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Unwinding the State subsidisation of private health insurance in Ireland

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ABSTRACT

Ireland's private health insurance market provides primarily supplementary health insurance for hospital services, operating alongside a public hospital system to which residents have universal access entitlements, subject to some copayments for those without a medical card. The State subsidises the purchase of private health insurance through measures including tax relief on premiums and not charging the full economic cost for private beds in public hospitals. Furthermore, privately insured patients occupying public beds in public hospitals did not, until 2014, incur charges for such accommodation, apart from modest statutory charges. In the Budget in October 2013, a number of measures were announced that began to unwind these subsidies. Although it was initially feared that these measures would add to premium inflation, leading in turn to further discontinuation of health insurance, the evidence suggests that premium inflation has eased and take-up has stabilised, although some of this may have been due to the introduction of lifetime community rating in May 2015. Nevertheless, it would appear that the restriction on the subsidisation of private health insurance has not had a significant adverse effect on the market, while it has reduced an inequitable cross-subsidy.

1. Introduction

The Irish health system contains a complex mix of public and private financing and delivery mechanisms, with significant overlaps between them. Many of these have developed over time rather than resulting from strategic planning.

Private health insurance has been a feature of the Irish health system since 1957 and is currently held by nearly 44 percent of the population [1]. Private patients may be treated in private hospitals (if their policy covers such hospitals) or in public hospitals, where, until the end of 2013, 20 percent of beds were designated as private beds, although some private patients were accommodated in public beds. Take-up of private health insurance is subsidised by the State in a number of ways, including the availability of tax relief on premiums and the fact that insurers are not charged the full economic cost of private beds in public hospitals, and, until 1st January 2014, only paid the statutory bed charge (currently €75 per night up to a maximum of €750 in any continuous 12-month period) if one of their members was accommodated in a public bed.

The current Government has committed to ending the two-tier nature of the health system, which favours privately insured patients at hospital level, and introducing universal health insurance if elected for a second term.[1] As part of the move towards the first goal, two measures were

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[1] The proposals for universal health insurance initially envisaged this being in place by 2016, but this timescale was later pushed back to 2019

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announced in Budget 2014 (delivered in October 2013), which affected the private health insurance market. The first is the capping of tax relief on premiums, while the second is the introduction of charges for the use of all beds in public hospitals by privately insured patients.

This paper examines the background to these measures and assesses their early impact on the private health insurance market in its current form, bearing in mind the Government's plans to introduce universal health insurance. Section 2 sets out the background to the Irish health system; Section 3 examines the reasoning for the unwinding of the State subsidies for private health insurance; Section 4 assesses the impacts of these measures on premiums and take-up, using data from the Central Statistics Office and the health insurance regulator; Section 5 draws conclusions.

2. The Irish health system

The Irish health system is predominantly tax funded, with contributions from out-of-pocket payments and private health insurance supplementing this measure. Figures for 2012 show that public expenditure accounted for 67.6 percent of funding, with almost all of this coming from taxation, while out-of-pocket payments accounted for almost 16.9 percent and private health insurance accounted for almost 13.4 percent (the remainder came from other sources, such as charitable donations.) [2]. However, these figures demonstrate a different pattern from earlier figures, largely due to a reduction in public expenditure on health due to recent austerity-related cutbacks in Irish government spending. For example, in 2008, private health insurance accounted for 8 percent of expenditure on health in Ireland, while taxation accounted for almost 77 percent [3].

Entitlements to health services in Ireland can be broken down into two categories. Those in Category I hold a medical card, eligibility for which is largely based on income grounds. Between 2001 and 2008 inclusive, there was universal eligibility for those aged 70 and over. Since 2009, eligibility for those in this age category has been means-tested, although the income thresholds for this age group are higher than for those aged under-70. Based on current population estimates, approximately 39 percent of people in Ireland hold medical cards [5,6].

Medical card holders are entitled to free GP care at the point of use, prescription drugs subject to relatively modest copayments (currently €2.50 per prescription item up to a maximum of €25 per family per month), free access to public hospitals for outpatient, inpatient, day case and emergency department treatment, and other less widely used benefits.

Those in Category II must pay out-of-pocket for GP visits, which typically cost around €50–55 [7] (although some people in Category II qualify for a GP Visit card, which entitles them to free GP care only – approximately 3.5 percent of the population have a GP Visit card [6,31]), must pay the first €144 per month of prescription drug costs, face a €100 charge to visit a hospital emergency department (this fee is waived if they have been referred by a GP) and a €75 per night bed charge in public hospitals, subject to a maximum of €750 in a continuous 12-month period.

Voluntary private health insurance is available in Ireland and anyone may purchase it. In practice, private health insurance is held by those in Category I as well as Category II, although take-up rates are lower for those in Category I [8]. The market has traditionally operated on the basis of community rating (everyone pays the same for the same plan, subject to exceptions for children aged under-18, full-time dependent students aged 18–23 and members of group schemes), open enrolment (insurers must accept any applicant, subject to some age-related maximum waiting periods) and lifetime cover (insurers may not refuse to renew cover).

Lifetime community rating was introduced on 1st May 2015, which mandates late entry loadings to be paid by consumers who take out health insurance for the first time (or after a break in cover of more than 13 weeks) at age 35 or above. However, measures were also introduced to standardise the maximum waiting periods irrespective of age, and to permit insurers to offer discounted premiums to young people aged up to 26.

Private health insurance in Ireland is primarily supplementary in nature,[2] conferring on those who hold it benefits such as faster access to hospital treatment, better accommodation (semi-private or private rooms, depending on level of cover and availability of such accommodation) and greater choice of provider (most plans available in the market cover private hospitals as well as public ones, although some plans only provide cover for public hospitals[3]).

In terms of faster access, figures from 2001 show that those with private health insurance were more likely to be waiting for shorter lengths of time for inpatient, outpatient and day case treatment than those without health insurance, and less likely to be waiting for longer. For example, the figures show that over 60 percent of those with private health insurance only, and over 70 percent of those with private health insurance and medical cards, had been waiting less than three months for inpatient treatment, compared with just over 36 percent of those with medical cards only and less than 31 percent of those with neither form of cover. Meanwhile, only 12.7 percent of those with private health insurance only were waiting longer than 12 months, compared with 25.3 percent of those with medical cards only and 38.5 percent of those with neither form of cover[4] [11]. There is also some evidence that private patients receive consultant-delivered care, while public patients sometimes receive consultant-led care [12].

and, more recently, the Minister for Health has suggested that even this timescale is somewhat ambitious [4].

[2] For a discussion of the differences between supplementary, complementary and substitutive care, see [9].

[3] Figures from the Health Insurance Authority show that, during the first half of 2014, the proportion of the insured population with non-advanced cover plans, which do not provide significant benefits in private hospitals, increased, but remained low at just over six percent [10].

[4] The sample size of those with both forms of cover waiting longer than 12 months was too small for the CSO to provide reliable estimates.