The scope for private health insurance to incorporate additional primary care services

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An estimated 24 million consultations occur in general practice in Ireland every year\(^1\), representing somewhere between 50 and 60% of utilisation of healthcare in the country (estimated)\(^2\). However, 90% of the cost of private health insurance claims relates to hospital treatment.

We believe that there should be a transfer of services from hospital to primary care, which is internationally regarded as a more efficient means of providing care\(^3\). However, this decision needs to be made definitively at a national level and acted upon. With 45%\(^4\) of Irish people having health insurance as a means of funding their healthcare, requiring health insurers to provide cover for primary care is an important part of the way for this transfer to occur. Government legislation is required for this to occur, as it will not happen solely as a result of market forces.

There is a large asymmetry of information between health care providers and patients as well as a consumer moral hazard when health insurance is being provided. Healthcare providers in a competitive marketplace will advertise the newest, most expensive healthcare products and services in order to attract patients. The reality is that these products may be achieving only marginal or even no benefit compared to older, less fashionable treatments. On the other hand, when patients have health insurance, they are not bearing any of this cost at their point of contact, and there is no incentive not to use these expensive services or to engage in cheap health improving behaviours. This results in a tendency for a much higher demand for expensive and excessive health care. High cost services, such as hospital services, will be over provided while more efficient, lower cost services, such as in primary care, will be less popular.

It is therefore incumbent on government authorities to step in to address this market failure. Part of this relies on education, but legislation on minimum provision of services for health insurers is also very important.

The provision of health insurance benefits in primary care and encouraging the use of primary care services should be overall cost saving for the patient and the insurer. It would provide services at a lower cost than in the hospital setting, while it would also incentivise GP’s to expand their practices to encompass a wider range of procedures otherwise performed in hospitals.

- **Initial level of cover should include:**
  - A basic consultation fee, which currently stands between €45-55 for a private patient in Ireland. Therefore, a minimum should be €40, with a €10 copayment being paid by the patient. This copayment should be paid directly to the GP surgery in order to reduce transaction costs.
  - Minimum fees for minor surgical procedures
    If a copayment is to be paid by the patient for this, it should be quite small, and certainly less than the equivalent in the hospital setting. The minimum benefit in the legislation should be set at a level quite close to the market value for the procedure.
  - Provision for joint injections/Mirena coil implants
  - Provision of outpatient radiology
  - Fee for phlebotomy
  - Provision for preventative medicine including risk screening
• Provision for addiction services
• Provision for nurse lead services

- A more widespread uptake of health insurance would provide greater certainty to GPs and would enable to have greater investment in the facilities needed to undertake many of the procedures done in the hospital. The problem would still remain where state healthcare funding (i.e. GMS) is much lower than which is needed to incentivise the investment in facilities which would result in the transfer of care from hospital to primary care. An increase in the private health insurance benefits has to be accompanied by a corresponding increase in payments for state sponsored healthcare. Otherwise, there would be a GP migration to areas with health insurance funding and the availability of good care would travel inversely with the need for it.

The alternative to an increase in state sponsored healthcare would be to make health insurance mandatory and to provide subsidies for this. But one of these options needs to be put in place.

- In order to achieve a genuine transfer of care from the less efficient hospital sector to the primary care sector, any increase in cover should made compulsory for all health insurance plans, and should be part of the minimum benefits. Primary care is an essential part of our healthcare system, and should be treated as such.

- Within the current healthcare system, we feel that cover for primary care is best suited to be included as part of every insurance plan, and not seen as a separate entity. The 1996 legislation for minimum benefits includes provision for services from blood test and X rays to coronary artery bypass surgery. Primary care is the cornerstone of healthcare in the country and should be included in these provisions as a routine.

Should a system of universal mandatory health insurance be in place, however, separating the insurance plans may be beneficial. In this scenario, which would be more equitable for the entire population, it may be easier to fully appreciate the more efficient and better value nature of healthcare in primary care. This could result in a lower cost for all.

- Payments may be supplemented by a modest copayment or deductible. These would act as a barrier to over-demand both on the part of the GP and the patient. It is vital, however, that these payments reflect the overall cost of the procedure or consultation - if a procedure is done in a GP surgery for a lower cost, it should be cheaper for the patient than if the procedure is done in a more expensive hospital setting. Patients, as well as insurers, should be saving money by using primary care services. This would help to encourage patient use of primary care services. It is also important to keep co-payments low so that primary care is price accessible to middle income families, aiding the transfer of care from hospital to primary care.

It may be reasonable to insert a maximum number of visits allowable per year, but care would need to be taken that this is not done at the expense of provision of care to those with long term chronic diseases. It is in these individuals that frequent and regular attendance to their GP would result in the greatest benefit to
the healthcare system in general by preventing complications and hospital admissions. Any disincentive for these individuals to attend their GP should be avoided. A list of conditions could be compiled which would increase the maximum number of allowable visits to, say, 20. This would include conditions such as Type 2 Diabetes, COPD, asthma, heart failure, dementia, etc.

Easy access to an electronic database, linked with the practice software, would be needed in order to give information on the number of visits left available to a person.

- Measures such as “free” health care to large numbers of the population, without a subsequent increase in investment in primary care and its facilities, will simply increase the volume of consults at primary without having an impact on the transfer of services from the hospital setting. Investment in facilities to perform many hospital services such as subsidised minor surgery kits, ease of access to allied health professionals such as physiotherapy and speech and language and ease of access to radiology/other diagnostic tests would all aid the transfer of services. In general, incentives for GP’s to take on hospital services, rather than just patients, need to be put in place. This would mean a proper fee per special item system on the public system (rather than the hugely outdated STC system) and the opening of health insurers to provide funds to primary care.

Another, simple way of improving transfer of care from hospital to primary care would be to increase the accessibility of senior specialist colleagues to general practice. If good advice could be gotten quickly, with proper support, there would be less need for patients to have to enter the hospital system at all. This may involve the employment of hospital consultants to do phone or virtual clinics. This may be state or privately funded.

Traditionally, dealing with individual GPs might result in quite high transaction costs for the insurer. However, quite highly developed secure IT systems are present in almost all GP surgeries presently and these should be utilised to create an efficient, nationwide billing process which would be incorporated into practice software. This would bring down transaction costs substantially.

A nationwide electronic method of checking a patient’s insurance status would also be beneficial.

The rollout of information technology for health insurance purposes may be used in order to drive quality, real-time medical records and information sharing between primary and secondary care. This collaboration is needed for care to be delivered in the simplest and most cost effective manner.

These things would not be free, and may well be more expensive to establish initially, but will produce huge saving and a much more efficient health system in the long term.

- In our experience, the capacity does exist within GP practices currently to take on these roles. As time passes, individual GP practices will continue to develop special
areas of interest, such as sports medicine, women’s health, minor surgery, etc to accompany their general practice. This will create an even more efficient system with time, and allow for more capacity within the system.

In summary, we feel that health insurance funding can lead to a better health service in Ireland. This can be achieved if funds are directed to where they will be used most efficiently such as primary care. This will create a virtuous circle of greater retention of skilled GP’s, better quality GP care, greater availability of community services and more utilisation of these services by the public rather than expensive hospital based care.

References