

## **Private Health Insurance**

### **Demand for Private Health Insurance**

It is unclear whether there is a complete national data set regarding medical outcomes and cost of treatment. This means that consumers do not know whether it is in their interests to hold private medical insurance and currently adopt the precautionary principle in large measure. This occurs in the first instance in order to assure treatment, secondly to obtain satisfactory consultant access and thirdly some modicum of comfort when in receipt of treatment. Individuals are vulnerable when they need treatment and on admission to hospital are rarely in a position to negotiate or reflect meaningfully on information and decisions which face them, particularly in acute situations. Naturally consumers respond by insuring themselves in order to reduce uncertainty and increase peace of mind in anticipation of facing treatment dilemmas. The State collaborates with the players in the market to continue this information deficit in the present regulatory regime, thereby guaranteeing a huge target market for the private insurers. The size of the private insurance market is in no small way determined by these parameters. It is significant that the invitation to comment on this market is framed in terms of switching between health insurers and does not address switching between private and public health insurance, particularly for all those individuals paying full PRSI with the promise of health care that accompanies it. The HIA needs to address the risk as perceived by consumers in taking out private health insurance and then assess the degree to which current market offerings meet the challenge of those risks. The HIA needs to produce independent expected values for private health insurance so that consumers by age cohort can assess its merits.

### **Regulatory Mosaic**

Three major players are regulated/governed through three different legal mediums: by Irish statute (VHI), by the Financial Regulator (Vivas) and by UK regulatory authorities (BUPA). It is not clear to consumers that this leads to a level playing field in terms of solvency and capitalisation, given the need to recover a return on capital and to hold appropriate reserves.

### **Market Structure**

There is an impression created that in health matters, an oligopoly is superior to a monopoly in competition terms. It is not at all clear that this is the case to Irish consumers. In a rational market with a high degree of concentration, price competition is likely to be severely limited as each player seeks to avoid cutting margins. There must be some lessons learned from the telecommunications market in this respect. The Health Insurance Authority needs to demonstrate to the public at large the existence of price competition in order to justify its existence. In fact valid exercise would be to compare the aggregate of the cost of health insurance in an oligopoly plus the associated regulatory costs to the cost of the monopoly with no regulation and to the cost of a comprehensive State scheme with an absolute unregulated market for those who wish to top up the State scheme. Irish consumers currently have no metrics which indicate that the present litigious and advertising led market place represents good use of resources in a health context.

### **The Illusion of Choice**

There is increasing evidence to suggest that consumers have difficulty making decisions when faced with significant complexity regarding product or service choices. In addition complexity often increases costs in product and service provision. It is beholden on the regulators to have regard to the evidence that exists regarding how consumers behave when faced with complexity and whether the choices thus made are what is intended by the type of market structure created through regulation. If the result is that consumers pay more and make decisions which are unsatisfactory from a welfare perspective, then regulation is failing. It is not sufficient in the health arena to hold that the revealed preferences of consumers made in their purchasing decisions are entirely acceptable to policymakers: why else do we have current levels of intervention on medicines, smoking, exercise, diet, seat belts or substance abuse?

### **Information Overload and Opaqueness**

It is a truism in insurance that you never know what your cover is or how adequate it is until you go to claim. There is some merit in a key features document being provided to the insured which summarises the benefits, exclusions etc in a similar fashion to key features documents provided with respect to other financial service products. It is also the case that the print size in much of the documentation provided with respect to policies is well below the character size of this note. No doubt the insurers claim this is for reasons of economy but a side effect is that it is not easy to read and comprehend. As experts in health, the companies should be well aware of the deterioration in sight experienced by most individuals as they grow older. This matter needs attention as it is an obstacle to effective shopping around which we are urged to do as consumers by our leaders and the authorities in the field.

### **Adverse Selection**

The HIA needs to determine to what extent the current regime results in consumers engaging in rational insurance shopping, coming in to the private market in anticipation of claims, buying insurance, making those claims and exiting the market again. This is a variation on adverse selection, a well understood phenomenon in the insurance industry. It is a direct consequence of the *open enrolment principle* adopted by the Department of Health and Children for this market.

John Maher  
Dept of Accounting & Economics  
Waterford Institute of Technology