of Consultant's Report

4. The object of the consultant's study was to review both general international trends in health care delivery[2] and spending, and some of the principal trends in Ireland, in order to identify the kinds of problems which could face Irish health care services in the 1980's.

5. Estimates of future health needs based solely on demographic forecasts are overlaid by a whole set of other variables of a technical, social and political nature. These cannot be quantified nor accurately predicted but they must at least be identified so that the main issues can be spotted before a crisis develops. The major trends which the consultants identified on an international level, and which increasingly apply in this country, were the growing popular demand for universal services free at the point of use, a desire to experiment with new methods of financing the health services and paying doctors, an increasing concern about the effectiveness of medical treatment, and concern about the cost effectiveness of medical procedures.

6. The consultants paid particular attention to the role of doctors, not only to the influence on their behaviour of the methods used to remunerate them, but also to their role in determining the supply of and demand for medical services. The study argues

1. In the time available, it was not possible to achieve a comprehensive coverage of *all* aspects of health policy — for example, the community care aspects of the health services has not been dealt with.
2. The term "health care delivery" is used to describe the process of the establishment, administration and use of services for the diagnosis, prevention and cure of sickness.

that it is the doctor who translates an individual's demand for health into an effective claim on resources. In essence, the rationing of scarce resources has been left to physicians, who at the same time have no clear mandate from society as to how that rationing function should be discharged. This phenomenon is true on an international scale, and not merely in Ireland.

7. The second chapter of the study relates the position in Ireland to that in other member countries of the EEC. Population trends in this country differ from those in the rest of the EEC, although there are some indications that the situation here is changing. In terms of expenditure on health as a percentage of GNP, Ireland probably spent at least as much as the UK in 1971-72. With regard to the provisions of the services, the study shows that this country has a high bed stock, and a low physician stock in comparison with the EEC, and that the coverage provided here appears to be less comprehensive than that provided elsewhere in the Community. The consultants conclude that during the next decade, there is likely to be increasing pressure in Ireland to emulate EEC trends by moving towards more comprehensive coverage.

8. In their third chapter, the consultants describe in some detail the present system of health care in Ireland. The categories of full and limited eligibility are examined. The consultants conclude that the criteria used to determine eligibility are complex and that they may consume considerable resources in their implementation. They also describe the system of expenditure on health and the sources of finance. Finally, they examine the stocks and distribution of hospital beds, doctors and other medical personnel, and conclude that, as in many other European countries, the geographical distribution of health care is somewhat uneven. If trends in other developed countries are followed here, these imbalances in the distribution of resources could become a major source of discontent with the present system.

9. The study then examines the problems and pitfalls of forecasting population and the implications for health services. The starting point used was the population projections made by Professor Walsh at the request of the Council. No detailed projections or forecasts are made, because of the "imponderables" which exist, particularly with regard to medical manpower requirements. The main difficulty here is that there is a lack of analysis of the cost of medical procedures, and a consequent lack of understanding of the potential for substituting less skilled (and less costly) manpower and capital for physicians. The usual difficulties of forecasting are compounded in this country by a system of care which the consultants think is likely to undergo fundamental and radical change in the 1980's, bringing it more into line with other developed countries in Europe.

10. The study then discusses the dilemma facing both the Irish community as a whole and policy makers in particular in the evaluation of health services. Increasing public expenditure and greater public awareness will lead to growing public intervention in the planning, regulation and monitoring of the health services. This will involve new thinking in Ireland, both in terms of financial and organisational arrangements. If the newly emerging relationships between the State, the public and the medical professions are to preserve the best of the present arrangements and provide efficiently and effectively for new needs and attitudes, then joint thinking about the future patterns of health care delivery is urgently required.

11. The final chapter of the study sets out the choices which must be made in order to cope with the new demands on the health services, which will arise from changing social attitudes, demographic changes, economic growth and advances in medical technology. The choices are presented as a series of questions:

    (a) If a comprehensive system of health care is to be introduced, how should it be financed?
    (b) What range of benefits should be included in a comprehensive system?

(c) What role will remain for private insurance and private practice in a comprehensive system?
(d) How will the Government set about allocating resources so that the maximum amount of "need" is met?
(e) How will equity in the health services be defined?
(f) How will the technical efficiency of the health service be evaluated on a continuing basis?
(g) How will the monitoring of the medical profession be carried out?
(h) How best can the community be involved in the management and monitoring of the health care system?

12. Answers will be found to none of these questions unless the objectives of the health services are clearly specified. Even then, the answers must be sought through the joint involvement of the State, the public and the professions. It is only in this way that solutions which are technically and economically feasible, and which at the same time contribute to the fundamental objective of the health services, can be found.

The Main Issues

13. Expenditure on health constitutes one of the largest components of public spending. In its Report on Public Expenditure[1], the Council has already set out its views on public expenditure as a whole, and the difficulties of curbing its growth. It is worth noting some points from that report which are particularly relevant to the present report on health. In the Council's view, curbing the growth of public expenditure in the short-term may mean that "new services and programmes can be introduced only to the extent that existing programmes and services are abandoned or curtailed"[2]. At the same time, "attempts should be made to identify public services in which standards (and therefore costs) can be reduced. Those who administer a service are naturally committed to raising its standards and quality — and if they are not, many would argue that they should be.

1. NESC, No. 21, Dublin 1976.
2. Op. cit. paragraph 5.17, page 43.

Those who work in providing services (such as education and health) are similarly committed. This commitment is part of their professional ethic and evidence of their dedication to the service and their belief in its importance to the community. All this is praise-worthy. But standards must be related to the costs of achieving and maintaining them, and to the capacity of the community to maintain them"[1]. The net benefit flowing from public expenditure should be concentrated to the maximum extent possible on those most in need[2]." This is of particular relevance to health services provided for the less well off members of the community.

14. Moreover, expenditure on health should aim at achieving the best possible results in terms of social equity: "expenditures on education and health are the two largest components in expenditure from the Exchequer, and it would be valid to ask whether the money spent on providing (health) services works in the direction of greater equity and less inequality of opportunity or whether it is regressive in its impact and effects"[3]. The discussion of health policy which follows must be seen in this context.

15. Although the consultants raise a number of fundamental questions concerning the future of the health service in this country, they do not provide the answers. This can be done only by politicians and planners in this country, given the desires of the community and the constraints applied by the resources available. In the following paragraphs, the Council indicates those questions to which in its view most attention should be given. These are not set out in any order of priority — indeed, given the links between them, these issues must of necessity be examined together.

(i) **Planning**

16. The consultants emphasise in their report the need for planning in the health services, so that the services will be developed

1. Op. cit. paragraph 5.18, page 43-4.
2. Op. cit. paragraph 5.24, page 46.
3. Op. cit. paragraph 69, page 52.

rationally and efficiently. Changing demographic trends and constantly developing medical technology may make planning and forecasting in the health services particularly difficult. Nevertheless, the Council regards planning for the future development of all services as fundamental to ordered progress and to the efficient and equitable use of public resources. The fact that the growth in expenditure on health services (as on other public services) may have to be constrained over at least the next few years is not an argument against planning now (even if the plans involve increased expenditure). Indeed the best time to plan is when resources are scarce, because this will ensure that when resources become less scarce they will be used more efficiently and effectively.

(ii) **Eligibility**

17. At present about thirty-five per cent of the population are covered by the General Medical Services scheme. This entitles them to all the medical care they require completely free of charge at the point of service. In order to obtain the medical card which entitles them to these services, a means test must be undergone by applicants. It is currently estimated that a further fifty per cent of the population are covered by limited eligibility. This entitles people to some services — in the main, free hospitalisation (both in-patient and out-patient services) — but not to free general practitioner services. The rest of the population (about fifteen per cent) are responsible for the full cost of any medical services they require (with some exceptions, e.g. treatment of infectious diseases). Most of this last group are insured for such costs with the Voluntary Health Insurance Board. All insured persons are entitled to a subsidy towards the cost of prescribed drugs and medicines.

18. The main problem with the present system is the complex nature of the limited eligibility scheme. There are eight categories of people who can claim limited eligibilty and the complexity of the rules leads to confusion for many people regarding their entitlement. It also seems likely that the rules (because of their complexity) are not administered uniformly

throughout the country. The first and most immediate task regarding limited eligibility is the simplification and clarification of its criteria and procedures.

19. The second and more long-term task is to determine the future nature and coverage of eligibility. There is likely to be an increasing demand over the next decade for health services which are free of charge for everyone at the point of utilisation. The extension of the present limited eligibility scheme to the entire population is already the stated aim of the Government. It is desirable that this aim be achieved as soon as the constraints on the availability of resources permit.

(iii) **Sources of Finance**

20. A second major issue which must be resolved about the health services is the method of financing them. This will be a problem for future resolution, regardless of whether the health services are extended or developed in any significant sense. It is clear that if present trends in this and other countries continue the cost of provision of health services will continue to rise. It is also clear that present economic problems will make it difficult in the immediate future to allocate all the extra real resources needed for the health services. The Council believes, however, that it is at just such a time as this that long-term thinking and planning must be done, so that when resources are more readily available, they will be wisely used.

21. There are a number of alternative methods of financing health care. One is a compulsory system covering the whole population and which would be financed by special health contributions; the other major alternative is finance through general taxation. The consultants discuss (Chapter 5, paragraphs 11 and 12) the advantages and disadvantages of both schemes. The Council believes a combination of both could possibly provide a workable and equitable alternative to either of the above schemes. Most countries (including the United Kingdom), operate such a "mixed" system. Compulsory contributions for health from the working population (both employed and self-

employed) should be combined with contributions to the cost of health sevices from general taxation. The compulsory contributions should be related to capacity to pay (for example, they might be determined as a percentage of income). They should not be related to the "health status" of the insured, even if this were practicable.

22. The "mixed" method of financing the health services does not preclude the possibility of imposing charges for some services at the point of use, and if the charges were appropriately structured, they need not be inequitable in their effects. The main arguments in favour of such changes are as follows: first, they could deter over-use of scarce resources, and second, that they make some contribution towards the cost of the health services. However, the Council believes that the introduction of charges for specific services (e.g. General practitioner or hospital services) raises complex issues that merit detailed examination. The administratve costs of collecting such charges might not be jutified in some cases by the extra money collected. Again, if the level of the charges were high enough to deter people from over-using the services, they might at the same time discourage those in real need from seeking them. Moreover, it is very often the case that a patient using a particular service has no control over his use of it. Apart from the initial decision to visit a doctor, decisions about the type and amount of health services "used" by an individual are, in the main, taken by doctors. The question must therefore be asked whether it is fair to impose charges on a patient when he has no effective control over the amount of resources his treatment is deemed to require. The Council would have reservatons about the extended use of patient charges, and recommends that full and careful consideration be given to all the implications before any decision is taken on whether or not they should be introduced.

23. The method of financing outlined in paragraph 20 should not preclude the possibility of voluntary private insurance being continued. If people want particular services (e.g. a private room in hospital), the facility should be there for them to pay

for these requirements either out of their own resources or from private insurance. This alternative would preserve some degree of freedom of choice within the health service. However, if progress were made towards making basic health services universally available, it would be desirable to examine whether the subsidisation implied in allowing premia paid to the VHI for additional services to be deductable for income tax purposes would still be justified.

(iv) **Control of Expenditure**

24. Whatever scheme is adopted for financing the health services in the future, the problem of controlling expenditure on the health services will remain. New needs will continue to be identified, and new ways of treating ill-health discovered. The continuing constraints on public expenditure will therefore mean that the demand for resources will always be greater than their supply. If resources are scarce, some form of rationing is unavoidable. It will therefore be necessary to impose some ceilings on expenditure. The fairest and most effective way in which to do this is to have clearly defined priorities which are strictly adhered to.

25. The medical profession plays an important role in determining the demand for resources for health care. Once a patient has taken a decision to visit a doctor, it is the medical profession which thereafter decides what further treatment the patient requires, and therefore what resources will be devoted to that patient's treatment. In effect, the medical profession plays a key role in determining the demand for resources for use in the health services, and in rationing whatever volume of resources is made available to these services. In considering ways in which health care costs might be contained, attention must therefore be given to the problem of monitoring the methods used by the profession and the demands it makes. If the imposition of charges for specific services is to be avoided, this monitoring assumes even greater importance.

26. Some attempt has been made in recent years in this and other countries to establish the effectiveness of medical treatment of par-

ticular types of medical care. But little attempt has been made to examine how much time doctors spend doing work for which their expensive medical education is irrelevant. Nor has much research been carried out to establish whether highly skilled and expensive medical manpower could be replaced by personnel with different skills but whose training was less costly — for example, by social workers, public health nurses, and clerical staff. One way of controlling expenditure would be to monitor on a continuing basis the methods used in health care, in order to assess their efficiency, both in terms of money spent and results obtained. Resources devoted to this work by the Department of Health and the Medico-Social Research Board could yield a high return in terms of a slower rate of growth in the cost of health services.

27. Another element of expenditure which should be examined is the cost of administration of the health services. The consultants state that as far as they are aware "no one has attempted to estimate the resource saving which might be possible if income testing were abolished and the service made fully comprehensive (i.e. covering the whole populaton regardless of income) in whole or in part (e.g. for hospitalisation only)." This underlines the need in designing health policy to have regard to the likely cost of administering decisions taken and the Council would be concerned that this be given proper weight. Administrative costs should be minimised and, within the health administration system, the emphasis should be on the capacity to plan and control the use of resources rather than in working out systems which may be unnecessarily cumbersome or intricate. Administrative costs within the health boards are controlled by the Minister for Health under the Health Act, 1970 insofar as numbers, types and levels of remuneration expenses, etc., must be approved by him. In common with other branches of the public service, the control is very rigidly applied at present, and has been extended to other health agencies, such as the voluntary hospitals. The Council recommends that scrutiny and control of the proportion of health expenditure devoted to

administrative costs should be continual, while recognising that in a field as complex as health, good administration is essential for getting value for the money spent on the services.

(v) **Community Involvement**

28. The views of the community at large on social priorities in health care must be taken into account. This raises the question of how the community at large should be involved not only in establishing priorities for health policy, but also in deciding on resource allocation. Some progress has been made already in Ireland towards this involvement through the establishment under the 1970 Health Act of Health Boards. The majority of the health board members are in fact non-medical. These boards have been in existence for over five years. It would be appropriate to review their operation now in order to establish the extent to which they fulfil the role of representing the community within the health service system.

29. Apart from these boards, however, there is also the problem of community involvement at national level. The policies which are implemented regionally are generally formulated at national level. The National Health Council is the statutory advisory body on the health services. The Council understands that the role and functions of this body are at present being reviewed. The Council recommends that in the course of this review, the ways in which the National Health Council could be developed to ensure that the aspirations and desires of the community are fully taken into account, and to involve the community more effectively in the control and allocation of resources, should be considered.

(vi) **Regional Inequity**

30. The final major issue which must be resolved is that of regional inequity. Changing demographic and migration trends make long-term regional planning difficult, especially where heavy capital expenditure, such as the building of hospitals, is involved. This is not a problem unique to this country — a report* published recently in England illustrated the regional

**Sharing Resources for Health in England.* H.M.S.O., September 1976.

disparities which exist there, and proposed ways in which these might be lessened. The main concern in considering the problem of geographical inequity must be that no-one is denied the health care which he or she needs simply because of their place of residence.

Conclusion

31. The issues raised in this report are of great importance in planning the future shape of the health services in this country. Present economic circumstances place severe constraints on the possibility of implementing major changes in the immediate future. Nevertheless, the appropriate discussions and planning should take place now, so that when resources become more readily available, they will be spent in the most effective manner. Finally, it is the Council's hope that the publication of this report will provoke constructive debate and discussion, and that the required research will be undertaken, so that future decisions about health policy will have a firm and rational foundation.

PART II

SOME MAJOR ISSUES IN HEALTH POLICY

by

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Preface

This monograph is not a mere forecasting exercise. In it, by setting Ireland in an international perspective, we have sought to identify not only some of the local trends and likely changes but also the wider currents that are moving in health care throughout the developed world and which one must expect to flow through Ireland too.

Accordingly, we have begun by examining these wider trends, particularly those concerning the world-wide move towards universal, 'free', health services. Our principal conclusion, borne out in detail in the subsequent chapters, is that Ireland has fallen behind. Although her health service is not cheap, it is neither as financially accessible nor as well-distributed geographically as one would expect. These factors, together with anticipated demographic changes and concern about the size and rate of growth of public spending, imply that pressure for quite fundamental change will mount in the coming decade.

The short term answer, not surprisingly, is that several key questions call out urgently for research, both to determine the detailed facts and to assess the likely consequences of change. The research that is needed is not abstract, 'pure', 'ivory-tower' research, but hardheaded empirical work addressed to pragmatic and real questions of immediate policy relevance.

Fortunately, as we try to indicate our choice of references there are precedents for all the kinds of work that need to be done. Given the will, the way can be found. But whether the will exists among the politicians, or whether they will be caught unawares when the crisis comes, is the least confident of all our predictions. The choice is really between a fundamental rethink now, or a botched-up effort when it will have already become too late to do the job properly.

Throughout the discussion which follows we have interpreted our remit restrictively in the sense that we have limited our analysis mostly to curative health services rather than preventive health care, and, within the curative services, we have tended to concentrate on the major items of expenditure.

Chapter 1

INTRODUCTION

1. Our purpose in the present monograph is to review both general international trends in health care delivery and spending and some of the principal trends in Ireland in order to anticipate the kinds of problems which will face Irish health services in 1986.

2. Although the usual approach in such exercises is either to make a variety of extrapolations of existing trends in population, etc., in order to arrive at 'needs' for the nation at some distant point in time, or, with greater sophistication, to attempt to build a "model" of the health sector using the techniques of multiple regression analysis, we shall both do more and less here. An important sense in which we shall do less is that we shall attempt to construct no empirical model of the health sector. Not only would this have been beyond the scope of the work reported here but also it is not possible to do satisfactorily, given the limited information that exists about the health services, as regards both basic data and previous research exploring, for example, quantitative relationships between different "inputs" in the system.

3. We shall, however, explore some of the wider issues that are raised by the kind of exercise attempted here. These concern chiefly social changes affecting the demand for health care, and administrative or technical changes that may alter its mode of delivery. Changes of both sorts can have immense consequences which are extremely hard to predict with accuracy. For example, the medical programmes of the 'Great Society' phase of recent American social legislation was accompanied by an unprecedented amount of research by operations researchers, economists, sociologists and public administrators, but no one succeeded in predicting the enormous extent to which these programmes, arising from a political

initiative, would increase utilisation and expenditure on health care. Similarly, on the technical side, no one would doubt that the regular use of health status measures of the sort recently developed by British, Canadian and American scholars, could revolutionise not only means of allocating care, but also, via more effective clinical trials, the types of care given and, via new means of monitoring physicians' behaviour, the effectiveness of clinical practice. Few, however, would be rash enough to predict exactly how such changes would affect expediture, manpower requirements or the optimal stock of beds.

4. The evident truth, however, that such changes can have immense impact means that even if we cannot quantify them precisely, we must at least take cognizance of them.

Universal "free" health care

5. One of the more clearly marked international trends in the evolution of delivery systems has been towards access free of charge at the point of use for all citizens regardless of income, class, etc.

6. We know of no systematic work examining the utilisation of health services by social class in Ireland. A typical finding for other countries, however, has been that even if *per capita* utilisation increases as one moves down the social spectrum, it increases less fast than one would expect given the state of health of the various groups as indicated by morbidity and mortality data (e.g. Rein (1969), Noyce, *et al* (1974)). To many, this indicates that a higher proportion of "needs" remain unmet among the poorer sections of the community than in the better-off sections. Since this finding exists for England and Wales, it cannot entirely be explained by the traditional bogey of money prices, though it should be said that there is ample evidence, especially from the U.S.A. and Canada, that user-prices do have a distinct and measurable impact on the rate of utilisation of health services by the poor. A reason commonly adduced to explain the phenomenon is that the lower social classes are simply less adept than the middle and upper classes at claiming their rights and at coping with (middle class) professionals in all

areas. Another reason sometimes put forward is that there is active discrimination against the lower social groups by (middle class) decision making groups. While there is doubtless some truth in these explanations, there can be little doubt that this is an extremely under-researched area. In particular, we do not know the quantitative significance of the kind of factors adduced. Nor is it altogether clear, even supposing we knew what their significance was, precisely what ought to be done about it.

7. There can scarcely be a country of the developed world which has not set itself the target of removing financial barriers to health care consumption *at the level of the individual consumer*. Unfortunately, we have not found any unambiguous statements of Irish policy objectives. The draft programme budget published in 1972 expressed the aim of Irish health policy as:

> "To promote the enjoyment by all of the higest possible level of health".

More specifically, the objectives were:

> "(a) to promote positive health measures and preventive and control measures designed to minimise the risk of disease or illness occurring in the community and to limit the incidence of disease or illness when it occurs;
> (b) to ensure that persons who become physically or mentally ill or who otherwise require health care are identified and provided with the services they require without financial hardship."

As a member of W.H.O. we may suppose that Ireland subscribes to the following broad declaration of intent:

> "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."
> (Constitution of the World Health Organisation).

While detailed enunciation and ranking of objectives may be lacking, it appears that Irish aims and aspirations are not very different

from those regarded as both desirable and attainable in other countries of broad comparability. Moreover, though there is a note of unrealism in the W.H.O's "highest attainable standard", for what is *possible* is rarely synonymous with what is *desirable* or *desired*, we shall take it that a major objective of the Irish health service is to make, out of given resources, the maximum impact on reducing ill-health, regardless of patients' incomes, willingness to pay, social class, religion, etc. The objective, in short, is to minimise some comprehensive (and hypothetical) index of the whole nation's ill-health as determined by medical judgements of fact and feasibility and social judgements of value.

8. The nature of this objective, which we take to be one of the principles subscribed to by Irish people and the Irish government, is, it should be noted, quite distinct from another distributional objective quite commonly pursued: namely, that there should be some redistribution of income from the relatively rich to the poorer sections of the community. While there have been very few studies in any country concerning the distributional impact (in this second sense) of public health service provision or subsidy (but see, e.g. Badgley (1967), Enterline (1973), Fraser (1968), Gillespie (1966), Johnson (n.d.), Manga (1967), Wilensky and Holohan (1972)) we need neither deny the importance of distribution in general nor that health service financing has redistributive effects, to emphasise that these issues have little bearing on the distribution of the "right to good health". Indeed, it would be possible for a general consensus to exist that the prevailing post-tax and post-expenditure distribution of *income* was satisfactory and, at the same time, a general consensus to exist that the existing distribution of *health states* was unsatisfactory.

9. The point is, of course, that despite some academic confusion about these things, ordinary men and women everywhere have increasingly come to believe that access to health services should be neither more easy nor more difficult for different income groups. In turn, this implies that the financing of health services (which may itself have to satisfy certain general distributional requirements) should not be such as to deter consumption, if it is not to meet the

one kind of distributional objective without offending against the other. In turn, this implies the desirability of the *absence* of marginal prices, or consumer charges that vary according to the quantity of services consumed.[1]

10. The potential conflict between this view and concern about efficiency in health care has been resolved increasingly in favour of the former. Yet in reality there are good reasons to doubt whether there exists a genuine trade-off between the two and as this becomes increasingly realised, the trend towards "universality" in access to health services everywhere will become intensified.

Two common arguments against universality are:-

(a) consumers of health care should finance health services;
(b) since patient charges do (as, indeed they do) deter consumption, such charges are at once both a useful deterrence against "wasteful" demands by patients and the most effective way of containing the explosive nature of public expenditures on health care.

In fact, efficiency in resource allocation does *not* depend upon (a). That consumers should finance the services is actually an asserted value judgement that is plainly at odds with public declarations that there is a general community interest in the equitable provision of health care.[2] Nor does there seem to be much validity in (b). The great fear with deterrent charges has been always that they discriminate mainly against the relatively poor, who are also the relatively sick. The evidence would seem to support this (e.g. Beck (1973), (1974)). A more general concern has been that patients

1. The judgement is commonly reached that some types of care are more 'fundamental' than others. Charges would be more abhorrent here (e.g. acute hospital care) than in less 'fundamental' areas (eye-glasses?)
2. Within the familiar (to economists at least) paradigm of welfare economics, we have only to suppose individuals to exist who anticipate never using the services themselves but who see a value (perhaps of a humanitarian sort) in others' use. In such a case, this non-user and non-potential-user has some "willingness to pay" for the services. Thus, even the individualistic framework of analysis, often used to justify laissez-faire, can serve to support our argument.

should not be discouraged from seeking advice from a physician: the main wastes, if there are indeed any at all, are likely to come either by the procedures of diagnosis or treatment. Again, the evidence here is that patient utilisation is best explained by patient health status and not by other characteristics supposedly related to a tendency to over-demand care (Wolfson 1976)[3]. Moreover there is an increasing mass of evidence that many medical procedures, some of them amongst the costliest, are of dubious value even in clinical terms, let alone according to any cost-benefit calculation (Cochrane (1972)).

11. Thus as both pure theory (for a review of the arguments at this level, see Culyer (1971)) and the evidence increasingly cut away the arguments for deterrent pricing, so the universal march towards universality in access to health services gathers momentum.

12. As informed opinion increasingly turns away from pricing and private insurance in health care and seeks systematic evidence concerning untreated illness in the community (which is quite extensive even in England and Wales)[4] so the attention of health service planners and administrators will inevitably become preoccupied with developing further policy instruments to control and monitor the system and to supplement existing financial and direct controls. A whole new set of policy options for the future is thus opened up which increases hazards already inherent in predicting what lies ahead. One such policy variable concerns the remuneration of doctors and its effects on clinical practice.

Patients and Doctors

13. The manner in which the individual's demand for health becomes translated into an effective claim on resources has been explored by, among others, Cooper (1975). It is far from clear what

3. It is worth noting that this is the only study to date to have properly tested this presumption in which it has been possible to distinguish legitimate demands based on health status from others.
4. See, e.g. Office of Health Economics (1964).

determines physician decisions in this area. For example, British evidence about the secular stability of hospital surgical waiting lists despite substantial increases in the capacity of the system to treat (and increases in the number of patients treated) suggests that physician judgements of need, in a country where they may be reasonably taken as independent of any effects on physician incomes, are highly relative: a demand for health becomes a demand (or need) for health care via the physician when available supply permits (Culyer and Cullis (1976)). Also, it is suggested sometimes (though this has yet to be systematically tested) that the regulation of waiting lists is affected by part-time consultants' consideration of the demand for private practice. Under fee-per-service systems the relative notion works in a different fashion: in Canada, for example, Evans has found the hypothesis that physicians seek to maintain a target income explains several puzzling phenomena: for example, why it is that items of service supplied to patients in Canada increase when the fees per item of service fall relative to the price level; or why it is that when relative fees change, more of those services whose prices have risen are supplied (Evans (1972, 1973, 1974)). In Wolfson's study (1976), referred to above, the only evidence of "abuse" he found related not to patient-initiated demands, which appeared unrelated to the patient's health, but to physician-initiated demands.

14. Advantages and disadvantages attach, of course, to each of the possible methods of medical remuneration. If fee-per-service (or fee per patient contact to a lesser extent) is conducive to hard work, fewer referrals and over-doctoring, then the reverse may be true of capitation and salary, or global budgets for group practices (see Glaser (1970)). Unfortunately there is remarkably little hard information about the quantitative effects various schemes have on, e.g. patient outcomes, cost, substitution of cheaper for costlier joint inputs, etc. *A priori* conjecture of a rather informal kind is what usually passes for analysis in this area — as well s considerable tub-thumping from the relevant vested interests.

15. The interesting phenomenon in all this is that, in all countries with which we are acquainted, the rationing function has been left

to physicians who not only (under any system of remuneration in current use) have a clear incentive to press always for more resources (except possibly physicians)[5] in health care but who also do not have any clear instructions from society as to how their rationing function is to be discharged. Nor, of course, has society as yet devised the means of monitoring this rationing for its consistency with some broader views about the objectives of the system. What is clear is that even in a system like Britain's, where money prices are effectively absent, the evidence seems to suggest that while the "poor" receive more health care than "the better off", they still have a higher prevalence of sickness (Social Trends 1975, Noyce *et al* (1974)). To be sure, such evidence is patchy and, moreover, cannot be regarded as conclusive proof that important "needs" which should be met are not being met, if only because for some needs there is no effective care. Nevertheless, these are significant "straws in the wind" which signify that, as society's concern with getting "value for money" in medicine increases, and as society also increasingly insists upon a universal system of access, there are likely to be substantial changes in some of the traditional concepts of professional medical practice involving, one way or another, a greater scrutiny of performance and insistence upon fulfilling the objectives of the society which pays the bill.

16. Secular increases in the utilisation of health care services, and consequent increases in spending, are perhaps the most conspicuous phenomena shared by most countries since World War II.

17. While population changes undoubtedly can be expected to lead to increasing demand for health as can rising real incomes (and expectations) and increasing concern over the distribution of ill-health in the community, whether these pressures become translated into rising demand for health services depends crucially upon the role of the medical professions as suppliers who create a demand for their own services. Whether, in turn, health spending increases its share of spending depends both upon this demand, the relative

5. In systems where increases in physician numbers are seen as threats to the incomes of existing physicians.

labour-intensity of medicine and the relative movement of wages to other prices. It appears, for example, to have been the experience of many countries that wages have risen faster than other input prices (e.g. capital) with the consequence that if the ratio of high grade labour to other inputs is not permitted to fall sufficiently to offset it, the relative cost of (expenditure on) labour-intensive (or "human capital" intensive) services will rise compared with less labour-intensive areas of production.

Summary

18. In summary, estimates of future health needs based solely on population and (what is particularly important for Ireland) demographic and migration forecasts are, apart from their own inherent uncertainties, overlaid with a whole set of other technical, social and political variables. While these are obviously extremely difficult to predict at all accurately, any forecast which fails to acknowledge their existence cannot be of much value. Even if one cannot predict the quantitative significance of many of these factors, at least their nature can be identified so that the issues can be spotted before a crisis develops and, hopefully, the appropriate research put in hand well in advance.

19. The major trends are these:

(i) an increasing popular demand for universal services free at the point of utilisation;
(ii) a desire to experiment with new ways of financing the health services and of paying doctors;
(iii) an increasing concern with the effectiveness of medical interventions in their impact on the natural history of disease;
(iv) an increasing concern with the cost-effectiveness of medical procedures, whether preventive, curative or 'caring'.

Chapter 2

INTERNATIONAL COMPARISONS OF HEALTH CARE INDICATORS

1. In order to set our discussion of health care in Ireland in an international and temporal context our concern in this section will be with the relative position of Ireland in the European Community during the period since the ratification of the Treaty of Rome by the initial six signatories. We shall examine population and health input/provision indicators and their evolution since about 1960. Before engaging in any comparisons it must be noted that international statistics are noted for problems such as lack of comparability. Whilst we have done our best to resolve these problems it is noted in our discussion that some problems remain and domestic and E.E.C. sources are, at times, at odds.

2. During the period from 1960 to 1973 it can be seen from Table 1 that the total population of the nine member countries of the European Community increased from 232 million to 256 million. The annual average rate of population growth of the Community declined from 1 per cent in the period 1960-65, to 0.6 per cent in the period 1965-70. In 1973 the rate was 0.6 per cent.

3. This general decline in the rate of growth of population in the European Community was the reverse of Ireland's experience. During the period 1960 to 1973 the population of Ireland grew from 2.8 to 3.1 million. The rate of population growth during the period 1960-65 was 0.3 per cent and during the next five year period (1965-70) it was 0.5 per cent. By 1973 Ireland's population growth rate was 2.0 per cent and thus twice that of the European Community as a whole.

4. The causes of the growth in the population are complex and will be discussed further in Chapter 4 below. One important factor is the birth rate. The Irish birth rate is the highest in the European Community (Table 1) and unlike the Community's rate, which fell by 21 per cent to 14.1 per 1,000 population, it rose during the period by 3.7 per cent from 21.5 to 22.3 per 1,000 population. The Department of Health has informed us that the E.E.C. live births figure for Ireland in 1973 was wrong and that the correct statistic is 22.5. This indicates that the birth rate in 1973 was even higher in comparison to 1960 than indicated by E.E.C. data. However the latest data (1975) indicate that the birth rate has fallen to 21.5. Another important cause of the population increase is that although the relative number of persons in the child bearing age group has not altered significantly (this is indicated in Table 2), the absolute number of child bearing adults has increased as the total population has increased. As we shall argue below these atypical (by West European standards) movements may be reversed in the next decade and Ireland's population trends may conform much more closely with the European Community norm.

5. One area in which this tendency was clearly noticeable prior to 1973 was in infant mortality trends. During the period 1960 to 1972 the number of deaths under the age of 1 year per 1,000 live births in the European Community fell from 30.8 to 19.9, i.e. by 35 per cent. The infant mortality rate in Ireland fell from 29.3 in 1960 to 18.0 in 1973, i.e. by 38 per cent. Although the Irish figure was, by 1973, below the West European average it remains high in comparison to Denmark, France, the United Kingdom, and the Netherlands. However it is lower than that of West Germany and Italy. It is to be remembered that lower infant mortality rates may not be unambigously better from the point of view of expenditure. The lives saved may be those of handicapped infants with high health care requirements. (Office of Health Economics 1974).

Population: Totals, Rates of Increase and Birthrates

	Total Population *Millions*		Annual average percentage rate of increase in population			Live births per 1,000 population	
	1960	1973	1960-65	1965-70	1973	1960	1973
Belgium	9.2	9.7	0.7	0.4	0.3	16.9	13.4
West Germany	55.4	62.0	1.1	0.7	0.5	17.4	10.3
France	45.7	52.1	1.3	0.8	0.8	18.0	16.4
Italy	50.2	54.9	0.7	0.6	0.9	18.1	16.0
Luxembourg	0.3	0.4	1.1	0.5	1.3	15.9	10.8
Netherlands	11.5	13.4	1.4	1.2	0.8	20.8	14.5
United Kingdom	52.6	56.0	0.7	0.4	0.2	17.5	14.0
Ireland	2.8	3.1	0.3	0.5	1.2*	21.5	22.3**
Denmark	4.6	5.0	0.8	0.7	0.6	16.6	14.3
Europe — 6	172.3	192.5	1.0	0.7	0.7	18.0	14.0
Europe — 9	232.2	256.6	1.0	0.6	0.6	17.9	14.1

Table 1

Note

*According to the original E.E.C. source the 1973 population growth rate in Ireland was 1.2 per cent. The Department of Health inform us that it was 2.0 per cent. Further discrepancies between E.E.C. and domestic sources are noted elsewhere.

**The Department of Health informs us that the correct figure is 22.5.

Source: Commission of the European Economic Communities (1975), pp. 220-23.

Population: Age Structure and Infant Mortality

	Age Structure (as percentages of the total)						Infant Mortality[1]	
	0-14 years		*15-64 years*		*65 years and over*			
	1960	1972	1960	1972	1960	1972	1960	1972
Belgium	23.7	23.1	64.3	63.2	12.0	13.7	31.2	17.0
West Germany	21.6	22.6	67.5	63.6	10.9	13.8	33.8	22.7
France	26.5	24.5	61.9	62.4	11.6	13.1	27.4	15.4
Italy	24.5	24.4	66.0	64.3	9.5	11.3	43.9	25.7
Luxembourg	21.4	21.3	67.8	65.9	10.8	12.8	31.5	15.3
Netherlands	30.0	26.6	61.0	63.0	9.0	10.4	16.5	11.5
United Kingdom	23.3	24.4	65.0	62.6	11.7	13.4	22.5	17.2
Ireland	31.1	31.3	57.7	57.6	11.2	11.1	29.3	17.8[2]
Denmark	24.9	23.0	64.4	64.2	10.7	12.8	21.5	11.5
Europe — 6	24.4	23.9	65.0	63.4	10.6	12.6	33.6	20.3
Europe — 9	24.2	24.0	64.9	63.2	10.9	12.8	30.8	19.4

Table 2

Notes

1. Number of deaths under the age of 1 year per 1,000 live births.
2. The Department of Health inform us this statistic should read 18.0

Source: op.cit. pages 220-23 and 260-61, and Commission of the European Economic Community (1976) page 218-219.

6. Attempts to arrive at health care expenditure figures are notoriously difficult. There are the problems of uniform definition of health care and the comprehensiveness of statistics. Consequently any statistics which are derived from available sources are approximate and should be treated with caution. The data in Table 3 are no exception. These show that Irish expenditure is substantial and nearly on a par with that of the United Kingdom.

Table 3

Health Care Expenditure as a Percentage of G.N.P.

	1971/72
Belgium	3.90[1]
West Germany	5.84
France	5.50
Italy	6.00
Netherlands	6.71[2]
United Kingdom	5.06[3]
Ireland	4.96[4]
Denmark	5.46

Notes

1. This figure is incomplete and includes the general scheme and one for self employed persons only.
2. This figure is incomplete as it does not include private expenditures.
3. N.H.S. expenditure only.
4. This figure is derived from incomplete data. In particular there appears to be no available estimate of private health care expenditures on, e.g., general practitioner care for those with limited eligibility only.

Source: Maynard (1975) page 257.

7. This expenditure is used to purchase a variety of health care inputs and the comparative level of Irish endowment for some of these inputs is shown in Table 4. It is to be remembered that these figures show inputs per 1,000 population and though the statistics may be static between the years in these terms, in absolute terms

they mean that substantial increases have taken place. Once again caution must be employed in using these statistics because of problems of ensuring uniformity in their composition. It can nevertheless be seen from the table that the level of provision of physicians per 1,000 population in Ireland declined from 1.05 to 1.03 during the period 1960 to 1970. Ireland was the only country in the Community to experience a decline on this provision indicator and by 1970 was by far the least well-endowed country from the point of view of physicians. However, the 1971 and 1972 physician stock figures for Ireland show a large rise to 1.20 and 1.18 respectively. This change does not affect the Irish ranking in the E.E.C. league table but it does indicate that the Irish physician stock suddenly began to expand rapidly in the recent past. The Irish provision level of pharmicists declined by a small amount in the 1960's but by the Community norm was quite high in 1970. By 1970, apart from Luxembourg, Ireland had the largest stock of hospital beds per 1,000 population. Although Ireland's hospital bed stock declined if we use E.E.C. data, by nearly 23 per cent from 14.8 per 1,000 in 1960 to 11.4 per 1,000 in 1970, it ended the decade with nearly as many hospital beds per person as Western Germany and over 37 per cent more than Denmark. If, as noted in Table 4, we use the usual definition of hospital beds this conclusion about the high stock is reinforced. Departmental figures indicate that if the beds in old peoples' homes and mental handicap institutions are included, as they should be, the Irish bed stock in 1970 was 12.7. Whilst this disagreement between E.E.C. and domestic statistical sources once again highlights the problems of acquiring international data which are strictly comparable, either statistic indicates a relative abundance of hospital bed facilities in Ireland. The utilisation of these bed stocks varies substantially. By Community standards the average length of stay in Irish hospital beds in 1974 was low at about 11.6 days in acute hospitals. This compares with 18.6 days in West Germany, 15.7 days in France, 12.3 days in Denmark and 10.2 days in the United Kingdom (Maynard 1975). Further reductions in the length of stay could increase the capacity of the Irish hospital system to care for patients but the scope for such improvements, although present, is less than that available in some other European Community hospital systems.

Table 4

Health Care Inputs: Physicians, Pharmacists and Hospital Beds

	Physicians per 1,000 population		Pharmacists per 1,000 population		Hospital beds[3] per 1,000 population	
	1960	1970	1960	1970	1960	1970
Belgium	1.28	1.61	0.59	0.71	8.6	8.3
Germany	1.34	1.73	0.29	0.37	N.A.	11.2
France	1.05	1.34	0.42	0.63	9.7	9.4
Italy	1.61	1.82[1]	0.61	0.66	N.A.	10.5
Luxembourg	1.02	1.07	0.54	0.49	11.8	12.4
Netherlands	1.22	1.23[2]	0.07	0.08	5.0	5.5
United Kingdom	1.07	1.29[2]	0.40	0.31	10.7	9.4
Ireland	1.05	1.03[4]	0.59	0.57	14.8	11.4[5]
Denmark	1.27	1.52[2]	0.30	0.40	9.6	8.3

Notes:

1. 1969 statistic.
2. 1971 statistic.
3. Including clinics, psychiatric hospitals, sanitoria, nursing homes and old peoples' homes.
4. Note the stock changes in the post-1970 figures mentioned in the text.
5. The Department of Health inform us that this E.E.C. statistic excludes old peoples' homes and beds in mental handicap institutions despite an E.E.C. definition in the source to the contrary. If the latter two categories are included the Irish bed stock in 1970 was 12.7 beds per 1,000 population.

Source: op. cit., pages 260-261.

8. The general trend in the European Community has been for the coverage of social health care insurance to increase over the period since the Treaty of Rome was signed by its initial signatories. The coverage of the schemes in Belgium, France, Luxembourg, the United Kingdom and Denmark was either complete or nearly so by 1971. Since then the Italians have introduced a comprehensive national health service (1975). The Dutch introduced a comprehensive heavy risks programme in 1967. This gave social insurance cover to all for hospitalisation over 365 days and coverage for expenditure associated with mental illness, handicap and other severe conditions. At present the Dutch have proposed legislation which will make their social health care insurance comprehensive for all categories of risk and for all sections of the population. Ireland is, thus, an exception to the general trend in that, if anything, the coverage of her health services is at best static. The return of fuller employment in Ireland will reduce the numbers in receipt of benefits under the full eligibility scheme and, although the ceiling for limited eligibility has been raised, if it is not related by statute to, for example, the consumer price index or the earnings index, the scope of limited eligibility may decline due to changes in earnings as a result of inflation.

9. The preceding brief description of some international social indicators shows that the experience of Ireland differs in many respects from those of the other eight members of the European Community. We shall take up some of the themes touched on above in the discussion which follows.

10. Those health service trends which run counter to E.E.C. experience are likely, we believe, to prove temporary. The upward population trend is likely also to continue although, as we mention below, its rate is hard to predict. These two factors, together with rising expectations and a demand for greater equity, imply that Ireland's health services are likely to come under very heavy pressure: a pressure that will manifest itself not only in heavy demands upon existing facilities, but in an increasing demand for a radical reorganisation. These trends are discussed more fully in Chapter 4.

Table 5

Health Care Coverage: Persons covered by social insurance as a percentage of the population

	1958	1971
Belgium	71	99
Germany	84	90
France	64	98
Italy	74	91[1]
Luxembourg	84	99
Netherlands	75	76[2]
United Kingdom	100	100
Ireland	30/90	30/90[3]
Denmark	86	100[4]

Notes:

1. A national health service has, since 1975, covered all the population of Italy.
2. 100% are covered for heavy risks (since 1967) and legislation is before Parliament to extend coverage to all the population (at present the most affluent 30% insure privately) but has been delayed because of expenditure constraints.
3. 30% (full eligibility) and 90% (limited eligibility). Both these statistics will be discussed more fully below — nowadays they appear to be circa 36%/85%.
4. Recent reforms have made coverage complete (see Maynard 1975).

Source: Commission of the European Economic Community (1974), pages 230-231.

Summary

11. In this chapter our concern has been to describe, in general terms, the position of Ireland in relation to the other members of the European Economic Community. The general population trends are higher than those in the rest of the Community although there are some indications that this situation is changing. In

terms of expenditure as a percentage of G.N.P., Ireland spent in 1971-72 probably at least as much as the United Kingdom when private outlays are included. In the case of provision Ireland has a high bed stock and a low physician stock in comparison to the other E.E.C. members. As we shall argue below the latter statistic is not an unambiguous indicator of relative deprivation. The final international health care indicator discussed is that of the coverage of the system. The coverage of the Irish system is low and it is probable that during the next decade there will be increasing pressure for the Irish Government to emulate E.E.C. trends by moving towards more comprehensive coverage.

Chapter 3

THE PRESENT SYSTEM OF HEALTH CARE IN IRELAND

Introduction

1. During the course of the present decade the structure of the Irish health service has changed in a significant manner. In this section we will examine the main elements of these changes. Firstly we will review the structure of benefits and the coverage of the public system and the private sector. Then the expenditure and revenue patterns of the service will be examined and in the following sections the provision of hospital beds and medical manpower will be analysed.

A. Eligibility and Coverage.

2. There are two major client groups in the Irish health care system: those persons/families with full eligibility and those with limited eligibility.

A(i). Full Eligibility: the General Medical Service.

3. Those with full eligibility have medical cards and have the right to benefits under the General Medical Services (G.M.S.) scheme. To acquire a card the citizen has to be in "hardship", a subjective concept defined by arbitrary criteria. The waiting time prior to the completion of the necessary procedures and the issue of the medical card varies from one Health Board to another. In some areas the Board notifies the applicant and gives him/her a list of private physicians who are willing to treat him/her under the G.M.S. scheme. This information can be used to decide which physician to use and the applicant must then get this practitioner's signature on a G.M.S. Doctor's Acceptance Form. When this signed form is returned to the Board a Medical Card is issued. If prior to the Card's issue the patient attends a list physician the Board will pay although the physician may if he chooses charge the patient directly.

4. In some areas this rather cumbersome procedure is cut short by including an Acceptance Form on the application form and then the Card is issued immediately after the processing of the application. Although this mechanism is more rapid it causes problems if the application is rejected and the physician has provisionally accepted the patient.

5. There is almost always a means test prior to the issue of the card. The exceptions are the following categories who have already had a separate means test to acquire the relevant benefits: those in receipt of non-contributory old age pensions, old age (care) allowances, non-contributory orphans' allowances, deserted wives' allowance, elderly single women's allowance, prisoners' wives allowance, single mothers' allowance, blind pension, disabled persons' maintenance allowance and infectious diseases maintenance allowance.

6. The means test is based on the total income before tax of the applicant and his or her spouse. The income of other members of the family is not normally taken into account. The details of the test at January 1st 1974, 1975 and 1976 are given in Table 6. Those people with income below the limits cited in the table receive all the benefits available under the full eligibility programme. Farm income is tested in a similar manner. The equity of this process depends on the honesty of the farmer in declaring his income. If honest outcomes from self-assessment are doubted inequities may be generated among farmers and as between farmers and non-farmers.

Table 6

Medical Cards Means Test 1974-76[1] (£)

Category	1974	1975	1976
		£ per week	
Single person living alone	14.00	17.00	19.50
Single person living with family	12.00	14.75	17.00
Married couple	20.00	24.50	28.25
Allowance per child under 16 years	1.75	2.25	2.60
Allowance for other dependants	2.75	3.25	3.75
Allowance for outgoings on house: Excess over	2.00	2.25	2.60
Other allowance	Reasonable expenses necessarily incurred when travelling to work.		

Note

1. As at January 1st each year. Mid year revisions took place in 1975 to meet the problems arising from inflation.

Source: Department of Health, Dublin.

7. The income guidelines of the means test are changed irregularly. There is no statutory obligation to review the means test. The initiative for reform lies with the Chief Executive Officers of the Health Boards and is determined by their concept of "hardship". Usually reviews take place annually (apart from 1975 when high inflation necessitated two revisions) and the Department's role is largely one of ensuring uniformity in the means tests in the different Health Board areas. The Minister is reluctant to become directly involved in setting the means test because if he assumed this role, pressure group activity would be diverted from the Health Board's Chief Executive Officers to him. All medical cards are reviewed periodically. However, in some areas cards have not been reviewed for years because of work pressures within the Health Board. Obviously differential regional review processes may result in people in similar circumstances being treated in dissimilar ways. Medical card holders are eligible for benefits provided their name is on the local Health Board's Medical Card Register: merely holding a Card is not sufficient for full eligibility. If people migrate they have to re-apply for a Card in their new Health Board Area in order to gain acceptance onto a new physician's list.

8. The Medical Card holder is eligible for a wide range of services. However, since it varies from one Health Board to another, especially with regard to dental care, we focus here on a general description. The first benefit is the choice of doctor scheme which enables the card holder to apply for entry to the list of any physician who has agreed with the Health Board to provide general practice services. Once accepted by the physician the card holder is eligible for the same services as provided for private fee-paying patients. The Medical Card covers the cost of all prescribed medicines and prescriptions can be made up by any chemist within the General Medical Scheme. The card holder is eligible for free out-patient and in-patient care, provided the latter is in a public ward. The care can be provided by any Health Board hospital or any other approved hospital. If care is provided in a private hospital the Board only makes a small fixed contribution to the cost. Home nursing services are available for all card holders, particularly the elderly. This type of care is usualy approved by the patient's physician and the service

is provided by the Public Health Nurses. Dental care is available in theory but in practice its availability is limited. Opthalmic services are similarly available free of charge but waiting lists may be long. The expectant mother who is covered by a Medical Card is entitled to full medical, surgical and midwifery services for all confinements. Other benefits available are hearing aids, walking aids, wheelchairs, a chiropody service (again the availability of this varies geographically), travel allowances for the ill and those visiting relatives in hospital, and free milk for mothers and children under five.

9. The number of people with Medical Cards and on the Health Board's register fluctuates due to changes in the means test and general economic conditions. At the end of 1975, with unemployment relatively high, some 37 per cent of the total population (i.e. 1,162,386 persons) were in receipt of benefits under the G.M.S. system. The regional variations in medical card coverage is substantial due, in part, to regional income differences: in December 1975, 22 per cent of the Eastern Health Board's population had medical cards, whilst in the Western Board's area over 61 per cent of the population were covered by the G.M.S.

A(ii). Limited Eligibility

10. Under the limited eligibility scheme expectant mothers who have such eligibility are entitled to free medical, surgical and midwifery services. The child is eligible for all services until the age of six weeks. Assistance to meet the costs of drugs is available to all insured persons irrespective of their income. If a person is paying more than £5 for prescribed drugs in any month, a partial refund of the cost can be acquired from the local Health Board. No one with Limited Eligibility need pay more than £6.50 in any one month for prescribed drugs. Receipts from chemists can be sent to the Health Board if over £5 is paid. If between £5 and £8 is paid, a refund of half the excess over £5 is made by the Board. If over £8 a month is paid a full refund on the excess over £6.50 is made.

11. Those not covered by the General Medical Service may be eligible for hospital benefits under the limited eligibility system. This part of the scheme is very complex and eligibility is related to numerous categories. If a person is in one of the undermentioned

categories and has no Medical Card he can get limited eligibility status for him/herself and his/her dependants. There are eight categories since the recent July 1976 revision of the criteria:

(1) A non-manual worker who pays insurance contributions and earns £3,000 or less per year.
(2) A non-manual worker who pays insurance contributions and whose income rises above £3,000 per year continues to have limited eligibility status for the balance of that contribution year and for two further contribution years after exceeding £3,000 limit. (All insured workers can get refunds on drugs irrespective of income (see above).
This carry-over period is extended by a further year in the case of a person whose remuneration was not more than £2,250 per annum on or after 1 April 1974 but had increased to over £3,000 by 1 July 1976 due to adjustments in pay under the National Wage Agreements.
(3) A manual worker who pays insurance under the Department of Social Welfare Social Insurance Scheme. (This category and its two predecessors provided scope for interesting semantic arguments about what is a manual worker. A train driver is a manual worker because in days gone by he shovelled coal. A bus driver is a non-manual worker because he has never had to have recourse to a shovell).
(4) A voluntary contributor who was making voluntary contributions on March 31st 1974, who had 24 stamps in the contribution year prior to applying for services or 72 stamps in the previous three contribution years.
(5) A voluntary contributor to the Social Welfare Insurance scheme on the date of application for services. To qualify for Limited Eligibility a voluntary contributor is required to have at least 24 stamps (including the health contribution) on his card for the last contribution year, or 72 stamps in the previous three contribution years.
(6) A retired person who was qualified as an insured person for limited eligibility when he reached the age at which the Old Age Pension is granted (e.g. 67 years) retains Limited Eligibility for life irrespective of means.

(7) A non-insured (e.g. a self-employed or retired person) whose means are less than £3,000 per year.
(8) A farmer whose farm has a rateable value of less than £60.

12. If a person qualifies under one of the preceding eight categories he/she is obliged to make a health contribution. The voluntarily and compulsorily insured pay this each week as part of their National Insurance Stamp, i.e. categories 1-6 pay 33 pence per week (£17.16 per annum). Categories 7 and 8 pay a yearly contribution of £15 directly to the Revenue Commissioners. Farmers pay a yearly contribution of £15 directly to their local Health Board These contribution rates are very low but obviously they offer the Administration an avenue by which increased contribution revenue could be raised in the future. Pay-related contributions by employees, in a manner similar to that used in other parts of the European Community, could generate substantial revenue flows.

13. Certain administrative problems arise. Some Health Boards investigate claimants' means when they claim benefits under the Limited Eligibility scheme e.g. on hospitalisation. If this shows ineligibility despite registration with and payment of contribution to the Revenue Commissioners, a refund of the contributon is possible. The Health Boards' use of the limited eligibility is not as rigorous or as informative as some might like e.g. their information documents do not list the eight criteria given above, merely two of them.

14. Those who do qualify for limited eligibility get free in-patient hospital treatment in a public ward and free out-patient treatment if the patient is referred by a physician. The hospital used must be a Health Board or Board-approved institution. Those who opt for private or semi-private ward treatment get only part of the costs covered by the Limited Eligibility scheme. The rest must be paid by the patient or by benefits derived from membership of the monopolistic Voluntary Health Insurance fund (see below).

15. The extent of limited eligibility is an interesting area of argument. The earnings limits have been raised in recent years and the inflation would have taken many more people out of the limited

eligibility category if it had not been for the "two year delay mechanism" described in category 2 above (paragraph 10). The Government faced by the need to check public expenditure inflation, has been loth to revise the limits and this reluctance was revised only when the costs (in terms, amongst other things, of vote losses) of present policies became too great. Public sympathies with such policies are not great as they lead to uncertainties and the possibility of urgent health needs not being met. At present the discussion of the total (i.e. limited and full eligibility) coverage is full of difficulties. Whilst we know the extent of Medical Card issues, some debate surrounds the extent of the availability of limited eligibility benefits. The Department of Health's present estimate is that 85 per cent are covered by full and limited eligibility. There is however, a margin of error, among other reasons, because of lags between increases in incomes, and income limits being raised.

16. It is clear from the preceding discussion of full and limited eligibility that the costs of administering these complex programmes must be substantial. As far as we are aware no one has attempted to estimate the resource saving which might be possible if income testing were abolished.

17. This costliness in resource use is accompanied by the patient being uncertain of his rights. The administrative costs and the uncertainty produced by this legislation suggest the accretion of *ad hoc* policies through time rather than a well thought out and administratively manageable scheme. Universal limited eligibility is rejected by the physicians because it would, they argue, increase demand. One may doubt this argument. Firstly, all the available evidence suggests that the price elasticity of demand for hospital care is low: the extension of limited eligibility to the 15 per cent not covered would not result in their rushing to demand hospitalisation. Patients tend to demand such care only when they are unwell and anyway, these 15 per cent may continue to use private facilities so the public expenditure resource implications of universal limited eligibility may be small. Secondly, the physicians' associations should not unambiguously predict increased demand when their predictions are contrary to the evidence of other health care

systems and when they, the physicians, are the people who determine the demand for hospital beds. Physicians ration scarce health care resources and their power to ration scarce hospital bed case would be no less under the universal limited eligibility that we feel is bound to come.

A(iii) Private Insurance

18. The incomplete coverage of the public health care system means that at least 15% of the population have to meet health expenditure from private sources of income or insurance. There is a monopoly of private health care insurance in Ireland which is held by the Voluntary Health Insurance Scheme. In February 1975, the total membership of the Scheme was 524,524 i.e. nearly 17 per cent of the population (some 76 per cent of total membership were covered under 2,150 group subscriptions). Contribution rates are not shown in the V.H.I. annual report and little detailed discussion of their clientele is contained therein. Private discussions with V.H.I. reveal that of those with cover some 25-28 per cent can be clearly identified as having limited eligibility. This is a minimum figure and the actual figure cannot be identified because of vague and/or inaccurate hospital returns. V.H.I. surveys indicated that about one third of private patients (i.e. patients paying their own bills) have no health insurance cover of any kind.

19. V.H.I. offers two main types of policy: a policy for hospital costs and an optional policy to cover non-hospital medical bills. The latter costs an extra £3 per annum and gives refunds for general practice physician services, drugs, x-rays, home nursing and specialist fees. The insured person must find the first £25 per annum of such bills (in the case of the family the deductible is £35). At present 180,000 persons (83,000 policies) are covered against this type of risk. In the fourteen months to September 1975 £881,000 (8,000 claims) were paid out by V.H.I. under this optional policy and of this sum 57 per cent met the cost of drugs and 24 per cent went to remunerate physicians. Given that the first £25 (individual) or £35 (family) of any claim has to be met out of private income, these claims imply that £200,000 to £280,000 of private expenditure must be added to V.H.I. outlay under this policy.

20. Like many other private, and indeed public insurance agencies in other countries, V.H.I. has not exhibited any vigorous desire to contain costs by demanding more cost-effective therapies of the physicians. The physician has considerable power to determine the demand for his product, and, as for any other person or institution, such discretion can be misused. We argue elsewhere about the potential gains to be derived from greater emphasis on therapy effectiveness and minimum cost procedures.

21. Apart from V.H.I. and limited and full eligibility the only other source of "cover" is private income and savings. The total amount of expenditure in this category is not known.

22. The preceding paragraphs of this section have indicated that the structure of health insurance coverage in Ireland is complex and easily criticised. The full eligibility category has grown in recent years due to changing economic conditions, in particular due to rising unemployment, and the standardisation of Health Boards' means tests by levelling up the criteria. The limited eligibility category may have declined in size in early 1976 and has been only partly restored to its former level by the revised eligibility criteria introduced in July 1976. V.H.I. expenditure has increased although its membership growth rate has levelled off. As in other areas of social policy (see National Economic and Social Council (1975)) there has been a lack of any inclination to measure the redistributive impact of the health service, showing who pays what of the total cost of private and publicly provided health care, and who gets the benefits. Such data and their analysis would throw much needed light onto the inner mysteries of the present system and would enable analysts and policy makers to examine the efficacy of the present structure in a more systematic manner than is possible at present.

B. Income and Expenditure

23. The finance and expenditure characteristics of the Irish health service are changing rapidly at present. By 1977 they will have reached a state of rest structurally. In the year 1975 the total expenditure by the Government on health care was £232.55 million. The task of highlighting the rate of growth of expenditure is com-

plicated by the change of financial year in 1974-75. If we assume that during the months of January, February and March 1974 expenditure was equal to one quarter of the 1973-74 outlay (i.e. £35.85 million) then total expenditure in 1974 was £158.74 million, 32 per cent less than the 1975 figure. The high money growth rate in expenditure is, in part, due to inflation. The consumer price index moved up 59.9 points (1953=100) during the 1974-75 period and so the rate of growth of real expenditure was 21 per cent.

24. The two major spending authorities of government monies are the Health Boards and the Voluntary Hospitals. The former are the more important for spending in 1973-74, the last year for which disaggregated data was available, £122.19 million or 85.19 per cent of the total. Of the services provided by the Boards the three most expensive are the general hospital system (£43.42 million or 35.5 per cent of total Health Board expenditure in 1973), psychiatric hospitals and hospitals and homes for the chronic sick, the handicapped and the aged (£37.53 million or 30.7 per cent of total 1973 expenditure), and the general medical service (£17.98 million or 14.7 per cent of the total).

25. The system of Government support for the other spending authority — the Voluntary hospitals — has changed in the last few years. Prior to April 1974 a system of capitation fees was paid to the Voluntary Hospitals by the Health Boards for full and limited eligibility patients. This system was inadequate to meet all the costs of the hospitals and State support was also forthcoming to finance their annual deficits. Since April 1974 this two part system has been replaced by an annual grant made by the State to those hospitals which fulfil the necessary regulations and submit annual budgets in advance of expenditure. These budgets are used to determine the level of the State grant.

26. The rate of growth of V.H.I. expenditure (Table 7, column 2) has also been affected by inflation. During the financial year 1974-75 V.H.I. expenditure rose from £4.97 million to £5.80 million: by 16.7 per cent in money terms. If we take account of price changes between the two years the real growth rate in expenditure was minus 6 per cent.

Table 7

Health Care Expenditure by the Government and V.H.I.

	Government Expenditure	Voluntary Health Insurance (V.H.I.) Expenditure	Total
	£m.	£m.	£m.
1965-66	35.96	1.02	36.98
1966-67	40.97	1.24	42.21
1967-68	44.94	1.52	46.46
1968-69	50.63	1.70	52.33
1969-70	59.19	1.91	61.10
1970-71	76.23	2.54	78.77
1971-72	88.21	3.19	91.40
1972-73	109.77	4.09	113.86
1973-74	143.43	4.97	148.40
1974 (Apr.-Dec.)	122.89	5.80 (1974-75)	(186.82)[1]
1975 (Jan.-Dec.)	232.55		

Note:

1. This statistic is the sum of V.H.I. expenditure in 1974-75 (£5.8m.), the April-December 1974 Government expenditure and one quarter of the 1975 Government expenditure (£58.13m).

Source: Department of Health, and the Voluntary Health Insurance Board's Eighteenth Report (1975), page 12.

27. The total health care expenditure of Ireland cannot be estimated because we have no available statistics concerning private expenditure (i.e. expenditure financed out of income and savings). Total expenditure by the State and V.H.I. is presented in Table 7. Once again the recent data are complicated by the changing financial years. However, given the assumptions made, expenditure rose by £38.42 million during the financial year 1974-75 to £186.82 million: by 25.8 per cent. In real terms the growth rate was 1.6 per cent (during the period mid-Febhuary 1974 to mid-February 1975 the price index increased by 23.8%).

28. In terms of Gross National Product, Maxwell produces estimates showing that during the period 1971-72 to 1974-75 health services expenditure rose from 4.6 to 5.7 per cent of the total.

(Department of Health (1975) page 13-15: the Waterford Seminar). An unexplained estimate of private expenditure in 1974-75 of 0.8 per cent of G.N.P. leads Maxwell to the conclusion that total health expenditure was 6.5 per cent of G.N.P. in 1974-75. This puts Irish expenditure in excess of recent West German, French and U.K. expenditure. The Americans, Swedes, Canadians and Dutch continue to lead this particular league table, spending in excess of 7 per cent of their G.N.P. on health care. The paradox of these figures is that public expenditure in Ireland (including V.H.I.) at 5.7 per cent of G.N.P. provides very limited health care coverage whilst a smaller proportion of U.K. Gross National Product provides 100 per cent coverage. This paradox is, in part at least, due to the lower level of Irish G.N.P. and it highlights the necessity to grapple with the problems of cost-effective health care if expenditure growth is to be contained and demands for universality to be met.

29. The expenditure figures for Ireland in the preceding paragraph indicate the magnitude of expenditure growth in recent years. In four years (1971-72 to 1974-75) expenditure increased by 1.1 per cent of G.N.P. or 0.275 per cent of G.N.P. per annum, i.e by nearly 24 per cent. If such a growth rate is extrapolated to 1980, 1990 and 2000 then the share of G.N.P. used to finance health care in those years will be 7.35, 10.10 and 12.85 per cent. Such simple extrapolations highlight the question of whether Irish society will be prepared to finance the cost of this kind of growth in health expenditure; structural changes will be demanded whose effects will include a reduction in these projected shares.

30. As expenditure has increased the finance of the service has changed. Health contributions make up a very small part of total income: some five per cent in recent years. The contribution was paid by insured persons at the rate of 26 pence per week and by non-insured persons at the rate of £12 per year until April 1st when they were raised to 33 pence per week and £15 per year respectively. No levy is made on employers, unlike many other countries in the European Community. Apart from this income from contributions and a small payment which results from the Irish Hospital sweepstake, the system is financed by taxation. The central government, via the health vote and the Exchequer vote, finances the

majority of expenditure from general taxation. In 1972-73 local government met approximately one third of the total cost of State provided medical care. Since April 1973 the financial picture has altered radically. The share of central government, which has been increasing since the last world war, has increased still further as a result of the implementation of a policy to transfer from local to central taxation that part of the cost of health care met out of local rates. This transfer process is being executed over a four year period ending in 1977. The effect of the decision in 1973-74 was that the Exchequer bore all the increase in health care expenditure plus an amount equivalent to a reduction of the 1972-73 local rate contribution of twenty five per cent. A further twenty five per cent is transferred to the Exchequer each year so that by 1977 all publicly provided health care will be centrally financed.

31. Large changes have taken place in the structure of health care expenditure and finance during the period since 1970. Although these structural changes will be completed by 1977 the rate of growth of expenditure shows no signs of abating. Ireland, like every other member of the European Community and most countries of the Western world, is facing a money expenditure inflation rate of sizeable proportions and a real rate of increase of around 1.6 per cent per annum. All those experiencing these pressures are seeking ways of restraining the growth rate and improving the efficiency of the use of present resource levels. As we emphasise throughout this paper, control, efficiency and equity may have to be sought largely by action on the supply side of the industry. Intervention on the demand side alone, for example by raising prices, restricts demand in arbitrary ways which are likely to become increasingly unacceptable. Rising public expenditure, the fact that high spending is combined — by international standards — with limited benefits, and the presence of other public unpopular features to be discussed below make it unlikely that Ireland's system in its present form can survive for long, notwithstanding the recent reorganisation. The problems run too deep for administrative face-lifting to have much impact.

C. The Provision of Hospitals and Medical Personnel

32. Since the beginning of the decade the administrative structure

of the Irish health service has been radically reformed. In 1971 the task of administering the day to day running of the Irish health service has been in the hands of eight Health Boards. Each board has a tripartite structure with one component covering each of the major areas: community care, general hospital services and "special" hospital services (services for the mentally ill and the mentally handicapped).

C(i) Hospital Provision

33. There are three hospital ownership categories in Ireland. The public (government owned) hospitals, formerly run by the local authorities and now administered and financed by the Health Boards, own fifty four per cent of acute hospital beds and the majority of psychiatric beds, as can be seen in Table 8. The voluntary hospitals have a substantial role in the acute and mental handicapped hospital sectors. These hospitals tend to be centred on the cities — Dublin in particular — and, although run by autonomous boards, they are dependent on the Department of Health for most of their finance. The channels for this finance — ninety one per cent of an expenditure total of £22 million in 1970-71 — were, until 1974, capitation grants paid by Health Boards for patients from their areas and payments by the Department to meet deficits. Since 1974 each voluntary hospital has been obliged to submit its planned annual budget in advance to the Department. The Department then finances those items — usually all items are approved — which it deems necessary. The third hospital sector is in private hands and controls about 2,500 beds in the acute and psychiatric hospitals.

34. Two important factors must be noted about the organisation of hospitals in Ireland: Their size and their geographical distribution. As was noted in the Fitzgerald Report (1968) the average size of Irish hospitals is small. The data in Table 8 show that the average size of Health Board acute units in 1974 was 107 beds, whilst the size of Voluntary acute units was 162. The Fitzgerald Report estimated that the acute bed requirement target should be 4.15 per 1,000 population (1968, page 53) and to achieve this target the present acute bed stock of 6.1 per 1,000 (Table 9) will have to be reduced considerably. The Fitzgerald target is to be achieved with a mix of local and regional hospitals. The local general hospital will

have three surgeons and three physicians and a bed size of about 300. Regional hospitals based in the East (Dublin), Cork and Galway will provide general hospital care for its immediate environment, specialist services for a wider regional area, and medical school facilities.

Table 8

Hospital Beds by Type and Ownership Category in 1974

Type	Owners			
	Health Board	*Voluntary*	*Private*	*Total*
(i) *Acute Hospitals*				
Number of units	98	46	14	158
Number of acute beds	8,194	6,514	1,280	15,988
Number of Maternity beds	1,020	750	189	1,959
Number of T.B. beds	212	162	—	374
Number of Geriatric beds	1,030	—	—	1,030
Number of Psychiatric beds	96	26	—	122
Total bed stock	10,552	7,452	1,469	19,473
(ii) *Psychiatric Hospitals*				
Number of units	26	—	11	37
Number of beds*	14,082	—	1,074	15,156
(iii) *Mental Handicap Hospitals*				
Number of units	1	30	—	37
Number of beds	22	4,691	—	4,713

*This figure refers to the number of psychiatric patients in care on 31st December, 1974. This figure may be an under-estimate. A census count taken by the Medico-Social Research Board on 31st March showed a figure approximately 500 higher than the December one.

Source: Department of Health, Dublin.

Table 9

Regional Distribution of Hospital Beds

Area	Acute beds[1] per 1000 population (As a percentage of the Irish average).	Psychiatric beds per 1000 population (As a percentage of the Irish average).
Eastern	7.9 (129)	3.7 (71)
Midland	4.8 (78)	8.0 (153)
Mid Western	4.9 (80)	5.3 (102)
North Eastern	4.4 (72)	3.9 (75)
North Western	3.8 (62)	7.0 (134)
South Eastern	4.3 (70)	7.4 (142)
South	6.5 (106)	3.6 (69)
West	4.8 (78)	8.0 (153)
Ireland	**6.1 (100)**	**5.2 (100)**

Notes:
1. Including maternity beds.
Source: Department of Health, Dublin.

35. Subsequent to the Fitzgerald Report (1968) Comhairle na nOspideal (the national body representative of the health professions and health administration) published guidelines which modified the Fitzgerald proposals. These guidelines (1973) proposed that:

(i) the general aim should be to organise the acute hospitals services so that the population served would be within a radius of 30 miles of the hospital centre;

(ii) the minimum staff of such an acute hospital should consist of two consultant surgeons and two consultant physicians with other consultant medical personnel and other staff as required by the case load;

(iii) a minimum scale consultant-staffed hospital conforming to the guidelines should serve usually a population of about 100,000, but where there were special considerations such as low population density, a lower figure would be appropriate, ranging down to 75,000 in exceptional circumstances.

The Government accepted these outlines and in October 1975 put forward detailed proposals for the development of the general hospital system. This plan was very general e.g. it was couched in terms of hospital capacity and made no mention of personnel or of the time scale for implementation. It seems rather artificial to treat hospital capacity in isolation but within the terms of reference of the plans the objectives are articulated clearly and are sensibly flexible in the case of potential population boom areas, such as Cork.

36. Throughout the Fitzgerald Report there is implicit consideration of geographical equity but relatively little policy analysis of how it is to be achieved. The Report proposed that all patients should have the right of access to Regional hospitals but the cost of exercising this right is obviously greater for some patients living in more isolated geographical areas. Similarly the 1975 Hospital Plan is relatively quiet about spatial provision equity. Geographical equality (i.e. comparable endowments of health care provision) is absent in many health care systems (Cooper and Culyer, (1970, 1971, 1972); Maynard, (1975)). The Irish system is no exception as can be seen in table 9. The Eastern Health Area is the best endowed region as far as acute hospital beds are concerned with an endowment 29 per cent better than the national average and 67 per cent better than the North Western Board. In the psychiatric hospital bed sector the Eastern Area is badly endowed (29 percent below the national average) whilst the Midland and Western areas are very well endowed with provision levels over fifty per cent better than that for Ireland as a whole.

37. The causes of such inequalities are complex. History is an important explanatory variable. Hospital bed stocks are often aged and built to serve populations which have long since either declined or migrated to other areas. Geographically unequal incomes and the geographically unequal philanthropic propensities of past generations are two other important variables. Another factor is that because of economies of scale specialised units are small in number, tend to be located in the East and people travel there to use them. These inter-regional flows blur the character of the crude statistics set out in Table 9 but they do not account for the magnitude of

the inequalities indicated. To pursue greater regional equality is often difficult in terms of administration and politics. Where efforts have been made to move to more equitable geographical distribution of provision as in England, France and Germany the success of these efforts is, as yet, difficult to assess (West (1973), Maynard (1975)).

38. This brief analysis of the hospital bed stock of Ireland indicates that overall provision is relatively high. This was recognised by the Fitzgerald Report which proposed reductions in the total stock, its reorganisation, and pressed for more efficient utilisation. The follow-up of the Fitzgerald proposals has been slow. There is scope for resource saving by reductions in the total stock and more efficient use of the existing stock (e.g. shorter lengths of stay). Furthermore the "nettle" of geographical equity waits to be grasped by the politicians and the administrators.

C(ii) Medical Personnel

(a) Physicians

39. The geographical equity of the distribution of physicians is related to the supply of such professionals and their remuneration. However before considering this in more detail the stock and distribution of physician manpower in Ireland will be reviewed.

40. In table 10 the general characteristics of the stock of physicians is shown. As can be seen the majority of physicians work in the hospital system: the regional distribution of physicians per thousand population is shown in table 11. The Eastern area is so well endowed relatively (it is the only above average area) that it skews the distribution enormously. The degree by which the other authorities have less than average endowments differs substantially. The South East, the Midland and the North Eastern are the least well endowed. The changes between 1966 and 1971 show the Eastern region maintaining its position and the Midland and South Eastern getting worse endowments in relation to the improved national average.

Table 10

The Estimated Distribution of the Total Physicians 1975

Health Board	Consultants	Junior Doctors	General[1] Practitioners	Public Health/ Community Care
Eastern	446	682	527	36
Midland	24	34	112	10
Mid-Western	51	71	123	22
North-Eastern	37	66	124	10
North-Western	25	35	87	10
Southern	143	171	223	17
South Eastern	48	51	161	15
Western	79	149	156	12
Ireland	**853**	**1,259**	**1,513**	**132**

Notes:

1. There will be other doctors employed in such areas as Department of Health (14) full time research, the army, industry and doctors doing solely private practice.

Source: Department of Health (Dublin).

Table 11

Physicians per 10,000 population

Area	1966	(a)	1971	(a)
Eastern	15.4	(148)	17.4	(145)
Midland	7.0	(67)	7.6	(63)
Mid-Western	7.7	(74)	8.7	(72)
North Eastern	6.9	(66)	7.7	(64)
North Western	7.1	(68)	9.5	(79)
South Eastern	7.2	(69)	7.5	(62)
South	9.9	(95)	11.1	(92)
West	8.8	(84)	11.0	(91)
Ireland	**10.4**	**(100)**	**12.0**	**(100)**

Notes:

a. As a percentage of the national average.

Source: Department of Health (Dublin).

41. One factor which influences the distribution of physician manpower is remuneration. General practitioners within the General Medical Service (i.e. treating those with full eligibility status) are paid by the Health Boards on a basis of fee per item of service (or fee per patient contact). The agreed fee for a consultation in normal working hours has been £1.40. Arbitration procedures to to get this and other fees negotiated so that the intervening price change could be taken into account, have failed (the arbitrator offered a 12½ per cent increase) and the current wages policy restricts the scope for increases.

42. One point of issue between the Government and the medical associations is that of G.M.S. entry. Physicians are seeking free entry to the scheme. The Government is seeking to achieve an average list size of no more than 2,000 eligible patients and is refusing to accept free entry because of the deleterious effects of such a system on the geographical distribution of physicians. At present entry is by open competition for available posts.

43. Hospital physicians and community physicians employed by the Health Boards are paid a salary (June 1976): circa £9,179 for a whole time consultant and about £7,293 (maximum) for a registrar. Those practising in Voluntary Hospitals are paid on a sessional basis for out-patient clinics and under a "pool" system[1] for in-patients in public wards; unlike the Health Board salary remuneration is not pensionable. By part-time working for the Board the consultant can acquire private income and the availability of this is greater in the more affluent and urban Eastern area. In June 1976, 80 permanent consultant posts were vacant, with the North Western and South Eastern areas havng the greatest number of permanent posts unfilled due to lack of adequate incentives to work outside the main urban area.

44. The second important influence on the stock and distribution of physicians is supply of new physicians. Turpin (1975 unpublished) has pointed out a need for a more rational and better articulated public policy in this area. Ireland trains more physicians

1. 'Pool' payments are payments per day for each public patient treated in the hospital. The 'pool' of these payments for each hospital is divided between the consultants to the hospital on a basis agreed among themselves.

than it needs. Joyce and Murphy (1972) found in a study of graduates from Irish medical schools at five intervals between 1943 and 1963 that 76 per cent were Irish born and, in 1971, only 38 per cent of these were living in Ireland. Of all graduates only 30 per cent resided in Ireland. Acheson (1975) calculated that the current cost of educating further medical graduates in Britain was £28,000 each in 1972 prices. Perhaps 55 per cent of this cost was attributable to the National Health Service rather than medical education per se (Hill 1964). Turpin (1975) has estimated that in 1973/74 the average expenditure per graduate was £5,800 and only 17 per cent (£1,000) of this expenditure was met by fee income from the graduate. The residue (£4,800) was a gift by Irish taxpayers to potentially highly affluent Irish graduate physicians, the majority of whom practise abroad. Where hospitals have to be specifically staffed up to provide medical education the total cost per graduate is estimated by Turpin to be about £25,000 (in 1973/74 prices). If Joyce and Murphy's estimates are correct, Ireland is producing graduates at substantial cost to her taxpayers and seven out of ten of these skilled personnel then migrate to work in other countries. This form of international aid is most generous but it is to be remembered that its beneficiaries are, for the most part, countries whose incomes are higher than those of Ireland. During the next decade the increased production of medical graduates in Western Europe and North America will produce a large manpower surplus: where will the Irish surplus go then? It would seem sensible for Ireland to cut back, in a substantial way, her production of physicians as there should be little risk of manpower shortages, and the resource savings would be substantial and better spent in other areas.

45. The medical manpower position in Ireland is unusual. The country has a low doctor-population ratio and severe inequalities in the spatial distribution of physicians. The low doctor-population ratio is an ambiguous indicator of health service quality and naive assumptions that it is necessary to have more physicians per 1,000 population as wealth and health service "quality" rise, should be avoided. There is substantial international evidence (Cooper (1975)) to show that physicians' work loads are often of a non-

medical (clerical) nature to a substantial extent. Substitution of less skilled labour for physicians for such clerical tasks frees physician time and enables them to treat more people without having to increase total physician employment. More will be said of these issues in the forecasting section below.

46. Two major problems which face decision makers with regard to physicians is their over-production and their unequal geographical distribution. More positive incentives to "bribe" physicians into under-staffed areas should be considered. Reductions in medical school output may, as Turpin quite rightly argues, be implemented very soon so that the present habit of the Irish to subsidise the English and the Americans by providing trained doctors at zero cost is at worst reduced, and, at best, stopped. Irish international aid should go to the less, rather than to the more affluent nations of the world.

(b) Other Skilled Health Personnel

47. In table 12 the distribution and evolution of the stocks of three other types of health personnel are listed: dentists, pharmacists and nurses.

48. The stock of dentists is low (659 in total in 1971), geographically unequal in distribution and growing very slowly (it grew by 52 between 1966 and 1971). Many Health Board areas are unable to provide dentistry services because of the lack of personnel. As usual the Eastern region is the best endowed with a dentist stock per 10,000 population 32 per cent better than the national average and 128 per cent better than the worst endowed area, the North Western (1971 figures). Compared with 1966 the advantage of the East in relation to the national average has declined (from 46 to 32 per cent better) and the advantage compared with the North West has declined (from 153 to 128 per cent). All areas except the East improved their dentist endowment in the five year period.

49. Some details of the stock of pharmacists (1,571 in total in 1971 and 81 less than in 1966) are presented also in Table 12. However these statistics must be interpreted with some caution. According to the 1971 Census there were 1,571 pharmacists in

Table 12
Other Health Personnel 1966 and 1971

Type and Area	1966	1971
(i) *dentists per 10,000 population*		
Eastern	3.06	2.92
Midland	1.40	1.90
Mid-Western	1.51	1.52
North Eastern	1.56	1.79
North Western	1.21	1.28
South Eastern	1.63	1.92
South	2.30	2.41
West	1.37	1.67
Ireland	**2.10**	**2.21**
(ii) *pharmacists per 10,000 population*		
Eastern	7.34	6.31
Midland	4.32	4.21
Mid-Western	5.02	4.52
North Eastern	5.58	4.73
North Western	4.52	4.28
South Eastern	4.60	4.50
South	5.70	5.80
West	4.43	4.51
Ireland	**5.73**	**5.27**
(iii) *nurses per 10,000 populaton*		
Eastern	68.5	72.2
Midland	49.3	61.5
Mid-Western	51.3	58.9
North Eastern	46.8	57.3
North Western	49.4	55.6
South Eastern	52.3	59.2
South	51.6	60.9
West	60.4	70.4
Ireland	**57.3**	**64.7**

Source: Department of Health (Dublin).

Ireland and their distribution is shown in the table. However according to the Pharmaceutical Register there were 2,033 pharmacists in Ireland in 1971. This divergence between the Census and the Register data is the reason why caution must be employed. No emigration-immigration figures are available but it is probable that some of the difference is due to Irish registration but practice abroad. The Eastern area has the best pharmacist endowment (nearly 20 per cent better than the national average) and the Midland area was the least well-endowed (20 per cent below the average and nearly 50 per cent below the East). Again, as with dentists, it can be seen that the East's pharmacists stock declined between 1966 and 1971. The experience of the other areas, in the face of a declining national average, was uneven.

50. The stock of nurses increased by 4,054 to 19,284 between 1966 and 1971. The majority of nurses, nearly 87 per cent, are female and this population was relatively stable during the 1966-1971 period. The ranking of the Eastern region is threatened in this sector by the West which, on most other indicators, fares badly. On the nurse provision indicator it is the North East and the North West which fare badly. In both 1966 and 1971 these areas were the worst off although between these dates the relative positions were reversed. In 1971 the North Western region had 16 per cent less nurses per 10,000 population than Ireland as a whole, and nearly 30 per cent less than the East.

51. The position of Ireland relative to the European Community varies enormously between the different personnel indicators outlined in this section. The Irish endowment of dentists is below the E.E.C. average (3.6 per 10,000 population) and near the bottom of this particular league table (Maynard (1975) page 263). Her endowment of pharmacists is above the E.E.C. average (4.6 per 10,000 population) and around the middle of the E.E.C. range. The Irish and the British endowment of nurses (often from the same country) are similar and very high by E.E.C. standards e.g. the West German endowment in 1969 was around 23 per 10,000 population and the Dutch statistic was about 45.

52. Most discussion of provision levels for various types of medical manpower highlights the fact that it is with inputs and not outputs with which much current debate is concerned. We must emphasise that it is the efficient combination and use of these inputs that is of prime importance. This point tends to be disguised by discussions of geographical inequality in the provision of inputs. However it must not be ignored for policy purposes.

Summary

53. This chapter has been concerned with an examination of the present Irish health care system. We have shown that the criteria used to determine whether a citizen has full or limited eligibility are complex and consume considerable resources in their implementation and adjustment to meet changed economic conditions. The second part of the chapter examined the relatively high level, in terms of percentage of G.N.P., of expenditure on health in Ireland. The last section analysed the stocks and distributions of hospital beds, physicians and other medical personnel. Like so many other countries in Europe the geographical distribution of health care facilities exhibits a considerable degree of unevenness.

54. In the absence of much systematic information about 'output' (e.g. reliable measures of morbidity and the impact of the health services upon it) focus has of necessity to be upon the geographical distribution of resources. The marked imbalances, whether or not there is some variation according to 'need' (which is doubtful), are likely to become a major source of discontent with the present system. Certainly, concern with a rational distribution of resources, which relate provision to need, is becoming increasingly a focus of concern in many other developed countries.

Chapter 4

FUTURE TRENDS AND THE POTENTIAL PITFALLS OF FORECASTING

(a) Demographic Trends

1. The health service of Ireland has evolved against a background of changing population size and structure. In Chapter 2 it was shown that the total population of Ireland increased by 300,000 between 1960 and 1973. Part of this increase was due to a high and increased birth rate (table 1) and a decreased infant mortality rate (table 2). The age structure of the Irish populaton is unusual by Community standards. The size of the 65 years and over section of the population declined in perentage terms between 1960 and 1972, although in absolute terms it rose. This section of the population is not large by Community standards. However the dependency rate (defined as young and old, i.e., 0-14 and 65 and over) is high: 42.4 per cent of the population in 1972. Indeed as can be seen from table 2, it is the highest in the Community. Two causes of this, the high birth rate and the decrease in infant mortality, have been referred to already. A third factor is increased life expectancy. In 1925-27 the life expectancy of males (females) at birth was 57.4 (57.9) years. Forty years later (1965-67) the life expetancy rate was 68.6 (72.9) years. Life expectancy at 65 years of age changed from 12.8 (13.4) years for males (females) in 1925-27 to 12.4 (14.7) years in 1965-67. By 1971 the life expectancy statistics were 69.3 years for males and 74.1 years for females.

2. The Walsh (1975) population forecasts are set out in table 13. Various assumptions were made by Walsh to arrive at these forecasts. For males over 15 he assumed that mortality rates would be constant at 1965-67 levels. For males under 15, and all females up to the age of 75, the 1960-62 to 1965-67 declining trend in

mortality was extrapolated forward. It was noted in the preceding paragraph that the rates changed for both sexes between the Walsh base date (1965-67) and 1971. With regard to migration two assumptions were made (i) zero net migration and (ii) net emigration of 5,000 a year. These assumptions are fragile. The current Irish experience, which may be short-lived due to the recent European slump or long-lived and thus a radical reversal of recent history, is net *immigration*. Any assumptons about future trends in fertility and nuptiality are hazardous but unavoidable if forecasts are to be made. The 1966-71 fertility rate (a declining trend) was used for one set of extrapolations and this rate was doubled to generate another set of estimates. Various manipulations were made to project nuptiality, but as Walsh indicates, the methodology is crude and worthy of further research.

Table 13

Population Estimates 1971-1986

	1971 Actual	1986 Projected			
		Low estimates		High estimates	
Age structure		mn.	growth rate	mn.	growth rate
0-14 years	0.93	1.08	1.0%	1.28	2.1%
15-19 years	0.27	0.31	0.9%	0.31	1.1%
20-24 years	0.22	0.29	1.9%	0.32	2.6%
25-44 years	0.63	0.92	2.6%	0.94	2.8%
45-64 years	0.61	0.56	–0.6%	0.56	–0.5%
65 years and over	0.33	0.36	0.7%	0.36	0.6%
Total	2.98	3.51	1.1%	3.78	1.6%

Source: National Economic and Social Council Report No. 5 (1975), page 9.

3. The Walsh forecasts indicate that the total population of Ireland between 1971 and 1986 will increase. Change in the structure of this population will affect the pattern of demand for health care. Walsh anticipates an increase in the active adult population, a

considerable increase in the number of children (both in absolute and relative terms), and a decline in the elderly section of the population in relation to the total. This change in the age structure will put pressure on the maternity services, other child health services and geriatric services.

4. Forecasting population trends is a very difficult exercise which is often erroneous. The average age of marriage in Ireland declined from 29.4 (26.0) years for males (females) in 1965 to 27.2 (24.8) years in 1973. The average age of maternity fell from 30.7 years to 29.0 years. Thus people are marrying earlier and, in terms of child-bearing married life, their potential for producing children is increased. However, it may be that Ireland will emulate the dramatic reductions in birth rate experienced by many other European countries in recent years. Obviously the more widespread use of birth control would encourage this trend towards reduced population pressure. Even if the birth rate is stable the nature of the health demand emanating from the increased child population may change. During the period 1965 to 1973 the percentage of births to mothers under the age of 25 years rose from 20 per cent to 28.8 per cent of the total. During the same period the percentage of births to mothers over 35 years fell from 26.4 per cent to 17.6 per cent. The high level of births of handicapped children in Ireland is, if current evidence is to be accepted, correlated with and probably caused by childbearing by elderly primates (i.e. over the age of 30). (Office of Health Economics, 1974). If the propensity to marry early and have children earlier is continued, the reduced level of births by elderly primates will affect the incidence of handicap in the Irish community and the need for health services for such people.

(b) Forecasting the Demand for Health Services

5. Once population forecasts are made the next step is preparing forecasts of the demand for health services. To do this trends in the utilisation and development of services have to be identified and extrapolated. A Department of Health document (Background Considerations for Planning (1975), unpublished), indicates how

this can be done. Trends in hospital care are identified: e.g. in the acute sector: increased numbers of patients treated, the state of the bed stock, the continued decline in the length of stay and the number of elderly patients receiving hospital care. In the mental sector the significant change is, as in the rest of Western Europe, the dehospitalisation of the mentally ill. In Ireland the number of psychiatric patients in hospital fell by 20 per cent (to 15,471) in the period 1963-1973. However, the number of mentally handicapped persons in residential centres increased substantially during the period 1964 to 1973: the 0-16 years old category rose by 37 per cent to 2,446, and the 16 and over category rose by 59 per cent to 2,102. Whether all demand is identified in this sector is a moot point: in the United Kingdom it is clear that the cases treated by the NHS are merely the tip of the iceberg of illness in society (Israel and Teeling-Smith, 1967). The coverage of the General Medical Service has increased in absolute terms (1964: 820,820, 1974 1,083,136) and relative terms. Limited eligibility may decline, or be stabilised, if the income limits are changed at a level of 85 per cent of the total population.

6. The analysis and extrapolation of such trends by the Department is set in a programme structure which has 14 sections with seventy-six subsections. Each sub-programme is assocated with an objective and the effectiveness of the programme is assessed in relation to the performance of the system in relation to its objective.

7. The objectives of the programme and its sub-programmes are not clearly articulated in the Department's paper. This is unfortunate because it is consequently impossible to analyse closely the assumptions used to extrapolate trends to 1986. The Department's paper gives one set of cost estimates for 1986. This uses Walsh's highest population projection and predicts that by 1986 the cost index will have risen to 120 (1971=100). The predicted increase under expenditure heads is acute hospitals 17 per cent, psychiatric hospitals 12 per cent, community services 24 per cent, geriatric accommodation 9 per cent, maternity 45 per cent, mental handicap 39 per cent and child health services 38 per cent.

(c) **The Pitfalls of Forecasting**

8. The difficulties of forecasting the demand for health care in future periods lie in four areas: population estimates, service characteristic assumptions, changing technology and community attitudes to health (partly in response to rising costs). In this section we examine briefly the first three of these issues. We have discussed already some aspects of the fourth in chapter 1.

9. Some reference has already been made to the inherent pitfalls of population forecasting. The Walsh estimates are a thorough exercise in the current state of the forecasting arts. Greater elaboration would, however, have been useful. Single point estimates of future population figures are of dubious value as they are almost always wrong. Walsh provides two point estimates. We think he should have provided a greater range of estimates. Comparison with European trends indicates that radical changes may take place in Irish population trends. These changes may mitigate the population increase and lead to structural changes different from those indicated. It seems clear that the population will increase in size although its growth rate is a matter of dispute. It seems likely that there will be more children, a greater need for maternity services and an increased demand for health care by a numerically larger elderly population group.

10. The second area of forecasting pitfalls concerns the health service itself, in particular its coverage. The Department's 1986 cost estimates appear to assume no coverage changes and merely indicate the implications for the service of population changes. We have already noted Ireland's unique position with regard to health care coverage in the European Community. During the next ten years the effects of positive income elasticity of demand, (Kleiman, (1974) and Newhouse, (1976)) equity considerations and E.E.C. harmonisation pressures will tend to push coverage to a higher level. Full and limited eligibility covers 85 per cent of the community. Some politicians are demanding more comprehensive cover perhaps on the lines of the General Medical Service. The present Government seems intent, in the short run at least, to maintain 85 per cent limited eligibility cover by changing income

limits and the present full eligibility cover of around 36 per cent. The Irish Medical Association (I.M.A.) favours a comprehensive insurance system, similar to that in Belgium and Canada, which would abolish the present two-tier (limited and full eligibility) structure but permit patients to opt for special accommodation and treatment.

11. This is an interesting idea. It proposes to make the health care system comprehensive and more uniform. The new systems would be financed by a V.H.I. type arrangement with premium payment by the State for low income groups and by the State and consumers for other income groups.The effect of such a system would be, in the absence of coinsurance and deductibles, that the price barrier to consumption would be abolished. The abolition of the price barrier and the existence of excess demand brings with it all the familiar problems of rationing referred to above and elsewhere (Cooper, 1975). Who should ration demand? What criteria should these decision makers use to ration demand? The Irish Medical Association proposal fails to pose, let alone answer, these important and unavoidable questions.

12. Furthermore the proposed structure (insurance finance by a monopolistic V.H.I. and provision by the present system) may lack efficiency compared with alternative structures. One possible attribute of a monopsonistic National Health Service in the U.K. is that it can counter the monoply power of monopolistic input suppliers, e.g. the medical profession and the pharmaceutical industry. The I.M.A. in its proposal favours a fee per item of service remuneration system. Such systems have observable effects which may not always be welcome to the community, e.g. the existence of a tendency to maximise medical acts or visits to increase or maintain incomes with scant regard of medical "need". The ability of the profession to dictate its remuneration terms could be limited if its monopoly power was countered by the use of monopsonistic (single buyer) powers by the State. Similarly the Voluntary Price Regulation System in the U.K. by which the Department of Health and Social Security tries to affect the pharmaceutical prices, seems to have the effect of reducing U.K. drug expenditure. There is clear evidence that U.K. drug prices are below those in many other

European countries (Cooper, (1975)). Irish health service drug expenditure in 1975 was nearly £17 million, and if the potential discouragement on drug companies to locate in Ireland can be tolerated, a monopsony (a sole buyer i.e. a price maker rather than a price taker) could reduce Irish drug prices. Certainly the possible advantages of financial control being concentrated in the State's hands should not be ignored. Such direct involvement by the State may be more effective than the use of anti-trust legislation in an attempt indirectly to affect the power of the medical professions and other input suppliers.

13. The third important area in which a forecast can fail is with regard to medical technology. Here we take an extreme position in comparison to general accepted opinion. We believe that many medical practices are untested in a systematic manner and may be wasteful of resources. There is a need to allocate far more resources to the testing of the relative effectiveness of therapeutic procedures. Then there is a necessity to compare the relative costs of these procedures. Cochrane (1972) has argued that perhaps as many as 60 per cent of procedures have no therapeutic effects. There is an abundance of provocative argument but a relatively small body of substantive knowledge (Cooper, (1975), Illich, (1975) and (1976)). Although there is a popular demand for more emphasis on preventative care than on cure, again there is frequently an absence of reliable evidence concerning its efficacy and, even more frequently, concerning its cost-effectiveness.

14. Despite this lack of knowledge medical argument often determines policy. In the United Kingdom maternity services have become hospital rather than home orientated. This is despite the fact that countries such as the Netherlands have very low (in comparison to the U.K. and Ireland) maternal and infant mortality rates and an emphasis on home delivery. Even if hospital deliveries are safer it has to be recognised that the public expenditure costs of hospitalisation are substantially greater than those of home care. How should mother and child safely be traded off against these costs? All risks cannot be covered and expensive hospitalisation deprives other caring areas of their share of scarce economic resources.

15. Another area of controversy is that of community and hospital care. The usual argument is that hospitalisation is expensive and community care is cheaper. Consequently we see the Irish and the English reducing their mental hospital populations and decreasing acute hospital lengths of stay. This policy may be wrong. Hospital care is expensive in comparison to community care if we look at *public* expenditure only. However, it must be remembered that community care has implications for *private* resource use i.e. the care of the mentally ill in the community consumes labour services and housing services. To take an extreme example which is contrary to established wisdom, a geriatric case can be cared for in the community or in a home/hospital. The latter may be more expensive in public expenditure terms but the former may be more expensive in private expenditure terms if, for example, the person occupies a house. It is essential when looking at such policy areas to look at both the public and private expenditure implications of alternatives. Often this may be difficult, e.g. how does one cost the family stress of patients resident in households? However, because it is difficult it should not be ignored. In the psychiatric area, where a shift towards community care has, throughout the world, been most dramatic, the clinical evidence for the effectiveness of such a shift is highly ambiguous (see, e.g., Murphy, Engelsmann and Tcheng-Laroche, (1976)).

16. Therapeutic outcomes are the result of mixes of inputs. One of the most important of these inputs is medical personnel. Unfortunately the utilisation of personnel is not above criticism. The traditional health forecasting exercise extrapolates medical manpower "needs" by using population forecasts and, usually, assuming a fixed doctor-patient ratio. There have been many attempts to forecast in this way in the United Kingdom (see Maynard and Walker, (1976)). There the practice has been to assume a fixed doctor-patient ratio of e.g. 1 to 2,500, to estimate the number of new graduate physicians between the forecast date (e.g. 1976) and the target date (e.g. 1986), to estimate migration, deaths, retirements and female labour force participation withdrawals and returns, and then to arrive at a supply statistic for physicians. Demand side calculations rest on population forecasts, the hazards of which we have

discussed already. By and large the British experience of forecasting is that the estimates have been poor and as a basis for policy they must be treated most carefully.

17. Turpin (1975) in his analysis of medical (physician) manpower planning uses manpower forecasting techniques similar to those used in the United Kingdom during the last twenty years. However, one difference is that he believes that Ireland's relatively low physician endowment and its potential increase in income during the next decade are grounds for allowing for an increase in the number of physicians and a decrease in list size. Even if these rationales are admitted the forecasting exercise shows a vast oversupply of physicians relative to Ireland's needs.

18. We believe that Turpin's estimates are in the right direction but of the wrong magnitude, i.e. we think there are grounds to believe that they under-estimate the over-supply possibilities. The reason for this are the familiar criticisms of standard forecasting procedures (Peacock and Shannon, (1967), Maynard and Walker, (1976)). Point population estmates should not be used. A broad range of the alternative point estimates should be calculated and used as estimation bases. Probabilities should then be assigned to each of these outcomes. Fixed technical coefficients (e.g. a stable doctor-patient ratio) should be viewed with great scepticism. One Canadian study has shown that a trained nurse could do 50 per cent of an average general practitioner's tasks with no deleterious effect on medical outcomes (Spitzer, (1974), quoted in Cooper, (1975)). There are similar studies showing the potential for substituting less skilled labour (nurses, secretaries, clerks, paramedical workers, social workers, etc.) for physicians. All too often the skills acquired at medical school are inapplicable (due to inconsistencies between their syllabus and e.g., general practitioners' work loads) or under-utilised. Under-utilisation of physicans is often due to their being burdened with tasks (especially of a clerical nature) for which their expensive medical education is irrelevant. Detailed work study of the activities of physicians is needed. The admittedly poor evidence that is available at present suggests that such examination would reveal great potential for substituting physicians with less skilled labour and/or capital. If physicians specialised in

medicine we might be able to get by with less of them than at present, or, at worst (from the cost point of view), maintain and possibly improve the standard of service available to patients. The possibility of such an outcome is heightened by the potential for improving the evidence about the effectiveness of alternative therapies. There is evidence that some time consuming procedures lack efficacy. Thus not only are there substitution possibilities but there are also possibilities of removing the use of therapies whose relevance is dubious.

19. The possibilities of substitution between different types of labour input (nurses, doctors, para-medical and social work staff) show the weakness of forecasting physician targets alone. Similar exercises should be carried out for other manpower types and each exercise must be made compatible with the others. It is indicative of the power of the physicians that usually we forecast their numbers independently of other resources, and where we do forecast elsewhere little account is taken of substitution possibilties. Much of the work necessary to highlight substitution possibilities will come only with the co-operation and participation of the physicians. This co-operation should be more active. To take one example if we follow Reinhardt and Smith (1974) we could argue that physician time in caring for paediatric cases could be reduced by 50 per cent if 1.5 paediatric nurses per doctor were used. This result means that the number of patients treated could be doubled without increasing the physician stock by the physicians delegating tasks to less skilled workers. Alternatively the result says we could maintain "output" with half the number of paediatricians in work if we could declare them redundant from the present tasks and substitute less expensive labour inputs into the production process. This result indicates the magnitude of physician saving that may be possible. Spitzer (1974) quoted in Cooper (1975) argues that similar savings could be made with regard to general practitioners. The use of health centres and the fuller use of (cheaper) para-medical and social work staff may offer substantial resource savings. Clearly before we swallow arguments for more physicians the efficiency of their work practices needs to be rigorously scrutinised.

20. This section has shown that whilst forecasting exercises can and should be undertaken, they must be treated with caution and conducted in a radical fashion. Fixed technical coefficient assumptions in an industry whose technology is evolving so rapidly are naive. Without doubt forecasting Irish trends in health care is difficult. Coverage may, or may not increase. Changing technology and knowledge of therapeutic efficacy may have radical organisational and expenditure implications. A wide range of forecasts is possible and each and every one of these forecasts should be costed so that their resource implications are explicit. Any individual forecast is of interest only if Irish society makes a variety of choices; the most pertinent of which we list in our final section below.

Summary

21. This chapter has been concerned with the problems and pitfalls of forecastng population and various health care variables. The starting point was Walsh's population estimates and we then went on to analyse the problems of forecasting the future supply and demand of physicians. The latter procedure poses some particularly difficult problems because of the lack of analysis of the cost effectiveness of medical procedures. As a consequence of this lack of analysis we do not have a clear understanding of the potential for substituting less skilled (and costly) manpower and capital for physicians. Some of the evidence that is available suggests that the substitution possibilities are considerable and that our demand for physician manpower could be adjusted downwards if substitutions could be implemented. In Ireland all the usual difficulties of forecasting are compounded by a system of care that, it would seem, cannot last until 1986, or shortly thereafter, without fundamental and radical change, bringing it more in line with other developed countries in Europe and North America. Some of the main options as we see them are presented in the final two chapters.

Chapter 5

HEALTH CARE DILEMMAS

The Problem of Objectives

1. We have not found any reason to suppose that the trends in Ireland, at least as far as aspirations are concerned, are likely to differ from those observed in countries similar in terms of development and cultural heritage. We consequently expect with some confidence to see increasing pressure on politicians for the provision of universal health services with negligible user-cost impositions. We would expect this both with respect to the population covered (with a widening of the principle of full eligibility) and with respect to regional resource availability.

2. We would predict those trends anyway. Three factors will, however, probably intensify them. The first is the expansion of population. Particularly relevant here are the expansion in the number of women bearing children (on maternity services) in the number of children (on paediatric services) and in the number of elderly persons (on geriatric, acute and community services). The second is the effect, particularly on the middle classes, of limited eligibility, both as real incomes grow and as inflation proceeds. These groups are likely to press not only to maintain their financial advantages, which without frequent revision of the income conditions they see being eroded, but also to improve them as expectations increase. Electorally, they are not an easy group to resist.

4. The third is the fact that the medical profession has already begun to press for universal compulsory insurance and is likely to intensify its insistence, not only because the trend is readily observeable on a world scale but because we believe the emigration prospects for Irish-trained doctors will diminish over the next 10 years and they will have every incentive to press for a buoyant market for their services at home.

5. These pressures, together with the moral arguments that will doubtless accompany them and the comparative experience of similar countries will focus attention on three key problems:

(a) the problem or organising and providing an efficient and equitable service;

(b) the problem of financing the service;

(c) the problem of monitoring and controlling the medical professions.

The Problem of Provision

6. The issues raised under this head are too vast for a full discussion here. We believe, however, that the broad areas in which attention will become focussed are the following:

(a) the balance of care provided by institutions (mainly hospitals) on the one hand and community based services on the other. There is a general presumption that avoidance of costly institutionalization is less expensive (though there are, as yet, insufficiently detailed and numerous studies fully to support the presumption and some, indeed, contradict it.) Moreover, there is evidence that, for some conditions (e.g. some coronary disease) patient care in the home, in day clinics and outpatient departments is medically not inferior and may even be superior in some cases. Further attention should be given to reduction in the length of hospital in-patient stays and studies should be implemented directly towards the complementary needs for strengthened community care.

(b) an intensification of trends away from solo general practice towards group practice, particularly in urban areas. Although the low density of population in some areas of Ireland will limit the scope of group practice, there is a *prima facie* ground for supposing that group practice enables higher quality care by enabling specialisation among GPs, more effective delegation of clerical and less-skilled medical tasks, and

more effective (and continuous) peer review, while also reducing unit costs. Once again, the evidence is not absolutely conclusive but here is an area ripe for detailed examination by Irish researchers. (Some relevant economic analysis is in Bailey (1970), Newhouse (1973) and Smith (1972)).

(c) the promotion of a more even geographical distribution of the basic primary and hospital care services. This raises important questions concerning the identification of area "needs" and budgeting procedures that have begun to be developed in, for example, the U.K. (see West, (1973)) and the U.S.A. (Community Profile Data Center, (1972)) but which are still very much in their infancy. If costs are to be contained it becomes important that area imbalances of physicians in particular are not redressed by using the net increase in the number of physicians. As we have seen above, the physician is the key to the problem of the rising demand for health care and one lesson that international experience is unanimous about is that physicians will always generate work. The demand for physicians must be determined by careful consideration of the impact they can make on an area's health status, not by reference to more-or-less arbitrary and fixed ratios of physicians to population.

The Problem of Finance

7. If Ireland moves, as we believe she will, towards more comprehensive and universal access to medical services, the question of finance and the controllability of public expenditure on health care will become in Ireland the central issue it has become elsewhere. There are no easy or obvious answers to the question of how health care spending can or should be curtailed.

8. The patient makes the first crucial choice, namely whether to consult a doctor. Thereafter, the physician is the crucial decision-maker. He decides whether a further visit should be made, what diagnostic resources are to be used, what course of treatment

followed, whether the patient is to be referred, etc. Today, the physician defines whether or not a patient is sick, what treatment he requires and whether he should receive it. This suggests, we believe, that means of controlling public expenditure in a system where access is free of charge be directed to the physician as decision maker rather than the patient. This conclusion is further reinforced by the equity considerations discussed above: financial impediments directed at the patient are likely chiefly to deter initial contact, which is not the most resource-intensive step in the medical decision-makng chain and militates against the practice of preventive medicine ande early diagnosis. Moreover, direct charges tend *(ceteris paribus)* to distribute medical services towards the relatively rich. Finally, if the objectives of the system include the maximum possible improvement in the health of the population, such an objective is better met by identifying those areas where the largest improvements per pound of public money are to be had by budgeting procedures whose object is to expand services in such areas, rather than by reducing the demand of those patients who most reduce their demand for care when price barriers are erected.

9. We believe that health expenditure can be controlled without (a) necessarily departing from the fee-per-contact basis of paying general practitioners and the salary basis of paying hospital doctors and (b) infringing greatly on the principal traditions of medical autonomy in clinical practice.

10. We should add, perhaps, that there is evidence that fee-per-contact encourages "over-provision" of services by giving physicians a direct financial incentive to be extremely risk-averse (e.g. encouraging second and third surgery visits), and that all the traditional privileges of medical autonomy are *not* justified by the fact that doctors are clearly experts in the aetiology, diagnosis and treatment of disease (for a very thoughtful review of medical autonomy see Freidson, (1970)).

11. One advantage of a compulsory and universal health insurance scheme that is sometimes put is that it educates the public about the cost of medical care — by forcing them to pay more directly

for it. Unfortunately, the better it 'educates' them, the more anti-social it becomes (in terms of the social aspirations discussed above). The reasons for this are plain: premiums cannot be adequately risk-rated in a compulsory scheme, so they tend to become a kind of poll-tax, regressive in incidence and, anyway, providing no deterrent effect to the consumer. Coupled with deductibles and coinsurance,[1] the system remains regressive and also provides a deterrent to the consumer, but one that makes the system even more regressive and militates against the maximum improvement in the nation's health. Of course, steps can be taken to mitigate these effects. For example, deductibles and coinsurance rates could be made to vary with income (beginning at zero) and a maximum ("catastrophic") limit set to any family's cash payments in any one year. Or the value (somehow assessed) of services received in a year could, with no deductibles or coinsurance, be added to taxable income. Such procedures, while theoretically possible, strike us as administratively cumbersome and probably subject to abuse.

12. The other major alternative is to finance the service out of general taxation and to provide for no deterrent charges at all. This procedure loses the "educational" purpose of a more genuine insurance system — though doubtless other means exist of bringing the potential enormity of health spending home to the populace — but it gains in terms of its simplicity, lack of regressivity and is not inconsistent with the objective of increasing the nation's health in the most effective way. The role of insurance becomes the residual one of providing cover for those wishing to have private medicine and those wishing for additional dimensions of care that may not be considered necessary on medical grounds (e.g. for the additional cost of the privacy of a single room in hospital).

13. Under such a system, financial controls on the patient are replaced by more stringent financial controls on the providers of services. It is, of course, of the highest order of desirability that

1. A deductible implies that the patient must pay the first £x of the total cost. Coinsurance implies that he pays a proportion of the total cost.

such budgetary controls *not* be arbitrarily or historically determined but related systematically to the provision of resources in areas (geographical) to persons (by diagnostic category) in institutions (clinics, hospitals, group practices, etc.) and for procedures where it is judged that their productivity is highest. And this, of course, implies a degree of planning, of articulation of objectives and of knowledge of the means of effecting objectives, that has not yet been achieved in the administration of health services in Western Europe, but for which the technical and statistical means are now being evolved.

14. Within such a system, medical remuneration could well continue to be made on the present bases. For example, fees-per-services or fees-per-contact could be set so that a conscientiously working GP would receive an "adequate" income (clearly to be negotiated between the profession's association and the government) and which encouraged the appropriate amount of (e.g.) diagnostic testing. They might well vary on a regional basis to encourage flows of doctors from the relatively well-endowed regions to the South-East, Midland and North Eastern regions. There would also, however, be a case for experimentation (in group practices, for example, a global budget based on capitation principles might be allocated, its division between the cooperating doctors to be determined on other considerations — perhaps left to the partners themselves to decide).

15. If arbitrariness and extant inefficiencies are not, however, to be built into such a system, the development of the fundamental instruments of planning must be accelerated. Fortunately, there is now a substantial body of work and experience with such instruments in other countries, especially with measures of health status of patients for use in planning resource distribution (e.g. Ahumada, (1965); Levine and Yett, (1973); Miller, (1970); Chen, (1973); Wolfson, (1974); Harris, (1971)) as well as several designed for more micro-efficiency purposes (e.g. Torrance, (1970)) and the work of Bush and his colleagues (for example, Fanshel and Bush, (1970)). The development of planning guidelines along these lines ought to be an immediate task both of in-house and outside research for the Department of Health.

The Problem of Monitoring

16. There are several areas where medical expertise is not a sufficient qualification, and possibly not even a necessary qualification, for resource allocation in the health services. The chief of these relate to decisions concerning the amount of resources to be made available for the use of physicians, the number of physicians, the definition of ill-health in terms of social functioning, and modes of finance.

17. In the specifically expert areas of diagnosis, treatment and medical research it becomes increasingly desirable that the quality of performance be subject to monitoring. Mainly this would consist of peer group reviews of technical performance and scrutiny of colleagues' practice. In a system which will increasingly use public funds it becomes no less important that those who decide how the available resources are to be used should be made accountable. Like all professions, the medical profession has successfully protected its inept members and its lazy members from the harsh light of publicity, just as it has successfully made it impossible for outsiders to assess the quality of the care received by systematic comparison of either the excellence of practitioners' qualifications or the relative success of their attempts to serve clients.

18. There are now several methods available for monitoring performance which do not violate the legitimately privileged parts of the doctor-patient relationship (e.g. Brook, 1973) but which, nevertheless, deny physicians the luxury of being responsible to no-one save their own consciences and their own interpretation of their duty to serve the public. In our view, it is perfectly right for the skilful exercise of sophisticated knowledge to be rewarded hghly in society. By the same token, as 'society' becomes more explicitly involved in the financing and planning of health care, it is also right that it should have the means of satisfying itself that the objectives for which it makes high rewards available are properly and accountably met. These means will have to be worked out with the

representatives of the profession, but with a view to ensuring that they work effectively towards the objective of ascertainable good practice and not to shield idiosyncratic or plain ineffective (or worsel) professional behaviour behind a facade of a professional monopoly, controlling entry to the profession itself and auditing its own activity, independently, for the most part, of its paymasters.

19. It is no longer true that the effectiveness of medical work in the community has to rest on the judgement of individual practitioners in terms of the relief given to their own patients. The profession has come increasingly to recognise this, to its credit. But it is true that much that is feasibly attainable along this road remains to be travelled. Partly this task is an educational one. The profession, along with everyone else, must become more conscious of what comes *out* rather than what goes *in;* of *patient outcomes* rather than *resource inputs*. Partly, however, it is administrative, involving the development of systems of record keeping that not only make for better management within clinical practice, but which also enable performance to be evaluated. Even in the short-term, quite substantial progress of a crude sort could be made in terms of comparing differential case fatalities; age and sex standardised death rates; etc., by practitioner and institution. Substantially higher rates may have perfectly legitimate justifications. The point is, comparisons should be made. Health care is and will increasingly become simply too costly a matter for the profession to be able to insulate itself, as it largely has to date, from a wider critical audience. While "he who pays the piper calls the tune" is too crude an interpretation to put upon our argument, it remains the case that payer and piper should agree what the tune is, what it ought increasingly to become, and to evolve mutually a means for relating the tune demanded to the tune supplied. At the broader level of resource allocation it is also of crucial importance that an adequate statistical base be established for the measurement of the health needs of the population by area, client group and diagnostic category. Only information of this kind can validly serve as the basis for evaluating the likely productivity of health care resources (and, indeed, other resources) in improving the health of the nation (for a fuller explanation of what this might entail, see Culyer, (1976)).

Summary

20. Increasing public expenditure and increasing public awareness will lead inexorably to increasing public intervention in the planning, regulation and monitoring of health services. This will involve new departures in Ireland, both in terms of financial and organisational arrangements. While we cannot, of course, be precise about the shape these will take, we believe that both the experience of other countries and our own analysis strongly support the general shape of the emerging problems outlined in this chapter.

21. If the newly emerging relationships between the state, the public and the medical professions are to be of the sort that will, in the future, both preserve the best of the present arrangements and provide efficiently and effectively for the new needs and attitudes that we identify, we think it important that collaborative thinking *now* about future patterns of health care delivery in Ireland be put in hand. Experience readily shows that events can move at speeds that may catch one entirely unawares.

Chapter 6

AGENDA FOR CHOICE

1. In this final section we bring together the principal results of our preceding analysis and its implications.

2. The framework we have set for the analysis is *social* for two reasons. First, there is a growing body of economic, demographic and sociological material whch indicates that concepts of illness, determinants of utilization, etc., are not merely clinical matters but are strongly influenced by prevailing notions of the significance of sickness, etc., as well as themselves helping to shape these notions. Second, there is a growing involvement, both in Ireland and elsewhere, of the state in health care organisation; an involvement which we expect to continue to grow rather than remain constant or diminish. In chapter 5 we have outlined some reasons for this. Our general conclusion is that social attitudes, demographic changes economic growth and technical changes in the practice of medicine itself, all point in the same direction. Health care can no longer be regarded as a purely private matter between patient and physician. To be sure, the essence of the doctor-patient relationship will remain always a personal one, and a private one. But the mutual interest that citizens have in one another's health, the need for co-ordination between different branches of medicine, increasing demands for fairness in health service availability to all, as well as the sheer cost of modern medicine, make the general trend we identify inescapable. This, then, is *not* a matter of choice. The choices relate to how these changes are, in the future, to be accommodated, and how the 'three estates' of medicine (doctor, patient and public) are mutually to forge a satisfactory set of institutions for the new circumstances.

3. There are, we believe, two major consequences of these developments for the *way we should think about health service planning*. The first of these concerns the demand/supply models of thought sometimes used by economists and also the medical profession. Because the crucial role of the doctor in determining demand *and* (within constraints) supply destroys much of the logical rationale of the separation of supply and demand into separate "boxes" that mutually interact to produce a stable "equilibrium" we believe that this model should be used with great caution. Similarly, the second implication concerns the natural (for some), but quite erroneous inference from the first that health care developments can be left, in a rather unspecified way, to the beneficent management of a bilateral monopoly arrangement between the state, as ultimate financier and custodian of social values, and the medical professions as the experts in clinical medicine and the custodians of the interests of individual patients. This medico-administrative model, like the demand-supply model, will not do.

4. Future arrangements will, we believe, be forged out of the tensions that exist and can be summarily depicted in a third model. This model, like the first, takes it for granted that there will never be sufficient resources to satisfy every potential demand in the health territory. It recognises that the health of the population is the single most important objective of health services but is also influenced strongly by other environmental factors such as housing, work conditions and pollution. It is predicated on the view that the expertise of doctors is a clinical expertise and not one that qualifies them, other than as citizens, to have a view about social priorities in health care; that the expertise, techniques and data available to the state are woefully inadequate at the moment for the task ahead; that the views of the population at large on priorities in health should be taken account of, for neither doctors nor ministers have the knowledge, nor can they ever acquire it, required to interpret in detail the wishes and aspirations of 3.1 million individual souls.

5. Demographic changes, in addition to those described above will serve to intensify the urgency of these tensions. But they would exist even if the projected growth in the population were not to become a reality.

6. The choices that will have to be made will principally be the following. We present these in brief as an encapsulation of the more detailed discussion in the preceding text.

(a) *Sources of Finance:* If, increasing pressure for universal, comprehensive health care for all Irish regardless of income, etc., but dependent only upon "need" for care, is to be met should the financing system be an insurance-type system, by general taxation, or by a special income-related, health tax? Or will it be some combination of these?

(b) *Eligbility:* If the demand we predict for full eligibility be met by extending it to the entire population, what range of benefits should be covered? for example, aside from primary and hospital care, what principles shall determine access to dental care, ophthalmic care and pharmaceutical products?

(c) *Private Practice:* Within the more comprehensive scheme, what role will remain for private insurance and private practice? Will it act as the agent for the government who will pay the premiums? Will it be permitted to operate as a separate sector alongside a public system with "contracting out" of the public scheme permitted? Or will it become very much a residual sector catering for special needs (e.g. for private or semi-private hospital beds)? Or will it cease to exist altogether?

(d) *Resource Allocation*: How will the government set about so allocating resources that the maximum amount of "need" is met? If the objective is principally that of making the maximum impact on the health of the population, how will this be measured and what procedures will be developed to test the impact that resources have on improving it?

(e) *Equity*: How will equity be defined? Will it relate to sheer physical (or value of) resources available by (e.g.) area, or will it relate to the health "needs" (see (d) above) of clients?

(f) *Technical Efficiency:* What procedures will be evolved to test out the effectiveness of existing and new medical procedures? How will the proper balance of community and institutional care be determined? What criteria will determine the amount of medical research undertaken and the kind of research it is to be?

(g) *Monitoring:* In addition to the usual requirements of financial audit, how are institutions and professional individuals to be monitored so that not only do they work in the most effective fashion, but also reflect in their actons the priorities set by the community as a whole? How will individual practitioners be paid such that incentives distorting the public interest and the interests of patients are minimised?

(h) *Community Involvement:* How best is the community to be involved in the management and monitoring of the health care system? Would it be through a decentralised system of local democracy as, for example, in the present Health Board structure in which lay persons, doctors and administrators determine local policy within constraints set by the central ministry? Or should it be more centralised, with community values sought out and incorporated in centrally determined plans and budgets?

7. We do not present these in any order of priority as we see it. But we do believe that these eight issues capture the essential areas of choice regarding the future. An adequate answer will be found to *none* of them without first clearly specifying what it is that is to be achieved: the objectives of the health services. If, as we believe it will be, the answer to this most fundamental question of all is crouched in terms of making the maximum impact on the nation's health, then neither the laissez-faire policies often implicit in *both* the demand-supply model *and* the medico-administrative monopoly model, will bring it about. Instead, it will have to be brought about by the mutual involvement of the state, the public and the professions in facing up to each of these eight issues and answering them in the light of (a) what is technically possible, (b) what resources will permit and (c) their expected contrbution to the objective.

8. The importance of the latter can scarcely be overemphasised. Public accountability, professional and clinical freedom, administrative neatness, etc., are none of them objectives but must be seen as means to the end of better health provided economically. Whether they are appropriate means is what has to be decided, not taken for granted. And while interest groups of all kinds will seek both to impose their own views concerning what is best, and also to convince the world that what is best for them is also best for the world, these views must, so far as possible, be critically evaluated in the light of Ireland's objectives for health.

9. The pressure of events, we believe, makes these considerations of high importance. Despite recent policy evaluations and programme changes no fundamental reform of the health care system has taken place. Without a radical rethink, Ireland's health services face a major crisis. Whether this would take a financial form, or come in terms of increasing administrative difficulties, electoral or professional resistance, or all of these, only time will tell. Currently, all trends point to the need for major re-evaluation and major change. Now is the time to be considering what forms it should take. Now is the time to begin mounting the substantive research in Ireland that will help to solve the problems that are looming.[1] The answers will not be found in mere administrative reorganisation but in clarifying policy objectives in the key areas we have identified and then establishing the necessary informational framework both to find out what policies would best serve these objectives and how best they can be carried out.

10. In the immediate future there are two principal areas upon which research activity should be focussed. The first of these relates to the main obective of Ireland's health services: the health status of the population and its potential for improvement. We have cited occupational, empirical and survey references which can be used as

1. Most of the problems and choices we have identified have been researched in other countries. We have, at appropriate points in the text, referred to some of these contributions which may provide the basis for their adaptation to Ireland's circumstances.

points of departure. The second relates to the degree to which non-physician manpower can be effectively substituted for medical doctors, particularly in the remoter rural areas of the West.

11. As far as administrative arrangements are concerned, we believe that the evidence points to substantial advantages in planning *now* for full eligibility to be universal for primary and secondary care, financed out of general taxation. Extension to dental and ophthalmic care and pharmaceutical services, is something for later consideration.

12. Within the context of the latter arrangements. and with the basic information provided by the former efforts, the stage will be set for a full public and professional discussion of how the remainng issues are to be resolved. These are therefore the priorities.

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