THE MARKET IN IRELAND FOR HEALTHCARE INSURANCE

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The healthcare market in Ireland is facing a series of problems arising from the dual nature of the market. Health insurance is an important element of this dual market. Yet the main issues confronting the health insurance industry – the ageing of the population and medical inflation – have not produced a set of insurance products in response. Subscribers thus face continued increases in charges well above inflation and these increased charges could well adversely affect new membership of younger people. The introduction of competition has not resolved this issue. Instead, it has concentrated attention on measures to maintain the existing situation. Some of the institutions associated with the regulatory environment, for example the Risk Equalisation Scheme, have their own problems; and while it is worthwhile to resolve them, it is more important to consider the long-term issues.

INTRODUCTION

Government in the 1950s established the Voluntary Health Insurance (VHI) Scheme, because of a failure of the market system to provide health insurance for those who were willing and able to pay for it. The market system failed to provide health insurance due to a lack of information in relation to the incidence and cost of treating illness, though in many other areas of life, e.g. house insurance and car insurance, this same lack of information did not deter firms. The situation in Ireland was not unique, as the history of the development of the US health insurance industry attests.

With the exception of some small schemes, the VHI since its inception has often been seen as enjoying a monopoly in the area of health insurance, on the basis of its legal status, at least until the advent of competition. However, while this was undoubtedly the case, health insurance is rarely sought for its own sake, but as a means of gaining access to health services and healthcare and paying for these. Given that entitlements exist to public care, and people have the option of paying directly for care, the monopoly element is somewhat reduced.
DUAL HEALTHCARE SYSTEM

In fact, the continuance in operation of the VHI and the growth in the number of subscribers and members reflects the true nature of health insurance in Ireland. What health insurance provides, in the majority of cases, is faster access to health services – services that people have entitlement to in any event. The fact that health insurance can deliver quicker access derives from what is often seen as the truly unique characteristic of the Irish healthcare system, namely the dual public and private role of many of the agents in the system. Public hospitals have public and private beds, hospital consultants can have public and private patients, and can function out of more than one hospital, and in public and private hospitals.

This dual nature has often been justified on the basis that without the possibility of private earnings, the best consultants would migrate from the public system, and if the healthcare system were wholly public, would migrate to other countries. It is difficult to see how a logical possibility could generate a system in the absence of analysis. The same logic could be applied to a whole range of professions, yet large outflows have not occurred. It is also difficult to see how the UK’s National Health Service (NHS) retained its pre-eminence for so long, given that employees were effectively salaried, though there may be other factors in the UK where some consultants have opportunities for overseas work to supplement income.

CURIOUS INCENTIVES

This dual system creates incentives that can influence behaviour. Both the hospital consultant and the public hospital have an incentive to lengthen waiting lists among public patients. The former since, if these public patients become private patients, the consultant’s income is enhanced; whilst hospitals can generate increased revenue if the number of private patients is increased, and, of course, budgets may increase due to public pressure arising from waiting lists.

It can be shown that the number taking up VHI membership is inversely related to public health expenditure (Durkan and Thorn, 1995). In periods when public health expenditure was curtailed, there was a tendency for VHI membership to rise. This inverse relationship is not directly observable, but is derived from a model explaining the demand for health insurance, where the relevant, estimated coefficient is negative. The public manifestation of curtailed public health expenditure is of course rising waiting lists. In the cutback period of 1987-1989 another phenomenon was observed. Many people with VHI membership had previously exercised their public entitlements, but, in the face of cutbacks, had then exercised their VHI entitlements. As a consequence, health
expenditure did not fall as much as initially expected; there was a shift from public to private. This shift, in turn, was one factor behind the financial difficulties experienced by the VHI during that period.

LIMITED ENTITLEMENTS

It is reasonable to ask why a State would create care entitlements for all and then provide facilities for some to gain quicker access to services. Part of the answer to this can be seen from the way the VHI operated. Although a monopoly (subject to the caveat noted earlier), the VHI never functioned as a classic profit maximising monopolist. Its operating objective could be described as follows: to maximise membership, subject to not making a loss. As the demand for health insurance is relatively price inelastic, this objective has not maximised profit, or revenue, but membership. The reason for concentrating on membership is to reduce the claims on public services.

It has often been observed that the existence of the VHI has increased the resources devoted to healthcare. If the objective were simply resources, maximising membership is not the appropriate target. However, there are reasons why maximising revenue might appear to be an inferior target to policymakers. Maximising revenue could be achieved by much higher charges to members. This would reduce the total number of subscribers as well as increasing revenue. The public hospital system might capture very little of the increased resources and more people would be claiming their public entitlements.

This is only part of the answer to the question posed earlier. The rest may lie in the relations between agents in the system and how these have evolved over time. The healthcare system is characterised by special interest groups. How these react between themselves and with government may provide a more complete answer.

COMMUNITY RATING

The system of health insurance that has developed in Ireland has been based on community rating rather than risk rating and on annual contracts rather than lifetime contracts. Community rating can be contrasted with experience rating. Community rating sets premia based on the risk characteristics of the entire membership of the scheme, and involves cross-subsidisation from low-risk to high-risk groups. In Ireland this results in a single premium across all age groups and other risk characteristics. Experience rating, on the other hand, sets premia based on risk categories, such as
age, gender, occupation, medical history. As a consequence of the community rating model premia are identical for all members of the VHI, with some difference for those under 18 and for members of group schemes. The rationale for the latter derives from reduced costs of administration of many, though not all, group schemes. Although the VHI and now BUPA have annual contracts, they cannot terminate or refuse to renew contracts (except in exceptional circumstances), so that in effect there is lifetime cover, though premia are variable.

This community rating approach has involved open enrolment without reference to age, gender, geographic location, or occupation. The rationale for the application of community rating here derives from notions of fairness – people should not have to pay more for healthcare because they have a greater likelihood of illness. However, this is more an argument for compulsory health insurance than for the voluntary nature of health insurance. Even within the Irish system there are better ways to deal with hard cases; and indeed the public healthcare system attempts to do precisely this, in many though not all cases.

The difficulty with community rating as applied in Ireland is that people can delay membership until quite late in life, when they are more likely to require healthcare and are subject to the same membership costs as those very much younger. As a consequence, premia for all will increase to reflect increasing claims experience. For those relatively young, given the increased cost of health insurance in relation to their current potential claims, there is an incentive to abandon health insurance or not to take it up until later in life, and this in turn will push up premia even more. In practice, this seems only to have happened at the margin, but it could become an important issue given the very large increases in premia over the past few years, and given the reduction in the tax benefit associated with health insurance payments.

A secondary issue is the impact of an ageing population, as this will push up premia even more, and act as a disincentive for younger people to take out health insurance. While this is not so much an immediate concern now, consideration needs to be given to the impact 20 years down the road of this ageing process.

**FUNDED AND UNFUNDED HEALTH INSURANCE**

This issue can be seen more clearly in relation to annual contracts for health insurance. In effect, health insurance is treated as very similar to car insurance. The individual has an annual renewable contract with the health insurance company. The VHI operated a Pay-As-You-Go (PAYG) system. However, with a PAYG system, you require a stable membership structure to maintain premia, assuming relative prices are static. If the
membership is ageing, premia must of necessity increase over time and, as indicated earlier, this increase will discourage membership of younger people.

However, the environment is not a stable one and the situation is of course exacerbated by medical inflation. A PAYG system was initially attractive as it kept premia low, but it involved inter-generational transfers, while many participants saw the system as inter-temporal, and believed they were purchasing rights into the future. Thus, much of the current membership subsidised older members in the past, but are now being asked to pay the full costs for themselves. Had the system been funded, the fund would now contain many billion, depending on the assumptions in relation to medical inflation.

**MEDICAL INFLATION**

The situation is further exacerbated by what is known as medical inflation – the tendency of the prices of healthcare products to rise faster than general prices. However, the term seems far too loose to capture what is going on in healthcare. Where we have administered prices, as in the case of private beds in public hospitals, these prices reflect what government decides, and this in turn can be based on a desire to increase revenue. There is no market that can validate these charges; though for some procedures, private hospitals are an alternative. Where products have been standardised as is the case with many drugs, relative prices have probably fallen. Where new products and new technologies have been developed – in the process changing the outcome for patients – the effects of prices and quality have not been disentangled.

The range of services available for patients has also increased. Hence, medical inflation is picking up not just relative price shifts, but also increases in the cost of healthcare that reflect changes in quality. It is unrealistic to think that technology will be frozen in time, or that a particular health service can decide this is as far as they are willing to go. It is equally unrealistic to think that relative prices in healthcare can continue to rise by 4% to 5% per annum forever – it does not take very long for all output to be devoted to healthcare.

**HEALTHCARE INFLATION AND GENERAL INFLATION**

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital Charges</th>
<th>Medical Fees</th>
<th>Medicines &amp; Drugs</th>
<th>Other Medical</th>
<th>Consumer Price Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975(Nov)</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>1980</td>
<td>151.4</td>
<td>197.0</td>
<td>190.5</td>
<td>191.7</td>
<td>187.3</td>
</tr>
<tr>
<td>1990</td>
<td>986.9</td>
<td>510.6</td>
<td>411.9</td>
<td>532.5</td>
<td>393.0</td>
</tr>
<tr>
<td>1994</td>
<td>1347.4</td>
<td>641.1</td>
<td>461.9</td>
<td>649.4</td>
<td>434.0</td>
</tr>
</tbody>
</table>

Source: Central Statistics Office
Even in the Irish system the effect of medical inflation can be seen, as the Consumer Price Index includes private healthcare expenditure. The following table summarises the main trends. It is self evident that prices of healthcare services and products have risen more rapidly than general prices.

Given that the population is ageing, it is inevitable that the cost of health insurance with a PAYG system will increase in real terms, and that this will discourage younger people from entering health insurance schemes. What the present system requires for its continuance are inter-generational transfers from young to old. These may not be forthcoming, however.

WHAT CONSUMERS WANT

This prompts the question as to what people are seeking from health insurance. There are really two parts: the first is cover in the case of a major unpredictable family/personal catastrophe, while the second is cover in old age when most hospitalisation occurs, though obviously not for everyone, or in the case of terminal illness. The first is a classic insurance issue, while the second combines an insurance element as well as a savings element; in other words, a funded scheme. This latter, which involves inter-temporal transfers, is not currently on offer. Had health insurance been seen in this light, it is unlikely that insurers would now be facing into such rapid increases in premia. Furthermore, it is unlikely that people would delay joining a health insurance scheme as clearly an individual premium would have to be related to age at joining.

There is a belief that a health insurer could never have offered such a scheme, but pension funds do precisely this in relation to pensions. For the VHI there were clearly problems, given the fact that it is a State company. Attempts at funding, in the face of a fiscal crisis, could easily be doomed if government regarded the fund as its own, or if charges for VHI subscribers in public hospitals were increased dramatically. It is difficult to argue that you should not fund because this might encourage government to behave foolishly. The more appropriate response is to take it out of the hands of government altogether. Funding could allow for some element of medical inflation. Having said this, it is difficult to see how the current system can be modified, as any insurer offering such a product would face relatively high charges for new entrants at first, against the promise of lower charges later.

HEALTH INSURANCE AND COST CONTAINMENT

Since the early 1980s in particular, the VHI has performed another function in relation to health insurance. It also sought to contain costs, particularly in relation to private hospitals. It was not simply a passive agent meeting the costs of healthcare and
adjusting premia accordingly. Indeed, for many subscribers the VHI was performing a
necessary and useful function. There was information in relation to hospital costs and
consultants’ charges not otherwise freely available. Ultimately, the VHI was seen as an
active agent on behalf of subscribers, providing full cover, and ensuring that costs were
reasonable through its ability to negotiate with hospitals and consultants.

This latter function came under threat with the judgement in the Ballinderry case, where
the VHI was seen as a monopsony purchaser of healthcare for its members and
abusing its dominant position. If the VHI can no longer act to contain costs, then premia
would be determined by the costs of healthcare as determined by the suppliers. Without
a high degree of competition between healthcare suppliers, this could only result in
increased premia and the situation could become very much like the US before the
emergence of Health Maintenance Organisations where insurance premia increased
continuously. Faced with a situation where the VHI cannot use its power to contain
costs, it will be forced to fix limits on its cover, with members paying additional costs
directly – balance billing or, more accurately, co-insurance. Co-insurance will
fundamentally alter patients’ views in relation to where they will go for treatment, and
possibly, to a lesser extent, the consultant. It has been argued that this function
inevitably implies that the VHI should become directly involved in hospital ownership, as
only then will it be in a position to know and determine costs.

THE ADVENT OF COMPETITION

The position of the VHI in health insurance was fundamentally altered by the Third
Directive on Non-Life Insurance, which came into effect in mid-1994, and by the
domestic Health Insurance Act of the same year. While requiring competition in the
health insurance market, the EU Directive accepted the need for regulation in that
market.

The Irish legislation sought to maintain the community rating system where
subscriptions were similar for everyone and where no one could be excluded from cover.
The mechanisms used to achieve this involved the creation of a Risk Equalisation Fund,
a requirement that those covered would be offered a minimum level of benefit and a
requirement that no individual could be refused cover, except in special cases. From a
competition perspective, these requirements would limit the degree of competition.
Effectively, a new entrant would be obliged to offer basically similar products to those
currently being offered by the VHI. This was confirmed by the failure of BUPA to have its
initial set of products accepted. The whole procedure surrounding the failed launch of its
initial products seemed very ad hoc and ultimately acts as a barrier to entry for any
potential new entrants.
RISK EQUALISATION SCHEME

The Risk Equalisation Scheme is designed to ensure that no company offering health insurance derives any benefit by attracting those who, by virtue of age or gender or claims frequency, are less likely to make claims. It attempts to equalise risk across insurers by imposing the market structure on all insurers. Firms with lower than average risk profiles are obliged to make payments into a Risk Equalisation Fund, while those with the opposite are to receive payments from the Fund. The principles behind the Scheme are clear, but the actual operation can give rise to difficulties. These arise in relation to the timing of the operation of the Fund, the size at which payments begin to apply, the level of benefit in relation to the formal plan to which insured people belong, the impact of efficiency in relation to hospital charges, and a variety of other issues.

The regulations in relation to the Risk Equalisation Scheme specify a delay in its operation, thereby creating an opportunity for a new entrant to select some target groups believed to have lower claims. This delay can allow a firm to enjoy non-trivial investment income before transfers into the Fund take place. Secondly, the maximum benefits specified in the rules are based on 1995 data and simply require updating on a regular basis. Thirdly, the use of actual claims payments for purposes of the Risk Equalisation Fund does not differentiate between differences in actual payments arising from benefit reduction and cost reduction.

There was a great deal of debate about the issue of cherry picking before the competition commenced. However, even if the profile of new members to BUPA is exactly the same as the profile of new entrants to the VHI, the average profiles must be different because of the existing stock of members in the latter. The Risk Equalisation Scheme is currently under review and there may well be changes to reflect the above concerns.

THE OUTCOME OF REGULATED COMPETITION

It is easy to see why the health insurance market should be regulated. The reasons derive from the peculiar nature of healthcare, where, in spite of increased sophistication among the population, there is still much ignorance in relation to illness, different treatments, possible and likely outcomes, charges and overall costs. These are quite different to those cited in the EU Directive and are further complicated by concerns with adverse selection and moral hazard. However, the form of regulation adopted here guarantees that the products offered by firms will be very similar – in other words consumer choice will remain constrained. One of the main advantages that comes from competition is a widening of the product range as firms seek to capture niche markets.
This will be stultified in the present climate, though there will be some change at the margin, as is currently the case. Charges to customers will be very similar. While much is made about differences in prices between the two insurers at present, the differences are not major, and it is not obvious that they will persist. Given the regulatory environment and the similarity in products the expectation is that prices will roughly equalise.

COMPETITION AND LONG-TERM ISSUES

In the debate about the introduction of competition, the question arose as to the impact of new entrants on price, particularly in the light of the recent increases in VHI charges. Competition was expected to reduce the rate of increase in prices and perhaps lead to a reduction. However, this was an unwarranted expectation. Given the operating objective of the VHI (maximise membership, subject to not losing money), it was difficult to see how new entrants could match prices for equivalent services, unless they were similar-not-for-profit organisations, or there was some massive inefficiency on the part of the VHI. Furthermore, given the effect of the Ballinderry case, the likelihood remained that charges by hospitals would increase, and that the VHI would be obliged to increase premia, or to move towards some form of co-insurance. Competition was also to be regulated to ensure that the products offered by firms were relatively homogeneous.

The question of the continued increase in healthcare costs, and the driving forces behind this, did not surface. There are now two companies facing into the problem of an ageing population and the impact this will have on charges to subscribers, in the context of medical inflation. The problems remain the same.

CONCLUSIONS

This paper addresses the consequence of the supposed unique characteristics of the Irish healthcare system, namely the mix of public and private healthcare and the relationship between the two. The health insurance industry facilitates the link. As long as the VHI was a State monopoly, the VHI could pursue a policy of maximising membership (subject to not making a loss), which had certain advantages from a public policy perspective. Why the State would create entitlements to care and not deliver the product is unclear, however.

The VHI operated a PAYG system, which took no account of the ageing of the population, rather than a funded system. The consequence is that those currently insured subsidised an earlier generation, but must now finance themselves. This
inevitably will lead to increased premia and will act to limit new membership from younger people in the population. This problem will be worsened to the extent that medical inflation exceeds general inflation.

Competition in the health insurance market does not address these issues. In fact this competition diverts attention from the long term. One of the main institutions of the new competition is the Risk Equalisation Scheme. Although operational for a very short period only, it is in need of reform. This may come, but it leaves the fundamental problem unaddressed.

It is clear that, were things to start all over again, the health insurance industry would be very different. It would be funded, and the principle of community rating could be preserved by establishing different premia based on age at entry. However, moving from where we are to that now seems impossible. A more thoroughgoing reform of the whole system, both public and private, is necessary, rather than the ad hoc measures so typical of policy in Ireland. A comparison of healthcare delivery systems in other countries reveals a wide variety of models. There is a tendency to see these as culturally determined, but they largely reflect an ad hoc approach also, driven by problems. However, some do work better than others, and it is these that should be looked at, and adopted, even if it involves disturbing special interest groups.

REFERENCE