

HEALTH SYSTEM FUNDING IN IRELAND

Universal Health Insurance and the Options



REPORT PREPARED FOR
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Contents

1. Introduction	3
2. Health System Funding	4
3. Alternative Funding Mechanisms	6
4. The Irish Health System	11
5. The Programme for Government Reforms in Ireland	20
6. Potential Issues with Universal Health Insurance	23
7. Conclusions	27
8. Bibliography	30

Disclaimer

The views expressed in this report are those of the author and do not necessarily represent the views of the School of Economics, University College Cork or Fianna Fáil.

Context

I have been opposition Health spokesperson since the general election in 2011 and one of the most significant commitments made in the Programme for Government was the introduction of Universal Health Insurance (UHI).

This commitment is not as simple as it is being portrayed and Fianna Fáil believe that citizens should be made fully aware of what this commitment will mean for our health service and how it will be funded.



The introduction of UHI will change how our health service is funded. It will also result in dramatic changes in how our hospital networks work and create the need for a Hospital Care Purchase Agency and Ireland's hospitals will become not-for profit trusts.

Fianna Fáil asked Dr Brian Turner Economist in UCC to outline an independent assessment about what Universal Health Insurance will mean for our citizens.

Even though this is a complex and specialised subject Dr Turner explains very clearly in this document the implications for how our health system will be funded if UHI is introduced.

It also illustrates the implications it will have for citizens without medical cards and those without health insurance and the potential extra costs to the state if UHI is introduced.

There is no doubt that our health system needs reform so that all patients receive health care on clinical need but there needs to be a national debate on how best to achieve this.

There is a need to assess whether the "Dutch model" is suitable for the Irish health system and whether in reality it will result in better health care.

I believe that this independent document will start a constructive debate on the advantages and disadvantages about Universal health Insurance.

If you have any queries or comments on this document please email me at billy.kelleher@oireachtas.ie.



Billy Kelleher TD

1. Introduction

In March 2011, a Fine Gael-Labour coalition Government was formed in Ireland. The agreed Programme for Government included proposals for a radical reform of the health system. A single-tier health system is proposed, with the removal of charges for seeing a general practitioner (GP), the shortening of waiting times in hospitals, a move from reimbursement based on fixed amounts to money-follows-the-patient to incentivise the treatment of more patients, and greater integration of services. These proposals envisage changes to the funding, allocation and delivery of health services in Ireland. A move to universal health insurance was proposed as part of these reforms.

Currently, the Irish health system is primarily funded by taxation, with contributions from out-of-pocket payments and voluntary private health insurance. The proposed reforms envisage a continuation of taxation as the main funding mechanism, but supported by universal health insurance. This would represent a significant change to the nature of health insurance in Ireland, which would bring it more in line with other insurance-based systems in Europe.

However, the timescale for these reforms is relatively short, particularly given their scope. It is also not clear that universal health insurance is a necessary step to achieve the aims of the proposals. In fact, universal health insurance would involve some potential problems that would not arise in a tax-funded system.

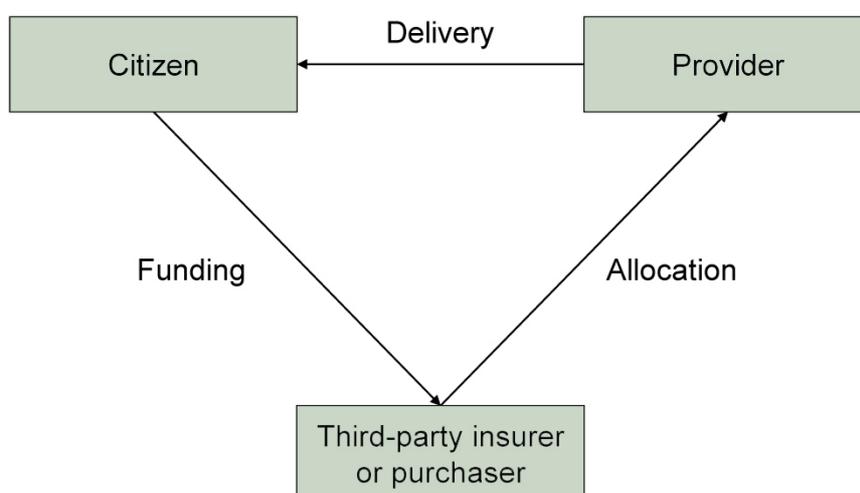
This report is structured as follows: Section 2 sets out the principles of health system funding; Section 3 examines alternative funding mechanisms and the advantages and disadvantages of each; Section 4 puts Ireland's existing health system funding into an international and a historic context; Section 5 sets out the reform proposals in more detail; Section 6 assesses some potential issues with universal health insurance in particular; and Section 7 concludes.

2. Health System Funding

Although health care can be considered a service from an economic point of view, it differs from other economic goods and services in a number of ways

Firstly, demand for health care is a derived demand. People do not demand health care for its own sake. Instead, people demand good health, the achievement of which requires health care in some cases. Secondly, the demand for health care involves greater uncertainty than the demand for many other goods and services. In particular, people do not, in many cases, know in advance whether, or when, they will require health care (a possible exception being those with chronic conditions). Therefore, people face considerable risk of exposure to health care expenses.

Figure 2.1: The Health Care Triangle



For this reason, many funding mechanisms for health care involve a third party purchaser (or multiple third party purchasers), which collects funds from a group of people (or a population), out of which it pays the health care costs for those who fall ill (see Figure 2.1). This third party purchaser therefore pools funds and pools risks, thus spreading the risk and cost of ill-health among a wider cohort, rather than having the risk and cost resting with the individual.

The third party purchaser therefore plays an important role in a health system, including collection of funds, allocation of these funds to providers, and rationing of health care. The choice of the third party purchaser is therefore central to the functioning of the health system and is one of the most important elements of the reform proposals in Ireland.

The third party purchasing function can be carried out by a single purchaser or multiple purchasers. If it is carried out by multiple purchasers, then some mechanism needs to be put in place in order to ensure that all of the population covered by the funding mechanism can get access to cover.

In a market for health care, some people are more likely to need care than others – or to put it another way, some people are high-risk, while others are low-risk.¹ With multiple

¹ In this case, risk refers to the likely medical expenses incurred.

purchasers of care, there is an incentive to cherry-pick the low-risk consumers and avoid the high-risk ones, and this needs to be addressed by means of a risk adjustment mechanism, which ensures that each pool of people covered has a level of funding appropriate to its mix of risks.

Another fundamental difference between health and other economic goods and services is the level of information asymmetry in the market for health care, which is a situation where one party to a transaction has information that another party does not. Unlike many goods and services, health care cannot be tested before purchase and in many cases consumers do not have the expertise to accurately assess the quality of health care after the event.

The presence of the third party purchaser adds to the information asymmetry issue, as there may be information asymmetry between the consumer and the third party purchaser, between the third party purchaser and the provider and between the provider and the consumer. In practice, health care providers have specialist knowledge that neither of the other parties (the consumer or the third party purchaser) would have.

The ultimate aim of health systems globally is to ensure that funding is based on ability to pay, while access is based on need.

3. Alternative Funding Mechanisms

There are a number of alternative funding mechanisms available for funding health systems. These are taxation, social health insurance, private health insurance, user charges and medical savings accounts. Each funding mechanism has advantages and disadvantages, the main ones of which are set out below.

3.1 Taxation

In many health systems, governments purchase care on behalf of some or all of the population. The funding for this comes from taxation. It should be noted that taxation can also be used to fund the provision of services, irrespective of the funding mechanism used to purchase health care. In systems where care is purchased and provided via taxation, the State has both the incentive and the capacity to control costs. Examples of such systems would include Ireland, Australia and the UK. This is not to suggest that the State is the sole payer, but rather that taxation is the dominant form of funding in these countries.

Taxation can take a number of different forms. Most countries use a mixture of direct and indirect taxes. Direct taxes (such as income tax) tend to be progressive, in that people on higher incomes pay a higher proportion of their income in direct taxes, while people on lower incomes pay a lower proportion of their income. Indirect taxes (such as VAT or excise duty) tend to be regressive, in that people on higher incomes pay a lower proportion of their income in indirect taxes, while people on lower incomes pay a higher proportion of their income. The mixture between direct and indirect taxation will affect the overall degree of progressivity of a tax system.

Taxes can also be paid at different levels – national, regional or local. Local taxes have the advantage of being more transparent, as people paying local taxes know that their taxes are being spent in their local area, while national taxes are less transparent in terms of where they are being spent. However, a potential disadvantage of local taxes is that local politicians can be reluctant to make unpopular decisions due to the likely effect on their constituents, whereas this may not necessarily be an issue for decisions taken by national governments.

Finally, taxes can be general or ring-fenced. General taxation allows for trade-offs between competing priorities for public spending, while ring-fenced taxes increase transparency. There is some evidence that people would be willing to pay more in ring-fenced taxes if they knew they were going to be spent on health. For example, HIA (2003) showed that just over a quarter of respondents said they would be willing to pay additional tax if they knew that the public health system would improve.

3.2 Social Health Insurance

Social health insurance is a popular financing mechanism on continental Europe, with countries such as France and Germany favouring this model. This funding mechanism usually involves employers and employees paying contributions on behalf of employees. These contributions are generally income related. For example, in Germany, the contributions are 7.3% from employers and 8.2% from employees (Loh et al, 2012). Concerns have been expressed about the effect of employer contributions on

competitiveness, but evidence suggests that there is a health insurance-wage trade-off in such systems. The purchasing function is usually carried out by a number of independent sickness funds. However, governments often set the contribution rates. Consumers usually have a choice of sickness funds. Although social health insurance models generally have high or full population coverage, in some countries, certain categories of people are either given the choice of opting out of the social insurance system or excluded from it. For example, in Germany, those on high incomes may opt out of the system and opt instead to purchase private health insurance.

One advantage of social health insurance as a funding mechanism is that it is transparent, in the same way as a ring-fenced tax would be. This can lead to more buy-in from consumers and is reflected in greater satisfaction with social health insurance systems than taxation systems. For example, the European Health Consumer Index (Health Powerhouse, 2012) notes that “Bismarck Beats Beveridge” is becoming an established feature of the international comparison of health systems in Europe – Bismarck being short-hand for social insurance based systems and Beveridge being short-hand for taxation based systems. However, this comparison does not necessarily mean that the quality of outcomes is better in social health insurance systems, but rather that consumer satisfaction tends to be higher.

However, social health insurance leads to a number of issues that need to be clarified. For example, consideration needs to be given to how contributions are set for the self-employed, while arrangements also need to be put in place for those who are not in employment, such as those who are unemployed, retired or unable to work. In many social health insurance systems, the State pays for these latter groups of people, thus meaning that taxation plays a role even in social insurance based models. A potential drawback with social insurance based systems is that, as contributions in such systems tend to be related to employment income, they do not take account of wealth or income from other sources. Furthermore, as social health insurance systems involve multiple purchasers of care, some form of risk adjustment mechanism is needed to deter sickness funds from cherry-picking healthier consumers. Social health insurance systems also tend to have higher spending on health care than taxation-funded systems, although it is unclear whether this is due to higher costs or higher volumes of treatment.

3.3 Private Health Insurance

Private health insurance can take a number of different forms, but is rarely the main funding mechanism used. Private health insurance can be substitutive, whereby it substitutes for the statutory health care system; complementary, whereby it covers services not provided by the statutory system or covers copayments that must be paid under the statutory system; or supplementary, whereby it grants additional benefits over and above those available under the statutory system.

The pricing of private health insurance can also take a number of forms. Premiums can be set on the basis of risk rating, whereby the risk that a person represents to an insurer will affect the premium they are charged; community rated, whereby everyone pays the same for a given insurance plan; or group rated, whereby members of a group pay the same as other members of that group but different groups pay different rates. Under a risk rated system, older and sicker people – who tend to be high risk from the point of view of health insurance – end up paying more than younger and healthier people.

Under a community rated system, low risk (younger and healthier) consumers end up paying more than they actuarially would, so there is an incentive for them not to take out insurance, while high risk (older and sicker) consumers end up paying less than they actuarially would, so there is an incentive for them to take out more insurance cover. If this happens, then the average risk of the insured community could be higher than under a risk rated system, leading to the potential for adverse selection.

Furthermore, with private health insurance, insurers have an incentive to engage in risk selection, also known as cherry-picking. This is a phenomenon whereby insurers try to attract low risk lives and discourage or, if permitted, refuse to cover, high risk lives. This can lead to high risk consumers finding it more difficult to get cover or paying more for cover. Although community rating, which is usually accompanied by open enrolment, whereby insurers are obliged to accept all applicants for health insurance, can reduce the opportunities for risk selection, it can increase the incentives for this type of behaviour. Furthermore, there is a natural tendency for a new insurer in a market to attract a younger than average risk profile, as it would primarily be attractive to first-time buyers of insurance and those who switch from another insurer, both of which tend to be younger than average.

In addition to the rating system, risk selection can take place as a result of marketing or plan design. Furthermore, if a standard plan is not a feature of the market, then insurers can design different plans to provide more attractive cover to different cohorts or segments of the market. They can thereby encourage these cohorts to self-select into different plans, leading to market segmentation. In a community rated market, this market segmentation can weaken the intergeneration solidarity, or cross-subsidisation between younger and older consumers, on which community rating is based. In this context, a market with a large number of heterogeneous plans can lead to difficulties for consumers in comparing plans, making it harder for consumers to know which plans provide the best value, thus reducing the benefits of competition for consumers.

A further problem that can occur in a private health insurance market is that, if risk selection is a feature of the market, this can lead to a situation where insurers can make profits on the basis of having a favourable risk profile, and could in some instances reduce the incentive for insurers to compete on the basis of efficiency (Mossialos & Thomson, 2002). This type of competition, if it were to manifest itself, would be socially undesirable (YHEC, 2003).

Private health insurance tends to be a regressive form of health system funding for a number of reasons. The first of these relates to the rating system. Although community rating is equitable in that older people do not pay any more than younger people and sicker people do not pay any more than healthier people, it is quite regressive in that people on higher incomes do not pay any more in absolute terms (and thus pay less relative to their income) compared with people on lower incomes.

If risk rating is used, health status may be a determining factor in setting premiums. Research has shown that those on lower incomes tend to have poorer health status than those on higher incomes, all other things being equal. For example, CSO (2012), which is based on the results of Census 2011, shows that those in lower social classes, who would tend to have lower incomes than those in higher social classes, are less likely to rate their health as very good, and more likely to rate their health as good, fair, bad or very bad (see Table 3.1). This would suggest that, in a risk rated system, people on lower incomes, who would tend to be in poorer health states, may be charged more than those on higher incomes, who would tend to be in better health states.

Table 3.1 – Self-Assessed Health Status by Social Class

	Very Good	Good	Fair	Bad/Very Bad
Professional Workers	75%	20%	4%	0.48%
Managerial & Technical	70%	24%	5%	0.68%
Non-manual	64%	28%	6%	0.88%
Skilled manual	58%	32%	8%	1.27%
Semi-skilled	55%	34%	9%	1.41%
Unskilled	45%	37%	14%	2.38%
All other gainfully employed & unknown	45%	29%	15%	3.91%
All Social Classes	60%	28%	8%	1.52%

Source: Data compiled from CSO (2012)

The second way in which private health insurance can be regressive is if tax relief or tax subsidies are granted across the board for the purchase of private health insurance in a voluntary market. Since those on higher incomes are more likely to be able to afford private health insurance, and are therefore more likely to take it up, they are more likely to benefit from such tax relief or subsidisation. In the Irish case, tax relief on premiums is available at the standard rate of tax (currently 20%). As Table 3.2 shows, the take-up of private health insurance in Ireland is higher among those in higher social classes. The Commission on Taxation (2009) suggested moving from a pro-rata tax relief to a flat rate tax relief, which would be less regressive.

Table 3.2 – Take-up of Private Health Insurance in Ireland by Social Class

Social Class	AB	C1	C2	DE	Farming	Overall
2003	70%		31%		39%	47%
2005	85%	75%	46%	18%	55%	52%
2008	89%	65%	42%	18%	49%	49%

Key: A – Upper middle class; B – Middle class; C1 – Lower middle class; C2 – Skilled working class; D – Other working class; E – Casual workers and those dependent on welfare Source: HIA (2003, 2005, 2008a)

3.4 User Charges

User charges are a feature of most health systems and exclude the third party purchaser, returning the arrangement to one that more closely resembles the payment for most goods and services, involving two actors – a purchaser and a provider.

User charges can come in a number of forms. The first is direct payments, whereby a consumer makes a direct payment to the provider of a service. Examples of this in Ireland would include direct payments to GPs and pharmacists (for prescription medication up to the Drug Payment Scheme threshold). The second category of user charges is perhaps less visible and includes copayments, coinsurance or excesses payable on health insurance contracts. For example, in recent years, private health insurers in Ireland have increasingly used excesses on contracts for treatment in private hospitals, and a number of them have

introduced copayments (fixed payments) or coinsurance (where the consumer must pay a certain percentage of the treatment costs) for certain procedures.

User charges tend to be regressive, as they do not vary by income, therefore meaning that a person on a low income must pay a higher proportion of their income for the charge than someone on a higher income. For example, paying €100 per month for prescription medication would represent 5% of the gross income of someone earning €24,000 per annum, but only 1% of the gross income of someone earning €120,000 per annum. Since they are made for services rendered to the consumer, they also do not involve pooling of funds or risks and therefore do not involve the social solidarity inherent in funding mechanisms that involve a third party purchaser.

However, they make the consumer more aware of the cost of treatment, as they are paying directly for it, and therefore they reduce the potential for moral hazard, or overuse of services. If levied at primary care level, then depending on the level of the charge, people may be discouraged from seeking necessary care, in which case an illness may progress to the point that, by the time to person does seek care, it may require hospitalisation, which is a more expensive form of care than primary care.

3.5 Medical Savings Accounts

Medical savings accounts are not widely used as a funding mechanism for health care, but are mentioned here for the sake of completeness. The best example of these in practice would be in Singapore. Medical savings accounts are accounts into which people are encouraged or obliged to put a proportion of their income, and the money in these accounts can then be used for their health care or that of their dependents.

Medical savings accounts share some of the characteristics of user charges. In particular, they do not involve pooling of funds or risks and therefore do not involve social solidarity as would be the case with funding mechanisms involving a third party purchaser. They also make consumers more aware of health care costs and could therefore potentially reduce moral hazard. Medical savings accounts however, would require a mechanism for dealing with catastrophic illness, which could involve expenses that consume more than the amount of money in the medical savings account. It would also require some basic element of cover for those who cannot afford to save.

4. The Irish Health System

The Irish health system is dominated by public funding and provision, with elements of private funding and provision running alongside it. This mixture of public and private funding mechanisms and public and private provision is not unusual in an international context, but the Irish system is characterised by a complex series of overlaps between the public and private funding and delivery mechanisms. Nolan (2005) notes that some services are publicly funded and delivered, others are publicly funded and privately delivered, others are privately funded and publicly delivered, while others still are privately funded and delivered. Smith (2009) examines flows of funds and finds widely different patterns of cross-subsidisation for different elements of the system.

The Irish health system is primarily funded by a mixture of taxation, user charges and private health insurance.² Taxation is the dominant form of funding, although since the economic downturn began, this dominance has been reduced. Table 4.1 shows the funding mix in the Irish health system over the last decade.

Table 4.1 – Health System Funding by Source in Ireland (%), 2000-2010

Year	GGEH/TEH	PEH/TEH	PHI/PEH	OOP/PEH	SSE/GGEH	GGEH/TGE
2000	75.1	24.9	30.9	60.8	1.2	14.7
2001	75.7	24.3	26.3	61.7	1.0	15.4
2002	76.3	23.7	26.5	61.3	0.9	16.0
2003	76.5	23.5	27.9	68.2	0.8	16.9
2004	77.4	22.6	30.0	69.1	0.8	17.3
2005	77.0	23.0	31.7	66.4	0.7	17.2
2006	76.8	23.2	35.7	61.9	0.9	16.8
2007	76.9	23.1	34.8	60.1	0.8	16.1
2008	76.7	23.3	34.1	61.8	0.8	15.8
2009	74.9	25.1	44.2	49.1	0.9	14.5
2010	69.2	30.8	44.2	49.1	0.5	9.5

Key: GGEH – General Government Expenditure on Health; TEH – Total Expenditure on Health; PEH – Private Expenditure on Health; PHI – Private Prepaid Plans; OOP – Out-of-pocket Payments; SSE – Social Security Expenditure; TGE – Total Government Expenditure Source: World Health Organisation

Table 4.1 shows that, in 2010, 69.2% of funding for the Irish health system came from public sources, while 30.8% came from private sources. Of the private expenditure on health, 44.2% came from private health insurance (equating to 13.6% of total health system funding), with a further 49.1% coming from out-of-pocket payments or user charges (equating to 15.1% of total health system funding). Of the public expenditure on health, only 0.5% came from social security expenditure, indicating that taxation financing was dominant in the public element of financing. Finally, government expenditure on health accounted for 9.5% of total government spending.

² There is a small element of funding from NGOs and charitable donations, but this makes up less than 2% of the total.

This table also shows that the composition of funding has changed since the onset of the economic downturn in Ireland. There has been a sharp drop in the proportion of health funding coming from public sources and a consequent rise in the proportion coming from private sources. Furthermore, the proportion of private funding coming from private health insurance has risen sharply, while the proportion coming from out-of-pocket payments has fallen, although the latter still accounts for a higher proportion of private funding than the former. The proportion of total government spending going to the health service has also dropped sharply, having previously been in line with international norms.³

The reason for this reduction in public health spending is the sharp cutbacks in the health budget in recent years. Figures from the Department of Public Spending and Reform show that, having peaked in 2008 at just over €16bn, the estimate for 2012 was just over €14bn, representing a fall of around €2bn or just over 12%. Approximately half of the budgetary adjustment to date has been in pay costs (including the effect of a reduction of 8,379 in Whole-Time Equivalent staff in the HSE between September 2007 and December 2011), with a similar amount coming from non-pay costs. The capital budget has accounted for the remainder of the reduction. The recently announced Budget 2013 figures estimate a further fall of €781m in 2013. The Future Health document (Department of Health, 2012) also envisaged a further reduction in HSE staff numbers of approximately 6,500 over the coming years.

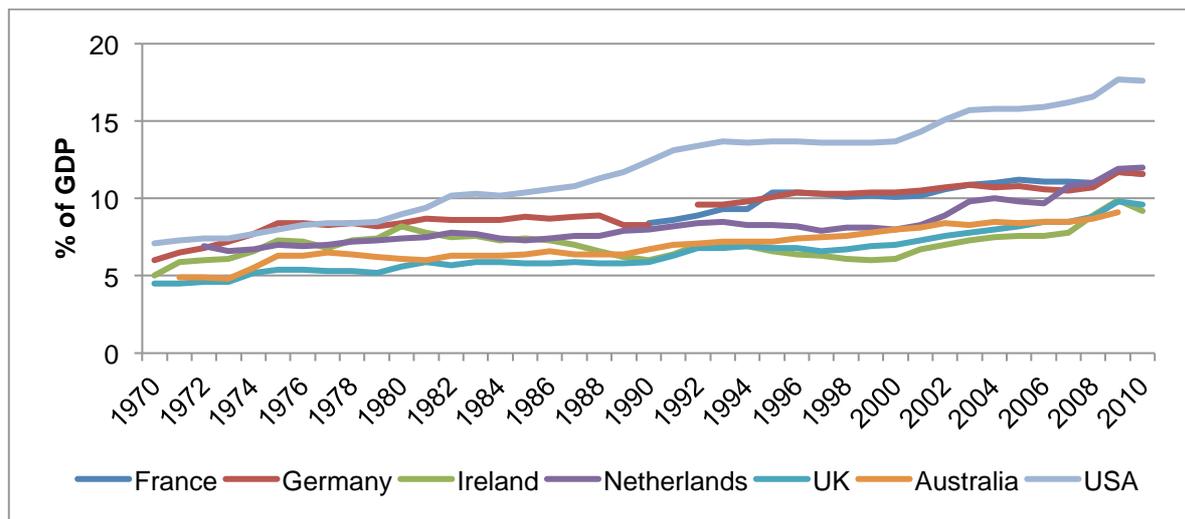
It is also useful to examine health spending per capita and as a percentage of GDP.⁴ Figures 4.1 and 4.2 show these measures for a selection of countries. A number of interesting features can be seen by examining these figures.

The first is the general and long-term upward trend in health spending both per capita and as a proportion of GDP. Health spending has been consuming an increasing proportion of countries' economic output for some time, notwithstanding the reduction in a number of countries in 2010. This trend has been exercising a number of governments in recent years, and has led in some cases to a reduction in the proportion of health funding coming from public sources (OECD, 2012). A number of factors are underlying this, including ageing populations, increased incidence of chronic illnesses and continued advances in medical technology that, although more effective, are also more expensive.

³ However, it should be noted that Government expenditure figures for 2009 and, more particularly, 2010 were affected by expenditure on measures to deal with the banking crisis (see <http://economic-incentives.blogspot.ie/2013/01/debt-and-deficits-decomposed.html> for details). If this banking-related expenditure were excluded, then government health expenditure as a proportion of total government expenditure would have been 15.4% in 2009 and 14.0% in 2010.

⁴ Although many economists argue that GNP is a better measure of economic activity in Ireland than GDP, international comparisons use health spending as a percentage of GDP, so these figures are used here. It should be noted however, that health spending as a percentage of GNP in Ireland would be significantly higher than if it were expressed as a percentage of GDP.

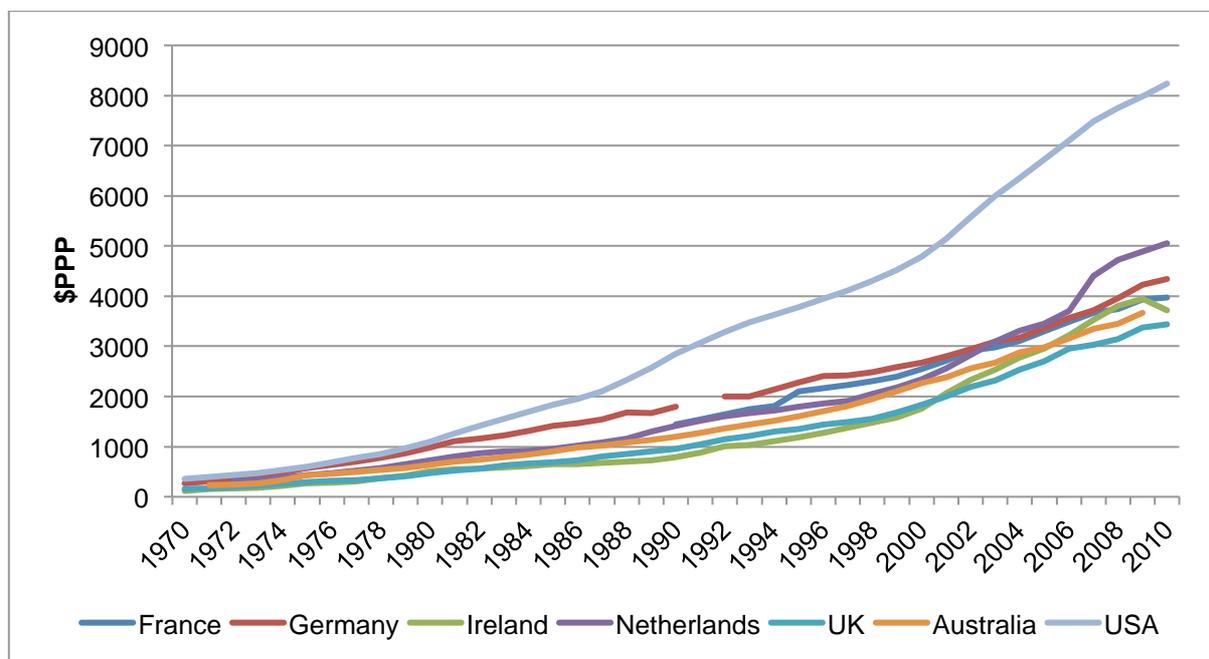
Figure 4.1 – Health Spending as a Percentage of GDP, 1970-2010



Source: OECD

The second feature that can be seen from these figures is that countries with different funding mechanisms tend to have different levels of spending. In these figures, Ireland, the UK and Australia are primarily tax-funded systems, while France, Germany and, particularly until 2006, the Netherlands are primarily social insurance based models. The US has a heavier reliance on private health insurance than any of the other countries in these figures. It can be seen that the three tax-funded systems tend to spend less, both in per capita terms and as a percentage of GDP, than the three social insurance based systems, which in turn spend less than the US, the latter of which spends a significantly higher amount and proportion than most other countries in the world.

Figure 4.2 – Health Spending Per Capita \$PPP, 1970-2010



Source: OECD

Another feature that is worthy of note is specific to Ireland. In the 1970s and early 1980s, the proportion of GDP spent on health in Ireland was quite favourable relative to the other countries featured here. However, the cutbacks in health spending in Ireland in the late 1980s and into the 1990s are evident in the fall back in the position of Ireland relative to these comparator countries. The cutbacks in health spending had a dramatic impact on the Irish health system which, in some cases, has not yet been fully unwound. For example, in the early 1980s, there were nearly 18,000 acute public hospital beds in Ireland, compared with approximately 14,000 in 2007 (Wren, 2003; HSE, 2007). Any comparisons of Ireland's health spending per capita or as a percentage of GDP with those of other countries therefore need to take account of the previous under-funding in the Irish health system.

Eligibility for health services in Ireland is determined to a large extent on the basis of whether or not someone is in possession of a medical card. A medical card grants its holder free access to a GP, prescription medications subject to a levy of €1.50 per prescription item up to a monthly limit of €19.50 per family⁵, free treatment in a public hospital bed, free access to an accident and emergency (A&E) department, and other less widely used benefits. Those without a medical card must pay out of pocket to visit a GP (typically around €50 per visit – Bourke & Roper, 2012), or for prescription medication (up to a maximum of €144 per month under the Drug Payment Scheme⁶), or for accommodation in a public hospital bed (€75 per night up to a maximum of €750 in any continuous 12-month period) or to visit an A&E department (€100 per visit if not referred by a GP).

At the end of 2011, approximately 37% of the Irish population had a medical card, while approximately a further three percent had a GP Visit card (HSE 2012), which allows them free access to a GP but does not confer the other benefits of a medical card.

Running alongside the public health system is a system of voluntary private health insurance, which is primarily supplementary in nature, although with elements of a complementary system in the form of partial reimbursement for some day-to-day medical expenses such as visits to the GP, physiotherapist, dentist or optician among others.

Despite universal access entitlements to the public hospital system (subject to copayments for those without medical cards), take-up of private health insurance in Ireland peaked in December 2008 at almost 2.3 million people, or just over half the population. Since then, take-up has fallen by 198,000, or just over 8.6%, to 2.099 million in December 2012 (HIA, 2013a). This represents a take-up rate of just under 46% of the population.

The private health insurance market in Ireland operates on the basis of community rating, open enrolment and lifetime cover (whereby an insurer may not refuse to renew cover). A system of minimum benefits is also specified, although many of these minimum benefits are now out of date, as they were specified in monetary terms in 1996 and not inflation-linked.

There are currently four insurers operating in the open market.⁷ The largest of these is Vhi Healthcare. This was established in 1957 as a statutory insurer and had a monopoly in the open market for 40 years. Following the passing of the Third EU Non-Life Insurance Directive in 1992, the Irish health insurance market was opened up to competition with the passing of the Health Insurance Act, 1994. The first competitor to Vhi Healthcare was BUPA

⁵ This previously stood at a levy of 50c per prescription item with a monthly limit of €10 until 1 January 2013.

⁶ This was increased from €132 per month on 1 January 2013.

⁷ There are also a number of restricted membership undertakings operating in Ireland, membership of which is limited to vocational or occupational groups. At the end of 2011, there were seven such undertakings (HIA, 2012a).

Ireland, which began selling health insurance in Ireland in 1997. BUPA Ireland exited the market in 2007, selling its business to Quinn Insurance Limited, which traded as Quinn Healthcare. In 2012, Quinn Healthcare was the subject of a management buyout and now trades as Laya Healthcare. In 2004, VIVAS Health was established. In 2008, this was bought by Hibernian Insurance and now trades as AVIVA. In July 2012, a fourth insurer, GloHealth began operating in the market.

Table 4.2 shows the market shares of the insurers (prior to the entry of GloHealth to the market). This shows that Vhi Healthcare's market share has been reducing in recent years, while that of AVIVA Health has grown strongly. The market share of Quinn Healthcare (now trading as Laya Healthcare) has been relatively stable over the period shown.

Table 4.2 – Market Shares in the Irish Private Health Insurance Market

December	AVIVA Health	Quinn Healthcare	Vhi Healthcare	Restricted Membership Undertakings
2008	7.7%	21.6%	66.8%	3.9%
2009	10.4%	22.8%	62.9%	3.9%
2010	13.7%	20.8%	61.6%	3.9%
2011	17.7%	20.9%	57.3%	4.0%

Source: HIA (2012c)

However, the Irish private health insurance market is currently suffering from a number of market failures. The three of most concern are adverse selection, risk selection and market segmentation.

Adverse selection is a tendency for those who need insurance most to demand more of it, while those who need it less demand less of it. Although this makes sense from an individual point of view, community rating requires sufficient low-risk individuals to take out private health insurance in order to cross-subsidise the high-risk individuals. In this regard, community rating relies on intergenerational solidarity, whereby younger people (who tend to be low risk on average) cross-subsidise older people (who tend to be high risk) in the expectation (conscious or otherwise) that when they get old they in turn will be cross-subsidised by a future generation of younger people.

This requires a constant stream of younger people to enter the market. If this stream of younger people is reduced or cut off then the cross-subsidisation effect will weaken and the average risk profile in the market will increase, leading to higher average claim costs, which in turn will lead to higher premiums, which in turn will lead to some people leaving the market (with the likelihood that these will be disproportionately the low-risk consumers who see insurance as poor value for money), which will further worsen the average risk profile and so on in a cycle that could ultimately end with the collapse of the market (a situation known as an adverse selection death spiral).

As can be seen from Table 4.3, in recent years the number of younger consumers in the market has fallen, while the number of older consumers has risen, both in absolute and relative terms.⁸ Although it is too early to determine whether this is the beginning of an

⁸ These figures exclude those who are serving initial waiting periods before cover becomes effective, those who are insured on products not subject to health insurance stamp duty and age-related tax credits, and those who are insured with restricted membership undertakings.

adverse selection death spiral, it certainly suggests that the average risk profile in the market has worsened in recent years.⁹

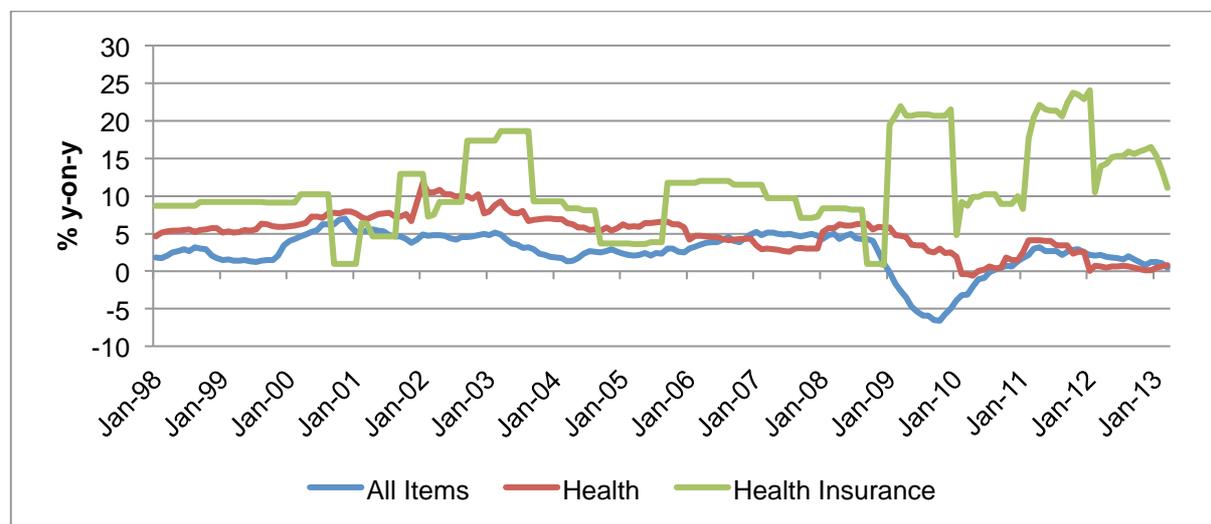
Table 4.3 – Age Structure of the Irish Private Health Insurance Market, 2009-2011

Age Group	2009	2010	2011
0-17	518	505	495
18-29	310	284	256
30-39	365	351	331
40-49	321	315	308
50-59	272	272	269
60-69	197	204	208
70-79	101	106	110
80+	39	42	44

Source: HIA (2012a), Appendix C

One of the reasons for the discontinuation of cover is significant premium inflation in the health insurance market in recent years. Figure 4.3 shows inflation in the health insurance sub-index of the Consumer Price Index, compared with inflation in the Health category and the overall inflation rate in Ireland. It can be seen from this Figure that inflation in the Health category of the Consumer Price Index tends to be higher than the All Items inflation rate (which is the headline inflation rate), and that inflation in the health insurance sub-index (which is not part of the Health category but rather part of the Miscellaneous Goods and Services category) tends to be higher than inflation in the Health category. Furthermore, it can be seen that health insurance inflation has been particularly high in recent years.

Figure 4.3 – Inflation in All Items, Health and Insurance connected with health



Source: Central Statistics Office Statbank database

⁹ McCarthy (2013) suggests that this effect is likely to continue, as younger age cohorts have, in recent years, been worst affected by emigration and unemployment and are therefore struggling to continue to afford private health insurance.

Risk selection is a phenomenon whereby insurers try to attract as many low risks as possible and either refuse to cover (if permitted) or discourage high risks from joining. Although community rating and open enrolment reduce the opportunities to engage in risk selection, they increase the incentive to engage in this kind of behaviour, as insurers will receive the same premium for a low risk as a high risk, despite the expected claim costs of the low risk being lower. Despite the presence of community rating and open enrolment, risk selection can occur in subtle ways, such as through marketing or plan design. For example, plans designed with generous benefits for sports injuries would, all other things being equal, appeal to a younger demographic, while plans providing more generous cover for hip replacements or cataract surgery would appeal more to an older demographic.

It should be noted that there is a possibility that what could be termed passive risk selection could take place, whereby a newer insurer in a market would naturally attract a younger age profile, as it would be competing for first-time buyers of health insurance and those who switch between insurers, both of which tend to be younger demographics than the average. A related phenomenon is what is known as adverse retention, whereby older, more established plans tend to have a higher concentration of older members than newer plans (Altman et al, 1998). In this regard, the fact that Vhi Healthcare was in the Irish market for 40 years before its first competitor would accentuate this effect.

Table 4.4 shows the market shares of the three insurers in the open market at the end of 2011 by age group. The figures show that Vhi Healthcare has a significantly higher share of older consumers than its overall market share, while the other insurers have significantly lower market shares among older consumer than their overall market shares. This suggests that there may be risk selection and/or adverse retention occurring in the Irish market.

Table 4.4 – Market Share by Age Group, 2011

Age Group	AVIVA Health	Quinn Healthcare	Vhi Healthcare
0-49	20%	24%	56%
50-59	19%	20%	60%
60-69	15%	18%	67%
70-79	9%	11%	80%
80+	5%	5%	90%
Total	18%	22%	60%

Source: HIA (2012c)

In this context, it is worth noting that the average claim costs for older consumers can be significantly higher than that for younger consumers. Figures from the US show that a small group of people account for a very high proportion of health care spending, while a large majority of people account for a very small proportion. Specifically, in 2009, 1% of the US population accounted for 20% of spending, while the 50% of the population with the lowest spending accounted for only 3% of total spending (NIHCM Foundation, 2012). These figures also show that older consumers or those with chronic medical conditions are significantly more likely to be among the high-spending consumers. In the Irish health insurance market, figures for average claim costs per insured member vary significantly, as can be seen in Table 4.5.

Table 4.5 – Average Claim Cost per Insured Member by Age Group, 2011

Age	17 & under	18-29	30-39	40-49	50-59	60-69	70-79	80+
Average Claim Cost	€208	€312	€538	€582	€988	€1,839	€3,099	€4,344

Source: HIA (2012b)

The third source of market failure in the Irish private health insurance market is market segmentation. In theory, competition is of benefit to consumers by giving them a choice of products or services and allowing them the freedom to choose the best value option. However, if consumers are unable to easily compare products or services then this benefit of competition may not be fully conferred. In this context, it is worth noting that there are over 200 plans currently available in the Irish private health insurance market and in many cases consumers find it difficult to accurately compare these plans, notwithstanding the presence of an independent comparison tool on the website of The Health Insurance Authority. It has been suggested in the literature that, in the absence of a standardised package of care, consumers may be confused about their options, thus limiting the benefits of competition (see, for example, Maynard & Dixon, 2002 or Thomson & Mossialos, 2007).

Furthermore, plan design can also be used to engage in market segmentation, in the same way as it can be used to engage in risk selection. Plans can be designed to be particularly attractive to different segments of the market, thereby encouraging them to self-select into different plans, which can then be priced differently, according to the risk profile of their members. For example, in the Irish market, a number of plans offer limited coverage for certain orthopaedic procedures (either in the form of coinsurance or a copayment for these procedures in private hospitals), while other similar plans from the same insurers, offering full cover for these procedures, tend to be more expensive. These procedures would intuitively be more likely to be needed by older consumers and therefore, in order to maintain full cover for these procedures, these consumers are required to pay higher premiums.

The Health Insurance Authority has expressed concern in recent years about the increase in market segmentation in the Irish private health insurance market (see, for example, HIA, 2008b, 2009). In particular, it points to the sharp increase in the number of plans available in the market, from five in 1996 to 18 in 2002, to over 100 in 2008. Since then the number of plans has increased further, to over 200 currently.

It is clear that the Irish health care system is currently facing a number of challenges. At the same time as budgets for the public health system have been cut in recent years, reliance on the system has increased as a result of more people qualifying for medical cards (an increase of around 50% between 2006 and the end of 2011) and more people dropping their health insurance cover. In this context, it should be noted that the volume of treatment in hospitals increased by approximately 25% for day-case procedures between 2008 and 2011, while inpatient and Emergency Department presentations were only slightly lower over the period. Further budget cuts are planned for 2013 and 2014, as well as further cuts in staff numbers (Department of Health, 2012).

Meanwhile, the private health insurance market is currently suffering from a number of market failures, specifically adverse selection, risk selection and market segmentation. Premium inflation in the market is also of concern, averaging double-digit annual rates in recent years and leading to an exit of consumers from the market. More worryingly, it is

younger consumers who tend to be discontinuing cover in greater numbers, thus leaving a higher concentration of high-risk consumers in the market.

It is in this challenging environment that the Programme for Government envisages introducing the most radical reforms of the health system in the history of the State.

5. The Programme for Government Reforms in Ireland

The Programme for Government (Department of the Taoiseach, 2011) outlines a radical reform package for the Irish health system, which the Government parties acknowledge will take a second term in office to fully implement. The reforms envisage changes to the funding, allocation and delivery of health care in Ireland, as well as reforms at the third-party purchaser and provider levels (see Figure 2.1).

One of the main aims of the reforms is to have a single-tier health system, where access is based on need rather than ability to pay. There is evidence to suggest that the current system facilitates those with private health insurance to access treatment more quickly in some cases than those who do not. For example, CSO figures relating to the third quarter of 2001 showed that those with private health insurance were more likely to be waiting less than three months and less likely to be waiting more than six months for inpatient, day-case or outpatient treatment than those without private health insurance (CSO, 2002).

Furthermore, given that the purchase of private health insurance is subsidised by the State (through tax relief at source on premiums, the fact that insurers are not charged the full economic cost for private beds in public hospitals and, to date, have not been charged for the use of public beds in public hospitals, and the fact that the State subsidises the training of medical professionals, some of whom work in private practice), and given that those on higher incomes are more likely to have private health insurance (see Table 3.2), the inequity is exacerbated.¹⁰ Previous Government policy was to maintain incentives for people to take out private health insurance as it meant that those who could afford it could take responsibility for meeting the cost of their own healthcare and reduce the pressure on the public hospital system (Department of Health and Children, 1999).

The current reforms are planned in three phases. The first phase involves a Special Delivery Unit (which was established in June 2011) reducing waiting times for Emergency Department, inpatient and outpatient treatment. The National Treatment Purchase Fund has been reorganised to support the mission of the SDU and there is evidence that waiting times have been reduced since the latter was established, with the number of people waiting longer than 12 months for treatment having fallen by 85% and the number waiting longer than nine months having fallen by 91% (O'Sullivan, 2012).

The second phase of the reforms involves providing free at the point of use GP care to all of the population. The idea behind this reform is to remove the financial barrier to accessing a GP in order to encourage people to seek treatment at an earlier stage, rather than delaying the decision to seek care until the point at which the illness has progressed to the point where it requires hospitalisation – a much more expensive form of care. Evidence suggests that around a quarter of Irish people who do not have a medical card have put off going to the GP on cost grounds (O'Reilly et al, 2007).

The extension of free at the point of use GP care to all (from the current situation where it is only available to those with medical cards or GP Visit cards) is due to take place on a phased basis. The plans had envisaged the first phase involving extending the service to those on the Long-Term Illness Scheme. This was originally due to take place in March 2012 and was then expected in 2013, but it has now been abandoned due to legal issues

¹⁰ However, Smith (2009) notes that this is not the only inequitable cross-subsidisation in the Irish health system.

and is now expected in 2013. The second phase in the original timeline had involved extending it to claimants of free drugs under the High-Tech Drugs scheme, after which it would be extended to the entire population. The Minister has now stated that, due to the legal difficulties, the first two phases will be by-passed and the extension will gradually take place on a population-wide basis.

Under the reform proposals, it is envisaged that GPs will be paid primarily on a capitation basis, which would represent a significant shift from the current mix of capitation for patients with medical cards or GP Visit cards and fee-for-service income from private patients. This will require agreement with GPs, and negotiations are currently believed to be at an early stage. Furthermore, the plans will oblige people to register with a GP, which is not currently the case. It was estimated that providing free at the point of use GP care to all would cost approximately €389m (Labour Party, 2011).

The third phase of the reforms would introduce Universal Health Insurance (UHI). The Government has acknowledged that this will not happen in its first term in office and would require a second term to be fully implemented. Under the proposals, it would be obligatory to purchase health insurance, which would provide hospital and some primary care cover (Department of Health, 2013a). The State would pay for premiums on behalf of those on low incomes and subsidise premiums for a further cohort. Prior to the election, Dr. James Reilly stated that the State would pay premiums on behalf of 40% of people and subsidise premiums for a further 30% on a sliding scale, with only the top 30% of people by income having to pay the full premiums themselves (Ryan & Shanahan, 2011).

It is envisaged that providers will compete to provide value for money to purchasers (insurers), with insurers permitted to engage in selective contracting, in other words not obliged to cover all providers. Public hospitals will become independent trusts or be organised into groups, and reorganisation of the public hospital system has already begun (see Higgins et al, 2013). These trusts or groups will then compete with private hospitals or groups. It is also envisaged that competition between insurers will keep premiums under control for consumers.

In order to provide incentives to treat patients, the allocation mechanism will change under the UHI proposals. Specifically, a system of money-follows-the-patient (MFTP) will be introduced, under which treatment of additional patients will generate additional revenue. This is in contrast to the current situation for public hospitals whereby the allocation is primarily based on a fixed budget, with some adjustment for Casemix (reflecting relative treatment complexity). The MFTP system will also encourage treatment at the lowest level of complexity, in order to reduce system-wide costs, as a longer-term aim is to allow money to follow the patient out of the hospital setting (Department of Health, 2013b).

The introduction of consistent remuneration for all patients should help to reduce the incentives that are currently built into the system to prioritise the treatment of some patients over others. Currently, GPs are remunerated on a capitation basis for patients with medical cards or GP Visit cards, while they receive fee-for-service income for private patients. Hospital consultants who work in both public and private practice are paid on a salary basis for their public work but a fee-for-service basis for their private work. Public hospitals are allocated budgets primarily on a fixed budget basis, but can earn additional income from accommodating private patients in private beds. In each case, treating additional public patients does not lead to increased income, but treating additional private patients does, leading to an incentive to treat more private patients. Evidence regarding the extent to which these incentives are followed is anecdotal rather than definitive, but the incentives remain.

However, in order to deliver the reforms, additional capacity will be needed in at least some areas of the health system. The Government has acknowledged that increased capacity will be needed at GP level, while there have also been calls for increased hospital bed capacity, and Ireland's provision of specialist doctors is below international norms. Agreement with key stakeholders – particularly consultants and GPs – will also be needed, and it is far from clear whether this will be forthcoming.

6. Potential Issues with Universal Health Insurance

While many of the reform proposals contained in the Programme for Government would represent positive steps if they come to pass – such as the creation of a single-tier health system, the removal of the financial barrier to accessing GP services and the shortening of waiting lists for hospital treatment – the plans for universal health insurance could raise a number of potential issues.

The first of these is that the introduction of competition in the purchasing of healthcare may not be a universally positive development. A system of competing purchasers would forego the monopsony benefits of a single purchaser. Introducing a more fragmented purchasing pool would mean that each purchaser (insurer) would have less bargaining power over providers than a single purchaser.

The introduction of competition for healthcare purchasing will also introduce incentives for risk selection, market segmentation and other sources of market failure. Professor Alain Enthoven, considered by many to be the father of managed competition, on which the Dutch reforms of 2006 were based, stated “A free market does not and cannot work in health insurance and health care. If not corrected by a careful design, this market is plagued by problems of free riders, biased risk selection, segmentation and other sources of market failure.” (Enthoven, 1993: 44).

As suggested by Enthoven (1993), careful regulation is required in order to ensure that competing purchasers of care do not engage in activity that would be disadvantageous to some consumers. In particular, a robust risk equalisation scheme would be essential to the proper functioning of such a market. In this regard, it should be noted that no risk adjustment mechanism is perfect, so there will always remain some incentive for risk selection, although it has been suggested that a risk adjustment mechanism does not need to be perfect, but rather sufficient to ensure that risk selection is no longer profitable (Van de Ven et al, 1994).

Previous experience of risk equalisation in Ireland also suggests that any scheme would need to be carefully designed. Although risk equalisation was on the statute books from 1996 to 1999 and again from 2003 to 2008, neither scheme resulted in monetary transfers being made between insurers. A set of interim measures in place from 2009 to 2012 led to partial redistribution of the cost of high-risk insured lives, and a new scheme of risk equalisation has commenced in 2013.

Although theoretically, competition should ensure that costs are minimised, the experience to date of competition in the Irish private health insurance market has not been one of reduced premiums. In fact, not only have premiums been reduced, but premium inflation has accelerated. According to figures from the Consumer Price Index released by the CSO, in the last seven years of Vhi Healthcare’s monopoly (December 1989 to December 1996), premiums increased by an average of 5.7% per annum. During the period when there were two insurers in the market (January 1997 to September 2004), premiums increased by 9.1% per annum on average. During the period when there were three insurers in the market (October 2004 to July 2012), premiums increased by an average of 12.6% per annum. The fourth entrant to the market only began selling insurance in July 2012, so it is too early to make comparisons under the four-player market.

It should be noted that the addition of insurers to the market is not the cause of the acceleration in premiums. However, what these figures do show is that competition in and of itself is not sufficient to reduce costs, particularly in light of the fact that many of the drivers of inflation are long-term trends.

There are a number of factors underlying premium inflation, including an ageing population, an increase in the number of people living with chronic illness, advances in medical technologies and treatments, population growth, the addition of new private hospital capacity in the last decade and an increase in the cover available on many private health insurance plans. Government policy to move towards charging the full economic cost of private beds in public hospitals (which would end one implicit subsidy of private patients that currently exists) has also raised costs for insurers and put upward pressure on premiums, while the commencement later this year (on a phased basis) of charging insurers for the use of public beds in public hospitals will also lead to further premium increases.

One way in which costs could be controlled under a move to universal health insurance is through the design of the standard plan that is envisaged. Logically, the more comprehensive is the cover on such a plan, the more expensive it is likely to be, reflecting higher claim costs. However, too low a level of cover on a standard plan could leave people without cover for certain procedures. It is also unclear at present whether, or to what extent, it is envisaged that people will be able to purchase complementary private health insurance for procedures or treatments not contained within the standard plan, and what type of rating system would be used should such an option be available. If such complementary cover were available on the basis of risk rating then older, sicker consumers could face higher charges for such cover.

Another concern relating to the affordability of universal health insurance cover relates to the cohort of the population that currently has neither a medical card nor private health insurance. According to figures from the CSO (2011), this cohort accounted for 23% of the adult population in the third quarter of 2010.¹¹ If these people do not have a medical card then it is unlikely that they would fall into the 40% of the population for whom universal health insurance premiums would be paid for by the State. Therefore, they would be obliged to pay some or all of their premiums themselves.

However, given that they do not currently have private health insurance, the requirement to pay premiums for universal health insurance would represent an additional financial burden on them, particularly as this cohort has significantly lower than average utilisation of health services for which they would currently be obliged to pay out-of-pocket. Prior to the general election in 2011, Dr. James Reilly stated that those who then had private health insurance would not pay any more than they already did under a move to universal health insurance. Given that figures from HIA show that the average premium paid per person (including children and students) in 2012 was €1,048, up from €926 in 2011 (HIA, 2013a, 2012b)¹², even paying part of the premium for universal health insurance could be beyond the ability of many of those who do not currently pay for private health insurance. Given that the plans for the future health system envisage it remaining primarily tax financed (Department of Health,

¹¹ Interestingly, there is a significant regional variation in these figures, ranging from 17% in the West to 27% in the Border region (CSO 2013).

¹² These figures represent gross premiums. Once tax relief at source is taken into account, the net premium payable in 2012 was €838.

2012), it is assumed that taxation levels to fund the health system will not be reduced to compensate for the introduction of universal health insurance premiums.

The premium inflation referred to above also raises an issue in relation to the State paying premiums for 40% of the population and subsidising them for another 30% of the population. If premium inflation is not brought under control then significant increases in State funding will be required year on year in order to continue paying for these premiums. If this were to transpire then the Government would need to either raise additional tax revenue or reduce spending in other areas to compensate. This could prove to be challenging, particularly in the context of the current fiscal programme. On the other hand, if the State were to use its purchasing power to aggressively negotiate lower premiums than would otherwise be charged, then it could have implications for the financial viability of insurers.

The regulatory need to maintain the financial viability of insurers would also need to be taken into account under a move to universal health insurance. Current Central Bank of Ireland regulation requires non-life insurers to hold 40% of premium income as solvency reserves. Therefore, any move to increase the size of the market from just under half of the population to the entire population, which would entail a significant increase in premium income at a market-wide level, would require significant increases in these reserves, among all authorised insurers in the market.

In this context, note should be taken of the existing issue surrounding solvency reserves at Vhi Healthcare. Following a European Court of Justice ruling in 2011, Vhi Healthcare is due to be authorised by the Central bank by the end of 2013. This will require an increase in its reserves and it is as yet unclear from where this injection of capital will come. One possibility is that this may come from the Government, although this may be challenged on the grounds of State Aid. However, if universal health insurance requires a further injection of capital in a relatively short timescale after the one that will be required this year, plans will need to be made regarding how this will be raised. If this is to be supplied by the Government, then the cost of this should be factored into the costs of implementing universal health insurance.

Another issue that needs to be considered is the progressivity of universal health insurance premiums relative to that of taxation. If, as has previously been indicated, community rating is used to determine premiums, then the progressivity of the health system could be reduced. While community rating is equitable in that high-risk policyholders (older and sicker members of society) do not pay any more than low-risk policyholders (younger and healthier members), it is regressive in that those on higher incomes do not pay any more than those on lower incomes in absolute terms, and therefore pay less in relative terms (as a proportion of their income). Even with a system in place to pay for the premiums of those on the lowest income and subsidise them for those on middle incomes, within the middle income and high income brackets (those who would be paying part or all of their premiums, respectively) there would be a divergence of incomes. Therefore, community rating, even within these categories, would lead to regressive funding arrangements within those categories. By contrast, taxation is generally considered to be progressive, albeit that the degree of progressivity depends on the mix of direct and indirect taxation levied.

The announcement of the proposed move to universal health insurance may also be having an adverse effect on the existing private health insurance market. As mentioned in Section 4, the private health insurance market is suffering from a number of market failures. The policy response to one of those failures, risk selection, is to introduce a risk equalisation scheme, the third version of which has commenced this year. This consists of a levy

payable by insurers for each of their members, and reimbursements to insurers for their older members. However, despite the stated intention when the legislation was being debated that a lower levy would apply to health insurance plans that provide lower levels of benefit, it was found that, based on the definition contained in the legislation as passed, all plans in the market at the end of 2012 fell into the category of advanced plans, and would have been subject to the same levy.¹³ This will increase the price of cheaper plans by a higher proportion.

As these plans are primarily attractive to younger consumers, this could accentuate the rate of discontinuation of health insurance among this younger age cohort, which would further worsen the risk profile of those in the market, which would add further upward pressure to premiums, thus worsening the problem of adverse selection. Therefore, the policy response to one market failure, as it is currently structured, could inadvertently lead to a deterioration of another market failure.

One policy response to adverse selection, which was successfully implemented in Australia in 2000, is lifetime community rating, whereby those taking out health insurance for the first time at older ages pay a late entry loading to reflect the fact that they had not previously been contributing to the cross-subsidisation of older consumers. This measure encouraged large numbers of younger consumers into the market for private health insurance in Australia when it was implemented. However, such a move in Ireland would not be credible in the context of a proposed move to universal health insurance. Younger consumers would not have the same incentive to take out health insurance to avoid late entry loadings if a system of mandatory health insurance were believed to be imminent. Even in the absence of a system of late entry loadings, it is quite possible that the anticipated introduction of UHI is reducing the incentive for younger people to join the private health insurance market in its current form.

¹³ Since then however, amendments have been made to a number of plans to bring them into the basic cover category, and therefore the lower levy will apply.

7. Conclusions

Ireland's health system is primarily tax financed, with out-of-pocket payments and private health insurance premiums contributing nearly 30% of overall funding. A majority of people are currently required to pay significant out-of-pocket payments to visit a GP, which is unusual by international comparisons. Hospital treatment as a public patient is available to all, with some nominal copayments for those without a medical card. However, those with private health insurance are, in some cases, able to access treatment more quickly, often in public hospitals, where 20% of beds are designated as private beds. The differential reimbursement of GPs, hospital consultants and public hospitals for public patients (fixed remuneration) versus private patients (fee-for-service) creates incentives to treat the latter category over the former. This leads to a multi-tier health system with consequent inequities.

There is widespread agreement that the Irish health system needs to be reformed. However, it is less clear that universal health insurance, as currently envisaged, would solve the problems within the system. Many of the current problems relate to the delivery of services and the allocation of money, rather than the funding source. The current plans envisage changes to all three areas. Tackling the issues in the allocation and delivery mechanisms does not necessarily require changes in the funding mechanism. This was also acknowledged by the Expert Group on Resource Allocation and Financing in the Health Sector (Ruane et al, 2010), which noted that the effectiveness of the system – which includes equity, transparency and sustainability – is more important than the funding mechanism *per se*.

One of the disadvantages of the current taxation-funded system in Ireland is that it is not as transparent as some other funding mechanisms would be (for example, under social health insurance or private health insurance, people know that their premium contributions are being used to purchase health care, but in a system funded by general taxation it is less clear for what purposes this money is being used and in what proportions). However, this transparency issue could be addressed by having a hypothecated – or ring-fenced – tax for health. This could also increase the buy-in among citizens, who would tend to look more favourably on taxation devoted to health care than that for other areas of public expenditure.^{14,15} A taxation-funded system also allows the government more control over the overall health care bill. It also aligns the incentives to control costs with the ability to do so, given that the State is the largest provider of health care services. By contrast, a system of universal health insurance with multiple purchasers of care would involve the government ceding some control over the overall level of resources devoted to health.

It would also devolve responsibility for the purchasing of health care to private insurers, some of which may be for-profit organisations (and therefore some of the funding may be directed towards profits rather than the provision of health care). The decisions on purchasing care taken by these organisations may be different from those that would be

¹⁴ One potential drawback of a ring-fenced tax, depending on what the base of such a tax is, is that it could lead to reduced funding available during times of economic downturn. Consideration would need to be given to how to structure such a tax in order to minimise any susceptibility to changes in economic conditions.

¹⁵ In theory, a ring-fenced social security contribution – such as the Health Levy that was previously collected in Ireland – could achieve the same goal. However, this would require changes to the taxation and social welfare systems, and therefore it might be administratively easier to use a taxation measure.

taken by the government. In particular, it would mean that health care rationing would be the responsibility of insurers (healthcare is rationed in every country as no country has sufficient resources to deliver all of the health care needs of its citizens when they require them). It is unclear at this point how insurers would ration care under a system of universal health insurance. Furthermore, if the purchasing of care is privatised, it may not be straightforward to re-nationalise it at some point in the future if it is felt that the government should regain responsibility for this.

There is also cause for concern in relation to the proposals for universal health insurance regarding the cost of such a system. Insurance-based systems (whether social insurance or private insurance) tend to have higher spending on health than those funded primarily from taxation (as seen in Section 4). Wagstaff (2009) found that countries that had moved from taxation financing to social health insurance financing experienced increases in per capita health spending of 3-4% on average, without any clear evidence of improved patient outcomes.

In addition, the Dutch system, on which Fine Gael based much of its Faircare proposals prior to the 2011 election, and which introduced universal private health insurance with managed competition in 2006, has seen health care spending per capita increase by 46% between 2005 (the last year prior to reform) and 2010 (the most recent data point) (OECD, 2013). This system, which is based on competing insurers selectively contracting with providers, with consumers obliged to purchase insurance, is similar to that proposed in Ireland by the current Government. Therefore, the Dutch reforms provide a salutary lesson for Ireland in terms of potential pitfalls of a universal insurance-based system.

Some potential reasons for increased costs under such a system (relative to a taxation financed system) include the reduction in bargaining power by moving from a monopsony purchaser to smaller purchasers, each of which would have less buying power; administrative costs (including marketing, underwriting and claims processing costs) incurred by insurers; and supplier-induced demand. The last of these appears to be one of the drivers of increased spending in the Netherlands since the 2006 reforms, and is linked to the money-follows-the-patient reimbursement system. This system incentivises the treatment of more patients, which is a good thing, but can lead to higher overall system-wide costs, which is a drawback.

An issue that would need to be addressed if the current tax-financing mechanism continues is the future role of the private health insurance market. At present, those with private health insurance are gaining advantages over public patients in terms of speed of access as well as superior accommodation and access to private hospitals. The State is providing explicit and implicit subsidies to those with private health insurance, who are disproportionately (although not by any means definitively) concentrated in the higher income brackets of society. This situation is not ideal and should not continue, although care will need to be taken in any transition to a new role for private health insurance, as the private health insurance market currently takes some pressure off the public hospital system and therefore any destabilisation of this market could have negative consequences for a public health system that is already experiencing increased demand with reduced resources.

There are a number of possible options for private health insurance that would facilitate consumer choice to purchase such cover while not interfering with the public system to the same extent as is currently the case. One option would be to move to a system of complementary health insurance, whereby the insurers could only cover benefits that are not already provided by the statutory health care system. Another option would be to restrict

private health insurance cover to private hospitals, so that the treatment of private patients would no longer have an impact on accessibility to public hospitals for public patients. A further option would be to allow those with private health insurance to access better accommodation in public hospitals (semi-private or private rooms) but to have public and private patients on a common waiting list (an idea that was put forward by the Commission on Health Funding, 1989, and Colombo & Tapay, 2004). Clearly, some of these options would involve negotiations with providers, some of whom have contractual entitlements to private practice in public hospitals, but agreements should be possible in this regard.

The current Government's health reform proposals contain a number of positive ideas, in particular the creation of a single-tier health system, the removal of the financial barrier to accessing GP services and the reduction of waiting times for hospital treatment. However, it is less clear that the introduction of universal health insurance, as envisaged, would be of benefit to the Irish health system. The maintenance of a tax-funded system, controlled by the government, would have a number of benefits over a multi-purchaser, insurance-based system. If a purchaser-provider split is desired then there is no reason why this could not take place within a tax-funded public system. There is simply insufficient evidence from international systems to suggest that a change in the funding mechanism would produce benefits sufficient to justify the disruption that such a change would cause, and indeed there is some evidence to suggest that such a move would lead to higher costs for the Irish public without significant improvements in health outcomes.

Furthermore, any reform of the funding mechanism would entail costs (including administrative costs and the opportunity costs of the time taken to design and manage the process of reform), which would need to be set against any benefits that it might bring. Given the significant structural reforms that have taken place in the Irish health system in the last decade, perhaps it would be better to maximise the benefits of the existing system, while making changes to the elements that are not functioning optimally, rather than embarking on a radical redesign of the entire system.

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