
Private Health Insurance in Ireland: A Case Study

Francesca Colombo and Nicole Tapay

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SUMMARY

1. This paper analyses the Irish private health insurance (PHI) market. It describes how PHI interacts with the public system, and assesses its contribution to equity, efficiency and responsiveness of the health system. The analysis identifies some of the factors affecting insurance market performance and its impact on the health system, including market characteristics, the regulatory and fiscal environment, health system organisation, and any actors' incentives and behaviours.

2. PHI plays a prominent role in Ireland. The health system is designed to offer comprehensive publicly funded health services to low-income groups, and universal public hospital coverage. Policies have encouraged the development of PHI to provide all individuals with a private alternative to the public system, as well as a means of funding cost-sharing and services not covered by the public system. With the implementation of the requirements of the Third EU Non-Life Directive, the PHI market, historically dominated by a quasi-monopolist state-backed insurer, was opened to competition. A buoyant economy, growing provision of PHI as an employment benefit, and confidence in the value of private cover have contributed to a steady increase in the share of the population buying PHI – now totalling nearly half of the population.

3. The Irish public-private mix has both advantages and drawbacks. Irish policy makers believe that a mixed health care system enhances individual well-being and health system performance. Private health insurance affords insurees greater choice over providers and the timing of care, thereby improving health system responsiveness. Furthermore, Ireland applies premium and access regulation to the whole private health insurance market, which has promoted equity of access to, and financing of, private coverage. However, affordability of private cover is endangered by continuous PHI premiums increases, which can impact public sector cost through premium-based tax advantages.

4. PHI has, however, given rise to equity concerns and also raises cost-related challenges. For example, providers face incentives to offer preferential treatment and quicker access to private patients in public hospitals. Several governmental measures seek to limit inequities in access to care. Because private patients are treated to a large extent in public hospitals, where a share of the cost of treatment is subsidised, private health insurance has not had a large impact on public hospitals' waiting times and cost. This can be improved by more effective channelling of demand towards private hospitals and continued increase of public hospitals' charges for private beds to reflect the full economic cost.

5. The Irish PHI market is also confronting challenges to the establishment of a more competitive market. The market is dominated by two insurers, with one dominant player, along with a handful of smaller funds with restricted membership. The establishment of risk equalisation to encourage fair competition across insurers gave rise to substantial controversy relating to its impact on the PHI market, although its implementation is likely to improve fair competition across insurers by reducing the appeal of competition based on risk selection. A change in the commercial status of the state-backed insurer, VHI, is still pending.

RESUME

6. Cet article analyse le marché de l'assurance maladie privée (AMP) en Irlande. Il décrit comment l'assurance maladie privée interagit avec le système public et évalue sa contribution à l'équité, l'efficacité et la réactivité du système de santé. Cette analyse identifie certains facteurs affectant la performance, y compris les caractéristiques du marché de l'assurance privée, la régulation et le cadre financier, l'organisation du système de santé, ainsi que les incitations et le comportement des différents acteurs.

7. L'AMP joue un rôle important en Irlande. Le système de santé offre des services de santé complets financés par des fonds publics aux groupes à bas revenus ainsi qu'une couverture universelle de frais d'hospitalisation. Les politiques de la santé ont encouragé le développement de l'AMP afin d'assurer à tous les individus une alternative au système public ainsi qu'un moyen pour financer le ticket modérateur et les services qui ne sont pas couverts par le système public. Avec la mise en place des conditions requises par la troisième directive de l'Union Européenne sur l'Assurance non-vie, le marché de l'AMP, historiquement dominé par un quasi monopole d'une compagnie d'assurance appartenant à l'état, a été ouvert à la concurrence. Une économie en croissance, l'offre progressive par les employeurs de l'AMP comme prestation de travail et une confiance dans la valeur de la AMP ont contribué à une augmentation soutenue de la population achetant une AMP, actuellement quasiment la moitié de la population.

8. Le système irlandais mixte privé/public a ses avantages et ses inconvénients. Les responsables des politiques de santé pensent qu'un système d'assurance maladie mixte entraîne l'amélioration du système de santé et du bien-être individuel. L'assurance maladie privée permet aux assurés un plus grand choix de prestataires de soins de santé et une réduction de délais de soins, et de ce fait, elle améliore la réactivité du système de santé. En outre, l'Irlande applique le règlement de primes et d'accès sur la totalité de l'assurance maladie privée, ce qui a favorisé l'égalité d'accès et de financement de la couverture privée. Cependant, l'accès à la couverture privée est mis en danger par la constante augmentation des primes de l'AMP, ce qui peut avoir un impact sur les dépenses publiques à travers les avantages fiscaux sur les primes de l'AMP.

9. L'AMP a cependant donné lieu à des soucis d'équité et des défis relatifs aux coûts. Par exemple, les fournisseurs sont confrontés par des incitations à donner un accès plus rapide aux patients dans les hôpitaux publics. Plusieurs mesures gouvernementales cherchent à limiter les inégalités de l'accès aux soins. Comme les patients privés sont traités dans une large mesure dans les hôpitaux publics, où une part du coût du traitement est subventionnée par l'état, l'assurance maladie privée n'a pas eu un grand impact sur les hôpitaux publics en terme de temps d'attente et de coûts. Ceci peut être amélioré en dirigeant plus efficacement les demandes vers les hôpitaux privés et en poursuivant l'augmentation des prix des lits privés dans les hôpitaux publics pour refléter le plein coût économique.

10. Le marché irlandais de l'AMP doit aussi relever le défi de créer un marché plus compétitif. Le marché est dominé par deux assureurs, dont un dominant, ainsi qu'un ensemble d'assureurs plus petits qui proposent un accès à l'AMP auprès des groupes restreints de utilisateurs. L'établissement d'un système de compensation de risques qui vise à encourager la compétition entre assureurs a entraîné une controverse considérable relative à son impact sur le marché de l'AMP, même si l'introduction d'un tel système va probablement stimuler la compétition équitable entre assureurs en réduisant la compétition basée sur la sélection des risques. Le changement du statut commercial de la compagnie d'assurance d'état, VHI, n'est pas encore réalisé.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	3
SUMMARY	4
RESUME.....	5
Introduction.....	7
1. Historical context and the policy relevance of private health insurance in Ireland	8
2. The role of PHI in Ireland and its interaction with the publicly financed health system.....	11
2.1 Interactions between the public and private health financing and delivery	12
2.2 The private health insurance market in Ireland	17
3. Overview of government policies and interventions.....	23
3.1 Requirements relating to access to PHI coverage in Ireland	24
3.2 Voluntary standards: self-regulation	31
3.3 Dispute resolution mechanisms	31
3.4 Tax relief and other government incentives to the purchase of PHI	32
3.5 Uniformity of regulation across PHI market segments	32
4. How well does the Irish PHI market and health insurance mix meet health policy goals?	33
4.1 How has PHI influenced cost pressures in the health system?	33
4.2 Has PHI increased health system cost-efficiency?	36
4.3 What challenges does PHI pose to equity and access?.....	38
4.4 Has PHI enhanced responsiveness of health systems?	42
5. Summary and conclusions	45
REFERENCES	48

Tables

Table 1. Evolution of policies pertaining private health insurance in Ireland	12
Table 2. Public and private coverage of population, health services and providers in Ireland.....	15
Table 3. Sources of financing of health expenditure in Ireland, 1999-2001.....	16
Table 4. Public and private hospital beds	16
Table 5. Population coverage by private health insurance	19
Table 6. Characteristics of PHI enrolees	22
Table 7. Market share of insurers on the Irish PHI market.....	23
Table 8. Hospital utilisation by public and private patients	34
Table 9. Premium increase for VHI, 1981-2002.	36
Table 10. Levels of subscription rates	36
Table 11. Health insurance status in 1994 and 1997 by age category	40
Table 12. Self – assessed health status by insurance status, 1994	41

Figures

Figure 1. Evolution of population coverage by PHI	9
Figure 2. Breakdown of claims paid by private insurers	35
Figure 3. Evolution of administration costs and loss ratio, VHI.....	37

Introduction

11. Ireland's health care financing system is an interesting mixture of public and private funding with a meaningful role for private health insurance (PHI),¹ despite the presence of universal public hospital coverage. Health care services are provided through a combination of public and private entities. A growing – albeit still relatively small – private hospital sector lies alongside a public hospital system whose services are available to all. PHI mainly duplicates universal hospital coverage, while it also supplements² and complements publicly financed health services. Over the past few decades, despite expansions in publicly funded services, an increasing portion of the Irish population has purchased PHI coverage.

12. Policy makers have placed a high priority on a continued prominent role for PHI and consider it to be an integral element of their efforts to improve access to health care services. In order to promote access to adequate private coverage, the Irish government maintains an active role in overseeing the PHI market and imposes a range of requirements on private health insurers. Current standards reflect the history and practice of private health insurance in Ireland, seeking to maintain solidarity within and across the private and public health financing schemes, while also promoting competition. However, the market remains dominated by two primary players, one of which is a state-backed insurer with a historical and continued dominant market share. Competition therefore is very limited at present.

13. The history of PHI in Ireland is particularly illustrative of challenges faced by governments who wish to preserve equity of access to care, while encouraging the development of a private provision sector and a competitive PHI market. The interactions between the PHI market and Ireland's Beveridge-style health system, in which tax-based financing is linked to public providers and PHI acts as an alternative source of coverage for certain hospital and health services, have raised challenges. Recent market developments, together with the implementation of the latest government requirements, have prompted a lively debate over the best way to extract improvements in responsiveness and efficiency from the mixed system of public and private financing and provision, while safeguarding solidarity. This debate has also revealed some tensions among policy goals and underscored different views on the appropriate role and practices of the PHI market. Topics under discussion include:

- The policy and legal questions regarding the implementation of mechanisms to promote fair competition across insurers in a system with community-rated premiums;
- Ways to promote the entry of new private health insurers into a market dominated by only two players;
- The corporate status of the largest insurer, the Voluntary Health Insurance Board (VHI), and the implications of VHI's relationship with the government for its commercial mandate;
- The extent to which the public system should subsidise the economic cost of private care.

1 *Private health insurance* is coverage financed mainly through private non-income related payments (premiums) made to an insuring entity. This coverage guarantee is usually set forth in a contract between a private party and the insurer that spells out the terms and conditions for payment or reimbursement of services. The insurer assumes much or all of the risk for paying for the contractually specified services.

2 See Colombo and Tapay (2004) for definitions of different roles of PHI. If one considers PHI coverage of non-covered outpatient care for a large category of the population to be substitutive coverage, PHI also plays a primary role in Ireland.

- The link between access to care within public hospitals and private insurance status for elective surgery, as PHI is increasingly used to obtain faster access to hospital care.³

14. This paper begins with an examination of the Irish PHI market, the factors behind its development, and its interactions with the Irish public systems of health care provision and financing. It then describes government policy and interventions relating to the PHI market and the interactions between PHI, public financing, and the health system. The study also assesses the contributions of PHI to health system goals, most importantly, cost-efficiency and effectiveness, equity and access, and choice. It identifies ongoing challenges relating to PHI's role in the Irish health system and suggests some areas where reforms may be considered.⁴

1. Historical context and the policy relevance of private health insurance in Ireland

15. Private health insurance covers 49% of the population in Ireland.⁵ This is one of the highest percentages of private coverage across OECD countries, following France (92%),⁶ the USA (72%), and Canada (65%). While PHI accounts for only 6.8% of total health expenditures (THE) in 2001, Ireland belongs to a cluster of OECD countries where PHI has a relatively significant financing role, after the USA (35.6%), the Netherlands (15.5%), France (12.7%), Germany (12.6%), and Canada (11.4%).⁷ The prominence of the Irish PHI market, defined in terms of its contribution to health financing and extent of population coverage, resembles the case of Australia, where 44% of the population has private hospital coverage and PHI accounts for 7.3% of total health expenditures.

16. The important role that private health insurance plays in the Irish context is first of all explained by historical factors, notably the evolution of eligibility to public coverage and Ireland's tradition of private health financing. Following a "social assistance model", entitlement to publicly financed health services was first available only to eligible low and middle-income groups, leaving the most affluent persons responsible for financing health costs privately. The Voluntary Health Insurance Board (VHI), a state-owned insurer, was established in 1957 to offer private health insurance to the wealthiest 15% of the population who were not eligible for public hospital coverage.⁸ The 1957 legislation also foresaw that others may wish to purchase PHI in order to benefit from insurance cover for health care provided through the private sector. Until recently, VHI operated virtually in a monopolist position.⁹

3 Some proposals to deal with the risk of creation of a two-tier system by implementing a mandatory universal health insurance system have been advanced (Wiley, 2001a), although a majority of the population would be in favour of introducing mandatory health insurance for able high-income individuals (Watson and Williams, 2001).

4 Information presented in this report was gathered through a variety of data collection tools: OECD statistical and regulatory questionnaires; on-site interviews and focussed group discussions with a range of stakeholders; and a literature review. This method is the same followed for case studies on the role of PHI in other OECD countries.

5 These data are based on data from the Department of Health and Children, 2003.

6 This figure includes individuals who obtained a complementary insurance policy with a high level of public subsidy as part of the programme Couverture Universel Maladie (CMU). Prior to the introduction of the CMU in 2002, population coverage was 86%.

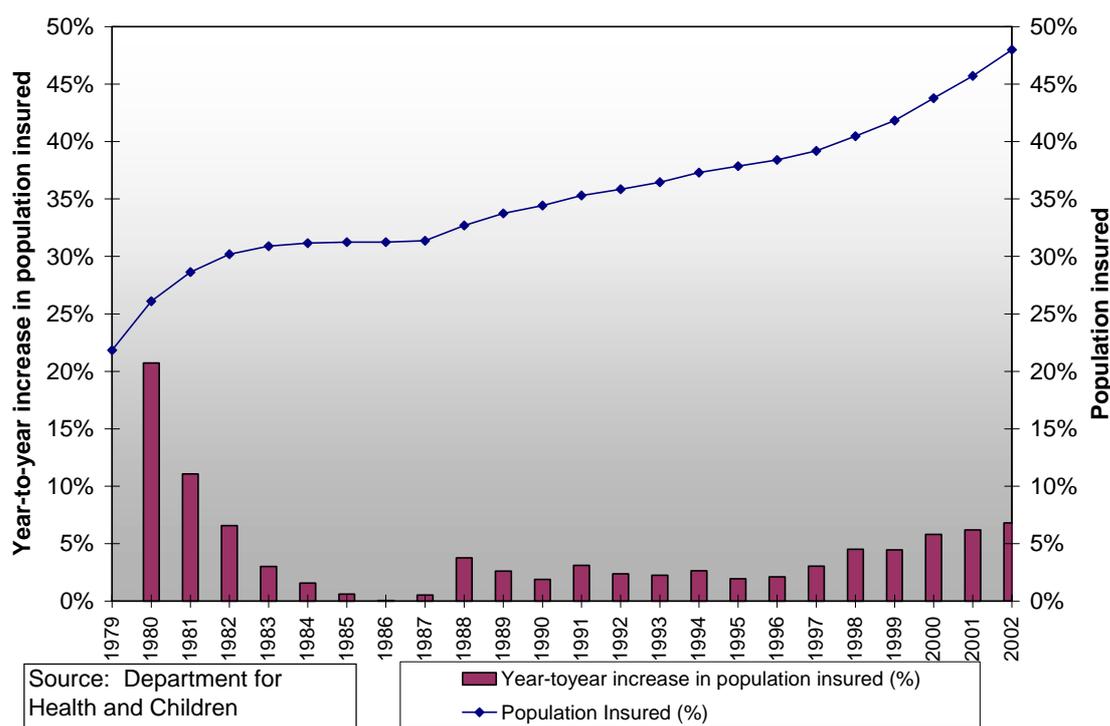
7 Source: OECD Health Data 2003. Data are for 2001, apart for Canada and Australia (2000).

8 Prior to the establishment of the Voluntary Health Insurance Board (VHI) in 1957, PHI was limited to a small portion of the Irish population with PHI coverage under vocational or employment-based schemes.

9 Apart from a number of "restricted membership undertakings" (RMUs) (employment-based coverage schemes) which provided cover to members of certain groups, *e.g.* vocational and occupational groups.

17. Despite the progressive extension of eligibility for public hospital coverage to the entire population,¹⁰ the prominent role of private health insurance in the Irish health system has not diminished. In fact, coverage has been growing steadily during periods when the eligibility for, and scope of, publicly financed health services was expanded, with membership increasing from 21.9% of the population in 1979 to 48% in 2002 (Figure 1). Plausible explanations for this growth include the rapid development of the Irish economy, continued policy support for private coverage, and a widening role of employers, in particular international companies, sponsoring PHI as a work-related benefit.

Figure 1. Evolution of population coverage by PHI



18. The role of private health insurance in relation to the public system has changed over the years because of the evolution of entitlement to publicly financed health services. While the initial function of PHI was to fill eligibility gaps in public hospital cover, which was not historically offered to the wealthiest segment of the population, Ireland has since eliminated the risk of “uninsurance” for hospital coverage for all of its population and provides coverage without co-payments for a significant segment of its population (30%). People continue to purchase PHI in order to enjoy increased choice over the timing and settings of care. Private insurees can access treatment in public hospitals as “private patients”¹¹ or they can opt for treatment in private hospitals. These latter are entirely financed through private sources. Private health insurance also covers primary GP services which are publicly financed only for the less affluent third of the population, as well as co-payments for the remaining two-thirds of the population who are liable to pay co-payments on inpatient treatments. Coverage of hospitalisation-related expenses (including co-payments) represents the largest share of PHI’s expenditures, while insurers have only recently begun to offer primary

10 Since 1979, universal eligibility included free hospital accommodation (subject to statutory charges, see footnote 21), and, since 1991, free specialist (consultant) services.

11 Private patients are patients who choose to be treated in private facilities within public hospitals and pay for treatment through their PHI policy or out-of-pocket, thereby enjoying freedom of choice of doctor and, when available, private or semi-private accommodation.

care benefits, which tend to be subject to high deductibles. PHI also plays some role in the offering of certain supplementary services.¹²

19. Irish government policy places a high priority on the continuation of a prominent role for PHI. It is considered a key part of overall efforts to maintain access to health services, and therefore is viewed as having an important social role. By supporting private care, PHI helps keep the medical profession satisfied, promotes an efficient use of specialists' time and skills, and provides hospitals with an additional income stream (Department of Health and Children, 1999). Finally, policymakers have regarded PHI as a channel to increase individual responsibility for the cost of care, thus hoping to reduce costs in the public system. The perceived social role of PHI and Ireland's wish to promote a mixed financing and provision system explain the on-going policy commitment to PHI (Table 1). Government support to PHI has included stringent regulatory requirements as well as fiscal and financial advantages.

20. The provision of private voluntary health insurance has historically operated pursuant to solidarity principles. Coverage provided by VHI had community-rated premiums, was issued to all applicants, and guaranteed to be renewed over the course of policyholders' lifetimes. Community rating guarantees that all insurees pay the same premium for a given plan, irrespective of their risk status. Open enrolment ensures that insurers accept all applicants. VHI's single-carrier status meant that it essentially community rated all the covered population. Lifetime cover guarantees the annual renewability of private cover throughout the lifetime of an enrollee. In response to the Third Non-Life Insurance Directive of the European Union,¹³ the Irish government enacted new legislation related to private health insurance. The 1994 Health Insurance Act and accompanying 1996 Health Insurance Regulations established a new regulatory framework for private health insurance and opened the Irish health insurance market to competition. As a result, a second player, BUPA Ireland, commenced operations in 1997. The legislation enshrined many existing PHI practices into law and made them applicable across the PHI market.

21. Regulation of private cover continued to be considered necessary to ensure the long-term sustainability of the established solidarity-based system (Department for Health and Children, 1999). For this reason, Ireland obtained legal approval from the EU to apply open enrolment, community rating, and lifetime cover requirements to an expanded PHI market in order to protect the "general good" (see section 3 for details). Community rating and open enrolment are, in particular, viewed as important regulatory pillars to maintain broad accessibility and affordability of private cover across different risk cohorts. The 1994 Health Insurance Act provided the government with the authority to implement a new risk-equalisation scheme to support community rating. This recommendation was supported in the government's White Paper on Private Health Insurance (Ministry of Health and Children, 1999) as was the commercialisation of VHI.¹⁴ Implementation of the risk-equalisation scheme began on 1st July 2003.¹⁵ These requirements have been put in place to protect consumers, improve market competition, build consumer confidence in private cover and protect the stability of the industry. A change in the commercial status of VHI, conversely, is still pending.

12 Termed "ancillary coverage" in Ireland and under Irish health insurance statutes.

13 European Council Directive 92/49/EEC of 18 June 1992. The Directive Contract shifted the focus of insurance regulation in the European Community from contract control to prudential control, with the goal of stimulating competition and enhancing consumer choice.

14 The White Paper on Private Health Insurance (Department of Health and Children, 1999) explains Ireland's commitment to private cover, outlines the Government's rationale for regulating private health insurance and identifies outstanding needs for improvements in the market.

15 Implementation of the risk equalisation scheme does not necessarily mean that payments under the scheme will be required, but rather that the assessment process required to determine if payments are appropriate has been put into effect.

22. Tax relief was initially introduced to encourage individuals without entitlement to hospital care to buy PHI. The desirability of such relief was later questioned on grounds of equity and effectiveness, resulting in a reduction of the level of tax relief from the marginal to the standard rate of tax in 1996.¹⁶ Despite an estimated resulting 40% increase in most PHI subscribers' costs, population coverage continued to expand, as shown in Figure 1. Private health insurance also benefits from other indirect subsidies. Public hospital charges for pay beds are kept below the full economic cost, and the public system also absorbs the cost of professional training, public hospital development, and accident and emergency costs.

2. The role of PHI in Ireland and its interaction with the publicly financed health system

23. The Irish health care financing system combines a public contract model with a private voluntary model.¹⁷ The former is tax-funded and provides universal public hospital services and GP coverage for an eligible third of the population. The latter is funded through private sources and includes GP services generally paid for on an out-of-pocket basis by the rest of the population and access to privately-financed hospital services on a voluntary basis (often covered by PHI). Hospital consultants are predominantly under public contract but are allowed to engage in privately financed practice within both public and private hospitals. Private hospitals are conversely entirely financed through private sources. Mechanisms for paying providers vary across the two models. Government health policies are inspired by principles of equity, people-centeredness, quality and accountability (Department of Health and Children, 2001a). They have historically supported a mix of public and private medicine.¹⁸ Responsibilities for the health delivery system are split between the Department for Health and Children (DOHC) and regionalised Health Boards.¹⁹

16 Relief was available at the highest rate of tax applying to an individual (either 27% or 48%), while from 1996 it was available only at the standard 27% rate, which was later reduced to 20%.

17 OECD (1992) defines a public contract model as a financing scheme where services are supplied in kind to eligible individuals, and non-competing funding bodies contract with, and pay, providers. A private voluntary model is a private health care market with or without health insurance.

18 In the Health Strategy (Department of Health and Children, 2001a) the Irish government affirmed that "*Private Health Insurance is a long-established feature of the system of acute care provision and will continue to play a vital part in the overall resourcing of health care in this country*".

19 The Department sets policies and has responsibility over strategic planning. The Health Boards are statutory bodies established under the Health Act 1970 with responsibility over a given region. They are responsible for the delivery of health and personal social services which they either provide or contract from health care providers. There are currently 7 Health Boards and 1 Health Authority. The Health Boards receive an annual budget from the DOHC, which includes revenue targets. If income targets are not met, the Department does not meet the shortfall. If the revenue targets are exceeded, the budget is adjusted down accordingly. Hence, in any given year, the Health Boards receive an adjustment to their budget in relation to activity and revenue from the previous year.

Table 1. Evolution of policies pertaining to PHI and public coverage in Ireland

Year	Policies towards public coverage	Policies towards private insurance
1957	<ul style="list-style-type: none"> All <u>but</u> top 15% earners of the population had public entitlement to free care in public hospitals as public patient 	<ul style="list-style-type: none"> 1957 Voluntary Health Insurance Act: <ul style="list-style-type: none"> - Regulated the provision of voluntary health insurance in Ireland - Key principles: community rating, lifetime cover, open enrolment - Established the Voluntary Health Insurance (VHI) Board. Income tax relief on premia, at marginal rate of tax.
1970	<ul style="list-style-type: none"> One third of the population (GMS, or medical card holders) entitled to free GP and drug coverage, the rest liable to pay for such services. 	
1979	<ul style="list-style-type: none"> Entitlement to public hospital accommodation becomes universal (including top 15% of the income earners) 	
1987	<ul style="list-style-type: none"> statutory charges for outpatient and inpatient treatments in public hospitals introduced for all but medical card holders 	
1991	<ul style="list-style-type: none"> Entitlement to public inpatient consultant services becomes universal (including top 15% of the income earners) 	
1992		<ul style="list-style-type: none"> Council Directive 92/49/EEC, known as the Third Non-Life Insurance Directive obliged member countries to make arrangement for completion of internal market in non-life (including health) insurance.
1994		<ul style="list-style-type: none"> Health Insurance Act 1994 (following the Third Non-Life Health Insurance Directive): <ul style="list-style-type: none"> - opened the Irish market to competition - EU commission accepted Ireland's entitlement to avail of article 54 of the Directories, permitting legislation to protect the "public good" (e.g., community rating, open enrolment).
1995-1996		<ul style="list-style-type: none"> Reduction of tax relief on PHI premiums from marginal rate to standard rate.
1996		<ul style="list-style-type: none"> Health Insurance Regulations (based on 1994 Health Insurance Act) <ul style="list-style-type: none"> - Provided for the initiation of a risk-equalisation system - Provided regulation for lifetime cover - Provided regulation for minimum benefits.
1997		<ul style="list-style-type: none"> BUPA Ireland enters the PHI market.
1999		<ul style="list-style-type: none"> White Paper on Private Health Insurance, setting government objectives towards private care and private cover, and an agenda for the future.
2001	<ul style="list-style-type: none"> Publication of the government Health Strategy "Quality and Fairness. A health system for you" presenting a new vision for the health system based on the principles of equity, people centeredness, quality, accountability. 	<ul style="list-style-type: none"> Establishment of the Health Insurance Authority under the provisions of the 1994 Health Insurance Act.
2003		<ul style="list-style-type: none"> Implementation of a risk-equalisation scheme on 1st July.

Sources: OECD. Based on OECD Regulatory Questionnaire on Private Health Insurance, OECD interviews with Irish stakeholders, Department of Health and Children (2001).

2.1 *Interactions between the public and private health financing and delivery*

Entitlement to public coverage and public-private financing of population, providers and services

24. The Irish public health care delivery system is primarily financed through general taxation and a 1.25% health levy applied to all earnings. Eligibility to publicly financed services is divided among two population groups, which are entitled to receive different services (Table 2). The "*Category I population*"

(*medical card holders, GMS*) includes about 30% of the overall population who are eligible to free coverage of GPs, specialists, public hospital care, dental care, pharmaceuticals, long-term care, rehabilitative care, and home care. Entitlement is based on a notion of hardship, defined by income and age guidelines.²⁰ The rest of the population, “*Category II*” or non-medical-card holders, is entitled to free public hospital coverage in public wards (subject to the payment of statutory charges)²¹ and publicly financed specialist care in public outpatient clinics. Eligibility extends to some dental and optical services,²² assistance for the purchase of pharmaceuticals, and rehabilitative and long-term care, though co-payments are required.²³ Long-term care is provided by the public system. Those availing themselves of such care as private patients in private nursing homes receive a public subsidy, which is income-related. Public hospital care for the entire population involves treatment in public hospital wards with no choice of treating doctor.

25. Services privately financed differ between the two eligibility categories. Category II patients pay out-of-pocket or through their private health insurance for GPs and most dental care. They are also liable for the cost of specialist care if they choose to be treated in specialists’ private rooms or as private patients in public hospitals. Both medical card holders and category II patients can elect to be treated privately in designated “pay beds” within a public hospital or in private hospitals, thereby enjoying freedom of choice of provider. Private patients are liable for the payment of hospital charges²⁴ and medical fees.

26. The relative importance of private health insurance and out-of-pocket expenditure in financing health services varies by type of health service. Private health insurance mainly covers the expenses of private hospitalisation, while privately-financed GPs, non-reimbursed drugs and other outpatient services are mainly paid for on an out-of-pocket basis. Despite its ability to pool health risks across a large population segment, to date PHI contributes a very limited amount to the coverage of outpatient services, accounting for only about 3% of the expenditures of the two largest health insurers.

27. Table 3 illustrates the composition of public and private sources of health care expenditures in Ireland. Public health expenditure accounts for about three-quarters of total health expenditures (THE), slightly higher than the OECD average of 72%. Out-of-pocket expenditures represent about 13.3% of THE in Ireland, below the average for OECD countries of 18.1%.²⁵ The contribution of PHI to THE (6.8%) is similar to the OECD average of 6.3% for 2000²⁶ (5.1% excluding the USA).

28. Since the mid-1990s, private expenditure on health, including out-of-pocket payments and private health insurance, has been falling steadily as a percentage of THE.²⁷ This trend occurred within the

20 Category I includes all people over the age of 70.

21 A per-diem of 45 Euro, with a maximum of 450 Euro over 12 months (these rates took effect on 1 January 2004).

22 The Department of Social, Community and Family Affairs provides dental, optical and hearing benefits for insured workers and their dependents who have enough contributions under the Treatment Benefit Scheme. Treatment is provided by private dentists and opticians/ophthalmic surgeons.

23 For drugs benefits, Class I (medical card holders) are entitled to free drugs and medicines. Class II patients pay up to 70 Euro per month, above which the purchase of drugs is publicly covered via the ‘drug payment scheme’.

24 Private patients are not liable to pay hospital charges other than the statutory charge if they are accommodated in public beds. Private patients may end up staying in public beds, for example if they are admitted on an emergency basis and all other private beds are already occupied (Nolan and Wiley, 2000).

25 Data from OECD Health Data 2001 from 28 countries for public health expenditures and from 18 countries for out-of-pocket payments (OOP).

26 Data from OECD Health Data 2003 and represent the unweighted average for the 22 OECD countries for which data are available or estimated. .

27 Trends in private expenditure are contained in OECD Health Data and in The National Economic and Social Forum (NESF) (2002), Annex 1, Table 2.1.

context of particularly strong growth in overall health spending.²⁸ Private health insurance has consistently represented around 8-9% of THE during the 1990s, although it declined slightly over the past 10 years from 9% in 1991. The recent decline in the proportional role of PHI in THE is likely to change as the charges applied to private patients in public hospitals have increased by 67% over the last three years (incorporating increases from 1/1/02 to 1/1/04 inclusive), much of which is anticipated to be covered by PHI. This increase in the cost for private hospital care is consistent with the policy of moving towards the economic rate of charging for private beds, outlined in the Government's White Paper (Department for Health and Children, 1999).

Provision of services in the public and private sector

29. Health care delivery comprises both public and private providers. General practitioners (GPs) are organised in individual or group practices and financed through a combination of public and private funds. Medical card holders need to enrol with a physician of their choice, chosen from a (limited) list. Category II individuals have to pay fees for each GP visit and are free to visit any doctor of their choice. There are about 1 700 medical specialists (so-called 'consultants'), or about 0.3 per 1 000 population. Most specialists operate in public practice but are allowed to engage in private practice (and most of them do so).²⁹ Specialists carry out public *outpatient* visits in public outpatient clinics which can be located within or outside a public hospital. Several of them also have a private practice in private rooms and clinics and, in some cases, private rooms exist within public hospitals. Specialists deliver public inpatient treatments in public hospitals, where they can also see private patients.³⁰ Less than 10% of all consultants operate exclusively in private hospitals. Private patients enjoy unrestricted choice of consultant.

30. Public hospitals tend to provide the most advanced tertiary treatments, accident and emergency services, and teaching facilities.³¹ There are 18 private hospitals, generally furnishing less complex non-emergency care, in particular elective surgical treatments, psychiatric care and maternity, with the exception of two high-technology hospitals providing advanced acute care.³² Private hospitals account for over 2 500 acute and psychiatric beds, representing about 50% of the private/semi-private stock of beds in Ireland (Table 4). Many private hospitals were established by religious orders and operate on a non-profit basis. The private sector also manages private nursing homes.

28 See NESF (2002), p. 16, Figure 2.1, trends in Total Health Expenditure, 1989-99. The decline in the total share of health expenditure as a share of GDP from 1993 to 2000 reflect the extremely strong growth rates in overall health spending.

29 Consultants' national contract with the Health Boards commits them to work 33 hours per week in public hospitals. The contract also sets the extent to which consultants can do private work. According to Wiley (2001a), the contract does not specify the commitment of consultant time to the treatment of public patients. No fee is charged to physicians for the use of public hospital equipment and premises when treating private patients.

30 There are two main categories of consultants. Those in category 1 operate only in public hospitals, but can have off-site private rooms. Those in category 2 can admit patients to private and public hospitals and can also have off-site private practices.

31 Public hospitals include about 30 voluntary hospitals, and 77 general hospitals, which are mostly funded and administered by Health Boards. The acute public hospital sector consists of about 12 300 beds (Watson and Williams, 2001).

32 The Minister of Health does not have any function in relation to the regulation and co-ordination of private hospitals, other than in relation to maternity and psychiatric services (Department of Health and Children, 2001a).

Table 2. Public and private coverage of population, health services and providers in Ireland

	PUBLIC COVERAGE	PRIVATE COVERAGE (private health insurance and/or out-of-pocket payments)
Hospital care		
Hospital charges	<u>Public patients in public hospitals</u> <ul style="list-style-type: none"> • Treatment in designated public hospital wards • Entirely free for Medical Card holders (GMS) • Subject to a statutory daily payment of 45 Euro (ceiling 450 Euro per year) for Category II individuals. 	<u>Private patients (in public hospitals)</u> <ul style="list-style-type: none"> • Patients liable to pay statutory charges and per diem charges (covered by PHI for those with private cover). • Accommodation in designated private or semi-private hospital beds. • The public system subsidises the cost of private patients by maintaining public hospital below the full cost. <u>Private patients (in private hospitals)</u> <ul style="list-style-type: none"> • Patients liable for all payments to hospitals. • Private health insurance covers part or all of hospital charges, depending on the hospital, type of accommodation chosen, and policy held by the patient.
Medical specialists (consultants) charges	<u>Public patients in public hospitals</u> <ul style="list-style-type: none"> • Treatment by salaried doctors with no choice of doctor. • Medical costs covered by the public system for all patients. 	<u>Private patients (in public and private hospitals)</u> <ul style="list-style-type: none"> • Fees are unregulated. • Private health insurance covers part or all of the medical fees of consultants, depending on whether consultants are part of fully participating agreements with insurers. • Choice of doctor.
Ambulatory care, Physician services	<ul style="list-style-type: none"> • GMS patients eligible to: <ul style="list-style-type: none"> - Free GP cover (GPs payments are capitated; limited choice of doctor) - Free specialist cover in public outpatient clinics (doctors salaried) • Category II patients eligible to: <ul style="list-style-type: none"> - Free specialist cover in public outpatient clinics (doctors salaried) • Doctors cannot charge extra bills. • No out-of-pocket payments. 	<ul style="list-style-type: none"> • Category II patients liable for paying fees for GPs (doctors paid fee-for-service). • Category II patients liable for paying fees to specialists (doctors paid fee-for-service). • Fees are unregulated. • All PHI plans reimburse some of the costs of outpatient treatment, subject to high deductibles. • Recently insurers are developing specific products offering better coverage of primary and outpatients care.
Prescription drugs	<ul style="list-style-type: none"> • Free public coverage for GMS patients. • Catastrophic public coverage for Category II patients (under the drug payment scheme), subject to a deductible. 	<ul style="list-style-type: none"> • Category II patients liable for deductible (78 euros per month).
Dental/optical services	<ul style="list-style-type: none"> • Free coverage for GMS patients. • Free coverage for patients under the Treatment Cover Scheme (social insurance). 	<ul style="list-style-type: none"> • Category II patients liable for all costs, other than people with enough contributions to the Treatment Cover Scheme. • Limited coverage by PHI.
Other benefits	<ul style="list-style-type: none"> • Rehabilitative, long-term care and home care available to GMS patients; some assistance towards cost for other patients. 	<ul style="list-style-type: none"> • Limited coverage by PHI.

Sources: OECD. Based on OECD Regulatory Questionnaire on Private Health Insurance, OECD interviews with Irish stakeholders, Department of Health and Children (2001); Watson and Williams (2001).

Table 3. Sources of financing of health expenditure in Ireland, 1999-2001

	1991	1994	1997	2000	2001
Government	72.2%	71.0%	73.7%	72.4%	75.2%
Social security schemes	0.8%	0.9%	0.8%	0.9%	0.8%
Out-of-pocket payments	16.4%	14.9%	13.5%	13.5%	13.3%
Private insurance	9.0%	9.2%	8.7%	7.6%	6.8%
All other private funds	1.6%	4.0%	3.3%	5.6%	3.9%

Source: OECD HEALTH DATA 2002 4th ed.

31. The Health (Amendment) Act 1991 provided for the designation of public hospital beds according to public or private status (Wiley, 2001a), reflecting different sources of financing. Individuals elect to be treated as “private patients,” drawing from PHI or out-of-pocket expenditures, or “public” patients, to which there is universal entitlement, at the point of service. Once they have made their election, they keep their status for the entire episode of care. A small portion of beds, such as those in intensive care and cardiac care, are not designated as either public or private (769 in 1999). About 80% of acute inpatient designated hospital beds have a public status, while the remaining 20% (about 2 500 beds in 1999) are designated for treatment of privately funded patients in private or semi-private rooms (with up to 5 beds per room). The balance between public and private beds differs slightly (two-thirds versus one-third) in the case of day beds (Nolan and Wiley, 2000). Private beds can be occupied by public patients, for example, upon emergency, if other beds are unavailable, and vice-versa. Nolan and Wiley have shown that there is a substantial crossover of patients with private status to public beds, which represents a larger flow than the crossover of public patients to private beds.

Table 4. Public and private hospital beds

	Public hospitals		Private hospitals
	Public beds	Private Beds	
<i>Bed designation</i>	8 995	2 528	2 500
- % of designated beds in public hospitals	78.1%	21.9%	--
- % of Total bed stock in Ireland	61%	17%	17%

Notes: The total bed stock includes also non-designated public hospital beds (769 in 1999).

Sources: Wiley (2001a); Department of Health and Children (2001a).

Provider payments and reimbursement in the public and private sector

32. GPs are paid on a capitation basis for treating medical cardholders and fee-for-service for category II patients. Consultants are salaried³³ for their public practice, while they are paid on a fee-for-service basis when operating in private practice. Private fees are unregulated and established competitively by physicians.³⁴ This is especially the case for outpatient services, where individuals settle their bills

33 Salary levels for all ‘consultants’ are set in national contracts negotiated over a 4-year period. Consultants who can admit private patients to public hospitals have a lower salary than those who cannot. There are in addition salary adjustments by location, reflecting higher proportion of public work outside major urban centres.

34 Consultants’ outpatient fees typically vary from 40 to 110 euros.

directly with providers, and may subsequently claim a reimbursement by insurers if they hold a PHI policy. For inpatient services, most consultants' private income originates from treating patients covered by private health insurance. Nearly all consultants accept as full payment the professional fee schedules negotiated with insurers in private hospitals.³⁵

33. Public hospitals are financed through global budgets with case mix adjustments. Private beds represent an additional income stream for public hospitals, who receive per diem payments for the use of pay beds by the patient (if they pay out-of-pocket) or by their insurer (if they hold a PHI policy). The level of per day charges applicable to private inpatient and day patient in public hospitals is set by the Minister of Health and Children.³⁶ Historically, the rationale for such low pricing was that individuals had already contributed towards the cost of public hospital services through their taxes.

34. Private hospitals set their own fee levels competitively. However, as only few patients self-finance their private hospital treatment, private hospitals receive the large majority of their payments directly from private health insurers. Virtually all private hospitals are involved in contractual relationships with insurers. Contracts are negotiated annually on an individual basis. The content of the contract concerns the level of the benefit paid, usually a mix of per diem and condition-based payments (apart from psychiatric services where payment is exclusively per diem). Often insurers establish caps on the amount of cash payments that they will make to a hospital in a year. Insurers have direct billing arrangements with most private hospitals that involve fully participating payments, with no additional out-of-pocket costs by patients, or partially-participating agreements, involving some limited payment by patients. Private hospital fees are higher than those charged to insurers for use of private beds in public hospitals. No public subsidy is paid to private hospitals.

2.2 *The private health insurance market in Ireland*

35. The main function of private health insurance is to provide a private alternative to the universal entitlement to public hospital services. This private alternative can include services in private hospitals, or private beds in public hospitals. PHI policyholders include a broad spectrum of the population, but they are concentrated in upper income brackets and in certain socio-demographic and employment groups. Demand for PHI tends to be related to income and entitlement to public services, with a substantial employment link.

35 Insurers hold discussion with the Irish Health Consultants Association (IHCA) on a periodic basis to negotiate fully participating fee levels (involving full cover by insurers with no payment needed by patients). After such negotiation, insurers write to each consultant, who may or not agree to accept the fully participating rates. If a consultant does not accept such rates as full payment, then insurers reimburse consultants' standard benefits (coinciding with minimum benefits prescribed by law, which are lower than fully participating fee levels; see section 3.1.1 for a description of minimum benefit requirements). Patients are liable to pay consultants any extra amount over and above the standard benefit. About 99% of consultants accept the negotiated rates as full payment. Smaller insurers, including BUPA, tend to be price followers based on rates negotiated by VHI.

36 Per diem charges in public hospitals differ depending on the category of the hospital and whether private or semi-private accommodation is used. Day care charges are set as a proportion of overnight charges. Hospital charges reflect the complexity of medical services provided by the hospital and the higher cost of upgraded amenities and hotel services enjoyed by private patients. Private patients are liable for paying these charges in addition to the public hospital statutory charges applicable to category II patients (Source: Department of Health and Children, 1999).

Functions of private health insurance and benefits covered

36. Insurers do not face any restriction over coverage of providers, while they are required to provide certain minimum benefits concerning coverage of services.³⁷ Health insurance plans are structured in an incremental manner and include a mix of different types of cover. All plans offer duplicate hospital coverage, which accounts for the largest share of the private health insurance market (87% of total premiums paid in 2000).³⁸ The lowest level plans cover semi-private accommodation and care within the public hospital system or an equivalent level of cover in a private hospital.³⁹ More comprehensive plans can cover the full cost of treatment in all private hospitals, including the two high-tech private hospitals. Although representing a limited portion of overall cost, all plans must also provide complementary cover of the statutory charges applicable to category II people who attend public hospitals.

37. Individuals face very limited out-of-pocket expenditures in relation to hospital coverage because patients are either entitled to publicly financed services or covered by private health insurance. Very few persons self-insure for private hospital care. Conversely, coverage for primary care is less comprehensive. Over two thirds of the Irish population are liable for their own primary care. Historically, the private health insurance market did not cover these services, but rather offered protection against the catastrophic costs associated with significant episodes of acute illness. Out-patient cover was designed to serve largely as a safety net in cases where insurees faced unusually high health expenses overall. Under most plans, benefits for outpatient care are still subject to high deductibles.⁴⁰

38. The two main insurers operating on the market offer plans that are similar. The most frequently purchased VHI and BUPA policies provide access to all public and most private hospitals. Some additional products are found on the market although product differentiation is still not substantial. Policies mainly differ according to their out-of-pocket payments on outpatient benefits (deductibles and annual limits), type of covered accommodation (private or semi-private), and the range of private hospitals which can be accessed by enrollees.⁴¹ There are also differences in the coverage of routine and preventative examinations or screening. The opening of the PHI market to competition has stimulated some product innovation. Insurers have, for example, designed new products aimed at providing more comprehensive primary care and outpatient cover. No variation in policies based on exclusions or limitations from cover of certain conditions can be found, apart from limits linked to waiting periods and pre-existing conditions.

37 The Health Insurance Act, 1994 (Minimum Benefits) Regulations, 1996 prescribe minimum benefits that an insurer shall pay to an insured person in respect to hospital charges and consultants' fees for in-patient and day-patient services, special hospital procedures, and hospital charges and consultants fees for outpatients.

38 Source: OECD Statistical questionnaire on Private Health Insurance. Response from Ireland.

39 Such level of coverage corresponds to minimum benefits that insurers are required to provide.

40 Such excesses range, for example, from 250 €per annum for an individual to 500 €for a family.

41 For inpatient and day surgery, basic plans offer semi-private accommodation in public hospitals and most private hospitals, excluding two high-tech private hospitals. More comprehensive plans offer private accommodation in the former hospitals, and semi-private accommodation in the high-tech hospitals. The most comprehensive plans offer private accommodation in all hospitals.

Demand for private health insurance

Coverage by private health insurance and interaction with entitlement to public health services

39. Private hospital insurance is estimated to cover nearly half of the Irish population.⁴² According to Watson and Williams (2001),⁴³ private health insurance covers 45% of the population, with a further 2% buying private hospital cash plans⁴⁴ *only* (out of a total of 6% buying hospital cash plans). Purchase of private health insurance is inversely related to entitlement to public coverage, since those with most generous public entitlements purchase less private coverage. Only 13% of those with a medical card buy private cover (4% of the population), compared to 62% of those in category II (43% of the population). For GMS individuals, PHI provides duplicate coverage, while for others PHI provides duplicate hospital coverage, complementary cover for statutory charges applicable in public hospitals, and substitute cover for primary care (Table 5).

Table 5. Population coverage by private health insurance

Groups:	PHI coverage		Types of coverage
	% of Population with PHI	% with PHI cover within the Group	
Medical Card Holders (31% of the population)	4%	13%	Duplicate
Category II individuals (69% of the population)	43%	62%	Duplicate Substitute (primary care) Complementary (statutory charges on public hospitals)
TOTAL	47%		

Source: OECD, based on data from Watson and Williams (2001)

Characteristics of PHI subscribers⁴⁵ and factors affecting demand for PHI

40. Private cover is correlated with socio-economic status, income, and educational levels (Watson and Williams, 2001), which is consistent with evidence from other OECD countries. There is a strong positive relationship between household income and ownership of private health insurance. Purchasers of

42 The Department of Health and Children estimates coverage in 2003 at 49%. The Health Insurance Authority (2003a) estimate for 2002 was 47%. The latter carried out a face-to-face survey on nationally representative sample of 1001 Irish adults above 18. The survey investigated several aspects of the PHI market including, among others, insurees' propensity to switch insurer, propensity to buy private cover, willingness to pay for PHI, attitudes towards the market, and knowledge of private cover.

43 Watson and Williams (2001) carried out a telephone survey on consumer confidence indicators which yielded 3 000 successfully completed and nationally representative questionnaires. The survey asked questions related to health status, health coverage, perception of quality of care in the public and private systems, reasons for or against buying PHI, and health care utilisation.

44 Hospital cash plans provide a fixed benefit upon hospitalisation and provide some compensation for loss of income.

45 Several surveys have been carried out in Ireland examining characteristics of PHI subscribers and reasons for buying PHI. This study draws from these data in different sections. Concerning data on insurance coverage, Nolan and Wiley (2000) and Harmon and Nolan (2001) present 1994 and 1997 data from two waves of the "Living in Ireland Survey" (the Irish European Community Household Panel). Concerning attitudes towards PHI, Nolan and Wiley (2000) and Watson and Williams (2001) analyse data collected from 1999 and 2000 from special modules that were added to the regular data collection on consumers' confidence carried out by the Economic and Social Research Institute for the European Community.

private health insurance are also more often men, in middle-age cohorts, and in full-time employment (Table 6). While purchasers of PHI tend to report better health status than people with a Medical Card, the self-assessed health status of category II individuals is similar for those with and without private cover (Watson and Williams, 2001). This suggests that no major difference by health status can be tracked in the privately insured population. Earlier analysis of the determinants of demand for private health insurance indicates that the probability of buying PHI is associated with higher income and educational attainments, with no significant evidence of self-selection by people in poor health (Harmon and Nolan, 2001; Nolan and Wiley, 2000).

41. The profile of PHI enrolees shows some variation by insurance company. BUPA Ireland's clients tend to be younger, from higher income and educational groups, and less likely to have a health problem than VHI subscribers (Table 6). Results from a different survey show that 46% of VHI customers are aged 45 and over, compared to 29% of BUPA's client base (Health Insurance Authority, 2003a). This can be explained by BUPA's success in attracting newly insured clients, who tend to be people at early stages of the life cycle, as well as a higher propensity of younger people switching across insurers. While only 6% of a sample of PHI enrolees changed insurers in the six years since competition was introduced in Ireland, about three-quarters of the switchers are under age 45 and this same $\frac{3}{4}$ proportion moved from VHI to BUPA (Health Insurance Authority, 2003a).

42. PHI price increases have not appeared to greatly impact the general distribution and characteristics of PHI enrolees. While limited evidence about price sensitivity of demand for private cover is available, demand has seemed to be rather inelastic to premium increases.⁴⁶ Population coverage has grown over time in spite of premium growth rates exceeding increases in per capita income⁴⁷ and the reduction in tax relief.⁴⁸ Employer-paid group coverage may nonetheless be more sensitive to price increases, as employers are more likely to change to cheaper insurers.⁴⁹ Improvements in the perceived affordability of private cover, which has been recorded through population surveys, might explain the resilience of demand to growth in prices (Nolan and Wiley, 2000; Watson and Williams, 2001). However, it is difficult to assess whether perceptions of value for money are shaped by confidence in the development of the Irish economy or by improvements in the quality of private coverage per se, particularly in relation to perceptions of quality of the public system.

43. However, the cost of PHI generally, as opposed to premium trends, does seem to impact the characteristics of covered populations. Among those uninsured, the main reason for not buying private cover is cost, especially for people in lower income groups. Further, there seems to be upper limits to the willingness to buy PHI irrespective of affordability. About 60% of all those uninsured would not buy private cover even if waiting times in the public system grew longer, and 58% are unwilling or unable to make any payment towards the cost of private cover (Watson and Williams, 2001). Results from a different survey indicate similar findings (Health Insurance Authority, 2003a). Young people below 35 are the population segment most likely to consider buying private cover as new clients, although they are likely to benefit much less from its purchase.

46 According to the Health Insurance Authority (2003a) survey, the average premium increase at which insurees would let their policy lapse was 32.5%.

47 During the period 1981-2001, the average annual increase of per capita income was 9.9% (OECD, Health Data 2003), compared to the annual average increase of PHI premium of about 8%.

48 Annual premiums net of tax for an adult varied from 250 to 1 200 euros in 2002.

49 For example, at the beginning of 2003, some major multinational companies defected from VHI to BUPA following an 18% hike in VHI's insurance premiums the previous September ("Software giants desert VHI for rival BUPA", *Sunday Business Post*, January 12, 2003).

Employer and other Group Health Insurance Offerings

44. While the purchase of PHI coverage has historically been an individual decision, funded largely by individuals and households, Ireland has a large and growing employer group coverage market. In 1997, 80% of premiums were paid by individuals, and 20% by employers (1997).⁵⁰ Recent figures indicate that 80% of premiums originated in the group market, which includes employers and other groups, and 20% in the individual market.⁵¹ The number of people having their health insurance premiums entirely met by their employers (20% in 1999 and 25% in 2003)⁵² appears to have grown over time, which may impact upon, and reduce, individuals' price sensitivity.⁵³

45. Most group schemes are administered by employers (78%), while others obtain coverage through a credit union (12%) or through other arrangements (8%) (Health Insurance Authority, 2003a). Unlike the case in some other OECD countries, the definition of "group" under Irish health insurance law is very broad and includes coverage that is not connected to, or subsidised by, a particular employer.⁵⁴ This means that a wide array of arrangements can benefit from the 10% premium discount permitted for group policies. Nor is there a requirement for an employer subsidy in order for PHI coverage to fall within this category. Restricted membership undertakings (RMUs) also offer PHI to some categories of employees.⁵⁵ In some cases, this coverage is among some of the most generous in Ireland. Certain RMUs offer ancillary (supplemental) coverage alone.

46. The significance of the group market in Ireland derives from several factors. Some of these are linked to the enlarging role of employment-based PHI. Plausible explanations for such as employer role include the strong expansion of the Irish economy, higher levels of employment, and a well-performing corporate sector, particularly multinational companies and the service industry. The increasing provision of private health insurance as an employment-related benefit may be one reason for the uninterrupted growth of the private health insurance coverage in Ireland.⁵⁶ Another may be the financial incentive provided to individuals to purchase non-employer-based "group" coverage.

50 Department of Health and Children (1999), p. 7.

51 OECD PHI Statistical Questionnaire, 2002, response from Ireland.

52 Department of Health and Children (1999) and Department for Health and Children estimates for 2003. Employers may pay entirely the premium, or subsidise the purchase of private cover, or pay no contribution although the premium is collected by the insurer directly from the employee's payroll.

53 Nolan and Wiley (2000) analyse how PHI evolved between 1994 and 1997. The importance of employer sponsoring of health insurance grew over this period, and is most likely indicative of a continuing trend.

54 The Health Insurance Act of 1994 permits reductions in premiums to not less than 90% "to a person who is a member, for the purposes of health insurance, of a group of persons..." The Health Insurance Act of 1994, Part II, Section 7(4)(b)(iii).

55 See below for a description of carriers of private health insurance.

56 The buoyant labour market and persistent labour shortages are putting pressures on employers to offer a greater range of health benefits, occupational health programmes and other services like childcare and wellness management in order to recruit and retain qualified staff. Source: VHI Health care: http://www.vhihealthcare.com/corporate/dev_phi1.html.

Table 6. Characteristics of PHI enrolees

Groups	PHI subscribers			Company	
	% of Group with private cover ⁽¹⁾	Profile of people with PHI cover	VHI	BUPA Ireland	Other
TOTAL	45%	100%, of which	85%, of which:	8%, of which:	7%, of which:
Gender					
▪ Male	46%	51%	49%	50%	68%
▪ Female	44%	49%	51%	50%	32%
Age					
▪ Under 30	46%	32%	30%	49%	35%
▪ Age 30-49	52%	38%	38%	42%	31%
▪ Age 49-64	46%	22%	23%	6%	27%
▪ Above 65	25%	8%	9%	4%	8%
Weekly Income					
▪ Under 200£	16%	8%	9%	6%	3%
▪ 200-334 £	37%	24%	24%	20%	25%
▪ 335-449 £	59%	33%	32%	41%	39%
▪ over 450 £	69%	35%	35%	33%	32%
Education					
▪ Primary only	28%	20%	21%	7%	25%
▪ Junior cycle	40%	21%	20%	23%	28%
▪ Leaving certificate	53%	33%	32%	40%	33%
▪ Third level	69%	26%	37%	30%	14%
Employment					
▪ Full-time employed	54%	57%	54%	61%	68%
▪ Unemployed	14%	1%	1%	3%	1%
▪ Full-time education	60%	14%	14%	11%	1%
Health status					
▪ No health problem	49%	92%	91%	96%	95%
▪ Health problem	25%	8%	9%	4%	5%

Note: ⁽¹⁾ Excludes hospital cash plans.

Source: Watson and Williams (2001).

Individual reasons for buying PHI and perceptions of publicly financed health system

47. The main reasons for buying private cover seem to be risk aversion (88% of a sample of insurees bought PHI cover in order to “avoid large bills”) and timely access to care (85% bought PHI cover to be sure to get into hospitals quickly).⁵⁷ Choice of doctor and securing doctors’ time are also important reasons in about half of the cases, while having private or semi-private accommodation is perceived to be of lesser importance.⁵⁸ Reasons for buying private cover are linked to perceptions and anxieties over the quality of the public system,⁵⁹ although the people most critical of the public system are those who never used it. Differentials in perceived quality between the public and the private sectors seem especially to relate to the length of waiting times, and are strongest among young people, those with private insurance, and upper socio-economic groups. People not buying PHI, such as the majority of medical card holders, rank the

57 Watson and Williams (2001), chapter 6.

58 These results are consistent with a similar survey carried out by in 1999 (Nolan and Wiley, 2000).

59 In the 1990s, such quality factors have become prominent reasons behind decisions to buy private cover, while earlier “access” was a more important reason (Nolan and Wiley, 2000).

quality of the public system higher than those with a PHI policy, although four out of five still believe that treatment can be obtained faster within the private sector (Watson and Williams, 2001).

Types of private health insurance carriers

48. PHI in Ireland is provided by two main non-profit health insurers.⁶⁰ The Voluntary Health Insurance Board (now VHI Healthcare) was established as a not-for-profit state-owned statutory body under the 1957 Voluntary Health Insurance Act. It operated as a near monopoly provider of PHI until 1997 when, following the opening of the Irish health insurance market to competition, a branch of the British United Provident Association, BUPA Ireland, commenced activity in the country. The 1999 White Paper on Private Health Insurance envisaged the incorporation of VHI with full commercial freedom, although this has not been completed as yet. All insurers are in principle subject to the same regulation and treatment, but VHI still needs to notify the Minister of Health of any proposed premium increases, and the Minister may reject them. It also needs to obtain the Minister's approval for any new health insurance schemes or amendment to existing ones.⁶¹ BUPA has progressively gained market shares since 1997 (Table 7). VHI retains a dominant share of the market, however, with an over 80% market share in 2002. Besides these two players, a smaller group of undertakings with membership restricted to particular occupational groups also operates on the Irish health insurance market,⁶² with a total market share of 5% in 2003.

Table 7. Market share of insurers on the Irish PHI market

	Before 1997 ⁽¹⁾	Year 1999 ⁽²⁾	Year 2000 ⁽³⁾	Year 2003 ⁽⁴⁾
VHI	95	85	85.9	82
BUPA	0	8	9.0	13
Restricted Membership Undertakings	Around 5%	7	5.1	5

Sources: (1) Estimates; (2) Watson and Williams (2001); (3) OECD Statistical Questionnaire on PHI (4) Health Insurance Authority (2003a).

3. Overview of government policies and interventions

49. Certain governments in OECD countries impose a range of requirements relating to access to coverage by PHI. This is particularly the case in countries where PHI plays a significant role. The history and extent of governmental involvement in setting standards for Ireland's private health insurance market stem from the particular history of private health care financing in Ireland, government priorities, and the types of entities operating in the market.

50. In recent years, Ireland's entry into the EU has greatly affected the potential nature of the Irish PHI market and its regulation. Ireland had to ensure that its PHI market and related requirements conformed with EU insurance directives and other applicable EU law. To date, however, some of these

60 BUPA is a provident association.

61 The VHI also benefits, under the EU Directive 73/239/EEC, from a derogation from the solvency requirements for authorised insurers. Yet it comfortably exceeds the EU's minimum requirement, although not that of the national authority which is typically set at 200% of the EU minimum. (Source: OECD Regulatory Questionnaire on Private Health Insurance, Ireland).

62 Restricted membership undertakings include people of common vocational and occupational group and their dependents. The largest among them include: the St. Paul's Garda Medical Aid Society, the Prison Officers' Medical Aid Society and the ESB Medical Provident Society. (Department of Health and Children, 2001a).

legal changes have been somewhat limited because of the predominant market share retained by VHI, which was historically subject to a range of requirements, not all of which are similar to provisions under EU law. The implementation of several measures to stimulate the development of a competitive health insurance market, together with the entry of a second insurance carrier in the PHI market, has raised several important policy and legal questions regarding the scope and nature of requirements appropriate to PHI in Ireland.

3.1 Requirements relating to access to PHI coverage in Ireland

51. Similar to other OECD countries where PHI plays a prominent role within the health system, Ireland imposes broad and strict requirements relating to access to, and the scope and premiums of, PHI coverage. These standards include issuance (“open enrolment”) and renewability requirements, limits on insurers’ ability to exclude coverage of certain conditions, community rating, and minimum benefit requirements. These different provisions constitute a “package” of standards encouraging equitable access and financing within the Irish PHI market. While VHI performed consistent with several such regulatory principles since its 1957 enabling legislation, the standards now apply to an expanded PHI market since the enactment, in 1994, of legislation to bring Ireland into conformance with the requirements of EU law, notably the EU third non-life insurance directive.

Benefit Standards for PHI Policies

52. PHI policies in Ireland are subject to minimum benefit requirements. These address both the benefits that must be covered, and the minimum reimbursement insurers must provide for these services. The 1994 Act imposed benefit requirements that had previously applied only to VHI policies upon the whole PHI market. Private health insurers must provide coverage with respect to semi-private accommodations within public hospitals, an equivalent level of cover within private hospitals, and co-payments for private patients in public hospitals. These requirements have some limitations. For example, the rates have not been updated in the past 10 years. Moreover, some evidence suggests that insurers offer limited maternity and psychiatric benefits as a direct result of this minimum benefit schedule.⁶³

53. Minimum benefit schedules do not prevent insurers from offering coverage beyond the required scope. For example, insurers have recently expanded benefits for primary care, non-acute services, and alternative treatments without any requirement for such coverage.⁶⁴ Nonetheless, the level of detail in such requirements can be cumbersome. The White Paper on Private Health Insurance (Department of Health and Children, 1999) suggests that the minimum benefit scheme could benefit from simplification. The government also is considering a more flexible regulatory structure to minimise the need to change regulatory reimbursement schedules in order to respond to market developments.⁶⁵ On a separate matter, the government noted that it would monitor market developments in the area of cost-sharing – particularly given its potential to influence utilisation.⁶⁶

63 However, the White Paper on PHI (Department of Health and Children, 1999, p. 56-7) examined the question of psychiatric care coverage and did not find a need to significantly alter in-patient psychiatric stays (minimum benefits require coverage of 100 days of in-patient treatment in a private psychiatric hospital during the calendar year). However, it recognised the benefit of assuring some psychiatric day-patient treatment coverage. The Government is therefore considering requiring insurers to cover 20 days of day-patient coverage.

64 OECD Regulatory Questionnaire, Ireland.

65 Department of Health and Children (1999), pp. 55-59.

66 *Ibid.*

54. Minimum benefit requirements require a minimum scope of coverage without restricting or standardising it in any way. This approach provides for more choice of coverage packages by insurers than government mandates requiring the offering of standardised benefit packages. While minimum benefits do not per se ensure ready comparability of coverage and cost on the part of insurees, the Irish PHI market is in practice concentrated on several popular products offered by insurers. Nonetheless, despite their relative comparative advantage vis-à-vis consumers in other countries, only about a quarter of Irish health insurance consumers report that they are very satisfied with the quality and accessibility of information that would help them compare health insurers' offerings, and about a half report they are satisfied.⁶⁷ Hence, improvements could still be made in the supply of PHI-related information to consumers. Interestingly, among those with PHI cover, less than one in five consumers believe they have a thorough understanding of the level of coverage they have for different treatments. However, despite this relative lack of familiarity, over half of the insurees report they are satisfied with their level of knowledge of their cover.⁶⁸ This would seem to indicate that most Irish consumers with PHI are satisfied with a moderate understanding of their coverage.

Standards assuring access to PHI coverage

55. Private health insurers are generally required to issue their products to all persons up to 65 years of age, at any time (sometimes referred to as a "guaranteed issuance" requirement, or "open enrolment").⁶⁹ RMUs are exempted from these broad issuance requirements. This exemption has not resulted in exclusionary activity on the part of these entities (membership is limited to the relevant vocational group), and thus has not undermined the success of open enrolment in the Irish PHI market. This is likely due to the small proportion of the PHI market represented by these carriers, their clear connection to specific industries or occupations, as well as the existence of protections concerning age-related membership and issuance decisions by these insurers.⁷⁰

56. The Irish open enrolment requirement is complemented by "lifetime cover," which prohibits PHI insurers from terminating or refusing to renew health insurance contracts without the consent of the insured person.⁷¹ Upon applying for coverage for the first time, as well as when seeking to renew it,⁷² consumers are assured the continued offering of private cover, irrespective of their health status.⁷³

57. Historically, VHI practices conformed to the above-described access-related requirements. The 1994 legislation made these requirements applicable to any new entrants into the Irish market, assuring that all players were subject to the same rules.⁷⁴

67 Health Insurance Authority (2003a), p. 21.

68 *Ibid*, pp. 27-28.

69 Insurers are currently not required to issue new products to those aged 65 and over. However, legislation enacted in 2001 gives the government authority to require them to do so, although implementing regulations have not yet been prescribed. Health Insurance Amendment Bill, 2001, Section 8.

70 *Health Insurance Act*, 1994, Section 8(2).

71 It is interesting to note that in Australia, the term "lifetime cover" has a different meaning than in Ireland (see footnote 82). This Irish requirement is also referred to as a "renewability" requirement in other OECD countries, such as the U.S, but age adjusted premiums have not been implemented in Ireland.

72 PHI coverage is offered through annual contracts in Ireland.

73 Prior to 1994, consumers might have faced some difficulty renewing coverage for particular conditions. There is, however, limited evidence indicating the extent to which these behaviours took place. Such action is now clearly prohibited under the 1994 Act.

74 Some of the issues relating to these requirements and EU law are described in section 4.1.

Standards to protect insurers from adverse selection while preserving access to coverage

58. Governments may employ several tools to try to reduce the risk of adverse selection; these include waiting periods and permitted but time-limited benefit exclusions. The 1994 Health Insurance Act includes several such protections. For example, insurers are permitted to protect themselves against some of the potential adverse selection that could accompany a broad open enrolment requirement by imposing modest “waiting periods” (a length of time before coverage becomes effective). Unless care is required due to an accident or injury, Irish law permits an initial waiting period of 26 weeks while in the case of maternity benefits or for those of or over 55 and under 65, it is 52 weeks.⁷⁵ This requirement carries trade-offs: it involves a reduction in coverage for those who purchase PHI, but it seeks to provide an incentive for persons to purchase coverage prior to its need.

59. In the case of coverage of “pre-existing conditions”,⁷⁶ Irish law imposes some broad restrictions on the ability of insurers to exclude coverage of such conditions. While such exclusions seek to protect insurers against adverse selection, and the limits provide assurance that policyholders gain coverage for a particular benefit at a later date if they remain insured, these limits are much looser than similar restrictions in other OECD countries that have included such standards in their PHI regulations.⁷⁷ Such exclusions are permitted to be up to 5 years long for those under 55 years of age, 7 years for those aged 55 or over but under 60, and 10 years for those aged 60 or over but under 65. However, the need for such lengthy exclusions has been reduced by the implementation of a risk-equalisation scheme, which seeks to compensate PHI insurers for certain differences that may exist in the health status or “risk profiles” of their covered populations (see Section 4.1.5 herein). Insurers could still be protected against adverse selection, while at the same time providing more protection to enrolees, if these limits were shortened.

60. Within a context where insurers offering voluntary cover are subject to community rating, they are exposed to adverse selection because they cannot adjust premiums to the health status of the insured. The advent of a newly competitive PHI market argues for the retention of some limits on pre-existing condition exclusions as a protection against “unfair” competition (*i.e.*, competition based upon the selection of good risks) – although shorter exclusions would still be able to provide that safeguard.

61. Irish law also provides for some portability between insurers and amongst products. Insured individuals can change insurers within a prescribed time period of 13 weeks without having a new exclusion period imposed for the same condition, if they have already exhausted such a limitation with another insurer; alternatively if such a period was only partially exhausted, their exclusion period with the new insurer can be reduced by the time they held previous coverage. In addition, insurers may only restrict those purchasing a more generous policy from receiving their additional, new benefits for a limited time period; this limit is 2 years for those under the age of 65 and 5 years for those over age 65 on the additional benefits involved. While exclusions seem to be applied only to a limited extent, insurers do employ extended waiting periods.

75 Irish response to the OECD Regulatory Questionnaire, Section C1.

76 Such exclusions under PHI contracts generally apply to medical or health conditions held prior to enrolment. These are defined under Irish law to be “an insured’s person medical condition, the date of onset of which is determined on the basis of medical advice to have been prior to the date he or she is first named in a health insurance contract other than where the insured person is an infant and has been so named within 13 weeks of his or her date of birth”. *See* OECD regulatory questionnaire response, section C4; Health Insurance Act, 1994 (Open Enrolment), Regulations 1996, Part 3, Section 8(1).

77 For example, the U.S. and Australia limit the length of permitted pre-existing condition exclusions to 12 months. Conversely, such restrictions have not been at all introduced in other PHI markets, such as for example Canada, Portugal and the U.K., among others. (See chapter 3 in OECD, 2004).

Restrictions upon PHI insurers' ability to consider health status in premium calculations

62. The 1994 Health Insurance Act introduced “community rating” into the Irish market, imposing a particular and uniform method of premium calculation on all PHI insurers in order to promote risk pooling across the privately insured population. To this end, the legislation prohibits insurers from varying premiums based on health status.⁷⁸ It further prohibits variation based on age, gender, sexual orientation and other factors. This requirement applies to all PHI insurers and to all PHI products meeting the legal definition of a “health insurance contract” – a broad definition encompassing nearly all PHI products.⁷⁹ In comparison with similar requirements in other OECD countries, Ireland’s 1994 requirement might be termed “pure” community rating, as it restricts variation in premiums based on age and other factors upon which variation is permitted under the community rating schemes in some other OECD countries, such as Australia.

63. There are a few exceptions to this requirement. First, insurers may charge no more than 50% for their premiums to children. Students between the ages of 18 and 23 can also receive discounts of not more than 50%. In addition, RMUs registered on or before January 1995 may charge reduced premiums to members receiving a pension. Finally, as discussed above, group schemes can offer 10% discount on premiums. Apart from group discounts, these exceptions are narrowly crafted; none appear to have undermined community rating.⁸⁰

64. Pure community rating could promote adverse selection because persons have little incentive to purchase care at a younger (and often healthier) age. In order to address these concerns, the 2001 Health Insurance Amendment Act permitted the introduction of age-related premium variation.⁸¹ This change would be as significant step towards a reduction in the risk of adverse selection and is also consistent with the recommendation of the 1999 White Paper on Private Health Insurance and was also affirmed by the Health Insurance Authority (HIA), an independent statutory body, in a report to the Government in late 2002.⁸² However, this more flexible premium standard has not been implemented yet.

65. Prior to 1994, VHI, the sole carrier on the market, offered its products at the same rate to purchasers, irrespective of their health status. This resulted in a PHI market that operated de facto on the basis of community rating. VHI could, however, vary the premiums according to the specific benefits covered under the benefit package – which PHI insurers can also continue to do under the 1994 community

78 Prohibited health status related factors include frequency of the provision of health care, claims, or the “prospective” suffering of disease. *See* Health Insurance Act of 1994.

79 *See* Section 4.1.5 for discussion of exceptions from risk equalisation that may be permitted for certain entities and certain benefit packages. Cash benefit policies are not subject to these requirements and are not considered to be health insurance products under this legislation. *See* Department for Health and Children (1999), p. 61.

80 In other OECD countries, exceptions to community rating legislation have resulted in shifts in the PHI market to those segments of the market not subject to the requirements, thereby reducing the potential risk-spreading impact and at times causing other undesirable results. *See e.g.* Discussion of impact of exemption from community rating for association plans in the U.S. state of Kentucky, in Tapay, N. and Feder J. (1999).

81 This legislation provides the Dept. of Health and Children with the authority to implement regulations for a system of “lifetime community rating.” This is a similar proposal to a measure introduced in Australia in 2000 (so-called “lifetime cover”) that allows insurers to adjust community rating according to the age of the insured if s/he takes coverage after age 30 or does not maintain continuous coverage, by an annual premium loading of 2% per year after age 30.

82 Department of Health and Children (1999), pp. 33-37; HIA (2002b). The DHC (1999) and HIA (2002b) differ on some of the details of how to implement such a program but concur on the general principle.

rating requirements. The 1994 and subsequent amendments and clarifications to this legislation,⁸³ seek to maintain a continuous emphasis on broad risk pooling, within a competitive and voluntary PHI market.

Risk Equalisation (“RE”) scheme

66. In recent years, there has been a heated policy debate in Ireland around the implementation of the RE scheme provided for under the 1994 legislation. An initial scheme established pursuant to 1996 regulations was revoked without any payments having been introduced. A new scheme was implemented in July 2003 under separate regulations. The RE scheme can require payment transfers among insurers to compensate for differences in their risk profiles. It seeks to prevent a situation where certain insurers benefit from lower risk profiles to gain an “unfair” competitive advantage. Undesired practices include insurers' charging market rates and benefiting from atypically low claims, or attracting certain consumers through premiums set below expected claim costs (and later raising premiums to cover claim costs), causing several undesirable distortions in the market. One policy question underlying the RE debate is the extent to which community rating needs to be underpinned by a risk-equalisation scheme. Other issues include the desirability of RE and/or community rating within a PHI market, as well as its compatibility with EU insurance law and interpretations of these requirements, as discussed in more detail under Section 4.1.6 below.

67. Opponents of risk equalisation find it incompatible with principles of competition and believe it will discourage insurers' efforts at containing cost. They also indicate that RE seeks to prevent a threat to the market that, in their view, is only hypothetical at the moment.⁸⁴ In the absence of such a scheme, however, there is the potential that insurers could compete on the basis of attracting a more healthy pool of clients.⁸⁵ In fact, as detailed in Table 6 above, there are some differences in the age and health status profiles of enrolees of the two insurers. Thus, the two insurers are not currently operating or competing upon a "level playing field."

68. With respect to the impact of such a scheme on competition, many experts believe that risk equalisation is a necessary buttress for fair competition within a community-rated environment. In the absence of adequate risk equalisation within an individual market subject to community rating and open enrolment, there will be large incentives for risk selection, and potential adverse effects on equity and market efficiency. There is also a general consensus in the health economics literature and among other experts supporting the importance of RE schemes in order to prevent risk selection.⁸⁶ Hence, Ireland's ongoing implementation of the scheme seems well-warranted. As discussed below, implementation of the scheme does not necessarily mean that payments will be required, but it does trigger the process under which HIA assesses whether to recommend such payments under the criteria set forth in the legislation and regulations.

83 The Health Insurance (Amendment) Acts of 2000 and 2001 provided some clarifications relating to areas addressed by the 1994 legislation. These included clarification of regulatory treatment of employer schemes, community rating, risk equalisation, and other health insurance coverage schemes.

84 BUPA Ireland (2000).

85 The Irish Government seeks to avoid such practices. Department for Health and Children (1999), pp. 41-42.

86 Comments by Wynand, P.M.M. van de ven, Professor of Health Insurance, Erasmus University, Rotterdam, Netherlands on the BUPA report "Irish Private Health Insurance and International Comparisons" (10 April 2000). Other experts also point to the dangers of risk selection in the absence of a RE scheme, including the Society of Actuaries in Ireland and the American Academy of Actuaries, among others. *See* Advisory Group on the RE Scheme (1998), pp. 32-33.

69. Under the current risk-equalisation scheme, the Health Insurance Authority (HIA), an independent statutory body, is authorized to make recommendations on whether the scheme will begin to require payments to be transferred from one insurer to another, if the market equalisation percentage – which measures the difference in risk profiles between insurers – is between 2 and 10%, as set forth in legislation and regulation.⁸⁷ The HIA is also given significant authority as the Administrator of such a scheme. Insurers will be required to file returns every 6 months, beginning in January 2004. Upon the basis of these returns, the HIA will assess the risk profiles of insurers and recommend to the Minister for Health and Children whether payments should be made under the scheme. New entrants are provided a limited opportunity to opt out of the scheme for 3 years, together with a phase-in period during which only 50% of any payments would be required. Restricted membership undertakings were also given an initial ability to opt out of the scheme.⁸⁸ All but one such undertaking declined to participate in the scheme.⁸⁹

70. In order to provide for a meaningful distribution of payments, the scheme will seek to “equalise” risk profiles between insurers for benefits provided under that portion of PHI benefit packages that correspond with the most common level of coverage.⁹⁰ That is to say, claims made for a comprehensive and common set of PHI benefits will be included in the risk-equalisation pool. This enables the risk-equalisation scheme to adequately compensate those insurers covering higher risk persons. In the absence of an adequate transfer of payments, “cherry picking” could persist as insurers would still experience reduced costs on a significant proportion of claims due to their risk profile. At the same time, by not extending the scheme to higher levels of benefits, the scheme avoids distortions that could result from very different benefit structures across insurers. It also links risk equalisation to those benefits considered to be related to essential health care services.⁹¹

71. The development of appropriate and fair risk adjusters is an ongoing technical challenge for governments seeking to equalise risks within social or private health insurance systems. The experiences of other OECD countries (such as the basic health insurance system of Switzerland and social health insurance in the Netherlands and Germany) show that demographic risk adjusters are inadequate predictors of the variability of individual health expenditure. The Irish RE scheme is to initially utilise demographic risk-adjustment factors (age and gender of the covered population) as a proxy for their risk profile. It may later include risk adjusters based upon utilisation of health care services. While this might reduce incentives for insurers to manage health risk and cost, and may enable insurer(s) to derive benefits from the efficiencies of competitor(s) in this area, it is a better predictor of individual health expenditure.⁹² It will be important for policymakers to monitor the extent to which transfers under the RE scheme appear to reflect the insurers' relative risk profiles and experience, while promoting incentives for efficiency. The initial RE calculation appears to strike the appropriate balance between these policy concerns, while maintaining the possibility of future adjustments after consideration of experience. An additional challenge concerning the implementation of the RE scheme in the current Irish context is that it would transfer money from one insurer to another, rather than among a pool of several insurers. The likely recipient is the insurer with a historically dominant market share, and hence the scheme may have the unintended result of helping the state-owned insurer and hindering the growth of a new entry. The implementation of the RE scheme is

87 If the market equalisation percentage exceeds 10%, the HIA is not required to include a recommendation in its report to the Minister. The Minister may decide, in consultation with HIA, whether to commence risk-equalisation payments. The Health Insurance Authority (2003b), p. 10.

88 The Health Insurance Authority (2003b).

89 HIA, Communication to the OECD, December 2003.

90 This is based on the widely purchased “B” policy of VHI, and BUPA’s similar product. Advisory Group on the Risk Equalisation Scheme (1998), p. 38.

91 *Ibid.* page 38.

92 See HIA (2003b), p. 14.

nonetheless very important to avoid the development of a market in which competition is based upon risk selection activities.

Impact of EU Law on the Irish PHI Market

72. The EU third non-life insurance directive seeks to promote insurers' ability to provide services across EU countries, while safeguarding consumers' interests. In the area of private health insurance, the Directive seeks to balance these goals with the necessity that such products dovetail with, and do not undermine, the structure and financing of national health systems.⁹³ To this end, the directive includes some provisions to allow for the specific national contexts and role that PHI plays within the EU system. Member countries must permit the offering of insurance products by insurers based in other member states, but these products must not "conflict with statutory provisions protecting the *general good* in the member country."⁹⁴

73. Furthermore, the Directive provides additional guidance with respect to private health cover that can be substituted either "wholly or in part" for cover under national social security systems.⁹⁵ Paragraph 24 of this directive specifically indicates that measures to protect the general good "may provide for open enrolment, rating on a uniform basis according to the type of policy and lifetime cover...by requiring undertakings offering [voluntary private health insurance]... to offer standard policies in line with the cover provided by statutory social security schemes at a premium rate at or below a prescribed maximum and to participate in loss compensation schemes." Thus, the Directive would appear to highlight the permissibility of several of Ireland's provisions relating to its PHI market, notably open enrolment, community rating and the risk-equalisation scheme. Ireland's PHI system has in fact been protected under these provisions. However, the interpretation of the meaning of the term "general good," particularly as applied to proposed requirements not yet scrutinised by the Commission or the Court of Justice of the European Union, remains an area of significant uncertainty.

74. In another area of EU law, certain stakeholders had raised questions concerning the compatibility of Ireland's RE scheme with EU state aid rules.⁹⁶ These EU rules seek to ensure that governments do not foreclose national markets nor falsify competition. To this end, they prohibit both direct state action, and indirect action (through preferential procurement contract awards).⁹⁷ "State aid" rules apply when a public body offers a direct or indirect financial advantage to an undertaking. Hence, certain state action towards private health insurers, as well as other types of health insurance funds, may be considered "state aid" – and hence prohibited under EU law – if it offers a certain advantage to an undertaking.⁹⁸ The European Commission recently held that Ireland's RE scheme does not involve State aid under relevant EU law⁹⁹ and in any event complies with relevant state aid rules. The decision notes, however, that the ruling in this area

93 Health care insurance forming part of social security systems is explicitly excluded from the EU insurance directives. Hatzopoulos (2002) p. 151, citing Article 2(1)(d) Directive 73/239/EEC (Council of the European Communities, 1973).

94 European Commission Interpretive Communication (2000/C 43/03).

95 *Ibid.*

96 See *e.g.* Letter of 9 October, 2002 to Mr. David Deacon of Internal Market DG, EC, from the Irish Authorities, detailing the Irish Government's view relating to the legality of the RE scheme under several areas of EU law.

97 Hatzopoulos (2002), p. 138.

98 The determination of whether a health insurance fund is an "undertaking" within the meaning of EU law is a complicated question that weighs several factors, including the organization's objective, whether it is compulsory, the extent to which benefits are delivered on a needs basis vs. according to contribution, its freedom to set contribution amounts and the degree of state control over the entity's decision making, degree of active management of funds, and whether it is in competition with private insurance companies. Hatzopoulos (2002), pp. 146-148.

99 "State aid" in the sense of Article 87(1) of the Treaty.

does not prejudice any decision that may arise under EU competition rules (Internal Market), and specifically the third non-life insurance directive.¹⁰⁰ This means that the Commission may still take other decisions with respect to the Irish RE system's compliance with requirements or principles of other applicable EU law. Furthermore, this "state aid" related decision has been recently appealed by the second insurer in the market.¹⁰¹

3.2 *Voluntary standards: self-regulation*

75. Although Ireland's PHI market is characterised by less product variation than PHI markets in several other OECD countries, there is still room to improve consumers' ability to compare insurer offerings. The White Paper on PHI recommended that the insurance industry develop a code of practice with respect to information to be provided to the consumer.¹⁰²

76. One of the most significant voluntary regulatory efforts is the Insurance Ombudsman of Ireland scheme, through which the Irish insurance industry, including the two major PHI carriers, have agreed to have certain disputes resolved by an independent entity. The scheme has boasted several notable accomplishments since its inception in 1992, important among which is the agreement among participating insurers to give binding legal effect to the Ombudsman's decisions. The Ombudsman regularly receives over a thousand complaints annually, with many disputes being resolved before a more formal investigation and action is needed. While many complaints involve other types of insurance, the Ombudsman does regularly address and receive complaints relating to PHI coverage. Among all of the cases considered by the Ombudsman from 1995 to 2001, 59% were adjudicated in favour of the company, and 41% in favour of the complainant.¹⁰³

3.3 *Dispute resolution mechanisms*

77. Consumers have several means of redress, if they have a complaint or problem with their private health insurer. A first step is to contact the insurer with their question or complaint. One survey found that only a very small minority of consumers have complained to their health insurer (3%). Of these, however, over half were not satisfied with the complaints procedure.¹⁰⁴ The HIA may become further involved gathering information on consumer experiences with PHI.

78. The Insurance Ombudsman scheme provides health insurance purchasers with the means of a more formal appeal, without resorting to expensive legal action involving the courts. The Ombudsman's

100 European Commission, May 13, 2003, C(2003) 1322fin.

101 BUPA appealed the decision on the procedural grounds that the Commission should have initiated a formal investigation procedure prior to making its decision. See Action Brought on 19 August, 2003 by British United Provident Association Limited, BUPA Insurance Limited and BUPA Ireland Limited Against Commission of the European Communities (Case T-289/03) (2003/C 264/55), *Official Journal of the European Union*, 1-11-2003, C/264/32-33.

102 The Irish Insurance Federation, which includes a wide range of insurers, including private health insurers, has developed voluntary codes of practice applicable to the practices of life and non-life insurers. (See www.iif.ie/consumer.) The White Paper indicates that a working group formed under the aegis of the HIA could explore the formulation of a standard information schedule for easy reference on the benefits covered or excluded from different PHI packages.

103 Insurance Ombudsman of Ireland (2001), p. 17.

104 Health Insurance Authority (2003a), page 34. The report notes the small number of respondents on this issue, however.

office resolves a range of questions; for example, one area of inquiry and complaints relates to whether a consumer is entitled to a particular service under their PHI contract.

3.4 *Tax relief and other government incentives to the purchase of PHI*

79. The Irish government provides tax relief to those purchasing PHI through a deduction for premiums, at the standard tax rate of 20%. Insurers can deduct this tax relief from premium charges.¹⁰⁵ If the current advantage were to be removed, it is estimated that the net cost of health insurance premiums for insurees would increase by 25%. There are presently no plans for its removal.¹⁰⁶ Out-of-pocket expenditures on health services not covered by PHI are also deductible, although one survey indicated that many are not aware of this advantage.¹⁰⁷ From 1 January 2004, employers are to pay “Employers Pay Related Social Insurance Contributions” (PRSI) on a broad range of ‘benefits in kind’ provided to employees. This will, among other things, result in employers paying PRSI on employer paid health insurance premiums. It also may hinder the growth in employer-provided PHI.

3.5 *Uniformity of regulation across PHI market segments*

80. Many aspects of Irish law promote even treatment amongst insurers and market segments. Unlike the case in some other OECD countries, Irish for-profit, not-for-profit, and mutual companies are subject to uniform rules (except in the area of corporate taxation). In Ireland, as a general matter, the health insurance laws relating to access and affordability apply across most products and to most insurers. However, there are exceptions for certain segments of the health insurance market. Ancillary and cash benefits policies are exempt from risk equalisation and mandated minimum benefits standards and RMUs have one chance to opt out of the RE scheme. Once RMUs have opted out, however, they cannot participate in the scheme at a later stage. Coverage outside the designated benefit package is also exempt from risk equalisation.

81. The regulatory structure for employer-sponsored and other group coverage is virtually identical from that applicable to individual policies, except that group policies can benefit from a 10% premium discount. In addition, VHI is subject to more intense government scrutiny in several important areas, as their products are subject to government approval. VHI is also subject to prior approval of its premium increases and products, unlike the case for the other major carrier, BUPA, as well as RMUs. There is also debate over whether it receives preferential treatment through its status as a government entity. Nonetheless, the uniform regulatory treatment within Ireland’s PHI market has reduced the potential for unintended distortions based upon particular market niches or types of insurers, as has sometimes occurred elsewhere. However, VHI’s corporate status as a statutory body operating in the state sector continues to raise questions regarding whether its status provides a competitive advantage. A move to full commercial freedom is envisaged and was recommended in the Government’s White Paper (Department for Health and Children, 1999). While this change is not yet achieved, proposals for legislation to alter VHI’s commercial status are to be presented to the Government. Such a change could have the desirable result of putting VHI on a more “even playing field” with other private entities in the marketplace. In addition, since the publication of the White Paper on Private Health Insurance, VHI has made significant progress with respect to improvement of its reserves ratio, which is now well above the level required under EU minimum solvency requirements.

105 OECD Regulatory Questionnaire, response from Ireland. Section F.1.

106 Department for Health and Children (1999), p. 24.

107 Health Insurance Authority (2003a) p. 39.

4. How well does the Irish PHI market and health insurance mix meet health policy goals?

4.1 How has PHI influenced cost pressures in the health system?

Impact of PHI on demand for hospital services and cost implications for the public system

82. Irish policymakers hope private health insurance will reduce demand for public hospital care, and thereby the cost of, the public hospital sector. As indicated in the White Paper on Private Health Insurance, “the Government considers that it is appropriate for the State to continue to facilitate arrangements for private health care because the taking of responsibility by insured persons for meeting the cost of their own health care displaces demand and cost which would otherwise fall on the public health system” (Department for Health and Children, 2001).

83. The impact of PHI on *demand* for public and private hospital services is complex to analyse, because it involves both an increase in overall demand and a partial demand shift across the public and private sectors. Existing evidence, albeit limited, indicates that people with private cover might receive more intense treatments (Harmon and Nolan, 2001; Nolan and Wiley, 2000).¹⁰⁸ This is consistent with the nature of financial incentives encouraging providers to give privately insured individuals some preferential treatment, particularly the different methods for paying consultants for their public and private practice (salary versus fee-for-service).

84. The structure of the Irish public-private mix has implications for demand shift across the two sectors. Increases in privately financed treatments do not result in proportionate increases in demand for private hospitals, because private patients can also be treated within public hospitals and public hospitals offer some treatments unavailable in the private hospital sector. The fact that private patients in public hospitals are not charged the full economic cost of their stays may also distort preferences regarding the use of public versus private hospitals.¹⁰⁹ As a consequence, demand does not distribute efficiently across available capacity, and private hospitals may not be efficiently utilised.¹¹⁰ Wiley (2001a) has discussed some empirical evidence showing a higher public hospital utilisation by private patients than the bed designation rate (Table 8).¹¹¹ On the other hand, should use by private patients of private hospitals grow, demand that would otherwise fall on public system is likely to be displaced.

85. Changes in demand for publicly and privately financed hospital treatments have *cost* implications for the public sector and the health system overall. The public sector is likely to benefit financially from increased privately financed hospital activity because private patients represent an additional income stream for public hospitals. If people who currently finance their hospital treatment privately did not forego their statutory entitlement to public hospital coverage by using private hospitals, public cost for hospital

108 Nolan and Wiley (2000) found that medical card holders (less likely to have PHI) are older, sicker, and have longer lengths of stay in public hospitals than non-medical card holders (two thirds of whom have PHI). The latter, however, utilise care more intensively and have higher per day costs of care. While such differences may be entirely linked to differences in age and health status of these two groups, providers also have incentives to increase volume and intensity of care provided to private patients. Harmon and Nolan (2001) indicate that PHI may increase the probability of hospital stay and the length of time spent in hospital.

109 This potential exists, despite the fact that demand for elective treatment is distributed through the referral system (by GPs to consultants and then to the hospitals where the consultants have admitting rights).

110 According to the Independent Hospital Association of Ireland, occupancy rates are around 80% in private hospitals, 90% in public hospitals, and 65% in private psychiatric hospitals.

111 Previous analysis (Nolan and Wiley, 2000) also shows that the proportion of all bed days spent in public hospitals rose from 18 to 21% between 1997 and 1999.

services would be even larger. There are, however, some caveats. First, because private patients utilise public hospitals to a large extent,¹¹² shifting of demand and cost onto private hospitals is constrained. Second, revenues received from PHI for public hospital services may be suboptimal due to the policy of charging fees below full cost in public hospitals.¹¹³ Other subsidies can also create cost challenges for the public sector. The public system absorbs the capital costs of public hospitals and the training costs of professionals. Tax relief for PHI premiums, although it was reduced from the marginal to the standard rate, also raises taxpayer cost. Any increase in PHI membership, premiums and public hospital utilisation by private patients affects public cost because of such direct and indirect subsidies. This cost offsets revenue and cost savings arising from private patients; however, estimates of such cost savings and the overall cost of subsidising private cover are not readily available, thereby making it difficult to ascertain the net impact on cost shifting from the public sector.

Table 8. Hospital utilisation by public and private patients

	Public hospitals			
	Public beds		Private Beds	
	1999	2000	1999	2000
<i>Discharges (inpatients)</i>	392 980	398 492	118 447	124 128
Planned patients	100 761	103 421	41 515	43 929
- % of total planned	70.8%	70.2%	29.2%	29.8%
Emergency patients	292 219	295 071	76 932	80 199
- % of total emergency	79.2%	78.6%	20.8%	21.4%
<i>Discharges (Day patients)</i>	193 399	209 805	54 029	62 883
- % of total day patients	78.2%	76.9%	21.8%	23.1%

Source: Wiley (2001a).

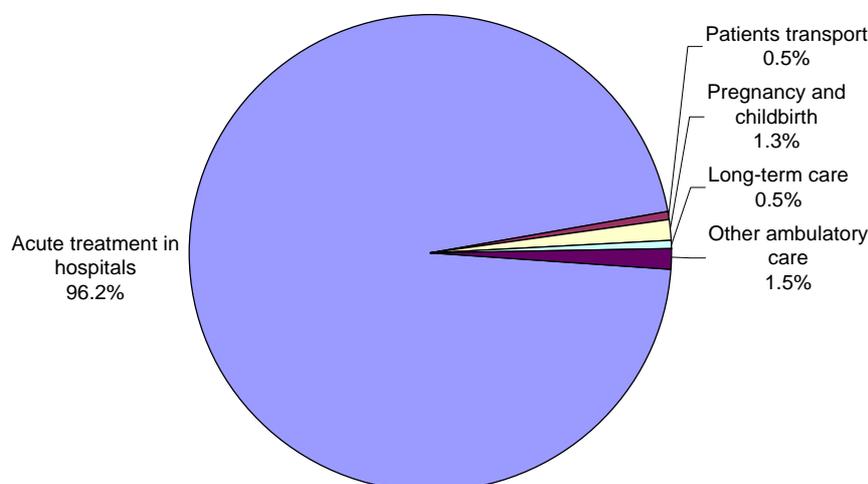
Impact of PHI on total health expenditure: has PHI contained cost?

86. Ireland has controlled costs in the public sector through a system of global budgeting for public hospitals and government-set capitation rates and salaries for doctors' engaged in public practice. Cost within the private sector is conversely contingent upon the volume of private activity, due to the fee-for-service method of paying private providers. Individuals' direct responsibility for payment of some of these costs has likely moderated growth of out-of-pocket expenditure, while insurers also implement cost controls to limit escalation in PHI expenditure.

87. Insurers have relied on demand-side mechanisms, particularly high front-end deductibles, to limit their cost exposure for outpatient and primary services. This resulted in a transfer of responsibilities for this cost directly onto the individuals, while insurers provided a safety net for catastrophic expenses. Figure 2 shows that hospital claims account well over 90% of claims paid by PHI. No evidence exists to quantify the impact of such large individual responsibility for outpatient costs on utilisation of these services.

112 The number of acute care pay-beds is the same in public and private hospitals (Table 4). The proportion of private patients treated in public hospitals has not decreased over the year, while private hospitals seem to have some spare capacity, as indicated by the success of the "National Treatment Purchase Fund and by higher occupancy rates in public than private hospitals. The NTPF is an initiative, set up in 2002, that has treated patients on waiting lists in private hospitals in Ireland as well as abroad.

113 Nolan and Wiley (2000) estimated the cost of this subsidy to be about 50% of the cost of treating private patients in public hospitals in 2000. The charge paid by private patients corresponds to the marginal cost of meals and the use of private rooms. According to a recent policy, the level of charges has been raised by 67% since 1 January 2003, taking into account medical inflation and the need to maintain stability of the PHI industry. While this is still not related to the full cost of the treatments being delivered, it represents a significant increase towards full economic charging of private beds.

Figure 2. Breakdown of claims paid by private insurers

Source: OECD (2002a)

88. PHI insurers' efforts to control costs in public and private hospitals have focused on negotiating reimbursement levels. This has been facilitated by subsidised public hospital charges and the exertion of strong bargaining power towards private hospitals, particularly by VHI. Due to the public subsidy, the public hospitals' PHI claims are lower than claims paid to private hospitals, for any given service or treatment level.¹¹⁴ Market concentration in the insurance industry and private hospitals' dependence on income from private enrollees has allowed insurers to exercise strong contractual power over private hospitals. VHI negotiates reimbursement levels which are followed by BUPA. Insurers have been able to contain increases in the level of benefits paid to private hospitals by negotiating freezes on prices. They have also not facilitated funding growth that would have resulted in increased capacity and purchase of equipment by private hospitals.¹¹⁵ They also implemented cost-control strategies involving annual budgets and reimbursement limits.¹¹⁶ Recently, insurers have begun negotiating with providers some predetermined length-of-stay agreements, and designation of procedures for day treatment.

89. Payments to consultants represent the second largest claim area for insurers. Insurers do not try to contain use of medical consultants' services although generally referral is by the GP to the consultant. Cost controls have focused upon negotiation of scheduled procedure prices. Nearly all consultants accept as full payment the professional fee schedule negotiated with insurers. If they do not accept such rates, insurers pay them a lower schedule (about 25-30% lower, coinciding with minimum benefits), and the doctor has to collect any extra billing from the patients themselves. This process of negotiation of fee levels may have limited fee escalation in the private sector, although it has not diminished utilisation. Utilisation increases

114 Indeed, public hospital claims account for a lower proportion of PHI claim expenditures than private hospitals. This is despite the fact that private beds are about the same number in public and in private hospitals, and occupancy is lower in private hospitals.

115 The relationship between insurers and private hospitals has been at times very difficult, because VHI imposed cost-containment practices that, in the view of hospitals, hampered productivity improvements. In their negotiation with insurers, hospitals cannot negotiate jointly as this is forbidden by the Competition Authority. This exposed them to the quasi-monopsonic bargaining power of the two main insurers.

116 Claims in excess of the budgeted amounts would be reimbursed at reduced rates, or not at all if the budgets represented a ceiling on claims (Department for Health and Children, 1999).

may be attributed to Ireland's growing population and rising real income per head, together with factors it shares with other countries, such as an ageing population and advances in and dissemination of technology.

Table 9. Premium increase for VHI, 1981-2002.

<i>Date</i>	<i>Premium increase</i>	<i>Date</i>	<i>Premium increase</i>
March 1981	23%	August 1993	6.0%
March 1982	41.5%	August 1994	8.5%
March 1983	11.5%	September 1995	6.0%
March 1984	13.5%	September 1996	6.0%
March 1985	7.5%	September 1997	9.0%
April 1986	8%	September 1998	9.0%
December 1987	8%	September 1999	9.4%
-	-	February 2001	6.25%
February 1989	7%	September 2001	9.0%
July 1990	4.0%	September 2002	18%
September 1991	5.1%	September 2003	7.5%
January 1992	4.1%	<i>Average (1981-2003)</i>	<i>10.4</i>
		<i>Average growth rate,</i>	<i>4.7%</i>
		<i>price index (1981-2001)¹</i>	

Note: Increases denotes averages across plans.

Source: Harmon and Nolan (2001) and Department of Health and Children. ¹ OECD Health Data 2003, 2nd Edition.

Table 10. Levels of subscription rates ⁽¹⁾

		Adult (Group rate)		Child (Group rate)	
VHI Healthcare – as of January 2004	Plan A	€26.04		€108.68	
	Plan B ¹	€66.44		€69.52	
	Plan C	€70.20		€79.24	
	Plan D	€81.40		€49.44	
	Plan E	€316.64		€49.44	
		Group	Individual	Group	Individual
BUPA Ireland	Essential	€72.39	€302.66	€87.97	€97.74
Applicable from	Essential Plus ⁽²⁾	€77.04	€418.93	€31.42	€46.02
1 st March 2003	Essential Plus ⁽²⁾ (no in-patient excess)	€416.38	€462.64	€48.64	€65.16
	Gold	€1350.77	€1500.86	€439.63	€488.48

Notes. (1) All subscriptions are shown net of the standard rate of income tax. (2) VHI Plan B and BUPA's Essential Plus (with or without excess) are generally comparable.

Source: VHI and BUPA websites.

90. Despite such cost controls, private health insurance claims and premiums have continued to rise significantly over the years (Table 9). Between 1980 and 1996, premium increases for VHI accumulated to a 438% nominal increase (Harmon and Nolan, 2001). The average premium increase has been higher than the 9.9%¹¹⁷ average growth of nominal per capita income over the same period. While BUPA's premiums are generally lower than those of VHI, BUPA tends to mirror VHI premium hikes (Table 10). Premium increases reflect insurers' widening medical costs, notably growing private hospital charges,¹¹⁸ increasing

117 OECD Health Data 2003, 2nd Edition.

118 Private hospitals have requested in recent years increases in bed prices of up to 25% (source: The Post, 6 July 2003, "Mc Manus lashes out at 50% VHI hike in 3 years"). VHI also reports increases in charges levied by private hospitals as one main source of cost escalation. Substantial increases in private hospitals' charges may have been implemented to counteract financial difficulties experienced by private hospitals. Cost containment measures implemented by VHI towards private hospitals over the years may have resulted in several hospitals suffering financial strains (VHI Annual

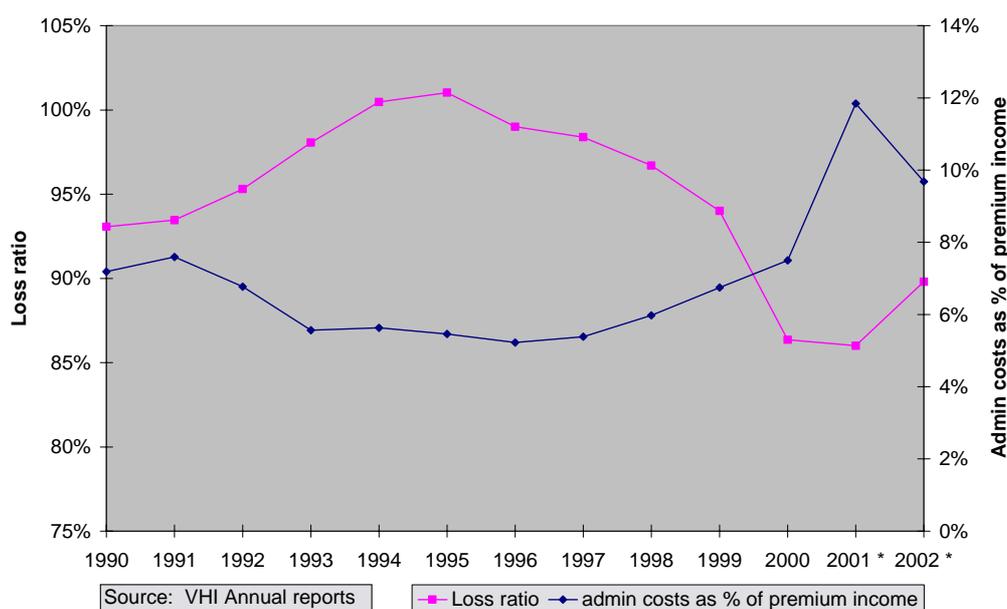
public bed prices,¹¹⁹ and growing volumes of care as people demand more and better care. Continued increases in premiums may impact upon the stability of the insurance industry and affordability of private cover by the population in the longer run.

4.2 Has PHI increased health system cost-efficiency?

How large are administrative costs?

91. Private health insurers sustain administrative costs for underwriting, advertising, marketing, billing, product-innovation, as well as the cost of contracting with providers. The administrative costs of VHI were estimated at 9.7% of premium income in 2002, with a loss ratio of 89.8%.¹²⁰ Administrative costs have been increasing over time, especially as the market was opened to competition, possibly as a result of larger investments in advertising, marketing and customer services (Figure 3). Comparable data from the other insurer, BUPA Ireland, are unavailable. Restricted membership undertakings may enjoy lower average administrative costs than VHI and BUPA, because they draw membership from people of common industrial and occupational groups, which should lower underwriting costs. By international standards, these are fairly low administration costs for private health insurers.

Figure 3. Evolution of administration costs and loss ratio, VHI



Reports and Accounts, 2002). Despite such cost pressures, PHI has not become a more important funding source of total health expenditure (Table 3), given injection of substantial public health financing over the years.

119 Public bed prices have risen by 60% since 1999 (source: The Post, 6 July 2003, "Mc Manus lashes out at 50% VHI hike in 3 years"). In 2002, the increase accounted for 15%. This is part of a government programme to charge private insurers the "full economic rate for private beds".

120 VHI calculates administrative cost as the share of net operating expenses in total earned premiums. Loss ratios are calculated as the percentage of earned premiums devoted to claims.

Has PHI enhanced efficiency and effectiveness in health care delivery?

92. Private insurers in Ireland do not currently actively seek to enhance effectiveness of care by purchasing health services from select providers. Although contracting with providers is the predominant reimbursement model, insurers have not established selective provider networks.

93. Insurers negotiate over providers' prices in order to contain cost, but they do not do much to influence the quantity, quality, and appropriateness of care provided. They do not intervene in doctors' medical decisions nor set medical guidelines and treatment protocols. Insurers do not generally control technology utilisation, although they have in some cases specified lists of conditions for which coverage of magnetic resonance imaging technology (MRI) is available. Ex-ante or ex-post reviews may be carried out for particularly expensive procedures, although these do not represent systematic pre- or post-authorisations of hospital admissions or treatments. Insurers provide information to consumers about fully participating providers in order to minimise their out-of-pocket expenditure. However, they do not direct insurees to use providers or services deemed to be particularly cost-effective. Insurers generally do not carry out health prevention and promotion initiatives, while case management and review of clinical outcomes of treatments is absent. Some evidence that PHI seems to result in larger hospital utilisation (Harmon and Nolan and, 2001) may call into question medical efficacy, but more evidence is needed on the impact of private coverage on the marginal effectiveness of treatments.

94. Several explanations for the limited insurers' influence in health care delivery are plausible. First, there is a desire not to restrict individual choice. Given the voluntary nature of PHI, insurers cover a broad range of providers because free choice is one significant reason people buy private policies. Providers, in turn, cannot afford not to have a contract with one insurer, given the concentration of the PHI market and their high dependence on income from privately insured patients. Second, limited PHI coverage of outpatient services may have reduced the scope and incentives for insurers to implement health prevention and disease management initiatives. New products offering better outpatient benefits tend to be used as a marketing tool to attract new insurees rather than as an instrument to manage risk. Third, insurers do not face substantial risk and cost exposure for inpatient treatments. Private hospitals generally concentrate services on less complex elective surgery. Within public hospitals, per diem charges are significantly below full economic cost. Fourth, PHI subscribers tend to overlap with individuals in category II, who have higher income and better health status than medical card holders. The cost of many high-risk patients is thus largely left with the public system. Last, managing care requires a certain sophistication of insurers' practices that is administratively costly and complex to implement.

4.3 What challenges does PHI pose to equity and access?

How does PHI affect coverage and access to health care across privately and publicly insured individuals?

95. Evidence suggests that PHI holders benefit from certain advantages in accessing the health system when compared to those with public cover alone. An analysis of the number of planned admissions for public versus private patients in public hospitals indicated that private patients account for 30% of planned admissions, despite the fact that only 20% of beds in the public hospital system are designated as private (Wiley, 2001a). Many of the procedures received by PHI holders on elective bases are those for which there are long public waiting lists. This would seem to indicate that PHI holders might be given preferential access to public hospital facilities.¹²¹ Private patients' use of public hospitals is also likely to have implications for availability of beds and doctors' time for treating public patients. Evidence suggests

121 Wiley (2001a), Ch. 4, pp. 81-88.

longer waits for treatment by medical card holders, who are more likely to use public facilities than category II individuals.¹²²

96. The structure of consultants' payments also contributes to differentials in access to care between the privately and publicly insured. Consultants are salaried for their public practice, while they are paid on a (unregulated) fee-for-service basis when operating in private practice. Reimbursement differentials are partially accounted for by the reductions in salaries for consultants who can admit private patients to public hospitals. This tiered reimbursement system nonetheless provides the privately insured with greater choice of consultant, particularly in inpatient settings. However, it also risks creating incentives for doctors to give privately financed patients preferential treatment.

97. In the case of private hospital facilities, the privately insured have a clear advantage since public coverage provides no reimbursement for services provided in these facilities. However, PHI patients do not necessarily have advantages for all types of hospital care as not all services are available in these private facilities, particularly in the case of accident and emergency ("A & E") services.¹²³

98. While the creation of differences in access to care by insurance status has raised equity concerns, as recognised by the Irish authorities and others, the benefits PHI enrolees enjoy by accessing care in private hospitals are not as worrisome, as long as the public hospital system can meet the health needs of those without access to private hospitals. In fact, one of the aims of encouraging PHI in Ireland is to enable those individuals who are willing to pay to enjoy a private alternative to publicly funded health services, while not hampering access to publicly funded care by those without private cover. If doctors' supply of services to public patients is significantly reduced by differential payment mechanisms, the advantage that private insurees enjoy in private hospitals may also become a policy concern.

99. There are a number of measures that could be introduced to address some of these equity-of-access concerns. One approach would be to limit the number of private patients that could be treated on an elective inpatient basis in public hospitals where there is a public waiting list for admission. The use of a single waiting list for admission to public hospitals might help ensure admissions based on medical need rather than insurance status, a policy that currently applies to both public and private patients in the area of A & E services.

100. An additional issue affecting access to services arises from the inefficiencies in the system that result in differences in lengths of stay and/or the costs of different providers performing the same procedure. An "efficiency audit" could be undertaken – especially relating to procedures for which there are waiting lists, in order to identify areas where resources might be used more efficiently.¹²⁴ Furthermore, improved monitoring of the placement of private patients in publicly designated public hospital beds could enable policymakers to better understand why designated ratios are being exceeded at times.¹²⁵

Equity of access to private health coverage

122 According to data from the Quarterly National Household Survey (Third Quarter 2001), nearly 25% of medical card holders on outpatient waiting lists were reported to wait for over 6 months, compared with 10% of those with private cover. For inpatient treatments, 46% of those on medical cards were on the lists for 6 months and more, compared with 26% of those with private health insurance.

123 *Ibid*, page 86.

124 The three suggestions described herein are recommended in Wiley (2001a), pp. 93-94.

125 Nolan and Wiley (2000), pp. 117-118.

101. The Irish government's commitment to equity of access within its health system is also reflected in its policies and regulations seeking to promote access to private health insurance coverage, described in more detail in section 3. The sustained upward trend in the portion of the Irish population with PHI may indicate the success of these government policies, although other factors likely contributed significantly to this trend.¹²⁶ Nonetheless, despite the significant portion of the population with PHI, an analysis of the breakdown of the different characteristics of the privately insured population reveals that PHI coverage remains concentrated within certain portions of the Irish population. PHI purchasers are clustered in middle age groups (30-49 years of age) and are slightly more likely to be male. Coverage levels are highest among those with full-time employment or in training or education. Those with higher levels of education also tend to be more likely to have PHI.¹²⁷ Hence, PHI coverage – and its concomitant advantages – is not distributed evenly across socio-economic groups in Ireland.

102. The extent to which certain population groups move in and out of PHI coverage affects equity of private coverage. For example, if older persons tended to be without coverage more often during a particular time period, this might indicate that the system's structure or regulations may not be adequately protecting some of the more vulnerable, less healthy segments of the population. This does not appear to be the case in Ireland. Between 1994 and 1997, those under the age of 24 were most likely to have moved in or out of private coverage (which likely follows changes in their dependent or student status), whereas the 35-44 population group had the largest proportion of persons insured during both time periods (Table 11). There does not appear to be evidence of adverse selection in the Irish market, despite the fact that more variation in insurance status appears in the very young population. This may be attributed to the fact that this age group may be moving off of parents' cover, and moving from school into employment, where they may obtain employment-based PHI coverage.

Table 11. Health insurance status in 1994 and 1997 by age category

Age in 1994	Insured in both waves	Insured in 1994, Not in 1997	Insured in 1997, Not in 1994
Under 24	12.7%	29.2%	25%
25-34	19.3%	23.2%	16.4%
35-44	27%	17.5%	19.8%
45-54	20.5%	14.2%	11.9%
55-64	10.8%	7.5%	18.2%
65+	9.7%	8.8%	8.5%
All	100%	100%	100%

Source: Nolan and Wiley (2000), Chapter 5.

103. When mobility in and out of PHI is examined, a significant link to household income remains. The above-described comparison of those with coverage in 1994 and 1997 also found that those who gained and lost insurance were more heavily concentrated in the bottom half on the household income distribution, and those who remained insured were heavily concentrated in the upper half. Over half of those insured in both years were in the upper two household income deciles.¹²⁸ When factors in addition to

126 Notably, as noted earlier, PHI membership increased despite the expansions in publicly financed services. Recent increases in participation are attributed to a strong economy and full employment, driving an increasing demand for PHI by both individuals and employers.

127 Watson and Williams, pp. 15-18.

128 Nolan and Wiley (2000), page 87.

income are considered, it appears that a vast majority (70% in one sample) of those in the upper to lower “middle class” social class have PHI, compared to only 31% of the working-class population.¹²⁹

104. The extent of this income-based inequity in health coverage is somewhat mitigated by eligibility for broader public coverage amongst the poorer and older populations. About 30% of the population is eligible for free GP services and pharmaceutical coverage. This eligibility group does not face co-payments for public hospital care, nor do they face co-payments for pharmaceutical, rehabilitative and long-term care, as do persons without a medical card. Equity concerns linked to income-skewed levels of PHI coverage are therefore somewhat mitigated by the structure of eligibility to public cover, which is more generous for those in lower income groups.

105. Poor self-reported health status appears to be negatively correlated with the likelihood of having PHI coverage, unlike the case in the PHI markets of some other OECD countries.¹³⁰ Table 12 shows that PHI holders are more likely to report themselves in very good or good health status than those without PHI or medical card coverage. A similar picture emerges when comparing PHI holders to those with a medical card (very few people have both). These results are likely to be linked to greater coverage by PHI of high-income individuals and people without a medical card, who tend to be in better health status.

Table 12. Self-assessed health status by insurance status, 1994

Health Status	Very Good	Good	Fair	Bad	Very Bad
	%	%	%	%	%
Private insurance	44.1	36.6	20.4	11.2	7.7
No insurance or medical card	33.8	31.3	21.9	18.3	3.1
Medical card	22.1	32.1	57.6	70.6	89.2

Source: Source: Nolan and Wiley (2000). Chapter 5.

Equity of financing and affordability

106. PHI purchasers benefit from a range of state incentives and financial support, which arguably reduce financing equity within the Irish health system because PHI purchasers are predominantly from families with incomes in the upper half of the Irish population. First, premiums are deductible, although this occurs now at the standard rate of income tax, a more equitable deduction than the marginal rate previously allowed. In addition, insurers do not reimburse public hospitals at the full economic cost of the care provided to private patients in these facilities. Some argue that represents a fair distribution of financing since PHI holders are also taxpayers. However, to the extent to which PHI holders receive quicker access to care within public hospitals, tax-financed public payments are contributing to inequities in access to care. Finally, public hospitals provide the bulk of expensive A & E and tertiary care, as well as professional training, which benefits private hospitals as well. Hence, PHI purchasers benefit from a number of cross-subsidies from public finances, yet the benefits of PHI are not distributed equally across the population and accrue largely to higher income and middle-age groups who predominantly buy private cover. Given inequities in access to health services between the privately and publicly insured, particularly in public hospitals, state subsidies may be viewed as contributing to inequities in access to care.

129 Health Insurance Authority (2003a), p. 3. The study uses a standard definition of social class based on occupation of the head of the household as well as income. The study’s category referred to as “working class” includes skilled and non-skilled working class, casual workers and those dependent on welfare.

130 Nolan and Wiley (2000), Chapter 5, page 85.

107. On the other hand, the system of community rating supports the spreading of costs across health status groups within the insured population, and this will occur to an even greater extent after the full implementation of the RE scheme. However, PHI premiums do not reflect income levels and therefore are less progressive than the tax system.

108. The presence of a significant employer-sponsored PHI market, which increasingly describes Ireland's PHI market, may positively impact the distribution of PHI across income and health status groups. It encourages risk spreading across the employed population. Employers and other groups may also benefit from the 10% discount insurers can offer group policies; health insurers also may offer employers separate services, such as occupational health schemes, which are not linked to health insurance plans. An employer group market may also display less adverse selection than is sometimes present in voluntary individual markets as individual health status is unlikely to figure into employer decisions to offer coverage, and may be less of a factor for individual take-up, especially if the employer contributes significantly to the coverage.

4.4 *Has PHI enhanced responsiveness of health systems?*

Promoting choice and flexibility

109. PHI enrollees in Ireland have a greater choice over timing and settings of care than their publicly insured counterparts. They may also receive preferential treatment by certain consultants. While enrollees currently only have the choice of two insurers, they express high degrees of satisfaction with the range of products and services offered by PHI. This is particularly notable since the Irish PHI market is characterised by significantly fewer product options than markets in some other OECD countries.¹³¹

110. The recent increase in coverage of outpatient care and certain alternative treatments highlights the ability of the PHI market to respond to changes in consumer demand and health care offerings. However, at present, outpatient coverage is often subject to high deductibles, limiting enrollees' ability to benefit from some of these improvements in PHI coverage. In addition, there is room for improvement in the range of insurer benefit offerings. In addition to improved coverage of general practitioner services, a survey indicated that increased dental cover and optical cover would be welcomed by a majority of PHI holders,¹³² although this will also depend upon purchasers' willingness to pay higher premiums for such additional benefits.

Satisfaction with the public and private systems

111. A large majority of insurees considers themselves satisfied with the value for money offered by private health insurance. Evidence of switching behaviours and trends in population coverage suggest that PHI enrollees are not likely to change insurer¹³³ or to let their policy lapse. Satisfaction with various aspects of private cover (customer service, claim process, the range of products and services offered by PHI) is

131 Health Insurance Authority (2003a), p. 32.

132 Id. page 35.

133 This is less true, in the employer-paid segment of the market. Although not specifically covered by the Health Insurance Authority Report, this segment is the most mobile and the one upon which insurers focus their attention most heavily.

considerably high.¹³⁴ Only a small minority seems to have filed a complaint with their health insurer, although those who did show moderate satisfaction with the process. Unsurprisingly, satisfaction with the quality of outpatient cover is lower than is the case for overall cover,¹³⁵ although hospital treatment and accommodation remain by far the most valued element of PHI. Enrolees are highly satisfied with the quality of care of the private delivery system, particularly with the timely access to treatment it affords (Watson and Williams, 2001).

112. Private health insurance improves individuals' satisfaction with the health system by enhancing options over the settings and time of care. It also contributes to keeping consultants satisfied by providing them with an additional income stream. There is limited indication that private health insurance contributes to improved satisfaction with the public health system. Perceptions from users of both the public and the private system concur that waiting times for treatments in public hospitals have worsened over the years. They also rate the quality in the private system consistently better than the public system, despite the fact that the same doctors treat both public and private patients, often in the same hospital. The current public-private mix risks giving rise to a dual, two-tiered system of care.

Impact of private health insurance on waiting

113. One considerable advantage of private health insurance in Ireland from an individual perspective is that it allows flexibility over the timing of care, and access to more timely care. Both people with and without private health insurance believe that they can obtain quicker hospital treatment in the private sector than in the public sector. In Ireland, public patients can indeed endure long waiting for all main elective surgical procedures (Hurst and Siciliani, 2003). This problem is not experienced by those who rely on private coverage, who receive more prompt treatment in private hospitals or as private patients within public hospitals. Indeed, the main reason why individuals buy private cover is to ensure quick access to care. Many of the elective procedures for which private patients are admitted to public hospitals are those for which there are long public waiting lists (Wiley, 2001a).

114. Despite the link between demand for private cover and waiting times, policy makers do not regard PHI as the main means of reducing queues in the public system. Policy initiatives have focused on dedicated funding to public hospitals, in exchange for an agreed level of waiting list activity, and on funding for purchasing treatments from private hospitals (Hurst and Siciliani, 2003). Policy makers do not oppose nonetheless the ability of privately insured individuals to obtain speedier access to care, provided this does not prevent patients in need of care from receiving publicly funded services within a reasonable period of time (Department for Health and Children, 1999). In fact, the Irish government supports PHI because, by providing access to private providers and facilities, it affords individuals an alternative to the public hospital system.

115. While PHI seems to offer those privately insured a way to bypass queues in the public system, it is not certain whether private cover helps to reduce the length of waiting in the public system. The causes of waiting times are multiple and complex to analyse. The increase in the share of the population covered by PHI has not coincided with a reduction in waiting times. This is despite the fact that PHI has contributed to increase utilisation and to meet a likely growing demand from an ageing Irish population. According to Hurst and Siciliani (2003), the percentage of patients waiting more than 12 months has

134 According to Health Insurance Authority (2003a), 93% of people who made a claim are satisfied with the claim process and 92% and 89% are satisfied or very satisfied with the range of products and services, and customer service, respectively.

135 76% of surveyed consumers think that private health insurance should provide for better coverage of GP and specialist services (Health Insurance Authority, 2003a).

increased for all the main specialities over the period 1993-2001, while the proportion of the population covered by PHI went from 36.5% to 45.7% during this timeframe. Data from June 2003 show some decline in waiting times and the length of waiting,¹³⁶ however it is too early to assess whether these trends will remain in the future.

116. Capacity and the link between private coverage and utilisation in the public and private sectors seem to be the critical factors driving waiting times. Neither the Government nor insurers have encouraged the development of a large private hospital sector, although policy support of PHI results in support to private hospitals. Public resources prioritised the public system¹³⁷ while private hospitals did not receive government funding.¹³⁸ Utilisation by privately financed patients has mirrored existing capacity structures. Limited demand shift from public to private hospitals may in part explain the bottlenecks that have arisen in public hospitals as well as the fact that some surplus capacity can be found in the private hospital sector, as recent government policies permitting the public sector to buy treatments from the private sector may indicate.¹³⁹ Also, public and private hospitals do not provide identical range of services, with public hospitals furnishing some of the more complicated and expensive care. Hence, public and private hospitals cannot respond equally to demand for certain services.

117. Furthermore, public hospitals have a long history of treating private patients, which is facilitated by doctors' right to exercise private practice on site.¹⁴⁰ Insurers have in turn balanced their purchase of services between the public and private hospitals.¹⁴¹ Financial incentives for consultants to treat private patients may create perverse incentives for public hospitals' waiting times to remain high (Hurst and Siciliani, 2003). The different mechanisms for paying consultants for public practice (salary) versus private practice (fee-for-service) may also alter the elasticity of supply of consultants' labour between public and private work.¹⁴² According to Wiley (2001a), utilisation by private patients for elective, emergency and day-care treatments has been growing faster than by public patients, resulting in an increasingly high proportion of private patients' discharges in public hospitals. The availability of beds and doctors' time for the treatment of public patients may suffer as a consequence.

136 Source: <http://www.doh.ie/statistics/wlist/wlist.html> and <http://www.doh.ie/pressroom/pr20031104b.html>.

137 Nonetheless, even in the public hospital system the number of acute hospital beds was reduced between 1980 and 1991, and was stabilised thereafter. The Irish Government has recently identified the need to expand the capacity of the acute hospital sector and to provide 3 000 additional acute beds.

138 A recent provision, contained in the Finance Acts 2001 and 2002, has however provided for capital allowances for building private hospitals, subject to meeting certain requirements, *e.g.*, size and availability to public patients of a small proportion of accommodation/services.

139 The Irish government has intended to utilise such capacity by buying some through the National Treatment Purchase Fund, an initiative to help alleviate the waiting times burden in public hospitals.

140 Doctors may prefer practising in public hospitals, both because this is practical (nearly 60% of all consultants have on-site private practice) and because public hospitals are generally better equipped and staffed.

141 Insurers have incentives to place insurees in public hospitals, because of the substantially lower cost (the per diem for pay beds in public hospitals is subsidised, while private hospital charges are competitively set; if a private patient is accommodated in public beds, insurers only pay consultants' fees and the costs for any amenities or private wards). All private health insurance plans must cover hospitalisation in semi-private wards of public hospitals, while coverage in private hospitals depends on the comprehensiveness of the policy purchased.

142 According to Wiley (2001a), the Consultants' Common Contract specifies a commitment for 33 hours of practice in public hospitals, but does not clearly indicate the expected commitment to treating public patients.

5. Summary and conclusions

118. Private health insurance plays a prominent role in Ireland. The health system is designed to offer comprehensive publicly funded health services to low-income groups, and universal public hospital coverage. Policies have encouraged the development of private health insurance, initially to finance hospital care for high-income groups, and, upon extension of public hospital coverage to the entire population, to provide all individuals with a private alternative to the public system, as well as a means of funding cost-sharing and services not covered by the public system. PHI has historically financed treatments of private patients within public hospitals, and, to a growing extent, in private hospitals. It has tended to provide only catastrophic cover for outpatient and GP treatments, despite the fact that over two-thirds of the population are not entitled to public GP coverage.

119. The Irish public-private mix has both advantages and drawbacks. Irish policy makers believe that a mixed health care system enhances individual well-being and health system performance. Private health insurance is seen as a vehicle to afford insurees greater choice over providers and the timing of care. Policymakers also hope to improve sustainability of the public health system by furnishing providers with additional income streams and promoting cost shifting from the public to the private sector. For these reasons, PHI has been supported and encouraged. Regulation and fiscal advantages have promoted access and affordability of private cover across different risk cohorts. A buoyant economy, growing provision of PHI as an employment benefit, confidence in the value of private cover and concerns over the quality (especially in terms of waiting times) of the public system have contributed to a steady increase in the share of the population buying PHI.

120. Meanwhile, a number of market and regulatory changes have been implemented. With the implementation of the requirements of the Third EU Non-Life Directive, the PHI market, historically dominated by a quasi-monopolist state-backed insurer, was opened to competition. A new regulatory regime established in 1994 extended to all insurers the key principles of a solidarity-based PHI system. While a new second player started operations in 1997, the market remains dominated by two insurers, one of which has a majority market share. Increasing the number of carriers within the market does not, however, necessarily mean that competition will automatically develop on cost-efficiency and quality grounds. Instead, insurers may have incentives to compete on the selection of risk, often necessitating regulatory interventions in order to reduce the risk of such unfair competition. Further changes intended to balance solidarity principles with the need to promote competition are in process or have been envisaged, including the establishment of risk equalisation across insurers. Yet, the implementation of the RE scheme gave rise to controversy relating to its potential impact on the PHI market and its compatibility with a competitive PHI market, highlighting the challenges for regulatory intervention in this area.

121. Ireland's detailed PHI regulatory system is supported by EU law, which permits governments to impose stricter requirements when PHI serves – wholly or in part– as an alternative to public health coverage. In fact, several aspects of Ireland's PHI standards have been specifically mentioned as permitted interventions for some countries within EU communications. However, the interpretation of EU law relating to PHI continues to evolve, and hence, the compatibility of certain elements of the Irish PHI system with EU law may be subject to further clarification in the future. The development of competition in the Irish PHI market, including the possible privatisation of VHI, as well as the implementation of the RE scheme, could influence the extent to which the Irish public/private health financing mix, and its regulation, continues to be found to be in compliance with EU law.

122. Ireland applies premium and access regulation to the whole private health insurance market. This has promoted equity of access to, and financing of, private coverage. However, the way private coverage interacts with entitlement to public care has also given rise to policy challenges. The separation of the population into two large categories with different eligibility to public coverage is largely mirrored by the

profile of subscribers to private coverage. This is problematic from an equity perspective to the extent to which PHI provides advantages beyond the additional financial protection already afforded to lower income persons under public coverage, such as quicker access to public hospitals for PHI enrollees. Several factors (availability of private facilities within public hospitals, different payment mechanisms in the public and private sectors, cost subsidisation for private bed charges in public hospitals) may distort the elasticity of the supply of doctors' time between the public and private sector. It also encourages providers to offer preferential treatment to private patients.

123. Several possible measures could limit inequities in access to care in public hospitals. Use of one unique waiting list for admission to public hospitals would promote access to care irrespective of insurance status. Better specification of consultants' rights to private practice and duties within public practice would help clarify the appropriate and desired allocation of time and patients between public and private facilities. If such rules were linked to financial incentives via payment systems, this would reduce incentives for treating private patients preferentially. Reporting and monitoring systems to ensure that private patients do not receive preferential treatment also need to be strengthened. A reassessment of the 20/80 designation ratio for private and pay beds in public hospitals may also be timely. This ratio was established under different conditions of private coverage and public sector rationing, and it is unclear whether it is currently able to match need and demand for care in an equitable and efficient manner, particularly for those without private cover. Obviously, these and other measures are likely to spark significant controversy among stakeholders. The ability to reach broad consensus and negotiate compensation for those who might be disadvantaged by such a modified system may become critical to the successful implementation of any such measures.

124. PHI has helped to improve health system responsiveness for those buying private cover in Ireland. Insurees enjoy greater choice over providers and can access more timely hospital care than those without private cover. They have a high level of satisfaction with PHI and the care it finances. Opportunities for improving the system exist nonetheless. Better PHI outpatient coverage would reduce financial exposure for individuals not entitled to public primary health services. Similarly, improved dental and optical cover would provide improved financial protection for these services and would meet consumer demand, provided there is adequate willingness to pay higher premiums for these services. Also, despite improvements in customer service since the opening of the system to competition, there may be room for strengthening insurer complaints processes.¹⁴³ Information about PHI products, including the financial implications of different policies and limitations linked to pre-existing conditions, is still opaque to a large number of insurees. Improvements in insurer internal complaint systems and in the offering of comparative and product-specific information could therefore heighten purchaser satisfaction. Finally, satisfaction of those who do not purchase PHI cover and overall confidence in the health system would improve if inequities in access to public hospitals based on insurance status were reduced.

125. The ability of private health insurance to relieve capacity pressures from public hospitals, especially for elective surgery, might improve if demand were more efficiently distributed across available public and private facilities. Private health insurance has not substantially contributed to shifting demand from public to private hospitals. Raising charges for private patients in public hospitals to the full economic cost, establishing policies for utilisation of pay and public beds in public hospitals and careful monitoring of their application could result in a shift of private patients from public to private hospitals. Obviously, higher charges would likely affect PHI insurers' costs and PHI premiums, creating another set of challenges.

143 However, limited information is available to date on consumer satisfaction with complaints processes available to those with PHI.

126. Insurers have relied on negotiating prices with providers and engaged in few efforts to manage volumes or promote cost-efficiency of care. They also have few incentives to selectively contract with providers because one main driver of demand for PHI is the added choice it furnishes. This is similar to the experience of other OECD countries with diverse PHI market structures, where PHI is not the primary form of cover, as in Ireland, and where similar reasons underlie demand for PHI. In Ireland insurers also face somewhat limited exposure to the cost of care, both because they have largely shifted cost onto individuals for outpatient services, and because they benefited from public subsidies and strong purchasing power over private providers for hospital treatments. Insurees may nonetheless be increasingly confronted with premium inflation. They demand more and better coverage for outpatient and primary care. The government is phasing in a policy of increasing public sector charges. Payments of benefits to private hospitals, both in terms of volumes and prices, have also increased. Under this scenario, insurers need to better manage expenditure growth. Even though individual choices to buy private cover seem rather resilient to premium increases, insurers need to secure affordability and value for money of private cover in the long run. The existence of substantial public subsidies towards private health insurance also creates pressures on public finances; an evaluation of the net cost and benefits of these subsidies is thus in order.

127. There is a rich debate in Ireland on the pros and cons of the public-private health financing mix, the optimal level and content of private health insurance regulation, and the cost-effectiveness of policies related to private cover. While new evidence is being gathered on the demonstrated advantages and disadvantages of PHI, there is still a dearth of data on the PHI market and the private health care delivery system.¹⁴⁴ This obstructs analysis of the advantages and drawbacks of private cover, and monitoring and evaluation of performance of the public-private mix. Some of the data gaps arise from limitations in the government's current authority to require insurer informational filings. This restricted access to information may warrant re-examination in order to improve policymaker and public understanding of the private market. Specification of homogeneous disclosure standards for providers and insurers across the public-private mix would improve consumer confidence and system transparency. In the presence of substantial governmental efforts and subsidies towards private cover and care, improved accountability and performance monitoring of the private health insurance and health delivery sectors are especially necessary and appropriate.

128. Policy goals for the Irish private health insurance sector may also require reassessment in light of recent evolutions in the system and evidence of its performance. Particularly, policymakers may have to address explicitly the trade-offs that arise from the public-private mix. Insurees' satisfaction needs to be maintained while improving the confidence in the public system of those without private cover. Equity concerns raised by differential access to public hospital care based upon insurance status also need to be addressed without hampering doctors' legitimate desire for a satisfactorily remunerative practice. Continued policymaker attention to these issues is recommended, as well as ongoing monitoring of any additional issues arising from the interaction between private and public health coverage in Ireland.

144 For example, data on utilisation and cost in private hospitals, waiting times by private patients, and the breakdown of insurers claims by procedure, cost, and public-private hospitals are unavailable.

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