



IMO Position Paper on
**The Market Model of
Health Care**
–Caveat Emptor

April 2012

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IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Mission Statement

The role of the IMO is to **represent** doctors
in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,
efficient and effective Health Service.

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Introduction

Faced with spiralling costs of health care, policy makers are increasingly looking to competition in health care markets in an effort to increase efficiency and quality of care and drive down costs. However health care markets are imperfect markets and the consequences of free competition in health care can conflict with policy goals. Because of market failure and because health is a major political issue most governments intervene in health care markets. In reality most countries rely on different mixtures of market mechanisms and regulation.¹

Health care markets can be considered in the context of private health insurers competing for enrollees and private providers (hospitals and physicians) competing for both patients and contracts with insurers.

The Government is proposing major reform of the Irish health care system, based on the Dutch health system, with managed competition between public and private health insurers and between public and private providers. This Position Paper will examine the impact of the market approach in health care and some of the negative consequences of competition in both the private health insurance (PHI) market and the curative health care provider market which we believe policy makers should consider before embarking on major market reform. We look at the experiences of competition in the US, the largest health care market, the impact of managed competition in the Netherlands as well as our own experiences of health care markets in Ireland in order that we can learn from other systems and address the undesirable features in advance.

MARKET FAILURES IN HEALTH CARE

Health care as a commodity

As Woolhandler and Himmelstein² state, the market model brings health care into the realm of commerce where commodities or homogenous goods and services are bought and sold for a profit. However health care services are far from homogenous and differ vastly as do patients needs and preferences. In addition, the OECD³ point out that health care markets are subject to externalities, where the consumption of health products by an individual can have benefits for others, for example, the treatment of or immunisation against contagious disease. Conversely, as health care is generally a scarce resource the consumption of unnecessary health care interventions may delay treatment of, or divert resources from necessary treatment.

Information asymetries

Information is integral to well-functioning markets allowing buyers to shop around for the best value products and services, however, as Porter and Tiesberg⁴ point out, when patients purchase health insurance, they are often well and do not know what illnesses may affect them in the future nor what constitutes adequate coverage. When patients are ill they are often vulnerable and lack the necessary information to make informed decisions about their care. Patients rely on the medical profession to advise them on their illness and the appropriateness of their care.

Even for experienced purchasers such as the government or health insurance companies, health care services are difficult to evaluate again as they rely on providers to create the data used for evaluation and payment.⁵ Providers themselves argue that data on outcomes can be difficult to measure in ways that adequately reflect the complexity or severity of patients' initial conditions.⁶

1 Jourard I. André C. Nicq C. Health Care Systems: Efficiency and Institutions *OECD Economics Department Working Paper No. 769* 2010:27

2 Woolhandler S. and Himmelstein D. Competition in a Publicly Funded Healthcare System, *British Medical Journal* 2007: 335: 1126-1129

3 Jourard I. André C. Nicq C. *OECD* 2010 : 122

4 Porter M. E. and Tiesberg E. O. Redefining Competition in Health Care, *Harvard Business Review* June 2004

5 Woolhandler S. and Himmelstein D. 2007

6 Porter M. E. and Tiesberg E. O. 2004

Moral hazard

Patients base their beliefs regarding their health care requirements on multiple sources of information of varying quality. Patients who do not have to bear the full cost of medical care may be inclined to consume more care than is necessary knowing that their insurance company will pick up the bill.⁷ Similarly providers may tend to over prescribe care or treatment knowing that the patient's insurance will cover the cost. The market responds to the increased demand leading to a profusion of services many of which could be described as optional rather than necessary.

Access to care

Markets by their very nature favour wealthier individuals and thus in health care can accentuate health inequalities. Both complex medical care and PHI are generally unaffordable for population groups on low income and this requires the State to provide some sort of safety net.

Insurance companies can further restrict access to care through risk selection whereby insurance companies tailor packages and prices to attract healthier low-risk individuals while high-risk sicker individuals, particularly elderly and disabled persons, are priced out of the market. Community rating can prevent PHI companies from selecting healthier clients and risk equalisation mechanisms can compensate insurers with a higher risk portfolio, however even with the tightest regulation in place for-profit insurers will always have the incentive to select low-risk clients.

Health care markets can also lead to the under-provision of services to lower income groups. There is generally a higher prevalence of chronic conditions amongst lower income groups who are less likely to be able to afford adequate care. Market conditions can incentivise providers to locate in areas where potential clients are both healthier and wealthier.

Provider incentives / fee for service payments

Fee for service payments are often thought to be pre-requisite to competition in health care markets as they allow health services to be divided into discreet saleable units. However the fee-for service model creates a number of adverse incentives for providers:

First, the fee-for-service model is unlikely to lead to an overall reduction in costs as payments provide an incentive to over-treat, rather than to minimise treatment or to prevent disease.⁸ The volume of services is likely to increase particularly if the price goes down.

Second, fee-for-service payments can have unfavourable consequences if they do not adequately reflect costs. For-profit-providers tend to cherry-pick more lucrative cases leaving complex costly care to public or not for profit providers. At the same time inadequate payment can cause providers to skimp on care.⁹

Many states are looking to alternative payment models that promote better quality care and integrated care such as pay-for-performance and bundled payments.

Conflicting values of commercialism v. professionalism

Commercialism substitutes the doctor patient relationship with a provider-customer relationship and the goal of curing the patient is substituted with the goal of profit. Physicians are faced with a moral and ethical conflict between the needs of the patient and economic imperatives.

7 Joumard I. André C. Nicq C. OECD 2010 : 124

8 Porter M. E. and Tiesberg E. O. Redefining Health Care – Creating Value-Based Competition on Results, *Boston: Harvard Business School Press* 2006: 74

9 Porter M. E. and Tiesberg E. O. 2004

Commercial imperatives conflict directly with the internationally affirmed values of professionalism to which Doctors subscribe. Doctors are aware that health services are a limited resource and base professional judgements on clinical indicators and the availability of resources. The Medical Council *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* states that doctors have a paramount responsibility to act in the best interest of their patients and at the same time be aware of the wider need to use limited health care resources efficiently and responsibly. A commercial competitive environment will inhibit doctors from reaching value judgements which are not in the interest of the patient or the State.

Monopoly and monopsony power

A market approach to health care provision also increases administration costs in terms of billing, marketing, and the provision of data for risk equalisation or for quality purposes. When administration costs are high substantial economies of scale can be gained through increase of market share. Economies of scale in health care provision and purchasing mean that often larger players enjoy some sort of monopoly or monopsony power.

In the PHI sector, high fixed administrative costs and efficiency gains associated with risk-pooling can generate economies of scale¹⁰ for larger companies making it difficult for smaller insurers to compete. One or two major insurers in a market can use their purchasing power to restrict competition securing higher quantities at lower prices.¹¹

In the hospital sector, specialist services and geographic location can mean there is often little real choice of provider.¹² As a result of advances in health care technology hospital care is becoming increasingly more specialised. Many specialist services in hospitals require a minimum level of activity and patient throughput to both justify investment and to guarantee quality and patient safety from a clinical perspective. For the same reasons geographic areas with low population levels are unlikely to warrant the services of more than one hospital.

Barriers to entry and exit

Free markets assume that providers are free to enter and exit the market at will. In both health care provision and health insurance markets significant barriers to entry and exit exist.

The entry of health care providers is highly regulated to ensure quality of care. Also strict regulations usually exist for health insurers in terms of financial reserves. Both health care providers and insurers rarely fail are often financially supported as it is often politically difficult to close local hospitals or large loss-making insurers.

PRIVATE HEALTH CARE IN THE US

The US is the largest private health care market. Apart from the two main public health care programmes, Medicare and Medicaid, which are restricted to the elderly, disabled and certain low income groups, health care in the US is essentially private. In 2009, 194.5 million people (approx 64% of the US population) had some form of private health insurance purchased mainly through employer-based schemes.¹³ Health insurance companies are private entities that either operate on a for-profit or not-for-profit basis. Similarly most hospitals are private hospitals of which 15% are investor owned and operating on a for-profit basis.¹⁴

10 Joumard I. André C. Nicq C. OECD 2010 : 124

11 Smith PC. Preker AS. Light DW. Richard S, Role of Markets and Competition, in *Fiqueras J. Robinson R. Jakubowski E. Purchasing to Improve Health System Performance, WHO European Observatory on Health Systems and Policies* 2005; 102- 121

12 Joumard I. André C. Nicq C. OECD 2010 : 123

13 DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2009, U.S. Government Printing Office, Washington, DC, 2010.

14 Woolhandler & Himmelstein 2007

The market model of health care has failed to contain overall costs in the US, where health care expenditure per capita is more than double the OECD average, and health insurance is unaffordable for many people on low income. While competition has led to innovation and some care is excellent, quality of care is not consistent and overall outcomes are poor.¹⁵

Competition in the health insurance market restricts patient access and choice

In the US private health insurance is voluntary, reflecting a political culture that emphasises freedom of choice. Since the introduction of the first Group plan in 1929, private health insurance has mainly been employer-based. Americans receive generous tax benefits (up to €10,000 per annum is protected from income and payroll tax) if their employer purchases health insurance on their behalf.¹⁶ However, the system of employer-based health plans caters poorly for elderly, disabled people and low income groups, particularly the unemployed. Despite the establishment of the Medicare and Medicaid in 1965,¹⁷ 50.7 million people (16.7% of the population) are uninsured¹⁸ and a further large share of the population are under-insured.¹⁹ The majority of uninsured belong to lower income groups, are unemployed or are not offered insurance by their employer because the firm is too small or because they work part-time.²⁰

In principle, US citizens should be able to choose from a wide range of insurers and health care plans offering different payment mechanisms, coverage and quality; in reality, choice is restricted.²¹ Citizens are locked into health plans through their employment or are unable to purchase insurance in the individual market, because the cost is prohibitive or because insurers are able to decline customers perceived as high risk.

Access to affordable care is a major issue in the US and The Patient Protection and Affordable Care Act signed by President Obama in 2010 introduces a range of measures that aim to increase coverage to 95% of the population through an individual mandate and to protect patients from some undesirable health insurance practices such as cancellation or annulment of coverage or denial of coverage for those with pre-existing conditions.

Managed care was introduced in the 1990's in order to cut costs.²² Managed care took the form of Health Maintenance Organisations (HMOs) and Preferred Provider organisations (PPOs). HMOs generally provide care through their own hospitals and clinics and through physicians and nurses employed by the HMO while PPOs provide care through networks of contracted hospitals and doctors. Managed care requires patients to check with their health plan for approval prior to treatment and restricts patient choice to the HMOs or the PPO's network.

Competition in the provider market has failed to reduce overall costs or improve outcomes

In the US competition in the provider market has failed to improve efficiency, or quality, or reduce overall expenditure, because:

Administration Costs – It is estimated that 7% of health expenditure in the US is spent on administration costs (such as marketing or billing) although this portion is much lower in the Medicare Program (less than 2%).²³ In

15 Porter M. E. and Tiesberg E. O. 2006

16 Irvine B. Background Briefing on US Health Care, Civitas 2002

17 Woolhandler & Himmelstein 2007

18 DeNavas-Walt et al, U.S. Census Bureau 2010

19 OECD 2008, Economic Survey of the United States, 2008, *OECD Policy Brief*

20 OECD 2008,

21 Smith PC. Preker AS. Light DW. 2005

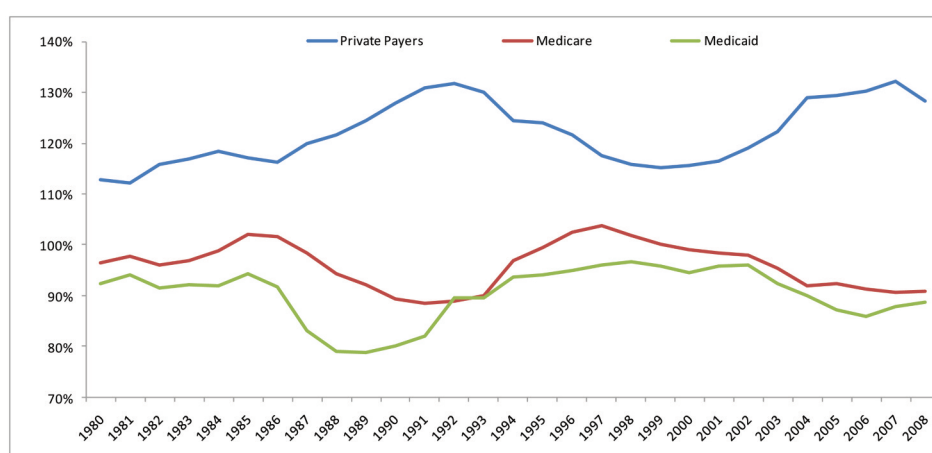
22 B. Irvine, Briefing Background on US Healthcare 2002 for Civitas Health Policy Consensus Group, downloaded from <http://www.civitas.org.uk/pdf/USABrief.pdf>

23 Kaiser Family Foundation, US Health Care Costs, Background Brief 2010 downloaded from <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx?p=1>

addition the high salaries of executives in for-profit companies drain money from care with for example, a pay gradient between the highest and lowest paid employees at Aetna health insurance company of 2000:1 compared to 15:1 in the US Government.²⁴

Monopsomy and Monopoly Power – Competition has led insurers and hospital groups alike to consolidate in search of greater bargaining power and, rather than creating efficiency and value for money, players use their bargaining power to shift costs.²⁵ From 1995 to 2006 there were more than 400 mergers in the health insurance market²⁶ and between 1996 and 2003 there were more than 850 mergers between hospitals.²⁷

Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

Porter and Tiesberg²⁸ and McKinsey Global Institute²⁹ have also highlighted the role of Medicare, the largest payer in the US market, in shaping industry pricing. Medicare uses a cost-based formula and updates prices by service and geography every one to five years. Medicare generally sets the benchmark price for a given procedure in a given location as well as playing a lead in the reimbursement of new procedures and new technologies. However trends in private payer levels are inversely correlated to Medicare pricing levels – when Medicare pricing slows private payer pricing accelerates implying that providers have significant influence in negotiating prices shifting costs to private payers when public payment growth slows.

Payment/ provider incentives: Fee-for-service payment requires providers to bear very little risk for adverse events and creates an incentive to provide more care and more profitable care.³⁰ Again McKinsey Global Institute³¹ show that the US provides a higher percentage of care on an outpatient basis than on an inpatient basis, accounting for 40% of overall expenditure. Fee-for-service payments again are the primary method for payment for outpatient care. While the shift to outpatient care is beneficial in terms of lower costs and quicker recovery times higher profit margins particularly for specialist care and diagnostic procedures has led to an increase in supply. In

24 Woolhandler S. and Himmelstein D. 2007

25 Porter M. E. and Tiesberg E. O. 2006 : 38-39

26 American Medical Association (AMA), Competition in Health Insurance – A Comprehensive Study of US Markets 2007 Update

27 Kaiser Family Foundation , Trends in the Structure of the Healthcare Market 2004 in Porter M. E. and Tiesberg E. O. 2006 : 38-39

28 Porter M. E. and Tiesberg E. O. 2006 : 37

29 McKinsey Global Institute, Accounting for the Cost of US health Care: A New Look at Why Americans Spend More, McKinsey and Company 2008

30 Porter M. E. and Tiesberg E. O. 2006

31 McKinsey Global Institute 2008

addition, while technological innovation in most other industries leads to more efficiency in health care, US providers can earn high prices for its use in outpatient settings.

Guterman³² examined two congressionally mandated reports into investor-owned specialty hospitals and found that specialty hospitals seem to treat less complex and more profitable cases and appear to avoid patients that are uninsured or underinsured. Woolhandler and Himmelstein³³ further point out that cherry-picking of more lucrative cases by investor owned hospitals threatens the profitability and institutional survival of community hospitals, which are left to cater for the acutely ill and the uninsured. In the past decade 425 emergency departments have closed and overcrowded emergency departments turn away on average one ambulance every minute.

Finally, the pursuit of profits can lead private companies to engage in unethical work practices. For example, the two largest private hospital firms in the US – Columbia/Hospital Corporation of America (HCA) and Tenet – have been accused of providing incentives to physicians for referrals and inflating medical bills to Medicare. Tenet has even been accused of performing unnecessary cardiac operations on patients.³⁴

Information asymmetry – In the US there is a severe lack of transparency in the cost and quality of care. While there is plenty of information available on health plan coverage and subscriber satisfactions surveys, there is little information available on outcomes, provider's experience in treating particular conditions or the number of patients treated, instead information is largely based on word of mouth.³⁵ In the absence of adequate information, patients may often assume that more care or care that is more expensive may lead to better outcomes.³⁶

Patient Choice – Lack of choice also prevents patient from shopping around. As mentioned above most patients are restricted to HMO or PPO networks of providers. Many hospitals also exercise monopolies as half of Americans live in regions too sparsely populated to enable any real competition.³⁷

MANAGED COMPETITION IN THE NETHERLANDS

In January 2006, major reform of the Dutch health system came into effect introducing compulsory private health insurance for all citizens and managed competition between health insurers. Insurers compete on price and quality of care and are allowed to selectively contract or integrate with health care providers. However, market reform of the Dutch health care system is still in progress. So far the Government has exercised a cautious approach to reform of the provider market and room for negotiation on cost and quality of care is restricted.

Fees for GPs and Specialists are still tightly regulated, although agreed prices are maximum prices and in theory there should be room to negotiate downwards.³⁸ The fee for the majority of hospital services is also fixed (Segment A) but a limited number of specialist hospital services are freely negotiable (Segment B). The number of freely negotiable Segment B services has risen from 10% in 2005 to 34% in 2009.

The majority of hospitals in the Netherlands are private not-for-profit entities. While there are signs that regulations may be relaxed, generally hospitals that provide inpatient care are not allowed to distribute profits. Only hospitals

32 Guterman S. Specialty Hospitals: A Problem or a Symptom? *Health Affairs* 2006; 25 (1): 95-105

33 Woolhandler S. and Himmelstein D. 2007

34 Woolhandler S. and Himmelstein D. 2007

35 Porter M. E. and Tiesberg E. O. 2006

36 McKinsey Global Institute 2008

37 Woolhandler S. and Himmelstein D. 2007

38 Schut F.T. and Van de Ven W.P.M.M. Effects of Purchaser Competition in the Dutch Health System: Is the Glass Half Full or Half Empty? *Health Economics, Policy and Law* 2011; 6: 109-123

providing ambulatory care alone are allowed to make a profit³⁹ including Independent Treatment Centres (ITCs) who are permitted to provide all health services in the B segment and all outpatient services in the A segment.⁴⁰

So far competition has failed to contain health care expenditure and has had little impact on quality of care. Health expenditure (health insurance premiums as well as income related contributions) continues to rise at a faster rate than inflation.⁴¹ Quality of care is generally high but improved performance seems to reflect pre-existing trends rather than increased competition.⁴²

Access and choice in the health insurance market

Social solidarity is central to Dutch health care politics and coverage in the Netherlands is universal. Just 1% of the 16.5million population are uninsured and a similar percentage are insured but have defaulted on payments.⁴³ Income related subsidies and strict regulation of the insurance market aim to make insurance accessible to all. Private health insurers must offer a state defined minimum benefits package and accept all enrollees regardless of their age or health status. A complex risk equalisation compensates insurers for enrollees with higher costs.

Dutch citizens are free to change their health insurer once a year. In the first year of competition, 20% of consumers switched health insurer, however the number switching dropped to 4-5% in subsequent years.⁴⁴ Research has shown that approximately 70% of the population in 2006-2008 felt they did not stand to benefit much by changing insurer. Since 2006, no new insurers have entered the market and there has been a rapid amalgamation of insurance companies. In 2010, the 4 largest insurance groups now control 88% of the market.⁴⁵ Competition has also led to a convergence of premiums. In 2010 premiums for the basic package ranged from €960 to €1176.⁴⁶

Citizens may also be locked into a particular insurer through supplementary insurance or through collective contracts. Over 90% of people purchase supplementary insurance which is sold as a joint product with the basic package. There are concerns that insurers may be using supplementary insurance to risk select.⁴⁷ The percentage of people who believe they would not be accepted if they applied for a new insurance policy has risen from 4% to 7%. Collective or group insurance contracts (often through employers) can receive discounts of up to 10%. The number of people insured through collective or group contracts has risen from 44% in 2006 to 65% in 2008. Many collective contracts are negotiated for 3 years and so far many collective contracts have renewed with the same insurer.

Competition has not yet impacted on patients' choice of provider as so far insurers have been reluctant to selectively contract and vertical integration of insurers and providers has been met with political opposition.⁴⁸

39 Schäfer W, Kroneman M, Boerma W, van den Berg M, Westert G, Devillé W and van Ginneken E. The Netherlands: Health System Review. *Health Systems in Transition*, 2010; 12(1):102

40 National Institute for Public Health and the Environment, Dutch Health Care Performance Report 2010, Ministry for Health, Welfare and Sport downloaded from http://www.gezondheidszorgbalans.nl/object_binary/o10298_dhCPR2010.pdf

41 National Institute for Public Health and the Environment, Dutch Health Care Performance Report 2010

42 Schut F.T. and Van de Ven W.P.M.M. 2011

43 Schäfer W, Kroneman M, Boerma W, van den Berg M, Westert G, Devillé W and van Ginneken E. 2010: 67

44 National Institute for Public Health and the Environment, Dutch Health Care Performance Report 2010

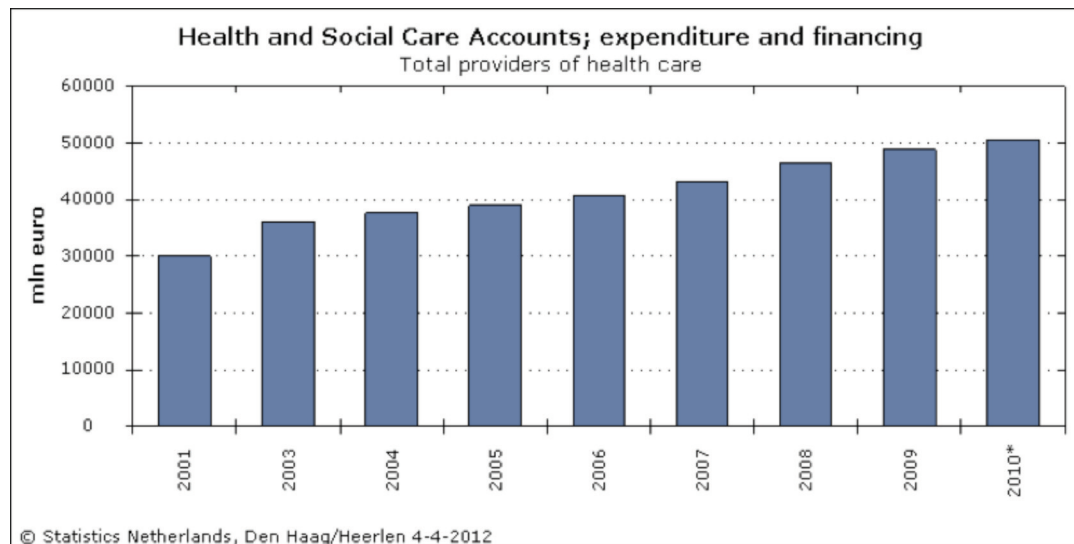
45 Lynch R and Altenburg-van den Broek E. The Drawbacks of Dutch-Style Health Care Rules: lessons for Americans, *Background, The Heritage Foundation*. 2010 : 2435

46 National Institute for Public Health and the Environment, Dutch Health Care Performance Report 2010

47 Schut F.T. and Van de Ven W.P.M.M. 2011

48 Maarse H and Paulus A. The Politics of Health-Care Reform in the Netherlands since 2006, *Health Economics, Policy and Law* 2011 :6 : 125-134

Competition in the provider market has had little impact on overall costs or quality of care



Netherlands Total Expenditure on Providers of Health Care. *Source:* CBS Statline 2012

The general consensus is that competition so far has primarily focused on cost rather than quality of care. However, cost savings have been offset by volume increases and have not resulted in any overall reduction in health expenditure. In order to contain costs the Minister for Health has begun removing some treatments (such as reducing the number of physiotherapy sessions) from the basic health insurance package.⁴⁹ Explanations for higher expenditure include:

Information Asymmetry – Comparable data on the quality of hospital services is still limited. While most contractual arrangements involve initiatives to improve quality, the use of quality indicators is still in its infancy and most relate to structure and process of care rather than outcomes.⁵⁰ Health care providers still report that quality information and health care profiles are still less important to insurers than the price to be paid.⁵¹

Monopoly/Monopsony Powers – Maarse and Paulus⁵² discuss how insurers struggle to negotiate any competitive advantage, particularly where there may be just one provider. For example, there is little negotiation on quality for price regulated services in Segment A. The leading insurer in a region determines contracts with a hospital and the other insurers simply conform to that contract. Perhaps fearing damage to their reputation, hospitals seem reluctant to give an insurer an exclusive contract based on quality.

Provider incentives – The fee-for service model has led to an increase in the volume of all services. While waiting lists have declined hospital costs in particular have escalated and there are indications that cost over runs in 2009 may be attributed to the sharp rise in services produced by ITCs.⁵³

Since the introduction of the B Segment of freely negotiable services the number of Independent Treatment

49 DutchNews.nl, More Cuts in Basic Health Insurance Package on the Way, 09-06-11 downloaded from http://www.dutchnews.nl/news/archives/2011/06/more_cuts_in_basic_health_insu.php

50 Schut F.T. and Van de Ven W.P.M.M. 2011

51 Westert GP, van den Berg MJ, Zwakhals SLN, Heijink R, de Jong JD, Verkleij H. Dutch health care performance report 2010. National Institute for Public Health and the Environment, 2010. www.healthcareperformance.nl

52 Maarse H and Paulus A. 2011

53 Maarse H. and Paulus A. 2011

Centres (ITCs) has grown to 198 in 2009.⁵⁴ Hospital services in Segment B are generally specialist elective procedures which allow ITCs to concentrate on more profitable and less complex cases while hospitals are required to treat the full spectrum of patients.⁵⁵ While price increases for Segment B hospital services appear to have slowed down,⁵⁶ they have largely been offset by an increase in the volume of services. For example, the number of cataract procedures increased by roughly 25% between 2005 and 2010.⁵⁷ Furthermore in geographic areas with centres that specialise in certain procedures, the rates of those procedures were much higher than in other areas.

Since the introduction of the B segment there is no conclusive evidence to suggest that specialist medical care at freely negotiable prices is more efficient or more economical than care with centrally determined fees.⁵⁸

Political Interference – Market advocates stipulate that competition will inevitably result in provider bankruptcies.⁵⁹, however, so far there has been a reluctance to allow hospitals to fail. On more than one occasion the government has intervened to prevent a hospital from closing as in the case of IJsselmeer Hospitals where the Minister for Health stepped in with financial support after concluding that continuity and accessibility to hospital care were at risk.

HEALTH CARE MARKETS IN IRELAND

In Ireland, currently 1.7million people or 36%⁶⁰ of the population are covered by a medical card and are entitled to free GP care and free public hospital care. A further 3% have a GP card and are entitled to free GP care. The remainder of the population are entitled to public hospital care subject to a limited co-payment but are required to pay in full for GP care. Almost half of the population (47.2% or 2.163million people) purchase private voluntary health insurance⁶¹ although PHI represents only about 8% of overall health expenditure.⁶² PHI plays both a supplementary role – offering faster access to care in the private sector or to private care in public hospitals – and a complementary role – reimbursing inpatient co-payments, and limited reimbursement of outpatient and GP charges.

The health insurance market is divided between three insurers. VHI Health care has the largest market share (61.6%), followed by Quinn Health care (20.8%) then Hibernian Aviva Health (13.7%).⁶³ VHI Health care is a State-owned not-for profit entity while the Quinn Health care and Hibernian Aviva Health are commercial for-profit companies.

Private hospital care has evolved in tandem with the public system and without any central planning. Currently there are at least 15 private for-profit hospitals operating in Ireland.⁶⁴ Private care is also available in public hospitals. 20% of beds in public hospitals are designated to private patients and hospital consultants with a B or B* contract may also treat private patients.

54 Schäfer et al, 2010: 119

55 Deuning CM. ZBC voortaan instelling voor medisch-specialistische zorg (IMSZ) [Independent treatment centres are from now on institutions for medical specialist care]. In: *Volksgezondheid Toekomst Verkenning, Nationale Atlas Volksgezondheid [Public health status and forecasts report, national atlas of public health]*. Bilthoven, National Institute for Public Health and the Environment (RIVM) 2009 cited in Schäfer et al, 2010; 12(1):119

56 Schut F.T. and Van de Ven W.P.M.M. 2011

57 Westert GP, M. Faber Commentary: The Dutch Approach to Unwarranted Medical Practice Variation *BMJ* 2011;342:d1429

58 Westert GP et al. 2010

59 Maarse H. and Paulus A. 2011

60 HSE Performance Report December 2011

61 Health Insurance Authority Newsletter February 2012 downloaded from <http://www.hia.ie/latest-news/newsletters.htm>

62 WHO World Health Statistics 2011

63 Health Insurance Authority Annual Report 2010

64 15 members of the Independent Hospital Association of Ireland. See <http://www.independenthospitals.ie/members.htm>

The General Practice market in Ireland is relatively unique in that for the majority of the population, the final consumers are the direct purchasers of care. GPs are generally self-employed in solo practice or in partnership.

The private health care market has created a multi-tier system

The market for private voluntary health insurance in Ireland was opened up to competing insurers in the mid-1990s and has been relatively volatile ever since. Prior to the entry of BUPA Ireland to the market in 1997, VHI Health care had been the sole statutory insurer since its establishment in 1957. New entrants to the market have generally attracted younger healthier members while VHI's members are generally older and less healthy. The regulatory system for the private health insurance market is based on the principles of community rating, lifetime cover, open enrolment, minimum benefits and risk equalisation. However, BUPA withdrew from the market in 2006 over payments to be made under the risk equalisation scheme claiming that they were subsidising the state insurer. Eventually the risk equalisation scheme was struck down by the Supreme Court in 2008. Pending the introduction of a new system, community rating is now supported by a Health Insurance Levy and age-related tax credits.

Up until now the VHI has been exempt from financial regulation by the Central Bank placing it at an economic advantage vis-a-vis its competitors. However a recent ruling by the European Court of Justice will require the Government to invest substantially in the State-owned VHI, in order to bring its financial reserves up to a level that will allow it to be authorised by the Central Bank.⁶⁵

In Ireland half the population purchase PHI primarily for quicker access to elective care through a wider choice of providers. However the private health care market has created a multi-tiered system where the richer echelons of society, who can afford PHI, are assessed and treated rapidly while those without wait inordinate lengths of time for both diagnosis and treatment with some in the latter group forced to pay out-of-pocket contributions to their care while others are not.

A two-tier system also exists in GP care. While General Practice in Ireland offers rapid access, good quality of care and value for money, studies show that having to pay the full cost of GP care acts as a real deterrent to individuals on low income who do not have a medical card. Medical Card holders visit their GP on average 5.2 times per year compared to 1.9 visits for those without and 2.2 visits for those who have private health cover.⁶⁶ While higher GP visits among medical card holders can be explained by the higher age and worse health of this group, analysis of earlier data on GP usage shows that gaining a medical card increases usage of GP services and while usage decreases with loss of entitlement.⁶⁷ Charging the full cost of GP care to patients who are unable to afford it poses a real moral and ethical dilemma to practitioners.

At just 58 GPs per 100,000 population⁶⁸, there is currently a shortage of GPs in Ireland which particularly affects rural areas and GPs located in deprived areas have high workloads or appear to be overstretched.⁶⁹ When filling new GMS posts, the HSE gave due consideration to the provision of proper level of services, choice of GP and the viability of practices in an area. These considerations have been withdrawn under the Health (Provision of General Practitioner Services) Act 2012, however the IMO has raised concerns that GPs will be encouraged to locate in more affluent areas with a higher proportion of private patients.

65 M. Wall, Ireland Loses Health Insurance Case, Irish Times 29 Sept. 2011

66 CSO, Health Status and Health Service Utilisation, Quarterly National Household Survey Q3 2010, Aug 2011

67 Layte R. Nolan A & Nolan B, Poor Prescriptions – Poverty and Access, Combat Poverty Agency 2007

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Private health care costs are rising and little is known about quality of care

While the private market has increased access for those who can afford it, the cost of private health insurance has been steadily rising at a higher rate than inflation and little is known about its impact on quality of care because:

Cost of private care – Between 2008 and 2009 VHI premiums rose by 13% while claims rose even more significantly by 19%.⁷⁰ Analysis by Milliman shows that while VHI's ageing portfolio has made some contribution, increases in VHI claims costs have essentially been driven by:

- *Material increases in utilisation in high-tech hospitals, which generally have higher unit costs than normal acute private hospitals. A large part of the trend can be attributable to two high-tech hospitals, which had substantial increases in utilisation, combined with high unit costs increases. This increased the average cost of an inpatient stay overall by a significant amount.*
- *High trend rates for day case utilisation at acute private hospitals, combined with substantial increases in average costs for inpatient procedures and more modest increases in costs for day case procedures at these hospitals. Some of the increase in average costs for inpatients appears to be driven by one or two hospitals, where inpatient unit costs have increased by 10%.⁷¹*

Private hospital care is generally more expensive than public care. The National Treatment Purchase Fund was set up in 2002 to reduce waiting lists for elective patients by purchasing care from the private sector. The Auditor General found that elective care procedures were purchased by the NTPF from the private sector at a substantially higher price than from the public sector (public hospital contracted prices were found to be 25% lower than private hospital contracted prices).⁷²

Monopoly and Monopsony Powers – According to the Competition Authority, as the largest health insurer, VHI Health care establishes the “rules of the game” in terms of provider contracts establishing a model for negotiation or setting a price floor for reimbursement rates for other health insurers.⁷³ and that “by virtue of its buyer power VHI Health care has a significant influence over the level of private hospital capacity in Ireland”. VHI have often stated that increasing claims costs are due to excess capacity in the private hospital market and supplier induced demand. Cork Medical Centre, a €90million private hospital closed less than 5 months after opening, because VHI refused to cover treatment at the facility again citing over-capacity in private hospital beds.⁷⁴

Payment Incentives – Private hospitals, in order to make a profit, tend to select patients for low cost elective care leaving more expensive intensive, emergency, complex or chronic cases to the public system. Differences in payment modes between the private system (fee-for-service) and the public system (per diem rates) further incentivises insurers to push more complex expensive cases into the public system.

Information Asymmetry – While comparable information on different health plans is available on the Health Insurance Authority's website, little information is available on the quality of care provided by public or private providers including GPs. The perceived difference in care between private and public hospitals is one of the main reasons why many purchase PHI⁷⁵, and yet information on quality of care or value for money in private hospitals is limited. Currently private acute hospitals are not subject to standards and inspection by the Health Information and

70 Milliman Inc. Review of VHI Claims Cost Control. DOHC 2010

71 Milliman Inc. Review of VHI Claims Cost Control. DOHC 2010

72 Public hospital prices are exclusive of consultant fees as these personnel are in receipt of a public salary and are not considered to be commercially sustainable. Controller and Auditor General, Annual Report 2008: 359 & 361

73 The Competition Authority, Competition in the Private health Insurance Market, Jan 2007

74 C. Shanahan, A Painful Lesson, *Irish Examiner*, 12 March 2011

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Quality Authority and while the HSE's Healthstat provides information on access, integration and resource use in public hospitals no such information is available in relation to private hospitals and Healthstat information is more relevant to HSE managers than to patients.

DISCUSSION and CONCLUSION

*The Government Programme for National Recovery 2011-2016*⁷⁶ sets out a range of measures for reform of the Irish health system based on the Dutch model of managed competition between public and private health insurers and public and private health care providers. The aim of the reform is to develop

“a universal, single-tier health service, which guarantees access to medical care based on need, not income. By reforming our model of delivering health care, so that more care is delivered in the community, and by reforming how we pay for health care through Universal Health Insurance, we can reduce the cost of achieving the best health outcomes for our citizens, and end the unfair, unequal and inefficient two-tier health system.”

However, details of the system of Universal Health Insurance in the form of a White Paper have yet to be published.

The IMO supports Universal Health Care and has laid out in its policy position paper on Universal Health Coverage the following principles which should form the basis of a future universal health care system regardless of the model of financing.

IMO Principles of Universal Health Care

(See *IMO Position Paper on Universal Health Coverage – April 2010*)

- Access to adequate health care for all
- Services that are free at the point of access
- Equity of access
- Solidarity
- Transparency
- Quality of care and value for money
- Choice and mobility
- Clinical autonomy
- Efficiency
- Affordability
- Sustainability

Based on our own experience and the experience of other countries, the IMO has doubts whether an unregulated competitive health care market is desirable and has grave concerns about access and choice, quality of care and affordability under a free market model of health care.

⁷⁶ Dept of the Taoiseach, Government for National Recovery 2011-2016 downloaded from http://www.taoiseach.ie/eng/Publications/Publications_2011/Programme_for_Government_2011.html

PHI does not offer satisfactory protection for poor people or high risk individuals and will require strict regulation to guarantee equity of access. A system of mandatory health insurance will require an adequate safety net for people on a lower income. A legally robust risk equalisation scheme and minimum benefits regulation will also be required to support community rating, lifetime cover and open enrolment and to avoid risk selection by astute insurers. Data collection for a complex risk equalisation scheme is likely to add to the administrative burden and costs for both insurers and providers.

Patient choice is likely to be restricted for various reasons. First, the Irish market is relatively small, thus monopoly and monopsony situations are inevitable. In the Netherlands after amalgamations just four main insurers provide comparable plans to a population of 16.5 million. Ireland's 4.58 million population is likely to allow just one insurer to reach equivalent economies of scale. Second, under the Hospital Transformation Programme, the major hospitals are being reconfigured into regional centres of excellence while smaller local hospitals are being downgraded. In many parts of the country emergency services and many specialist services will only be available in one regional hospital. Third, choice will be further restricted as, in order to cut costs, insurers are likely to vertically integrate with providers or establish preferred provider networks.

Competition in health care so far seems to have little impact on cost or quality of care. Fee for service payments incentivise increased activity rather than any price competition. Costs will escalate as both the necessary and unnecessary consumption of services increase due to both consumer demand and supplier led demand. The Government will be gradually forced to reduce the minimum benefits package which may reduce needed care for certain patients.

Quality indicators so far tend to emphasise structure and process and little data is available on outcomes. Alternative payment models linked to quality outcomes may be required to encourage quality of care and value for money. Even with comparative information available, the sick patients will rely on their doctor to advise them of the most appropriate care for their individual needs.

Finally, the Role of the Doctor will be threatened as practitioners are forced to trade professionalism for commercialism. All doctors balance the clinical need of the patient with the availability of resources and GPs in particular pay a vital role as guardians/gatekeepers of the Health System. The market model of health care forces doctors to consider profit and loss in the treatment of patients and the GP gatekeeper role may end up lost to profit-driven enterprises and fee-for-service provider imperatives.

IMO RECOMMENDATIONS

- The IMO urges the Government to carefully consider and address the negative effects of competition on health care in terms of access, choice, quality and affordability before embarking on further market reform;
- The IMO is calling for the publication of the White Paper on Universal Health Insurance in order to progress the debate on the future of Ireland's health care system;
- The Government must respect the nature of the Doctor-Patient relationship which is not commercial and must always view patients as persons undergoing medical treatment as opposed to persons purchasing goods or services;
- The role of the GP as gatekeeper/guardian of the health system must be recognised as in the best interest of the patient and the State.

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