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Insuring a healthy future

Whatever the resolution of the risk equalisation issue, it will have a major effect on the state's health policy, write **Claire Finn and Colm Harmon**

The debate about the Irish health insurance market shows no sign of abating, with familiar arguments flaring up again following Sean Quinn's purchase of Bupa's Irish operations last week and the imminent report from the Competition Authority and Health Insurance Authority on the market.

Once again, the issues of risk equalisation and competition come to the fore. As ever, the discussion has come to be framed around the debate that competition is not possible in a market with risk equalisation. This does not need to be the case.

Competition in any market is generally positive for consumers and helps keep prices down. In a competitive insurance market, it is expected that insurers would compete for customers on product and price.

Some now argue that the decision by Bupa to pull out has, by extension, implied that risk equalisation is blocking the emergence of a competitive insurance market. The fact that the first question asked of the Sean Quinn takeover relates to a suggested derogation of risk equalisation payments emphasises the problem.

This argument essentially relates to what kind of market we want. In a fully competitive insurance market with no community rating, such as the US, individuals typically pay a premium that is dependent on their individual risk level. Those who are older and less healthy pay more and – like car insurance – after you make a claim, your premium goes up. In this way, insurers risk-adjust their premiums, so any premium depends on the characteristics of the insured individual.

In contrast, our system is based on so-called community rating, which means that the insurer charges the same premium to everyone, regardless of their risk status. So older and less healthy people pay the same premium as everyone else. More precisely, they pay a premium based on the average risk level of the 'group'.

Currently, in an Irish context – a market, for all of the debate, that hasn't yet actually implemented risk equalisation – there are three of these 'groups' – those insured with VHI, Bupa/Quinn or Vivas, with each insurer offering a premium based on the average risk level of its group of customers. As Bupa's customer base is younger and healthier, it can offer lower premiums than VHI.

With risk equalisation, however, there is only one 'group' – the total insured population. The idea is that the playing field is levelled by making those companies with younger customers pay an annual levy to those with older customers.

It is here that the problem of risk equalisation, community rating and competition become difficult to disentangle. Insurance companies can maximise their profit by increased efficiency (that is reducing their costs).

The former Bupa operation, which will be run by Quinn, might argue that if, in a competitive market, it is successful at keeping its costs down andpassing on that saving to its customers in the form of a reduced premium, why should it be required to pass on that profit to a possibly less-efficient competitor?

Of course, the argument is not as simple as that – an insurance company may also increase profits, not because it is more efficient, but because it is better at attracting the lower-risk individuals.

In the absence of the ability to charge people according to their risk profile, there is an incentive for insurers to attract or select these lower-risk groups (for example, by offering plans that are not attractive to the higher risk group).

As it stands, our research has shown that, even under the current regulations where the opportunity for cream-skimming is low, those with poorer health status remain less likely to insure.

Either way, the debate around competition versus risk equalisation is a non-argument. We have, and will have, community rating and risk equalisation. This debate is also, to a large part, baloney. Insurance markets do exist in many countries with community rating and risk equalisation. One example is Australia. We need to figure out the market shape against this backdrop and stop trying to see the future purely in free market terms.

The issue is not competition versus risk equalisation, but rather questioning what competitive system can emerge, subject to the preservation of community rating and risk equalisation.

There is only so much scope for a competitive market, if by competitive we mean one with a large number of firms. The government is faced with the difficult task of integrating a well-established, government-supported, monopoly insurer into an embryonic competitive insurance market. VHI inherited, not just a 'special position, but also a legacy of being the only insurer over a period of 40 years.

Our research shows that there is significant inertia in the Irish market – once people purchase insurance, they are likely to keep it, to avoid having to take the time to familiarise themselves with different rules or different doctors. For this reason, Bupa grew the market by being successful at capturing new entrants, albeit those in their 20s and 30s.

This is the crux of the issue we now face and which the group established by Mary Harney to advise her on the future of the market must address. The special position of the VHI in the Irish insurance market has blurred the argument. If the VHI operates under preferential conditions, then it is easy for risk equalisation to be classified as one of these grace and favour issues.

However, the concept of risk equalisation is not an Irish invention, one introduced to favour VHI, or a mechanism to capture the legitimate profits of the newer insurers. It is a mechanism

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necessary to uphold a system of community rating, the ethos of which we uphold as a society. That said, it is important to ensure that the rules under which risk equalisation is introduced do not result in an insurer having to share legitimate profits made from cost-cutting and efficiency.

We favour the presence of competition in this market. To understand this, we need to strip back the working of the market to see what it could look like in the long term, when the issues related to the history of Irish health insurance and the dominance of the VHI are no longer so dominant.

Only then can we really determine how this market is going to function and only then can we determine the policy response to deal with the current impasse.

We can only assume that this is precisely the direction the imminent review of the market is going to take.

We should, equally, not lose sight of the far bigger issues of insurance in the context of the direction of the health service as a whole.

Our own research has examined the impact of insurance on the demand for health services – and insurance remains the preserve of the middle classes. We have a policy environment in Ireland that is sympathetic to private insurance and private health care, but we don't have any real sense of the impact of that.

In Ireland we have an arrangement for the less well-off through the medical card system, but we have a large chunk of the population in the netherworld of no private insurance and no medical card.

We are in favour of a radical study to examine this. This sort of research will uncover and unlock the real impact of health insurance on the health system.

In the meantime, the group set up to review the shape of the market faces the delicate task of balancing the need for competition with the requirement of underpinning risk equalisation in the long term. It may not be easy, but it should not be impossible.

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The 'special position' of the VHI in the Iris insurance

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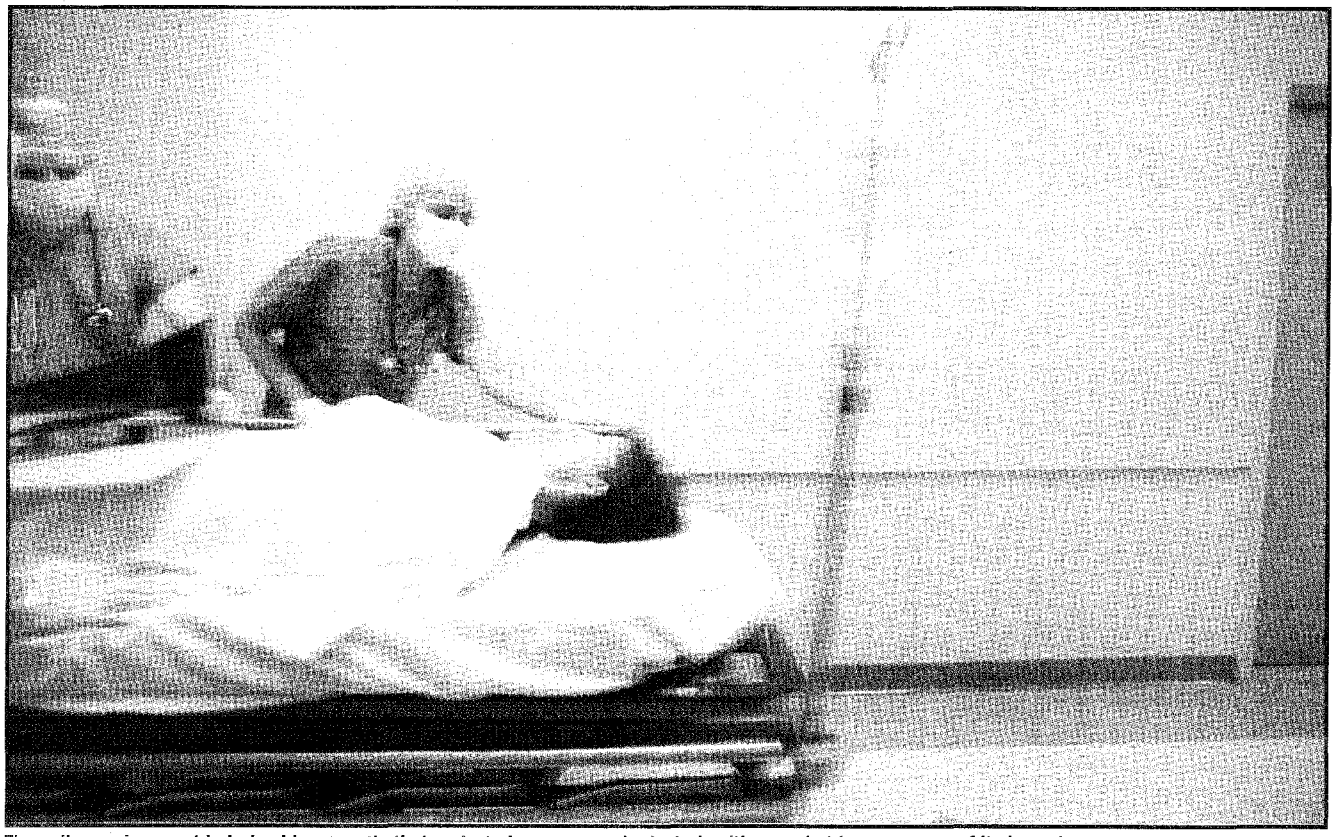

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