White Paper  Private Health Insurance

Government’s Objectives for Private Health Insurance

The Government’s approach to determining the future shape of the private health insurance market involves measures aimed at enhancing, in the interests of the consumer, stability, competition, innovation, health status, quality of service and information provision.

This will involve legislative, structural and other changes designed to:

- Underpin the financial stability of the community rated system by encouraging entry to the system at the charged premium ago and safeguarding against adverse selection.
- Provide a fair and stable environment for health insurers to pursue the conduct of their business on a cost effective and innovative basis, and to enable greater scope for innovative approaches to cost, quality and differentiation of cover.

2.14 Chapters 5 to 8 set out the detail of the regulations changes to be introduced and Chapters 7 and 8 deal with structural changes.

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white paper Private Health Insurance
This White Paper, which arises from commitments in the Action Programme for the New Millennium, sets out the Government's policy objectives and proposals regarding the role of private health insurance in the overall healthcare system, the regulation of the health insurance market, and the corporate structure and status of the Voluntary Health Insurance Board.

There have been considerable changes in recent years in the area of private health insurance. The private health insurance market was opened to competition with the enactment of the Health Insurance Act, 1994. The cost of private health insurance premiums has increased over the last decade but the number of persons availing of such insurance has also risen. The Voluntary Health Insurance Board, which has played a unique role in the provision of private health insurance for over 40 years, has expressed the need to have a much greater degree of freedom in its management arrangements and in its product development.

This White Paper is therefore timely. Its proposals are intended to encourage competition in the market while also promoting the stability of community rating in the interests of the common good. It also contains proposals to place VHI on a more commercial footing to meet the challenges and opportunities presented by a competitive market. To achieve these objectives, the White Paper affirms the key principles which underpin the health insurance framework, identifies reforms to be instituted on the regulatory side, and makes proposals in relation to legislative requirements and the future direction of the VHI.

The White Paper also refers to the need for continuing improvement in the acute public hospital service and affirms the Government's commitment to the on-going development and improvement of the public health system.

The preparation of the White Paper has involved an in-depth consultative process with interested parties. It is my hope that the implementation of the proposals in the White Paper will ensure a sound basis for the future provision of private health insurance in this country.

Brian Cowen TD
Minister for Health and Children
September, 1999
Background
The Government’s Action Programme for the New Millennium envisaged a comprehensive review of the structures and regulation governing private health insurance, including the preparation of a White Paper covering such matters as rationalising the roles of the Minister for Health and Children, improving the existing regulations, and examining options regarding the future status of the Voluntary Health Insurance Board.

A commitment was also given at the time of the passage of the Health Insurance Act, 1994, that the Act would be reviewed within five years to assess the impact and operation of the regulatory framework in the light of actual market developments and experience.

Consultation Process
The preparation of this White Paper has involved consultations with a wide range of interests. In March 1998, the Department of Health and Children issued invitations to the public through press advertisements, and directly to interested parties, for submissions on the structure, financing, delivery, quality and development of private health insurance. A total of 71 submissions were received. Officials of the Department held meetings with 27 organisations and individuals who requested the opportunity to discuss their respective submissions. A list of individuals, organisations and bodies from whom submissions were received is at Appendix I.

A broad consensus was apparent from this consultation process regarding a number of aspects considered central to the regulation and operation of the market. In particular, widespread support was expressed for the core principles of community rating, open enrolment and lifetime cover on which the system of voluntary private health insurance is based. There was also general support for change in the structural aspects of market operation and regulation.

Report of Advisory Group on Risk Equalisation
An important input to the preparation of the White Paper has been provided by the report of the independent Advisory Group on the Risk Equalisation Scheme. The Advisory Group was established by the Minister for Health to review the scheme of Risk Equalisation made pursuant to the Health Insurance Act, 1994. The membership and terms of reference of the Advisory Group are set out in Appendix II.

The Advisory Group reported to the Minister for Health and Children in April, 1998. The Group made a number of recommendations on how best to make community rating and risk equalisation consistent with stability, meaningful competition, and innovation. The Group also made recommendations in relation to the wider private healthcare environment which are taken into account throughout this White Paper.

Technical Paper on Risk Equalisation
Arising from its consideration of the Advisory Group’s report and the submissions received on the White Paper, the Department of Health and Children issued a technical paper in January, 1999 proposing the elements of an amended risk equalisation scheme. A list of those who responded to the technical paper is at Appendix III. Discussions were also held with officials of the EU Commission in connection with the technical paper and proposals for an amended risk equalisation scheme.
Professional Advice
Drafting of the White Paper has been greatly facilitated by the Department of Health and Children's actuarial and insurance advisers, Mercer Limited.

Structure of the White Paper
The White Paper comprises three parts, as follows:

Part I (Chapters 1-2) - relating to the role of private health insurance and the regulatory environment;

Part II (Chapters 3-7) - relating to the future regulation of private health insurance;

Part III (Chapter 8) - relating to the future of the Voluntary Health Insurance Board.

To facilitate the reader there is an overview provided at the beginning of each chapter. There is also an executive summary immediately after Chapter 8.
part 1

The Role of Private Health Insurance and the Regulatory Environment

chapter 1

Private Health Insurance in the Irish Healthcare System
This Chapter describes the background to the development of private health insurance as an integral part of the funding and delivery of hospital-based care and the Government's recognition of the distinct, but related, interests of public and private patients.

There has been a sustained growth of private health insurance over the last 40 years, notwithstanding the introduction of universal eligibility, increased premium costs and reduced income tax relief. The factors which will influence its continued strong popularity as a means of providing for individual healthcare needs are identified.

The practice of private medicine in public hospitals is regarded as being contingent upon it providing benefits to the public hospital system generally. The unique position of medical consultants in terms of both determining and meeting service demand is identified. Private hospitals are recognised as having contributed to the development of an effective hospital system through the provision of an alternative to public hospitals for elective medical procedures.

An independent review of the health system which was conducted as part of the OECD's Economic Survey of Ireland 1997 concluded that a good provision of healthcare at relatively low cost to the taxpayer has been achieved within a unique mixture of public and private care.

The feasibility of moving from the present system of voluntary health insurance, which represents an alternative to tax-funded public services, to a mandatory social insurance-based system is raised and a number of inhibiting factors are identified which would seem to rule out this possibility at the present time.

In the interests of the overall sustainability of the private health insurance system, the Government are anxious for insurers and service providers to explore new and imaginative means on which to base the delivery of effective and high quality healthcare. The Government will ensure that the regulatory framework facilitates any such innovation in the market.

The Government support the conclusion of the Advisory Group on Risk Equalisation as to the benefits which could derive from the development of clinical protocols between insurers and service providers and the desirability of the greater use of fixed price procedures to encourage competition and contain cost.

The impact of an ageing population on the financing of private health insurance is considered to be sustainable, provided there is a maximising of efficiency in the funding and delivery of private healthcare. Managed care practices are identified as offering possible scope for improving cost effectiveness, transparency and accountability in the health system, but any move towards managed care arrangements will have to be primarily motivated by the interests of the insured person.

The Government consider that a fundamental departure from the existing system of voluntary private health insurance is not warranted in view of the reforms envisaged to improve the resilience and operation of the system which are outlined in this White Paper.
**Definition**

1.1 Private health insurance, or to be more technically correct, private medical insurance, provides indemnity insurance against the unforeseen and potentially financially serious consequences of ill health which require acute intervention or care. It applies generally to payments made in respect of reimbursement, in whole or in part, of fees or charges. This form of insurance needs to be differentiated from critical illness insurance, which gives the insured person a lump sum payment in the event of diagnosis of specified medical conditions; permanent health insurance (also known as income protection insurance), which provides for income replacement up to retirement in the event of sickness or disability; and hospital cash plans, which provide for cash payments primarily intended to meet the out-of-pocket expenses associated with hospitalisation.

**The Growth of Private Health Insurance**

1.2 The system of private health insurance was formally inaugurated in 1957 with the establishment of the Voluntary Health Insurance Board (VHI). The primary reason for this initiative was to provide a means of insurance against hospitalisation costs to the 15% of the population who were not eligible for public hospital services. At the time, a small proportion of the population had access to private health insurance through restricted vocational or employment based schemes.

1.3 Although the private health insurance system was primarily established to provide cover for the proportion of the population without an entitlement to public health services, it was also envisaged that others who might wish to avail of alternative private healthcare would also avail of private health insurance schemes. Private health insurance coverage has increased consistently since the establishment of VHI to the present day. Within 10 years of VHI’s establishment, approximately 300,000 persons had private health insurance cover, and by 1977 this figure had increased to over 600,000 persons. By the end of the 1980s, 1.2m persons had private health insurance cover. Growth has continued in recent years, aided by improved economic circumstances and a significant rise in the numbers employed, and since 1997, by the advent of competition in the private health insurance market. The current number of persons covered by private health insurance is estimated to be in excess of 1.5 million, nearly 42% of the total population. The increase in private health insurance coverage is illustrated below and set out in detail in Appendix IV.

![Chart 1: Growth in Private Health Insurance 1985 - 1999](image)

1.4 Notwithstanding improved economic circumstances, the growth of private health
insurance coverage is noteworthy given that there have been significant changes over the years regarding enhanced entitlement to public hospital in-patient services; tax relief in respect of private health insurance has been reduced from the marginal to the standard rate; and premium charges have increased considerably. The rise in premiums has been principally due to higher claims costs because of greater utilisation, increases in the cost of services in private and public hospitals, and increases in fees paid to medical consultants.

Why People Take Out Private Health Insurance

1.5 Findings from research undertaken by the VHI indicate that the most commonly cited reasons for taking out health insurance are:
- protection against large hospital/medical bills;
- peace of mind about healthcare needs;
- faster access to hospital beds/avoidance of waiting lists;
- option of private/semi-private accommodation.

1.6 These findings are consistent with research conducted by the Economic and Social Research Institute which identified considerations of security and access as motivating people to take out private health insurance.

1.7 The taking out of health insurance has remained an essentially voluntary decision on the part of the individual consumer. However, there is an emerging and significant provision of private health insurance as an employee benefit, which is now estimated to account for approximately 20% of the value of all premiums.

Regulation of Private Health Insurance

1.8 The key principles of community rating, open enrolment and lifetime cover, on which the system voluntarily operated up to 1994, have played a crucial role in making private health insurance cover accessible to a substantial proportion of the Irish population and, in particular, to higher risk groups such as the elderly and the chronically ill.

1.9 Prior to 1 July, 1994, the provision of private health insurance in Ireland was subject to the terms of the Voluntary Health Insurance Act, 1957. This Act established the Voluntary Health Insurance Board (VHI) and required other bodies engaged in the business of health insurance to be licensed by the Minister for Health. Under this system, VHI developed as a virtual monopoly because membership of the only other schemes granted licenses was confined to people of a common vocational or occupational group and their dependants. These schemes are referred to as restricted membership undertakings, the largest of which are the St. Paul's Garda Medical Aid Society, the Prison Officers' Medical Aid Society and the ESB Medical Provident Fund.

1.11 The Directive provides that any non-life insurance company which is authorised to transact insurance business in an EU Member State must be allowed to transact the same classes of business in any other Member State. The Directive also recognises that an EU Member State may adopt and maintain specific legal provisions to protect the general good, as part of its regulatory framework governing health insurance, including provisions relating to open enrolment, rating on a uniform basis, lifetime cover, standard benefits and loss compensation schemes between insurers.

1.12 Prior to the completion of the regulatory framework in 1996, it was established that the EU Commission accepted, in principle, Ireland’s entitlement to avail of Article 54 of the Directive, permitting legislation to protect the general good.

1.13 The Irish health insurance market was opened to competition under the provisions of the 1994 Act and the 1996 Health Insurance Regulations. The British United Provident Association (BUPA) commenced providing private health insurance cover in the market, through its branch operation BUPA Ireland, with effect from 1 January 1997.

Private Health Service Providers

1.14 Private health insurance generally covers the full or partial cost of treatment and care services provided by private hospitals, medical consultants, and private facilities in public hospitals.

Private Hospitals

1.15 The Minister for Health and Children does not have any function in relation to the regulation, co-ordination or assessment of the services provided by private hospitals, other than in relation to maternity or psychiatric services.

1.16 The private hospital sector provides over 2,500 private/semi-private beds which represent about 50% of the total private/semi-private acute and psychiatric bed stock in the hospital system. Most of these beds are dedicated to elective surgical treatment, maternity care and mental health treatment. It is estimated that there are 250,000 in-patient and day case admissions to private hospitals annually and over 3,000 jobs in total are provided in the sector.

1.17 The acute public hospital sector comprises a total of approximately 12,300 beds, with approximately 2,500 of these designated for use by private patients.

1.18 Notwithstanding the similarity in private bed numbers in each sector, the historical charging policy for beds in public hospitals results in a significantly greater proportion of private health insurance claims expenditure being accounted for by private hospitals. However, the private hospitals see it as necessary to competition that the public hospitals should charge a full economic rate for the services they provide to private patients.

1.19 The majority of private hospitals were established by religious orders which placed primary emphasis on the caring nature of the services they provided. This ethos has been preserved through the years and is something upon which the hospitals governed by religious orders continue to place a high value today. The private hospital sector’s commitment to providing high quality care has been evident over the years and is reflected in the submissions received from it on the White Paper. This commitment to the provision of quality of care is reflected in the initiative of the private hospitals to develop their own system of accreditation, which is referred to later in the White Paper.
1.20 The Government recognise the contribution which the private hospitals have made to the healthcare system generally. The White Paper identifies a number of matters in respect of which cooperation between the public sector and the private hospitals should prove mutually beneficial.

Medical Consultants

1.21 There are 1,458 medical consultants employed in this country. The majority are engaged in both public and private practice, with about 250 consultants employed in private practice only. The following table refers:

**TABLE 1: Consultant Manpower**

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 (On-site private practice)</td>
<td>637</td>
</tr>
<tr>
<td>Category 2 (Off-site private practice)</td>
<td>425</td>
</tr>
<tr>
<td>Geographical Wholistic (On-site, no private income)</td>
<td>57</td>
</tr>
<tr>
<td>Full Time Academic (Generally Category 1)</td>
<td>66</td>
</tr>
<tr>
<td>Category 2 Part-time</td>
<td>12</td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>1,208</td>
</tr>
<tr>
<td>Private Only*</td>
<td>250</td>
</tr>
</tbody>
</table>

(Source: Comhairle na nOspideal (1999) and Irish Hospital Consultants Association*)

1.22 In the context of private healthcare, medical consultants operate as independent service providers and, generally, the patient incurs a separate professional fee claim in respect of the consultant’s services which is usually charged on a ‘fee for service’ basis. Consultants are remunerated by insurers in accordance with professional fee schedules, which are either fully participating (i.e. involving amounts accepted as full discharge of the insured person’s liability for fees) or partially participating (i.e. involving a liability for the insured person to receive a balance bill for fees). The former remuneration arrangement occurs where agreement is negotiated between an insurer and the representative bodies for the medical consultants. In recent years, the vast majority of medical consultants have been party to fully participating arrangements. Consultants’ fees account for the second largest proportion of private medical insurers’ claims costs (i.e. after claims expenditure on private hospital services).

1.23 The Common Contract for Hospital Consultants in the public health services specifies that consultants are entitled to engage in private practice in public hospitals, having regard to the eligibility arrangements introduced in 1991 under the Programme for Economic and Social Progress (PESP). It is open to medical consultants to combine their public hospital commitment with private practice in public and/or private hospitals.

1.24 The Review Body on Higher Remuneration in the Public Sector, Report No. 36 on Hospital Consultants (the Buckley Report), published in 1996, acknowledged the need for a careful balancing of the rights of public and private patients. It stated that ‘care is required to avoid undermining the mix of public and private healthcare within public hospitals and the mix of public and private service providers’. Although the Buckley Report considered that it would not be appropriate to fix an upper limit on the extent of a consultant’s on-site private
practice, it recognised that, as stated in the Health Strategy, "it is important to ensure that the co-existence of public and private practice does not undermine the principle of equitable access" and that "the discharge of the public commitment is not adversely affected by off-site practice".

1.25 Medical consultants have a crucial influence on insurance claims costs as their decisions and activities greatly shape the extent and intensity of utilisation of hospital services. The Government, therefore, recognise that the interaction between medical consultants and insurers is pivotal to the sustainability of our present private health insurance system.

1.26 The Government have noted that the Medical Manpower Forum, which is representative of professional, Departmental and health agency interests, is seeking to propose policies that maintain and improve patient care while providing a satisfactory working environment and career structure for hospital doctors. As a basic principle, the Forum accepts that all patients should have equal access to hospital medical services and all patients should be diagnosed by fully trained doctors. In this context, the Department of Health and Children has outlined possible approaches for consideration by the Forum, relating to changes in the structure of medical staffing in acute hospitals which are designed to improve patient care by increasing the number and availability of trained doctors in the system.

Healthcare Financing

1.27 There are three general models for financing health systems: general taxation, compulsory social insurance, and private health insurance. Most developed countries' health care systems employ, to some extent, a combination of these financing methods.

1.28 In Ireland, there has been a general consensus that the public at large should have access to a certain level of necessary health services, including primary care, hospital care, long-term care and personal social services. Consequently:

- the Irish health services are funded primarily from general taxation;
- the entire population is entitled to a core publicly-funded service, including public hospital in-patient services;
- there is a mix of public and private care in the Irish health services;
- patients have to make an explicit choice between public and private care at the point of delivery of hospital services.

1.29 Approximately 75% of the health services are publicly funded, the major portion of which is derived from Exchequer grants. The remaining 25% comprises expenditure by private health insurance undertakings and private spending by households. Out of a total national health expenditure in excess of £4 billion (€5 billion), private health insurance contributes approximately £350 million (€444 million) - most of which relates to hospital services - with about £85 million (€108 million) going directly to the public hospital system.

Eligibility for Public Hospital Services and Private Practice in Public Hospitals

1.30 Universal entitlement to public hospital accommodation was introduced in 1979. Full universal entitlement followed in 1991 with the introduction of eligibility for medical consultant services in public hospitals. This decision derived from the recommendations of the Commission on
Health Funding, 1989, and, more particularly, from the PESP, which was instrumental in introducing changes in the eligibility structure and designation of ward accommodation. The PESP also contained a commitment by Government to maintain the position of private practice within and outside the public hospital system.

1.31 The PESP contained the following provision in relation to the management and organisation of the public hospital bed stock:

"In gradually implementing the new (bed designation) system, the Government will be sensitive to the need to ensure that the public hospital system caters adequately for the requirements of private patients and that the important role and contribution of voluntary health insurance is not diminished in any way".

1.32 In the context of the 1991 changes, it was accepted that the public hospital system would continue to cater for the needs of private patients, based on the benefits accruing to the system from having a balanced mix of public and private practice. The eligibility arrangements introduced drew a clear distinction between patients availing of services as public patients and those availing of services as private patients. Patients are now required to avail of services as either public patients or as private patients, and those who choose to avail of services as private patients are required to remain private for the duration of their care. In addition to this, persons availing of private hospital services have always been seen as availing of an alternative service to the public system.

**Public Hospital Bed Designations**

1.33 The Health Services (In-patient) Regulations, 1991 specify that all public hospital beds must be formally designated by the Minister for Health and Children, and that private patients must, except in cases of emergency, be accommodated in designated private beds. The purpose of this measure is to ensure equity of access to public hospital facilities.

1.34 The designation by the Minister of private beds in public hospitals arises for consideration only at the request of the individual public hospital authorities. Designation does not oblige insurance companies to automatically recognise the facilities concerned.

1.35 The following table shows the current position in relation to acute hospitals:

**TABLE 2: Acute Hospital Bed Designations, 1999**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Beds</td>
<td>8,995</td>
</tr>
<tr>
<td>Private Beds</td>
<td>2,528</td>
</tr>
<tr>
<td>Non-Designated Beds</td>
<td>769</td>
</tr>
<tr>
<td>Total Beds</td>
<td>12,292</td>
</tr>
<tr>
<td>% Private Beds</td>
<td>21</td>
</tr>
<tr>
<td>% Persons Insured</td>
<td>42</td>
</tr>
</tbody>
</table>

1.36 While there has been an increase of over 18% in the proportion of the population insured since 1991 (see Appendix IV), the increase in the proportion of designated private beds in public acute hospitals has been just over 6%.

**The Public/Private Mix in the Hospital System**

1.37 The 1994 Health Strategy - Shaping a Healthier Future acknowledged that the mix of public and private service providers in
the Irish healthcare system enables each to play a complementary role, and that there is a considerable degree of interdependence between the public and the private sectors in the provision of hospital services for the population.

1.38 The principal advantages of the public and private mix of hospital services are:

- it helps to ensure that medical and other professional and technical staff of the highest calibre continue to be attracted into, and retained in, the public system;
- it promotes more efficient use of consultants’ time by having public and private patients on the same site;
- it facilitates active linkage between the two delivery systems in terms of the dissemination of current medical knowledge and best practice;
- as accident and emergency services are primarily provided by the public hospital system, it enables patients to avail of private healthcare when admitted to public hospitals on an emergency basis;
- it represents an additional income stream to the public hospital system (see 2.37).

1.39 On the other hand, there are potential drawbacks to the mixed model of care delivery which, if not adequately addressed, may lead to inequities in the distribution of available public facilities as between public and private patients. The weaknesses have more to do with the management of demand for, and access to, services at the level of the hospital than with the principle of having a mixed system. These include:

- the absence of economic charging for use of public hospital paybeds, which may give rise to some distortion in the market for hospital services and a less than optimal revenue yield to the State from that source;
- due to the different methods of payment for consultant services (fee per item against salary), rational economic behaviour would suggest that a stronger incentive exists for those consultants who are significantly involved in private practice to concentrate a disproportionate amount of personal time on these private patients. This situation is exacerbated by the fact that the private hospitals employ relatively few consultant or other medical staff of their own, relying to a great degree on the availability of doctors who also hold public contracts;
- the extent to which private health insurance coverage has now grown may represent a potential threat regarding access to the facilities and services available to public patients in the public hospital system.

1.40 There is a widely held public perception that public patients tend to receive more of their care from medical staff other than consultants. The Report of the Review Group on the Waiting List Initiative, for example, noted that waiting lists are a phenomenon of public rather than private health services, and argued that it was important to ensure equity of access for all patients in the context of a mixed public/private system in public hospitals. It will continue to be a key objective of policy to manage the balance between public and private demand in the health system in a way which respects the entitlements and legitimate expectations of both groups of patients. Specific measures to achieve this are discussed in Chapter 2.
OECD Review of Ireland's Health System

1.41 This country's health system, based as it is on a unique mixture of public and private care, was acknowledged by the Organisation for Economic Co-operation and Development in its Economic Survey of Ireland 1997 as having achieved a good provision of healthcare at relatively low cost to the taxpayer.

1.42 The survey noted that:

- a significant private health sector has been developed alongside the public sector in Ireland;
- private health insurance has operated in a way that tries to ensure that a significant number of people stay in the private system, relieving the cost of hospital care to the public finances;
- working in public hospitals remains attractive to consultants; and
- health insurance premiums do not vary with age, making it more likely that older people, with the highest demand on hospital care, stay in the system.

1.43 However, the OECD also drew attention to some problems in managing the complicated interface between the public and private provision of medical care and suggested that:

- the expected commitments of consultants to both the public and private sectors need to be better defined;
- resource allocation would be improved by putting charges for the use of public hospital facilities on a more economic basis; and
- the impact of competition should be carefully monitored so as to avoid high risk groups being pushed back into the public sector with adverse consequences on health expenditure.

Sustaining Private Health Insurance

1.44 Apart from continued economic prosperity, sustaining a vibrant health insurance system will be influenced by:

- demographic factors, because of the importance of attracting younger subscribers and the impact of a generally ageing population;
- achieving optimum efficiency in resource use, including the minimisation of ineffective or unnecessary expenditure;
- enhancing the quality of service and choice to the consumer.

Demographic Context and Implications for Private Health Insurance Coverage

1.45 All developed countries cite an ageing population among the factors presenting a challenge to containing increased cost and utilisation of health services into the future. The OECD report Maintaining Prosperity in an Ageing Society (1998) points out that people are living longer and healthier lives, and that while population ageing means that health costs are likely to rise, their impact may be perhaps less than was once feared.

1.46 Life expectancy in Ireland has increased substantially. By 1994 life expectancies for males and females were 73.2 and 78.7, respectively; the corresponding figures for 1950 were 64.5 and 67.1. There is a general acceptance that life expectancy will continue to increase and that mortality rates will continue to reduce for the foreseeable future.
1.47 The 1997 OECD Economic Survey of Ireland observed that the negative impact on health needs arising from ageing may be offset to a certain extent by the improved average health status of elderly people, and by the lower proportion of births and very young children which could lower health spending.

1.48 It is evident from Table 3 that Ireland has a demographic profile which is considerably more favourable than that of other EU countries, and present indications are that this will continue to be the case well into the next century. About 48% of our population is under the age of 30 years.

**TABLE 3:**
Projections of Elderly Dependency Ratio 1990 – 2030

(Population aged 65 and over as a percentage of population aged 15 – 64 in EU)

<table>
<thead>
<tr>
<th>Country</th>
<th>1990</th>
<th>2010</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>22.4</td>
<td>25.6</td>
<td>41.1</td>
</tr>
<tr>
<td>Denmark</td>
<td>22.7</td>
<td>24.9</td>
<td>37.7</td>
</tr>
<tr>
<td>Germany</td>
<td>21.7</td>
<td>30.3</td>
<td>45.2</td>
</tr>
<tr>
<td>Greece</td>
<td>21.2</td>
<td>28.8</td>
<td>40.9</td>
</tr>
<tr>
<td>Spain</td>
<td>19.8</td>
<td>25.9</td>
<td>41</td>
</tr>
<tr>
<td>France</td>
<td>20.8</td>
<td>24.6</td>
<td>39.1</td>
</tr>
<tr>
<td>Ireland</td>
<td>18.4</td>
<td>18</td>
<td>25.3</td>
</tr>
<tr>
<td>Italy</td>
<td>21.6</td>
<td>31.2</td>
<td>48.3</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>19.9</td>
<td>25.9</td>
<td>44</td>
</tr>
<tr>
<td>Netherlands</td>
<td>19.1</td>
<td>24.2</td>
<td>45.1</td>
</tr>
<tr>
<td>Austria</td>
<td>22.4</td>
<td>27.7</td>
<td>44</td>
</tr>
<tr>
<td>Portugal</td>
<td>19.5</td>
<td>22</td>
<td>33.5</td>
</tr>
<tr>
<td>Finland</td>
<td>19.7</td>
<td>24.3</td>
<td>41.1</td>
</tr>
<tr>
<td>Sweden</td>
<td>27.6</td>
<td>29.1</td>
<td>39.4</td>
</tr>
<tr>
<td>UK</td>
<td>24</td>
<td>25.8</td>
<td>38.7</td>
</tr>
<tr>
<td>EU-15</td>
<td>21.4</td>
<td>25.8</td>
<td>40.3</td>
</tr>
</tbody>
</table>

(Source: Eurostat)

1.49 The Advisory Group on Risk Equalisation asked its actuarial advisers to assess the impact of demographic change on health insurance premiums. The impact of demographic change was estimated to increase premiums by about 0.5% per annum. In this context, it is noted that medical inflation had exceeded general price inflation by about 5% to 6% per annum in recent years. It concluded therefore that it was clear that factors other than demographic factors were the main drivers of medical inflation.

1.50 Based on population projections carried out for the recent Actuarial Review of Social Welfare Pensions, it is estimated that ageing will account for an increase of less than 1% per annum in health insurance costs over the period up to the middle of the next century. This analysis suggests that, provided the age profile of the insured population progresses in tandem with that of the general population (an issue addressed in later Chapters), demographic change will give rise to cost increases of manageable proportions. Indeed, other cost drivers such as technological change, advances in medical treatments, heightened consumer expectations and ‘defensive medicine’ practices are likely to be much more significant. This position contrasts with the more dramatic cost increases that have been predicted for social welfare pensions over the same period due to demographic change. However, ageing, per se, will impact more severely on pensions because:

- once a person retires they stop contributing to the pension system whereas people pay health insurance premiums throughout their lives;
- pension costs (under a pay-as-you-go system) arise suddenly at age 65 while, although they increase as people get older, some health costs arise at every age.
1.51 Having regard to the above, it is clear that the demographic considerations in relation to pensions and health insurance differ significantly. Most importantly, the impact of growth in the elderly dependency ratio is not as severe for health insurance. It is therefore considered that, for the foreseeable future, population ageing alone will not have a disproportionate effect on health insurance premiums.

Cost Management

1.52 The tolerance of subscribers to increases in health insurance costs has shown considerable inelasticity up to the present. The Government recognise that a close correlation exists between the viability of a broadly-based health insurance market and the curtailment of claims costs. Effective management of claims cost increases represents the most crucial challenge to those concerned with ensuring the viability of private health insurance.

1.53 The Government consider it imperative that the health insurance legal framework does not inhibit, but rather enables, the development between insurers and providers of a range of effective and durable responses to this challenge, so as to properly serve the consumer and support the system overall.

1.54 The Government noted that the Advisory Group on Risk Equalisation laid considerable emphasis on the need to contain private health insurance claims costs. The Advisory Group pointed to the benefits which clinical protocols have for patients and health care managers and it recommended that insurers adopt such protocols. It also recommended that insurers and service providers introduce fixed price procedures as a means of encouraging cost containment and promoting competition.

1.55 It is widely recognised that there is a number of significant cost drivers unique to the healthcare sector. It is estimated that over recent years the annual rate of medical inflation has been approximately 7%, which is consistent with the international trend.

1.56 Medical inflation manifests itself in the insurers’ claims costs and is attributable, to a significant extent, to a higher incidence of claims. The elements which contribute to this include expanded facilities, “defensive medicine”, new procedures, greater consumer expectations and an ageing population, with the inter-action of these elements creating the potential for a more complex mix in the claims experience.

1.57 Cost containment approaches have been based upon the negotiation of scheduled procedure prices, generally representing full settlement of fee claims with medical consultants. In relation to hospital claims costs, the approach to containing cost has involved annual budgets, with claims in excess of the budgeted amount being reimbursed at a reduced (marginal) rate or not at all in circumstances where the budget constituted a cap on public hospital claims. Recent initiatives relate to pre-determined length of stay agreements and schedules of private hospital charges, and designation of procedures as day-care (not necessitating an overnight stay) or side room (not necessitating use of a hospital bed) for benefit payment purposes. The management of utilisation has been a less significant feature of arrangements between insurers and service providers.

1.58 A number of submissions identified scope for further cost savings which could be achieved through a range of measures.
These may be summarised as involving:

- accurately defining the true cost of delivery of care;
- replacing fee-for-service, per diem and cost-plus reimbursement arrangements, which provide incentives to hospitalise and treat, by a prospective/capitation approach;
- instituting preferred provider/managed care arrangements by insurers with provider consortia;
- adopting a pro-active approach to promoting healthy lifestyles and illness prevention;
- developing non-acute hospital-based care (i.e. step-down facilities or home nursing) to facilitate earlier discharges;
- developing evidence-based medicine.

1.59 Internationally, initiatives of different kinds have been taken by governments and other healthcare funders to maintain the increasing cost of healthcare within sustainable limits. The common term ascribed to such measures is Managed Care. This is a generic term for a variety of mechanisms which are intended to reverse the incentives to over-claim and over-treat that arise under private health insurance.

1.60 Managed care constitutes a set of techniques used by, or on behalf of, purchasers of healthcare benefits to manage healthcare costs by influencing patient care decision-making through assessment of appropriateness of care. Mechanisms of managed care include preferred provider networks, pre-authorisation of hospital admission/treatment, length of stay arrangements, treatment protocols, case management and clinical outcome review.

1.61 The Government recognise that the system of private health insurance is a voluntary one based predominantly on a personal decision to participate. Clearly, the scope for, and sustainability of, managed care practices in such a system would depend greatly on the broad understanding and acceptance by insured persons of the basis and aims of such practices. This places a positive discipline on insurers to ensure that their cost containment strategies are characterised by accountability, fairness and sensitivity, and that they are primarily motivated by, and directed at, the interests of the insured person.

1.62 The Government consider it reasonable that the regulatory framework should enable the development of practices which permit insurers to satisfy themselves as to the standard, efficacy and cost-effectiveness of services being purchased. The Government are convinced that there is scope for insurers and service providers to minimise/eliminate unnecessary cost or utilisation in a system where annual claims payments, in 1998, were estimated to total about £350 million (€444 million). This is primarily a matter to be addressed by the market participants, with increased competition between and among insurers and service providers driving new approaches and solutions. The Government’s role in this respect is to ensure that the regulations do not impede such development, are not themselves inflationary, and safeguard the broad rights and interests of insured persons.

Universal Health Insurance Coverage

1.63 The Government were requested in submissions on the White Paper to consider radically altering the basis on which health insurance cover is organised, for instance, by moving to a mandatory social insurance based-system.
1.64 The Government have given consideration to the possibilities of taking such action but have decided not to proceed along this course for the following reasons:

- the current private system is considered to be capable of meeting future needs, subject to the implementation of reforms to enhance its structure and operation;

- concerns about equity in relation to access to healthcare for public patients, as compared with private patients, can be appropriately and transparently dealt with in terms of targeted initiatives and general improvements in the public health system. A more rigorous enforcement by hospital management of the bed designation arrangements currently in place and of the terms of the 1997 Consultants' Common Contract governing the extent of private practice by individual doctors can also support equity in relation to public patient access;

- there has been little to indicate that the level of consensus required among the currently insured population, service providers and insurers, would be forthcoming to successfully and effectively implement radical change of the order that would be required;

- European countries operating predominantly social insurance-based systems are grappling with many of the same challenges that face the health system here, and reform has yet to resolve the underlying difficulties;

- the system would involve greater complexity and cost to administer than applies to current arrangements;

- it would require a radical overhaul of the current healthcare and health insurance systems which would incur significant costs. The Government consider that the resources which this process would demand would be better used for the improvement of the public healthcare system;

- the OECD survey commented favourably on the results achieved by our mixed system and its conclusions would not suggest a need for radical change in the existing overall financing arrangements.

1.65 The Government therefore consider that a fundamental departure from the existing system of voluntary private health insurance is not warranted in view of reforms envisaged to improve the resilience and operation of the system which are outlined in this White Paper.
chapter 2

The State’s Role in Relation to Private Health Insurance
This Chapter describes the need for State regulation of private health insurance in the developing competitive market environment. The Government regard private health insurance as primarily providing an alternative for those wishing to have access to providers outside the public system and to such private treatment facilities as exist in public hospitals. The Government wish to safeguard the core values of the private health insurance system, while facilitating further competition. It is the Government’s intention to regulate the market only to the extent necessary to protect the interests of the common good and to ensure that the regulatory framework is fair and consistent.

The Government consider it appropriate that the State should continue to facilitate arrangements for private healthcare and, as a general principle, have no plans to alter the available premium tax relief in respect of health insurance premiums.

The Government propose to address the important matter of charges for services provided to private patients in public hospitals by means of the development of pricing arrangements which more closely reflect the economic cost of such services. However, the Government intend to approach this matter in a manner that will be sensitive to the stability of the private health insurance market.

On balance, the Government are satisfied that sustaining the mix of public and private practice in public hospitals is desirable and to the benefit of all patients. They recognise, however, that vigilance must be exercised to ensure that the pursuit of private practice will not disadvantage public patients.

The Government recognise the need for, and have already initiated, a major programme of investment in services and facilities to improve the position of public patients. Current initiatives in this area, individually and cumulatively, will serve to narrow the gap which has grown between access to services for public patients vis-à-vis private patients, which is most evident in terms of waiting times for surgical procedures.

With a view to achieving and maintaining equitable access to services, the Government’s aim is to ensure that no adult should have to wait on a public in-patient list for more than twelve months and no child should have to wait for more than six months in targeted specialities. Specifically, in relation to public waiting lists for cardiac surgery, the Government have now agreed to the objective of an average waiting time overall of 6 months for public patients, both adult and children. A major programme of investment in cardiac surgery infrastructure is underway to support this objective. More generally, a report will be prepared, at an early date, by the Minister for Health and Children in relation to the availability and adequacy of public bed supply.

The Minister for Health and Children will retain responsibility for private bed designations in public hospitals, with a view to closely regulating the extent and impact of private treatment in public hospitals.
The Need for Regulation in the Interests of the Common Good

2.1 The Irish system of private health insurance is based on the principle of solidarity between insured generations, as expressed through community rating, open enrolment and lifetime cover. It is obviously necessary and appropriate to specify in law how these principles should be applied in practice to ensure guaranteed access to cover and continuity of cover at a reasonable cost.

2.2 With the opening of the market to competition, regulation was considered necessary to ensure the long-term stability of the established solidarity-based system. Competing insurers will have an understandable propensity to seek out good risks and eschew bad ones. This has the potential to seriously undermine the system. Furthermore, there is a need to ensure that the level of cover meets a minimum standard in terms of the nature and extent of indemnity provided.

2.3 In commercial terms, a health insurer’s interests depend as much on the make-up as on the size of its insured population. This is because the former element will significantly determine the extent of its surplus of premium income over claims expenditure. It will also have a bearing on its administrative costs given that a young/healthy insured population requires less administration than one that is elderly and involves considerable attention at the claims level.

2.4 The Government recognise the potential for conflict between the need to maintain both solidarity and competition in the private health insurance system. They consider that an unrestrained market would not offer adequate protection to the vulnerable in society seeking access to a social good like healthcare. The Government consider that community rating/open enrolment, if not properly protected, could easily be destabilised.

Encouragement of New Entrants

2.5 The Government wish to see more insurers entering the private health insurance market. While recognising the need to encourage greater participation and competition in the market, they consider that regulatory arrangements which serve the interests of the common good must be maintained. They believe that a market covering almost 42% of the population, in a growing economy and with a relatively positive demographic profile, should lend itself to competition.

2.6 The regulatory environment is not the only consideration which influences the decision of an insurer to enter any particular market. It must also take into account the number and strength of insurers in the market already. It must consider whether it can differentiate itself sufficiently, perhaps through marketing techniques or innovation in the areas of provider arrangements and product development, to provide it with a sufficient business base and financial return to warrant the investment required.

2.7 Most importantly, a market entrant must be reasonably sure that it can attain the necessary critical mass in circumstances where the total population is approximately 3.75 million people (32% of whom are entitled to full free medical services on a means-tested basis).

2.8 Other considerations on the part of interested insurers would relate to the cost of establishing a new brand, the scope for a good margin of return on investment, and the scope to influence the structure of service provider reimbursement arrangements.
2.9 The Government consider that the measures set out in the White Paper will serve to realise greater competition in the market.

The Purpose of Regulation

2.10 An important consideration for the Government, from a regulatory perspective, is that the rules are applied fairly and consistently and only to the extent that is necessary to secure the protection of the common good.

2.11 The Government consider that, in general terms, the existing health insurance framework represents an appropriate and balanced approach to securing the following objectives:

- adequate statutory protection for the principles of community rating, open enrolment and lifetime cover;
- a broadly-based and widely accessible private health insurance system;
- a "level playing field" for all insurers as regards the application of the above-mentioned principles in a competitive market;
- genuine competition based on cost, product quality, marketing and distribution;
- a regulatory environment which encourages insurers and healthcare providers to operate efficiently.

2.12 The Government believe that the health insurance framework already established is capable of meeting the objective of protecting community rating while facilitating competition based on quality and service. They recognise, however, that it warrants review to ensure that it supports the development of competition and efficiency in the system to the fullest possible extent.

The Government's Objectives for Private Health Insurance

2.13 The Government's approach to determining the future shape of the private health insurance market involves measures aimed at enhancing - in the interests of the consumer - stability, competition, innovation, health status, quality of service and information provision.

This will involve legislative, structural and other changes designed to:

- underpin the financial stability of the community rated system by encouraging entry to the system at the youngest possible age and safeguarding against adverse selection;
- provide a fair and stable environment for health insurers to pursue the conduct of their business on a cost-effective and innovative basis, and to enable greater scope for innovative approaches to cost containment and differentiation of products;
- afford greater commercial freedom to the Voluntary Health Insurance Board to increase the company's strategic and operational flexibility;
- rationalise the multiple responsibilities of the Minister for Health and Children and provide independent regulation for the market;
- ensure that charges in respect of the provision of private treatment in public hospitals reflect, to a greater extent, the economic costs incurred by the public health system in the provision of such services;
• maintain State support for the private health insurance sector in view of the alternative it provides to publicly-funded care and in recognition of the importance of community rating/open enrolment;
• encourage the development of schemes aimed at the maintenance of good health, early intervention and non-hospital care;
• facilitate greater choice of private health insurance coverage for the consumer;
• further empower the consumer through improved information provision;
• promote the development of information systems on the cost and delivery of acute healthcare;
• facilitate the constructive exchange of views between health insurers, service providers and consumers.

2.14 Chapters 3 to 6 set out the detail of the regulatory changes to be introduced and Chapters 7 and 8 deal with structural changes.

The Government’s Commitment to Facilitating Arrangements for Private Healthcare

2.15 The Government consider that it is appropriate for the State to continue to facilitate arrangements for private healthcare for the following reasons:

• the taking of responsibility by insured persons for meeting the cost of their own healthcare displaces demand and costs which would otherwise fall on the public health system;
• the enhanced scope, in terms of the facilities and services, available through the private sector to meet a burgeoning demand for acute care;
• it is affordable, and accessible, to a broad population because of the application of community rating and open enrolment.

State Incentives and Supports

2.16 There has been in existence, over many years, a range of State incentives and supports to ensure that private health insurance has remained an attractive option to those in a position to voluntarily contribute towards meeting the cost of their healthcare, and who wish to have access to the alternative private hospital system. The most prominent of these are:

• the availability of tax relief on health insurance premiums;
• the maintenance of public hospital charges for services to private patients at a level below the economic cost (representing a subsidy to insurers in terms of reduced claims outlay); and
• the absorption of costs by the public hospital system in relation to accident and emergency services, national and tertiary specialities, and professional training.

Income Tax Relief

2.17 Tax relief was originally introduced to encourage those without an entitlement to hospital services to avail of private health insurance. The Commission on Taxation (1982) recommended that the available reliefs be abolished, even though public health services eligibility arrangements at that time provided that a proportion of the population remained liable for medical consultants’ fees. The Commission on Health Funding (1989) also recommended that tax relief be abolished, although on a phased basis to enable the effect on demand for private health insurance to be monitored. The availability of such relief was primarily questioned on grounds of equity and effectiveness.
2.18 The concerns expressed were addressed through the reduction in relief from the marginal to the standard rate of tax which was phased in over two years (1995/96 and 1996/97). The reduction of relief to the standard rate increased the net cost by 40% for a person on the higher rate of income tax (38% of income tax payers in 1996/97). It did not adversely affect the number of persons covered by private health insurance plans, although this outcome may have been influenced by the upsurge in economic growth and prosperity.

2.19 On the other hand, a case can be made in favour of some level of State incentive to the individual to effect private health insurance, on the basis that those who opt for private cover effectively forgo a statutory entitlement while continuing to contribute to the funding of the public health service through taxation. Community rating, open enrolment and lifetime cover allow the elderly and the chronically ill to avail of private health insurance at a reasonable cost, and this contribution to the general good can provide a justification for State support in the form of tax relief on premiums. In addition, income tax relief is an important feature in making private health insurance affordable to a large section of the population and thus to creating a market attractive to competing insurers. The cost of private health insurance relief is estimated at £62 million (€79 million).

2.20 While demand for health insurance has proved to be resilient in the face of both premium increases and the standard rating of tax relief, it cannot be assumed to be totally inelastic in regard to price. If the costs of health insurance rose to a point where it became markedly less affordable, it is likely that the young and healthy would be the first to leave the system, thereby generating a spiral of instability in the market for health insurance.

2.21 As a general principle, there are no plans to alter the available relief in respect of health insurance premiums, the total removal of which would increase the net cost of health insurance premiums by 32%.

The Pricing of Private Treatment and Care in Public Hospitals

2.22 The Government consider that there is a need to address issues relating to the pricing of public hospital beds at less than the full economic cost. In developing new charging arrangements for public hospital services to private patients, the extent and pace of adjustment, while allowing for medical inflation, will be sensitive to the need for continuing stability in the private health insurance market.

Current Levels of Charges Applicable to Private Patients in Public Hospitals

2.23 The level of charges applicable to private in-patients and day patients in public hospitals are set by the Minister for Health and Children. Under present arrangements, these charges vary only in relation to the category of the hospital and whether private or semi-private accommodation is being used. Day care charges are set as a percentage of the overnight charge applicable to the particular hospital. The current charges are set out in the following table:
2.24 The charges are not explicitly related to the real costs of maintaining and providing services to private patients and are intended only as a contribution to the cost of care in public hospitals. The different rates applied to different categories of hospitals are primarily intended to reflect the fact that there are varying levels of costs between major tertiary and teaching hospitals and general hospitals. The estimated total annual cost of this subsidy is £35m.

**Particular Public Hospital Costs**

2.25 Public acute hospitals carry a disproportionate burden of costs for important areas of the health services, including those outlined below. Consequently, any review of the charges which it would be appropriate for these hospitals to raise would involve consideration of whether, and to what extent, the costs of such services should be taken into account.

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**TABLE 4: Charges per day in Public Hospitals***

<table>
<thead>
<tr>
<th>Hospital Category</th>
<th>Private Accommodation</th>
<th>Semi-Private Accommodation</th>
<th>Day-care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Board Regional Hospitals and Voluntary and Joint Board Teaching Hospitals</td>
<td>£171 (£217)</td>
<td>£134 (£170)</td>
<td>£122 (£155)</td>
</tr>
<tr>
<td>Health Board County Hospitals and Voluntary non-Teaching Hospitals</td>
<td>£141 (£179)</td>
<td>£114 (£145)</td>
<td>£102 (£130)</td>
</tr>
<tr>
<td>Health Board District Hospitals</td>
<td>£88 (£112)</td>
<td>£76 (£97)</td>
<td>£65 (£83)</td>
</tr>
</tbody>
</table>

*These charges are additional to the public hospital statutory in-patient charge, currently set at £25 (€32) per day/night subject to a maximum of £250 (€317) in any twelve months.

2.26 Public hospitals exclusively provide accident and emergency services which have a significant and volatile influence on the activity of acute hospitals. These services are not provided by the private sector at present, which delivers an elective service that is more manageable and predictable in cost and service terms.

**National Specialties**

2.27 A number of national specialty services are provided exclusively in the public sector. Typically, these are extremely high-cost, low-volume, sophisticated services which require a concentration of expertise and equipment. Liver transplants and heart transplants are examples, amongst others, of surgical programmes of this kind which the private sector does not choose to provide for commercial reasons.

**Non-designated Beds**

2.28 Of the total of 12,292 beds in public acute hospitals, 769 (6.3%) are classified as ‘non-
designated' beds. These beds are found in areas such as intensive care and coronary care. The fact that they are non-designated means that no private accommodation charge is applied to private patients occupying these beds, even though they would be in receipt of intensive and costly care at the time. This is a particularly advantageous situation for insurers, as public hospitals carry the costs of the services provided to insured persons.

**Training**

2.29 The Exchequer bears a significant degree of expenditure because of the commitments to train medical and other staff. These groups may very often subsequently work in private hospitals and clinics. The health insurers also benefit from the absorption of this cost entirely by the public system. There is a clear recognition of the importance of the public responsibility to facilitate the training of hospital personnel. There is, however, the consideration that training costs constitute a major element of teaching hospitals' expenditure. These costs do not arise, to any comparable extent, in the private hospital sector.

**Equipment**

2.30 Another area of subsidy is the cost to the Exchequer of public hospital equipment which benefits both public and private patients. The charges raised by public hospitals for private patients do not specifically cover the use of equipment, although the cost of equipping a modern hospital is considerable. No specific provision has been included for such expenditure because of the difficulty in apportioning costs of equipment and its use between public and private patients.

**Casemix**

2.31 Since 1993, work has been carried out by the Department of Health and Children and health agencies on developing casemix measurement as a major factor in determining public hospital budgets. Casemix measurement captures the efficiency and complexity of different hospitals by looking in great detail at about 500 different conditions on a Diagnostic Related Group (DRG) basis and analysing their related costs. The thirty largest public general hospitals are now covered by casemix and it is planned to extend the system to the remaining hospitals over the next year.

2.32 Casemix has an important bearing on the overall level of resources available to individual hospitals and must therefore reflect, to a high degree, the actual costs of delivering defined services. Casemix provides an important database for hospitals in developing economic pricing of private beds and should form the future base for setting pay bed charges in public hospitals.

2.33 In addition, there is a need to create greater market transparency in the identification of costs associated with treatment in public hospitals. Private hospitals have their own budget arrangements with insurers, which are more closely related to actual costs than the centrally determined charge currently applying in the public hospitals. It would be appropriate to implement a comparable charging system which recognises the real costs in the public hospitals.

2.34 The Government will therefore make arrangements for the phased introduction of economic pricing over a period of 5 to 7 years. The Department of Health and
Children will consult agencies and insurers in the near future on the best approach to adopt in this regard. The main beneficiaries from the introduction of more realistic costing will be the major teaching and regional hospitals where the gap between current charges and non-capital costs is most apparent.

**Improving Access for Public Patients**

2.35 While the Government recognise the contribution which private insurance and the private hospital system make towards meeting the healthcare needs of the population, their primary concern is to ensure equitable access to the public health services. The Government remain committed to the principle that access to healthcare should be determined by actual need for services rather than ability to pay or geographic location.

2.36 The Government regard private health insurance as primarily providing a self-funded system of access to providers outside the public system and to such private treatment facilities maintained within the public system as are consistent with the interests of the system overall. Therefore, it affords individuals an alternative to reliance on acute care services that are entirely publicly-funded.

2.37 The Government are committed to maintaining universal eligibility for health services, and in particular to ensuring that the rights of public patients are protected in accordance with the principles set out in the Health Strategy - Shaping a healthier future. They are satisfied, therefore, that the additional revenue accruing from an increase in charges for pay beds in public hospitals should be applied by the hospitals for further investment in the upgrading of the public hospital system.

2.38 The Commission on Health Funding noted that it was not inequitable that private health insurance should enable individuals to obtain speedier or otherwise unavailable treatment, provided that comprehensive and cost-effective publicly funded health services were available within a reasonable period of time to all those assessed as in need of them.

2.39 It is the responsibility of the managements of health boards and of public hospitals to ensure, on a day to day basis, that private patient demand is not satisfied at the expense of public patients.

**Improving Acute Public Health Services**

2.40 The Government recognise the need for a planned and concerted approach to improving the acute public hospital service available to the public generally and have already undertaken a number of initiatives in this regard. These include:

- a substantial increase in the resources for the public health services;
- improved accommodation for public patients;
- a structured approach to dealing with waiting lists;
- strategic planning and development of cancer and cardiovascular services;
- monitoring of the impact of private practice on access for public patients.

**Resources**

2.41 The Government have acknowledged, and have embarked upon addressing, the need for increased investment in the health services. Over the past two years health spending has increased by almost 30%. In 1999 spending on services under the aegis of the Minister for Health and Children will...
be in excess of £3.5 billion (€4.4 billion), and at the end of this year it is estimated that 75,000 people will be employed in the health services.

**Capital Investment**

2.42 The Government have agreed a three year capital investment programme in the public system. This is the first occasion on which a commitment has been made to a multi-annual planning framework. It represents a greatly increased level of funding for capital projects; a total of £525 million (€666.6 million) is being allocated over the period 1999 - 2001 compared to £281 million (€356.8 million) for 1994 - 1996.

2.43 There are major public hospital developments under construction, or in the course of planning, across the country. In addition, an annual medical equipment replacement programme has been put in place, for the first time.

2.44 It is evident from these developments that the Government are making significant resources available to ensure that the infrastructure of the services is enhanced. This means that both public and private patients can benefit from the extra investment and that standards of care and treatment will continue to improve. The capital programme under way will provide for the greatest level of investment ever in the health services, and will ensure that patients have access to a high quality service going forward.

**Waiting Lists**

2.45 The Government endorse the views expressed in the Report of the Review Group on the Waiting List Initiative that a series of immediate, medium term and long term initiatives must be taken if waiting lists and waiting times for public patients are to be reduced substantially.

The Government have already taken a number of immediate steps to address the issue, including the improvement of information systems, further validation of waiting list data and a series of initiatives to improve the operation of hospital services. In addition, the Government are making progress on addressing the medium and longer term requirements addressed by the Review Group. These include the introduction in 1999 of an incentive-based system for funding waiting list treatments and the investment of £9 million (€11.4 million) in services for older people and of £2 million (€2.54 million) in accident and emergency services which will help to release hospital beds for acute patients.

2.46 The Government accept that the establishment of efficient programmes to reduce unacceptably long waiting lists and waiting times can only be achieved by an integrated development of the healthcare system. The Government endorse the view of the Review Group that an effective response must span the full range of health services; the acute hospital sector must not be considered in isolation. The Minister for Health and Children has taken a series of initiatives with this in mind. These include:

- measures to improve liaison between primary care services and acute hospitals, including a structured system of communication for general practitioners. This will keep general practitioners informed of the status of individual patients on hospital waiting lists and of average waiting times by speciality and consultant;
- improved processes of organisation and management in hospitals, including arrangements for the efficient management of waiting lists;
improved management of out-patient waiting lists. This includes optimising the discharge of patients to their general practitioner, reducing the number of internal hospital referrals and ensuring that, as much as possible, patients are seen by a senior doctor (consultant or senior non-consultant hospital doctor);

• arranging for appropriate post-hospital care of those requiring rehabilitation, step-down facilities and other forms of non-acute services. This is a central principle of the approach advocated by the Review Group, which emphasised the need to increase the availability of places for sub-acute services. Health agencies are being encouraged to optimise their use of existing facilities in this regard.

2.47 The Government’s commitment to reducing waiting lists and waiting times is reflected in the substantial additional investment made in waiting list treatments since 1997. Funding was increased by 50% in 1998 to £12 million (€15.2 million) and was further increased in 1999 to £20 million (€25.4 million).

2.48 Taking account of the measures proposed above, the Government’s overall aim is to ensure that no adult should have to wait on a public in-patient list for more than twelve months and that no child should have to wait for more than six months in the specialties targeted for attention. Progress on the reduction of waiting times for the procedures being targeted will continue to be monitored and any further measures required by service providers to address these will be put in place.

Assessing the Acute Hospital Bed Stock

2.49 There has been understandable criticism of the difficulties which arise during peak demand periods in providing beds promptly for emergency admissions. Despite improvements in the management and staffing of Accident and Emergency Departments, considerable difficulty can still arise in providing sufficient beds for acute medical admissions. Occupancy levels in the acute hospitals are very high, reflecting intensive use of facilities and high productivity by hospital staff. While some advantage can be gained from providing more facilities of a less intensive nature for those who have completed the acute phase of their treatment, there is now a need to analyse more thoroughly the adequacy and appropriateness of the acute bed stock, particularly with regard to changing demography - including the proportion of the population with private health insurance, the effectiveness of new treatments and improved care for frail and sick elderly. The Minister for Health and Children intends to produce a report at an early date with a view to determining what further action should be pursued.

Strategic Planning and Development of Cancer and Cardiovascular Services

2.50 Strategic approaches to integrating all services in pursuit of better health outcomes have been particularly evident in relation to tackling cancer and cardiovascular disease, which remain the two main causes of premature deaths in the Irish population:

Cancer Services

• the Government have provided £21 million (€26.7 million) to implement the provisions of the National Cancer Strategy. This substantial funding is addressing, inter alia, regional imbalances in the availability of cancer treatment services outside Dublin;

• since implementation of the Strategy commenced, a total of 22 additional medical consultant posts have been
provided in the treatment and care of people with cancer, alongside a range of important support staff, who have either taken up duty or are currently being recruited.

**Cardiovascular Services**

- A national strategy has been formulated on how the incidence and management of cardiovascular disease can be improved. This addresses the preventive, medical and rehabilitation services needed to reduce the incidence of the disease and improve the services available to those who develop cardiovascular problems;

- Additional cardiac surgery facilities which have been announced will increase existing adult public cardiac surgery capacity by over 50% and will significantly increase existing paediatric cardiac surgery capacity. The Government have agreed to the objective of an average waiting time, overall, of six months for cardiac surgery for public patients, both adult and children.

**Monitoring**

2.51 Private beds account for slightly over 20% of total public hospital bed numbers. Private practice activity accounts for about one-fifth of the bed-days used in public hospitals. This suggests that, overall, the distribution of public hospital bed days is being managed through the bed designation system in a way which is fair to both public and private patients currently. The Government are determined that the extent of private health insurance coverage should not adversely affect the position of public patients. The Minister for Health and Children will, therefore, retain the responsibility for designating the number of beds in public hospitals which may be used to treat private patients.

2.52 The significant on-going growth in the rate of day case activity in hospitals, if not properly managed, has the potential to distort public-private usage patterns through directing an inordinate amount of resources to private patients. Accordingly, day treatment will be particularly monitored with a view to ensuring that access by public patients will not be adversely affected as a result of any development of an over-concentration of resources on private treatment in this area.

**Other measures**

2.53 In addition to the various service measures referred to, a number of important initiatives are being pursued in conjunction with management and professional interests, with a view to strengthening the hospital system in key areas such as governance, quality management, clinical audit and manpower provision. The approach to each of these areas is informed by a strong service user focus with the purpose of enhancing the overall impact of the performance of the public hospital system on both public and private patients.

2.54 The Economic and Social Research Institute is currently carrying out a study on behalf of the Minister for Health and Children to establish the extent, nature and the cost of private practice within the public hospital system. The focus of the study is on the role of private healthcare within public hospitals rather than the broader public/private mix within the overall hospital sector, or indeed within the healthcare system as a whole. The result of this research, to be finalised in the current year, will enable the Minister for Health and Children to consider what changes to the existing process, or new measures, if any, should be implemented in relation to the impact of private practice in public hospitals vis-à-vis meeting the entitlements of public patients.
This Chapter describes the basis for community rating. It recognises a particular vulnerability relating to the entry of individuals to the system at older ages, which needs to be addressed in the interests of the viability of the system as a whole. It specifies changes which will enable insurers to introduce a more equitable and flexible method of setting premiums in respect of persons who seek private health insurance cover for the first time later in life or who take cover out again after a prolonged lapse.

The Government regard community rating as the corner-stone of the Irish health insurance market. They are mindful of the fact that the viability of the system is heavily reliant on the effective operation of solidarity between different generations, through which the young subsidise the healthcare costs of the elderly and are subsidised in their turn by the following generation.

The Government have decided to amend the Health Insurance Act, 1994, to give insurers the discretion to apply late entry premium loadings, on a tiered basis, to persons who enter health insurance for the first time at age 35 years and over. It will also be open to insurers to apply loadings to persons who join cover after a prolonged lapse, but this will be subject to giving credit for previous participation in the system. Similarly, persons increasing cover later in life may be subject to a loading on that element of the cover which is additional.

Maximum permitted loadings will range from 10% to 80% of the normal community rate determined by the insurer in respect of a given plan. The aim is to ensure that late joiners will be liable to pay sufficient extra premiums to make up for the surplus they would have contributed to the system if they had joined at an earlier age.

The arrangements to enable the application of late entry loadings will not affect the calculation of premiums payable by persons who are currently insured, except to the extent that they may increase their level of cover at a future date.

The Government have decided to extend the upper age limit (from 21 to 23 years) under which insurers have discretion to reduce premiums for students in full time education.
Community Rating

3.1 The 1994 Health Insurance Act requires that under a health insurance contract for any specific level of benefit, a health insurer must charge the same premium in respect of all such contracts regardless of the age, gender, sexual orientation or current or prospective health status of insured persons. The main exceptions to the application of this principle under the Act are:

- the rate charged for children under 18 cannot exceed 50% of the adult subscription rate for the same level of cover;
- the rate charged for students in full-time education who are between the ages of 18 years and 21 years, and are dependent on the person with whom the contract is effected, may be reduced by up to 50% of the adult rate;
- insurers may give discounts of up to 10% on premiums which are paid through a group scheme.

3.2 Community rating is the cornerstone of the Irish health insurance system. In the absence of community rating, today's healthy individual could become tomorrow's uninsurable risk. The very existence of community rating therefore represents a broad protection to the community as a whole in terms of individual insurance rate stability and equitable access to insurance cover. It provides all insured persons with the peace of mind and certainty that the advent of chronic illness or sustaining serious injury will not render the cost of cover unaffordable. In particular, the inter-generational solidarity which is at the very core of community rating in Ireland has made insurance accessible to those (i.e. the elderly and the chronically ill) who might otherwise not be able to afford the cost of cover.

The Vulnerability of Community Rating

3.3 The future viability of community rating in a voluntary environment is dependent on people joining the private health insurance system at a young age. The surpluses that young healthy people contribute to the system facilitate the insurance of older, sicker people at premium rates that would not otherwise be affordable. If the flow of young healthy lives into the system were to taper off, then the community rate that insurers charge would be forced up, as it would be based on a worsening risk profile. This could have a compounding effect, as high premium inflation could possibly cause young healthy people to question the value of their insurance and terminate their cover, thereby causing the community rate to increase further.

3.4 The Government recognise that the waiting periods which insurers have discretion to apply (see Chapter 5 - Open Enrolment), before an insured person is entitled to claim benefit, act as a disincentive to ‘hit and run’ practices, whereby persons may choose to join health insurance only when they believe that they will need to claim. However, the Government wish to provide an environment that promotes joining health insurance early and have considered the valuable work carried out by the Advisory Group on Risk Equalisation on this subject, and submissions made by various interested parties.

Strengthening Community Rating

3.5 The Government have therefore decided to introduce the principle of “lifetime community rating” to underpin the future viability of community rating. Under this
system insurers will be allowed to charge an extra premium (in the form of a permitted maximum percentage loading on the standard community rate) to those who join private health insurance for the first time at a later age or re-join after a prolonged gap in coverage.

3.6 The Government believe that this would be inherently fairer than the present system, as:

- it would reward those who take out private health insurance early;
- it would place an appropriate premium burden on those who defer taking out health insurance until later in life when the prospect of claiming benefits is greater;
- it would be consistent with the general principle of community rating, because a 70 year old person who had joined the system at age 25 would pay the same premium as a new entrant aged 25.

3.7 The concept of advance funding in conjunction with lifetime community rating was described in the Report of the Advisory Group on Risk Equalisation. Under a funded system, premiums paid by younger people would be held in reserve and used to subsidise the shortfall of premium to claims when they are older. Comparisons can be drawn here with funding for pensions. In the private sector, contributions are made to a fund for members of the pension scheme during their working lifetime, and this fund is used to pay pensions when the members retire. In contrast, provision for pensions in the public sector is unfunded, with contributions paid by working members being used to pay pensions for retired persons. The current system of unfunded community rating in private health insurance is comparable to the system of pension provision in the public sector. The Advisory Group recognised that converting the present system to a funded one was not a practical option in view of the enormous demand it would place on existing subscribers in the form of increased premium payments.

3.8 The unfunded health insurance liability relates to the amount of funds on reserve that would be needed to maintain current premium rates (with no future adjustment for the ageing of members but with adjustment for future medical costs inflation), if no new persons were ever to enter private health insurance. Because key assumptions must be made regarding future cost trends, various values can be placed on the unfunded liability, and the Advisory Group commissioned calculations of this amount. However, provided young people continue to join private health insurance at a sufficient rate, the unfunded liability remains largely theoretical. The Government believe that the introduction of lifetime community rating will encourage new young people to continue to join, and thereby protect the current system without the need for advance funding.

3.9 The Government have decided to allow insurers the discretion to apply, or waive, late entry premium loadings as their business needs and plans require, in the interest of ensuring that there are no barriers to the movement of cover between insurers and in the interest of enhancing competition.

3.10 In theory, the risk equalisation system should incorporate an adjustment to reflect any extra premium loadings collected.
However, in practice, this could mean that individual insurers would have little incentive to apply the loadings. Accordingly, it has been decided that insurers should be allowed to retain any loadings they choose to impose. As a result, late entry premium loadings will be ignored under the risk equalisation system (see Chapter 4).

3.11 The primary purpose of introducing lifetime community rating is to encourage people to join the system at a young age, to protect the stability of the community rate for health insurance. This key consideration would not apply to circumstances where the insured person switches from a low cover plan to a high cover plan. Nevertheless, the Government are willing to allow insurers the discretion to charge a premium loading to people who switch to plans with a higher level of cover at a later stage in life as there can be adverse selection behaviour around such decisions. The loading may only apply to the additional premium charged for the high level plan, above the premium level for the plan to which the insured person previously subscribed.

**Appropriate Level of Late Entry Premium Loadings**

3.12 The Government have decided that the Minister for Health and Children should prescribe in regulations maximum premium loadings to ensure that late entrants are not charged disproportionate premiums.

3.13 The actuarial calculation of maximum late entry loadings will aim to ensure that late joiners would be liable to pay sufficient extra premiums to make up the surplus they would have contributed to the system if they joined at an earlier preferred age. The effect is shown in Chart 2.

3.14 Any determination of the appropriate magnitude of late entry loadings depends crucially on the rate of future claims inflation assumed. The Government therefore intend that the maximum loadings will be reviewed about every 5 years, to take account of events which may change future expectations regarding claims inflation. However, the aim will be to adjust maximum loadings only if they are deemed to be significantly out of line.

3.15 Based on actuarial advice, the Government propose the following set of maximum late entry premium loadings:
TABLE 5:
Late Entry Premium Loadings

<table>
<thead>
<tr>
<th>Age at joining</th>
<th>Maximum premium loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 35</td>
<td>0%</td>
</tr>
<tr>
<td>35 – 44</td>
<td>10%</td>
</tr>
<tr>
<td>45 – 54</td>
<td>25%</td>
</tr>
<tr>
<td>55 – 64</td>
<td>45%</td>
</tr>
<tr>
<td>65+</td>
<td>80%</td>
</tr>
</tbody>
</table>

3.16 These limits will also apply in respect of the loading that may be charged on additional premiums payable to increase a member’s level of cover. The loading can be applied based on the insured person’s age at the time of purchase of the increased cover.

3.17 People may terminate their private health insurance on a temporary basis for a variety of reasons, such as a period spent living abroad or a temporary change in financial circumstances. It is equitable that such people be given credit for any period for which they subscribed to the system of community rated private health insurance in this country.

3.18 The Government will provide that when a person joins health insurance, their age at entry for the purpose of calculating the maximum loading that may be applied will be deemed to be their current age less the number of years that they may previously have held a health insurance contract.

Validation of Individual’s Insurance History

3.19 An insurer must have information on previous periods of coverage under a health insurance contract to determine whether a late entry premium loading can be applied to a new customer. In the first instance, this information can be requested directly from the individual concerned, but the insurer should have a means of checking the accuracy of the details provided. It is proposed, therefore, that the insurer may check stated periods of membership with a previous insurer, and the previous insurer will be required to provide such information in a timely manner.

Premia for Students

3.20 The Health Insurance Act 1994 (section 7(4)(b)(i)) provides for insurers to have discretion to reduce premiums:

to a person who is of or over the age of 18 years and under the age of 21 years, is receiving full time education and is dependent on the person with whom the contract is effected.

3.21 The Government have decided that discretion of insurers in this area will be extended by raising the upper age specified from 21 to 23 years to more closely reflect the age profile of persons completing further education courses.

Smoking

3.22 Consideration was given when the 1994 legislation was being introduced to allowing health insurers charge lower premiums in respect of non-smokers. However, it was considered that this could have undermined the community rating principle. In addition, issues relating to effectively implementing such a measure and technical difficulties in relation to risk equalisation were identified.

3.23 The Government have noted the disappointing results of The National Health & Lifestyle Surveys (1999) in relation to smoking. The Surveys found that 29% of non-GMS respondents (which would
correlate to a significant extent with those who avail of private health insurance) reported smoking regularly/occasionally, while, 36% of GMS respondents did so. These figures are well in excess of the Health Strategy target to reduce the percentage of those who smoke by at least 1 percentage point per year so that more than 80 per cent of the population aged 15 years and over would be non-smokers by the year 2000.

3.24 The Government wish to ensure that all reasonable steps are taken to facilitate attainment of reductions in the proportion of the population that smokes. However, they do not consider that a limited premium loading for smokers under the private health insurance framework offers a suitable vehicle to address the issue. It is evident from the Surveys that modest financial disincentives alone are unlikely to change tobacco consumption behaviour to any significant extent. More specifically, the relative inelasticity of health insurance premiums and the results of the Surveys suggest that the concept of a limited premium loading for smokers would be less likely to prove effective in relation to the insured population.

3.25 In summary, any loading for smokers would be unlikely to impact upon the behaviour of insured persons or the cost of claims which may be attributable to smoking induced illnesses. In addition, the Government are concerned that to penalise any specific lifestyle factor could lead to demands for other risk factors to be taken into account, thereby undermining community rating. However, the Government expect insurers to promote, in the context of customer care initiatives, policies which would address the issue of smoking and other lifestyle factors covered in the Surveys and in the Health Strategy.
chapter 4

Risk Equalisation
This Chapter sets out the reasons why risk equalisation is required in a community rated private health insurance market. It describes the objectives which risk equalisation seeks to achieve, with particular reference to the balance which needs to be struck between maintaining the stability of community rating and encouraging competition in private health insurance.

Risk equalisation is a process that aims to equitably neutralise differences in insurers' costs due to variations in the health status of their members. A risk equalisation scheme results in cash transfers from insurers with healthier members to those with less healthy members.

The Government's view, supported by a wide range of independent experts and interests, is that risk equalisation is essential to underpin community rating. The key objective of risk equalisation is to protect the stability of community rating. Subject to this objective, it should facilitate and encourage competition. The Government have decided to make changes to the existing risk equalisation scheme to further encourage competition.

The Government's preference is to implement a risk equalisation system based on age, gender and prior utilisation. It is intended, as quickly as possible, to quantify utilisation using a casemix classification system and June 2002 has been set as the latest date for its full implementation. The Minister for Health and Children will commission a feasibility study to assess the full implications of this development, including timescales and resource requirements. Subject to further examination, it is proposed that the new system would equalise only the more resource-intensive types of in-patient discharge, thereby giving insurers an incentive to support preventive medicine and to provide treatment in the most cost-effective setting.

Until casemix data is available, regulations will provide for an interim scheme using length of hospital stay as a proxy for casemix. Under the interim scheme, the utilisation measure to be adopted will be 50% based on an insurer's own bed night experience and 50% based on market bed night experience.

Prior to commencing trading, an insurer entering the health insurance market will be given the choice of availing of a temporary exemption from participation in the risk equalisation scheme. The period of exemption will be a maximum of 18 months from the commencement of trading. This is intended to give new insurers an opportunity to establish their information systems and recover some set-up costs.

The Government have decided to give restricted membership undertakings, established prior to 1994, and subsequently entered in the Register of Health Benefits Undertakings, a 'once-off' option to be excluded from the risk equalisation scheme.
Background

4.1 The 1994 Health Insurance Act, and the related regulations, made provision for the introduction of a risk equalisation scheme to support the continued operation of community rating, open enrolment and lifetime cover in a competitive market. The EU’s Third Non-Life Directive envisaged that specific legal provisions adopted by Member States to protect the general good could include loss compensation schemes (otherwise known as risk equalisation) between insurers. In the course of introducing the Health Insurance Act, 1994 and the extensive consultations on the formulation of the health insurance framework, the Department fully informed all interested parties about the nature and the operational basis of the risk equalisation arrangements being put in place.

4.2 A major review of the risk equalisation system was carried out by the independent Advisory Group on the Risk Equalisation Scheme. The Advisory Group was established in June, 1997 by the then Minister for Health, following consultation with the two commercial private health insurers, and reported its findings in April, 1998. The Government's consideration of risk equalisation has been facilitated and informed by the work of the Advisory Group.

4.3 The Minister for Health and Children decided in December 1998 not to proceed with the risk equalisation arrangements as originally envisaged (the Original Scheme) pending the outcome of the White Paper. Following this decision, the Department of Health and Children issued a Technical Paper setting out a proposed amended risk equalisation scheme and held discussions with interested parties.

Need for Risk Equalisation

4.4 As the name implies, risk equalisation is a process which aims to equitably neutralise differences in health insurers' costs that arise due to variations in risk profiles. This results in cash transfers from insurers with healthier than average risk profiles to those with less favourable risk profiles.

4.5 The Advisory Group concluded that risk equalisation is necessary in a community rated market. In reaching this conclusion, the Advisory Group cited a wide range of Irish and international expert opinion and experience.

4.6 Without risk equalisation, each health insurer would have a strong incentive to target low-risk individuals (preferred risk selection) so as to be able to charge a lower community rate (or take a higher profit margin) than its competitors. Even with compulsory open enrolment, health insurers could seek to achieve a better risk profile by, for example, selective marketing techniques, targeting group occupational schemes, benefit design, or selective quality of service. Although insurers may not deliberately set out to attract healthier than average individuals, this could still arise because it is these individuals who tend to be more willing to consider moving between insurers. Any process, whether deliberate or accidental, which gives rise to significant differences in risk profiles between insurers is known as risk selection.

4.7 If risk selection arises, it would be expected that per capita claims costs would spiral for those insurers who are left with a higher proportion of less healthy individuals. This, in a community rated environment, would lead to significant market instability and erosion of public confidence.
4.8 Preferred risk selection would not enhance the efficiency of the market. There would be no net benefit to the market as a whole if insurers were to spend heavily on attracting younger lives and discouraging older lives. The cost of insuring older lives would simply shift from one insurer to another. It would be more beneficial to the market in the long run if investment was directed toward activities that fundamentally reduce the cost of claims and improve service.

4.9 Risk equalisation does not prevent insurers from gaining competitive advantage. Many potential sources of competitive advantage are completely, or substantially, unaffected by effective risk equalisation. These include: distribution, brand, customer responsiveness, provider relations, product innovation, claims management, purchasing efficiency and administrative efficiency. The Government believe that risk equalisation is compatible with a competitive insurance market. Furthermore, they are of the view that a risk equalisation system is an essential feature of a health insurance market where insurers are required to operate on a community rating/open enrolment basis.

**Risk Equalisation Objectives**

4.10 The objectives which the Government have adopted for an effective risk equalisation scheme are:

a) to preserve the stability of community rating in a competitive environment;

b) subject to a), to facilitate competition in the Irish health insurance market;

c) to satisfy the ‘general good’ principles underlying the EU’s Third Non-Life Directive;

d) to be self-financing; and to meet as far as possible, the following criteria;

**Equalisation of Risk Profiles**

- the scheme should provide a stable environment for community rating/open enrolment, through eliminating incentives for health insurers to select preferred risks, by ensuring that each health insurer bears the cost of a risk profile equivalent to the risk profile of all insured lives;

**Equity**

- the scheme should be perceived to be equitable between health insurers and should not result in any health insurer having to share profits which it has made as a result of its own efficiencies and cost controls;

**Cost Containment**

- the scheme should not present disincentives to health insurers to maximise efficiency and control costs;

**Non-Equalisation of Benefit Levels**

- the scheme should not equalise different levels of benefit paid by different health insurance plans;

**Practicality**

- the scheme should be understandable and practical to operate;

**Predictability**

- the scheme should produce results which are as predictable as possible, to allow health insurers to cost their policies appropriately.

4.11 In the context of these objectives, it is the Government’s view that a stable health insurance market is one which, inter alia, exhibits the following characteristics:
• the overall market is not materially distorted as a result of risk selection;
• individual insurers are not unfairly penalised as a result of risk selection;
• the age profile of the covered population does not alter significantly over time, relative to the age profile of the general population; and
• increases in premium rates are kept to the absolute minimum necessary.

4.12 The Government recognise that some tension can arise in simultaneously ensuring that each health insurer bears the cost of a risk profile equivalent to the risk profile of all insured lives and that risk equalisation does not result in an insurer having to share profits that it has made as a result of its own efficiencies and cost controls.

4.13 While the stability of community rating remains a public policy priority, the Government appreciate that, as well as being vulnerable to risk selection, stability can also be significantly undermined by uncontrolled costs leading to price increases. Additional competition has the potential to mitigate price increase pressures by, in particular, encouraging insurers to adopt cost containment measures.

4.14 The Government have, therefore, decided that amended risk equalisation arrangements are warranted (hereinafter referred to as the Amended Scheme) to strike a balance between protecting against risk selection and giving increased weight to encouraging competition.

**Methodology**

4.15 Consideration has been given to a risk equalisation approach under which transfers would be determined on a prospective basis (i.e., in advance of a particular assessment period) based on the age, gender and self-reported health status of the insured population. This approach could have merit from the point of view of encouraging cost containment practices among insurers. However, self-reported health status information could only be gathered by asking each insured person (or at a minimum a large sample of the insured population) to complete, at regular intervals, a relatively detailed personal questionnaire.

Specific problems with the viability of this approach include:

• the scale of the data collection exercise involved, even if a sampling technique is adopted;
• the likelihood of a generally low response rate and indeed variations in response rates between different risk groups which could result in the emergence of unrepresentative risk profiles;
• the individual health data returned may be of questionable reliability, since respondents may (wrongly) believe that the information supplied will affect their future insurability;
• resistance arising from concern about possible breaches of confidentiality.

4.16 Accordingly, the Government have decided that the Amended Scheme will operate on a retrospective basis (i.e., transfers are determined after a particular assessment period). This is in line with the Original Scheme and is consistent with the view of the Advisory Group.

4.17 An approach known as the Utilisation Adjusted Risk Profile Method was adopted for the Original Scheme. Under this method each health insurer’s risk profile is assessed
and a calculation is made to determine what the insurer's claims would have been if the lives which it covers had a risk profile equivalent to that of the total insured population. The Amended Scheme will also adopt this method.

4.18 Age and gender are risk factors that can easily be incorporated into the analysis of relative risk profiles. However, authoritative opinion, based on Irish and overseas research and experience (as cited in the Advisory Group report) supports the view that, on their own, these factors are not sufficient to achieve effective risk differentiation. Clearly, a healthy 30 year old represents a better business prospect for an insurer than a 30 year old with a chronic medical condition. Therefore, prior utilisation is used within the method as a proxy for health status factors that cannot be readily identified or measured.

Utilisation Measure

4.19 The choice of an appropriate measure of prior utilisation is a key element of the Utilisation Adjusted Risk Profile Method because it determines to a large extent the scale of transfers between insurers. The utilisation measure chosen should aim to both maintain stability, through the discouragement of preferred risk selection, and encourage efficient claims management by insurers.

4.20 In the light of the observation of actual competition over the past couple of years, the Government's view is that there is scope to adjust the risk equalisation framework to enhance recognition of claims management and facilitate insurer efficiency, without jeopardising stability. The choice of utilisation measure for the Amended Scheme is the area identified for making such an adjustment.

Casemix Based Measure

4.21 The Advisory Group concluded that "claims rate and insurers' own claims costs, based on DRG\(^1\) data can be used as a basis for risk equalisation". The Government also believe that a casemix-based approach offers the best potential for achieving the objectives set out previously.

4.22 However, as most commonly used patient classification systems relate only to episodes of in-patient hospital care, an approach based on all in-patient discharges might introduce a bias in favour of hospitalising cases where effective treatments outside hospital are available. Also, it would not reward investment in preventive practices. These shortcomings can be addressed by aiming to equalise only those more resource-intensive types of in-patient discharge where the diagnosis involved, in almost all circumstances, requires hospital treatment.

4.23 An approach along these lines can best be implemented by equalising Casemix Index (CMI)\(^2\) scores within each age and gender category and is the preferred basis for the Amended Scheme. The formulae and operational details underlying this Scheme are described in Appendix V.

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\(^1\) Diagnosis Related Groups (DRGs) are a casemix based patient classification system which categories hospital patients by principal diagnosis, treatment involved, presence or absence of complications and other relevant criteria. DRGs are currently used in Ireland for budgeting and service planning purposes in the public hospital system.

\(^2\) Casemix Index (CMI) is a measure of the relative resource intensity of a group of claims. It is arrived at by multiplying the number of claims in each DRG category by a weighting factor which indicates its relative costliness and summing the result.
Interim Arrangements

4.24 It is not possible to implement a casemix-based approach immediately, due to data deficits and the need to allow data capture/reporting systems sufficient time to develop. The Government intend to implement a risk equalisation scheme based on casemix, as quickly as possible. They have set June 2002 as the latest date for the full implementation of such a scheme. In this context, the Government have decided to immediately commission a feasibility study to:

- assess the current state of development of hospital information systems;
- identify barriers to casemix reporting and suggest how these might be overcome;
- propose a project plan for the full implementation of casemix reporting;
- estimate the earliest reasonable date for the implementation of a full and consistent risk equalisation scheme based on casemix.

4.25 Pending the establishment of a casemix-based system, there is a need to identify an appropriate interim utilisation measure. As there is a strong correlation between CMI and length of stay, it is proposed that number of bed nights (treating each day case as a one night in-patient stay) should be adopted as an interim proxy for CMI. However, to ensure that, under the interim measure, insurers have an incentive to promote shorter lengths of stay, early detection, prevention and best practice, a high weight will be attached to an insurer’s own experience. Accordingly, the utilisation measure to be adopted, pending the early establishment of a casemix-based measure, will be 50% based on an insurer’s own bed night experience and 50% based on the market experience. The formulae and details underlying this approach are set out in Appendix VI.

4.26 The effect of the proposed interim measure, by comparison with the arrangements provided for under the Original Scheme, will be to place considerably greater reliance on an insurer’s own claims experience in determining transfer amounts. This is intended during the period up to the introduction of a casemix-based measure, to give insurers a greater incentive to manage both the incidence and duration of hospital claims.

Benefits to be Equalised

4.27 Under the terms of the Original Scheme, an upper limit was placed on claim payments eligible for inclusion in the equalisation pool. The upper limit was chosen to correspond approximately with the most common level of cover in the market.

4.28 The proportion of each claim which is subject to risk equalisation, described in the regulations as the “prescribed equalised benefit”, was determined broadly in line with the following table:
### TABLE 6: Maximum Prescribed Equalised Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Maximum Prescribed Equalised Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospital per diem rate</td>
<td>Full charges</td>
</tr>
<tr>
<td>Private Hospital per diem rate</td>
<td>£250 (€317) or the actual charge if lesser</td>
</tr>
<tr>
<td>Private psychiatric hospital per diem rate</td>
<td>£100 (€127)</td>
</tr>
<tr>
<td>Fixed price procedures</td>
<td>90% of the scheduled procedure price</td>
</tr>
<tr>
<td>Consultant fees</td>
<td>90% of the scheduled participating rate</td>
</tr>
</tbody>
</table>

4.29 The VHI fee schedules were chosen as a basis for the initial regulations because they represented established market practice at that time.

4.30 If the equalisation limits are now set at a lower level, insufficient equalisation of risk profiles would result. In this scenario, insurers could profit significantly from preferred risk selection through reduced claims costs on the substantial proportion of claims cost above the equalisation level.

4.31 Conversely, it would be disproportionate to extend equalisation to all benefits. Also, if the equalisation system were to be so extended, the complexity of the system would be significantly increased. Two separate pools would be required, one for benefits up to the current level and another for benefits in excess of that level.

4.32 The Government have therefore decided that the level of hospital charges to be subject to equalisation under the Amended Scheme should be maintained at the Original Scheme levels, as adjusted from time to time in respect of increases in actual charges.

4.33 The current schedules of consultants’ fees are cumbersome for insurers and difficult to maintain. For these reasons, the Government have decided that the schedules of consultants’ fees will no longer apply and all consultants’ fees paid in respect of day case or in-patient treatment will be deemed equalised benefits. A similar approach has also been decided in relation to the equalisation of benefits payable by insurers in relation to fixed price procedures (i.e., procedures which are subject to a specified total cost covering both hospital services and medical consultant fees).

#### Triggers

4.34 Under the Original Scheme, the commencement of risk equalisation depended on either of two conditions (specified in the regulations) being satisfied. The triggers were set by reference to what was considered to represent emerging material differences in the risk profiles of insurers, and which would have the effect of undermining stability of community rating or would unfairly or materially penalise an individual insurer as a result of risk selection.

4.35 As these criteria remain appropriate and relevant, the Government are satisfied that they should be included under the Amended Scheme but with the minor
modification that the test should be based on aggregate data over two successive quarters. However, having regard to the change decided in relation to the interim utilisation measure and other changes in the operation of the Amended Scheme, it is not possible to predict when the conditions giving rise to the commencement of actual risk equalisation will occur.

4.36 The Original Scheme envisaged that risk equalisation payments would commence six months after the period in which the triggers were reached. Considering the postponement of the commencement of risk equalisation due to the consultation process on the Technical Paper (referred to at 4.3) and the preparation of the White Paper, it has been decided to make provision for payments to commence in respect of the quarter immediately following the six month period in which the materiality conditions referred to in the previous paragraph are reached.

Operational Responsibility

4.37 The Government are satisfied that responsibility for the operation of risk equalisation should rest with the Health Insurance Authority (as already envisaged under the Health Insurance Act, 1994).

Disclosure of Information

4.38 Section 12(4)(d) of the 1994 Act specifies that information which "can be related to individual undertakings" shall be disclosed only in limited circumstances. The Government are aware of the need to give insurers operating in the market as much information as possible to assist their business and financial planning, while also maintaining confidentiality. Accordingly, the Government have decided to amend the Act to enable the disclosure, each quarter, of total market equalised benefits and the aggregate volume of transfers (notional or actual) to and from the risk equalisation fund.

Restricted Membership Undertakings

4.39 The Health Insurance Act,1994, provided for restricted membership undertakings (e.g.schemes covering Gardaí, Prison Officers, ESB staff), which were conducting health insurance business at 30th June 1994, to be excluded from the operation of risk equalisation up to 30th June 1999. In view of the particular circumstances of these long established undertakings, the Government have decided to make provision for them to be given a 'once off' choice to be excluded from risk equalisation. The entitlements of insured persons of a restricted undertaking opting for exclusion, as regards open enrolment and community rating (as modified to provide for late entry premium loadings), would be confined to the particular undertaking concerned and they may be regarded as "new to health insurance" should they seek to transfer to another registered insurer. An exception to this situation would involve dependent children who would no longer be eligible for cover under the rules of an individual undertaking, on attaining a certain age.

4.40 Irrespective of the decisions that may arise in relation to the participation of these undertakings in risk equalisation, they would be disregarded for the purpose of determining whether the trigger conditions specified under the Amended Scheme have been satisfied.
New Market Participants

4.41 Under the Original Scheme, any new insurers to enter the Irish market would immediately be included in the risk equalisation scheme.

4.42 In recognition of the value, in terms of enhanced competition, which new entrants serving the market as a whole are in a position to bring to consumers, and having regard to administrative and information systems requirements placed by risk equalisation on a new insurer, the Government have decided that, prior to commencing trading, an insurer entering the health insurance market would be given the choice of availing of a temporary exemption from participation in the risk equalisation scheme. The period of exemption would be for a total of 18 months from the commencement of trading, during the first 6 months of which, a new entrant would not be required to submit prescribed risk equalisation returns, and would only make 'shadow returns' for the following 12 months. After the period of 18 months has elapsed, a new entrant's returns would be included for the purposes of calculating risk equalisation transfers between insurers.

4.43 The choice of temporary exemption from risk equalisation would not apply to companies that are subsidiaries of, or otherwise associated with, health insurance undertakings already operating in the Irish market or to new restricted membership undertakings.

Treatment of Late Entry Premium Loadings

4.44 Provision is being made for late entry loadings on the basis that insurers have discretion as to their application. As explained in Chapter 3 (3.10), where these are applied, the insurer will be permitted to retain the additional premium involved. Accordingly, no adjustment will arise under risk equalisation in respect of such premiums.
chapter 5

Further Changes to the Regulatory Frame
This Chapter describes various areas of the regulatory framework which require change so as to provide additional competitive scope to insurers. The proposals formulated are based on actual experience to date which suggests that certain steps are warranted in the interests of more effective market operation and to benefit the consumer. The areas addressed include amending the key definition of a ‘health insurance contract’ contained in the Health Insurance Act, 1994; extending the open enrolment entitlement (which is currently limited to persons under 65 years of age); adopting a less elaborate approach to minimum benefit regulations; and encouraging health insurance products in the primary care area.

The existing legislation will be amended to exclude ancillary health services from the definition of a ‘health insurance contract’, thereby freeing insurers from regulatory requirements in this area, which includes primary care. The definition will be strengthened to include circumstances where employers undertake to discharge the healthcare costs of their employees and to cover any part of a composite insurance contract which provides health insurance.

As a corollary to changes in the application of community rating (set out in Chapter 3), the entitlement to cover under open enrolment provisions will apply to persons aged 65 years and over who enter community rated health insurance for the first time or after a prolonged lapse in cover. The maximum initial waiting period for payment of benefit which insurers may impose upon such persons will be 2 years, with the waiting period in respect of pre-existing conditions being subject to the existing maximum of 10 years.

The regulations which entitle insured persons to lifetime cover are to be retained in their present form, as are the regulations governing the registration of insurers.

The principal change in the area of minimum benefit involves removing much of the regulatory detail, currently in the form of statutory schedules showing prices and medical procedures, in favour of maintaining a broad protection for the insured person in relation to the level of benefits which a health insurance contract must include. This is intended both to simplify the current arrangements and to remove any impediment which they could represent to insurers implementing new and different reimbursement arrangements with service providers.

In addition to the requirement that insurers provide minimum benefit of 100 days in-patient treatment in respect of the treatment of psychiatric illness, the Government will require that they provide an additional 20 days day-patient care. Their intention in this regard is to encourage the development between insurers and service providers of day care services as an alternative to in-patient treatment.
**Definition of Health Insurance Contract**

5.1 The definition of a health insurance contract is central to the 1994 Act. It determines what constitutes ‘health insurance business’ for the purposes of application of the provisions of the Act (including community rating, open enrolment, minimum benefit, etc.).

5.2 The Health Insurance Act, 1994 (section 2) defines a health insurance contract as follows:

"health insurance contract means a contract of insurance, or any other insurance arrangement, the sole or principal purpose of which is to provide for the making of payments by undertakings, whether or not in conjunction with other payments, specifically for the reimbursement or discharge in whole or in part of fees or charges in respect of the provision of hospital in-patient services or ancillary health services, but does not include a contract of insurance, or any other insurance arrangement, the sole purpose of which is to provide for the making of payments by undertakings in respect of sickness, injury or disease of amounts calculated by reference only to the duration of the sickness, injury or disease."

5.3 It defines ancillary health services as follows:

- (a) out-patient services and general medical practitioner services,
- (b) dental services, other than those involving surgical procedures carried out in a hospital on an in-patient basis,
- (c) services consisting of the supply, alteration, maintenance or repair of hearing aids, spectacles, contact lenses, artificial teeth, eyes or limbs (including parts of teeth or limbs) or other medical, surgical, prosthetic or dental aids, equipment or appliances,
- (d) services consisting of the supply of drugs or medicinal preparations,
- (e) ambulance services,
- (f) services by an attendant of a person who is sick or disabled (other than as part of a hospital in-patient service), and
- (g) any other health service, or any health service included in a class of health service, prescribed for the purposes of this paragraph,

but does not include-

- (i) hospital in-patient (including day patient) services, or
- (ii) any health service (including a health service specified in paragraphs (a) to (g)), or any health service included in a class of health service, prescribed for the purposes of this paragraph."

5.4 As can be seen, the scope of the definition covers all insurance contracts or arrangements which have the sole or principal purpose of fully or partially indemnifying an insured person against the cost of hospital in-patient services or ancillary health services. It specifically excludes schemes which have the sole purpose of providing payments based only on duration of sickness, injury or disease.

5.5 To date, the definition has served its purpose as a basis for determining what products and arrangements are to come within the remit of the Act. It is considered, however, that the definition should be amended in the following respects:

- the removal of ‘ancillary health services’ from its scope, for the reasons set out later in this Chapter;
- the removal of any doubt that an employer undertaking to discharge the hospital in-patient or day case fees or
charges of any member of its workforce (referred to as self-insurance) would be engaging in health insurance business and would be subject to the provisions of the Act. The purpose of this move is to provide a more explicit protection for community rating against the development of self-insurance practices which would have the potential to remove predominantly young and healthy lives from the system;

• the application of the definition to composite insurance arrangements/policies, which relate to full or partial indemnity for hospital in-patient or day-patient fees or charges, so as to regard any such element as a health insurance contract in its own right.

5.6 The Department of Health and Children and the Revenue Commissioners will ensure, insofar as possible, harmonisation between the definitions of a health insurance contract used for regulatory and tax relief purposes.

Open Enrolment

5.7 It is a strong feature of the health insurance system that insurers are required to accept all individuals aged under 65 who wish to enrol and that once an individual has enrolled the health insurer may not cancel or refuse to renew his/her cover. These requirements, allied to mandatory community rating, represent a significant benefit to, and protection for, the insured population.

5.8 However, an underwriting provision commonly found in health insurance contracts relates to the application of moratoria on the payment of benefits for specified periods following first enrolment, as well as in respect of claims arising from a condition that existed prior to enrolling. This provides some measure of protection to the market against the practice of adverse selection (i.e. where an individual may effect, or increase, cover to secure benefit in the knowledge of increased likelihood of treatment).

5.9 The open enrolment regulations allow insurers to impose waiting periods within the following limitations:

• a general moratorium, known as the initial waiting period, of not more than 26 weeks (52 weeks in the case of maternity benefit or if a person is of or over the age of 55 at time of enrolment) following the date on which the individual first enrols and

• not more than 5, 7 or 10 years on payment of benefit for treatment arising from a pre-existing condition where the age at enrolment was:
  under 55;
  55 or over and under 60;
  60 or over and under 65 years, respectively.

5.10 The regulations also provide that an insurer will not be required to pay benefit at a higher level during a period of two years following the effective date of an increase in the level of an insured person's cover.

5.11 An important feature, from an insured person's viewpoint, is the safeguarding of waiting periods already served or partially served following transfer between registered insurers, provided that cover has not ceased for more than 13 weeks. This facilitates free movement for insured persons between registered insurers which is essential to providing consumers with the benefits of competition as they relate to choice of insurer.
5.12 Adopting lifetime community rating, as described in Chapter 3, will also address a shortcoming in the existing system as regards the provision of first time cover by insurers to persons of or over the age of 65 years. This may arise in a number of situations, such as where a person returns to the country from abroad on retirement or where a son/daughter wishes to purchase cover for an elderly parent who could not previously afford it from his/her own means.

5.13 As matters stand, insurers have discretion as to whether they provide cover to such persons. However, should they decide to do so they must adhere to 'flat' community rating and lifetime cover. The impact of these conditions is that, on balance, an insurer may perceive its interests as being best served by not providing cover to such persons. The application of late entry premium loadings will address this situation and make possible the extension of entitlement to cover, under open enrolment, to persons of or over the age of 65 years.

5.14 However, it should be recognised that, for certain people, late entry loadings on their own may not be enough to discourage 'hit and run'. An older person may be able to avoid paying a late entry loading due to the practice of insurers, or, indeed, he/she may be willing to pay additional premium in the knowledge of a higher propensity to claim. Waiting periods, therefore, offer an important further facility to insurers to combat such adverse selection.

5.15 It is the Government's intention, therefore, to extend the permitted initial waiting period to 104 weeks for persons aged 65 or over. On the other hand, it is proposed to retain the maximum permitted waiting periods in respect of pre-existing conditions at their current level because it is already open to insurers to impose a waiting period of up to 10 years for pre-existing conditions in respect of all new entrants aged 60 years and over.

5.16 Particular consideration in respect of open enrolment will be applied to insured persons of existing restricted membership undertakings which choose to opt out of the Risk Equalisation Scheme (see Chapter 4). These insured persons may be treated as new to health insurance for the purpose of determining waiting periods and late entry premium loadings, if they leave the restricted membership undertaking and join a registered health insurer. However, this provision shall not apply to children of insured persons of restricted membership undertakings who must leave the scheme when they reach a certain age. Their period of insurance cover with the restricted membership undertaking shall be recognised by insurers for the purpose of calculating waiting periods.

Maternity Benefit

5.17 The level of cover provided in health insurance contracts for costs associated with pregnancy and childbirth, generally, leaves a substantial shortfall to be met by the insured person. Insurers may feel that the inclusion of comprehensive cover for such costs would expose them to the risk of adverse selection. To give insurers a reasonable basis to provide more comprehensive cover in this area, the Government will amend the regulations to allow insurers to impose a waiting period of up to three years in respect of maternity benefits which are in excess of the level prescribed under minimum benefit.
Lifetime Cover

5.18 Lifetime cover regulations ensure that a health insurer cannot refuse to renew an insured person's health insurance cover, except in the event of a fraudulent misrepresentation in relation to a claim or a medical condition. This gives protection for every insured person so that - as they get older, or as their health may deteriorate, or in the event of sustaining serious injury - their health insurance cover may not be terminated by their insurer. The Government do not propose any change in the provisions relating to lifetime cover.

Registration

5.19 The Health Insurance Act, 1994 provides that insurers carrying on health insurance business must be entered in the Register of Health Benefits Undertakings. The registration requirement ensures that the regulator of the market is aware of all undertakings operating in the market and is in a position to check that the health insurance products offered comply with the provisions of the regulatory framework. The process of registration is an administratively simple one, designed to facilitate insurers. The Register is currently maintained by the Minister for Health and Children, but, as already provided for under the Health Insurance Act, 1994, responsibility for it will transfer to the Health Insurance Authority on its establishment. The Government propose to retain the provisions relating to registration.

Minimum Benefit Regulation

5.20 Each health insurance contract must not provide benefits below a prescribed level, which is referred to as 'minimum benefit'. The key purposes of this requirement are as follows:

• to maintain inter-generational solidarity within the community rating system;
• to ensure the continued availability of the type of broad hospital care cover traditionally held, as a minimum, by the insured population;
• to ensure that individuals do not significantly under-insure due to lack of proper understanding of the restrictions which, in the absence of a specified minimum entitlement, could apply to some types of policies.

5.21 The success of community rating is dependent on inter-generational solidarity. If insurers are in a position to offer health insurance contracts aimed at low risk groups with lower levels of, or less extensive, cover than is generally available, the degree of inter-generational solidarity within the present health insurance market could be undermined. In the absence of minimum benefit requirements, it would be open to insurers to design plans specifically to attract younger low risk people. If significant numbers of low risk people dropped out of comprehensive plans, the community rate charged for such plans would rise. Members of such plans would predominantly be older, less healthy people.

5.22 Consequently, the regulations require that a minimum level of benefits must be paid in respect of a broad range of medical investigation or curative treatment, which is 'appropriate and necessary', provided on an in-patient or day-patient basis. Within this structure, health insurers are permitted to determine whether it is appropriate to pay benefits on an in-patient, day-patient or outpatient basis.

5.23 Under Minimum Benefit regulations, insurers may also specify the healthcare providers in respect of whose services the insured
person is covered, which permits them to make arrangements with preferred providers. Preferred provider network schemes have the potential to offer an effective cost-containment innovation for insurers in their efforts to contain premium cost increases, without affecting quality of service.

Changes to Minimum Benefit

5.24 The Government support the continuation of a minimum benefit regime but consider that the present arrangements, which involve extensive detailed schedules listing medical procedures and benefits payable, can be simplified. They also consider that there is a need to remove dependence on amending regulatory schedules to reflect changes in the market and/or developments between insurers and service providers.

5.25 In the case of consultants' fees the minimum benefit will be deemed to be either of the following:

- the reimbursement rate applicable where the consultant is party to a fully participating agreement with the insurer; or
- the minimum amounts which the insurer has determined to be payable, for procedures of different kinds, on a non-participating basis and which it has notified to the Health Insurance Authority.

5.26 In the case of reimbursement of consultants fees on a non-participating basis, if the amount notified by the insurer is considered by the Health Insurance Authority to be less than 75% of the lowest reasonable market cost for any specified procedure, the Authority may, at its discretion, set a higher amount which it deems to reflect such a level of reimbursement. The Authority may determine lowest reasonable market cost by reference to market practice and to past reimbursement agreements between insurers and medical consultants. The insurer concerned must adjust the benefit payable in accordance with the cost determined by the Authority in this regard.

5.27 As is the case at present, minimum levels of benefit in respect of hospital charges will be specified by broad hospital category. Minimum benefit will also continue to be payable for certain 'prescribed health services', including a specified grant-in-aid towards the cost of child birth.

5.28 This broadly-based approach is intended to reduce complexity without diminishing the entitlements of the public under the regulations. It should also provide the flexibility to incorporate reimbursement arrangements other than fee-for-service.

Psychiatric In-Patient Minimum Benefit

5.29 The Government have given careful consideration to the matter of the prescribed minimum benefit for psychiatric treatment. At present, the regulations entitle the insured person to not less than a specified minimum daily payment for up to 100 days in-patient treatment in a private psychiatric hospital during a calendar year. Accordingly, health insurance contracts cannot provide less than this level of benefit to all insured persons.

5.30 The Government note that the market currently offers choice to consumers as regards the availability of benefits for psychiatric care, and that one insurer provides for cover up to 180 days. They further note recent developments involving the introduction of day-patient treatment in
the case of certain conditions which were previously managed on an in-patient basis.

5.31 Statistics provided in the Health Research Board’s report on Activities of Irish Psychiatric Services, 1997 show that 93.3% of discharges from private hospitals occurred within a period of three months, with 42.9% of stays being of one to three months duration. The equivalent figures for lengths of stay in public psychiatric hospitals were 92.5% and 18.1%.

5.32 The trend in treatment of psychiatric illness in public hospitals has been to reduce dependence on in-patient services. The Government consider that augmenting the minimum regulatory entitlement of privately insured persons in respect of psychiatric treatment by 20 days day-patient benefit would be consistent with the wider trend in the delivery of care. Having regard to the emerging market developments, they consider that appropriate programmes can be developed by service providers in conjunction with insurers, to promote treatment on a day-patient basis and reduce reliance on the delivery of care in an in-patient setting.

5.33 The Government therefore consider that entitlement to specified minimum payments for 100 in-patient days and 20 day-patient days in respect of psychiatric treatment represents a sufficient protection for persons purchasing health insurance.

Extending the Scope of Minimum Benefits

5.34 A number of submissions called for the enhancement of the minimum benefit requirements under health insurance contracts. The case was put, in some instances, that interventions of particular kinds, encouraged by the availability of benefits, would actually prove cost-effective for insurers in that they would reduce the incidence, duration or frequency of hospital in-patient stays, and consequently alleviate the associated high cost of such claims.

5.35 The Government consider this to be essentially a product development issue, the merits of which should be pursued by the promoting interests with insurers. The primary rationale for minimum benefit is the support and protection of community rating by limiting the scope for the development of health insurance contracts which are targeted at low risk groups, to the exclusion of the elderly and high risk groups such as the chronically ill. It also ensures that, in a competitive market, members of the public will be entitled to at least the type of minimum cover against the unforeseen and high cost of hospitalisation, traditionally available to them under the health insurance system. Consequently, there is not a strong argument for imposing duties on insurers as regards new areas of benefit under minimum benefit. Any further regulatory requirements relating to minimum benefit, in areas not previously covered as a core element of health insurance contracts, could constitute an undue interference with the commercial freedom of insurers.

Primary Care

5.36 A number of submissions called attention to the absence of a genuine primary care dimension to our current private health insurance system. The benefits which could accrue to the system as a whole - in terms of a general improvement in health status and awareness among the insured population - were advanced in the context of the pivotal role which General Practitioners have the capacity to play.
5.37 In considering the role of primary care in the private health insurance system, it is important to bear in mind that the principal rationale on which the system was introduced was to secure protection against the cost of hospitalisation for those who did not have an entitlement to public hospital services.

5.38 The Advisory Body on whose recommendation the Voluntary Health Insurance Board was established in 1957, considered that “a scheme of voluntary health insurance is not a savings scheme whereby a sum of money is put aside to meet expenses that are foreseeable (but)...... is an arrangement under which, in return for the payment of contributions which are small in relation to the benefits covered, a person is enabled to secure protection against the heavy and unpredictable expenses of ill-health”.

5.39 Private health insurance has developed in this way up to the present time and so retains an orientation towards hospital-delivered care. From an insurance perspective, consumers will continue to expect that private health insurance should provide certainty and peace of mind in terms of protection against the significant medical costs associated with chronic ill health or serious injury and that it should ensure ready access to hospital for necessary treatment. Cover for primary care has been minor, relative to the cover provided for acute hospital services. The individual usually has little discretion regarding resort to acute hospital services and the resulting costs can be beyond the means of the average person.

5.40 Notwithstanding this, the existing regulatory structure recognises the ‘gatekeeping’ role of General Practitioners which applies to access to hospital care and treatment for insured persons. This is the intent behind the stipulation under the Minimum Benefit Regulations that, apart from services provided in an emergency and in connection with an obstetric condition, an insurer is not obliged to provide benefits unless these are the result of the insured person having been referred to the health services provider by a registered medical practitioner. This means that, other than in the area of obstetrics, an insurer may require confirmation of the referral by the doctor concerned before payment of benefit is authorised in the case of elective treatment on an in-patient or day-patient basis.

5.41 It is considered that a strategic change in the extent of the regulatory structure will provide greater opportunity for insurers to develop a new generation of health insurance plans aimed at aspects of the individual’s healthcare needs which fall outside the mainstream cover provided by traditional (acute care) health insurance contracts. The Government’s intentions in this regard are set out in the following section which deals with ‘ancillary benefits schemes’.

5.42 The regulations will also be examined, and discussions held with insurers, with a view to avoiding situations where the application of an ‘excess’ on out-patient services may provide a perverse incentive for minor procedures to be carried out in a hospital setting rather than a local surgery. Consistent with the objective of encouraging care in the most cost-effective setting, the benefit for minor procedures should be determined by the insurer in such a manner as not to constitute an incentive on the part of the insured individual to seek treatment in a hospital setting.
5.43 The Government consider that the further evolution of private health insurance should include steps to promote the position of primary care in the system. They are of the view, however, that the placing of a compulsion on health insurers to cover primary healthcare is not necessary for the protection of the interests of the common good, as reflected in the core principles of the private health insurance market - community rating, open enrolment and lifetime cover. Accordingly, an approach prescribing that insurers should include an extensive range of benefits in the area of primary care in their cover arrangements is not being proposed. Such an approach would significantly curtail the freedom of insurers to differentiate their products and to operate commercially in the competitive market. It could also have significant implications for the claims exposure of insurers and, consequently, for premium levels.

5.44 The Government would nonetheless urge health insurers to look at ways to reflect in their plans, and benefit structures, the particular role that General Practitioners are positioned to play in maintaining and improving the health awareness and status of the public.

5.45 At present the only patient registration arrangements at primary care level relate to the 32% of the population who are medical card holders. The Government consider that it would be beneficial for insurers and General Practitioners to explore the possibilities for encouraging primary care level registration among privately insured patients. As well as laying the basis for a more integrated approach to the insured person’s healthcare, this could enable a more extensive basis for national epidemiological studies, assessments of population health status, targeted preventive interventions based on known health risk profiles, and a more structured process for delivering primary healthcare.

Ancillary Benefits Schemes

5.46 The current regulatory arrangements classify health services as falling under two categories, viz. hospital in-patient and day care services or ancillary health services. Schemes of indemnity cover which provide benefits in respect of the former, except where these relate solely to cover for statutory public hospital charges, are subject to all aspects of the legislation. Schemes that provide indemnity cover solely for ancillary benefits are not subject to minimum benefit and risk equalisation, but are subject to community rating, open enrolment and lifetime cover.

5.47 The Government have considered the recommendation of the Risk Equalisation Advisory Group that ancillary health services should be removed from the scope of the legislation. They note that a strong market for ancillary benefits has not developed to date. This may be due to the fact that the lower costs associated with ancillary-type services (as against acute services) militate against any general move from a self-paid system to a community rated insurance product. By allowing insurers to determine their own basis for rating of premiums, a market for ancillary benefits may have a stronger chance of developing.

5.48 It would be open to health insurers to use such schemes to promote wellness, and developments in this area would have the potential to contribute to the improvement of public health generally, given that subscribers to such schemes could be encouraged to better look after their
health, or to avail of earlier medical or other professional services, on the basis that their costs would be defrayed.

5.49 The Government consider that the removal of 'ancillary health services' from the scope of the health insurance legislation would not be detrimental to the arrangements put in place to safeguard the interests of the common good. They further consider that such a move may lead to the development of insurance products which, over time, could offer the possibility of some improvement in health status of the insured population. The Government will, therefore, change the regulatory framework to remove 'ancillary health services' from the scope of the 1994 Act. This, however, will not preclude insurers from having ancillary health services covered under community rated insurance plans as heretofore.

5.50 The change proposed in relation to the definition of a 'health insurance contract' will impact upon the operation of premium relief under section 470(2) of the Taxes Consolidation Act, 1997. At present, to be eligible for consideration for such relief, the insurer offering the product must be entered in the Register of Health Benefits Undertakings which is maintained by the Minister for Health and Children under the Health Insurance Act, 1994. However, the proposed change will mean that the requirements of registration will not extend to insurers providing solely ancillary benefit products. In the circumstances, the Government will give careful consideration to the provision of tax relief in respect of premiums relating to products providing cover for ancillary services only, and/or the early detection of, or the prevention of, disease.

**Deductibles**

5.51 It is possible that developments in the market, relating to competition and cost containment, may incline insurers towards imposing significant cost-sharing arrangements on insured persons. The motivation behind this would be to influence consumer behaviour in relation to the utilisation of health services.

5.52 The term 'deductibles' is used by insurers in respect of cost-sharing arrangements. These may be applied on a 'front-end' basis, in the form of an excess, or on a co-insurance basis, in the form of a percentage of all costs payable in connection with an episode of treatment. Where an excess applies, the insured person has prior knowledge of the exact amount he/she must pay, but in a co-insurance arrangement the amount of the individual's liability will be determined by the overall cost of the treatment. In Irish health insurance practice, the application of an excess payment has long been a feature of out-patient benefit arrangements.

5.53 While there are legitimate concerns in relation to the desirability of deductibles and to their effectiveness as a cost-containment measure, the Government are anxious that insurers be given as much commercial freedom as possible in the design of new contracts. Accordingly they do not propose, at this stage, to specify maximum deductibles because the revised minimum benefit regime (paragraphs 5.24 to 5.28) provides adequate consumer protection. However, the Health Insurance Authority will be asked to monitor market developments in this area on an ongoing basis and to recommend such action as may be considered necessary.
Related Issues

Long-term care

5.54 This White Paper concerns sickness insurance which is classified as non-life insurance business under EU Directives. Long-term care insurance, which is akin to a form of retirement provision, is classified as life insurance business. These two distinct classes of business are conducted by the industry as separate branches and the design and funding of benefits reflect this situation.

5.55 There is no basis in the EU Non-Life Insurance Directives which would leave it open to the Government to encompass long-term care insurance within the special legal provisions which apply to the conduct of private health insurance.

5.56 The Government acknowledge that a number of the submissions received in connection with the White Paper advocated the introduction of private insurance arrangements in respect of long-term care services. They recognise the importance of this issue, particularly in view of demographic trends which show ongoing growth in the proportion of elderly in the population.

5.57 The Government are aware of the work being done in other Member States of the EU to address the issue of funding long-term care provision. Furthermore, they note that the analysis contained in the Review of the Carer's Allowance (1998) of the Department of Social, Community and Family Affairs and in the report on Financing Long Term Care in Ireland (1998) - prepared jointly by the Irish Association of Pension Funds, the Irish Insurance Federation and the Society of Actuaries in Ireland - have served to stimulate debate and focus interest on this important matter. The Government regard these reports as representing a valuable contribution to consideration of the many issues involved in this area in the Irish context.

5.58 The Government recognise that, as is the case in other countries, this important social issue merits consideration in its own right. In this context, the Government have noted the intention of the Minister for Social, Community and Family Affairs to commission a consultancy report on the role of social insurance in funding long-term care.

Cash Plans

5.59 The Government are aware that a significant number of people subscribe to plans which provide benefits in the nature of cash payments, rather than indemnity, in respect of the occurrence or duration of hospitalisation, the occurrence of specified diseases, major surgery undergone and other health related incidents. These are known in the market as critical illness plans, major medical or hospital cash plans. Generally, such plans either provide relatively limited or highly specific benefits, but fall considerably short of the broad protection provided by indemnity health insurance. Some of the available plans may be viewed as complementary to health insurance in that they provide sizeable cash payments which can accommodate lifestyle changes resulting from major illness.

5.60 Experience elsewhere points to such health-related insurance products representing a potential threat to indemnity health insurance business. Clearly, the potential exists for cash plans to closely mirror certain benefits, or be represented as resembling benefits, obtainable under health insurance plans. In such circumstances, it may be necessary to
consider further whether the purpose of such plans is to provide ‘de facto’ indemnity cover. The Government will keep under review the question of whether they should be subject to requirements imposed on indemnity-based health insurance contracts.

5.61 Health cash plans are not covered by the statutory protections applicable to private health insurance business. Persons who were holders of cash plans who may decide to take out health insurance at a later stage will therefore be regarded as first time entrants to health insurance and will be liable to incur the late entry premium loadings provided for in Chapter 3 and the waiting periods described above.
chapter 6

Consumer Protection and Quality Assurance
This Chapter describes the importance of information in enabling consumers to make an effective choice between health insurance products. It also looks at the importance of effective mechanisms of redress for dealing with consumer complaints.

The Government propose the establishment of a working group, under the aegis of the Health Insurance Authority, to devise guidelines for the provision of information to the consumer. They consider that this represents a positive way for insurers to satisfy consumers that all appropriate steps are being taken to meet their information needs in regard to product choice.

The Minister for Health and Children is pursuing with the private hospitals the potential of developing a uniform approach to accreditation. He will also encourage, and facilitate as far as possible, the participation of private hospitals in the patient activity systems currently available in the public hospital system.

The development and use of medical technology can have significant cost implications for insurers. There is a need for new technology to be carefully assessed and monitored, as to the efficacy of its use, so that insurers can make informed decisions concerning the provision of cover. The Minister for Health and Children will facilitate the effective dissemination of information among service providers and insurers on developments in medical technology.

The Government consider that the interests of both the public and private hospitals will be served by developing standard management information systems.

Overall, the Government aims to encourage, on the basis of mutual benefit, closer co-operation and information sharing, between the public and private hospital sectors so as to improve service provision and establish a more complete database on acute healthcare provision nationally.
Protects in the Current Regulatory Framework

6.1 Given the nature and importance of health insurance, it is essential that an individual should fully understand the cover provided, and any limitations or exclusions applicable, under available policies.

6.2 It is necessary, therefore, to ensure that the consumer is properly served in terms of the clarity/cover of the product and his/her relationship with the insurer under the contract.

6.3 There are a number of significant protections available to the individual in the current health insurance regulatory framework, i.e. the Health Insurance Act, 1994 and the Health Insurance Regulations, 1996, particularly in terms of access to cover, continuity of cover, mobility between insurers and the guarantee of a minimum level of cover which insurers are obliged to provide.

6.4 The 1994 Act also gives the Minister for Health and Children the power to make regulations “for the purpose of ensuring that any advertising or promotion of health insurance business is accurate and truthful, is not misleading or exaggerated and does not convey an impression that is false, misleading, inaccurate or exaggerated”. To date, it has not been considered necessary to make such regulations. However, the Minister for Health and Children will have recourse to this power should the need arise and he will take full cognisance of any views which the Health Insurance Authority (see section 7.4) may offer in that regard in the future.

Role of the Insurer in Providing Information

6.5 A key benefit of the competitive health insurance market should be the facility for consumers to shop around between insurers and compare health insurance plans on offer to decide which plan best meets his/her personal needs. However, this can often prove difficult as health insurance plans can be complex and contain insurance/medical terms and definitions which are not familiar to the consumer. This can be compounded by the conflicting claims of insurers, as a normal part of their competitive business, about the strength and value of the respective cover they offer.

6.6 The products on offer should be readily comparable if the consumer is to be in a position to unlock the maximum potential of mobility between insurers which competition can provide and which the regulations guarantee. Notwithstanding the fact that health insurance contracts are subject to the European Communities (Unfair Terms in Consumer Contracts) Regulations, 1995, it can be difficult for the individual to establish, and to understand, exactly what is available under each plan so as to make a valid comparison in terms of cover and value for money between those available from competing insurers.

Code of Practice

6.7 The Government consider that the health insurance sector should develop and adopt a Code of Practice in relation to the provision of information to the consumer. Accordingly, the Minister for Health and Children will propose to insurers that a working group, involving consumer interests, be formed under the aegis of the Health Insurance Authority to devise guidelines for the industry in meeting the information needs of the public. It is envisaged that the work of such a group would include exploring the formulation of a standard information
schedule, for inclusion with promotional and policy documentation, which would provide the consumer with an easy reference to what is and is not covered under any particular plan.

6.8 There are other ways in which the business practices of insurers can reinforce the consumer’s right to mobility in the market. For instance, one insurer provides for the refund of premium to be made on request within 21 days of payment, subject to no claim having been made in that period. The Government recognise this as a positive situation from the consumer’s perspective.

Mechanisms to Deal with Consumer Grievances

6.9 The Government consider it highly desirable that consumers have access to both a genuine internal review/appeals mechanism and an external independent adjudicator in the event of complaints or dispute over terms of cover, settlement of claims, etc.

6.10 The Insurance Ombudsman of Ireland Scheme - which is a non-statutory scheme - provides for the independent settlement of disputes between policy holders and insurance companies. The Insurance Ombudsman adjudicates in relation to complaints, disputes and claims made in connection with, or arising from, policies of insurance effected or proposed to be effected with members of the Scheme. The Office of the Insurance Ombudsman, since its foundation in 1992, has set down minimum standards in relation to customer care and complaints handling procedures which the policy holder can reasonably expect from a member company.

6.11 The Insurance Ombudsman is able to assist by conciliating between the insured person and the insurer and by adjudicating in relation to a matter of dispute. Insurers who are members of the Scheme have agreed to be bound by the Ombudsman’s decision; the policyholder is free to accept or reject the decision.

6.12 The Government welcome the fact that the commercial health insurers currently operating in the Irish market participate in the Insurance Ombudsman Scheme, as this provides their respective members with access to an independent arbitrator in the event of a dispute arising. The fact of membership of the Scheme is not an end in itself and insurers need to advise their members that the Insurance Ombudsman’s services are available to them. Furthermore, to underpin consumer confidence, it is necessary for insurers themselves to establish and conscientiously maintain strong internal arrangements for consumer redress which are user-friendly and effective, subject to independent periodic evaluation, and well-publicised among their customers.

Provision of Quality Healthcare

6.13 Insurers and service providers aim to ensure that quality healthcare is available to the consumer under health insurance. From the consumer’s point of view, he/she must be confident regarding security against the cost of, access to, and quality of treatment. An insurer will want to ensure that its consumers get the most effective, necessary care in the appropriate setting and, at the most economical cost. The provider wishes to be fairly paid for service rendered and has a professional and commercial interest in acquiring/maintaining a reputation for quality and excellence.

6.14 Under the Minimum Benefit regulations, insurers are free to select the service providers in respect of whom benefit will be payable. This leaves it open to insurers...
to make their own assessments as to how best to meet the needs of their consumers - both as regards the cost and quality of care - in determining service provider arrangements. The development between service providers and insurers of clinical protocols, procedures based on established best practice and rooted in evidence-based medicine, have the potential to contribute greatly to the quality of healthcare and to satisfying the expectations of the public as to what would constitute appropriate and effective care. The Government believe that the development of such approaches would add greatly to the strength of the market by enhancing transparency of service for the consumer.

**Accreditation of Public and Private Hospitals**

6.15 The Irish acute hospital sector has, over the years, compared favourably with its European counterparts across a range of parameters. In recent years there has been an increasing world-wide trend towards the development of accreditation schemes. The emphasis, however, has shifted from a focus on departments and their functions, to patients and the combined areas of process and outcome in the provision of hospital services. The development of hospital accreditation is seen as offering the potential either to verify high standards or address shortcomings within the hospital sector.

6.16 At present there is no formal hospital accreditation system in operation in the Irish public health system. The Government note that the Department of Health and Children has agreed the development, on a pilot basis, of an accreditation system for the acute general hospital system. The scheme will initially be concentrated in seven major teaching hospitals but will be structured in such a way that it can eventually encompass other hospitals and agencies across the public health sector, on completion of the pilot phase.

6.17 Participation in the scheme will be voluntary and the accreditation environment will be positive and constructive. The scheme will be characterised by openness and the sharing of information and experiences across the pilot sites. It is envisaged that the scheme will demonstrably add value for patients and other clients of the institutions involved. The Accreditation Steering Group, which is developing the proposed accreditation programme, is finalising the details and, phasing of the scheme, which is to commence shortly.

6.18 The primary objective of the scheme will be to have an accreditation system in place that would allow public hospitals to both assess their performance against an objectively agreed set of standards and, within this framework, to create an environment of continuous review and improvement of structures, processes and outcomes.

6.19 The objective of this approach is to promote patient and public confidence in the public hospital system and to develop a consistently high quality and patient-centred service.

6.20 The Government note that the private hospital sector is also progressing towards the institution of hospital accreditation. The Independent Hospital Association of Ireland (IHAI), which is the representative body for most private hospitals, is committed to the development of an accreditation system for its members.
6.21 Clearly, the interests of the consumer/patient, and indeed those of the hospitals themselves, would be most effectively and comprehensively served by a common or joint approach to the development of hospital accreditation measures. Accordingly, the Minister for Health and Children is pursuing with the private hospital interests the potential for developing a uniform approach to this objective.

6.22 In a third party payer context, such as insurance, advances in medical technology give rise to a significant dilemma as regards usage and funding. Patients perceive it as in their interests to have immediate access to all new technology. The dissemination of information through the Internet, and otherwise, has enhanced the general level of awareness about latest developments in the delivery of medical services. Insurers, although keenly aware that health insurance is primarily purchased as a key to access services, need to have regard to exposure to immediate and longer term increases in claims costs which new technology, more often than not, represents. There are also concerns that the efficacy of technology be proven before it takes hold and that it should as far as possible replace, and not be incremental to, the cost of existing technology.

6.23 Medical inflation throughout the developed world exceeds general inflation by a significant margin. One dimension of medical inflation is the ongoing development of expensive technological procedures, their availability, and - directly related to availability - extent and intensity of usage. The Health Strategy pointed to the continuing acceleration in the introduction of new medical technologies into the health services here and in other countries and also the high costs associated with such developments.

6.24 There is a clear need for the assessment of health technology to ensure that healthcare delivery is as effective as possible and to achieve optimum use of scarce resources. Evaluation and performance measurement must be more vigorously asserted as a key part of the management function within the health services.

6.25 The Department of Health and Children’s Strategy Statement 1998-2001 specifically addressed the need to institute a system to assess new technology and to monitor the effectiveness of existing technology in the acute hospital sector. The Government note that within the Department of Health and Children a working group has been established to determine the best approach to Health Technology Assessment (HTA) in the current situation of the health services in Ireland.

6.26 In addition, a European-wide approach to consider the best methods and structures for determining effectiveness of health technology is being proposed to the EU Commission under the HTA Europe banner to which the Departmental group will link. Information and developments arising from the European-wide initiative will be disseminated by the Minister for Health and Children to public and private hospital interests and to insurers.

6.27 The current service plans for the Health Boards and public voluntary hospitals set out the priorities, levels of activity and financial limits determined by the Minister for Health and Children and are the benchmark against which expenditure and output activity can be measured.
the environment in which HTA must operate in the public hospital system. The increased flow of knowledge from the HTA framework, will contribute to enhanced decision-making in relation to the allocation of resources, by enabling the benefits and cost effectiveness of technology coming on-stream to be measured and evaluated against international trends.

6.28 It is apparent that an incentive for utilisation is present in circumstances where service providers invest heavily in new technology, and require this to be reimbursed through private patient revenue. However, it is not considered appropriate to attempt to limit the utilisation of new technology through a licensing procedure. It is essentially a matter for insurers to manage their experience in this aspect of their business. The existing health insurance regulatory provisions, as they relate to use of preferred providers, give insurers the capacity to determine for themselves what facilities they are in a position to cover on behalf of their customers. Furthermore, the momentum of competition between service providers has the potential to deliver over time, the keenest possible costs through exposing any excessive pricing, wasteful over-provision or inefficient service delivery.

Improving Hospital Activity Information Systems

6.29 There is widespread acceptance of the need to develop national information systems which can be used to maximise the planning, efficiency and effectiveness of healthcare provision. The private hospital sector in Ireland has developed independently of the public hospital system. One consequence is that the information systems of the public and private hospitals have evolved quite separately and at differing rates.

6.30 The Government consider that it would be beneficial to develop an information system which would provide the greatest possible coverage across public and private hospitals. In the consultative process, private hospitals and other healthcare providers expressed an interest in the development of national information systems, covering all categories of patients, in relation to hospital services.

6.31 The Government are committed to increasing the level of resources available to further implement the development of management information technology in the public hospitals. Initially, the objective will be to expand the public hospital patient information system and achieve further development and implementation of the hospital casemix information system.

6.32 The Department of Health and Children is in the process of addressing the absence of the identification of the public or private status of patients from the current Hospital In-Patient Enquiry (HIPE), which already provides a range of information on public hospital discharges. The introduction of this distinction in the data set will enable the production of better data to assist decision making on policy and operational matters relating to patient care in public hospitals.

6.33 Private hospital interests have indicated that they would see merit, for their own use and in the global context, in being included within HIPE coverage. The Minister for Health and Children will facilitate, as far as possible, the participation of private hospitals in patient activity information systems.
6.34 The ultimate aim of this process is the development of a comprehensive information system for hospital activity into the future, covering all public and private patients. The arrangements envisaged for a casemix-based risk equalisation system (see Chapter 4) will represent one element of development in this area. Overall, such advancements will facilitate, as set out in the Health Strategy, the development of the co-ordinated and integrated approach to epidemiology being pursued nationally and within health board regions, as well as supporting the planning and evaluation of services at both the local and the national level.
chapter 7

Structural Changes
This Chapter describes structural anomalies in the market and sets out changes aimed at providing for the needs of the modern and developing market. The roles of the Minister for Health and Children, the Health Insurance Authority, prudential supervision and the reporting relationship of the VHI are addressed. It also deals with the need to establish a consultative structure designed to facilitate the development of a consensus approach among the various market interests on managing opportunities and threats in the maintenance of a vibrant voluntary health insurance system.

The Government recognise the need for change in current arrangements under which the Minister for Health and Children is simultaneously the authority for setting private bed charges in public hospitals, the market regulator and the 'owner' of the VHI. This complex mix of roles is not considered appropriate to current and future needs.

The Government will establish an independent Health Insurance Authority, as envisaged in the 1994 Health Insurance Act, and will give it the widest possible responsibilities, consistent with its purpose of safeguarding the common good aspects of health insurance. The relationship between the Minister for Health and Children and the VHI Board will be fundamentally altered, initially, to give commercial freedom and autonomy to the Board, and also providing for VHI to develop completely independently of the State should circumstances warrant.

The Government believe that there is a need, as envisaged in the 'Health Strategy', for a specific forum through which dialogue and understanding between insurers, service providers and service users can be promoted. Accordingly, the Minister for Health and Children will establish a private healthcare forum which will bring together the interests concerned with a view to exploring and, if possible, constructing a consensus on issues relating to the funding, delivery and quality of private healthcare, the operation of private health insurance and the interaction of the public and private aspects of the health system.
Role of the Minister for Health and Children

7.1 The Government recognise that, at present, the various responsibilities attached to the Minister for Health and Children in connection with the private health insurance sector involve potential for conflicts of interests to occur. As matters stand, the Minister is simultaneously the 'owner' of the VHI, the market regulator, and the authority for setting private bed charges in public hospitals (which account for approximately 50% of the total private bed stock).

7.2 The measures being announced by the Government in this White Paper will significantly address these various responsibilities, over the short and medium-term, through:

• giving VHI a clear commercial mandate, with greater legislative freedom to pursue its business goals and to have the capacity to, ultimately, become a wholly privately owned company;
• establishing an independent Health Insurance Authority;
• addressing issues relating to the pricing of public beds at less than the full economic cost.

7.3 The implementation of these changes will result in the Minister for Health and Children retaining a more conventional range of regulatory responsibilities:

• liaison with the Health Insurance Authority;
• designation of beds in public hospitals;
• facilitating developments aimed at (i) enhancing understanding and cooperation between sectoral interests and (ii) improving insurance-related claims reporting systems in hospitals;
• preparation of legislation, as necessary.

The Health Insurance Authority

Provisions of the Health Insurance Act, 1994

7.4 Part IV of the Health Insurance Act, 1994 provides for the establishment of a Health Insurance Authority which will administer the Risk Equalisation Fund. The Act provides that the Authority will also carry out other functions, which are currently performed by the Minister. Under the Act, the cost of sustaining the ongoing operation of the Authority will be met from the proceeds of a levy on registered insurers, although the initial setting-up costs will be funded by the Exchequer.

Existing Functions

7.5 The key functions of the Authority, as provided for in the Act, are:

• establishing and administering the Risk Equalisation Fund;
• keeping the Register of Health Benefits Undertakings, including removal therefrom;
• ensuring that appropriate records are kept by health insurers;
• provision of an annual report and audited accounts to be submitted to the Minister and laid before the Oireachtas;
• advising the Minister on matters relating to:
  (i) his functions under the Act;
  (ii) the Authority's own functions;
  (iii) health insurance generally; and
• monitoring the following:
(i) the operation of the Act;
(ii) the carrying on of health insurance business;
(iii) health insurance developments generally.

7.6 In the context of developing the regulatory environment, the Act provides that the Minister may, with the consent of the Minister for Finance, confer on the Authority any additional functions which he sees as appropriate.

Authority's Reporting Relationship

7.7 A number of the submissions on the White Paper addressed the issue of an appropriate reporting arrangement for the Authority. There was a difference in emphasis on the precise regulatory arrangements to be put in place, with some interests proposing that the Authority should be independent of the Minister or the Government in terms of reporting and responsibilities.

7.8 The Government have given approval, in principle, to the establishment of the Health Insurance Authority. Under the provisions of the Health Insurance Act, 1994, the Health Insurance Authority is required to report to the Minister for Health and Children. The Government see no reason to change this situation, on the basis that the Authority is to be independent in the exercise of its functions. The Minister, in considering appointments to the Authority, will seek nominations in regard to suitable persons from appropriate professional and representative bodies.

Additional functions

7.9 The Advisory Group on the Risk Equalisation Scheme recommended that the Health Insurance Authority should have additional functions. The Government wish to give the Health Insurance Authority a remit which is consistent with the effective operation of existing regulatory arrangements for the conduct of business generally in the country. In this context, the Government are satisfied that issues relating to effective competition in the private health insurance market, including matters involving certification, licensing and enforcement of competition, are entirely proper to the Competition Authority. It would not be consistent with orderly and effective regulation of the market for the Health Insurance Authority to have overlapping responsibilities or powers in this area.

7.10 In addition to the functions of the Health Insurance Authority specified in the Act, the Government have determined that it will assign the following responsibilities to the Authority:

- promoting the stability of community rating through, inter alia, the effective operation of risk equalisation;
- reviewing the continued appropriateness of maximum late entry loadings which insurers may apply in the case of persons joining health insurance at an older age;
- considering and assessing the minimum benefit arrangements on an on-going basis;
- assessing the effect of the regulations on the interests of consumers, in terms of access to, cost of, and quality of cover available;
- monitoring cash plans and assessing their impact, if any, on the health insurance market;
- monitoring stability of the market;
where necessary, providing directions to insurers as regards advertising, publications, notices etc;

- collecting and publishing statistics on the market;

- facilitating potential or confirmed, new entrants to the market in terms of information about the regulatory system, the private healthcare delivery system and statistical data;

- facilitating information provision to the consumer;

- conducting such research or studies relating to the operation of the market as may be deemed necessary, or valuable, to the performance of its functions.

### Regulatory Control over Prudential Aspects

7.11 The Government have already announced their agreement in principle to the establishment, at the earliest date possible, of a single regulatory authority for the financial services sector. They are satisfied that supervision of the prudential aspects of the health insurance sector would properly fall to be considered in the context of that broad sectoral initiative. They see no need for separate supervisory arrangements of a prudential nature for health insurers.

### Public/Private Healthcare Forum

7.12 The private healthcare system is characterised by a high level of interdependence and mutual interest among its participants. Insurers and service providers have as a core objective of their activities the provision of the best possible service to the customer/patient.

7.13 The Government believe that there is a need, as envisaged in the ‘Health Strategy’, for a specific forum through which dialogue and understanding between insurers, service providers and service users may be promoted. Accordingly, the Minister for Health and Children will facilitate the establishment of a public/private healthcare forum which will bring together the interests concerned, with a view to exploring and, if possible, constructing a consensus approach to issues relating to the funding, delivery and quality of private healthcare, as well as the operation of private health insurance, and the interaction of the public and private aspects of the health system.

7.14 It is intended that the Forum should stimulate and inform public debate on the challenges and opportunities involved in maintaining a vibrant private healthcare system so as to allow it to continue to play a significant role within the total health system. The Health Strategy - Shaping a healthier future - identified the potential for such a Forum to address the following matters:

- the exchange of information on policy developments likely to affect the providers of private care;

- ongoing review of the balance between supply and demand in the provision of facilities for private patients;

- the development of protocols, which would guide both the public and private systems on the further enhancement of technological capacity;

- examining the processes in place in private hospitals for the maintenance of acceptable standards and good practice and the review of complaints made by, or on behalf of, patients.
7.15 In addition to these, the Forum would have the potential to be a unique and effective vehicle for the exchange of views and the development of consensus in regard to:

- the pursuit of quality assurance;
- effective options for the funding and delivery of services;
- challenges and opportunities in the developing market;
- information sharing and development;
- how best to serve consumer's needs and interests.

Reporting Relationship of the Voluntary Health Insurance Board

7.16 In its First Report, the Seventh Joint Oireachtas Committee on Commercial State-Sponsored Bodies (1994) stated that it believed that, in the open market, the Minister would have to adopt an "arms length" posture vis-à-vis the VHI.

7.17 The Report of the Advisory Group on Risk Equalisation (1998) strongly advocated change in relation to governance arrangements for VHI, including recommending that, in terms of any continued ownership by the State, it should have reporting lines to another Department.

7.18 A number of submissions received recommended that the Minister divest himself of any relationship to VHI. The VHI Board itself recommended that it should no longer come under the aegis of the Department of Health and Children.

7.19 The environment in which VHI now operates is radically different from that which existed at the time of its establishment over 40 years ago. A change in the VHI's reporting relationship with Government would reflect the change to the competitive market. The Government consider that there is no longer any case for VHI to retain a direct link to the Department of Health and Children. They are satisfied that VHI's future lies in being regarded as an insurance business operating in accordance with a strong commercial and competitive mandate.

7.20 The steps which will be required to fundamentally change the basis of the relationship between the Minister for Health and Children and the VHI are set out in Chapter 8. Notwithstanding the above, the Government consider that, on balance, it is not feasible to assign responsibility for VHI to another Department at this crucial juncture in its development. Neither does the Government consider that such a change would necessarily aid progress on the transition envisaged. They are satisfied that the continued reporting relationship to the Minister for Health and Children, over the short term, is of diminished significance in light of the definite commitment to change in the VHI's legal and business structure set out later in this White Paper. Given the fundamental policy change now indicated, i.e. to develop VHI to a position of commercial autonomy, the imperative is to proceed in this direction as quickly as possible.
part 111
Future of the Voluntary Health Insurance Board

chapter 8
The Voluntary Health Insurance Board
This Chapter outlines the future status and direction envisaged for the VHI arising from consultations with the Board. In the Action Programme for the New Millennium the Government stated its commitment to deliver on priorities in healthcare, to create a customer-focused healthcare service and to target key healthcare areas for special attention. Its key priorities in this connection envisaged fundamental change in the position of the VHI. It is intended that the proposed changes will enable VHI to operate successfully as a commercial enterprise into the future.

There is a tradition in this country of extensive involvement of the public sector in the provision of goods and services through commercial State-sponsored bodies. The issues facing VHI are in many ways similar to those of other State bodies who are making the transition from restricted to more liberal markets, often as a result of the need for compliance with the requirements of Ireland's membership of the European Union.

There are substantial challenges facing VHI arising from the ending of its monopoly position, continuing medical inflation and increasing incidence of claims. In the over 40 years of its existence, but most especially during this decade, VHI has faced an increasingly demanding trading and financial environment. On the basis of a continuation of present structures and arrangements, the Government consider that there are likely to be serious threats to the competitive viability of VHI.

The Government will therefore implement legislation to give greater commercial freedom to VHI and to secure, in the interests of its members and staff, a corporate status commensurate with the needs of the competitive environment in which it operates. As referred to in the previous Chapter, change will focus on giving commercial freedom and autonomy to the Board, with provision also being made for VHI to develop completely independently of the State should circumstances warrant. The Government recognise that the changes envisaged will lead to the removal of VHI's derogation from prudential requirements under the EU Non-Life Insurance Directives.

In summary, the Government propose to:

- give VHI full commercial freedom of operation;
- repeal the VHI Acts 1957 to 1998 and bring forward legislation to convert the VHI, in the first instance, to the status of a public limited company owned by the State;
- provide a financial injection, of the order of £50million (€63.5million), to restructure VHI's capital base and to enable it to be considered for authorisation as an insurance company;
- make provision in the legislation for a third party investor to acquire a shareholding in VHI, and for its eventual full sale, if deemed desirable;
- in the event of the full sale of the State's shareholding in VHI, allocate a portion of the original value of the reserves to medical science and research or other similar purposes;

In the context of the full sale of VHI, the Government would intend to make arrangements for an employee share option programme.
Introduction

8.1 The Minister for Health and Children, on behalf of the Government, has ensured that the issue of corporate development for VHI has been pursued, as a priority, with the full participation and co-operation of the VHI Board. The Government intend to enable VHI to compete to the fullest possible extent in a market that can provide many possibilities and opportunities for an enterprising and dynamic service organisation.

Status of the VHI

8.2 The Voluntary Health Insurance Board (VHI) was set up in 1957 following a report to the Minister for Health in 1956 by an Advisory Body on the establishment of a Voluntary Health Insurance Scheme. The Advisory Body assumed that it was asked to advise on a type of scheme which should “... afford protection against the high and unforeseeable costs of ill-health, which are difficult to budget for and which are usually beyond the resources of the individual”.

8.3 Up to the establishment of the VHI, voluntary health insurance benefits were provided only on a limited scale, mainly through Friendly Societies or particular firms or organisations. Few if any of the commercial companies transacted health insurance business to any material extent. In 1953, one company introduced a scheme offering hospital, medical and surgical benefits but this was terminated after two year’s experience.

8.4 The Voluntary Health Insurance Board is governed by the terms of the Voluntary Health Insurance Acts, 1957-1998. It is not specifically subject to the general body of company or insurance law. The Board was established as a statutory body under the 1957 Act. The function of the VHI as specified under the Voluntary Health Insurance (Amendment) Act, 1996, is to "make and carry out health insurance schemes", and to "make and carry out such health-related insurance schemes as it may think fit", with the consent of the Minister for Health and Children. The Minister for Health and Children appoints the twelve members of the VHI Board and gives consent to the appointment of its chief executive (a position which is currently filled on an acting basis).

8.5 The original purpose of the VHI was to provide insurance for health services to those persons who were not entitled to free public health services (approximately 15% of the population at the time), or who wished to opt for private insurance through VHI, although entitled to public health services.

8.6 There have been considerable changes since VHI’s foundation regarding extended eligibility for public hospital services. In 1979 universal entitlement to public hospital accommodation was introduced, although those with incomes above a certain level remained liable for consultant fees. In 1991, all persons were given an entitlement to public hospital accommodation and public hospital consultant services. Notwithstanding these changes and the reduction in tax relief on health insurance premia, many people entitled to public health services have continued to opt for private insurance through VHI and the numbers insured by VHI have grown significantly over the years. In total, VHI now has over 1.46 million members, which represents nearly 40% of the population. Growth in VHI membership is shown below in Chart 3 and set out in detail in Appendix VII.
Financial Performance

VHI has generally operated on a “break-even” basis. As a statutory non-profit organisation, it has consistently shown a shortfall of premium income to claims and expenses, although a marginal operating surplus has been achieved in recent years when allowance is made for income on investments. VHI’s underwriting results since 1990 are shown below in Table 7.

TABLE 7: VHI Surplus and Underwriting Result 1990 - 1999

<table>
<thead>
<tr>
<th>Year</th>
<th>Subscriptions</th>
<th>Claims</th>
<th>Expenses</th>
<th>Investment</th>
<th>Surplus</th>
<th>Reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>158.7</td>
<td>-147.7</td>
<td>-11.4</td>
<td>8.5</td>
<td>8.1</td>
<td>12.8</td>
</tr>
<tr>
<td>1991</td>
<td>171.2</td>
<td>-160.0</td>
<td>-13.0</td>
<td>10.6</td>
<td>8.8</td>
<td>21.3</td>
</tr>
<tr>
<td>1992</td>
<td>183.1</td>
<td>-174.5</td>
<td>-12.4</td>
<td>12.2</td>
<td>84</td>
<td>30.7</td>
</tr>
<tr>
<td>1993</td>
<td>195.9</td>
<td>-192.1</td>
<td>-10.9</td>
<td>15.9</td>
<td>5.8</td>
<td>38.0</td>
</tr>
<tr>
<td>1994</td>
<td>211.4</td>
<td>-212.4</td>
<td>-11.9</td>
<td>17.8</td>
<td>279.9</td>
<td>67.5</td>
</tr>
<tr>
<td>1995</td>
<td>232.6</td>
<td>-235.0</td>
<td>-12.7</td>
<td>10.2</td>
<td>0.1</td>
<td>58.3</td>
</tr>
<tr>
<td>1996</td>
<td>257.9</td>
<td>-255.3</td>
<td>-13.5</td>
<td>11.9</td>
<td>1.0</td>
<td>64.5</td>
</tr>
<tr>
<td>1997</td>
<td>281.1</td>
<td>-276.5</td>
<td>-15.1</td>
<td>12.2</td>
<td>2.8</td>
<td>69.1</td>
</tr>
<tr>
<td>1998</td>
<td>304.4</td>
<td>-294.3</td>
<td>-18.2</td>
<td>10.9</td>
<td>8.8</td>
<td>76.2</td>
</tr>
<tr>
<td>1999</td>
<td>343.0</td>
<td>-322.4</td>
<td>-23.1</td>
<td>13.7</td>
<td>1</td>
<td>87.0</td>
</tr>
</tbody>
</table>

1 Year ending February
2 Incorporating release of age equalisation reserve (£2.5m in 1994 and £5m in 1995)
3 After the deduction of taxation charge
8.8 VHI has a relatively low ratio of administration expenses to subscription income at 6.7%. Recent increases in administration expenses have arisen from increased marketing, staffing and product development costs. Provision has also been made for investment in information technology, and, inter alia, to address Year 2000 issues and to develop systems to deal with the Euro Currency.

Claims Costs and Premium Increases

8.9 The average claim cost per member experienced by VHI has increased substantially in recent years. Pressures on the cost of private health insurance have arisen from a combination of:

- general medical inflation, due to advances in treatment and diagnostic processes;
- an increase in the volume of treatments per person;
- increases in provider charges in respect of private and public hospitals, and medical consultant fees;
- the impact of an ageing population;
- provision of full indemnity and minimising the practice known as "balance billing";
- increased consumer expectations and the challenge of competition;
- the need to maintain a prudent level of reserves.

8.10 As a result, in common with the experience of health insurers internationally, VHI premium increases have been significantly higher than general inflation. Since 1990, the increases in VHI Plans have been as follows:

**TABLE 8:**

<table>
<thead>
<tr>
<th>Date</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1990</td>
<td>4</td>
</tr>
<tr>
<td>September 1991</td>
<td>5.1</td>
</tr>
<tr>
<td>January 1993</td>
<td>4.1</td>
</tr>
<tr>
<td>August 1993</td>
<td>6</td>
</tr>
<tr>
<td>August 1994</td>
<td>8.5</td>
</tr>
<tr>
<td>September 1995</td>
<td>6</td>
</tr>
<tr>
<td>September 1996</td>
<td>6</td>
</tr>
<tr>
<td>September 1997</td>
<td>9</td>
</tr>
<tr>
<td>September 1998</td>
<td>9</td>
</tr>
<tr>
<td>September 1999</td>
<td>9.4</td>
</tr>
</tbody>
</table>

*Average across Plans

Cost Containment

8.11 These increases in premiums have occurred notwithstanding the VHI Board's commitment to containment of claims costs. As outlined in the VHI's Report and Accounts 1998, the Board has undertaken significant cost containment initiatives with service providers, including:

- the development and introduction throughout the private hospital system of a new hospital reimbursement scheme for hospital technical services based on itemised schedules and standard description of procedures;
- negotiated professional fee schedules;
- support for day care and side room procedures which do not incur unnecessary and expensive overnight stays.

Notwithstanding these initiatives, it is clear that continued active management of claims is necessary to contain future premium increases.
8.12 The Government recognise the important role which the VHI, in over 40 years of its existence, has played in fostering and sustaining private health insurance in Ireland. However, during the last decade, VHI has faced an ever-demanding trading and financial environment while legal constraints and under-capitalisation have limited its ability to expand its range of services and to introduce new products. In the new competitive market environment VHI has to be empowered to succeed as a commercial insurer.

Modernisation of Commercial State-Sponsored Bodies

8.13 Since the second half of the 1980s, major policy initiatives have been undertaken in many countries to open markets and improve competitiveness. In most cases these have encompassed examination of the scope of, and the rationale for, State involvement in a wide range of services.

8.14 The issues and challenges facing VHI are in many ways similar to those of other State bodies which are making the transition from restricted to more liberal markets, often as a result of the need for compliance with the requirements of Ireland’s membership of the European Union. Like VHI, a number of State bodies were not incorporated as companies under the Companies Acts. They were also restricted from raising equity from capital markets.

8.15 A significant number of these State-sponsored bodies have been, or are being, restructured to make them more commercially responsive. To achieve this, attention has been given to improving their operating performance, balance sheet position and management structure, as well as addressing public service obligations.

Restructuring Objectives

8.16 The Government have identified the following principal objectives to be considered in relation to the restructuring of VHI:

- to extend the scope and independence of VHI to allow it to compete on an equal footing in the private health insurance market;
- to ensure VHI’s financial and competitive viability in the interest of its members and staff;
- to improve VHI’s range of products and increase customer choice;
- to ensure compliance with EU obligations and requirements.

Not-for-profit Status and Reserves

8.17 VHI was established as a not-for-profit body. Its financial brief, as set out in the Voluntary Health Insurance Acts 1957 to 1998, is to charge premiums which, together with other revenues, are just sufficient to cover claims, expenses and “such allowance as it thinks proper for reserves”. At year end February 1999, VHI’s reserves were £87 million (€110.5 million).

8.18 VHI is exempt from requiring authorisation from the Department of Enterprise, Trade, and Employment to conduct insurance business, by virtue of Article 4 of the EU First Non-Life Insurance Directive.
exemption applies for so long as VHI's statutes and laws remain unchanged as regards "capacity". It is prudent to assume that change in VHI's corporate structure would entail the removal of this derogation. This would require VHI to meet such prudential and other criteria as may be determined for the conduct of the business of health insurance on an establishment basis in this country by the Department of Enterprise, Trade and Employment, in the exercise of its responsibilities pursuant to the European Communities (Non-Life Insurance) Framework Regulations, 1994.

8.19 In VHI's Report and Accounts, 1998 the Chairman stated: "Historically an annual break-even result has been acceptable in VHI. It is the strongly held view of the Board and its advisors that this level of surplus is no longer adequate." In the 1999 Report and Accounts, he again drew attention to the fact that: "In the year to February 1999...a pre-tax profit of £11.2 million was earned compared to £2.8 million in the previous year. This is an excellent result and represents real progress in moving towards achieving an acceptable commercial return on the Board's activities". The VHI considers that its exemption from meeting commercial solvency requirements is not sustainable in the short to medium term as the exemption is tied to a fairly narrow set of business objectives. The Government endorses the VHI Board's view that the organisation needs to significantly enhance its reserves position so as to make prudent provision against a range of possible business risks.

Pricing and Product Development

8.20 Two operational areas where the Minister for Health and Children has key functions under the Voluntary Health Insurance Acts relate to:

- the power to direct the Board not to implement proposed price increases within 30 days of being notified by the Board concerning such increases (the Board is obliged to notify the Minister for Health and Children of any proposed price increase not less than 30 days before the intended implementation date);

- the requirement to obtain the Minister's consent to any amendments to schemes or for new health insurance schemes which the Board wishes to operate.

8.21 VHI currently has 10 main health insurance products, Plans A to E and related enhanced "options" plans introduced in 1997. The plans discharge in full, or in part, the costs of hospital care and consultants fees. Out-patient costs are also provided for but are subject to eligible expenses and annual claims excess amounts, which limit the individual's capacity to claim. Plans A to E are mainly differentiated by the extent and type of hospital accommodation covered; and to a lesser extent by the levels of treatments covered. Under these plans the Board seeks to cover the fees of most consultants in full. VHI also offers Plan P which covers the statutory charges for public hospitals. More recently, legislative provision was made through the Voluntary Health Insurance (Amendment) Act, 1998 for the introduction of an international plan aimed at providing members who temporarily reside outside the State with comprehensive cover for their healthcare costs.

8.22 Following an invitation from the Minister for Health and Children for proposals in relation to its corporate status, the VHI Board indicated that it is currently prevented from offering additional products and services and that, due to the new
competitive market, it needs to expand its product range, to enhance its earnings stream, and to offer greater choice to its members. In the 1999 Report and Accounts, the Acting Chief Executive placed emphasis upon addressing customer needs, offering and delivering a broader range of products and services in the years ahead.

8.23 The Government are satisfied that it is now necessary to re-examine the arrangements which govern the Board’s overall activities and operations and that VHI must be enabled to exploit emerging opportunities for profitable diversification into ancillary services and activities of practical relevance and benefit to its existing business. The Government consider that the most appropriate course of action would be to provide the Board with the same freedom as its current and potential competitors in the areas of product development and pricing. Amending legislation will provide for removal of the power of the Minister to veto new products and price increases.

Corporate Status

8.24 The Government consider that there is a compelling case for change in VHI’s corporate status. They consider that maintaining the status quo would only contribute to, or perpetuate, perceived problems in relation to the dual role of the Minister for Health and Children as ‘owner’ of VHI and regulator of the private health insurance market. The Government consider that the private health insurance market will benefit from the removal of VHI’s derogation from solvency requirements and by giving VHI a commercial mandate.

8.25 The Government therefore consider that VHI should:

- operate in accordance with strict commercial criteria;
- be a market-driven, customer-focused company capable of competing in the liberalised private health insurance market;
- exploit new business opportunities, subject to it continuing to provide indemnity insurance for private healthcare.

8.26 A range of strategic options has been considered by the Board in conjunction with the Department of Health and Children, including maintaining its present status, or conversion to a mutual society or trust. These particular options were considered as being unsatisfactory in addressing the critical need to put the organisation on a sound commercial, strategic, and financial footing, with the capacity to readily adapt to meeting developing consumer needs and business opportunities.

Legislative Proposals

8.27 The Government will implement legislation to give full commercial freedom to VHI and to secure, in the interests of its members and staff, a corporate status commensurate with the needs of the competitive environment in which it operates, and which will provide it with the optimum operational and strategic flexibility.

8.28 Given that VHI has been operating as a near monopoly for over 40 years, the Government consider that an immediate full sale of VHI, at this time, would not be in the best interests of VHI. The Government consider that, as a first step, it is necessary to regularise the current position of VHI and put it on the same footing as other State companies.
8.29 The Voluntary Health Insurance Acts 1957-1998 will therefore be repealed and legislation will be introduced to establish VHI as a public limited company under the Companies Acts, with the power to establish subsidiary companies. Establishment under the Companies Acts will make VHI subject to all of the legal obligations and responsibilities that apply under company law.

8.30 The Government will arrange for a 'once-off' financial injection to facilitate the restructuring of VHI. This will also enable VHI to be considered for authorisation as an insurance company. Based on reserves of £87 million (€110.5 million) at 28 February 1999 the level of the injection which the Government has decided would be of the order of £50 million (€63.5 million). The total assets of the Voluntary Health Insurance Board will be transferred to the new company and the shareholding in the new company will be held by the Minister for Finance.

8.31 From the point of view of the Exchequer, any change in VHI should incorporate the minimum outlay of capital from the State necessary to enable it become a successful commercial entity, without a requirement for further recourse to the Exchequer in the future. The terms and conditions relating to this injection will be determined by the Minister for Finance together with the Minister for Health and Children, in consultation with the VHI Board, and having regard to EU requirements (see 8.36).

Third Party Investment

8.32 The strengths of VHI include the power of its brand name, its distribution channels, its accumulated expertise in the area of funding private healthcare, and its customer base. It is understood that these attributes are of interest to a number of potential investors. The Government consider that outside investment from commercial enterprise would offer VHI the availability of external expertise, assistance with diversification of products, and provide a potential source of future capital.

8.33 The Government, with the involvement and co-operation of the VHI Board and the new VHI company, will pursue, as a matter of urgency, the question of outside investment, in order to enhance the position and prospects of VHI. The legislation to effect a change in VHI's corporate status will allow for third party investment, and will also include provision for the eventual full sale of the State's interest in VHI if deemed desirable. A key aim of the Government in assessing the suitability of an investor will be the securing of the best interests of VHI members through its maintenance as a commercially strong and successful insurer into the future. A corporate finance institution and legal advisers will be appointed, following a tender process, to advise the Government on this matter.

Proceeds from Sale of Shares

8.34 Any proceeds from the sale, in full or in part, of the shares of the Minister for Finance in the new VHI company will accrue to the Exchequer. In the event of the full sale of the State's shareholding in VHI, a portion of the original value of the reserves will be allocated to medical science and research or other similar purposes.
Employee Share Ownership

8.35 As with other State-sponsored bodies, the Government accept the principle of an employee share ownership plan for the new company. Accordingly, it is open to making provision under the new legislation that, in the event of the full sale of VHI, the company may issue shares as part of an employee profit sharing scheme, subject to such terms and conditions as may be approved by the Minister for Finance.

European Union

8.36 Any provisions in respect of the restructuring of VHI will take account of EU Guidelines as they relate to State Aid in the restructuring of firms. The main purpose of the guidelines is to ensure that State Aid cannot be used to distort competition. The Government will ensure that careful attention is given to satisfying EU requirements in this area.
executive summary
The Government consider that, in general terms, the existing health insurance framework represents an appropriate and balanced approach to securing the following objectives:

- to provide adequate statutory protection for the principles of community rating, open enrolment and lifetime cover;
- to preserve a broadly-based and widely accessible private health insurance system;
- to provide a "level playing field" for all insurers as regards the application of the above-mentioned principles in a competitive market;
- to facilitate genuine competition based on cost, product quality, marketing and/or distribution;
- to structure the regulatory environment so as to maximise the opportunity for insurers and health care providers to operate efficiently.

However, the Government recognise that the original regulatory arrangements and established market structures warrant change in order to ensure that they more fully support the development of competition and efficiency in the system.

The Government’s approach to determining the future shape of the private health insurance market involves measures aimed at enhancing - in the interests of the consumer - stability, competition, innovation, health status, quality of service and information provision.
Key Proposals in the White Paper

Structures:
The Voluntary Health Insurance Board
The Government propose to give the VHI full commercial freedom of operation.

The Government intend to repeal the VHI Acts 1957 to 1998 and bring forward legislation to convert the VHI to the status of a public limited company owned by the State.

The Government intend to provide a financial injection of the order of £50 million (€63.5 million) to restructure VHI's capital base and to enable it to be considered for authorisation as an insurance company.

The Government intend to include in the legislation on a new corporate status for VHI, enabling provision for third party investment in VHI and for its full sale, if deemed desirable.

The Government intend to provide, in the event of the full sale of VHI, for an Employee Share Option Programme.

On the full sale of the State's shareholding in VHI, the Government will allocate a proportion of the value of the original share capital to medical science and research or similar purposes.

The Health Insurance Authority
The Government have given approval, in principle, to the establishment of the Health Insurance Authority with a remit relating to the maintenance of the common good aspects of the health insurance system.

Private Healthcare Forum
The Minister for Health and Children will promote and facilitate the establishment of a private healthcare forum, which will bring together the interests concerned with the funding, delivery and use of private acute health services.

Consumer Information Provision
The Minister for Health and Children will propose to insurers that a working group, including consumer interests, be formed, under the aegis of the Health Insurance Authority, to devise guidelines for the industry as regards meeting the information needs of the public.

Regulation:
Lifetime Community Rating
The Government have decided to introduce the principle of "lifetime community rating" to underpin the future viability of community rating. Lifetime community rating will be introduced on the basis of allowing insurers the discretion to apply or waive, late entry premium loadings as their business needs and plans require. Late entry loadings will not affect persons currently insured, except to the limited extent where they may increase their level of cover at a later date.

Risk Equalisation
The Government have decided to make changes to the risk equalisation scheme to encourage further competition.

The Government are committed to implementing, as quickly as possible, a risk equalisation system based on a casemix approach. They have decided that the Minister for Health and Children should immediately commission a feasibility study on full implementation of such a system by the earliest reasonable date, but in any event not later than June 2002.

Pending the move to a casemix-based system, an interim risk equalisation scheme will apply. This will be based on factors of age, gender and hospital utilisation (as a proxy for the resource intensity of claims). The utilisation measure to be adopted will be 50% based on an insurer's own hospital bed utilisation.
night experience and 50% based on the market bed night experience.

In view of the particular circumstances of the long-established ‘restricted membership undertakings’ (i.e. schemes limited to particular vocational/employee groups such as Gardaí, Prison Officers and ESB staff), the Government have decided to make provision for them to be given a 'once off' choice to be excluded from risk equalisation.

The Government have decided that a new insurer, offering cover to the general public, will be afforded the option of not being liable to fully participate in risk equalisation for a period of 18 months following commencement of trading.

**Minimum Benefit**

The Government consider that the arrangements relating to minimum benefit, which currently involve extensive statutory schedules listing medical procedures and benefits payable, should be simplified and they have decided that the Minister for Health and Children should arrange for minimum benefit to be expressed in broad terms.

The Government have decided to increase the minimum benefit applicable to the treatment of psychiatric illness. Accordingly, they will require entitlement to specified minimum payments for 20 day-patient days, in addition to the minimum of 100 in-patient days currently prescribed.

**Ancillary Health Services**

The Government will change the regulatory framework to remove ‘ancillary health services’ from the scope of the Health Insurance Act, 1994. The effect of this will be to free insurers from regulatory requirements in this area and to encourage the development of new products to cover such services.

**Tax Relief on Health Insurance Premiums**

As a general principle, there are no plans to alter the available standard rate tax relief on health insurance premiums, as one of the main supports to a community-rated private health insurance system.

**Hospital Services:**

**Public Hospital Waiting Lists**

The Government's aim in relation to the impact of initiatives and strategies in the area of public hospital waiting lists is that no adult should have to wait for more than 12 months and that no child should have to wait for more than 6 months in the specialities targeted for attention.

**Public Hospital Bed Stock**

The Minister for Health and Children will undertake a study and bring forward a Report which will assess the adequacy and appropriateness of the acute bed stock.

**Public Hospital Bed Designation**

The Government are determined that the extent of private health insurance coverage should not impinge upon the position of public patients. The Minister for Health and Children will, therefore, retain the responsibility for designating the number of beds in public hospitals which may be used to treat private patients.

**Public Hospital Bed Charges**

The Government consider that there is a need to address the unsatisfactory situation relating to the pricing of private beds in public hospitals at less than the full economic cost. The Minister for Health and Children will therefore implement a process to move to a system of charging which more fully reflects the economic cost of the services provided. The progression towards more economic pricing will, however, be determined in a way which is sensitive to maintaining stability in the market for private health insurance.

**Hospital Accreditation**

The Minister for Health and Children is pursuing
with private hospital interests the potential for developing a uniform approach to hospital accreditation arrangements.

Health Technology Assessment
The Minister for Health and Children will disseminate information arising from national and European-wide initiatives on Health Technology Assessment to public and private hospital interests and to insurers.

Hospital Management Information Technology
The Government are committed to increasing the level of resources available for the further development of management information technology in the public hospitals.

The Minister for Health and Children will explore and facilitate, as far as possible, the desire of private hospitals to participate in the patient activity information systems currently available across the acute public hospital system.

Competitive Impact of Recommendations
The Government believe that the following changes proposed in the White Paper will enhance the attractiveness of the private health insurance market to new entrants, thus increasing the scope for competition:

• the future restructuring of VHI will place its relationship, for the time being, with the Minister on a more appropriate footing and remove its exemption from meeting commercial solvency requirements;

• the establishment of the Health Insurance Authority will provide independent oversight of the operation of the health insurance market;

• the market for ancillary health benefits will be liberalised and insurers may structure and price such insurance schemes with greater commercial freedom;

• regulations regarding minimum benefit will be liberalised to facilitate insurers in developing new provider reimbursement arrangements;

• the risk equalisation scheme will be significantly amended to facilitate competition to a greater extent.

In addition to the above, the continued existence of tax relief for health insurance premiums and regulatory protection for consumers will continue to support the uptake of private health insurance.
appendices
APPENDIX 1

Submissions Received

1. Association of University Departments of General Practice in Ireland
2. Bons Secours Hospital, Cork
3. Bons Secours Hospital, Glasnevin
4. Bons Secours Hospital, Tralee
5. Buckley, Dr. David
6. BUPA Ireland
7. Byrne, Ms. Aisling
8. Carr, Dr. Alan
9. Cotter, Ms. Mary
10. Denny, Mr. Peter F.
11. Director of Consumer Affairs
12. Dooley, Ms. Mary
13. Doran, Ms. Beatrice M.
14. ESB Staff Medical Provident Fund
15. Friends First
16. Gay HIV Strategies
17. Goulding Voluntary Medical Scheme
18. Grealy, P.B.
19. Health Board Chief Executive Officers Group
20. Hibernian Group
21. Highfield Hospital Group
22. Hospital Saturday Fund
23. Incorporated Orthopaedic Hospital
24. Independent Hospital Association of Ireland
25. Insurance Ombudsman
27. Irish Association of Speech & Language Therapists in Private Practice
28. Irish College of General Practitioners
29. Irish College of Sports Medicine Physicians
30. Irish Hospitals Consultants Association
31. Irish Insurance Federation
32. Irish Medical Organisation
33. Irish Patients' Association
34. Irish Senior Citizens National Parliament
35. Kelleher, Dr. Cecily
36. Kennedy, Ms. Aisling
37. Kinsella, Professor Ray
38. Lavan, Mr. Martin F.
39. Light, Dr. Donald W.
40. Maher, Mr. John
41. Mater Misericordiae Hospital
42. Mater Private Hospital
43. Midland Health Board
44. Mid-Western Health Board
45. Moroney, Mr. Michael
46. Mount Carmel Hospital
47. McCormack, Ms. Eileen
48. McLoughlin, Mr. Ray
49. McNamara, Ms. Catherine
50. National Council on Ageing and Older People
51. National Maternity Hospital
52. Power, Mr. Paul J.
53. Prison Officers' Medical Aid Society
54. Prospectus
55. Psychological Society of Ireland
56. Rotunda Hospital
57. Rutland Centre Ltd.
58. Schizophrenia Ireland
59. Society of Actuaries in Ireland
60. St. James's Hospital
61. St. John of God Hospital
62. St. Vincent's Hospital
63. St. Vincent's Private Hospital
64. Tallaght/Clondalkin GP Association
65. Voluntary Health Insurance Board
66. VHI Members' Advisory Council
67. VHI/MSF Joint Union Committee
68. White, Mrs. E.G.
69. Wickham, Mr. Terry
Composition of Advisory Group

Mr. Gerard Harvey, former Chief Executive, An Post, and former President and Chief Executive Officer of the International Post Corporation (Chairman of the Group)

Mr. William Hannan, Actuary and Past President of the Society of Actuaries in Ireland

Mr. James Golden, Economist, Senior Treasury Manager and Lecturer in Finance, University College, Dublin

Explanatory Notes and Terms of Reference

Background

1. The main objective of the statutory framework established for health insurance in Ireland is the protection of the key principles of community rating, open enrolment and lifetime cover set down in the Health Insurance Act, 1994.

2. A risk equalisation mechanism is an essential feature of a competitive health insurance market which operates under these principles. It provides protection for both health insurers and subscribers to health insurance schemes and without it the system of community rating/open enrolment would be inherently unstable.

3. A risk equalisation scheme has been introduced within the Irish health insurance regulatory framework by means of Statutory Instrument No. 84 of 1996, made pursuant to the Health Insurance Act, 1994.

4. The objectives which the risk equalisation scheme seeks to achieve are:

   (a) to preserve the stability of community rating in a competitive environment;

   (b) subject to (a), to facilitate competition in the Irish health insurance market;

   (c) to satisfy the general good principles underlying the 3rd EU Non-Life Directive;

   (d) to be self-financingand

   (e) to meet, as far as possible, the following criteria:

   (i) Equalisation of Risk Profiles

   The scheme should provide a stable environment for community rating/open enrolment, through eliminating incentives for health insurers to select preferred risks, by ensuring that each health insurer bears the cost of a risk profile equivalent to the risk profile of all insured lives;

   (ii) Equity

   The scheme should be perceived to be equitable between health insurers and should not result in any health insurer having to share profits which it has made as a result of its own efficiencies and cost controls;

   (iii) Cost Containment

   The scheme should not contain any inherent disincentives for health insurers to seek to maximise efficiency and to control costs;

   (iv) Non-Equalisation of Benefit Levels

   The scheme should not equalise different levels of benefit paid by different health insurance plans;
(v) Practicality
The scheme should be understandable and practical to operate;

(vi) Predictability
The scheme should produce results which are as predictable as possible, in order to allow health insurers to cost their policies appropriately.

Terms of Reference
5. The Minister has set the following tasks for the Advisory Group:
   - to consider the existing risk equalisation scheme;
   - to seek submissions from interested parties on the scheme; and
   - to make recommendations to him/her, in the light of its consideration of the submissions received, on the improvements (if any) which he/she may consider making to the scheme in furtherance of the objectives set out at paragraph 4 above.

In its deliberations the Advisory Group should consider:
- the need for the Risk Equalisation Scheme to be clearly and effectively consistent with meaningful competition, commerciality, and innovation;
- risk equalisation schemes that operate in other community rated health insurance systems, the features of such mechanisms, those characteristics that are successful and those that are not in achieving the key objective of stability, while facilitating competition and innovation;
- the extent of benefit that should be subject to risk equalisation in order to achieve stability, considering the requirement to be proportionate in the protection of the general good.
APPENDIX III

Submissions received on Technical Paper on a Proposed Amended Risk Equalisation Scheme

1. Former members of the Advisory Group on the Risk Equalisation Scheme

2. BUPA Ireland

3. Hibernian Group

4. Moore, Dr. Michael

5. Society of Actuaries in Ireland

6. Voluntary Health Insurance Board
### APPENDIX IV

#### Table 9: Estimated Growth in Private Health Insured Population (000's)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number Insured (End February)</th>
<th>Population (April)</th>
<th>Insured %</th>
<th>Total at Work (April)</th>
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<td>1979</td>
<td>735,346</td>
<td>3,368,000</td>
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<td>887,741</td>
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<td>1,206,993</td>
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<td>1,363,554</td>
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<td>1,281,700</td>
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<td>1,434,980</td>
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<td>1,379,900</td>
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APPENDIX V

Casemix-based Risk Equalisation Formula

In simplified terms, the risk equalisation methodology proposed when a casemix-based system is fully implemented will result in each insurer emerging with the following claims cost in respect of equalised benefits after contributing to or receiving funds from the risk equalisation pool:

The sum for all age and gender cells of:

For benefits paid in respect of Specified Diagnoses

- Total population covered by insurer
- Market population proportion for that cell
- Market Casemix Index for that cell
- Insurer's own average benefit per Casemix Index Unit

Plus

For benefits paid other than in respect of Specified Diagnoses

- Total population covered by insurer
- Market population proportion for that cell
- Insurer's own average benefit per insured person

Algebraically this post equalisation claims cost can be expressed as:

\[
\text{UEAR} \times \text{UIT} \times \sum_{n,x} [\text{UBAn_x} + \text{MCMn_x} \times \text{UBCMn_x}] \div \text{MEAR}
\]
where

$n$ indicates a specified age group

$x$ is gender

$\text{UEAR}$ is a value determined for each insurer, based on its fully insured population at the start of the quarter, in accordance with the following formula:

\[
\text{Adult lives (over 18)} + \frac{\text{Child lives}}{3} \times \frac{\text{UIP}}{\text{MEAR}}
\]

$\text{MEAR}$ is a value, for the market as a whole, corresponding to $\text{UEAR}$ above

$\text{UIP}$ is an insurer’s fully insured population at the start of the quarter

$\text{MP}_n,x$ is the proportion, for the market as a whole, of the fully insured population in a specified age/gender cell at the start of the quarter

$\text{UBA}_n,x$ is the aggregate of equalised benefits paid by an insurer during the quarter in respect of non-Specified Diagnoses, for an age/gender cell, divided by the insurer’s fully insured population for that cell at the start of the quarter

$\text{MCMI}_n,x$ is the market average Casemix Index rate in respect of Specified Diagnoses for an age/gender cell, derived by dividing the market Casemix Index for that cell during the quarter by the corresponding market fully insured population at the start of the quarter

$\text{UBCM}_n,x$ is the aggregate of equalised benefits paid by an insurer during the quarter, in respect of Specified Diagnoses, for an age/gender cell, divided by the insurer’s corresponding Casemix Index.

The above calculations do not necessarily, when applied to the overall market, result in a zero sum. Therefore, to ensure the system is self-financing, the results emerging will be ratioed up or down by the application of the following factor:

\[
\frac{\text{MEB}}{\text{MSB}}
\]

where

$\text{MEB}$ is the aggregate of equalised benefits paid over the whole market

$\text{MSB}$ is the aggregate of the post equalisation claims costs for the market as whole based on the formula above.

Notes

1. Specified Diagnoses will be a list of diagnoses designated by the Health Insurance Authority based on criteria set out in paragraph 4.22. The Minister for Health and Children will suggest to the Authority that it adopts as a starting point those diagnoses with a resource intensity greater than the median recognising that over time this list will be subject to refinement and review, with clinical input, as circumstances warrant.

2. Casemix Index will be built up by summing the product of the number of cases under each Specified Diagnosis and a factor intended to reflect resource intensity for that Specified Diagnosis. Initially it is anticipated that the Health Insurance Authority will base these weighting factors on international research and experience, though, in time, factors based specifically on Irish experience may be developed.

3. The equivalent adult lives adjustment is necessary in order to reflect the fact that, as an exception to the principle of community rating, it is market practice to allow insurers to charge a significantly lower premium for children under 18. Not to reflect this in the risk equalisation formula would cause distortions where insurers have different ratios of child and adult members.

4. The fully insured population at the start of the quarter, as opposed to the average insured
population at the start and end of a quarter, will be used throughout. This is because claims incurred in a quarter reflect the experience of the insured population of a slightly earlier period, due to the inevitable time lags in settlement of claims.

5. The fully insured population will exclude individuals who are not eligible for benefits because they have not completed the initial waiting period. This will bring claims experience into line with the population in respect of which an insurer is at risk.

6 (a) To address statistical distortions that might arise due to a very low incidence of Specified Diagnoses in certain age/gender cells the Scheme will provide that where the Casemix Index is less than a figure to be set by the Health Insurance Authority the market average benefit will be substituted for the insurer’s own experience.

(b) Similarly, in the case of equalisation of non Specified Diagnoses if the number of claims experienced by an insurer in a given quarter for an age/gender cell is less than a minimum to be set by the Health Insurance Authority, the market average benefit will be substituted for the insurer’s own experience.

7. Additional rules will be devised to deal with special situations including where:
   a) episodes of hospital care linked to the same or related diagnoses closely follow one another;
   b) treatment is divided between the public and private system;
   c) there are delays in obtaining casemix information;
   d) retrospective adjustments in returns are necessary;
   e) insurers negotiate special payment terms with providers.
APPENDIX VI

Interim Risk Equalisation Formula

Under the Interim Scheme each insurer would emerge with the following claims cost, after contributing funds to or receiving fund from the risk equalisation pool.

The sum for all age and gender cells of

- Total population covered by insurer
- Market population proportion for that cell
- Composite own/market bed night experience for that cell
- Insurer's average claim cost per bed night

Composite utilisation will be made up of 50% of the insurer's own bed night experience and 50% of the market experience (for the reasons set out in 4.25).

Algebraically this post equalisation claim cost can be expressed as:

\[ \text{UEAR} \times \text{UIP} \times \sum \text{MP} \times \text{CU} \times \text{UEBAn} \times \text{MEAR} \]
where
n indicates a specified age group
x is gender
UEAR is a value determined for each insurer, based on its fully insured population at the start of the quarter, in accordance with the following formula:

$$\text{Adult lives (over 18)} + \frac{\text{Child lives}}{3}$$

UEAR is a value determined for each insurer, based on its fully insured population at the start of the quarter, in accordance with the following formula:

$$\text{UEAR} = \frac{\text{Adult lives (over 18)} + \frac{\text{Child lives}}{3}}{\text{UIP}}$$

MEAR is a value, for the market as a whole, corresponding to UEAR above
UIP is an insurer’s fully insured population at the start of the quarter
MP is the market’s fully insured population at the start of the quarter
MPMn,x is the population, for the market as a whole, of the fully insured population in a specified age/gender cell at the start of the quarter
CU is 50% of the insurer’s own bed night rate plus 50% of the market bed night rate for an age/gender cell. These rates will be derived by dividing total bed nights (treating each day case as a 1 night in-patient stay) during the quarter by the fully insured population at the start of the quarter.
UEBA is the aggregate of equalised benefits paid by an insurer for an age/gender cell during the quarter divided by the insurer’s own total bed nights (treating each day case as a 1 night in-patient stay) during the quarter.
MEB is the aggregate of equalised benefits paid over the whole market
MSB is the aggregate of the post equalisation claims costs for the market as whole based on the formula above.

Notes

1. To address statistical distortions that might arise due to a very low incidence of bed nights in certain age and gender cells the Interim Scheme will provide that where the bed nights in an age/gender cell are less than 20, the corresponding market average equalised bed night cost will be substituted for the insurer’s own experience.

2. The equivalent adult lives adjustment is necessary in order to reflect the fact that, as an exception to the principle of community rating, it is market practice to allow insurers to charge a significantly lower premium for children under 18. Not to reflect this in the risk equalisation formula would cause distortions where insurers have different ratios of child and adult members.

3. The fully insured population at the start of the quarter, as opposed to the average insured population at the start and end of a quarter, will be used throughout. This is because claims incurred in a quarter reflect the experience of the insured population of a slightly earlier period, due to the inevitable time lags in settlement of claims.

4. The fully insured population will exclude individuals who are not eligible for benefits because they have not completed the initial waiting period. This will bring claims experience into line with the population in respect of which an insurer is at risk.

5. Additional rules will be devised to deal with special situations including where

a) retrospective adjustments in returns are necessary;

b) insurers negotiate special payment terms with providers.
## APPENDIX VII

**Table 10: VHI Membership (All Plans) 1958 - 1999**

<table>
<thead>
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<th>Year</th>
<th>Number</th>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
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<td>1980</td>
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<td>1983</td>
<td>1,013,745</td>
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<td>1963</td>
<td>167,016</td>
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<td>1964</td>
<td>195,189</td>
<td>1985</td>
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<td>1965</td>
<td>220,617</td>
<td>1986</td>
<td>1,032,709</td>
</tr>
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<td>262,029</td>
<td>1987</td>
<td>1,037,480</td>
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<td>645,165</td>
<td>1999</td>
<td>1,464,757</td>
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APPENDIX VIII

References

Legislation

Voluntary Health Insurance Act, 1957 (No. 1 of 1957).
Voluntary Health Insurance (Amendment) Act, 1996 (No. 4 of 1996).
Health Insurance Act, 1994 (No. 16 of 1994).

Other References


Irish Association of Pension Funds, The Irish Insurance Federation and The Society of Actuaries in Ireland, Financing Long Term Care in Ireland, 1998.


