# A Note on the Irish Health Care System

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This essay criticizes the system of primary health care currently in place in Ireland. It is argued that this system, by discriminating against preventative medicine, debilitates the health of the lower-socio economic classes. Harts inverse care law applies directly.

Section one will consider the two fundamental concepts underpinning effective health care, while section two will illustrate how the system of General Practice prevailing militates against the incorporation of these concepts into the Irish health care system.

**Cost effective health care**

Consider two hospital beds. In one there is a 19 year old expectant mother close to the time of delivery. In the other, there is a 71 year old man admitted to hospital for the a recurrence of a smoking-related disease. The obstetric bed contains a combined life expectancy of over 130 years, and the majority of these years will be productive ones. The geriatric bed contains a life expectancy of 2 to 3 years at the outside, most or all of which will use up health care resources, and none of which are likely to be productive. This scenario will be returned to below.

Cost effective health care is based on two simple concepts. Prevention is always far better and ultimately far cheaper than cure. The most appropriate arena for prevention is outside, in the community, in the General Practitioners surgery. It involves the drafting of enlightened, action-oriented legislation, the effective use of the media, and imaginative educational policies aimed at both children and adults in school and in the workplace.

In contradistinction, the cure of disease is a costly business. When a person becomes a patient, they incur charges, costs, and loss of productivity. Walking into the GP's surgery is relatively inexpensive. Walking into a hospital casualty department is more expensive, and most expensive of all is the cost of "high tech" inpatient treatments, where hotel costs start at £150 to £200 per day in a general hospital, even before treatment is commenced.

**The bias against prevention in Ireland**

These criterion can be used to assess the efficacy of the provision of Irish health care services, and in particular, the provision of primary care.

General Practice (or primary care) represents a midway between the healthy man in the street and the luckless individual caught up in the miasma of the high technology intensive care unit. In countries like Ireland and the UK, over 90% of doctor patient contacts involve a General Practitioner, making General Practice the largest interface between the public and the medical profession.

The General Medical Services Scheme (GMS) is a government sponsored agreement which provides free primary care to the patient at the point of delivery. It applies, roughly, to the least well-off 40% of the population. The GP provides his services to these patients according to a contract that is based on a mixed capitation/ fee-per-item system. The GP also provides his services to the remainder of the

population, based on an arbitrary system of payment.

It is instructive to look at the impact which the GMS has on the provision of health services. Capitation fees, which represent a set fee per patient per annum, average approximately £30. In addition, GPs can claim an additional fee for carrying out specific services. These additional items are limited and specific. In particular, they are all services which would otherwise need to be carried out (more expensively) in a hospital. Yet they do not include any activity which could be described as preventative or effective in preserving health.

For those patients on a private fee schedule, GPs receive their payments exclusively on a fee-per-item schedule. Consultation prices range from £10 to £20 per visit, with additional charges levied for any other services. In practical terms, this means that a GP is effectively penalized for spending extra time with a GMS ("poor") patient. The marginal revenue from each additional visit to such a patient is zero. In contrast, the marginal revenue from additional visits to a "rich" private patient remains constant, and may in certain circumstances be increasing. The private patient will be profitably invited back to have valuable and recognized preventative procedures discussed and carried out, a benefit which will not accrue to the GMS patient. The irony is that the wealthy patient will, in in many cases, have his/her excess costs paid by insurance premiums which are in turn subsidized by public monies through tax write-offs.

Thus, in considering these fee schedules, we can see a perfect example of poor decision making. Harts inverse care law, which states that if resources are made available for health purposes, they are most likely to be taken up by those who least need them, applies directly.

It is good economics to control GMS expenses. However, the manner in which this control is exercised in Ireland is reprehensible. It demonstrates a narrow-minded concern with short-term cost containment, rather than with more laudable aims such as cost-effective, preventative medicine. The absolute lack of any incentives for prevention in the GMS agreement is even more disturbing when it is remembered that the Irish, and particularly the lower socio-economic classes, have a particularly poor record for self-induced illnesses caused by over-eating and smoking.

To return to the initial scenario of the two hospital beds, if we follow a rational approach based on preventative medicine, it follows that the expectant mother should be targeted for family planning advice, smoking prevention and parenting skills. None of these health care options are particularly expensive. Nevertheless, if she was admitted from a council estate, it is likely that she will return there without ever having these services.

The 71 year old patient, by contrast, will be treated royally by comparative economic terms. Despite the pessimistic prognosis which cannot be changed, he will be irradiated, resuscitated and possibly operated on. The number of costly operations carried out each year for end-stage atheromatous disease (caused in large part by smoking) is staggering. If he dies in the hospital, he will probably do so with all the costly and futile blessings of a sophisticated self-perpetuating tertiary care centre. If, on the other hand, he is returned home, for another year or two, he will be discharged with a costly list of medications[1].

This is money spent unwisely in treating the symptoms of advanced diseases which

1 The pharmacy bill for the GMS is roughly twice the entire amount paid to doctors, and is mostly the result of Geriatric polypharmacy.

are still not being prevented in Ireland. Despite strong evidence of the value of prevention elsewhere, Irish health-policy makers remain obstinate.

**Conclusion**

This essay has attacked the GMS system currently in place in Ireland. It is clear that it runs contrary to the established foundations of any efficient health care structure.

By contrast, in a re-negotiation of the NHS Contract for English General Practice, incentives have been provided to GP's to carry out certain preventative measures. For example, they can earn an additional payment if they screen a target of 70% of women at risk in their practice for cervical cancer, and an even higher payment if they reach a 90% target. It is on the adoption of policies such as this that prospects for redress hinge.