

Care not Cash Working Party

Care not Cash – the Salvation of Health Insurance?

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Note

This paper was prepared primarily for the 2003 Health Conference of the Actuarial Profession. The working party would be prepared, however, to refine the paper and the associated product research to develop an appropriate paper for submission to the Staple Inn Actuarial Society.

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by G C Orros, A Cox, S Cross, S Evans, P Gatenby, A Loughlin, M Moliver, R Thomas

1. Synopsis

The Care not Cash Working Party was set up to explore the health and care insurance issues associated with giving policyholders Care rather than Cash benefits. We determined at an early stage to focus on the social policy perspective and the public interest issues in the UK and Ireland.

Care is defined as arranging a service package designed to meet assessed treatment needs; it includes care guidance and information services. Cash is defined as providing direct cash payments to allow self-selection and payment for care services. The product development potential of Care not Cash has been reviewed as a guiding principle in respect of health and care insurance products. Although interesting product developments have also been identified in other countries, we have focused on the practical expertise of the working party members in UK and Ireland.

We have assembled a research database of over 30 health and care insurance products and a product comparison template for recording their benefit components. Any “care not cash” elements were identified and investigated. The health and care insurance products reviewed included PMI (private medical insurance), HCP (health cash plans), LTC (long-term care), CI (critical illness), IP (income protection) and MME (major medical expenses). This initial paper has focused on the products where the working party members had the most expertise, namely PMI, HCP and LTC insurance.

PMI in the UK was introduced in the 19th century and precedes the introduction of the NHS in 1948. Market penetration has stabilised at 11% of the population, despite many marketing initiatives in recent years. The political climate is generally in favour of the publicly funded NHS, which has been subjected to several modernisation initiatives over the years. PMI in Ireland was introduced to meet the cost of hospital-based treatment for the 15% of the population that did not have entitlement to free treatment in public hospitals. It has proven popular and covers 50% of the total population; reflecting disposable income growth and a perceived decline in public hospitals performance. PMI in Ireland was also encouraged via tax relief on premiums, but this has now been restricted.

HCP in the UK were also introduced in the 19th century and seek to complement rather than replace NHS services. Market penetration has stabilised at around 10% of the population, with signs of modest growth. The political climate has been neutral on health cash plans, although there are signs that they may have a growing role to play in a modernised NHS.

LTC insurance is in its infancy in the UK (with small sales volumes and some public confusion as to the perceived role of the state) and has not developed in Ireland. In the UK, government responsibility on LTC is being redefined via interaction between the NHS, Local Authorities, charities and the judiciary. It may be a little while before there is clarity and new products are developed to meet the perceived **Care and Cash** needs of the older population. Discussion of LTC funding is linked to wider issues such as pension planning, although this is outside the scope of the paper.

Whilst this paper has a strong focus on PMI, HCP and LTC in the UK and Ireland, it also recognises that there are numerous developments within other, related classes of business that may inform future product development, particularly in relation to the provision of care. A summary of these is contained in Section 5 “Other Health Initiatives”, including reference to IP, CI, MME and the growing ‘self pay’ markets in the UK. It also looks at some of the more common forms of Care Service provision that are growing up around Health and Protection products.

The working party has debated whether the guiding principle should be **Care not Cash** or **Cash not Care**. We have concluded that there is a “third way”, which is **Care and Cash**.

2. Conclusions

2.1 Principal Conclusions

The working party has explored the product concepts of **Care not Cash** and **Cash not Care**. This has resulted in a consensus that there is a “third way”, which is **Care and Cash**. The rationale for this approach is that, although people generally prefer the option of **Cash not Care**, they may also want to access the insurer’s preferred provider network to obtain high quality, safe and appropriate care at a cost effective price. People may also want help in arranging a package of care services (e.g. in-patient treatment and post-operative rehabilitation). Although people generally receive **Care not Cash**, they also want the option of **Cash not Care**, so that they can choose to receive care from their own doctor, regardless of the insurer’s dictat. Hence the product concept of **Care and Cash**.

Elements of **Care and Cash** already exist in LTC insurance products, which have attempted to develop the use of care assessment to help individuals to commission their own preferred care services. New variants of health care insurance may arise out of changes in the industry structure. The distinction between private healthcare and health cash products is becoming increasingly blurred. There is also a blurring of the demarcation between the product territories of commercial insurers and mutual insurers. The former are marketing health cash products, whereas the latter are acquiring private healthcare insurers. This may lead to a new generation of health care insurances where the **Care and Cash** boundaries evolve to meet the objectives of mutual and commercial insurers.

The social policy context and the associated levels of market encouragement in the UK and Ireland have led to different levels of PMI market development. The market encouragement in Ireland e.g. community rating, tax relief, open enrolment, lifetime cover and minimum benefits, have helped to stimulate steady growth. It could be argued that the UK has much to learn from Ireland in developing private sources of health care funding which appear both fair and equitable. The UK Government’s agenda to modernise the NHS aims to increase investment and patient choice, encourage diversity in service provision, enable greater local autonomy and, in turn, reduce NHS waiting times. There is no market encouragement for UK PMI and a neutral stance on HCP.

We believe that the Care not Cash debate on healthcare insurance products in the UK and Ireland is strongly affected by the social policy perspective and the associated public/community interest issues. This is evidenced by the fact that 11% of the UK population has PMI, versus 50% in Ireland. Public perception is especially important, as are the national political messages on the need for PMI to complement and/or supplement the publicly funded national health service.

We have identified several public/community interest issues for private healthcare insurance products. These issues are listed below and are discussed in detail in Section 4.2 of the paper.

- Intangible insurance benefits
- What care will the healthcare insurance products actually buy?
- What if patient then needs more care?
- What if patient’s doctor is not covered?
- What if medical advice is contrary?
- What if care leads to patient harm?

Our overall conclusion is that health actuaries have the potential to add significant value to the development of health and care insurance products in the UK and Ireland. They will, however, need to take greater account of the social policy context and the public/community interest issues in formulating their advice and in communicating with their publics. **Care and Cash** might provide an interesting way forward which has the potential to capture the public imagination.

2.2 Summary of Findings

Care not Cash – product and market comparisons

The product comparisons highlighted the trend for private medical insurance to provide reimbursement of costs, rather than a true care component. Corporate products are a possible exception where the use of hospital networks and managed care approaches have directed employees to specific providers and treatment programmes. Individual consumers may be less satisfied with any perceived attempt to restrict their choice of specialist and hospital, or provide a second-opinion on their proposed treatment plan.

Long-term care insurance products have attempted to blend care and cash options, allowing people the option to have their benefit as care services or receive cash to directly commission their own care. The logistics of arranging home care services, often involving multiple providers and where the need for services will not be constant, has favoured cash payments to the insured. People may also prefer to commission services without any perceived interference from a third-party. This trend is also reflected in the introduction of Direct Payments by Local Authority Social Services.

Health cash products are designed to provide relatively small cash sums to help pay towards the cost of health care contingencies. Insureds tend to view the products as a form of savings plan. Some providers pay benefits directly to the insured's bank account, to reinforce the saving account perception and help to control fraud. Historically, the only differentiation between markets has involved price and distribution. Commercial entrants may develop differentiated products in the same way as PMI products. Existing mutual insurers may also seek to differentiate their products in order to manage portfolio experience and compete with new competitors.

Contrast between UK and Ireland

The large contrast between the healthcare insurance market penetration in the UK and Ireland was intriguing and worthy of some debate. In the UK, only 11% of the population have PMI and 18% have PMI and/or HCP cover, whereas in Ireland 50% have private healthcare insurance cover. The main difference between these markets appears to be the social policy context, and the associated market encouragement (in Ireland) via community rating, tax relief, open enrolment, lifetime cover and minimum benefits. It could be argued that the UK has much to learn from Ireland in developing private sources of health care funding which appear both fair and equitable.

PMI in Ireland was introduced originally in 1957 to meet the cost of hospital-based treatment for that proportion of the population (around 15%) that did not have entitlement to free treatment in a public hospital. Although full access has been available to all Irish citizens since 1991, PMI coverage has proven to be politically acceptable and popular. The market growth reflects greater affluence and a worsening perception of the public hospitals. Full tax relief on premiums has encouraged PMI growth, although has recently been restricted to a standard rate of 20% relief on all premiums.

The important private healthcare insurance contrasts between UK and Ireland include:

1. PMI is sold in the UK but bought in Ireland
2. Product design is from the insurer in the UK but partly regulated in Ireland
3. Intermediate & direct sales in the UK versus direct sales channels in Ireland
4. Product pricing is from the insurer in the UK but partly regulated in Ireland
5. Political antagonism in the UK versus consensus support in Ireland
6. Tax relief in Ireland but not in the UK
7. Community rating in Ireland but not in the UK
8. Open enrolment in Ireland but not in the UK
9. Lifetime cover in Ireland but not in the UK
10. Minimum benefits schedules in Ireland but not in the UK

Health Cash Plans

Health cash plans in both the UK and Ireland seek to complement the existing services for providing insurance cover for the incidental expenses associated with ill health. However, with increasing affluence, they also need to offer more care and treatment services in order to remain relevant. The NHS Plan in the UK and Public Health Service in Ireland are neutral on health cash plans, which may lead to market growth at the expense of PMI.

HCP products can provide cash payments for a range of family health services, primary, community and secondary care. They are sold as income replacement, partial expense reimbursement and supplementing NHS / Public health services. The benefits help to cover the costs of primary care treatment, hospital treatment expenses (excluding the costs of private patient treatment), specialist consultations, diagnostic tests and post-operative treatment expenses. They have been available in the UK for around 100 years and in Ireland for about 55 years, and they have met a public need for low cost and affordable health cash benefits for working people.

There have been historical links with the trade unions and manufacturing industry employers and the public sector employers. Consequently, the traditional product designs did not seek to replace any core NHS / Public health (or pre-NHS) services. The traditional health cash plan model emphasises the value of cash in hand for policyholders and tends to regard preferred providers as a form of unnecessary vertical integration. However, the recent acquisition by HCP insurers of PMI businesses may encourage more supplementary covers, perhaps accompanied by care provider networks.

Long Term Care Insurance

Long-term care (LTC) insurance is seen as providing a means to an end. Pre-funded LTC products provide extra cash so that appropriate care in the appropriate setting can be purchased. Following changes to the tax rules it became possible to pay cash benefits free of any income tax. Subsequently, most LTC providers offered the option of cash or care. In almost all instances where customers are given this choice they have opted for cash.

The provision of cash rather than care offers much more flexibility for the customer. The care required when a need for long-term care arises depends on a number of factors including type and level of disability, access to informal care and living environment. Cash offers greater flexibility in allowing individuals and their carers to select care services and to allow for changes in needs.

Irrespective of whether care or cash is selected, individuals and their carers can access a skilled care assessor. The care assessor can advise the customer on appropriate care services to their needs. This is an important component of LTC insurance products. The Cash versus Care debate is less of an issue for immediate needs long term care plans. The individual's need is for a guarantee that care home fees can be funded for as long as institutional care is required.

2.3 Debate on *Care not Cash* versus *Cash not Care*

2.3.1 Care not Cash

A **Care not Cash** product model assumes that people want their benefits expressed via appropriate health care services. The insurer, or a third-party, may provide the translation of cash into care services. For example, LTC insurance products utilise care advisors to help suggest care packages to meet individual needs. Care components can be developed in-house or via outsourcing. Delivering care not cash may also mean offering services earlier than point-of-claim. The insurance offer would have a package price, combining insurance benefits with the care service component. The customer could then be offered care, advice, counselling and/or treatment, rather than just Cash, which is only a means to an end (such as good health and/or treatment).

2.3.2 Cash not Care

A **Cash not Care** product model gives the insured flexibility in their choice of care provider, as well as protecting the insurer by capping the claim to the maximum amount shown in the benefit schedule. It is then up to the insured to find a care provider that will convert their cash funds in an appropriate care service package. Cash not Care assumes that consumers want to exercise choice and control over the care they receive. Cash can allow for a greater flexibility in commissioning home care services.

2.3.3 Care Components

The Care not Cash model relies on the ability to suggest the care components required to deliver a holistic package of appropriate care services. In practice, an effective care provider network might need to extend beyond secondary care providers to encompass family health services and community care services. People might also need access to a service capable of assessing need, including interpreting assessments provided by different agencies, such as the NHS and Social Services.

2.3.4 In between the health cash and private medical camps

In recent years, the demarcation lines between health cash plans and private medical insurance have been receding. There is now a growing overlap of product design features, such as health screening, laser eye surgery, infertility treatment, specialist consultations, diagnostic treatment. Also, health cash providers are acquiring private medical insurers, and may seek to develop hybrid products. This gradual blurring between the two product types is set to continue.

2.3.5 The Third Way – Care and Cash

There is a third way, **Care and Cash**, that could provide advice on appropriate care services, offer competitive prices for services and enable people and their doctors to exercise greater choice. This has the potential to give people the best of both worlds, safe appropriate care with the flexibility that they need regarding the choice of care provider. If this can be achieved, it has the potential to capture the public imagination and lead to a situation where health insurance products are generally bought rather than sold (as is perhaps the case with PMI in Ireland). **Care and Cash** product concepts might prove to be the salvation of health insurance.

3. NHS context in UK and Ireland

3.1 United Kingdom

3.1.1 National Health Services

State health care in the UK is provided through the NHS, which is available to all those normally resident in the UK. The NHS comprises services provided by General Practitioners, dentists, opticians and the community health services, e.g. health visitors, ambulance services etc, together with specialist care in State hospitals.

The NHS is largely funded out of taxation. Approximately 85% of the cost is met from general taxation, 13% from the NHS element of the National Insurance contributions paid by employers, employees and the self-employed and 2% from patient payments.

The comprehensive services are generally free at the time of use. Nominal charges are made for pharmaceutical, dental and ophthalmic services, although there are widespread exemptions from payment e.g. for pregnant women, children, the elderly and the chronically sick. Benefits for unemployment, loss of income following long- and short-term sickness, industrial injury and disablement are available under the separate State Social Security system, which is financed mainly from the NI contributions (about 88%) with the remainder coming mainly from government subsidy.

In the longer term, patient user charges may need to increase to help reduce unnecessary utilisation of services. The extension of charging to a wider range of NHS services might become more acceptable as consumer awareness grows of the constraints that reliance on public funds places on their available treatment choices. In the meantime, NHS patient charges are more likely to increase for ancillary services, such as prescriptions, dentistry, hospital amenity beds and home care support.

3.1.2 The NHS Plan

"The NHS Plan: A plan for investment, a plan for reform" and "The Government's response to the Royal Commission on Long Term Care" were issued in July 2000. These have been followed by several additional NHS Plan reports and policy announcements, on subjects such as dentistry, pharmacy, cancer and patient safety. A Modernisation Board is now overseeing the implementation.

The NHS Plan objectives are primarily to increase investment and patient choice, encourage diversity in service provision and to enable local providers to have greater freedom from central Government control. It is hoped that NHS waiting times will be reduced, primarily by allowing patients to choose from a wide pool of providers who have incentives to offer timely, high quality treatment.

According to the NHS Plan (extracts):

"People over 65 account for two-thirds of hospital patients and 40% of all emergency admissions. Too often they are treated in inappropriate acute hospital settings because there is nowhere else. Older people also worry about the prospect of deteriorating health, and can be anxious that they do not receive the care they need, sometimes simply because of their age. They are also distressed when service providers fail to respect their dignity and privacy – a problem which can occur at home or in a nursing home, as well as on the hospital ward."

"... the time may come when longer term care and support is necessary. Residential and nursing homes have provided much of this and the Government is taking action to ensure that the standards here are high. But a good range of other options is needed, including housing developments with immediate care and support available close by, as well as adaptations and care in people's own homes. The aim must always be to help people to do things for themselves, not to do things to them."

“pilot an NHS retirement health check, a free health check on retirement, to review any current treatment and to identify any further potential health problems.”

“In future, the NHS and local social services should support older people to make a faster recovery from illness, encouraging independence rather than institutional care, and providing reliable, high quality on-going support at home.”

“Most people prefer to remain in their own homes, living independently, for as long as they can. This needs effective support from primary and community health services, social services and housing.”

“A new tier of services – “intermediate care” – will give more people the help they need to remain independent at home, immediately after or even through a period of acute illness.”

“This part of the NHS Plan analyses alternative funding models against the twin tests of efficiency and equity. It concludes that the NHS remains a fair and efficient way of funding healthcare, and that it is the right choice for our country.”

“Proponents of patient charges argue that new charges should be introduced for a range of health services to encourage responsible use of resources and raise more revenue for the NHS.”

“Some European countries do make more use of user charges than Britain. For example, in parts of Sweden in 1996 there were charges for seeing a GP at about £10 per visit and for seeing a consultant of about £20 per consultant.”

“The Government is firmly committed to making high quality NHS dentistry available to all who want it by September 2001. ... It will reward dentists’ commitment to the NHS and foster better quality services for patients, making NHS dentistry a modern and truly national service again. Health authorities will take the lead in delivering the changes which patients expect.”

It remains to be seen how the NHS Plan will be implemented over the next few years. Some may be encouraged to buy HCP as a supplement to the NHS services, as well as to help cover the additional expenses likely to be incurred during a period of ill health.

NHS Plan initiatives to put patients ‘in the driving seat’ may succeed in levelling up standards of care as providers compete for patients. In the event that the NHS is modernised and NHS waiting lists are contained, private medical insurance will need to change its message to remain relevant. However, it could be argued that the NHS will always need to set priorities and that their translation into treatment and drug budgets will inevitably restrict consumer choice. Insurance solutions may allow consumers to move in and out of the NHS in order to have greater choice and flexibility around care options.

Many of the NHS Plan recent initiatives have been focused on the political need to reduce the waiting lists for consultations and treatment. The latest waiting list figures as at 30 June 2003 show that:

- The overall inpatient waiting list has fallen below 1 million, to 992,600. This is 62,100 less than at 30 June 2002 and 165,400 less than at 31 March 1997
- There were 34 patients waiting over 12 months for inpatient treatment at 30 June 2003, down from 159 at 31 May 2002. This is 20,500 less than at 30 June 2002, and 30,200 less than at 31 March 1997
- There were 197 patients waiting over 21 weeks for outpatient treatment, down from 328 at 31 May 2002. This is 29,900 less than at 30 June 2002. The number of people waiting 13 weeks for outpatient treatment has also fallen by 2,446 since 31 May 2002 to 158,800, which is 86,700 less than at 30 June 2002.
- No patients have been waiting for more than the 9 month standard for inpatient treatment of coronary heart disease.

3.1.3 Private Healthcare Insurances

PMI (private medical insurance) is purchased by approximately 11% of the population to supplement or provide a private alternative to some benefits otherwise available under the NHS. It covers the costs of specialist treatment and acute surgery but benefits may also be available for e.g. the treatment of alcoholism or psychiatric treatment. Individuals with PMI continue to pay for the NHS through general taxation and NI contributions. Individually paid premiums may not be offset against tax. Thus, these people are effectively paying twice for parts of their health care. They do, of course, remain entitled to use all NHS facilities.

HCP (hospital cash plans) are purchased by approximately 10% of the population to provide cash amounts in the event of specified medical events, such as hospital stays, maternity, dentistry and optical care. There is considerable overlap between PMI and HCP cover; around 18% of the population have PMI and/or HCP.

Some elements of PMI and HCP pre-date the introduction of the NHS. The National Insurance Act of 1911 established a statutory, compulsory scheme that supplemented benefits already being offered by Friendly Societies. For manual workers in employment, the Friendly Societies continued to offer insurance cover to those not protected by the 1911 Act. From 1911 to 1939, both the State and private schemes extended their roles substantially and in 1948 the NHS was established, against opposition from sectors of the medical profession.

Individual PMI premiums cannot be offset against income tax. Employees receiving Group PMI are treated as receiving a benefit in kind, which is subject to personal income tax on the value of the premium paid by the employer. However, very low-paid employees are not taxed on such benefits, whatever their purpose. Insurance Premium Tax (IPT), at a rate of 5%, applies to non-life health insurance including private medical expenses insurance.

The private healthcare insurance market has been overshadowed in recent times by the continuing growth of the private healthcare self-pay market. Some observers have estimated the recent self-pay market growth to be in the region of 25% p.a., which is clearly unsustainable in the long-term.

3.1.4 Long Term Care Insurances

Responsibilities for funding long term care needs in England and Wales are being redefined via interaction between the NHS, Local Authorities, charities and the judiciary. The impact of recent litigation on retrospective claims for NHS continuing care may lead to recommendations for greater clarity and consistency in the NHS provision of continuing nursing care. Moves towards clearer definitions of core and non-core NHS services, and responsibilities for funding such care, may help the development of a new generation of long term care insurances. The current situation in the UK is that, although the long-term care insurance market exists, it is somewhat undeveloped and is in need of innovative product development and other radical changes.

3.2 Republic of Ireland

3.2.1 Public Health Services

The Department of Health and Children has responsibility for the provision of all necessary healthcare services in Ireland through a network of 8 Health Board regions. Essentially, the system is a mix of public and private provision.

3.2.2 Eligibility for public health services

Currently there are two separate categories:

⇒ **Category I** comprises those who, on the basis of a means test, are entitled to receive all health services including GP services, prescription drugs and hospital services free of charge.

⇒ **Category II** comprises the remainder of the population who are entitled to free hospital treatment in a publicly funded hospital, subject only to payment of a daily levy of €40 per day up to an annual maximum of €400. Those in this category also have to pay the full cost of GP services and prescription drugs up to a maximum of €70 per month.

3.2.3 Primary care

Independent doctors provide General Practitioner services. Persons in Category II have to pay the full cost of this service, which is charged on a fee-for-service basis. The typical fee is in the region of €30 to €40. Very limited reimbursement of such fees is available through private health insurance. Those in Category II also have to meet the full cost of prescription drugs up to a maximum of €70 per month. Expenditure in excess of this amount is reimbursed by the State. It is important to note that no contribution towards prescribed drugs is covered by private health insurance.

3.2.4 Dental and Optical Benefits

Subject to meeting the specified contribution conditions, the following services are provided to those insured under PRSI (Pay Related Social Insurance) and to their dependants.

Dental

- Free dental examination and diagnosis.
- Free scaling and polishing and mild gum disorder treatment.

For other services such as fillings, extractions, dentures, root canal treatment and severe gum treatment, part of the cost, which varies with the treatment, is payable.

Optical

- A free sight test up to €34 in value every 2 years.
- Free glasses subject to selecting a certain type of frame. For other frames a fixed amount is reimbursed.

No income limit applies to optical benefit. Except for sight testing and emergency dental treatment immediately following an accident, the health insurers in the market do not currently provide comprehensive benefits in this area.

3.2.5 Private Health Insurance

Private health insurance was introduced in 1957 to meet the cost of hospital-based treatment for that proportion of the population (around 15% at the time) that did not have entitlement to free treatment in a public hospital. Although this entitlement has been available to all citizens since 1991, the coverage of private health insurance has grown since then. This probably reflects a combination of greater disposable income and a worsening perception of the service in the public hospitals except, perhaps, for emergency treatment. Allowing full tax relief on premiums also encouraged the growth

in private insurance. Over the last few years this relief has been restricted and is now only available at the standard rate of tax (currently 20%). As yet, the reduction in relief has had no noticeable impact on the level of coverage. Currently about 50% of the population have private health insurance. Around 70% of these are on a voluntary basis with the balance in company-paid schemes. The numbers covered have been growing by approximately 1.5% net per annum in recent years.

3.2.6 Health Insurance Act 1994

Prior to 1994, the Voluntary Health Insurance Board, which is Government controlled, had a monopoly in providing private health insurance. However, as a consequence of receiving exemption from the provisions of the Third EU Non-Life Directive, the Irish Government had to accept the controlled opening up of the market to competition. The basis for this is set out in the 1994 Health Insurance Act. Essentially, this Act provides that the Irish Government can, through a series of regulations, specify the broad terms on which any insurer in the market could offer health insurance products. It was not until 1 January 1997 that another health insurer entered the market.

Community Rating

The main thrust of the 1994 legislation is that all insurance contracts that are on an indemnity basis (i.e., reimburse the customer for medical costs incurred) must be community rated. This means that the same premium rate must apply to all adults effecting a particular level of cover regardless of age, sex or current state of health. However, insurers are permitted to exclude cover for pre-existing conditions for a limited period. Insurers are also allowed to charge a lower premium for children and to allow a group scheme discount up to a maximum of 10%. The requirement of community rating is underpinned by a series of regulations on open enrolment, lifetime cover and minimum benefit requirements, supported by a Risk Equalisation Fund.

Open Enrolment

An insurer cannot refuse cover to any person under age 65 (although a waiting period and the exclusion of cover for pre-existing conditions is allowed).

Lifetime Cover

An insurer is not allowed to refuse the renewal of an existing contract, unless the member tries to defraud the insurer or does not pay their premium for more than 13 weeks.

Minimum Benefit

The regulations require that every contract must provide a specified minimum level of benefit. Broadly speaking, this means covering the full cost of all medically necessary treatment in a public hospital, which is curative in nature. Long-term care is thus excluded. Consultants' fees have to be covered at the rate applicable to those who do not opt for the Full Cover Scheme, i.e. partially participating. In addition to medically necessary curative treatment, a specified minimum level of benefit has to be provided for childbirth, psychiatric treatment, substance abuse and short-term convalescence.

Risk Equalisation Scheme

This scheme, with the minimum benefit regulations, is needed to support the principle of community rating. Essentially, it provides that an insurer who suffers a disproportionately heavy claims experience is compensated out of a central 'risk equalisation' fund into which insurers who have a disproportionately low claims experience are required to contribute. The scheme is not currently in operation, as the regulations require that this only happens when the level of competition reaches a specified level.

A recent development has been the introduction of the Risk Equalisation Scheme 2003 with effect from 1 July 2003. The Health Insurance Authority will oversee the scheme and will collect the data upon which financial decisions will be made. It is understood that this Act might be contested.

3.2.7 Long Term Care Insurances

Unlike the UK, LTC insurance is not currently being offered in Ireland and there are no indications that this will change in the near future.

3.3 Comparative healthcare data

3.3.1 OECD comparative data

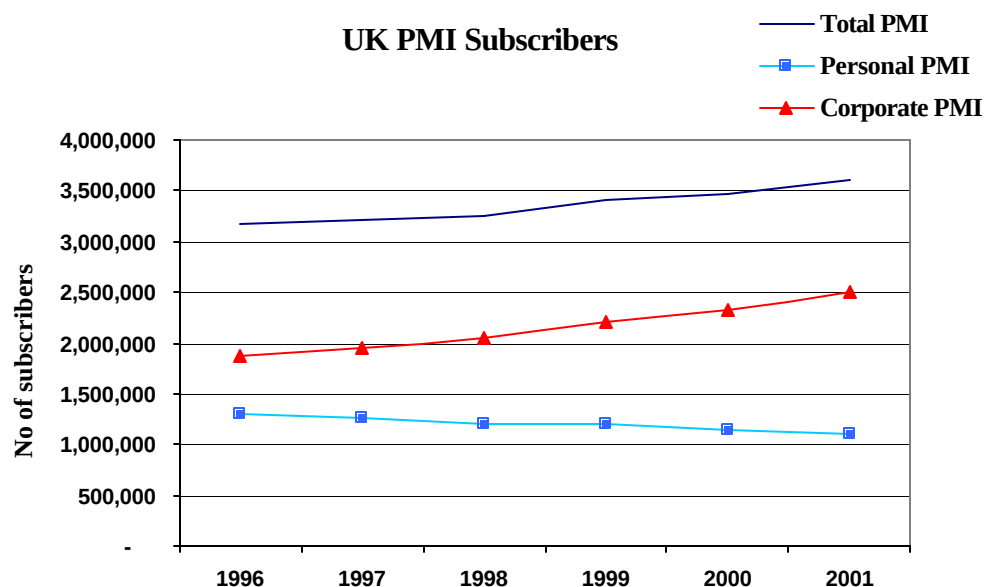
The OECD maintains health statistics on all OECD countries, including United Kingdom and Republic of Ireland. The total healthcare expenditures in both countries, as a % of GDP, can be subdivided by private and public health expenditures. It is noteworthy that Republic of Ireland has always (since 1960) maintained a relatively larger private healthcare sector.

OECD Health Data	1960	1970	1980	1985	1990	1995	1996	1997	1998	1999	2000
Total health expenditure - % GDP											
Republic of Ireland	3.6	5.1	8.4	7.6	6.6	7.2	7.0	6.9	6.8	6.8	6.7
United Kingdom	3.9	4.5	5.6	5.9	6.0	7.0	7.0	6.8	6.8	7.1	7.3
Public health expenditure - % GDP											
Republic of Ireland	2.8	4.2	6.8	5.8	4.8	5.3	5.1	5.3	5.2	5.2	5.1
United Kingdom	3.3	3.9	5.0	5.0	5.0	5.8	5.8	5.4	5.5	5.7	5.9
Private health expenditure - % GDP											
Republic of Ireland	0.8	0.9	1.6	1.8	1.8	1.9	1.9	1.6	1.6	1.6	1.6
United Kingdom	0.6	0.6	0.6	0.9	1.0	1.2	1.2	1.4	1.3	1.4	1.4
Private as % of Total											
Republic of Ireland	22%	18%	19%	24%	27%	26%	27%	23%	24%	24%	24%
United Kingdom	15%	13%	11%	15%	17%	17%	17%	21%	19%	20%	19%

Source: OECD Health Data statistics

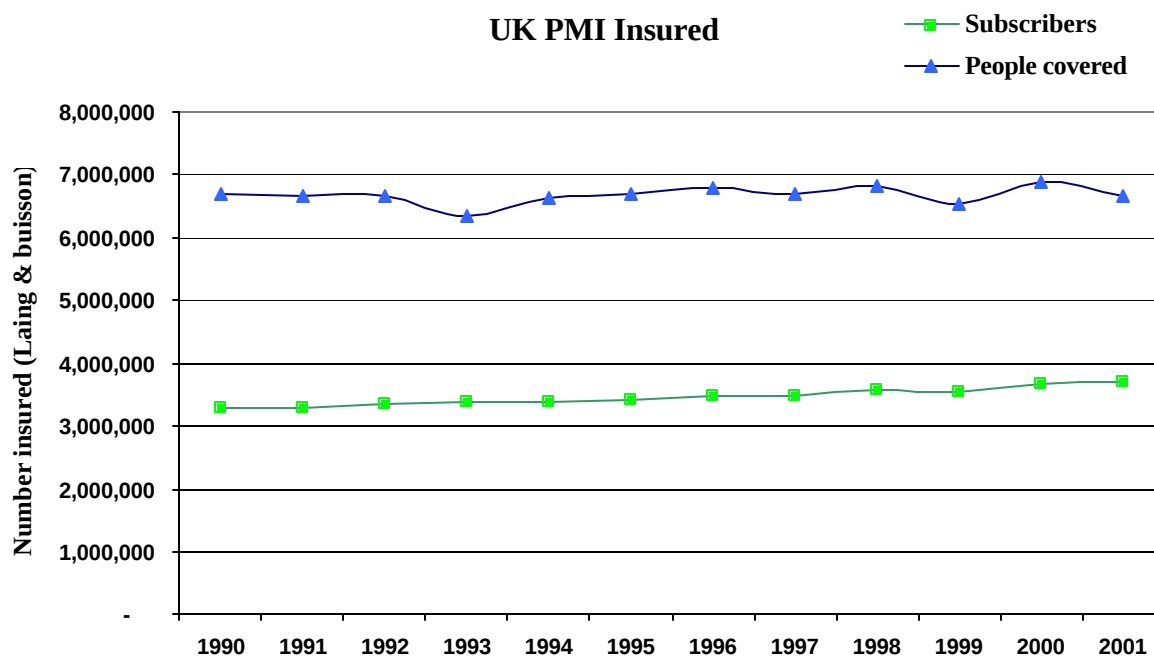
3.3.2 UK private medical insurance data

The overall number of PMI subscribers (i.e. family units) in the UK has been slowly increasing over the past decade. However, this feature disguises a switch from personal to corporate policyholders, as indicated by the following graph.



Source: ABI Annual Returns

It also disguises a reduction in the average number of people covered per family unit. Another industry data source provides the trend factors in both subscriber and the number of people insured.

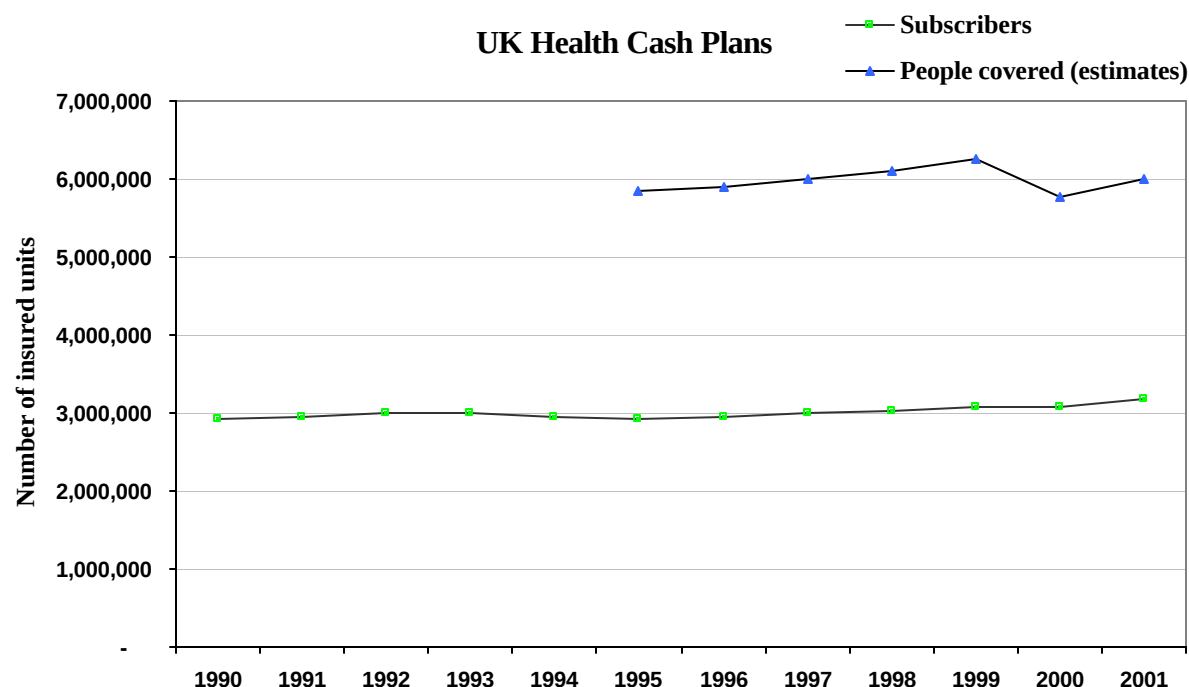


Source: Laing & Buisson "Private medical insurance, UK market sector report 2002"

Although the overall number of PMI subscribers in the UK has been slowly increasing over the past decade, the number of people covered appears to have reached a plateau.

3.3.3 UK health cash plans data

The overall number of HCP subscribers in the UK has been slowly increasing over the past decade. However, the same cannot be said for the number of people covered, which seems to have reached a plateau, or at least have no discernable trend.



Source: Laing & Buisson “Health cash plans, UK market sector report 2002”

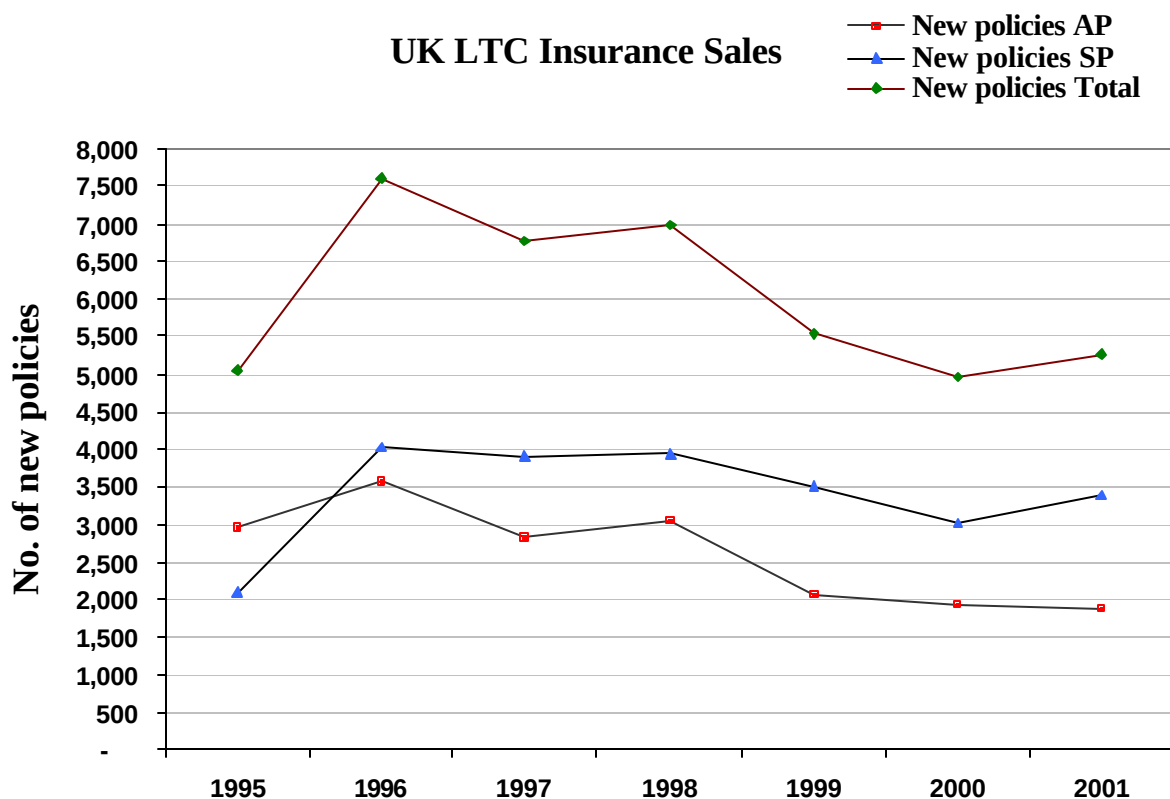
The secular trend in personal versus corporate sales is not known (unlike PMI). However, there are indications (see table below) that around 15% of HCP sales in 2001 were company paid, the other 85% being individual or voluntary group sales.

HCP sales distribution - 2001			
	Intermediated	Direct	Total
Company paid HCP	1%	14%	15%
Other HCP	1%	84%	85%
Total	2%	98%	100%

Source: Laing & Buisson “Health cash plans, UK market sector report 2002”

3.3.4 UK LTC insurance sales

The number of LTC insurance sales have been modest in recent years, with no discernable trend. The total number of sales has ranged between 5,000 and 7,500 per annum, which indicates little public appetite or demand for the product.



Source: ABI Annual Returns

Note

AP denotes annual premium policies

SP denotes single premium policies

4. Health Insurance Stakeholders UK and Ireland

4.1 Introduction

Those who have a direct interest in the health insurance market (the ‘stakeholders’) are outlined below. For each group different interests and viewpoints will apply, but these may generally be considered under the following headings.

- a. Will a greater care component make the stakeholder’s existence easier or more manageable?
- b. Will a greater care component address any specific need(s) of the stakeholder?
- c. Will a greater care component offer the stakeholder any financial, commercial or psychological improvement?

All of these stakeholders are relevant to both the UK and Irish systems with the exception of those marked with an (*), who are not stakeholders in the Irish system.

Health insurance stakeholders and ‘interested’ sub-groups include the following.

- ☐ Individual consumers
 - Self-employed
 - Households
 - Voluntary group
 - Older/Younger
 - Pre-/Post-Retirement
- ☐ Employers
 - Group-paid
 - Self-insured
- ☐ Insurers
 - Direct carriers
 - Reinsurers * (With the exception of Overseas International cover)
- ☐ Distributors
 - Direct
 - IFAs
 - Online
 - Other Agents + Brokers
- ☐ Providers
 - Hospitals
 - Clinicians
 - Nurses
 - Home-based
 - Nursing Homes
 - Therapists (e.g. physiotherapists)
- ☐ NHS / Irish Department of Health and Children
- ☐ Government
 - Executive
 - Treasury
 - Social Security

Local Authorities

The main proposition of this paper is that customers would welcome (more) certain *provision* of treatment, care and service, rather than cash benefits or reimbursements. Exactly which mix of elements, between direct treatment and care or guidance and support, is potentially most valued by customers is not immediately clear. An educated speculation at this stage might be that *fear and uncertainty* is the main area of customer difficulty that these changes could help with. Although customers may have supposedly adequate financial/medical coverage, their worries would be concerned with issues such as

- a) Late treatment
- b) Incompetent treatment
- c) No expert advice
- d) Can't get second opinion.

What they would very likely really value therefore, in the first instance, is not necessarily stipulated treatment but 'expert support' (and 'inside knowledge') to tell them where to go and what to do to get the best possible outcome for their particular situation (and then help them through it). Notwithstanding the above, the following reflects on the differences in viewpoints of the various stakeholders.

4.2 Social Policy Perspective

An important aspect of the Care not Cash debate in the UK and Ireland is the social policy perspective and the associated public/community interest in health insurance products. The fact that 11% of the UK population has private healthcare insurance, versus 50% in Ireland indicates that the social policy context and the public/community interest issues may have a key role to play. Public perception is especially important, as are the national political messages on the need for a private healthcare insurance sector to complement and/or supplement the publicly funded national health service. The public/community interest issues include:

4.2.1 Intangible insurance benefits

Healthcare insurance products that seem to give Care rather than Cash are generally actually giving a reimbursement of usual, reasonable and customary charges from an approved care provider in the insurer's care network. However, the arbitrator is usually the insurance company and the patient is not really in a position to challenge the insurer's decisions on whether to reimburse the care provider. Products that offer Cash rather than Care benefits may seem more tangible, until the patient discovers that the Cash is insufficient to purchase the Care that they need and thought that they had insured. The public interest issue is that the insured care benefits might be intangible and difficult to explain to the policyholder, leading to potential mis-selling concerns.

4.2.2 What care will the healthcare insurance products actually buy?

Claimants need to know the care that they can expect to receive in the event of a genuine claim. This puts the insurer in a difficult position, as they are generally neither guaranteeing the care nor its appropriateness. They also do not want any claim against them if the care proves to be inappropriate. The public interest issue is concerned with the transparency of the insured Care benefits.

4.2.3 What if patient then needs more care?

Private healthcare insurance is generally restricted to acute care episodes, where there is a cure or restorative treatment. In the UK, it does not cover chronic or incurable conditions, which it regards as the responsibility of the state. However, it may prove difficult to defend the accusation of "cherry

picking” the simple acute treatments and leaving the state (and the taxpayer) to pay for the chronic and incurable conditions in due course. There is also a potential for “queue jumping”, as the patient that has received the private acute healthcare treatment might then be given priority access to publicly funded care for their chronic or incurable conditions. The public interest issue is how access to (publicly funded) chronic care to ex-private acute care patients should be regulated.

4.2.4 What if patient’s doctor is not covered?

There is a trust relationship between the patient and their physician. Although the insurer may decide that the physician is to be excluded from their preferred care network, perhaps on the grounds of price, this may be unpalatable to the patient. Furthermore, the insurer insistence on an alternative physician (or hospital) may prove to be unfortunate, especially if there is a lack of patient trust, or if inappropriate care is given. The public interest issue is whether healthcare insurers should be regulated as regards their care provider networks and need to justify their choice of preferred physicians (or hospitals).

4.2.5 What if medical advice is contrary?

The insurer is on difficult ground if they seek to deny a claim on medical grounds, especially if there is a range of medical opinions on the subject. The public interest issue is whether insurers should be regulated such that they have to justify their medical decisions to an independent review panel.

4.2.6 What if care leads to patient harm?

Medical interventions are risky and sometimes lead to patient harm, which can be fatal. Although the healthcare insurer may seek to deny any responsibility in respect of patient harm, this may be difficult to defend if an approved care provider was used and the service was provided in a network hospital. The public interest issue is one of liability in the event of private patient harm.

4.3 Insured persons

As noted above, the greatest added value for individual consumers’ concerns may well be on advice and support, rather than stipulated treatment arrangements. Services that offer direct discussion and consideration of the customer’s problem and the choices available, followed by active support of the customer in managing the necessary processes could be of the greatest interest and value to this group. Anything that extends and supplements the usefulness for the customer such as visiting the customer at home, conducting certain logistics on the customer’s behalf (contacting specialists and hospitals, etc.), helps the customer to achieve the best outcome with maximum peace of mind. It is also assumed that, within the ‘advice and support’ heading, *quality* of care (e.g., doctors, hospitals, practitioners) is included for all consumers, to the extent that propriety allows.

4.3.1 Self-employed

The conventional wisdom for this group is that their priority is *speed* of treatment and recovery, together with some possibility of functionality while away from familiar surroundings. This is the supposed appeal for them of private health insurance in the first place. On this basis, any ‘care’ elements that enhance these types of features would be valued.

4.3.2 Voluntary group

There are no obvious distinctions between this subgroup and the ‘Households’ group, other than a common association of the members with the sponsoring organisation. There may be some opportunity for care items to reflect or utilise elements of the organisation’s facilities (e.g. book confidential face-to-face consultations with care advisors on the organisation’s premises).

4.3.3. Older/Younger

The immediate thoughts on this category are that younger customers would more often also be focussed on the needs of young families and may (?) be less fearful of potential illnesses and treatments than older customers.

4.3.4. Pre-/Post-Retirement

The obvious distinction here would be that post-retirement customers would normally have more (discretionary) time available than pre-retirement customers. They may also (depending on exact circumstances) place greater value on home-based services to support both the affected customer and the customer's spouse.

4.4 Individual policyholders (family units)

4.4.1 Overview

Most healthcare products are designed to give the customer access to care services when they need them. In most cases the end consumer sees the insurance product provider as providing the means to the end rather than actually providing the care services. In some cases the means to the end consists of advice and information but more importantly it means the money to pay for the care.

Some of the health insurance product providers are subsidiaries of larger corporate groups. These corporate bodies sometimes include health and care providers, although this is not necessarily a material factor for the potential customer.

The various healthcare products being considered by the Working Party are quite different in nature and are, therefore, considered separately in this section from an individual policyholders point of view. For example, the considerations for PMI, HCP and LTC are summarised below.

4.4.2 Private Medical Insurance (PMI)

The main motivation behind most individual purchases of PMI is to provide access to specialists and medical treatment more rapidly than is the case via the NHS/Public Healthcare system. The current system in the UK and Ireland is one of rationing of secondary and tertiary care leading to waiting lists which for more minor (less important) procedures can be quite long.

The customer views the medical insurer mainly as a provider of the cash to pay for the healthcare although the end result of owning a PMI policy will actually be the care. The customer does not expect to receive care from the insurer since the medical profession will provide this.

Just as with many other types of insurance, PMI policies generally provide access to various related telephone helplines, however these extra product features are not the main motivation for purchase.

There are some instances where individual purchases of PMI are designed to provide access to better quality care in the form of more luxurious surroundings, however it is still the case that this is made possible because the insurer is providing the cash which in turn provides the access.

When looking at PMI in isolation the care not cash or cash not care debate is not simple.

In most cases of claim the insurer pays the care provider directly following a claim made by the customer. There are occasions in which the customer will have paid the care provider directly and will be claiming the cash back from the insurer. The former option is the most common.

Does this mean, therefore, that PMI is generally providing care not cash or is PMI providing the cash to pay for the care with the direct payment to the care provider an added service?

To some extent the debate is irrelevant to the individual customer. All that is relevant is that when a need for medical services covered by the policy arises the insurer provides the payment. Therefore by virtue of owning the policy the customer has been able to access the care because the insurer has admitted the claim and then paid for the care.

4.4.2 Health Cash Plans (HCP)

Health Cash Plans are designed to pay cash benefits, which are in some cases linked directly to a medical service or requirement (e.g. dental or optical) and in some cases an amount of cash following medical treatment (e.g. hospital stay).

The main purchasing motivation for the individual is that for a relatively small upfront premium, cash will be received once one of the insured events occurs. This cash does not have to be used directly to purchase healthcare services but for whatever the customer requires. Unlike PMI the HCP is not generally viewed as a means of accessing private healthcare but as a way of receiving financial reward if an insured healthcare need arises. Many customers will expect to claim during a policy year especially if dental and optical benefits are included. It is possible to add some care related benefits in the form of helplines but the main motivation is cash.

4.4.3 Long Term Care Insurance (LTC)

As is the case with PMI, long-term care insurance is seen as providing a means to an end. The customer knows that there may well be a need for care in the future and that the cost of this care could be high. The pre-funded LTC product is used to provide extra cash so that the appropriate care in the appropriate setting can be purchased.

In the early days of LTC the providers did not pay cash to the customer but, for tax reasons, paid the care provider directly. Once the tax rules were changed to allow cash to be paid to the policyholder free of any income tax then most providers offered the option of cash or care. In almost all instances where customers are given this choice they have opted for cash.

The provision of cash rather than care offers much more flexibility for the customer. The care required when a need for long-term care arises depends on a number of factors including:

- The type of disability
- The level of disability being experienced
- Whether a partner, relative or friend is living either with or close by the person needing care
- The surroundings

Consequently, no two cases are the same and the care services required can vary quite enormously from round the clock skilled nursing care to someone to help with the gardening. Cash offers great flexibility and so is preferred by individual policyholders.

An important service offered by most providers as part of the claims process is access to a skilled care assessor who can advise the customer on the care services that would be of most use. This is an extremely important service when the customer is opting for cash benefits in helping to make sure that the person needing care knows what they need and what is available.

The cash versus care debate is less of an issue when the customer needs to go into a care home. In this case the most important issue is that the money is there to pay the care fees and will continue to be so for the whole of the time that they need to stay in the care home.

4.5 Group policyholders (employers)

4.5.1 Conventional wisdom

The conventional wisdom here is that employers provide health insurance for their employees for the following reasons:

- a) Increase job attractiveness and staff loyalty
- b) Minimise lost working time through illness, accident, etc.

At the same time, employers will obviously be keen to keep associated costs down.

4.5.2 Why does a company choose to provide employee health benefits?

The main reason that a company offers health related benefits to employees is to control sickness absence by ensuring prompt treatment for illnesses, particularly for key staff. As the demands upon the Public healthcare services have increased the number of companies considering health insurance has increased too. Employee benefits related to health may vary from access to a health information line through cash plan products to full PMI. Employees also generally appreciate receiving health related benefits in kind and employee satisfaction and retention rates may be improved.

In Ireland, the provision of employer paid PMI is for exactly the same reasons as in the UK even though the contract with the PMI provider is held with each individual employee and not with the employer who is paying the premium in full.

4.5.3 What do employers look for when choosing a health benefit provider?

The size of the company and the number of employees offered health benefits tend to affect an employer's priorities:

- a) A smaller company, whilst looking for a reasonable price for the chosen level of cover, will possibly place reasonable importance on the efficiency of administration and payment of claims.
- b) A larger company, whilst also looking for a reasonable price for the chosen level of cover, is more likely to build a working relationship with the health insurance provider.
- c) A larger company where health benefits are offered to a small percentage of employees will probably fit in between the two scenarios above

4.5.4 Care not cash?

For companies offering health benefits to their employees it is perceived to be a balancing act between achieving value for money, a cash focus, and controlling the sickness absence and its effect on productivity, more care focused but also having a cash element.

4.6 Healthcare providers (e.g. hospitals, doctors)

4.6.1 Introduction

Care versus Cash issues and concerns are particularly relevant for the healthcare provider community (e.g. hospitals and doctors). The key issues and concerns are outlined below.

- a. *Participation in Preferred Provider Networks*
This offers providers two main advantages: an enhanced flow of business and a potentially more robust basis for their own business planning. The quid pro quo is a reduced unit charge to the 'commissioning partner'.

- b. *Effects on Providers' own arrangements, structures and planning*
- c. *Opportunities for new or overseas Providers*
- d. *Advantages and disadvantages of increasing care components*
- e. *Information and guidance versus direct care provision*
To the extent that direct treatment within own facilities is inherent to the provider's business, information and guidance services pose a potential threat by giving customers reasons to prefer other providers. Conversely, such providers would be in an excellent position to benefit from greater direct care provision, if they can successfully secure themselves as the supplier.
- f. *Basis of information and guidance*

▫ **Official/formal versus unofficial/informal**

There is little doubt that many customers regard medical and care provision as a complicated, cabalistic, anxiety-provoking minefield. Consequently, they feel the need for expert guidance and support (not often available), preferably with 'inside knowledge', to help them identify and manage the best option(s) available to them. Preferred provider arrangements offer elements of 'quality control', but do not remove the need to ask pertinent questions and make informed choices between alternatives, albeit a qualified subset of 'the whole'. Similarly, although recent Government developments have begun to put certain performance and quality information into the public domain, the reality is still that considerable know-how and 'inside knowledge' is required to successfully identify and obtain the best available care.

▫ **Legal risks**

Given the above, there is a potential conflict between the sharing of 'specialist'/'inside' knowledge with customers and possible exposure to formal (or informal) hostile actions by potentially offended parties. This may prove a significant stumbling-block once one moves beyond purely objective or documented matters of cost and medical generalities to unpublished (though nevertheless widely acknowledged) matters of practice quality.

4.6.2 Hospitals

Hospitals will require prompt payment for services provided e.g. accommodation, either by cheque or by electronic transfer. This is very cash focused.

4.6.3 Healthcare Professionals

Healthcare professionals (e.g. doctors, anaesthetists) are care focused and concentrate on improving the health of their patient. In the event that a patient has a health insurance policy with limited benefits, the patient's physician will need to consider the costs of the proposed treatments versus the potential improvement in health. A balance is needed between care and cash focus. Overall, the healthcare professional whilst requiring prompt full payment for services provided will generally also have some focus on the care elements of the product. If the costs of treatment exceed the benefit limits of the policy, the patient will have a benefit shortfall. Issues may arise from the apportionment of the excess cost between the patient and the healthcare provider.

4.6.4 Clinicians

Many of the comments above relating to preferred providers can also apply to clinicians. Recent developments of anaesthetists successfully forming ‘practice chambers’, to better manage the offering of their services, may also extend to other clinicians. This may have some relevance in future possibilities for greater direct care arrangements.

4.6.5 Nurses

In many of the scenarios being considered under information and guidance, nurses have a potentially pivotal role to play. Over the spectrum of remote/telephone access through to home visits, nurses would appear to be a prime candidate as expert, but also trusted and approachable, proponent (as many medical helplines already bear witness).

4.6.6 NHS / Irish Dept. of Health & Children

In many ways, the NHS and Irish public healthcare systems are simply **another healthcare provider**. They will have similar interests to other healthcare providers, striving to optimise their services and financial viability. The key differences arise from the larger scale, with the associated complications of public interest and various governmental and political overlays. However, they may be starting from the opposite end of the Care versus Cash spectrum, with a focus on Care rather than Cash, albeit perhaps seeking to encourage patient choice and empowerment.

4.6.7 Care homes

Care homes are interested in receiving the fees required for the level of service / care that the residents need. In particular they need some comfort that fees will continue to be paid for as long as the customer continues to need care. To this extent the question of care or cash from a long term care insurance policy is of no relevance. What is relevant is that the benefit is sufficient to meet the continuing and increasing fees.

Some insurers pay the care home directly whilst others pay the cash to the customer who then in turn pays the care home. The former approach may be of some interest to the care home provider as it avoids the possibility of the money being diverted for other reasons / costs after leaving the insurer.

4.7 Insurance companies

Insurers are one of the natural stakeholders for the future of health insurances.

The insurance company interest in possible product changes is either to make products more attractive to customers (i.e. sell more) and/or to improve their profitability.

Two immediate distinctions influencing insurers’ potential viewpoints are

- ❑ **‘Integrated’** versus **Unintegrated**
- ❑ **Large** versus **Small**

4.7.1 ‘Integrated’ versus Unintegrated

By ‘integrated’ we mean also owning or controlling means of care provision. Insurers in this position might be more enthusiastic or forceful in pursuing greater care content in their product offerings.

Notwithstanding the involvement of public interest agencies (e.g., the Office of Fair Trading), some healthcare insurers appear to have decided to try and make use of their own care services and facilities. From the insurance company’s point of view, such an approach could add value to their

product offerings, while having more direct control over quality and costs of provision elements, as well as keeping the maximum amount of revenue within the organisation.

In Ireland with the exception of BUPA having a shareholding in one high tech facility (Blackrock Clinic), neither insurer has or seems to have plans to own or manage their own care facilities.

4.7.2 Large versus Small

Larger insurers have the power to achieve best cost/value situations and also to obtain customised elements according to their requirements. In this respect, they may have similar characteristics to integrated carriers in pursuing greater care content in their customer offerings. To the extent that they do not own possible care providers, they are arguably in a more flexible position than integrated carriers, although perhaps the latter may achieve more streamlined dovetailing and quality control.

4.7.3 Long term care insurance

Insurance companies providing long term care insurance have developed products over the years, which contain elements of cash and elements of care. Most provide advice and information to customers via telephone helplines as well as care advice and management at time of claim.

Insured benefits tend to be cash related since this is how the level of cover purchased by the customer is defined. On one hand there are arguments for the insurer providing care not cash in that if all benefits were defined as care then the insurer could decide what care is required. By controlling costs in this way it may be possible to reduce the cost of long term care insurance.

On the other hand, care in the home should include domiciliary care services such as cleaning, gardening, home maintenance etc. and it would be an administrative nightmare for the insurer to arrange for the provision of all of these care services. Hence it is much simpler to pay the cash to the policyholder and let them or their dependants organise the care.

The industry seems to have decided that the best way forward is to provide the cash along with the care advisory services mentioned above.

4.8 Reinsurance companies

Invariably, reinsurance companies have an interest in care services only through the arrangements they have with insurance companies. The extent to which they have a stake in this varies depending on the degree in which they are purely providing reinsurance capacity or moving further into a full partnership relationship with their clients (the insurers).

Taking the case where they have a full relationship with the client, this would include, for example, where reinsurance is proportional and interests are aligned with those of the insurer. Here, the same considerations of customer attractiveness, company market profile and possibility for enhanced profitability mirror the insurer. In these cases, they are a more interested stakeholder.

It could be argued that the same considerations are not really appropriate where capacity only is being provided. This would include, for example, non-proportional reinsurance partnerships. Considerations here are more aligned with simply claims control and claim size reduction techniques more associated with risk and profitability issues only.

It may be considered that there is a natural divide here between the professional reinsurers and other reinsurers including the Lloyds of London insurance market. Whilst all types conduct reinsurance for capacity only it is usually considered that only the professional reinsurers deliver the full service proposition referred to above.

A further possible consideration is the different attitude between the Life and Non-Life management strategies. There can be different interpretations of the segregation of the shorter-term (e.g., private medical insurance, major medical expenses, health cash plan) products compared to the longer-term business (e.g., income protection, critical illness, long term care). This may be reflected in the willingness to invest in developing **Care** rather than **Cash** related products.

The issues are, however, not clear-cut and it may be interesting to briefly consider some possible scenarios:

- In many cases, the care elements are not reinsured. The care provider covers any utilisation risk. However, there could still be an added benefit to reinsurers' claims management considerations and profitability enhancement.
- In some instances, reinsurers have partnerships with third party providers. In these cases, there could be a direct interest in the provision of any of the care services set out in this paper.
- To the extent that reinsurers make their reputations in market research, there will be a benefit in them understanding the types of care services that are available. Indeed, in order to provide a full relationship with healthcare insurance providers, it can be argued that this level of knowledge is required.
- It can be argued further that reinsurers are in a position to provide a forum for discussion of any issue of general interest that affect the insurance market. This may be useful in facilitating discussion on the impact of care services should this be considered an important topic in its own right.
- Finally, with reinsurers often looked on to provide the pricing support to the market, they will have an interest in collecting data on the utilisation and costs of any care services where there is a pricing consideration that they have agreed to support.

So, whilst on the face of it, a reinsurer may be considered ambivalent towards the inclusion of care services in insurance products, there are many areas where they should be more of an interested party.

4.9 Distribution channels

Distributors of health insurance products are potentially in a difficult position. On the one hand, anything that has a potential to bring them closer to the customer is attractive. On the other hand, they may risk putting themselves in the firing line if customers' expectations are disappointed. In this respect, greater care content in health insurance products would seem to offer both potential advantages and disadvantages.

4.9.1 Advantages

Clearly, if the greater care content of products is well constructed to make a more attractive offering, then the IFA/Broker/Salesman/..., etc. will have an easier sale and a more satisfied client (at least initially). There will also be an opportunity for the distributor to be a point of contact for information and guidance services.

4.9.2 Disadvantages

Many of the potential disadvantages are the flip side of the possible advantages. By pursuing a closer involvement with the customer, the distributor will also be the first port of call for customer disappointments and complaints. This is nominally the current situation. However, it may well be a more difficult situation for a broker trying to pursue a customer's care-related difficulties with a provider and/or insurer than a financial claim with the insurer.

There is also the potential for customers to look to the distributor for information and guidance on direct care use that the distributor is not in a position to provide. More direct care elements may well also make up-front product comparisons more difficult.

4.9.3 Long term care insurance

IFAs (independent financial advisors) provide the primary distribution channel for long term care insurance. The product continues to be viewed as a difficult sale by many IFAs as they find it difficult to discuss the care issues involved. Although a list of ADLs (activities of daily living) looks quite simple at first sight it is difficult to explain to a prospective customer what failing say 2 out of a list of 6 ADLs actually means.

The IFA also needs to be able to explain how State and local authority benefits operate in the prospect's case. Long-term care insurance is generally sold as a top up since most people can afford to pay some of their care costs themselves.

Consequently the easiest option for the IFA is to be able to focus on the cash benefits from the policy to the customer. Most IFAs would therefore opt for cash not care although they do value the care advisory services offered by most providers.

5. Other Health Initiatives

5.1. Income Protection

- a) **Motivation** - The primary motivation for the customer is cash. As with LTC, it is possible to add care services, advice and information to the product but the clear priority is to replace lost income.
- b) **Product outline** - Income Protection is very much a monetary-related product proposition in that, by definition, it provides cash when the customer is unable to work and continue to earn money. In most cases, the benefit is not seen as paying for care (although it could be used to pay for care services if the customer so wished) but to pay for general living expenses.
- c) **Distribution channels** - All principal channels offer IP products. IFAs dominate, especially in the Group market.
- d) **Care not Cash elements** - An important Care not Cash element is rehabilitation services, whereby the insurer decides to 'invest' in claims that might be foreshortened by rehabilitation. The provision of physiotherapy for musculo-skeletal claims, or counselling for stress and depression would be the most obvious examples. Usually positioned as a 'win, win' as both insurer and claimant stand to benefit from successful rehabilitation. Rehabilitation pilot schemes sponsored by the Department of Work and Pensions will inform future Government policy on rehabilitation, including the extent to which rehabilitation may become a pre-requisite to benefits. This sentiment might, over time, influence design of future Income Protection policies.
- e) **Cash benefits** - Essentially still seen as a cash-based product.

5.2. Critical Illness

- a) **Motivation** - The primary motivation for purchase of this product is to receive a relatively large cash sum if one of the insured events occurs. It is often sold as part of a mortgage protection package in which case the cash is intended to pay off the mortgage.
- b) **Product outline** - The product design and the definition of the various health conditions for which benefit is payable have been outstripped by advances in medical science leading to a much higher proportion of 'windfall' claims. Early diagnosis and treatment in the key areas of cancer, heart disease and stroke mean that many claimants effect a full recovery and return to work with a substantial cash payment. It can be argued that this is not the purpose of the product.
- c) **Distribution channels** (direct on-line, direct sales force, brokers) - Primary distribution channel has been the IFA market, and with particular penetration in the mortgage market where it has played the role of a replacement product for endowment mortgage business.
- d) **Care not Cash elements** - Some insurers appear to be supporting their critical illness products and/or customer care strategies via the care advisory services. Care not Cash elements might in future increase as a result of growing product sophistication and differentiation.
- e) **Cash benefits** - Although the cash could be used to pay for care and in many cases some of the proceeds will be used for care, CI is very much a cash based insurance product in the eyes of the individual consumer.

5.3. Major Medical Expenses

- a) **Motivation** - To cover the high cost procedures, usually in a private medical setting. The key motivation is financial. Buyers of this product are usually happy to self-fund the more common, lower cost procedures, but want the assurance that very high cost procedures will be covered. At present in Ireland MME policies are not available.
- b) **Product outline** - The product will usually specify the conditions for which benefit can be claimed, e.g. major organ transplant, and can be structured with an excess or on a co-payment basis. Another derivative is the 'Out of Country' product where a UK policyholder can elect to have treatment in another country (usually the USA) up to a cost of £1 million. Low utilisation is to be expected, but where a procedure might be deemed 'leading edge' in the UK but commonplace in the USA, the policyholder may feel more inclined to travel. Transportation and concierge services would be included in the cover.
- c) **Distribution channels** - Predominantly IFA and specialist medical brokers.
- d) **Care not Cash elements** - Helplines (24/365) can help bring utility to a product that may not be used frequently. In addition, navigation services may help the customer source care for procedures not covered by the product. For the 'Out of Country' version, similar support services might be needed to help the patient integrate back into NHS mainstream care.
- e) **Cash benefits** - Financial issues dominate because of the very high costs of certain procedures and treatment. However, where comparatively new or rare interventions are involved, medical second opinion services and the ability to source the best doctor will be important features.

5.4 Health Account and self-pay potential

- a) **Motivation (UK)** - Conventional PMI is seen by many observers as being 'poor value' or 'too expensive', particularly by those in older age groups who leave company-paid arrangements. According to the Independent Healthcare Association, the number of patients paying for private hospital treatment out of their own pockets has tripled since Labour took power in 1997. A recent Laing & Buisson report showed that NHS hospitals raised their private patient income by 7.6% in the financial year to last April. Growth in the self-pay market could be seen as an opportunity rather than a threat.
- b) **Motivation (Ireland)** – Due to Community Rating of PMI premiums, the amount of people who opt to self-pay is thought to be extremely low but there are as yet no official figures.
- c) **Product outline** - A variety of mechanisms are available to assist the self-pay market, including high excess PMI products. This approach can be extended to provide the savings vehicle through which self-payers accumulate their own fund. The fund can be drawn down or supplemented by unsecured borrowing depending on the cost of the procedures and the amount of the excess.
- d) **Distribution channels** - Likely to appeal to Banks and Building Societies who can readily offer the savings vehicle. They also control access to large numbers of potential buyers.
- e) **Care not Cash elements** - Care Elements assume greater importance because, in many situations, the customer will be arranging their own care. Consequently, navigation services, care advice and second opinion services may form an important part of the total package.
- f) **Cash benefits** - Not applicable unless the excess is breached.

5.5 Care Services

5.5.1 Helplines

Simple and cheap to provide, helplines usually give 24/365 utility to products that may otherwise be infrequently used. In reality most helplines are, themselves, little used and tend to represent a nice marketing ‘wrapper’. They are frequently found across most classes of Health and Protection business and can be generic, e.g. a ‘health concerns’ helpline or specific, e.g. GP helpline.

5.5.2 Advisory Services

These usually take the form of information and advice given to fill gaps in mainstream services. Typical examples:

- Medical second opinion
- ‘Find the best doctor’
- Home visit services for medical specialisms, therapy and counselling.

They are designed to widen choice by enhancing or extending what is generally available from the State.

5.5.3 Rehabilitation Services

Usually, but not exclusively, found in Income Protection markets, the Insurer may decide to ‘invest’ in claims that might be foreshortened by rehabilitation. The provision of physiotherapy for musculo-skeletal claims or counselling for stress and depression would be the most obvious examples. Usually positioned as a ‘win, win’ as both insurer and claimant stand to benefit from successful rehabilitation. ASU (accident, sickness and unemployment) insurance markets are also regular users of rehabilitation but stringent cost/ benefit analysis is applied because of the shorter duration of these contracts.

5.5.4 Managed Care Services

Similar in concept to rehabilitation, but seen mainly in the LTC sector where elderly people needing domiciliary care have programmes put together that meet their care and special equipment needs. The insurer then settles accounts directly with providers. There is an argument that suggests people should be given cash and allowed to purchase their own care, or use an independent agency to source it. However, an elderly person living alone may not find this practical. The other difference to rehabilitation is that, with LTC, the Sum Assured or Benefit is being used to fund the care. With IP, rehabilitation costs are funded by the insurer over and above the cost of the policy benefits.

5.5.5 Navigation Services

These services are designed to support people who want to fund their own risk or to carry a high proportion of it by way of substantial excess, e.g. the first £5000 of a PMI claim. Designs recognise that, within the excess, people needing care will require help to navigate their way around the healthcare maze. Identification of locations where a particular procedure may be available within a short timeframe at a ‘package’ price would be a typical example. The surrounding administration is also often part of the service.

PMI (private medical insurance) in the UK

1. State welfare context (funding, tax incentives)

State healthcare in the UK is provided through the NHS and is available to all those normally resident in the UK. Tax incentives depend upon whether PMI is purchased by an individual or a company.

- Individual:* Tax incentives to purchase PMI are no longer available to individuals.
- Company paid:* Companies offering PMI to employees may offset the cost for tax purposes. Employees receiving Company paid are treated as receiving a benefit in kind, which is subject to personal income tax on the value of the premium paid by the employer.

Insurance premium tax (IPT), currently at a rate of 5%, applies to PMI at the point of sale.

2. Product outline (benefit schedule)

- an indemnity based product
- provides private medical treatment for acute conditions
- excludes emergency conditions and chronic conditions which are generally covered by the NHS
- The level of treatment available depends upon the cover purchased, as indicated below.

Benefits	Comprehensive	Budget
Out-patient	Overall annual limit or on some treatments	No cover
In-patient	Full refund	Full refund
Primary and community	None	None
Other	Private ambulance, Health information line	None
General	Options include excesses, hospital network	excesses, hospital network
Exclusions	None	Psychiatric cover

3. Care provider network (hospitals, consultants)

Policyholders can choose between products that do and do not limit the care providers (e.g. hospitals and specialists) that can be used. Some products either restrict a policyholder's choice of consultant/specialist or restrict the amount that the healthcare insurance company will pay towards the consultation and treatment.

4. Distribution channels (direct on-line, direct sales force, brokers)

Wide range of direct and intermediated distribution channels. The method of distribution tends to depend upon whether PMI is purchased by an individual or a company.

- Individual:* The majority of individual PMI business is sold through a direct sales force using direct marketing techniques. Sales through brokers tend to be lower possibly because the commission incentives relative to the amount of time and knowledge needed is low compared to the sale of general or life insurance policies. On-line direct sales is a new distribution channel.
- Company:* Conversely the majority of Group PMI business is sold through brokers. Although the larger PMI companies often have a Group business direct sales force it is usually not a viable option for smaller PMI companies due to the costs involved. Direct sales on line is more likely to be used by a broker on behalf of a company rather than a prospective company client.

5. Care not Cash elements

- The care and cash elements depend on the benefits covered. A comprehensive product where all treatments are covered with no benefit limits or excesses could be perceived as offering only Care not Cash benefits. However the majority of products have some benefit limits or excesses that bring a cash element to the product; e.g. the care provider network restrictions.
- Care not Cash elements generally take the form of information and advice given to fill gaps in mainstream services. For example, medical second opinion, find a Consultant with relevant specialism, find a complementary medicine therapist, counselling services. These can be designed to widen choice by enhancing or extending what is generally available from the State.
- Helplines generally provide 24 (hour) 365 (day) utility services that can supplement products that might otherwise be infrequently used; they can be generic (e.g. health concerns, nutrition advice) or specific (e.g. find a hospital, find a doctor, GP/nurse advice).

6. Self-pay possibilities (excess, co-payment, percentages, health account)

The private healthcare self-pay market has recently been increasing; some observers have estimated growth at 25% p.a. The growth in self-pay has been associated with private healthcare navigation products, either stand-alone products or associated with high excess PMI and/or MME.

PMI (private medical insurance) in Ireland

1. State welfare context (funding, tax incentives)

State healthcare in Ireland is provided through mainly general taxation and is available to all those normally resident in Ireland. Tax incentives depend upon whether PMI is purchased by an individual or a company.

- a. *Individual:* Tax relief given at 20% of full PMI premium paid to all persons.
- b. *Company paid:* Companies offering PMI to employees may offset the cost for tax purposes. Employees receiving Company paid are treated as receiving a benefit in kind, which is subject to tax at a person's marginal rate (currently 42% or 20%) on the value of the premium paid by the employer but are also eligible to claim standard rate relief (currently 20%) on the full premium paid.

2. Product outline (benefit schedule)

- an indemnity based product
- provides private medical treatment for most medical conditions including emergency conditions and chronic conditions.
- The level of treatment available is the same on all PMI plans due to Government regulated minimum benefit requirements with the only real difference between plans being the level of accommodation available.

3. Care provider network (hospitals, consultants)

Policyholders can choose between products that do and do not limit the care providers (e.g. hospitals and specialists) that can be used. Some products either restrict a policyholder's choice of consultant/specialist or restrict the amount that the healthcare insurance company will pay towards the consultation and treatment.

4. Distribution channels (direct on-line, direct sales force, brokers)

A range of direct distribution channels, but the intermediated channels are still in their infancy. The method of distribution tends to depend upon whether PMI is purchased by an individual or a company.

- a. *Individual:* The majority of individual PMI business is sold through a direct sales force using direct marketing techniques. Broker sales do not take place in Ireland, as PMI providers do not pay commissions. On-line direct sales is a new distribution channel, which is proving very popular for PMI providers in Ireland.
- b. *Company:* The majority of Group PMI business is sold through the PMI providers direct sales force but the use by companies of the independent expertise of Employee Benefit consultants is on the increase.

5. Care not Cash elements

- a. The care and cash elements depend on the benefits covered. For most plans in Ireland the only hospital benefit limit for medically necessary treatment is a 180 day in-patient rule per year and could be perceived as offering only Care not Cash benefits. However the majority of products have some benefit limits or excesses on non-hospital care such as Outpatient expenses etc.
- b. Care not Cash elements generally take the form of information and advice given to fill gaps in mainstream services. For example, medical second opinion, find a Consultant with relevant specialism, find a complementary medicine therapist, counselling services. These can be designed to widen choice by enhancing or extending what is generally available from the State.
- c. Helplines generally provide 24 (hour) 365 (day) utility services that can supplement products that might otherwise be infrequently used; they can be generic (e.g. health concerns, nutrition advice) or specific (e.g. find a hospital, find a doctor, GP/nurse advice)

6. Self-pay possibilities (excess, co-payment, percentages, health account)

Can be an option in Ireland due to full tax relief being allowed at a person's marginal rate of taxation on all eligible medical expenses not recoverable from another source. There are currently no official figures on the take up of this option.

Excess products are available in Ireland for In-Patient cover but the excess amounts are quite low (€63) and will only decrease a person's premium by about 10%.

HCP (health cash plans) in UK and Ireland

1. State welfare context (funding, tax incentives)

The main medical services in the UK and Ireland are provided free though some elements are charged for though subsidised (e.g. dental treatment, prescriptions). Many ancillary health services are provided privately (e.g. chiropody, physiotherapy etc) in addition to limited State provision. The main services are also duplicated by private services funded by insurance or by self-pay.

2. Product outline (benefit schedule)

There are a wide variety of health cash plans available in the UK providing an enormous range of health related cash payments. In Ireland at present there are only 3 providers. The most complex plans provide as many as 100 (20 in Ireland) separate benefits and are often sold with different benefit levels. Typical plans will include

- a. Cash payments to reimburse all or part of a health related cost. Examples of this would include dental and optical bills.
- b. Cash payments that recognize that additional expenses will be incurred when a health related event occurs. Examples of this include cash payable in respect of each day as a hospital inpatient, in respect of day patient care or for a maternity.
- c. Personal accidents
- d. Provision of telephone based medical and other assistance services. (Not available in Ireland)

3. Care provider network (hospitals, consultants)

Some arrangements are in place to allow the policyholder to enjoy reduced costs for example with national chains of opticians. These arrangements would not be mandatory. (Not available in Ireland)

4. Distribution channels (direct on-line, direct sales force, brokers)

The main channels are through company or affinity group sponsorship (trade unions are significant) backed by workplace marketing, Direct Sales often telephone based for individuals, Brokers for company paid and sponsored. More recently the product has been sold as an add-on with PMI.

5. Care not Cash elements

- a. Limited to medical helplines and other assistance helplines.
- b. Some insurers have pro-active helplines with outgoing calls triggered by medical claims.
- c. Helplines generally provide 24 (hour) 365 (day) utility services that can supplement products that might otherwise be infrequently used; they can be generic (e.g. health concerns, nutrition advice) or specific (e.g. find a hospital, find a doctor, GP/nurse advice).
- d. The above are at present not provided by Cash Plan insurers in Ireland.

6. Self-pay possibilities (excess, co-payment, percentages, health account)

Not applicable

LTC (long term care)

1. State welfare context (funding, tax incentives)

State provision of long-term care has become quite complex in the UK in recent years with different rules in England, Scotland, Northern Ireland and Wales.

In Ireland there is no Long Term Care insurance available, so the burden of provision falls to the State or to the individual who is deemed to be in a position to provide for the services themselves.

For those people of limited means the State will generally provide (pay for) both homecare services and care in a registered care home within certain monetary limits. The individual needing care will still contribute some of their own income towards care in a care home.

For those people with greater means of their own the system is now one in which a proportion of the care home fees will be paid for by the State whilst the remainder has to be paid by the individual. The rules covering how much is funded by the State differ in the four countries.

In theory, homecare is free in Scotland and Wales, however only certain types of homecare are covered by the rules and so there are still some services which would have to be paid for by the individual.

An added complication in understanding the State provision of long-term care is that some long-term care services are provided by the NHS (e.g. the district nurse administering medication at home) whilst Local Authorities and Social Services provide others.

There are two tax incentives, which apply to long-term care insurance products. Benefits, whether cash or care are free of tax in the hand of the customer; and pre-funded long term care insurance can be written in the PHI Fund and so be priced on a gross of tax basis.

There are no plans to provide further tax incentives on the premiums that are paid for insurance cover.

IPT does not apply since long-term care insurance is classed as long term insurance business.

2. Product outline (benefit schedule)

There are three main types of long term care insurance product:

- Pre-funded insurance (no investment element, insurance only)
- Investment linked long term care
- Immediate Needs Annuities

The first two provide long term care benefits once a policyholder reaches a certain level of disability, generally by reference to failing to be able to perform a number of activities of daily living (ADLs) or due to reaching a certain level of cognitive impairment.

The first will generally only provide the long term care insurance benefits although in some cases life insurance cover can be added as well whilst the second will also provide an investment fund which means that if the customer never needs to claim under the insurance policy an investment fund will still be available to their estate.

The third product is effectively an impaired life annuity designed for those people who already need care. It can be used to pay for care in the customer's own home, however they are more usually used to pay for care in a registered care home.

Long term care insurance product benefits are monetary related in that the product is mainly purchased to provide for the difference in the amount that the customer can afford to pay towards the care and the full potential cost of the care.

Once a claim has been triggered then the monetary benefit becomes payable (usually after a deferred period of three months). Most customers prefer to receive the cash although in some cases the product provider will pay the care provider directly. Most products provide for different monetary amounts at different levels of disability (e.g. different benefits become payable at failure of 1, 2 or 3 ADLs).

An important feature of all pre-funded products is the provision of a care advisory service at the time of claim. This service will usually complement the assessment made by social services and provide the customer with a comprehensive care programme designed to meet their particular needs.

Most product providers also provide access to telephone helplines covering care related issues.

Most products also provide for the provision of an additional monetary benefit to cover the purchase of assistive devices generally linked to the ADLs being failed.

3. Care provider network (hospitals, consultants)

As most products provide monetary benefits there are no restrictions on the care providers. Some product providers may be able to offer special rates with certain providers, however the number of policyholders and number of claims to date are so small to make this an irrelevant feature at present.

4. Distribution channels (direct on-line, direct sales force, brokers)

The primary distribution channel for both pre-funded and immediate needs products is via Independent Financial Advisers (IFAs) with over 75% of all sales made via this channel. There are some sales via direct sales forces and the Internet is a valuable source of information via the providers' websites.

5. Care not Cash elements

- a. Early independent assessment of care needs avoids implications of delay within Social Services process and informs family on early intervention in support of independent living. For example, care not cash benefits that enable early access to an oncology specialist, or counsellor, designed to allay fears and help patient get the best out of NHS provision.
- b. Managed care services, whereby those needing domiciliary care sometimes have personalised programmes that meet their care and special equipment needs; in some cases the insurer will then settle accounts directly with providers.
- c. Helplines generally provide 24 (hour) 365 (day) utility services that can supplement products that might otherwise be infrequently used; they can be generic (e.g. health concerns, nutrition advice, State benefits) or specific (e.g. find a care home, find a homecare provider).
- d. The provision of the assistive device benefit at an earlier stage of disability (e.g. on failing 1 ADL) can help delay the onset of more severe disability.

6. Self-pay possibilities (excess, co-payment, percentages, health account)

Self-pay already exists to some extent in that the customer uses long term care insurance to fund the difference between the full care costs and the portion that they can afford to pay themselves.

The possibility exists to provide a longer deferred period (e.g. 1 or 2 years) before insurance benefits become payable during which the customer pays all of their own care costs.

Expatriate healthcare insurances

1. State welfare context (funding, tax incentives)

Varies from state to state.

2. Product outline (benefit schedule)

An insurance that covers medical costs for a UK / Irish national resident overseas covering subject to benefit conditions and maximum sums insured, as listed below (depending upon policyholder choice):

- a. Accident and emergency
- b. Acute inpatient cover
- c. Acute outpatient cover
- d. Chronic cover
- e. Additional benefits
- f. Helplines

3. Care provider network (hospitals, consultants)

To be confirmed.

4. Distribution channels (direct on-line, direct sales force, brokers)

Brokers

5. Care not Cash elements

- a. Helplines
- b. The policy provides for the reimbursement of expenses but this may be regarded as the provision of care as the level of cover provided approaches full refund.

6. Self-pay possibilities (excess, co-payment, percentages, health account)

Not a valid option, except for residents in Europe where reciprocal arrangements exist for the expatriate to receive state benefits through E111.

Republic of Ireland (Public Hospital Services)

Exemptions from public hospital charges

People in Category II are liable to public hospital charges except in the following cases:

- Women receiving maternity services
- Children up to 6 weeks old
- Children receiving treatment for mental handicap, mental illness, phenylketonuria, cystic fibrosis, spina bifida, hydrocephalus, haemophilia or cerebral palsy
- Children referred from child health clinics and school health examinations
- Persons receiving services in respect of prescribed infectious diseases
- Long stay patients who are already being charged under the Health Regulations

Immunisation

A range of infectious diseases, such as diphtheria, whooping cough, polio, measles, mumps and rubella, can be prevented through childhood immunisation. A primary childhood immunisation service is available to everyone without charge.

Health Promotion

The Health Promotion unit of the Department of Health in Ireland, develops policies and implements preventive and promotional programmes, which aim to improve peoples health and quality of life. The unit co-ordinates, with other statutory and voluntary agencies, multi-sectoral health promotion programmes, and provides resources and support to those involved in health education and personal development activities.

The unit co-ordinates a number of national programmes, which include:

- Lifestyle programmes
- Smoking cessation
- Alcohol awareness
- Cancer prevention
- AIDS awareness
- Nutrition education

The Health Promotion unit is mainly involved in national campaigns but will also provide a full list of leaflets to the public and maintains a selection of videos on health related topics, which are available for loan without charge to health and education professionals.

Mother and Infant care service

A mother and infant care service, including the services of a general practitioner during pregnancy and general practitioner services for mother and baby for up to six week after birth, is available free of charge to all women.

Public Hospital Services

There are approximately 65 public hospitals funded by the State. Each region has at least one major acute hospital, which provides a wide range of medical services. Most public hospitals also have a number of designated private beds in which private treatment may be carried out. Access to such beds varies considerably for elective treatment. The various public hospitals also endeavour to provide better accommodation and other non-medical services for private patients; in practice the standard is quite variable. Public hospitals charge an all-inclusive daily rate for all hospital-related costs other than consultants' fees. This charge is significantly less than the corresponding cost in a private hospital so that private health insurance is a good deal cheaper when access is limited to the private facilities of public hospitals.

Private Hospital Services

In addition to the private facilities in public hospitals, there are around 40 hospitals in Ireland privately owned and managed. These include two major Dublin based 'high tech' hospitals – the Blackrock Clinic and the Mater Private Hospital – which provide a more comprehensive range of medical services, especially in cardiology, and offer better quality accommodation. Private hospitals charge fully for the services (accommodation, drugs, theatre, etc.) provided and reimbursement is available through private health insurance. The two 'high tech' hospitals have higher charges and this is reflected in the insurance options available in the market.

Hospital Consultants

Hospital consultants receive a salary for carrying out an agreed level of services for public patients. Most consultants are also entitled to carry out private work that they charge for on a fee-per-service basis. In many cases, consultants are also allowed to carry out their private practice in a convenient private hospital. There are a small number of consultants who are solely involved in private practice. Insurers operate Full Cover Schemes under which consultants accept the insurers' published charge in full settlement of their fees. Currently, the majority of consultants participate in such schemes but this is subject to change. Consultants who opt not to participate in the Full Cover Scheme receive a lower fee from the insurer and are free to 'balance bill' their patient direct (although not all do so). Consultants' fees for private practice are independent of whether the work is carried out in the private facilities of a public hospital or in a private hospital.

Tax Relief on Unreimbursed Medical Expenses

Tax relief is allowed to all at their top rate of taxation on medical expenses not refundable from any other source i.e. Private Medical Insurance. Current tax rates in Ireland are 20% or 42%. Relief of unreimbursed medical expenses is allowed in excess of €127 (individual) or €254 (family). Maternity care is allowable, as is a Psychological Assessment and Speech Therapy for children. You can also claim for the medical expenses of a dependent relative regardless of their means. The claiming of tax relief on routine dental and optical expenses is not allowed.