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Compulsory Health Insurance-The Next Step?

By

Joe Durkan

UCD

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Compulsory Health Insurance: The Next Step?

Introduction

Everyone has a statutory entitlement to public hospital care. This entitlement cannot be met and is not met by public hospital services, as the existence of waiting lists and private hospital care in both public and private hospitals attest. The gap between performance and entitlements, the actual performance of the public hospital services in spite of ever-increasing financial allocations, and the current difficulties, all suggest that a different approach is needed to provide a hospital service that meets the needs of the population. This paper suggests one change.

Entitlements

Universal entitlement to public hospital care was introduced in 1979 when 21.8 per cent of the population held private health insurance (PHI), while full universal entitlement-including consultant services- was introduced in 1991, when 35.3 per cent of the population was covered by PHI. The situation now is that 42 per cent of the population have PHI. The extension of entitlements has thus been accompanied by an increase in the numbers purchasing health insurance rather than a reduction.

In fact entitlements are not being met, there are significant numbers awaiting treatment (and these numbers are not adequately captured by official waiting lists), waiting lists are affected by death, treatment- either public or private, new entrants, discouraged patients. The health services have created a new category of treatment - "elective" surgery as if people were casually seeking treatment, and the only benefit from treatment is "social gain", rather than "health gain". Health services have a particular approach to the elderly, where entitlements have been changed without discussion as in the case of long-term care, and in the case of hospital care of young children where the resources are obviously inadequate. The most recent budget replaced the Drugs Refund Scheme designed to reduce the costs associated with chronic conditions with a Drugs Payment Scheme as a consequence of which the costs for a very large number of people have increased significantly. Asthma
sufferers, those with heart problems, are among the groups, not covered by medical cards, affected.

**Why are entitlements not met?**

The Irish Healthcare System is characterised by a mixture of public and private entitlements to services. On the supply side, general practitioners offer services to both public and private patients; there are public and private hospitals - public hospitals cater for both public and private patients, and hospital consultants take public and private patients in public hospitals and also private patients in private hospitals.

The public/private mix in the Irish Healthcare System is often seen as not only unique in terms of scale, but also a major advantage. The particular advantage claimed is that it allows the best physicians to function in both areas of the market, so that the public system is not adversely affected by the loss of the best to the private system. Their public hours of work are governed by contract. Once this contractual obligation is met, they can function as private agents. There is thus an incentive for consultants to create waiting lists for treatment, in the expectation that since a significant proportion of the population have health insurance, people with a public entitlement to care will use their health insurance to pay for treatment. Such queue-jumping is now an integral part of the Irish healthcare system.

This public/private mix also affects public hospitals. They are allowed to take private patients up to certain limits. (These limits are unaffected by the closure of public wards). Private patients enhance hospital earnings, given their budgets from the State. There is thus an incentive for hospitals to increase the number of private beds, even though there is a public waiting list.

Furthermore, the average length of stay of private patients in private beds in public hospitals is longer than that of public patients. (There is also an incentive to reduce the average length of stay of public patients, as this impacts on hospital costs and can influence the public allocation of funds to hospitals via the casemix system). As the
charges for hospital stay are fixed by Government and are above the marginal cost of additional days of care for many patients, the hospital can enhance its resources by extending the length of stay for private patients.

The existence of a waiting list can be used as a control mechanism for public patients who are treated. The system has selected them while others are waiting, and hence they should be grateful. The existence of waiting lists further divorces the link, tenuous though it is, between tax payments by the individual and the receipt of services. The patient is being provided with services, rather than purchasing services. The terminology surrounding waiting lists (elective surgery referred to earlier) is an attempt to trivialise real suffering, and to ignore the benefits from treatment. Waiting lists, in the context of the scale of private provision of services, are the most obvious sign of the failure to meet the entitlements of the population.

In recent years entitlements have become further constrained. In a significant policy change, the notification for which was never made public, it has been decided that private patients in public hospitals should bear the full costs of their treatment. This explains why charges for private patients have risen so dramatically recently and why VHI premia have also risen sharply. In the recent White Paper several references are made to the subsidy to private patients in public hospitals, and to the notion that opting for private treatment is equivalent to forgoing public entitlement. In fact, in the White Paper it is stated (1.32) that:

"In the context of the 1991 changes, it was accepted that the public hospital system would continue to cater for the needs of private patients, based on the benefits accruing to the system from having a balanced mix of public and private practice. The eligibility arrangements introduced drew a clear distinction between patients availing of services as public patients and those availing of services as private patients. Patients are now required to avail of services as either public patients or as private patients and those who choose to avail of services as private patients are required to remain private for the duration of their care. In addition to this, patients availing of private hospital services have always been seen as availing of an alternative service to the public system."
As a description of a change this is somewhat less than accurate. It is not obvious that the principle contained in the first sentence was accepted by the population, since it was never put to them. It may very well have been accepted by the providers of services. This is the only sense that can be given to the remainder of the paragraph. It cannot make any treatment difference to patients, once they are being treated, whether they are public or private. The final sentence is simply wrong. Patients who opted for private treatment in public hospitals were not availing of an alternative treatment service- they were availing of the same treatment service, but getting it earlier, and having a variable accommodation service. This was and is a major feature of PHI-it provides resources for queue-jumping.

Of course the idea contained above lie at the heart of the justification for full cost charging. The private patient forgoes entitlement and hence must bear full costs. Interestingly, from such limited studies available to those not in the healthcare system, it is clear that private patients in fact do pay far in excess of the costs associated with their care in public hospitals, but the hospital does not recover full costs.

Insurers do not have access to complete cost information at present, which is one reason the present situation can continue. However, with the introduction of DRG based risk equalisation, insurance companies will have information on costs of procedures, and this may lead to significant differences in payment procedures. Some preliminary work could now be done using the Relative Values now available in the public domain (Appendix B, Risk Equalisation and Health Insurance in Ireland. Technical Paper on a Proposed Amended Scheme, Department of Health and Children, January 1999).

There is a much simpler approach to the question of entitlements. Rather than deprive people of their entitlements, assign a monetary value to entitlements based on the appropriate treatment category (DRG), and allow this to be transferable. If someone opts for private treatment in a public hospital, then there is an offset against the cost. If there are waiting lists in public hospitals then the patient waits, or goes to a private hospital for treatment, and carries the entitlement. (The DRG casemix basis of allocation is not as refined as is widely assumed, as within each DRG there can be significant differences in procedures and hence in costs, so that more work needs to
be done on this). Since the hospital is receiving the same payment from both public and private patients, and payments reflect costs, there is no incentive to maximise the average length of stay of private patients. Similarly public patients, faced with delays, could opt for private treatment, within the limits of their entitlement.

The advantage of the approach is that it would reduce waiting lists, but would cost the State more. However more fundamental change may be needed as a consequence of the dynamic instability of the health insurance market. Curiously, in the White paper it is suggested that the tax relief on health insurance payments continue. One reason given is that PHI contributes to the common good, while what is really meant is that it reduces state expenditure in relation to healthcare. The more obvious approach would be to eliminate the tax benefit and provide specific entitlements. Presumably the view in the White Paper was influenced by the Department's view about its own allocation from central funds.

**The Health Insurance Market**

Once there is a private healthcare industry the fundamental reason for a health insurance market is the existence of risk averse individuals, whose willingness to pay provides an opportunity for firms, whether private, public, not-for profit or for profit, to cover their costs. The premium, which is essentially the same for all members (though obviously differences can exist between companies offering health insurance) must cover the expected benefit to members plus the costs. If the gap between the premium, and the expected benefit widens, there will be a reduction in the value that people receive, and some will choose not to take health insurance.

The particular form that health insurance takes in Ireland is a pay-as-you-go scheme, where premium income in any year covers costs in that year. Where the structure of the insured population is stable over time this approach makes sense. In Ireland the structure is not stable. Where the insured population is ageing then the costs to all members rises over time, given that hospital expenditure is mainly age related. Hence the gap between the premium and the expected benefit will increase for potential new younger members, and this will reduce the number of new entrants. This does not
mean that there will be no new entrants, as people have different approaches to risk. It means that there will be less than otherwise. Hence the cost to existing members will increase, and this will widen the gap between the premium and the expected benefit. This is not a stable situation.

The current situation is complicated by what has loosely become known as medical inflation. Medical inflation refers to the characteristic of prices for healthcare increasing more rapidly than general price inflation. In recent years in Ireland medical inflation has been a multiple of general inflation. The principal reason for this is that there have been very significant increases in hospital charges for private patients. This enters directly into our measures of medical inflation, where people pay directly for hospital care, and indirectly through the effect it has on health insurance premia. When allowance is made for this medical inflation is very much less, and it reflects improvements in technology/drugs which are actually quality not price changes.

The position is complicated further now by the market difficulties associated with opening the health insurance market. The majority of people take up health insurance relatively early in life, and well before they make claims on the system. (The 60-year old joining now that he/she will need healthcare is not typical). In the present situation new entrants are likely to join either of the two companies offering health insurance. When we make some allowance for those who, for a variety of reasons were not covered by the VHI and who took out policies with BUPA, the numbers of new entrants by company is very similar. Given the stock of people covered by the VHI it is inevitable that BUPA will have a relatively younger age profile. Since the VHI operates a pay-as-you-go system it is no surprise that its premia have increased, and its relative position has worsened.

The White Paper does not consider the ageing issue to be serious, as it is estimated to add less than 1% per annum to costs. However, in the context of the premium cost to young members, and their expected benefit, this becomes significant over time. (The compound interest implications of the figures in the White Paper were obviously not considered). The implications of this are that over time the costs will continue to rise significantly in real terms. As costs increase, more young potential members will not
join health insurance schemes, and some existing members will drop out as costs rise. Since people will continue to need hospital care the demands on the public system will tend to increase. In fact the outcome is likely to be complex, as the state of the public health services also influences membership of health insurance schemes. In effect we cannot run away from the issue of entitlements. As with all potential crises there are serious policy choices.

**Policy Problem**

The initial approach to emerging policy problems is to ignore them, and then to try and patch up the existing system. However, when we consider the existing situation it is difficult to see it as an ideal system that needs some minor adjustment. The existing system was not planned, as the UK NHS was initially, but has come about over time, and in response to differing market, lobby and political pressures. There are many approaches to healthcare, from the fully private, to the fully public. None are without problems, mostly arising from variations of the principal-agent problem, but there are also issues of equity, and resource allocation.

Where systems are public aggregate decisions are heavily influenced by budgetary considerations, while micro decisions (type of treatment, time, etc) are influenced by the interests of providers. The principal agent problem is between the providers and the immediate source of funds. There are no great incentives to contain costs, though it may be possible to introduce some cost containing allocation rules, as with casemix. In the Irish case the Department is directly involved in running hospitals, which makes the regulatory function ambiguous, and indeed it has no regulatory function in relation to private hospitals. A consequence of the latter is that we have poor information in relation to treatment nationally. A wholly private system is likely to suffer extremes of the equity problem, which will ultimately require state intervention.
Reform or change in systems of healthcare are difficult to implement as beneficiaries of the existing system will resist change, while potential beneficiaries, viz. consumers, are dispersed and have little say. Yet it is clear, for reasons discussed earlier, that the existing system cannot continue. It is in this context that an alternative approach—that of requiring everybody to take out health insurance—may have some advantages.

**Compulsory Health Insurance**

Under a compulsory health insurance scheme everyone is required to have health insurance. This eliminates opting out which is a characteristic of voluntary insurance schemes, and prevents the instability referred to earlier. Contributions can be income related, as in Germany, or flat rate, with subsidies/transfers for those on low incomes. Because the system is insurance financed tax rates can be reduced. (Widen tax bands/proper tax credit). Insurance companies would compete for customers, and this competition would increase choice of company and range of products to suit different consumer preferences. Competition among insurance companies could result in HMO-type organisations, where internalising information could result in cost savings. Hospitals would compete for patients thus forcing efficiencies within hospitals. Patients would purchase services, not be given services, thus fundamentally altering the position of patient and hospital. Government would have a regulatory role, setting minimum standards, and conducting health audits to contain the effect of the principal agent problem. Additional costs associated with teaching hospitals and research would require separate funding by government. The attraction for government is that it removes government from the day-to-day running of hospitals, so that it can concentrate on its primary regulatory function. The attraction for patients is that it widens their choice and will reduce waiting lists. For providers of services life will become more difficult. This could be applied to GP services.

It is possible to come to the same conclusion in regard to compulsory health insurance by looking at the actual practice in hospitals, where there is effectively a two-tier system with ready access by private patients, but long delays by public patients. This
might lead policymakers to go down the route of a wholly public system. The merits of competition in areas previously considered wholly public sector are now obvious.

The White Paper rejects a mandatory social insurance health system, under the heading of Universal Health Insurance Coverage. Universal Health Insurance with compulsory health insurance is not the same as a social insurance based scheme. The White Paper does not fully appreciate that a compulsory health insurance scheme would be essentially a private scheme. The reasons for the rejection make it clear that the point has been missed. These reasons are listed below:

- the private system is capable of meeting future needs
- equity can be dealt with by administrative means
- no consensus
- other countries with social insurance based systems have similar problems
- more complex system
- radical overhaul would require resources which could be better used
- OECD said mixed system was OK

A compulsory health insurance scheme, as outlined above is a different product.