IRISH MEDICAL ORGANISATION

Ceardchumann Dochtúirí na hÉireann

Submission to the Health Information Authority (HIA) on Minimum Benefits Regulations in the Irish Private Health Insurance Market

September 2010

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Private Health Insurance (PHI) markets are inefficient markets and require Government intervention to address market failures. The Irish PHI regulatory system is based on the key principles of community rating, lifetime cover, open enrolment and minimum benefit. Community rating requires a health insurer to charge the same rate of premium for a given level of benefits irrespective of age, sex or health status. The aim of Minimum Benefits Regulations is to maintain inter-generational solidarity and to prevent risk selection and risk segmentation whereby insurance companies design packages aimed at lower risk younger healthier people rather than high risk older sicker people.

Government policy on PHI states that

> *Private health insurance can also play an expanding role in providing cover for primary care. The Minister has stated that expanding primary care in health insurance minimum benefits can dovetail with reform for public health eligibility legislation, so primary care plays a more prominent role in health care for the whole population.*

At the same time the Government has left the option open to introduce compulsory private health insurance.

PHI does not offer satisfactory protection for poor people or high risk individuals and little research has been done into the real effects of mandatory PHI on quality of care and efficiency. Any proposal that an adequately funded public universal health care system could be entirely substituted by PHI would raise concern among IMO members – as healthcare decisions could be left to market forces rather than based on the opinions of professionals and the needs of patients.

The interaction between PHI policy and the Irish public health systems is complex. The Irish healthcare system faces a number of issues and challenges including access to services, future sustainability and inequity. Policies promoting private hospital care and PHI to increase access and provide extra funding for healthcare have at the same time contributed to a multi-tiered health system. IMO members are concerned that healthcare in Ireland is becoming increasingly unaffordable for lower income groups who are not covered by a Medical Card or Private Health Insurance as:

- Out-of-pocket payments for hospital services and pharmaceuticals have been gradually increasing with each budget;
- Services are increasingly being transferred from secondary to primary care settings without the equivalent transfer of public funds and to where the majority of services are paid for privately.

IMO members are calling for a Universal Health Care system whereby all residents in Ireland should be entitled to medically necessary healthcare regardless of ability to pay and based on the following principles:

- *Universality - access to adequate healthcare 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*[1]

Even with an adequately funded universal healthcare system the IMO recognises that there will always be a demand for PHI. In funding healthcare privately the same principles should apply. However PHI should remain voluntary and people should not feel compelled nor be able to purchase PHI to side-step waiting lists.

Questions

Q1 Which services should be included in Minimum Benefit Regulations, or alternatively, how should the benefits to be included in Minimum Benefit Regulations be determined?

The IMO supports the principal of universality whereby all residents in Ireland should have access to appropriate 'promotive, preventive, curative and rehabilitative healthcare'[2]. This means that all residents should be entitled to medically necessary care in the public system including prescription drugs, hospital and GP services as well as services such as public health services and long-term care services.

If individuals choose to insure themselves privately, the Minimum Benefits Package should be comprehensive and include all medically necessary care including all primary, secondary and tertiary care services. Purchasers of voluntary PHI generally wish to ensure themselves against unforeseen medical expenses therefore if the Minimum Benefits Package is comprehensive individuals need not be concerned about being under-insured.

The purpose of Minimum Benefits Regulations in PHI markets is to support community rating whereby the cost of a particular level of cover is same for all insured lives, irrespective of age, sex or health status. Therefore the aim of Minimum Benefits Regulations is to prevent risk selection and risk segmentation whereby insurance companies design packages aimed at lower risk individuals or groups, or example younger healthier people rather than older sicker people. Minimum Benefits Regulations must guarantee inter-generational solidarity. Therefore the range of benefits provided by health insurers needs to be sufficiently comprehensive to ensure that the medically-necessary services relevant to each group are equally represented.

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[1] See IMO position paper on Universal Health Coverage – April 2010

[2] WHO Achieving Universal Health Coverage: Developing the Health Financing System *Technical Briefs for Policy-Makers No. 1* 2005

Q2 At what levels should minimum payment levels be set, or alternatively, how should minimum payment levels be determined?

Methods for containing costs must be evidence-based. Cost-sharing is known to prevent both necessary and unnecessary care and must be applied carefully. Excesses should be limited to protect individuals from high out-of-pocket costs.

Inter-generational solidarity must also be a key consideration when determining how minimum payment levels should be set. Cost-sharing must be applied equally so that no group should be subject to higher out-of-pocket payments.

In respect of hospital cover, minimum payment levels should be set at the level required to ensure that all insured are covered for physician and procedure/treatment costs in the most cost effective institution.

Q3 What measures are necessary to ensure that the list of services remains up to date with medical developments?

Q4 How should provision be made for future changes in the cost of health services?

Minimum Benefits Regulations should be regularly reviewed to stay up to date with medical developments and changes in the cost of health services. New health technologies and treatments should only be included in Minimum Benefits following evaluation for clinical and cost effectiveness.

The requirement for Insurance companies to have adequate capital reserves must be maintained.

Q5 Should excesses on claim benefits be provided for explicitly in the Regulations? In particular, should there be limits on excesses?

As mentioned above cost-sharing is known to prevent both necessary and unnecessary care and must be applied carefully. Individuals purchase to protect themselves from high out-of-pocket costs. Limits on excesses should be provided for explicitly.

Q6 Should the manner in which minimum payment levels are specified be simplified, and if so, how?

Q7 What are your views on the possible approaches for simplifying the specification of minimum payment levels referred to earlier?

The IMO also supports the principal of transparency in health care financing. Purchasers of PHI should be able to see clearly what they are paying towards healthcare and what they are receiving in return, thus allowing people to make a better judgement on whether they are receiving value for money or not. The Minimum benefits package should be clearly defined. Simply stating that the prescribed minimum benefits would incorporate all health services provided by the public system is insufficient unless entitlement to services in the public system are clearly defined first. The HIA should continue to provide independent guidance and comparison of products to the public.

Q8 How should recent developments in healthcare and healthcare policy (including with regard to primary care and chronic disease management) be reflected in Minimum Benefit Regulations?

Q9 Which primary care and chronic disease management services should be covered by Minimum Benefit Regulations and to what extent?

Advances in medical technology and pharmaceuticals means more patients are treated in primary and community-based settings rather than a hospital-based setting. National health policy supports this transfer although it has not been accompanied by appropriate resources and incentives. For the majority of the population that are not covered by a medical card the fee structure in the public system for drugs and services encourages hospital care rather than primary care or care in the community.

Limiting Minimum Payment Benefit to hospital services is also contrary to best practice and national policy as it creates incentives for patients to be treated in a hospital setting rather than a more appropriate primary or community-based setting. Therefore all medically necessary primary care services and Chronic Disease Management (CDM) services should be covered in Minimum Benefits regulations. Payment levels should encourage the most appropriate care in the most appropriate setting.

Cost-sharing can deter consumption of services particularly preventive care. Evidence-based preventive care should be included in the Minimum Benefits Package at no extra cost to the insuree.

Q10 Do practical issues arise with respect to including primary care benefits in Minimum Benefit Regulations? How could such issues be addressed?

Q11 What are the other consequences of including primary care and chronic disease management in Minimum Benefit Regulations?

Patients with chronic disease require services from a wide range of professionals with the majority of care is provided in the community with transfer to acute or long-stay facilities at intermittent intervals. CDM requires both integrated care and continuity of care and is best suited the General Practitioner under contract.

Evidence-based treatment protocols for chronic diseases should be elaborated and implemented across the health service and fees and payments for both public and private patients should adequately reflect the level of treatment.

Q12 A significant requirement of the current Regulations relates to private care in public hospitals. Should the Regulations provide for a possible reduction in private services in public hospitals, if so how?

Q13 How should the Minimum Benefit Regulations recognise the interaction of private healthcare provision in public hospitals with provision in private hospitals and other private provision?

Private hospitals operate on a for-profit basis and tend to 'cherry-pick' more lucrative elective cases while public hospitals tend to deal with the more expensive complex cases. Current regulations provide for different payments to private and public hospitals and create further incentives for the treatment of more expensive care in public hospitals and less expensive care in private hospitals.

Charges for private patients in public hospitals are set to change and the IMO recommend that they more accurately reflect the level of treatment provided. The IMO believe that public hospitals and private hospitals should charge and be reimbursed on the same basis.

Q14 How do the current Minimum Benefit Regulations impact on economic efficiency within the health insurance and private healthcare markets?

Q15 What impact would you expect the amendments discussed in this paper to have on economic efficiency within the health insurance and private healthcare markets?

Q16 Do you consider that some changes to the Minimum Benefit Regulations are warranted in order to achieve more economically efficient provision of private health insurance or private healthcare, while providing the best healthcare outcome? If you do, please describe the changes that you consider are warranted.

Even with the tightest regulation in place, for-profit PHI companies will always try to compete on cost and may be able to negotiate better rates for care in the private sector than in the public sector or through vertical integration whereby the insurance company is both the purchaser and the provider of care.

The IMO believe that quality of care, value for money, choice of provider and clinical autonomy must continue to be at the core of health service provision in Ireland regardless of whether purchasers and/or providers are public, private or voluntary not-for-profit.

Standards of care in both the public and the private sector must be based on evidence and international best-practice. Private providers must be subject to standards of care established and monitored by the Health Information and Quality Authority (HIQA).

The doctor-patient relationship must be respected. Patients must be allowed to choose their physician. The doctor-patient relationship is built on trust and understanding and is often built up over time. This continuity of care has been found to be associated with time saving, reduced referrals, reduced prescriptions and improved compliance.[3]Contracts between PHI companies and providers must not restrict a patient's choice of physician.

Clinical autonomy must be guaranteed. Physicians must be free to diagnose and treat patients without interference from third party insurers. Conflicting commercial interests must not be allowed to impact on a doctor's professional duty to act in the best interest of the patient.

[3] Primary care – A New Direction

The IMO supports the referral system from General Practice to Hospital Consultants in public and/or private practice as this is in the best interests of patients and is considered more effective in reducing overall health costs.

Q17 Do you consider that amendments to the Minimum Benefit Regulations are required in respect of maternity, psychiatric, addiction related or step-down nursing home care?

Minimum Benefit Regulations should include all medically necessary maternity, psychiatric, addiction related or step-down nursing home care.