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Competitive Health Insurance: The Implications of
Removing the VHI Monopoly

by
Moore McDowell

Policy Paper No. PP89/2

February 1989

The Policy Paper series of the Centre for Economic Research consists of preliminary reports on policy-oriented research carried out by members or associates of the Department of Political Economy, University College Dublin. All opinions expressed are those of the contributors and do not necessarily reflect the views of other members of the Department. A complete list of other publications of the Centre is available on request.

An earlier version of this paper "The VHI and 1992 : The Case for Competitive Structures", was delivered to a Seminar on Health Insurance organised by the Irish Hospital Consultants Association in Dublin, January 28, 1989.
The role of voluntary insurance in financing health-care, and the appropriate market structures for an efficient health insurance system deserve careful consideration by the Government in deciding on its response to current problems of health finance and to the problems of the insurance sector post 1992. It seems likely that the response to both problems will take the form of an attempt to shore up the protected position of the V.H.I. The purpose of this paper is to demonstrate that such a response would be mistaken, given the implications of monopoly and competitive structures in health insurance.

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PART 1: INTRODUCTION

The financial problems of the health sector are to a great extent the result of changes affecting the supply side of health-care in this country and elsewhere. Technical developments in surgery and breakthroughs in biotechnology are, perhaps, the most publicised aspects of these changes. Just as important, however, are developments in the area of preventative medicine: the growth in knowledge of the impact of diet, lifestyle and environment on the quality and length of life.

These have resulted in a revolution in the conditions affecting the supply and cost of effective medical treatment, and call into question the continued viability of structures designed to meet yesterday's perceived problems. Simultaneously, there is clear evidence of rapid growth in the demand for health-care relative both to income and population. The search for cost-containing scale economies has changed the face of the hospital sector as hospitals grow in size and shrink in number.

In recent years the financial position of the health sector has steadily deteriorated. At first the problem appeared to be confined to the tax-financed public health sector. More recently, however, it has become clear that the private sector is in similar difficulties. These difficulties reflect the rise in demand, increased technological complexity, the rise in supply costs and institutional inadequacies in the health-care sector. An understanding of their economic aspects is vital if the sector's financial problems are to be solved.
The principal factors affecting the demand growth for health-care in any economic system are: (a) income per head; (b) demographic factors; (c) changes in fundamental medical technology. It is well established from both cross-section and time series research that the income elasticity of demand for health-care exceeds unity. Expenditure on health is, therefore, predicted to increase as a proportion of GNP as the latter rises unless quantitative restrictions are imposed by government. If the average age of the population rises, cet. par., demand for health-care will rise, too. Changes in medical technology shift the demand for health-care: in the first place, new medical techniques increase possibilities for successful treatment, creating new demands for treatment; secondly, medical advances improve life expectancy which through its impact on the age-structure of the population creates a feedback mechanism whereby improved health creates increased demand for health-care. As real incomes rise, qualitative changes in the composition of medical treatment take place. Expensive treatment of non-life-threatening conditions (for example hip replacements) becomes more common. While initially, these may not impose a strain on health finances (being privately funded), inevitably political pressure will lead to their being extended to the public health sector and consequent problems for the finances of that sector. This is even more the case with treatment of life threatening conditions, as the demand for open-heart surgery demonstrates.

The increased complexity of medical care is expected to increase the demand for health-care through yet another mechanism. Asymmetry of information between the consumer (the patient) and the supplier (the health professional) increases. The latter, whether responding to ethical precepts on treatment or to the fact that the cost of treatment to the patient is usually low or even zero at the margin, or to a less worthy but under-
standable desire to raise his own income, has an incentive to increase the quantity and quality of medical treatment even when the marginal benefit to the patient is low or zero and is certainly less than the marginal cost. This is usually referred to in the literature as physician-induced demand. The growing capital and research intensity of medicine increases the impact of these demand-side effects on the costs of health-care.

Increasing demand and rising costs can be reconciled only by either rationing treatment or by increasing expenditure or by some combination of the two. If expenditure is to increase, it is unrealistic to expect patients to meet soaring per unit costs of treatment on an out of pocket, pay as you use basis. Those who want or feel they will have to pay for private care are likely to insure against the potentially catastrophic wealth consequences of modern treatment. Political considerations of income distribution make some form of tax-financed health-care for the less well off inevitable. The shift to tax and insurance financed medicine in turn produces yet a further increase in demand and costs (1). On the demand side, the consumer now faces a low or zero cost of treatment. On the cost side, indemnity based finance and physician self interest combine to raise the unit costs of treatment above the level which would otherwise obtain. Finally, a tax/insurance financed system is bound to exhibit excess demand and queues unless the Government is willing to meet any expenditures required by patient or physician on demand. Excess demand implies an element of professional market power, and upward pressure on professional remuneration.

Hence, against a background of rising supply costs and income-induced demand, the question of market structures and institutions in both health provision and health finance assume crucial importance as determinants of the cost, quality and distribution of med-
ical care. In the context of 1992, the issues posed for the health insurance market are much more important than simply whether or not it's in general a good thing to have a state controlled monopoly supplier of a particular, although socially sensitive, commodity.

PART 2: FINANCING HEALTH CARE: THE ROLE OF THE V.H.I.

When the V.H.I. was established it was expressly designed to be a complement to a state financed health service which concentrated on providing care for the less well off (2). Its quasi-monopoly position was justified by the government and accepted by the opposition on two grounds: (a) a monopoly was needed to ensure public confidence that the V.H.I. could and would survive; (b) it was needed to ensure widely available insurance on a community rated basis (3). This would enable the board to cross-subsidise higher risk groups from actuarially excessive premia charged to lower risk groups. This would be impossible due to adverse selection difficulties if the board faced competition. This second reason remains the cornerstone of the argument for maintaining the V.H.I.'s monopoly today, at least officially. Another, possibly the real, reason for the Government's apparent reluctance to contemplate a competitive health insurance market, is to be found in the Government's relations with the V.H.I. Under the terms of the 1957 Act which set it up the V.H.I. is explicitly subject to Government control in matters affecting the Board's range of cover, its benefits and the level and structure of its premia.
Furthermore, in terms of its operating procedures, it is very much dependent on the cost implications of Government policy with respect to the state-financed health sector. In particular, maintenance expenditure by the Board is partly dependent on the level of state support from the Exchequer for public beds in the public and voluntary hospitals. In recent years it has, on government instructions, extended benefit cover to medical expenses which are not properly considered insurable risks: normal maternity expenses and drugs for established chronic illnesses such as asthma.

This relationship is not that of a regulatory Government with a state protected health insurance agency. It resembles more a relationship between a Government and a body charged with raising the necessary revenue on a semi-voluntary basis to finance a sector of a state health service. Evidence that this is indeed the case may be found in the assertion of the Secretary of the Department of Health that the V.H.I. is "an arm of Government social policy"(4). Whatever the characteristics of the insurance service the V.H.I. might offer as a non-profit independent state insurance corporation, its current operations and performance must be regarded as reflecting the implications of meeting the demands of "public policy".

This implies that the question of the economic efficiency of the Board's operations has to be looked at in a broader context than its financial returns. It has been operating as a source of regulation at one remove, whereby the Government seeks to influence prices and quantities in both the insurance market and the market for the supply of medical care. In a competitive market it might be acceptable to measure the efficiency of the V.H.I. by examining its administrative costs. In terms of that criterion, the Board appears to operate very efficiently indeed. By international standards its admin-
istrative costs are quite low, and have been declining. V.H.I. disbursements have averaged about 92% of premium income over the last decade. By way of comparison, PPP in the U.K. claim a ratio of 85% in their promotional literature, and the average ratio over the U.S. health insurance is of the order of 90%. A high disbursement ratio, of course, might merely reflect actuarial underestimates of claims. In a competitive market this would mean eventual financial failure, as has already been experienced in Ireland in the P.M.P.A. and I.C.I. collapses. Where the market is a monopoly with substantial regulatory intervention by the Government it is not possible to draw much by way of conclusion about the efficiency of an insurer from the disbursement ratio alone. Specifically, it offers no direct evidence on whether the service supplied is what the customers want, or on whether the costs of insurance and/or health-care financed by the V.H.I. is higher or lower than it might be otherwise.

There are two aspects of the Board's operations which have recently been identified as sources of its financial difficulties and which illustrate the problems of evaluating the efficiency of the V.H.I. These are the "Blackrock Clinic" problem and the drugs refund scheme. There has been considerable press comment to the effect that the financial problems which surfaced in 1988 in the V.H.I. were due to the unexpectedly high cost to the Board of meeting claims from members who took out cover for treatment in the new, expensive private clinics in Dublin. During 1987 and 1988 there was controversy over whether a similar clinic might be established in Cork. The V.H.I. effectively stopped the proposal by making it clear that it would not make insurance cover available. To the outside observer the alleged difficulties with the Dublin clinics and the determination not to permit the emergence of a similar clinic in Cork were difficult to understand. After all, if the customers were willing to pay premia sufficient to cover the charges of these clinics in sufficient numbers to make the clinics financially viable, why should
the V.H.I. worry?...unless, that is, it emerged that the V.H.I. had effectively given the
clinics a blank cheque in negotiating reimbursement rates. If that were the case, then
the Board would have failed doubly: it would have made serious underwriting errors,
and would have failed in its obligation to its customers adequately to monitor the cost
of delivery of health care so as to minimise the cost of treatment per quality-adjusted
unit. In a competitive insurance market such errors if continued would result in finan-
cial collapse. It is reasonable to conclude that the difficulties of the V.H.I. in so far
as they are related to the high cost clinics offer prima facie evidence of seriously
deficient management decision-making and cost control.

It is, of course, possible that the apparent underwriting failure is due to the impact of
regulation. Perhaps the V.H.I. was effectively unable to charge realistic premia because
of Government intervention in the Board's pricing policy. If this is the case, presumably
the V.H.I. can make that information available. There is no doubt that at least some of its
recent financial difficulties are the direct responsibility of the Government: the Board
has incurred major expenses in covering uninsurable risks related to maternity and
chronic illness. Its capacity to meet these costs through cross-subsidisation has been
limited by both government reluctance to see premia rise and, in the end, by the threat
of reduced take-up of cover by the public.

Further evidence of problems that are internal to the V.H.I. rather than due to outside
interference is to be found in the underlying cost problems it is facing in operating its
community rated premium system. Until recently the annual report of the V.H.I. con-
tained some very useful data on the non-financial side of its operations, namely a table
giving the age profile of its subscribers. This was discontinued in 1984. When data for
the financial year 1983-4 are compared with the population figures from the census of 1981, the following picture emerges:

<table>
<thead>
<tr>
<th>AGE</th>
<th>V.H.I. 1983/4 %</th>
<th>POPULATION 1981 %</th>
<th>(1)-(2)</th>
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<tr>
<td>0 - 14</td>
<td>31.3</td>
<td>30.3</td>
<td>+1.0</td>
</tr>
<tr>
<td>15 - 23</td>
<td>8.7</td>
<td>9.5</td>
<td>-0.8</td>
</tr>
<tr>
<td>25 - 34</td>
<td>15.5</td>
<td>13.8</td>
<td>+1.7</td>
</tr>
<tr>
<td>35 - 44</td>
<td>14.8</td>
<td>10.4</td>
<td>+4.4</td>
</tr>
<tr>
<td>45 - 54</td>
<td>10.5</td>
<td>8.7</td>
<td>+1.8</td>
</tr>
<tr>
<td>55 - 64</td>
<td>7.9</td>
<td>8.3</td>
<td>-0.4</td>
</tr>
<tr>
<td>65 - 74</td>
<td>4.2</td>
<td>6.9</td>
<td>-2.7</td>
</tr>
<tr>
<td>75 +</td>
<td>1.4</td>
<td>4.0</td>
<td>-2.6</td>
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In the early 1980s the V.H.I.'s subscribers' age profile was biased (relative to that of the population) towards the age groups in which the incidence of sickness is lower. Even if population mortality rates applied to the insured population (unlikely, since the insured population has a higher average income than the population as a whole, and mortality is negatively correlated to income) the average age of the subscribing population would rise relative to that of the population as a whole. Given a higher survival rate of higher income groups, this trend is likely to be enhanced. The average incidence of illness in the insured population will rise as the insured population ages. Hence the costs of the V.H.I. are predicted to rise more rapidly than health.
costs for the country as a whole over the next 10 to 15 years. On average, therefore, V.H.I. subscriptions will have to rise relative to the average cost of medical treatment.

Not only does this mean a perceived fall in "value for money" for any given premium, but it increases the degree of cross-subsidisation between age groups within the V.H.I. If price-responsiveness means anything, one can predict a fall in the numbers choosing to join the V.H.I. and/or a fall in the level of cover opted for on average. This will further worsen the Board's financial position since, by and large, new subscribers are in the young adult age group which, on community-rating, subsidises the older members.

Given the evidence that all is not well with the voluntary insurance sector of health care, and that this appears to reflect more than transitory problems of finance, it's not surprising that the question of the role and structure of insurance financed health care should become a matter of policy debate. The debate centres on two issues: the scope for voluntary insurance in the health system, and the structures which are appropriate, given whatever role is assigned to voluntary insurance. The second of these is the principal issue addressed in this paper, but some reference to the first is unavoidable.

The most recent attempt at an authoritative analysis of this aspect of health-care finance in Ireland was the E.S.R.I. policy paper on the subject which appeared last autumn (5). The author concluded amongst other things that private insurance is unsuitable as the principal method of financing health care on a national basis. The likely gaps in coverage that would emerge unacceptable political and social problems, or else would give rise to a level of free riding on the system that would threaten its financial viability. Experience in the U.S.A. does not fully support that line of argument, but it is
probably the case that political considerations of an ideological nature rule out primary reliance on private insurance here as in the U.K. In addition, pressure for a degree of harmonisation of health and social security arrangements among the member states of the E.C. makes it unlikely that such a change in this country's health finance arrangements could be put on the political agenda. To that extent, sustainable or not, Brian Nolan's criticism of the role of private insurance is irrelevant. To the extent, however, that it may be taken as ruling out ANY expansion of the insurance sector, it is open to serious questioning as to the degree to which the evidence he cites supports his view that insurance ought not play a substantial role in health finance, and that increased competition in the health insurance market may not be desirable.

In the first place, if the insurance sector does not expand to meet the predicted increase for health care, the burden on the already overloaded tax financed sector is bound to increase. If the Government does not dramatically increase tax-based funds to the health sector, the quality of service must decline through congestion. Given the accepted need to hold down taxation and public spending, it's difficult to see how a major expansion of the public health sector can be viewed as feasible. In the second place, the present health insurance and health supply structures are clearly in need of reform, and, as will be explained below, greater freedom of competition offers some hope of providing a more efficient, responsive and cheaper method of insuring against given medical costs, as well as improving society's ability to contain the growth of those costs.

This is very very important. I cannot stress the importance enough!
PART 3: MONOPOLY AND COMPETITION IN HEALTH INSURANCE:

ALTERNATIVE STRUCTURES AND THEIR IMPLICATIONS.

If, as already pointed out, the V.H.I. has very low administration costs, what efficiency gains might be expected from increased competition? Three possible sources of improved efficiency are suggested by economic theory and by experience.

1. A wider range of options and different prices for health insurance.

2. A mechanism providing better controls on the growth of health-care costs under present supply structures.

3. Changes in the supply structures in health-care provision.

(1) The range of cover and the cost of cover offered by the V.H.I. reflect its status as a non-profit, regulated monopoly. This status was established precisely in order to permit it to offer a particular type of insurance cover. With the approval of the Government it has offered low/zero coinsurance, community-rated, limited indemnity cover contracts. This means that the insured person

(a) is covered by costs incurred by him on an agreed basis, subject to certain limits,

and to a maximum ceiling in relation to certain types of spending;

(b) subject to these limits, carries none of the risk;
(c) pays a premium based on the overall risk incidence of the community regardless of his own health experience or statistical prospects.

Absence of **coinsurance** increases the **moral hazard problem** facing any insurer. The policy holder has no incentive to **limit the costs incurred** (5). Consequently, the V.H.I. must establish a **maximum schedule of unit prices for treatment and maintenance by the suppliers in advance.** The number of units and type of treatment or maintenance is left in effect to the supplier and the insured to determine. Where **maintenance** is concerned, neither of these bears the incremental cost of service.

In the case of surgical and anaesthesia costs there is an unusual and to an extent unpredictable element of coinsurance. Cover is only provided up to a **maximum amount per treatment per insurance fee unit.** It is not immediately obvious to the insured how much cover he is taking out, since the Board does not publicise the rates it will pay per insurance unit for different procedures. Worse still, there is no way he can easily establish what the expected cost of any procedure is. The V.H.I. claims that its payments per unit are based on average costs of treatment, implying that the **maximum permitted number of units - 30 - offers 100% cover for expected costs.** A lower number of units would then involve an element of coinsurance. Since the insured has no reliable information on the cost of any treatment, his degree of coinsurance before the event is not known. This is not consistent with efficient transactions in the insurance market, and with risk aversion will lead to a level of insurance in excess of that which be taken out if the consumer had more reliable information on the financial dimensions of his liability in the event of illness. Finally, while there is no hard evidence that fees
charged will usually exceed agreed rates. There is plenty of anecdotal support. Certainly it would be naive to expect that fees would in general be less than the agreed V.H.I. rates, given that an insured person is carrying the maximum cover.

There is no doubt that fully articulated coinsurance contracts will induce increased efficiency in the provision of health-care by reducing moral hazard. It does not follow that a contract in which the level of coinsurance is unknown before the event will have the same effect. At the margin, of course, it leaves the insured paying 100% of the extra cost of treatment, which is obviously a brake on spending; on the other hand, the level of indemnity sought by the insured may well rise due to the uncertainty as to the degree of coinsurance and to the expectation that the cost of treatment will exceed the maximum amount against which he can insure. A higher level of insurance cover will, of course, encourage a rise in the average level of surgical fees, etc. par.

Whether or not coinsurance contracts are taken out in a competitive market will depend on the costs of alternative contracts. It may be the case that at competitive prices in a market where insurance companies are risk neutral (or at least less risk averse than those taking out health insurance) zero coinsurance may dominate. There is some evidence to that effect from the U.S. (6), and press comment in Ireland suggests that the V.H.I. thinks this is the case. From the point of view of containing costs by reducing moral hazard, positive coinsurance contracts are socially preferable. In imperfectly competitive markets one would expect such contracts to be common as insurers use market power to oblige their customers to carry part of the risk so as to lower medical costs. The promotional literature circulated by health insurers in the U.K. contains evidence to support this expectation. The failure of the V.H.I. to use its position in the Irish market
to introduce more rational (from its own point of view) contracts casts further doubt on its overall efficiency. The problem, of course, is that as a non-profit monopoly it has little or no incentive to pursue that option (7).

A further economic inefficiency in the V.H.I.'s insurance system is that which results from its obligation to offer community-rated insurance only. In effect neither the age-related actuarial risk of illness nor, broadly speaking, the insured's personal health experience is taken into account in determining the appropriate premium to charge. The immediately obvious effect of this is to introduce a large element of cross-subsidisation. The general presumption seems to be that it is socially desirable that those less likely to experience episodes of illness should subvent those who are more at risk. Not only is the logic of this open to question, but it has serious implications for the overall cost and level of health insurance cover. The fact that any insurance scheme transfers resources ex post between groups of people by its nature does not mean that the ex ante basis of the insurance contract should actuarially transfer wealth between identifiable sub-groups of the population. To do so is to increase incentives for adverse selection. Adverse selection exists where any individual uses information about the probability of any event befalling him which is not in effect available to the issuer of insurance. Given the cost of acquiring information on any individual's risk exposure, the insurer relies on past experience with groups and assigns an ex ante risk rating to any individual based on the experience of the most relevant group. That risk rating reflects the mean riskiness of the group. The broader the group classification, the greater the dispersion of individual risk around the mean risk, and the greater the number of people in the group for whom, at an actuarially fair group-related premium, the attractiveness of insurance is either reduced or increased. The former are those who have private information that their risk is less than that of the group; the latter are
who are aware of higher risk factors. Lower risk people will take out less insurance; higher risk people will take out more. To deal with this the insurer has to raise the average premium. Consequently, when the group is the whole community the average premium will, cet. par., be higher than for any other premium rating structure.

If the costs of health insurance were liberalized it is virtually certain that community rating would be replaced by experience rating. This will raise a case of redistribution of the cost of health insurance which must be dealt with. The first of these arises because it will mean that those who are at a higher risk of illness through their medical history will on average pay higher premia than those at lower risk. It may well be the case that public perceptions of "fairness" reject such an arrangement. It has to be faced that if this is so it is tantamount to rejecting the principle of insurance for health purposes on ethical grounds.

Against this view it can be argued that (a) the overall cost of insurance will fall under experience rating for reasons already outlined; (b) it would still be open to competitive insurers to offer contracts which did not raise premia after illness (i.e., not including loadings or no-claim bonuses) to new customers with clean bills of health. They would, however, be more expensive. Again it is interesting to note that in the U.K. market both types of contract are available.

The second argument against experience rating on distributive grounds is that it is regressive in terms of income. It is well established that there is a negative cross section correlation between illness and income, cet. par. Consequently, the average cost of insurance per unit of cover would be lower for those in the higher income groups ex
post. It is conceivable that ex ante an insurance company might load premia for those in the lower income groups if experience proved that poorer people turned out to be a significantly worse risk. In a system in which insurance was expected to finance the bulk of health-care, as in the U.S.A., this argument would carry more weight than in the case of Ireland or the U.K., where it is a complement and supplement to a national health service. The health-poverty linkage reflects the illness experience of those at the lower end of the income distribution, to whom the insurance financing of health-care is not supposed to apply. Even if it were the case that public policy envisaged the extension of insurance to the lower end of the income distribution, it would be economically more efficient to subsidise the disadvantaged groups than to prohibit experience rating. Once again, the U.K. seems to have accepted this point in that the Government announced in January 1969, that tax incentives for health insurance for the elderly were to be introduced.

A third argument against experience rating is that it would raise insurance costs for the elderly. It should be remembered, however, that age invariant premia are a substitute for saving. Presumably, were it not for the relatively preferential tax treatment of health insurance, it would be in the interest of any insurer, even the V.H.I., to make lower average cost, age related insurance contracts available to new, younger customers if they demanded them. If tax treatment did not change, one would assume that in a competitive market the age-premium relation would not change either, unless that is, the V.H.I. is performing inefficiently at present.

Finally, experience rating will eliminate or at least severely curtail cover for drugs for chronic conditions. As already pointed out, this is not an expenditure for which ex ante indemnity insurance is appropriate.
(2) The growth of health-care costs is a major political problem. The arrangements made to control those costs must take into account the impact on medical costs of the structures of the health insurance market. The background to this is that any society has two basic strategies from which to choose in seeking to control these costs: (a) it can rely on supervisory regulation, involving monitoring, price controls, resource allocation by government decision and rationing of service; or, (b), it can rely on market competition.

Neither strategy is costless. Regulation uses resources directly; it also induces resource using responses from those who are regulated. Competition, on the other hand, may raise problems of coverage gaps, and over supply through physician induced demand. The policy problem is to choose the less costly strategy and to reduce the costs associated with it.

The policy to date in Ireland has been to rely mainly on regulation. This has been done both by direct Government involvement in health-care supply and indirectly by using the V.H.I. to control spending, outputs and resource allocation in the health sector. Regulation as a means of social control has two major weaknesses: regulatory capture and regulation response. Both tend to raise rather than lower costs, and may outweigh any beneficial effects of regulation. Regulatory capture is the well established mechanism through which, given enough time, regulatory agencies end up implementing regulations benefiting the interests of those in the regulated industry rather than the interests of the general public (8). The classic example of this is the airline industry. The phenomenon reflects one or both of two causes: (a) regulation may initially be sought by the industry affected, usually with a view to reducing competition; (b) dependence on the target industry for relevant information results in the regulatory authority being unable or unwilling to regulate against the industry's interests.
Regulatory response refers to the consequences for outputs and costs induced by the self-interest of the regulated firm or industry when the standard price/quality/advertising dimensions of competitive behaviour are partially or totally suppressed by regulation.

The steady rise in health supply costs over the last 20 years does not inspire confidence in the effectiveness of regulatory effectiveness as a mechanism to enhance efficiency in health-care supply in Ireland. The continued faith of civil servants in the superiority of regulation may not be unconnected with the fact that their incomes depend on it. Economists to a great extent have long lost this faith. Pointing to the incentives for opportunistic behaviour and deception in the bargaining that lies at the heart of the regulatory process, and the associated incidence of regulatory failure, they have tried to shift the emphasis of policy back to reliance on market competition to ensure economic efficiency.

Health care is no exception to this trend. Even in the context of a national health insurance system the British Government's recent White Paper on the health services signalled the return to competition as a mechanism to control costs and to align health care outputs with patient needs.

The market structure of the health insurance system is a crucial factor in determining its effectiveness in controlling health costs. A monopoly supplier of insurance to the public, especially a non-profit one, has a relatively weak incentive to monitor and bargain with the suppliers of health-care (the hospitals and the health-care professionals).
since higher costs of supply can be that much more easily/less painfully be passed on to the public as premium increases. Competitive suppliers, especially for-profit ones, on the other hand, have a strong incentive to seek cost effective methods of achieving any given quantity and quality of health-care. In the U.S. and the U.K. this may be seen in the emergence of a system of "preferred suppliers". By this the insurance companies restrict cover to service supplied by producers with whom cost-efficient contracts have been agreed.

(3) Competition in the insurance market is likely to produce efficiency seeking structural changes in the structure of both health insurance financing and health-care supply. In the area of insurance, experience in the U.S. suggests that large employers are likely to get more involved in the provision of health insurance, and through this to increase the number of financial methods of health insurance finance. Indirectly, they are likely to use their market power to bargain with insurers, which will produce corresponding gains in efficiency to be captured within the bargaining firms. Directly, there is evidence of large employers entering the health-care supply industry themselves, effectively taking on the role of insurers. This presumably reflects their superior monitoring ability where their own employees are concerned as well as the reduced incidence of moral hazard. Similar effects can be seen emerging on the health-care supply side of the market. The rise of pre-paid health-care plans, the so-called Health Maintenance Organisations, can be seen as a medical supply based response to the problems of moral hazard, adverse selection and physician-induced demand in a highly competitive environment. HMOs and the like effectively involve the suppliers of medical care screening and insuring the customer population. They drastically reduce the incentive to doctors to prescribe unnecessarily; they encourage cost-reducing methods of treatment; their
screening reduces frivolous customer demands; and all these are reflected in a lower level of premium levels which in structure resemble limited community rating (9).

Suppose that, the above arguments notwithstanding, it were felt to be socially undesirable to permit experience rating. Would it then follow that the V.H.I.'s monopoly has to be maintained in order to ensure community rating?

As long ago as 1977 a competitive community rating health insurance scheme was proposed in the U.S. Entitled "Consumer-Choice Health Plan", it proposed that to qualify for tax relief, insurers would have to offer periodic open enrollment on a demographic basis with community rating and catastrophic expense protection (10). In effect, this meant tendering for the health insurance of a representative group of those seeking insurance. Community rating, therefore, can be reconciled with competition. In the case of Ireland this would be feasible if tax exemption was restricted to those insurers who offered non-experience rated insurance. It would be easier, of course, if Britain and the other E.C. countries were implementing similar policies.

**PART 3 : CONCLUSION.**
The main implication of the contents of the last two sections is that the market for health insurance in Ireland should be liberalised. At present, indications are that the government is in the process of seeking to be permitted to retain the monopoly position of the V.H.I. after 1992. In practice, it is doubtful whether in the medium term that option is feasible, let alone desirable.

Apart from the arguments about the modalities of the insurance market already considered, the case against liberalisation depends on a weak argument about scale economies, or on interest group considerations. The scale economies argument is that the Irish market is large enough to support one supplier of insurance to the market and only one. Whether scale economies are as suggested in this argument is a moot point. There is no hard evidence one way or another, although the decline in the administration cost ratio of the V.H.I. is consistent with the operation of scale economies. Unfortunately, it is also consistent with learning by doing, or with the impact of successful government regulatory pressure over the decade.

Whether scale economies exist or not is, however beside the point in the context of 1992. At issue is not the question of whether more than one firm could survive if supplying insurance to the Irish market alone at a cost comparable to that of the V.H.I today. It is whether existing, large scale insurers already operating in the U.K. or on the European mainland could or would, if given access, offer lower cost insurance than that available today under whatever rating system is mandated.

Interest group opposition to liberalisation is likely to come from four principal sources, reflecting experience in the U.S. (11), when it was proposed to extend the range of insur-
ance financed medical care under the Carter Administration. These were: the civil service, organised labour, hospital managements and existing insurers.

Civil service objections were based on the expressed conviction that regulation by them was a superior way to control the growth of health-care costs. In common with civil servants elsewhere, including Ireland, they believe in the superiority of planning to the market as a mechanism for resource allocation. Their incomes depend on this belief being reflected in public policy.

Organised labour objected for two reasons. The first was the general ideological objection to the market as an allocation mechanism. In the second place, they recognised that increased competition would threaten incomes based on restrictive practices in the labour end of medical care supply.

Hospital managements were reluctant to move from a regime in which demand for their outputs was growing and price-insensitive and in which they could use their superior information in bargaining with bureaucracy over resource allocation to a regime in which conventional economic pressures would determine success or failure.

Existing health insurers, like any business interest, were in favour of more competition everywhere - except health insurance, where they felt it to be excessive already. In fact, at the time in the U.S. they wanted a relaxation of anti-trust legislation for health-care and more government regulation.
Strangely, American medical opinion was not in general hostile to increased insurance competition, despite the fact that more competition between insurers should exert downward pressure on economic rents in medicine. Presumably this reflected their experience under regulation. It is hardly coincidental that the medical profession in Ireland has been canvassing for increased competition in medical insurance here.

In practice, however, it seems unlikely that in the medium term the V.H.I.'s monopoly can be maintained, even if this were desirable. Short of making it a criminal offence to approach an insurer in the U.K. to seek cover, which would be unlikely to be politically acceptable at home or tolerated by the E.C., the government will have to accept that if lower cost insurance is available people will take it up. At the moment the V.H.I.'s position is protected by the restriction of tax relief to payments to designated insurers, which, in effect, means the V.H.I. It is possible that this privileged may be permitted to continue for a while after 1992, but it would be foolish to expect such a derogation to last for long. In any case, the recent performance of the V.H.I. and the coming upward trend in its premium costs mean that even tax exempt status will not protect it for long either.
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(9) J.E. Ware et al.: "Comparison of Health Outcomes at a Health Maintenance Organisation with those of Fee for Service Care": THE LANCET, MAY 3 1986, pp1017-1022. The implications of competition for non-profit organisations in medicine are very interesting and are well surveyed in M.V. Pauly: "Non-Profit Firms in Medical Markets": AMERICAN ECONOMIC ASSOCIATION, PAPERS AND PROCEEDINGS, VOL 77 MAY 1987, pp257-262.


(11) A.C. Enthoven: "How Interest Groups have Responded to a Proposal for Economic Competition in Health Services": AMERICAN ECONOMIC ASSOCIATION, PAPERS AND PROCEEDINGS, VOL 70 MAY 1980, pp142-148. Government reluctance to accept competition may also reflect awareness that a regulated, monopolistic market enables them to shift public patient costs onto private patients; cf F. Sloan: "Government and the Regulation of Hospital Care": AMERICAN ECONOMIC ASSOCIATION, PAPERS AND PROCEEDINGS, VOL 72 MAY 1982, pp196-201.