“Spending in Health - the Evidence”

Some perspective

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Outline of Presentation

1. Key motivations in having SHA
2. What we learnt on private health related expenditures
3. Step to facilitate better use of health data
4. Summary key messages

Key motivations

- Historically no data available for Ireland so note-worthy to have an understanding on what we spend, where we spend it and who spends on health

- Without timely, relevant and accurate data
  i. Define & reward value in health system
  ii. Measure the success of various health programmes
  iii. Provide information for providers to meet needs of patients
  iv. Understand the flows within the health sector and compare ourselves internationally

Private health expenditure

Will limit myself to bringing out some of results from private sector.

Key points:

1. We need to be cautious about considering what is private expenditure:
    i. Is it all non-health expenditure including out of pocket expenditure or not?
    ii. Much of our services are provided by private agents working within public health system (e.g. Private income for consultants in voluntary & statutory hospitals)
2. Role of private healthcare has been underexplored for many years
3. Nonetheless, private expenditure data is a rich source of information as information within insurance industry means can easily track patterns of consumption for individuals across the system
4. Data collection often challenge for private sector element of SHA due to multiple parties involved, non-standardised data collection systems, lack of data
5. Often need use of survey work to supplement primary data collection (See OECD Health Working Paper No. 52). Each were used here.

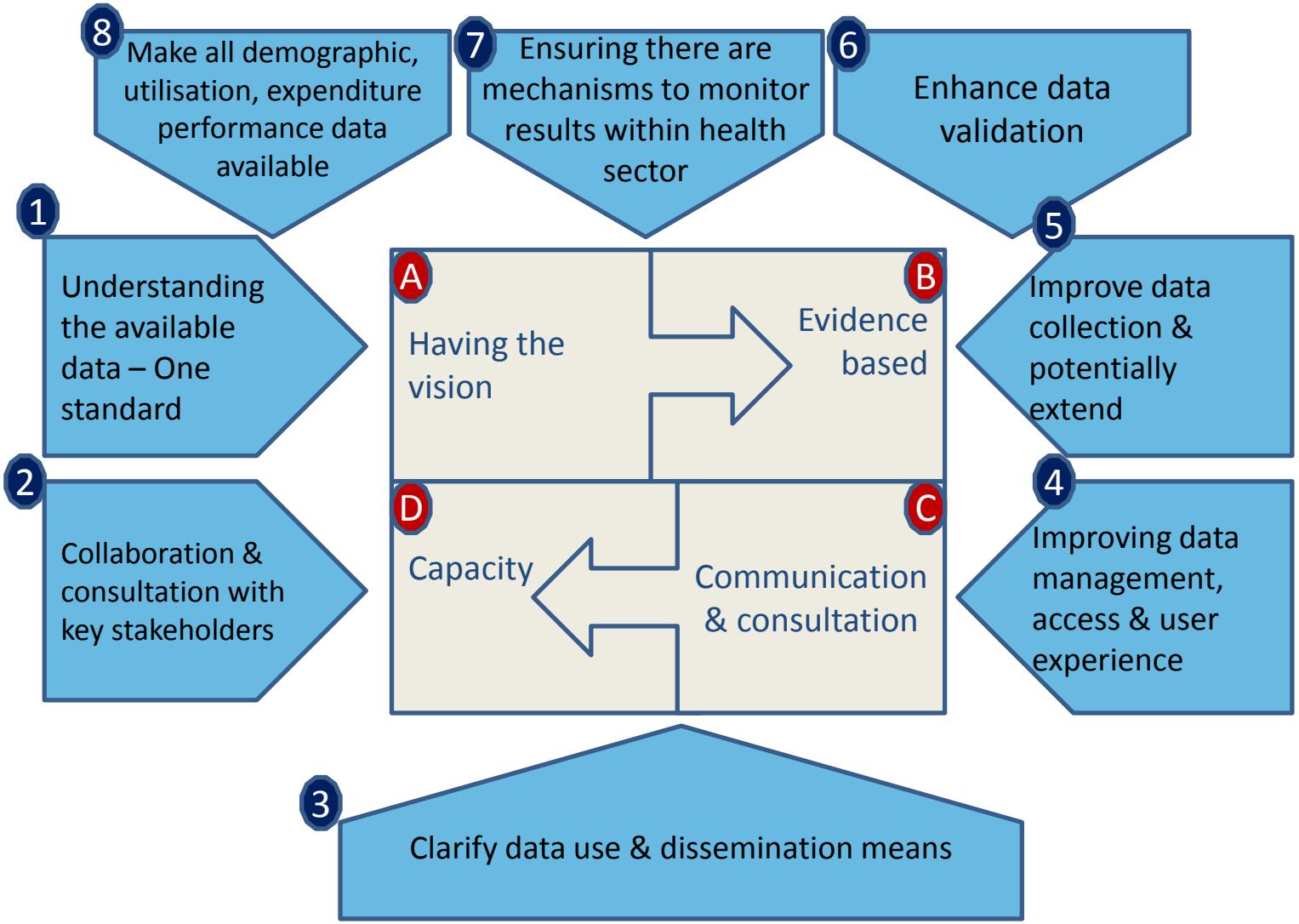
Private health expenditure

6. Confidentiality key issue, hence need for Statutory Instrument and independence of CSO
7. Importance of correspondence of data (accounting definition of accruals, ‘funnies’ (e.g. risk equalisation)

Key results:

1. 31% of expenditures in 2014 are non-government including about 13% from private insurance
2. 75% of health insurance expenditure were paid to hospital, equating to about 26% of total hospital expenditures.
3. Including out of pocket expenditures non-government expenditures about 28% of all hospital funding comes from non-government sources

The steps to deliver on overall goal of making better use of and extending access to health related data while meet our confidentiality requirements



Key messages

1. Having our SHA data is to be welcomed
2. Needs to be embraced as the standard for data comparison and potentially some potentially uncomfortable facts need to be accepted – It is now the standard
3. Our work has not finished we need to ensure quality of SHA on an on-going basis
4. We need to publish more data (i.e. Extend granularity of release need to be considered)
5. Potentially expand data collection (e.g. Demographic splits). Termed in literature as sub-accounts
6. Other related information needs to be captured accurately:
    i. Quality and performance data
    ii. Data relevant to measuring equity
    iii. Data relevant for measuring 'value for money' of what we spend
7. All of the above would allow us develop an actuarial health financing model to allow longer term projections of not just costs but funding options such as we have in other areas of social protection