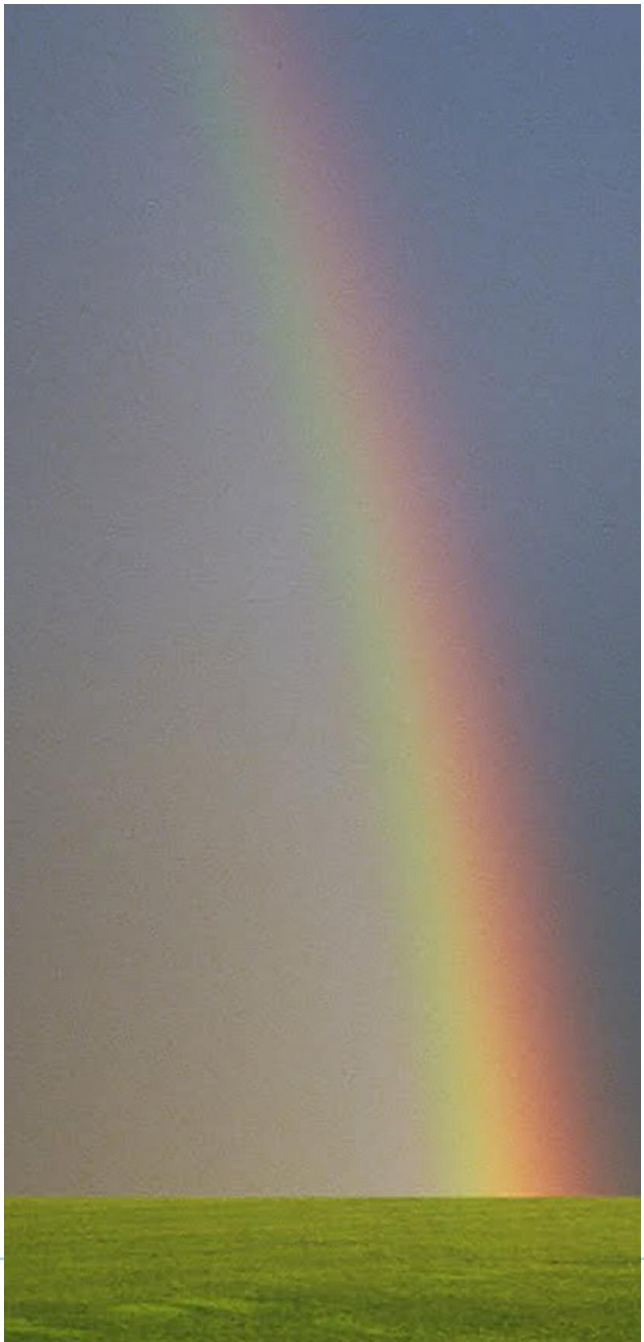
An Irish regulatory rainbow after the recent storms?



Planned regulatory changes in Ireland should see 1m more people take out private medical insurance, based on the impact of similar legislation in the Netherlands and Australia. This should improve performance after the private sector over-expanded in the early Noughties and suffered badly in the recent recession. Equity investment in existing providers now starts to make sense. Recent transactions this year have included the sale of The Beacon and the attempted sale of Mount Carmel Hospital by Adam Scott and Jean Redmond of Mansfield Advisors LLP.

It's well-known that following rapid economic expansion during the 'Celtic Tiger' years of 1999-2007, Ireland experienced a fiscal crisis after the State stepped in to rescue Irish banks over-exposed to the property market. Tax-financed public health spending dropped from 7.3 to 5.2% of GDP between 2009 and 2012. This traumatic experience has encouraged a wholesale move of the Irish health system towards Universal Health Insurance – which would ensure more overall spending amongst other things. Fundamental change is years away, but some important changes are happening already.

The distinctive feature of the current system is its 'two-tier' nature in public hospitals, where they rely heavily on private insurance income alongside their state block grants. 'Private' insurance is in fact dominated by state-owned VHI, which accounts for >50% of all packages and >65% of all paid claims. Nearly half the population have such insurance. Private insurance is used first to avoid lengthy waiting lists in public hospitals and then, especially in Dublin, to access private hospitals which aim to outperform the public sector on all dimensions, including complex surgeries.

Recent years have certainly been difficult for private providers. The 'great recession' from 2007 -2013 put private health insurance into a downward spiral and resulted simultaneously in a state fiscal crisis. The private providers lost material insurance and all National Treatment Purchase Fund (the state paid NTPF) volume.

The 21 private hospitals have a sixth of the acute capacity and 13% of the discharges. The greater Dublin area has 47% of private beds, of which the Mater Private, the Blackrock Clinic and The Beacon are termed the 'high-tech' hospitals and may require higher-premium insurance plans. Other major providers are St Vincent's Private, Hermitage, The Galway Clinic and Bons Secours.

Insured totals fell from 2008's 2.3m (51%) to 2.04m six years later, or from 51% to 44% penetration. That downward spiral we mentioned resulted from insurers compensating for dropped policies by increasing premiums, which persuaded more people to drop their insurance. Conor Keegan, a researcher at Trinity College

Dublin, explained it to us: "As low risk policyholders (younger, healthier) drop out of the market, premia increase as the market risk-profile worsens, motivating further exit and further price increases - it's an adverse selection spiral." However, since those who remained were older, the resulting volume decline on hospitals was less.

Owing to long waiting lists in the public system, the NTPF had been founded in 2002 to pay for additional activity in both public and private hospitals. It no longer spends €80-100m on private providers as it did before 2011. However, owing to the high number of people still on hospital waiting lists – close to 50,000 in 2014, we have been told that there is some limited purchasing again in the private sector by the government.

To weaken the position of private providers even further, private capacity still expanded 15% from around 2,700 beds to 3,200 in the three years after 2008, although contraction in public hospital beds over the period negated to some extent the increase in private beds. Now in 2014, the 20% regulatory limit on private patients in public hospitals has been lifted. This had likely prevented some competition, since that prescribed limit since was not far above the actual 2012 17% private share in public hospitals.

Employment changes introduced in 2008 do mean that nearly all new consultants are prevented from obtaining contracts allowing them to treat private patients in their own time. However, they can still serve private patients for their public hospital employers as salaried employees. So public hospitals can and will target private patients for standard activity when prices are €1,046 versus €100 per night for public patients. They are likely to be able to find some additional capacity, though how much is really available remains to be seen while increasing demand continues to push pressure on the whole system, growing 5% a year from 2008 to 2012 for those aged 65+.

The current Irish Fine Gael-Labour coalition government – in power from 2011 – put healthcare reforms high on the political agenda. These reforms had vocal support from Dr James Reilly, Minister of Health until July 2014. The imminent regulatory change, which was signed into legislation in July 2014, is financial penalties for people who acquire private insurance later in their lives. Insurance premiums do not discriminate on age in the current 'community rating' system, which incentivises retaining insurance when premiums would otherwise increase with age. This regulation means younger people have been even less likely to acquire insurance since they face higher payments than otherwise, so under the new 'lifetime community rating' regulation their annual premiums will increase the longer they avoid joining a scheme.

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A representative from the Health Insurance Authority (HIA) told us "the change in legislation next year will most likely mean that younger people start taking out insurance again." After May next year, anyone who waits until after they are 35 will face 2% higher premiums per year's delay, though those under 25 may be offered a discount.

Lifetime Community Rating was introduced in Australia in 2000, which had a reasonably similar system to Ireland. Private health insurance jumped from 31.3% penetration at the end of 1999 to 43% six months later as individuals rushed to avoid higher lifetime payments. This also lowered the average age by 1.5 years. Therefore, it's not difficult to envisage a double figure increase in insurance penetration over the next six months. A disproportionate share will be younger, but it must be positive for private hospitals' elective work in particular.

The new healthcare system already coming into place is fundamentally different. For the first time, state provision and purchasing of services will be split. The Health Service Executive, which managed state provision, will be replaced by a Health Commissioning Agency and the public hospitals combined into seven Trusts. Independent managements will have both operating and financial responsibility.

The "Money Follows the Patient" payment mechanism will include both public and private providers. Insurers will continue to negotiate with private hospitals, but the Minister for Health will set private prices centrally for public hospitals. The Healthcare Pricing Office, which was set up (if not fully operational) in January 2014, will set public paid prices, although it is still unclear how private paid prices will be affected. It is thought that the Healthcare Pricing Office may receive additional powers, including supporting the Healthcare Commissioning Agency, in moving to a purchasing model underpinned by pre-agreed performance contracts and prices.

In the longer term, the introduction of Universal Health Insurance holds great promise. The current Fine Gael-Labour coalition government are committed to the introduction of a 'single-tier multi-payer' model of Universal Health Insurance (UHI). The proposed UHI system will build upon the current regulations that include the right to be accepted by a chosen insurer (open enrolment), the right to renew a UHI policy (lifetime cover)

and the right to be charged the same premium regardless of risk profile (community rating.) The state would continue to pay directly for some services including ambulances and long-term residential care. Everyone can choose their preferred insurer who must provide at minimum a low priced but comprehensive package.

Companies may offer lower premiums for plans with different co-payment/excess levels, or may offer supplementary packages covering services not included in the basic plan, such as cosmetic surgery. This would make private health insurance mandatory and state-paid for those unable or exempt. These are likely to already have a 'medical card' which absolves them from fees.

The model will comprise 'for-profit' insurers and the state-owned VHI, continuing the 'risk equalisation' scheme already in place.

The coalition government claims "total spending by the State on healthcare in Ireland under a single-tier UHI system should not exceed its total spending under the two-tier system which it replaces."

The introduction of universal health insurance in the Netherlands led to growth in total expenditure on health per capita (purchasing power parity) of 5% CAGR in from 2007 to 2012, according to OECD data. This probably wouldn't put Irish reformers off as the Netherlands performs well in international comparisons, for example Health Consumer Powerhouse's conclusion in their Europe-wide comparison was "the Dutch system should set the standard for reform - it's the best in the world."

However in July 2014 the new Minister for Health, Dr Leo Varadkar, of the Fine Gael party, admitted "the original timetable to have Universal Health Insurance in place by 2019 is too ambitious." This implies full implementation by 2019 is unlikely. Sean Fleming, speaking for the Fianna Fail, an opposition political party, believes that "UHI has been taken off the agenda for the next 5 years. The idea is to completely reform the whole health service in the next 10years, to follow the Dutch system… but that took 20 years to get into place so it's quite ambitious for Ireland." But even more recently the Minister did emphasize "It's still the vision to have everyone insured in the way they are in most European countries".

The future of UHI is likely to be determined by the next general election – due by April 2016. A report commissioned by Fianna Fail was not supportive of UHI. The left wing party, Sinn Fein, are also unsupportive of UHI, believing that it promotes private, rather than public interest. But current polls suggest its proponents Fine Gael will continue in government, even if outsiders Sinn Fein has grown in popularity recently.

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(though more will be insured following the introduction of 'lifetime community rating') and ±40% of the population will probably qualify for state-paid UHI. That still leaves a minority who relied on occasional self-pay who would now be more likely potential patients for private hospitals with the mandatory insurance.

Sean Fleming, Fianna Fail party representative, told us that they believe that "the core package won't cover essentials". Another Fianna Fail spokesperson noted that there is "no clarity at all" as to what the cost of UHI will be for families.

But one way or another, these regulatory changes will increase the market penetration of private insurance in Ireland, and should result in a marked increase in volumes for private providers. If the proposed UHI is successful, a fifth more of the population, about a million more people, will get private medical insurance in the next five to ten years and will be paying with income previously spent elsewhere (i.e. those without insurance or a medical card currently).

Private providers will be able to compete with public hospitals who will be more commercially constrained. Diarmuid McNamee, of the Mater Private, believes that "In general UHI will be a huge positive for the private sector as our market doubles in size". If we use the Dutch per person basic package price of €1,038 as a rough guide, then additional spending on Irish healthcare could be close to a billion euros. This will displace some current 'self-pay' but it's clear the new system will favour private providers and, drive private sector growth.

One way or another a fifth more of the population, about a million more people, will get private medical insurance in the next five to ten years, because of these regulatory changes and will be paying with income previously spent elsewhere (i.e. those without insurance or a medical card currently). If we use the Dutch per person basic package price of €1038 as a rough guide, then additional spending on Irish healthcare could be close to a billion euros.

This will displace some current 'self-pay' but that is still a pot of gold at the end of the rainbow to look forward to. HCE