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WHAT KIND OF HEALTH SERVICE DO WE REALLY NEED?

Remarks of
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Annual Conference 1980
Irish Private Hospitals and Nursing Homes Association
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It is a privilege to be invited by this Association to address such a distinguished audience.

Permit me to begin this afternoon by describing the nature and progress of my work at the Economic and Social Research Institute. As some of you know, I spent 1975 and 1976 at the Institute, doing research that in 1978 resulted in my paper on expenditures in education. I returned to the Institute last September, to undertake a project on health care expenditures. I have spent the time since September acquainting myself with the Irish health care system; acting as a consultant to the Oireachtais Joint Committee on State-Sponsored Bodies, on their study of the Voluntary Health Insurance Board; developing a report on "Poverty and Health" for the Irish Team, under the Institute of Public Administration, of a European Community study of poverty; and, as may not surprise you, trying to defend my paper on educational expenditures.

Hence I have no results to report to you on health care expenditures. What I will have to say today is based on what is already generally known about the Irish system of health care, together with my understanding of health economics. I reserve the right to modify later the positions I take today.

What kind of health care system do we need and want? I will offer the economists' answer: a system which is <u>equitable</u> in its treatment of persons, and <u>efficient</u> in its use of resources. As you will see, these terms are elastic enough to cover the preservation of health and life.

I will spend most of my time this afternoon discussing equity and efficiency, in the context of the Irish health care system. I will begin with equity, as I will have, I regret to say, very little to say about it.

Equity has always had a very central role to play in economics, whether it be the economics of welfare or social optimality, the economics of the public sector and taxation, or the economics of health. Unfortunately, economics has no single standard of equity to offer to the world, except possibly that those in equal circumstances should be treated equally. There are as many standards of equity in economics as there are of justice in philosophy: that is, one per economist, and one per philosopher. There seems, however, to be a minimal consensus that violation of either or both of the following two propositions by a health care system would constitute inequity:

(1) No one should be denied needed access to health care because of limited means.

(2) If quality is defined in terms of medical outcomes, i.e., in terms of the probability of correct and timely diagnoses, and probability of medical intervention which prevents or appropriately treats illnesses, then medical care of equal quality should be available to all, irrespective of means or social status.

Satisfaction of those two criteria is consistent with a very wide range of health care systems, ranging from a mixed system with very substantial reliance on a private sector, to direct state provision of all health care services. I am satisfied that the Irish system comes close to meeting the first criterion of access for all who needed care, and I am not convinced that the system in my own country, the United States, meets it. As to the second criterion, that care of equal quality be available to all, I am not prepared to offer an opinion at the moment, except that the differences, if any, are not large.

I described the consensus of these two standards of equity as "minimal". Some, including I suspect many in this room, would go no further; whilst others would argue that equity requires that the market play no role at all in health care,

and that the full range of health services be provided to everyone, free of charge at the point of delivery. I have my own opinion on this question, but I will reserve it, because at the moment I have nothing to contribute to a convincing resolution of it. Besides, I want to save most of my ammunition for the question of efficiency. Before leaving equity, though, I must comment that it and efficiency are often found to conflict in the realm of economics, and this is no less true in the economics of health than elsewhere.

I want to spend a few minutes defining economic efficiency. Another name for economic efficiency is the "optimal allocation of resources in society," and within the field of economics its study, at higher levels, is theoretical and technical, as well as being dull and largely pointless. Some of its more basic propositions are, however, intuitive, important, and useful. The resources of the Irish economy, or any economy for that matter -- the labour power and productive capacity which are used to produce each year's Gross National Product -- are limited. Hence it is important not only that we use them -- that they not lie needlessly idle -- but that we use them to produce the most and the best commodities we can. Efficiency requires not only that output be maximised for a given set of resources, but that the set or mix of goods produced be the right ones, capable of giving the most satisfaction of needs and wants, and providing optimally for the future as well.

The theory of economic efficiency tells us that we can have optimal resource use if we get the same amount of added benefit from the last pound spent on each item in our budget. This rule works for families, trying to allocate their incomes. The last pound spent on shoes, recreation, transportation, and so on, should all yield the same added benefit, as evaluated by the family. If the benefit is not the same on all items, then a reallocation in the budget, to make the family still better off, is possible. If the family members feel they get more benefit from the last pound spent on annual holidays than on reading matter, then they should reallocate money from the latter to the former, and continue to do so until equality is achieved. The rule also works for society as a whole: the last expenditure on

housing, on food, on education, and on medical care should yield the same added benefit, public and private, to society. And within the health care system, the last pound spent on personnel should yield the same added benefit as the last pound spent on hospitals, and the last pound spent on private care should yield the same benefit as the last pound spent on public care. If there are inequalities here, and the last pound spent in some areas provides more benefit than that spent in others, a reallocation could raise total benefits with no change in expenditures.

Of course, the family is the only judge of whether its income is optimally allocated. But anyone has a right to an opinion on whether society's resources are appropriately distributed.

Economic efficiency in the health care system means that health care has the right share of society's productive resources, and that there is the best mix or distribution of resources within health care. The former requires that the last expenditure of a pound on health care in society bring the same added benefit to the country as the last pound spent outside of health care. The latter requires that the added benefit be the same from the final expenditure in each component of the health care system.

It may at first seem novel to some to attempt to apply such criteria to health care. After all, in the final analysis, is not the business of health care the saving of lives? And is not the value of a human life infinite? Are economists about the business of setting a value on the saving of life, and comparing it, for example, with the benefits of automobiles, motion pictures, and pints of stout?

The answer is that <u>society</u> places a value on human life, a value incidentally which is far from infinity, and economists observe, note, and report this. There is actually a fairly sizeable literature in economics on the value of human life, and it is virtually all empirical -- that is, it is based on observation of behaviour of society. (I must admit to having been shocked the first time I came across this literature, but eventually I became accustomed to the idea. I suspect that those in the medical profession have similar experiences in their careers.)

The first step in the economics of the value of human life is to distinguish

between the value of an abstract or anonymous human life, and the value of the life of a known individual. If we ask, how many lives per year can we save if we improve a dangerous turn in a highway, or enforce emission controls on motor vehicles, or restrict smoking in public places, and if we decide on the basis of such calculations whether to undertake the necessary costs, we are implicitly placing a value on an abstract human life. If, however, a specific child falls down a mine shaft, a yachtsman is lost at sea, or a patient requires an available but costly treatment, there typically is no limit to the amount we are willing to spend to save life.

Everyone is familiar with the evidence for the proposition that we place a far higher value on a known than an abstract life.

I think that this is one reason why we chronically underspend on prevention, as opposed to cure. Most of prevention, and in particular that part of prevention on which we underspend, deals with saving, on a probabalistic basis, the lives and health of an infinitesmal and anonymous portion of the population. Most of medical care is concerned with detecting, diagnosing, and treating ill health of non-abstract, known individuals. When we undervalue the life of the abstract or statistical person as compared with that of the known individual, we evidently are doing what is natural, or at least what is done in virtually every society on the globe; but we are allocating society's life- and health-saving resources sub-optimally.

I will return to the issue of prevention later, but I want to deal first with a number of other economic efficiency issues than the optimal balance between prevention and treatment. The central question, and the question that involves the theme of this afternoon's symposium, is how does one organise a health care system so that it more or less automatically tends toward efficient results? How do we avoid wasteful over-utilisation of health care resources on the one hand, and not discourage necessary utilisation on the other? There are four parties involved in this process: the public -- patients and potential patients, who are also those who pay for the system, whether in fees and charges or in taxes; the providers, the doctors and other professionals, the hospitals, the pharmacists, and the like,

whose incomes derive in whole or in part from health care, and who stand opposite the public in the market (such as we have) for health care services; the planners -- the civil servants and others who have constructed the health care system that we face; and the politicians, who bear ultimate responsibility for the structure of the system, and for the finance of at least the public portion.

I would like to discuss the extent to which we can rely on each of these parties -- the public, the providers, the planners, and the politicians -- to behave in such a fashion as to bring about an efficient health care system.

Let me begin with the public. In general, at least in the private sector, the main responsibility for economising behaviour lies with the public, through the institution of the market. Where people are charged prices which more or less reflect the true cost to society of producing commodities, then they can weigh the contribution to their welfare of the last bit of expenditure on each item, and the sum of all this individual optimising behaviour is a social optimum. There is a very long list of reasons, based not only on equity but on efficiency, why we cannot do this for health care. No health care system in the world finds it possible or desireable to rely on patients to pay the full costs of health care from their own resources. Instead, finance is based on some combination of pre-paid care, voluntary insurance, social security, and the exchequer, i.e., taxpayer finance. An apparently inevitable consequence appears to be that users of medical services are not cost-conscious, and do not engage in economising behaviour. This, as I said, is true everywhere; yet there are differences of degree. For example, the choice-of-doctor scheme, in the General Medical Service, relies more on the market, and hence on the economising behaviour of the public, than the old dispensary system. But there is nothing in the structure of the General Medical Service which encourages patients of general practitioners to take costs to society into account when they decide whether to see a doctor. Perhaps as a consequence, Medical Card holders in Ireland see their GPs approximately $5\frac{1}{2}$ times a year, which is an extraordinarily high statistic. Perhaps more startling is the fact that GPs write 1.7 prescriptions per visit (in the Eastern Health Board it is more than 2.0) in the General Medical

Service. One might expect those outside the GMS to be somewhat more cost-conscious, as they pay at least a fraction of their own GP fees and prescription costs; but we have no statistics on the consultation and prescribing rates outside the GMS. The same problem exists, to a still greater degree, where the real money is spent, in the hospitals. Those with incomes up to £7000 are entitled to free hospitalisation; and neither they nor the doctors who refer them to hospital are liable to be cost-conscious. What about private patients? While the new scheme introduced by the VHI in April of last year represents an improvement in many respects, there can be little doubt that it means that subscribers will be still less cost-conscious than before. The abolition of the old unit scheme and its substitution by what amounts to a take-it-or-leave-it package plan means that subscribers have no opportunity to co-insure, should they desire. The VHI's indemnity scheme, which guarantees total cover against hospital bills, provided the patient remains within the accomodation level at which he or she has opted to insure, means that subscribers will have no interest whatever in the accomodation and ancillary charge schedules of the various hospitals. The Irish health care system, which has a substantial private component, provides the public with as little reason to economise on health resources as in a comprehensive system of nationalised care. In the league table of the EEC, Ireland's hospital admission rate is in the high group, in what amounts to a bi-modal distribution, along with those of Germany, Italy, and Denmark, and well above those of the rest of the Community.

A number of devices are available to make the public more cost-conscious: deductibles; co-insurance; even a voucher scheme. They have equity as well as efficiency implications, and these deserve careful consideration before any such device is recommended. Evidence from other countries does show that such devices do significantly influence utilisation rates. What is required in Ireland is some very serious attention to changes in the financing of health care, in both the public and private sectors, to provide the public with some incentive to attempt to economise on health care resources, while not sacrificing and if possible enhancing

the equity of the system. At the moment, however, I think the extent to which we can rely on the public to economise in the use of health care resources is extremely limited.

Let me turn, then, to the providers. The first question is whether the way in which they are paid for their services encourages them to economise. General practitioners, both in and out of the GMS, are paid on a fee-for-service basis, rather than by salary or by capitation. There certainly is no economic reason for GPs to discourage over-consultation; quite the contrary. Indeed, as far as GPs in the GMS are concerned, this country would appear to have the worst possible combination for resource efficiency: no charge to patients, who are then encouraged to treat GP time as free, and a fee-per-consultation payment to practitioners, who are then encouraged to see patients as frequently as possible. What would the consultation rate be (and I want to emphasise that I am not advocating this) if these two were reversed, and patients paid £3 a visit, but doctors' incomes were not affected by the number of consultations? Private patients not only pay GP fees, but these are probably double those paid by the GMS Payments Board. In short, we have no reason to expect general practitioners to economise on health care resources.

Let me add two more points about GPs. One is that the existing fee system does nothing to encourage the use of practice nurses and other medical and para-medical personnel below the level of doctor, and hence does not encourage economising on doctors' increasingly valuable time. The other is that the fee system does nothing to encourage other changes which might contribute to a more effective organisation of general practice, and in particular to movement away from the pattern of un-aided solo practice which is the rule in this country.

The writing of a prescription is essentially costless to the physician, and there is hence no reason to expect the latter to economise in this area. This is a problem in all health care systems, to which I will return in a moment.

The most important providers of health care services, in terms of cost,

are the hospitals. Here the question is, does the way hospitals and consultants are paid encourage efficient utilisation of acute hospital beds? Or does the method of payment lead in a significant number of cases to excessive hospital stays? This would be an important question even if there were an excess supply of beds, because a patient uses resources other than simply space; but Ireland appears to have a shortage of beds, requiring long waits for admission for some procedures. I say "appears" to have, because the apparent shortage may itself be a product of the payment method, which encourages providers to keep beds occupied. I would suggest that the method of payment, especially to consultants, far from encouraging economical use of beds, may encourage excessive stays. If the consultant were paid for the operation or other procedure, and were charged rather than paid per patient-day in hospital, what would happen to average stays in hospital in Ireland? (Again, I must emphasise that the question is hypothetical, and does not reflect a policy proposal.)

There is little in the way providers are paid which would give them an incentive to economise on resources. Likewise, there seem to be no peer review procedures, hospital bed utilisation committees, or the like, which might substitute for marked-like forces, in institutionalising economising behaviour, and in discouraging waste. Medical resources cost money; but the public and a large part of the profession are encouraged to act as if they were free.

What about the planners? To what extent can we rely, for economising behaviour, on those who, though they have no role in providing health care services themselves, have an administrative responsibility for the system? I refer mainly to civil servants in the Department of Health, of course, but there are others, such as the Voluntary Health Insurance Board, who fall into this category. An alternative to peer review is some form of bureaucratic control over or review of consultation rates, prescribing rates, admissions to hospital, surgical and medical procedures, lengths of hospital stay, and the like. These can be employed not only by the state, but by voluntary health insurance societies as well. In Ireland, however, no such procedures exist, at least to my knowledge. Planners, this time referring specifically to the Department, can influence the gross allocation of resources through the budgetary process;they and other bodies, such as the Health Boards and Comhairle

na nOspideal, can indirectly influence resource allocation, through their decisions on numbers of hospital beds and consultant positions; but planners must be more aware than anyone else of the limits on their ability, through these blunt instruments to assure that added benefits are equal for the last pound spent in each component of the health care system.

That leaves the politicians. If only gross and indirect devices are open to the planners to influence resource allocation in health care, that is even more so of the politicians. Moreover, just as we examined the incentives that exist in the market and elsewhere for the public and the providers to economise on health care resources, so too should we look to the system of rewards and penalties that politicians face. Obviously, there are substantial pressures on politicians to economise on health care expenditures, and indeed on all public expenditures. But there are also counterpressures which are difficult to resist. I am not referring to the income threshhold for Category II eligibility, which is not, by itself, a resource decision in the sense in which I am using that term. That is, it does not directly influence what share of GNP goes into health care, or the exact mix of health care expenditures, though it probably influences the behaviour of the public and the providers. Instead, I am referring to such resource decisions as the number, size, and location of hospitals. There are a number of reasons the FitzGerald Report was not implemented, but there seems to be agreement that the main one was political, based on the opposition of localities to having their County and District hospitals closed or downgraded to nursing homes, health centres, etc., as recommended in the Report. It has been said (Irish Times, December 11, 1978) that "the policy of a 'hospital within sight of every polling booth' has triumphed." It would be surprising indeed if the institutional arrangements within which politicians work, and the pressures to which they are subject, produced a health care system in which resources are efficiently distributed.

Undoubtedly, I overstate the case. While there are indeed signs of inefficient resource allocation in the Irish health care system, these are no more severe than in many other countries. And while health care costs have risen and

continue to rise at spectacular rates, the same is true in other countries with quite different pricing, income, and institutional arrangements. Yet the fact remains that the Irish health care system is not a cost-conscious system; and that fact will pose increasing problems, both fiscal and medical, in the 1980s.

I want to conclude with a final word about prevention. Without research, and with only casual empirical observation, I am secure in saying that each added pound of expenditure in appropriate categories of prevention can yield greater benefits in this country, in the form of health and life, than equal added expenditure in medicine. I want to emphasise that when I refer to prevention, I am not confining myself to health education or advertising, or to anti-smoking or other lifestyle campaigns which have become so linked in the public's minds with prevention. These are essential, but they are far from being the whole of prevention. Instead, I am talking of the whole range of prevention -- controlling air pollution by dealing with automobile -- and bus -- emissions, trash burning, and perhaps even heating fuels; protecting non-smokers from having to be captive, passive smokers in cinemas and other enclosed public places; routinely and systematically testing inner-city children for lead build-up; enforcement of motor vehicle laws, which often seem to the foreign observer to be advisory only; providing for and protecting bicyclists; adoption of child-resistant containers for dangerous medicines and household products such as chlorine bleach; and (though this will surely brand me as a curmudgeon) doing something to reduce the extraordinary rate at which Irish children consume sweets and destroy their teeth. In every one of these areas, Ireland lags behind most of Europe and North America, as this country does <u>not</u> lag behind in medical care. We have a Taoiseach who as Minister for Health was identified in the public mind with prevention; and his successor, Dr. Woods, is clearly committed to that work. But prevention is not the job alone of the Department of Health, the Health Education Bureau, and the health care system. Within government, it is the job of the Departments of the Environment, of Education, of Finance, of Local Government, of Energy --

indeed, of every department, semi-state and state-sponsored body. Fortunately, Mr. Haughey is well placed to influence them all.

It used to be said that "an ounce of prevention is worth a pound of cure." That saying was made up before the industrial age, that is, before the leading causes of disease and death began to relate to hazards in our environment and our lifestyles. Undoubtedly, the ratio has changed. To be thoroughly modern, i.e., metric, we might guess that a gram of prevention is today worth a kilogram of cure. In light of the soaring cost of cure, that makes prevention a real bargain.

What kind of health care system do we really need? With all respect to this audience, we need a system in which health care is the business of the whole society, and not one sector or profession. We need a system which resists rather than nurtures environmental health hazards. A system which tolerates a dangerous and unhealthy environment and lifestyle, whether in the name of economic growth, human freedom, or saving money, and then spends millions to treat the resulting illnesses, is worse than merely inequitable and inefficient. But that, I fear, is the kind of system we have.