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Health Insurance in Ireland: Issues and Challenges

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Introduction

Over the past decade or so the context in which Ireland's complex mix of public and private health care operates has changed radically, as the numbers purchasing health insurance have soared and the nature of the insurance market has changed in response to EU regulations. This has widened the divide between those with and without health insurance, and called into question the public-private structure on which Ireland has relied for many years. Almost half the Irish population now pay for private health insurance, one of the highest levels of coverage in the OECD. This is despite the fact that hospital care is what private health insurance mostly covers, and everyone has entitlement to public hospital care from the state. The insured can avail of "private" health care, but much of this private care is actually delivered in public hospitals. The resulting two-tier system is now widely regarded as problematic from an equity perspective, but there are also serious efficiency issues arising from the incentive structures embedded in this particularly close intertwining of public and private.

1. The Structure and Role of Health Insurance in Ireland

For many years those towards the top of the income distribution in Ireland have been encouraged to take out "private" health insurance. In the late 1950s a monopoly state-backed not-for-profit health insurer – the Voluntary Health Insurance Board (VHI) – was established to cater for the top 15% or so of the income distribution, who did not (then) have entitlement to public hospital care

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from the state. This state-backed insurer operated community rating and income tax relief was available on premia paid. This structure was designed, *inter alia*, to ensure that the entire population had access to hospital care while satisfying the demands of medical consultants that their private practice not be undermined. Those towards the top of the distribution were in effect encouraged to take out “private” insurance, while the cost of in-patient care for the rest of the population was fully covered by the state.

To complicate the picture – and it is a crucial difference between Ireland and many other countries – not only was “private” insurance provided for many years by what was to all intents and purposes an arm of the State, much of the “private” care it covers was and is delivered in public hospitals. Medical consultants retained the right to treat their private patients in public hospitals, and about half of all private hospital care is in fact delivered in those hospitals. Most patient receiving private care – in a public or private hospital – have insurance, and the insurer reimburses both medical consultant and hospital. However, for many years public hospitals only charged for the “hotel” facilities associated with being in a private room. In addition, most medical consultants are contracted to care for public patients in public hospitals on a salaried basis, while maintaining the scope to treat private patients on a fee-for-service basis. We try to tease out the implications of the complex mix of incentives involved below, but the key point is that public and private systems in Ireland, rather than being distinct, have what has accurately been described as a symbiotic relationship (Barrington 1987).

From the 1950s to the late 1970s or early 1980s, this public-private mix supported by “private” health insurance functioned in roughly the way it was designed to do, with a monopoly insurer covering private care for the well-off and in effect “topping off” the public system. There have been fundamental changes in the health insurance landscape since then. The first is the dramatic rise in the percentage of the population buying health insurance. This jumped up from about 20 % to 30 % in the late 1970s, jumped once again in 1987 to 35 %, rose steadily through the 1990s and by now is very close to half the population. This occurred despite the fact that full entitlement to public hospital care (subject to some charges levied on all those above a low income threshold) was extended to the top part of the income distribution in the early 1990s.

Another major change is that there are now competing insurers. In response to the EU’s 1992 Third Non-Life Insurance Directive, designed to stimulate competition in insurance, the Irish government enacted new legislation opening up the health insurance market. As a result a second significant insurer, BUPA Ireland (a subsidiary of the British insurer) commenced operation in 1997. However, the way the market operates is tightly regulated: Ireland obtained approval from the EU to continue to require all insurers to apply open enrolment, community rating and lifetime cover, as enshrined in the 1994 Health Insurance Act and the 1996

Health Insurance Regulations. In 2001 a Health Insurance Authority was set up to oversee and regulate the market. Among its responsibilities is implementation of a risk equalisation scheme in order to support community rating. This has proved particularly controversial and no transfer of funds across insurers has yet taken place. The VHI continues to dominate the market, with about 95% of subscribers, and although its status has been debated it remains a not-for-profit body whose board is appointed by the Minister for Health, requiring official approval for changes in premium levels. None the less, the entry of BUPA and potential entry of further insurers is a fundamental change in the health insurance market.¹

2. Understanding Recent Trends and Their Implications

So health insurance in Ireland, having been the preserve of the better-off for many years, now covers half the population. Quite why this increase in the numbers buying health insurance has occurred is not well understood. The scale of economic growth and increasing real household incomes in Ireland during the 1990s – the “Celtic Tiger” – has clearly made it possible for more people, but this does not explain why they want or feel the need to have health insurance cover. The upward trend in numbers insured has also proved remarkably resilient in the face of significant annual premium increases and a diminution in income tax relief as tax rates fell and relief was scaled back to the standard rather than the purchaser’s marginal tax rate. Econometric time-series analysis also suggests that the evolution of income and price still leave much of the increase in demand to be explained, so it is also important to explore what people think they are buying when they buy insurance, and the alternative they face or believe they face without it.

Attitudinal surveys² suggest that concern about waiting times for public hospital care is uppermost in people’s minds, that quality of care has also come to be seen as a significant issue, and that having a private room or other “hotel” aspects are not seen as an important reason for buying private insurance. Waiting times for public hospitals are widely perceived to be long, both by those with and without insurance. So what people essentially believe they are buying is the assurance that they can access hospital care when they need it, without undue waiting and with care from a medical consultant of their choice.

1. A recent OECD review of private health insurance in Ireland, in a series on this topic in a range of countries, has a useful description of the system and discussion of some of the issues highlighted here ((Colombo and Tapay 2004).

2. See Watson and Williams (2001), Health Insurance Authority 2003.

It seems plausible then that perceptions of access to public hospitals combined with perceptions of the quality of public versus private care are key drivers underpinning demand for health insurance. The role of media coverage in influencing such perceptions merits examination, but there are indeed long waits for certain types of public hospital treatment that are by-passed by those with insurance. In one of the attitudinal surveys, for example, almost half the respondents said they personally knew someone who recently had a lengthy wait for public hospital treatment – so they were not simply influenced by media reports. Econometric analysis of data from household surveys measuring utilisation also suggests that those with insurance have a higher probability of an in-patient stay than those without, controlling for available measures of “need”.

This two-tier hospital system is now widely regarded as problematic from an equity perspective. Indeed, the issue of equity of access to hospital care for public versus private patients has become a very high profile one politically, and equity as a goal has been highlighted in the official health strategy produced after lengthy consultation in 2001. The focus of policy has been on regulating access to public hospitals, on the proportion of private versus public beds in them, on the charges for private care in public hospitals, and on reducing waiting times for public patients. As argued in the next section, though, this focus misses some deep-seated structural problems, in respect to both equity and efficiency, which the recent upsurge in numbers insured has not created but has certainly exacerbated.

3. Key Structural Issues

Dealing first with equity, a number of different layers to the argument may be usefully distinguished in assessing the fairness of the current system. Where separate and distinct public and private healthcare systems operate side-by-side and private health insurance provides cover for the latter, then a likely outcome is that those with insurance – who are most often on higher incomes – will have more rapid access to health care. Views may, and do, differ about whether this is equitable, both within and across societies. However, the role of the state in subsidising health insurance or private health care, directly or indirectly, adds a further dimension: some who see differential access as fair if the full cost is being paid by those “going privately” might question its fairness if the taxpayer is in effect covering part of the cost. A further, and even more complex, dimension arises when – as in the Irish case – much of the private care to which those with insurance gain access is actually being delivered in public hospitals. In that situation, the financial flows underpinning the system are more difficult to disentangle

but the two-tier nature of access by those with versus without insurance is more striking.

So what is distinctive about the Irish case is that the *public* hospital system has come to be seen very widely as a two-tier one, offering the better-off more rapid access; the fact that they are in effect subsidised by the taxpayer in doing so is less widely debated but well understood by analysts. Subsidisation comes through tax breaks on insurance premia and below-cost charges for private care in public hospital; recently this charge has been raised significantly but still represents an implicit subsidy to private care in public hospitals (Nolan and Wiley (2000)). The clarity of the distinction between private versus public beds in those hospitals and how to ensure that private patients do not obtain preferential access through public beds have also been the focus of particular attention from policy-makers.

Even if private care in public hospitals covered its full cost or even generated a surplus to cross-subsidise care of public patients, an equity concern would arise about two-speed access to those hospitals. The main argument advanced for retention of private care in public hospitals is that this allows the most able medical specialists to be available to care for public patients. There has been no attempt to assess the scale of the purported benefits to the public system, nor whether of close interaction with private care are outweighed by the costs.

These costs include not only the direct and indirect subsidisation already mentioned, but also the distortionary impact of the incentives for medical consultants and hospital managers associated with the inter-mingling of public and private care. Most medical consultants employed to treat public patients, and paid a salary for doing so, also have private patients for whom they are paid on a fee-per-service basis. While consultants are committed to a specified number of hours per week caring for public patients there is no effective monitoring, and the incentive they face to concentrate more of their attention on private patients – even if it is by working very long hours over and above their public commitment – may clearly be to the detriment of public patients. (Unlike private patients, many public patients will be treated by more junior doctors). Public hospital managers also face an incentive to maximise revenue from private patients in any given year, since this is one of the few sources of additional revenue available to them.

Some of these incentive issues might still feature, though they would probably be less pronounced, if private care was delivered only in private hospitals – if for example consultants still had a mix of private and public patients and were in effect incentivised to prioritise the former. Equity concerns could still be raised about faster access to such private hospitals, especially if the state subsidises them not only indirectly by favourable tax treatment of insurance premia and via training of staff in the public system, but also by direct tax breaks to encourage building private facilities as have recently been introduced by the Irish govern-

ment. However, both efficiency and equity concerns are undoubtedly heightened by Ireland's peculiarly intimate public-private mix.

4. Insurance, Efficiency and Equity

It will be clear that health insurance underpins private hospital care in Ireland. The opening up of the market for health insurance has undoubtedly altered the situation significantly. The fact that the former monopoly insurer VHI, though still dominating the market, faces real competition from BUPA Ireland and the potential for entry by more competitors has clearly affected behaviour in the market. This is most obvious in the range of new insurance products which continue to appear and the efforts to market them. Despite price competition, however, the cost of insurance has continued to rise.

The highly regulated nature of the private health insurance market in Ireland remains distinctive. Open enrolment, community rating and lifetime cover are enshrined as core principles, reflecting the role which public policy has traditionally assigned to insurance in the health care system.³ These restrictions have not been much debated and appear widely supported, although their rationale is open to question. The logic that applied when public policy saw insurance financing hospital care for the well-off cannot simply carry over to what is now a very different situation. Indeed, it is far from clear where policy now sees insurance fitting in and going, in a situation where everyone is entitled to avail of public care on the same basis but half chose to buy insurance.

Implementation of the risk equalisation scheme in order to support community rating, on the other hand, has proved controversial – at least between the two insurers who would be affected! A vigorous debate between them has continued as to the justification for such a scheme and the need for a transfer, and no transfer of funds across insurers has yet taken place.⁴ This uncertainty may be acting as a deterrent to the entry of further insurers to compete in the Irish market.

As well as the supply side, the prospects for the demand for health insurance are also uncertain. Even if it were to plateau at about the current level, the dynamic effects of recent growth in the numbers purchasing health insurance still have to work their way through. It is not clear, from a financial or broader public policy perspective, whether a 50 %/50 % split between those with and without insurance, is inherently unstable. From a public policy perspective, it is hard to see why the number taking out private insurance should in itself be a

3. See Department of Health and Children 1999a, b, Health Insurance Authority (2002).

4. See Health Insurance Authority (2003), BUPA Ireland (2000), Van de Ven (2000).

target variable. If however public policy gave priority to effectively improving access to, and quality of, care for public patients in public hospitals this might have a significant impact on demand for private insurance, given the apparent importance of perceptions of the public system in promoting that demand.

While health has become an extremely high-profile and politically sensitive topic, health insurance has not come centre-stage in that debate – which has focused on waiting times for public hospital care and the location of those hospitals. There has been some political debate about alternative involving “insurance for all”, either via social insurance or subsidised private insurance, but this has not as yet progressed very far. The slogan that “everyone should be a private patient” amply illustrates that having 50% of the population with insurance alters the context for such a debate. However, it will clearly be difficult to move forward when “insurance for all” means very different things to those advocating it – and clarity about who would gain and lose is notably lacking.

5. Conclusions

Almost half the Irish population now pay for private health insurance, one of the highest levels of coverage in the OECD. This is despite the fact that everyone has entitlement to public hospital care from the state, and hospital care is what private health insurance mostly covers. The insured can avail of “private” health care, although much of this private care is actually delivered in public hospitals. The resulting two-tier system is now widely regarded as problematic from an equity perspective, but there are also serious efficiency issues to be faced because of the incentive structures embedded in this particularly close intertwining of public and private. The recent introduction of competition in the health insurance market, in a tightly regulated setting, has led to the introduction of a wider range of insurance products but does not address these fundamental problems. The Irish experience shows that a structure designed to take advantage of possible benefits for the public system of close interaction with private care can create perverse incentives, be inequitable in terms of access and utilisation, and undermine that public system. The political economy of reform is however highly problematic.

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