Why Patients aren't Virtues

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David Comerford investigates the wisdom of the recent proposal to extend health insurance to all. He examines the health systems of a number of different countries and he concludes that the proposal is not a feasible or well thought out solution to the problems of the Irish health system.

Introduction

A recent proposal by Ruadhri Quinn, leader of the Irish Labour Party, to extend health insurance to all members of society attracted considerable praise for its progressiveness. However, it is my contention in this essay that when exposed to commonsensical scrutiny, detached from the murky policy quagmire that is our present context, the logic behind Mr Quinn's suggestion disintegrates.

Let us firstly look at the state of the health service in Ireland as it stands. It is obviously the case that any radical suggestion such as this is the product of a crisis which mere tweaking will not fix. Politicians are loath to upset the applecart unless the applecart in question has already spilled its load. In the case of the Irish healthcare system, this is universally acknowledged as the case.

Despite having an age profile significantly younger, and consequently less reliant on healthcare, than our European colleagues, Ireland still manages to spend more on average on health. Not only that, but our mixture of public and private service provision means that although healthcare is universal, there are significant delays for those who cannot supplement government investment in it.

This is not a new experience for Ireland and indeed over the course of the past five years, in view of our newfound prosperity, the government undertook what they considered to be remedial action. However, their view of remedial action did not involve apple proofing the cart but rather, stretching a metaphor to breaking point, paving the road with money so that when the apples inevitably do fall, they will have a softer landing. There is no disputing the fact that the government did indeed spend twice as much on health last year as they did in 1996, but that is a far cry from claiming that the healthcare provided by the state was twice as good. So where did the money go?

We would hope that it bought us improved hospital treatment. Well, unfortunately, the powers that be are reluctant to let us know, since the most recent figures we have to work with are from 1996. We have also been told that the number of people employed by the state directly in the provision of healthcare is 80,000. Back in 1996 that figure was 67,775. But if trends are consistent, and in the public sector they tend to be, the vast majority of those new recruits are employed in administration. In 1979 doctors, nurses and dentists made up 60% of those employed in healthcare. In 1996, they accounted for less than half. We also know for example that nursing wages increased since then.

That is not to say that even if the government had invested our money in more doctors, we would be seeing a doctor any sooner. If there is any market in which supply creates its own demand, healthcare is that market. When Canada increased its number of doctors by 5%, the total workload for doctors increased by 4%.[1] The main reason for this was not the reduction in largest cost to the consumer at point of entry to a free service, i.e. the time cost, although it is a significant factor. Rather, Cullis and West report, the reason was found to be that *'increased availability leads to demand generated by increasing repeat visits'*. So it seems that the demand was not autonomous, but had been instilled by suppliers. This ability of suppliers to insist on consumption is the primary reason for state intervention in the health sector.[2]

There are many more explanations for increased state expenditure in health. The nature of health is such that at any given time consumers are not aware whether or not they should be demanding health services, and if they should, they are ignorant of which to demand. Culyer cites a survey in London that showed that 95% of people had felt ill in the preceding fortnight, but only 20% went to a doctor[3]. Even if the rest had gone to a doctor, it is doubtful that they would have gained much. He goes on to cite studies which have shown that doctors are only eighty percent successful in diagnosis. The odds of being restored to full health are further hampered by discrepancies in treatments, such as thirty prescriptions for an identical ailment.[4] The bane of the health economist's job, however, is the fact that even after

[1] Cullis and West ch.4

[2] O'Hagan Ch. 3

[3] In Grant & Shaw, Current issues in Economic Policy

[4] In Grant & Shaw, Current issues in Economic Policy

all these steps have been taken, there is no measurement to gauge output from investment in health; the bane of all our lives is that there is no measurement to gauge our health.

Consequently, Grant concludes, policy should focus mainly on identifying the effective procedures, identifying the least costly procedure and allocating the resources appropriate to undertake these procedures[4]. So let us analyse the current system according to this criteria and then compare it to Dr Quinn, Medicine Man's, model.

Diagnosis

The procedures which are identified by the current system are procedures identified by doctors. There has never been any suggestion that we could get rid of doctors, even if we wanted to. However, what we can do is limit their conflicts of interest so as the procedures they are recommending are the procedures that they consider the most effective. An example is the cash back scheme that rewards GPs for prescribing generic drugs rather than branded drugs. It is well known that drug companies charge huge rents on their products, but because doctors are spending other people's money, pharmaceutical companies realise that they can be easily persuaded to opt for one product over another. An illustration of this is health conferences which are sponsored by drug companies. The effectiveness of this lobbying is spelt out by the constant mergers and take-overs that plague this industry, with the result that there are now only a handful of gargantuan players left in the market.

Fuchs points to the *'technological imperative'*[5] which drives doctors to prescribe and consumers to demand expensive treatment. Not only are the machines used in these expensive procedures, but so too are the staff who are specially trained to operate them. Since there is no measure of output, there is no way of telling for certain if these procedures are indeed more effective. For example, intensive care treatment in coronary care units has yet to be established as being any better than bed rest[6]. The government does not actually plug out life support machines in cases where they have been deemed inefficient, but at least they have a vested interest in determining the effectiveness of procedures, as they are the bill payers.

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[5] Cullis and West, Ch. 4

[6] In Grant & Shaw, Current issues in Economic Policy

Ultimately, the government wants to keep costs down, whereas individuals can pass the bill on to private insurance companies, who can just pass the bill on to the other members. In order to fully explain why the insurance company is not particularly concerned by receiving an unnecessarily hefty bill, I'll first have to take a look at the peculiarities of the Irish health insurance industry.

The Voluntary Health Insurance (VHI), scheme was a government ordained one. This has lead to problems. As Alan Shatter of Fine Gael said, it is no longer tenable for the Minister for Health to perform the *'contradictory role of regulator of private health insurance, owner of the VHI and price fixer for private beds in public hospitals'*.[7] Despite his complaints however, the Minister for Health retains these functions. The good news is that he is no longer a monopolist. In 1996, the health insurance industry was finally opened to competition after three years of bureaucratic wrangling. The competition is very limited however. Firstly, there is only one other provider, BUPA Ireland. Secondly, the Irish model of health insurance was kept intact. *'Irish insurance is based on solidarity between insured generations, community ratings, open enrolment, lifetime cover and risk equalisation'*[8]. Consequently, a premium bears no correlation with the individual's risk. Costs are aggregated and then distributed among members. Therefore, the individual has no incentive to change risky behaviour. Smoking is a huge area of debate in this regard as its dangers have been conclusively proven. Despite that fact, the 1999 White Paper on health insurance refused to allow insurance companies to charge smokers a higher premium than non-smokers. Ostensibly, the relative inelasticity of insurance premia meant that such an action would have no effect. Despite the fact that this logic undermines the rationale for excise taxes, Ireland retains community ratings.

Insurance competition had a lot more going for it in the UK in the 1980s. In that case increased competition led to non-smoker discounts, no claims bonuses and discounts for nominal fee payment. For the consumer, these measures had a double impact, both beneficial to society. Firstly, by rewarding healthy behaviour, competition in insurance directly promoted health. This is something that the public monopoly in Ireland has only ever done ineffectually and ineffectively. Secondly, by introducing nominal fee payment, insurance companies brought home to consumers

[7] Irish Times 1-8-98

[8] O'Hagan , p. 329

the very real costs incurred by the health sector. This awareness palpably reduces the moral hazard of indiscriminate hospital use. With the knowledge that hospitalisation is by far the most expensive part of the healthcare system[9], it goes without saying that Britain will produce health more efficiently, in the parlance of economists,. Britain's 7.9% of GNP spent on health care, when compared with Ireland's 8.3%.

Another important aspect is the incentives insurance creates for producers. Insurers provide full cover only for approved hospitals and by rewarding them with customers, encourage quality. Only partial remuneration goes to customers of disfavoured ones. The onus is therefore on the hospital itself to improve quality. This form of competition has the advantage of avoiding price competition and the necessary trade-offs that entails. For example, Norwich Union went so far as to offer £250 per night cash back for patients who opt for cheaper treatments. In the market place, consumers will rationally continue to use cheaper hospitals until they feel spasms of pain, which they would rather spend £250 a day to avoid than carry on suffering. The result is that hospitals are encouraged to engage in price wars. Meanwhile, Norwich Union attracts more customers, customers are offered £250 and all the benefits of a night in hospital to feign diseases and hospitals cut corners to get the money from the insurance companies. Given that that we never know our own state of health, we are unlikely to guess when £250 worth of damage has been done until it is too late.

It is this same immeasurability of health that gives rise to moral hazard. Since treatment is either paid for by government or, if it can be afforded, by an insurance company, the financial costs to the consumer at time of purchase are zero. This gives rise to a rational phenomenon with irrational consequences. Consumers will demand healthcare until the marginal utility of so doing is equal to the opportunity cost of their time. Those who can most accurately identify a potential health risk are those who are best informed. These tend to be people who are formally educated to quite a high level or those who educate themselves in health. Both types of person tend to be people on higher than average income. Since wages are the most tangible form of opportunity costs for time, those on higher wages will place more value on, and will demand quicker treatment. It is the way of the market, therefore, that those who are on higher incomes value their health more highly and are able to pay for it. Having established that delays are the blight on Irish healthcare, we can thus explain the

[9] O'Hagan, cited by Dr. Sean Barrett. In 1983, 73.4% of health budget went to hospitals

Also Tussing, Dale, The Irish Times, 31-1-01

popularity of private health insurance amongst the Irish.

So let us now identify the least costly procedure. We have already established that hospitals are the most expensive procedure. This is true in terms of both accounting and opportunity costs. O'Hagan has noted that Ireland is more expensive than most in the OECD for hospital beds, and that our costs more than doubled between 1966 and 1979. Dale Tussing draws this premise to its conclusion when he observes that funding should go to GPs, who are the gatekeepers to the system. The Irish system falls at this hurdle. Private customers are sent directly to consultants, whereas those in the public sector are piled on to a waiting list. Since consultants receive a salary for public patients, once they have reached their quota of public patients it is far more profitable for them to take private patients, as they will pay fee per item. The inequality continues after the visit to the consultant. Consultants have priority over 20% of hospital beds, and empirically these are filled with private patients.

Prognosis

The conclusion that Ireland has a two-tiered health sector is, in the light of all this evidence, a valid one. However, the jury is still out on the way to reform it, or how best to allocate the resources to the most effective procedures, if you will. This brings us neatly back to Ruadhri Quinn's suggestion. Any public policy decision, as with most decisions, comes down to whether the costs outweigh the benefits. If we are better off, overall, as a result of adopting this policy, then we should adopt it. It is my contention, however, that in an Ireland in which, let us invoke the ceteris paribus assumption, nothing has changed in the health system other than provision of health insurance, this plan is not feasible.

There is, in Ireland, universal health coverage. This is the status quo. Given that the primary complaint is the delay in attaining treatment, removing this delay should be the aim of our reform. Mr Quinn has no option but to share with us the above findings. There are no value judgements in my analysis of the current healthcare system. He has recognised that the return on health insurance is speedy treatment. We are thus far at least, in agreement

Where we differ is in the conclusion he draws from this. Ruadhri's argument is that since we are trying to achieve speedy treatment for all, logically we should extend health insurance to all. What he has failed to notice is that private insurance gains priority treatment, which in this case, happens to be speedy treatment. However, thinking logically, if we all have priority treatment, none of us can have priority

treatment. If we are all on an equal footing going into a doctor's surgery, we will receive a meritorious position on the waiting list, but we will remain on the waiting list. Our suppliers, the individual doctors and nurses are still the same. The consumers, buying from the same producers, remain the same. All that has changed are the middlemen. And even then, the government remains the supplier of suppliers (I cannot envisage health insurers educating doctors), all that insurers do is buy for consumers. The result is an inefficient addendum to a prescription that is already too long.

The results are obvious. Private insurers would not even have the government's self-control when they receive hospital bills. Since the Irish insurance system is community based, no one individual's premium is any worse off than anyone else's in that same company. However, risk equalisation means that if either of the two suppliers is seen to be making a supernormal profit because their clients are costing less for treatment, they will have to refund the other company the difference. It is a logical, if instinctively perverse, conclusion then that there is a disincentive to keeping costs down, as those savings are transferred directly to the competition. Indeed, if medical costs are constantly rising, insurance companies' profits as a proportion of revenue can remain the same, while their real profits rise. In order to observe this, one must merely look at the American model. Here the health service accounts for 13% of GNP, though it is not universally provided. Rents from insurance and drug companies alone make up 2% of America's GNP[10].

Conclusion

While universal private insurance coverage may seem to fulfil the Labour Party's objective of equalising the playing field, it ultimately does so by raising it on a platform twenty metres high. To redress inequality, healthcare priorities should be redressed, there is already universal access. The problem with Ruadhri Quinn's proposal is that I do not even credit it with enough sophistication to be egalitarian. There are already degrees of coverage within health insurance. If the primary incentive for buying health insurance is skipping the queue, then the wealthy will be willing to pay it. The government already spend over £8000 per household on healthcare. Subscriptions to health insurance companies are typically less than one thousand pounds per household. It is foolish to believe that the wealthy are not prepared to pay more. If the government anticipates this and puts a cap on health insurance premia, we are left with a universal, per capita, equal payment towards the

[10] Wren, Maeve Ann - The Irish Times 17-10-01

community's health requirements. Effectively, health insurance premia would amount to no more than another tax, and one which has already been paid at that. The government would then be doing that most inefficient of things, subsidising a private sector middleman. The product would remain the exact same as under a system in which private insurance is banned outright, except it would cost more and be decided by the middlemen instead of the ultimate consumers. To make his system work without reforming the health care industry substantially, Mr Quinn will have to change human nature. If he believes he can do that, he has confused a placebo with a panacea. In trying to level the playing field, he has only moved the goalposts and upset the apple cart, and the result is as chaotic as it sounds.

Bibliography

Cullis, J. and West, P. (1979) *The Economics of Health*, Robertson.

Culyer, A. (1975) 'The Economics of Health' in Grant, R.M. and Shaw, G.K., *Current Issues in Economic Policy*. Alan.

O'Hagan, J. (2000) *The Economy Of Ireland.* Dublin: Gill & Macmillan.

The Irish Times, Various authors.