# THE ECONOMICS OF COMPETITION IN HEALTH INSURANCE-

# THE IRISH CASE STUDY.

**Trinity Economic Paper Series**

**Paper No. 2000/9**

**JEL Classification: L82**

**Sean D. Barrett, Ph.D, FTCD,**

**Department of Economics,**

**Trinity College, Dublin.**

**Acknowledgements**

The views expressed in this paper belong to the author and do not necessarily reflect the views of the Department of Economics, TCD.

## I INTRODUCTION.

In the White Paper on Private Health Insurance (WP) in 1999 the Government of Ireland decided against competition among the providers of private health insurance. This paper reviews the economic aspects of the decision to forego in health insurance the normal benefits of competition such as the stimulus of new market entrants, competitive pressures to reduce costs and the needs to respond to consumer preferences and to innovate.

## II THE CASE AGAINST COMPETITION

The introduction to the White Paper notes that in submissions "widespread support was expressed for the core principles of community rating, open enrolment, and lifetime cover." (WP,2).

Lifetime Community Rating requires the same premium regardless of age, gender, sexual orientation or current or prospective health status. This requirement is enforced under the Health Insurance Act, 1994. The White Paper states that "community rating is the corner-stone of the Irish health insurance system. In the absence of community rating, today's healthy individual could become tomorrow's uninsurable risk..... In particular, the intergenerational solidarity which is at the very core of community rating in Ireland has made insurance accessible to those( i.e. the elderly and chronically ill) who might not be able to afford the cost of cover." (p.33). The reference to the elderly and chronically ill must be qualified however. O"Shea (1999) notes that private long-term care insurance is currently not available in Ireland." (p.5)

Community rating depends, however, on younger members joining the health insurance schemes in order to provide the resources from which cross-subsidisation may take place. The White Paper proposes a maximum premium loading for those who join a scheme in middle age or later. The loading ranges from 10% for those joining at ages 35 to 44 to 80% for those who join at age 65 or over. In addition the White Paper allows 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" ( WP,35).

Community rating is further eroded in the White Paper by the provision to increase from 21 to 23 years the upper age for reduced premiums for students. On the other hand the White Paper rejected a proposal to charge lower premiums to non-smokers. "It was considered that this could have undermined the community rating system. In addition, issues relating to effectively implementing such a measure and technical difficulties in relation to risk

equalisation were identified." (WP, 36) The White Paper states that " any loading for smokers would be unlikely to impact on 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."

Open enrolment is currently subject to moratoria on payment of benefits for specified periods following first enrolment as well as in respect of claims arising from a condition that existed prior to enroling. The general moratorium or waiting period is currently 26 weeks. In the case of maternity and a person over 55 at the age of enrolment the initial waiting period is 52 weeks. The White Paper recommends extending the initial waiting period to 104 weeks for persons aged 65 or over. The permitted waiting period is not more than 5, 7 or 10 years on payment of benefit for treatment arising from a pre-existing condition where the age of enrolment was respectively under 55, between 55 and 60 and between 60 and 65. The White Paper extended the entitlement to cover under open enrolment provisions to persons aged 65 and over with a maximum waiting time period of 2 years and a waiting period in respect of pre-existing conditions at the existing maximum of ten years.

Lifetime cover provides that as insured persons gets older, their health deteriorates or they sustain a serious injury their health insurance cover may not be terminated by the insurer.

In addition there is a prescribed minimum benefit of 100 days in-patient treatment in a private psychiatric hospital during a calendar year. The White Paper notes that one insurer provides for cover up to 180 days.

The remaining part of the policy environment for commercial insurance in the White Paper is loss compensation or risk equalisation. The White Paper defines risk equalisation as "a process which aims to equitably neutralise differences in health insurance 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." (WP, 41).

Given the other parameters within which the health insurance market is required to operate why is the additional constraint or safeguard required? The White Paper states that " 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" (WP, 41).

The case made in the White Paper is that " any process, whether deliberate or accidental, which gives rise to significant differences in risk profiles" would cause per capita claims costs to spiral for insurers 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." (WP, 41). Competition in the health insurance market would be restricted to "distribution, brand customer responsiveness, product innovation, claims management, purchasing efficiency and administrative efficiency." (WP, 42).

The Government's risk equalisation proposals are due to come into force in June 2002. They will be implemented by equalising casemix index scores within each age and gender category. Casemix is a measure of the relative resource intensity of a group of claims. The number of claims in each category is multiplied by a weighting factor which indicates its relative cost. The White Paper's prescribed minimum equalised benefits are based on VHI schedules because they represented established market practices at that time."

## III THE DEVELOPMENT OF PRIVATE HEALTH INSURANCE IN IRELAND.

The Voluntary Health Insurance Board was established in 1957. Its purpose was to provide insurance for health services for the richest 15 per cent of the population who were not entitled to free public hospital services. In 1979 the top income group became eligible for free hospital accommodation and in 1991 this was extended to hospital consultant services. Membership of VHI has increased from 288,496 in 1968, ten years after its foundation, to 697,346 in 1979, 1,289,262 in 1991 and 1,464,757 in 1999. In the year ended February 1999 VHI had subscription income of £343m and accumulated reserves of £87m. (WP, 80).

The extension of full eligibility for the public health services to the richest 15% of the population in 1991 was a regressive measure. The Household Budget Survey 1994-1997 indicates that the richest third of households spend ten times as much on health insurance as the lowest income third. Only at the seventh decile does private health insurance expenditure exceed the average over all households. The benefits sought by the state from community rating in the Irish health insurance market are therefore heavily skewed up in the income distribution scale. The market being regulated is a discretionary one in a system where all persons, no matter how high their incomes, have full eligibility for hospital and consultants' fees.

The private health insurance market was opened to competition by the Health Insurance Act, 1994. In 1999 there were 1.556 million members of private health insurance schemes, of which 1.465m were in VHI, giving it a 93.6% market share. There were three

group schemes for the Gardai, Prison Officers and ESB staff. The only competitor in the general health insurance market was BUPA with an estimated 2% market share.

The cost of VHI premiums rose by 91% between 1990 and 1999 (WP, 81). The increase in gross current expenditure on the public health service from £1.4b in 1990 to £4.3b in 1999 was 207%. The increase in the consumer price index over the same period was 24%. Ireland thus has serious problems of cost escalation in the public health service.

The increase in gross current public health expenditure in the 1990s was 2.3 times the increase in VHI premiums which in turn rose by 3.8 times the consumer price index. The basket of goods and services covered by VHI differs from those provided by the exchequer funded health services. The increase in VHI premiums is transparent in members' bills whereas the more rapid escalation in the cost of the public health service is obscured in the public mind by the huge revenue buoyancy in the public finances in the second half of the 1990s.

The administration cost of VHI is 6.7 per cent of premium revenues (WP, 81). The potential gains from competition in respect of administration cost savings is therefore small. Despite operating in a health sector with rapidly escalating public health service costs VHI has managed to restrict the growth of its premiums to 44% of the rate of increase in public health service costs. On the other hand the VHI premium increase was 3.8 times the increase in consumer prices indicating scope for a better price performance by a new entrant.

VHI is controlled by the Department of Health which also regulates the market in health insurance and controls prices in the public sector. The White Paper proposes to remove VHI from the province of the Department of Health and to have a Health Insurance Authority to regulate the sector.

## IV GOVERNMENT INTERVENTION IN THE MARKET FOR HEALTH SERVICES.

Government intervention in the market for health services in Ireland is a large and rapidly increasing part of the national budget. Implicit in that policy is that, left to themselves, people would spend too little on their health. The White Paper estimates that approximately 75 per cent of health services expenditures are publicly funded. "The remaining 25 per cent comprises expenditure by private health insurance undertakings and private spending by households" (WP, 11). The composition of the latter is 17 per cent spent by households and 8 per cent spent by private insurance companies. (O'Rourke, p.1)

The reasons why, in the absence of government intervention, individuals might spend too little on their health services include factors such as;

(a) ignorance of the costs and risks involved

(b) the existence of spillover benefits or externalities to society as a whole from the doctor-patient transaction; and

(c) the inability of low income persons to afford health expenditures (Buchanan, 1966).

The contrary arguments are that the problem of ignorance is best dealt with by the supply of information rather than by public provision. It is also maintained that the spillover benefits from health expenditures are in fact small and that the benefits overwhelmingly accrue to patients rather than to society as a whole. The inability of low income persons to afford healthcare could also be tackled by programmes of income distribution designed to benefit low income as a whole (Allan,C, 1971, 114).

In 1973 the International Economics Association examined a number of causes of the rapidly rising cost of healthcare such as:

(a) the increase in medical expenditures rather than changes in diet, exercise and other aspects of lifestyle;

(b) the moral hazard factor caused by both social and commercial insurance finance of health services;

(c) the ability of producers of medical services to determine both the demand for, and supply of, healthcare services; and

(d) the poor measures of outcomes of health expenditures (Perlman,1974).

Tussing (1985) found several of the above factors significant in his examination of Irish healthcare expenditures. There was a heavy emphasis on hospital rather than primary healthcare expenditure. Tussing recommended free general practitioner services for all and charges for outpatient and inpatient services to reflect social priorities in favour of primary healthcare. He favoured group general practice as a way to reduce referral rates to hospital by general practitioners. Tussing proposed medical audit to examine differences in healthcare costs for similar conditions and outcomes.

Tussing also recommended capitation rather than fee per item systems of payment and the establishment of pre-paid group plans (PPGPs) or health maintenance organisations (HMOs) as an alternative to both commercial and social insurance in order to give doctors an equity stake in low cost treatments.

The Commission on Health Funding found that " the major attraction of the HMO is that the individual making the resource-using decision is either an owner or an employee of

the organisation which bears the resultant cost. Consequently, preventive care is emphasised; medicines, X rays and tests are not ordered unnecessarily; and, although studies show that patients in those plans have as many, or more, visits to the doctor as under traditional models, they typically have less hospitalisation . This has been found to be the principal reason for the savings which are estimated at 10-40 per cent on traditional models" (CHF,101).

There has been a large increase in employment in the Irish health service in recent decades. The White Paper estimates that there are currently over 75,000 employees in the service. This compares with 43,000 in 1975, 58,400 in 1990, and 65,800 in 1996. Nurses in 1996 were the largest single category of employees in the health service, accounting for 41 per cent of all staff. The Irish ratio of nurses to hospital beds for example, in 1987 was 1.2. This compared with 0.5 in Belgium, 0.45 in Germany, 0.55 in France, 0.47 in Spain, 0.91 in New Zealand and 0.69 in Britain. (OECD,1990, Table 46). The number of nurses in Ireland increased by a further 9 per cent between 1987 and 1996 while the number of beds remained constant.

OECD studies indicate that the Irish healthcare system is heavily based on hospitalisation. The estimate for 1983 is that Ireland spent 73.4% of its public health care expenditure on institutional services compared to an OECD average of 54.4% and 59.7 per cent in the United Kingdom (OECD, 1990, 33). In 1982 the hospitalisation rate in Ireland was 17.6 per cent compared to 12.7 per cent in the United Kingdom (OECD, 1985, 15). Britain's share of its population over 65 years is 40 per cent higher than the share in Ireland. Since 15.5 per cent of the population of Britain is over 65 years compared to 11.0 per cent in Ireland (OECD, 1990, 88) one would expect hospitalisation rates in Ireland to be significantly lower than in Britain rather than 38 per cent higher as in 1982. The cost of health services by age is illustrated as a U-shaped curve with higher health expenditures by the young and the old than by the 16 to 44 age group. For example United Kingdom data for the three years to 1998/1999 indicate that expenditure on the hospital and community health services was lowest in the 5 to 15 age group. Expenditures per head on the over 85, 75 to 85 and 65 to 75 age groups were, respectively, 7.4, 4.7, and 1.4 times the expenditures on the age group 16 to 44. The problem of a relatively young population and a relatively high cost health service is shared by Ireland and the United States whereas Sweden, Norway, Denmark, Germany and the United Kingdom have a relatively large number of older people in their populations (Jonsson, OECD, 1990).

O'Hagan (1984) found that the cost per hospital bednight increased from 3.386 to 6.929 times GDP per head in Ireland between 1966 and 1979. The cost ratio increase of

104.6 per cent compared with 107.8 per cent in Germany, 81.1per cent in Britain,71.8 per cent in Sweden, 65.8 per cent in the United States and reductions in the cost ratio in Australia, Austria, and Finland. Inpatient price indices for the years 1960 to 1983 show the Irish increase, at 20.3 times compared to 10.9 in the United Kingdom and 9.3 for sixteen countries. Only Italy at 21.7 exceeded the Irish inpatient price index growth. (OECD, 1990).

In addition to meeting 75 per cent of the total health bill the government in Ireland provides assistance to private health expenditures. The White Paper lists the most prominent incentives by the State to private health insurance as tax relief on health insurance contributions, public hospital charges to private patients at below the economic cost and the bearing of costs by the state in relation to accident and emergency services, national and tertiary specialities and professional training (WP, 75).

The White Paper estimated the cost of private health insurance tax relief in 1999 at £62m. (WP, 24). The private hospital sector provides 2,500 private and semi-private beds compared to 2,500, also designated as private beds in public hospitals, some 21 per cent of the total beds in public hospitals. The White Paper estimated that there was a subsidy of £35m to private patients in public hospitals because " 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." (WP. 25). The White Paper states that " the Government will therefore make arrangements for the phased introduction of economic pricing over a period of 5 to 7 years." (WP, 26).

Of the 12,292 beds in public acute hospitals 21 per cent are designated private beds and 6 per cent are non-designated. No charge is made for these " non-designated" beds to private patients according to the White Paper " 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." (WP. 26).

Of 1,208 medical consultants, only 250 or 21 per cent are entirely in private practice. The White Paper states that the fee per item system of paying consultants in public hospitals in respect of their private patients compared to salary in respect of public patients suggests that " a stronger incentive exists for those consultants who are significantly involved in private practice to devote 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." (WP, 13). The contrary point is, of course, that

all taxpayers have contributed to the public health service and have thus a call on it when private hospitals find it too expensive to provide certain services.

The White Paper indicates, therefore, that the stand-alone private sector in the Irish health services is relatively small and that there is a complex relationship between public and private sector costs in public sector hospitals.

## V GOVERNMENT INTERVENTION IN THE HEALTH INSURANCE MARKET.

The White Paper gives the reasons for government intervention to increase consumer expenditure on private health insurance as follows:-

(a) individuals taking responsibility for meeting the cost of their own healthcare displaces demand that would otherwise fall on the public health system.

(b) private health insurance provides facilities to meet a burgeoning demand for acute care.

(c) private health insurance is affordable and accessible because of community rating and open enrolment (WP, 23)

Research by VHI and the ESRI indicates that consumers buy private health insurance for the following reasons;-

(a) protection against large hospital/medical bills

(b) peace of mind about healthcare needs

(c) faster access to hospital beds/avoidance of waiting lists

(d) option of private/semi-private accommodation. (WP, 23).

While the White Paper presents community rating, open enrolment and lifetime cover as the values underpinning the health insurance market O'Connor (1999) presents a less benign view. "The VHI, as a monopoly, was free to choose how to levy its members to cover its claim cost, and naturally, chose the administratively simple route of open enrolment and lifetime cover. That such features, with minor modifications are now deemed prerequisites of a competitive private medical insurance market speaks volumes for the sheltered evolution of the Irish approach to financing health care!" (p.3).

O'Connor also states that, with the option of open enrolment, many potential members may choose to replace promises with personal savings. As they age, they have both saved resources and the same promise as all other members. The benefits from private health insurance are of the hotel type i.e. accommodation and food benefits. As O'Connor emphasises " catastrophic risk is, of course, covered by universal public health access."(p.4). In the health insurance sector " service provision is focused on improvement in choice, access or comfort, rather than the provision of "All Up" healthcare."

Durkan (1999) contradicts the White Paper statement that " patients availing of private hospital services have always been seen as availing of an alternative service to the public system."(p.12). He says that the sentence is simply wrong. "Patients who opted for private treatment in public hospitals were not availing of an alternative treatment service- they were availing of the same treatment service, but getting it earlier, and having a variable accommodation service. This was and is a major feature of Private Health Insurance- it provides resources for queue-jumping." (p.4). One policy in Britain offers the patient the option of either private care or a cash payment of £250 per night spent in a public hospital with the choice being made at the time of hospitalisation (Norwich Union, 1999).

O'Rourke states that in Ireland "the vast majority of private medical insurance claims are not for major amounts"(p.2) and that private medical insurance funds only 8.1% of healthcare expenditure in Ireland.

Government policies to restrict competition in the market for health insurance in Ireland seem therefore to lack an economic rationale. The protected sector provides some benefits which are private goods such as perceived greater comfort and peace of mind and one benefit, the ability to jump the queues, which might be claimed to be a social cost rather than a social benefit. It is also of note that while the protected private health insurance market covers some 42% of the population it contributes only 8.1 per cent of the costs of healthcare in Ireland.

The White Paper relies, inter alia, on an OECD assessment of the Irish mixture of public and private healthcare in 1997 to support its policy stance. The OECD acknowledged Ireland's "unique mixture of public and private care" as "having achieved a good provision of healthcare at relatively low cost to the taxpayer." (WP, 14).

The OECD noted that a significant private health sector had developed alongside the public sector; that a significant number of people stay in the private system thus relieving the cost of hospital care to the public finances; that working in public hospitals remains attractive to consultants; and that older people remain in the system because health insurance premiums do not vary with age." However the OECD also noted "problems in managing the complicated interface between the public and private provision of medical care." The problems cited include defining the expected commitment of consultants to both sectors; putting charges for the use of public hospitals on a more economic basis and the need to avoid high risk groups being pushed into the public sector. (WP, 14).

Three years later the OECD report appears complacent about the provision of healthcare at a relatively low cost to the taxpayer. Public health spending has increased by 52 per cent, comprising almost 30 per cent in 1998 and 1999 (WP, 27) and 17 per cent in 2000

thus weakening the OECD argument. An earlier study by Schieber and Poullier found that over the 1975-1987 period the elasticity of per capita health care expenditure relative to GDP was 1.5 in Ireland, 1.3 in the OECD as a whole and 1.1 in the United Kingdom.

While a significant number of people have private health insurance their contribution to the health service costs is less than a fifth of their share in the population. The benefits to society as a whole from the policy are not obvious in the case of private benefits such as comfort and peace of mind and open to question in the case of incentives to jump health service queues.

## VI COMPETITION IN HEALTH INSURANCE AND HEALTH SERVICE EFFICIENCY.

The interaction between efficiency enhancing proposals such as those by Tussing and deregulation of the health insurance market is an important one. Competition in health insurance might increase total costs if it increased the administration and marketing burden. There might be little impact if the present pattern of healthcare expenditure were financed by two rather than one health insurance company. On the other hand competition in health insurance might stimulate some improvements in resource allocation in the Irish healthcare system. The reduction in hospitalisation rates and hospital unit costs, the substitution of primary care for hospital care, the substitution of capitation payment of doctors for fee per item payments, and incentives to patients to avoid the harm to health caused by factors such as smoking, excess alcohol consumption, and disregard of safety at work, on the roads and in the home, might be some of the results which would flow from the introduction of competition if the insured persons shopped around for better value. The Commission on Health Funding (1989) found that " the introduction of general insurance companies to the private healthcare market in the United Kingdom since 1980, in competition with the long-established provident associations, has led to innovations such as non-smoker discounts, no-claims bonuses, discounts where the consumer pays a percentage or an initial amount of each claim, and in one case, full cover for the use of approved preferred hospitals but only partial cover for the use of other hospitals." (p.130)

The competition proposed by the White Paper is limited to the following areas:

Distribution, Brand, Customer Responsiveness, Product Innovation, Claims Management, Purchasing Efficient and Administrative Efficiency. (WP, 42). Some of these non-price types of competition would increase costs. Nonprice competition in aviation, for example, led to high costs expensive brand-imaging, service competition in terms of seat pitch and food and drink on offer, decor of aircraft, expensive forms of retailing, and frequency of service with low load factors. Similarly in banking the absence of price competition led to service competition with an increased number of branches.

The White Paper rules out the targeting of low-risk individuals and incentives to change the conduct of either the individuals insured or the medical sector. A major complaint by BUPA against the White Paper is that it prevents them from changing the incentive structures for both patients and producers which have pushed up costs.

The improvements which BUPA wishes to make which would be negatived by risk equalisation as proposed by the Irish government include the following;-

(a) Insurers encouraging people to stay healthy, through screening, preventative programmes and better systems of managed care;

(b) Insurers who have shorter lengths of hospital stay;

(c) Insurers who encourage day care rather than inpatient care;

(d) Insurers who encourage people to use alternative medicines; and

(e) Insurers who choose drugs rather than invasive surgery(O'Rourke, 1999).

The context of risk equalisation in Ireland is one in which everyone is covered for hospital and consultant costs. Government interference in the market for health insurance is thus concerned with bypassing queues and accessing the hotel aspects of hospitals such as perceived differences in food and room furnishings. VHI itself cross subsidises its high cost plans from its basic product. VHI has a 91 per cent market share in Irish health insurance, thus making it impossible for BUPA or possible other new entrants to cross-subsidise such a market dominant company. The benefits of risk equalisation are nil but the cost in deterring new entrants and preventing efficiency improvements are considerable.

The White Paper recognises the inefficiencies inherent in the risk equalisation policy it proposes. The White paper states that " the regulations will also be examined and discussions held with insurers with a view to avoiding situations where an 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 in a local surgery." (WP, 57)

While supporting "steps to promote the position of primary care in the system" the White Paper paradoxically states that " a compulsion 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."(WP, 58)

O'Connor states that a further difficulty is that the risk equalisation scheme " does not discriminate adequately between artificial cost savings caused by benefit restrictions and genuine cost savings caused by negotiation of supplier discounts etc." (p.6).

The White paper notes that " a significant number of people subscribe to plans which provide benefits in the nature of cash payments rather than indemnity", in respect of hospitalisation, specific diseases, major surgery or other health related incidents. (WP. 61). The White Paper states that experience elsewhere indicates that such cash plans are " a potential threat to indemnity health insurance business." In a further move to restrict competition the White Paper states that "the Government will keep under review the question of whether they (cash plans) should be subject to requirements imposed on indemnity-based health insurance contracts." (WP, 61).

## VII THE POTENTIAL FOR COMPETITION IN THE IRISH HEALTH INSURANCE MARKET.

The Indecon Report found that in Ireland in 1997 had the least competitive health insurance market in sixteen countries examined in the EU plus Australia and New Zealand. In Ireland, the market share of the largest producer of private health insurance was 91.3 per cent compared to 42.2 per cent in the UK, an average of 31.7 per cent in the sixteen countries and low market leader shares of 9 per cent in the Netherlands, 11.1 per cent in Italy, 16.0 per cent in Sweden, 16.9 per cent in Germany and 17.2 per cent in France. The most competitive health insurance market s were the UK and Spain. The UK had 81 companies in the health insurance market. (p.62).

Indecon sought the views of 28 foreign health insurance companies on competition in the health insurance market and their potential interest in the Irish market and ten replied. The important factors associated with competition according to these health insurance companies were reduced cost and product innovations which 60% rated as very important (Indecon,34).

An assessment of the impact of competition in the health insurance market in Ireland by the Consumers Association of Ireland found that " BUPA is cheaper at the lower end of

the market while VHI charges less for Plan E, its top of the range policy. A core difference between the two is in their attitudes to health. BUPA has a broader perspective, covering preventative healthcare and alternative medicine which may be more attractive for younger subscribers. ..... VHI, however, wins hands down for its support and information network that spans the country and offers a wider range of consultants and hospitals." (Indecon, 80).

## VIII CONCLUSION.

Ireland has an expensive healthcare system and its costs have increased by over 50 per cent in the last three years. Its costs are disguised by the tax buoyancy of the exchequer during the present period of unprecedented growth and the low dependency ratio of the population in Ireland compared to other European countries. Productivity in the Irish system appears low and the extent of fee per item payments has been a cause of concern elsewhere. Price incentives favour hospital rather than primary healthcare. While 42 per cent of the population have private healthcare insurance the sector bears only 8 per cent of the country's health expenditures. The market in which the White Paper seeks to restrict competition is a relatively small market in

hotel-type services and queue-jumping but in doing so the prospect of competition in the provision of health services is precluded.

The weak form of competition proposed by the White Paper for health insurance sector is unnecessarily harsh on new entrants. It protects the 93.6% dominance of VHI, which heretofore has enjoyed a monopoly maintained by the sole shareholder, the Minister for Health. The risk equalisation scheme should not have been added to the lifetime enrolment, open membership and community rating requirements already in force. To require the only new entrant, BUPA, to make compensation to an incumbent thirty times its size is a huge barrier to competition. The normal market leader in health insurance markets has about a third of the market. To permit only service competition is likely to increase costs compared to a system of price and product competition. It is also inefficient that community rating is protected even to the extent that discounts for non-smokers are not allowed.

## References


Allan,C. (1971), The Theory of Taxation, Penguin.

Barrett, S. D. (1979) Social and Economic Aspects of the Health Services, Irish Banking Review, March.

Buchanan, J..M., (1966), Inconsistencies in the National Health Service, London, Institute of Economic Affairs.

Commission on Health Funding (1989), Dublin, Government Publications.

Cullis,J.G., and West, P.A., (1979), The Economics of Health, Oxford, Robertson.

Culyer,A.J. (1976), Need and the National Health Service, London, Robertson.

Culyer, A.J. (1980), The Political Economy of Social Policy, Oxford, Robertson.

Department of Health and Children (1999), Health Statistics, Dublin, Government Publications.

Durkan,J. (1999), Compulsory Health Insurance- The Next Step, Dublin Economics Workshop Kenmare Conference,October.

Government of Ireland (1999), White Paper on Private Health Insurance, Dublin.

Indecon (1998), Assessment of the Potential Impact of Competition in the Irish Health Insurance Market, Dublin.

Jonsson, B., (1990) What can Americans learn from Europeans? in OECD, Health Care Systems in Transition, Paris.

Mooney, G. (1992), Economics, Medicine and Health Care, London, Harvester.

O'Connor R. (1999), Risk Equalisation and Health Insurance, Dublin Economics Workshop Kenmare Conference, October.

OECD (1985). Measuring Health Care 1960-1983, Paris

OECD (1990), Health Care Systems in Transition, Paris.

O'Hagan J.W. (1984), Components of the Growth in Current Public Expenditure on Education and Health, Economic and Social Review, January.

O'Rourke, M., (1999), The White Paper on Health Insurance, Dublin Economics Workshop Kenmare Conference, October.

O'Shea, E., (1999), Ageing, Caring and Sharing; Funding Long-Term Care in Ireland, Dublin Economics Workshop Kenmare Conference, October,

Perlman, M., (1974), The Economics of Health and Medical Care, London, Macmillan.

Schieler,G., and Poullier, J.P., (1990) Overview of international comparisons of health care expenditures, in OECD (1990) op. cit.

Tussing, D., (1985), Irish Medical Care Resources: An Economic Analysis, Dublin,

Economic and Social Research Institute.

Wiley, M., (1998), Health Expenditure Trends in Ireland, Past, Present and Future, in Leahy, A., and Wiley, M., The Irish Health System in the 21st Century, Dublin, Oak Tree Press.