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Competition Policy in the Irish Health Sector

Declan Purcell
Member of the Irish Competition Authority, and Director of Advocacy
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1 INTRODUCTION

I'm delighted to be here today to give an Irish perspective on health care and competition law and policy. I propose to begin with a brief word about Irish competition law and the role of the Irish Competition Authority (the 'Authority'), mentioning in particular the Authority's advocacy role. I'll follow that with a brief overview of the Irish health sector, both public and private. I'll turn then to some specific competition topics in healthcare, including:

- Health Insurance;
- The Hospital Sector;
- The Pharmaceutical Sector; and
- Professional Regulation.

I'll conclude with some comments on competition policy in the Irish health sector going forward.

2 COMPETITION LAW AND THE COMPETITION AUTHORITY

The Competition Authority is a public body established by law in 1991. Both the law on competition in Ireland and the Authority's functions are now codified in the Competition Act, 2002.[1] Among other things, the 2002 Act enhanced the Authority's

[1] The Competition Act, 2002 is available for download at – *www.tca.ie* .

advocacy function, its merger control function and its enforcement and investigative powers.

Broadly speaking, the Authority has four main functions:

- **Cartels**: The Authority is responsible for the detection and prosecution of cartel offences in the Irish economy.
- **Monopolies**: The Authority also investigates and, in appropriate cases proceeds against, firms that abuse their large size in a market to the detriment of other businesses and consumers.
- **Mergers**: Since January 1, 2003, all mergers above specified turnover thresholds must be notified to, and cleared by, the Authority.[2]
- **Advocacy**: The Authority's advocacy function[3] is concerned with monitoring and studying competition policy in regulated markets, and advocates the removal of unnecessary or disproportionate restrictions on competition.

As well as monitoring and studying the operation of competition in (mainly State-regulated) markets, the Authority may also advise Ministers and Government bodies on both new and existing legislation and may "*carry on such activities as it considers appropriate so as to inform the public about issues concerning competition*."[4]

3 THE IRISH HEALTH SECTOR

3.1 Scale and Economic Importance of the Irish Health Sector

As elsewhere, healthcare in Ireland is an enormously important sector from both economic and fiscal points of view:

- In 2001, total healthcare expenditure amounted to 6.5% of GDP, or $10.5 billion[5]. 76% of that total ($8bn), came from public sources.

[2] For details of which transactions are notifiable, interested persons should consult the 2002 Act and "*Guidelines for Merger Analysis* (N/02/004)" which explains the Authority's position on substantive issues in merger control – *www.tca.ie*.
[3] Section 30 of the Competition Act, 2002.
[4] Section 30(1)(g) of the 2002 Act.
[5] Using an exchange rate of €1= $1.14

- The remaining 24%, or $2.5bn, came from private sources and largely comprised payments made by insurance companies and direct out-of-pocket expenses incurred by individuals.
- In 2001, 6.8% of total expenditure on health was attributable to private insurance, down from 8.7% in 1997.[6]
- More than a fifth of the Government's total budget is devoted to healthcare, and this share appears to be climbing (almost 23% in 2002).
- Based on this estimate, gross public expenditure has risen 125% from $4.1 billion in 1997 to $9.4 billion in 2002. This equates to $2,300 per person within the State.[7]

3.2 The Irish Public Health Sector

The current structure of the Irish public healthcare system dates from 1970 and is based on a system of ten regional publicly-funded Health Boards, each responsible for the provision of health services in their respective catchment areas. The services provided by these regional Health Boards are delivered under three core programmes:

- General hospital programmes;
- Special hospital programmes; and
- Community care programmes.

The Health Boards, whose membership is mainly political, receive their Government funding from the Department of Health & Children.[8] In addition to allocating funding to the Health Boards, the Department of Health & Children is responsible for the development of national health policy and strategy.[9]

In addition to the 10 Health Boards there are as many as fifty-three agencies with executive powers operating at a national level with responsibility for administration, service delivery and other regulatory functions.

[6] Health expenditure figures are placed in an international context in section 3.
[7] Brennan Commission (2003), pp. 21, available at – www.doh.ie/publications/hsreform.html.
[8] The majority of Health Board members are appointed by local government bodies, with the remainder consisting of consumer and health professional representatives and ministerial appointees.
[9] See for example Health Strategy 2001, available for download from – *www.doh.ie/hstrat/index.html*.

The public health service is funded predominantly (80%+) through taxation. The bulk of the remaining 20% comes from out-of-pocket expenses incurred by users of outpatient services and inpatient care in public hospitals.

Coverage and entitlement

In terms of coverage and entitlement under the public health system, the population is broadly divided into two types of patient, Category I patients who account for approximately 31% of the population, and Category II patients who account for the remaining 69%.

Qualification for Category I status is determined on the basis of income limits set by the Government. In general, people who can not, without undue hardship, arrange General Practitioner ("GP") or hospital surgical services for themselves and their dependants are entitled to free access to GP medical services, to hospital surgical services, and to free prescription medicines and appliances. Since July 2001, all persons over 70 years of age are also entitled to free coverage, regardless of their income.

While the remaining 69% of the population (Category II patients) must in principle pay for their own medical care, there is some overlap:

- For example, Category II patients are also entitled to care in the public hospital system on payment of a *per diem* charge. The charge for Category II patient occupying a public hospital bed is less than $50 a day, considerably less than the economic cost of providing the bed.
- Also, prescribed drugs and medicines are to some extent subsidised by the State under a number of Community Drugs Schemes.[10]

The most important thing to note is that entitlement to free care under the Irish public health system does not equate to timely access to many medical and surgical services. Anything but, in fact.

[10] Under the Community Drugs Schemes, GPs and Dentists may prescribe from a list of approved medicines agreed between the Department of Health & Children and the Irish Pharmaceutical Healthcare Association, and consumers are only required to pay up to a maximum of $80 per month per family for prescribed drugs.

System performance

The performance of the public health service has been strongly criticised over the last number of years, mainly on the grounds that it is not delivering value for money. Since 1997, public spending on health care has increased by about 125%, yet the popular perception is that the quantity and quality of medical services provided has not improved. Certainly, public waiting lists are still long – very long in many cases. A number of official reports over the last three years have pointed to organisational issues and inflexibility as the chief cause of failure within the system.[11] The consensus is that radical overhaul of the system is required, with emphasis on the need to have greater financial accountability, and on the need to rationalise the existing array of multiple agencies, with the creation of a single executive body with responsibility for managing the system as a unitary service.

3.3 The Irish Private Health Sector

Alongside the public health sector, a sizeable private health sector has developed in Ireland. For the 69% of the population not fully covered by the public service, GP medical services, prescription drugs and hospital services must be privately financed either out-of-pocket or through private health insurance.

Private markets also exist where State health agencies and boards out-source certain services to private operators.

In addition to their entitlement under the public system, 47% of the population have invested in private health insurance coverage. At present there are only two mainstream providers of health insurance, the (State-owned) Voluntary Health Insurance Board ("VHI") with 87% market share and BUPA Ireland with the remainder.

The private and public sector health systems are intertwined at almost every level, with the same personnel often delivering services to both public and private patients,

[11] See for example Deloitte & Touche in conjunction with The York Health Economics Consortium (2001), "*Value for Money Audit of the Irish Health System*", Brennan Commission (2003), "*Report of the Commission on Financial Management and Control Systems in the Health Service*", commissioned by the Department of Finance, Ireland. Available for download from – www.doh.ie/publications/hsreform.html.

often indeed in the same facility.[12] The main difference between public and private care appears to be speed of access to care, and not quality of care *per se*. This has led to allegations that the Irish health system is essentially a two-tier system. In this context, private insurance is often seen as a mechanism for avoiding the often long waiting lists for public care.

4 PERCEIVED PROBLEMS

So there are a number of perceived problems with the Irish health care system. At the most general level, there are questions about:

- **Waiting lists**: Despite an enormous and unprecedented increase in healthcare expenditure, excessively long waiting lists are still a major problem.
- **Medical inflation**: Medical inflation, which is running at approximately 10%, far out-strips general inflation, which is running at about 4%, and has the potential to undermine the market for private health insurance.
- Extra-territorial **purchase of public health services**: One policy response to the problems of medical inflation and growing waiting lists has been for the Government to purchase medical services abroad because it cannot buy them at a 'reasonable' price in Ireland.
- **Inflexible health system**: There are questions about the ability of the health care system to expand to meet growing and diverse demand for medical services.
- **Role of the State**: There are also questions about the role of the State, which often acts as regulator, supplier and indeed in some cases consumer of medical services.

At the individual market, or sub-sector, level there are questions about:

- **Hospital capacity**: Hospital capacity appears to be extremely constrained, especially in emergency rooms.

[12] Wiley, Miriam M. (2001), "*Reform and Renewal of the Irish Health Care System: Policy and Practice*", Budget Perspectives Conference Proceedings of October 9, 2001, Economic and Social Research Institute.

- **Competition in primary care**: There are concerns that competition in the provision of primary care is not as strong as it might be, with collective bargaining with the Department of Health & Children and insurance companies appearing to be commonplace.
- **Prices for specific services**: There are also concerns that the prices paid for many services are totally out of line with those charged in other countries, e.g. MRI services.
- **Medical professionals**: There are issues concerning entry, demarcation, and pricing in the medical professions, e.g. medical practitioners (GPs and hospital consultant doctors), dentists, pharmacists and optometrists.
- **Pharmacy/Pharmaceutical issues**: Whether the Department of Health & Children does well as a buyer of drugs on behalf of public patients is an open question. There are also many competition concerns in the retail pharmacy sector.
- **Risk equalization**: Whether risk equalization is an insurmountable barrier to competition and entry in private health insurance markets is also problematical.

5 SELECTED COMPETITION ISSUES IN HEALTH CARE

In this section I describe a selection of competition issues in the medical sub-sectors. From what I've said already about the system, you'll gather that this selection is certainly not exhaustive.

5.1 Health Insurance

Prior to 1996, the State-owned private health insurance company (VHI) had an effective monopoly. This effective monopoly came to an end in 1996 when BUPA Ireland entered the health insurance market. BUPA Ireland's entry was made possible by the enactment of the Health Insurance Act, 1994.[13] Despite BUPA's entry to the Irish health insurance market, the VHI is still the dominant entity, having

[13] The Health Insurance Act, 1994 gave effect to a 1992 European Union Directive (Council Directive 92/49/EEC - the *Third Non-Life Insurance Directive*).

approximately an 87% market share. Competition, unsurprisingly, is perceived to be weak.

While the health insurance market has, since 1994, in principle been open to competition, barriers to entry are significant. Perceived potential barriers include the system of regulation of the health insurance market, which is underpinned by the principles of *community rating* and *open enrolment*. In combination, the implication is that private health insurance is guaranteed to all members of the community, should they choose to purchase it, regardless of the risk (health status) each individual presents to the insurer. Furthermore, premiums may take no account of the risk characteristics of the insured.[14] It is recognised that this kind of health insurance system is potentially unstable. In particular, new entrants have the incentive to cream-skim low risk individuals from the incumbents. To counteract this effect a system of *risk equalisation* is being instituted, though much uncertainty remains as to precisely how the scheme will operate in practice.[15]

Risk equalisation, however necessary, undoubtedly represents a barrier to entry to the health insurance market, as does the uncertainty about how the scheme will operate. While the Health Insurance Authority will administer the scheme, the Minister for Health & Children retains a degree of control.[16] Given that the Minister is (jointly with the Minister for Finance) the principal shareholder of the incumbent (VHI), the Minister may have conflicted incentives.

At present BUPA is in the European courts arguing that risk equalisation transfers are a State Aid and therefore prohibited under European law. The European courts have so far not agreed with BUPA. An appeal is currently in process.[17]

The Health Insurance Authority is currently undertaking a study of competition in the health insurance market and will address issues related to risk equalisation and the privatisation of VHI. It may well be felt, however, that VHI is too large to privatise

[14] Section 7 of the 1994 Health Act requires that a health insurer must charge the same premium for a given level of cover to all customers, regardless of age, gender, sexual orientation, or current or prospective health status (there are some limited exceptions).
[15] Risk equalisation schemes are designed to compensate insurers with unfavourable risk profiles, and therefore operates as a disincentive to cream skim low risk individuals.
[16] For background on the role and function of the Health Insurance Authority consult – *www.hia.ie*.
[17] For more information on this case, see http://europa.eu.int/comm/competition/index_en.html.

as a single entity and that a splitting of the company in two would be required were privatisation to proceed.[18]

5.2 The Hospital Sector

The Irish public hospital sector is essentially organised as an integrated system and comprises both 'private' and 'public' elements.[19] The system is integrated in the sense that there is no purchaser-provider split in the delivery of public hospital services. Even where ownership of the public hospital facility lies in the private sector, as is the case with public voluntary hospitals[20], services are delivered according to provider plans agreed with the Department of Health or the relevant health board. The emphasis is therefore on co-operation and not competition.

In addition to the public hospitals there are also a significant number of private hospitals. About 15% of total hospital bed capacity in the State is privately owned. In addition, 20% of beds in public hospitals have been designated for use by private patients, although this percentage is regularly exceeded, and is probably closer to 30%.[21] Thus, about a third of hospital beds in the State are effectively available for private use.

One competition issue in the hospital sector concerns the manner in which private insurance companies are charged for the use of public hospital beds by private patients. Specifically, insurance companies are charged less than the economic cost of providing the beds. For example, in 2001 the cost per inpatient bed day in the major teaching hospitals was $623, yet private patients were only being charged $273, implying an implicit subsidy of private care from the public purse of $350. To the extent that the public hospitals charge below cost for beds used by private patients, private providers of hospital beds are competitively disadvantaged. The implication is

[18] "*VHI privatisation plan dropped*", Sunday Business Post 14th September 2003.
[19] Broadly speaking there are three types of hospitals in Ireland: (i) health board hospitals that are owned and funded by the relevant regional health board; (ii) public voluntary hospitals which are generally owned by religious or charitable organisations and are funded directly by the Department of Health and Children; and (iii) private hospitals that are owned privately and receive no funding from the State.
[20] See previous footnote.
[21] See Wiley, Miriam M. (2001), "*Reform and Renewal of the Irish Health Care System: Policy and Practice*", Budget Perspectives Conference Proceedings of October 9, 2001, Economic and Social Research Institute.

that the public hospital sector has probably inhibited the growth of the private hospital sector.

One possible reason why this situation has been allowed to continue as long as it has is that an increase in the price charged for public hospital beds used by private patients would, at least in the short-run, necessitate a rise in health insurance premiums. The dominant player in the health insurance market, the State-owned private health insurance company, needs to seek approval from the Minister for Health & Children in his capacity as joint shareholder (along with the Minister for Finance), for a rise in premiums. Thus, a move towards the full economic costing of public hospital beds used by private patients would create obvious political pressure on the Government.

5.3 The Pharmaceutical Sector

There have been competition-related problems with this sector for many years. The retail pharmacy sector in Ireland is relatively un-concentrated, the biggest chain owning only 4% of the outlets. The value of the market is around $1.4bn per annum, or just under 1% of GDP. Pharmacies are considerably more valuable assets than other forms of retail outlet, reflecting the restrictive regulatory environment in which they operate, and the ensuing rents to be made by incumbents.

Nature of the market

We're all probably familiar with the three defining characteristics of the consumer medicines market worldwide:

1. The existence of public or private health insurance cover – this means that consumers' normal price incentives do not generally apply and, therefore, the normal drivers of price competition do not operate,
2. The escalating costs of healthcare – particularly in relation to medicines – prompts Governments to intervene by way of price or profit controls at various stages of the distribution chain, and

3. A myriad of non-price regulatory interventions such as controls on medicine supply and sale, as well as severe barriers to entry (chiefly by way of controls on ownership, establishment and location of outlets).

Drug prices

Under a long-standing agreement, the Government and drug manufacturers/importers set the import prices and maximum wholesale prices of the vast bulk of retail medicines in Ireland. At retail level, pharmacies charge a 50% mark-up on medicines supplied to most consumers (in addition to prescription fees); this practice has existed for many years, and does not appear ever to been explicitly agreed, altered or challenged. The overall effect is that Irish pharmacies benefit from the highest overall retail margin on medicines in Europe, averaging 33%.

Other competition issues

The two most important *barriers to entry* are a chronic underprovision of Degree Course places over the past quarter century, mainly through the granting of a monopoly on pharmacy education in the mid-1970s to one University and, ironically, a statutory restriction on overseas-trained graduates (including Irish students) which effectively prevents them from ever opening their own outlet. The most controversial restrictions affecting the *establishment of businesses*, introduced in 1996 to control the number and location of outlets, were revoked in 2002, following a legal challenge to their validity. Although there are no specific controls on *ownership of pharmacy outlets* in Ireland, a Government-sponsored Review has recommended that such controls be introduced; however, there may be some legal difficulties associated with doing this.

5.4 Professional Regulation

The enforcement of competition law in respect of the medical and para-medical professions[22] is complicated by the fact that many of the restrictions on competition are bound up in public regulation and therefore risk being beyond the scope of direct enforcement.

[22] For example, medical practitioners, pharmacists, dentists and optometrists.

The clear implication is that there is an expanded role for competition advocacy in respect of the professions involved. In 2002, the Authority commissioned a wide-ranging Consultancy Report on competition in eight professions, including three in the medical field – medical practitioners, optometrists and dentists.

This Report was published in March 2003[23], and its preliminary findings indicate three basic classes of restriction on competition:

- Restrictions on entry;
- Restrictions on behaviour; and
- Restrictions on organisational form.

For example, there are considerable restrictions on entry to the medical profession, both at the level of the General Practitioner (GP) and the specialised and senior position of Hospital Consultant. Some restrictions are indirect, in that they arise due to a lack of State funding for medical training and for the appointment of consultants. The shortage of consultants, when combined with the inability of consumers to directly approach them, instead having to be referred by a GP, will be the subject of special attention, and the Authority may seek to recommend direct access to consultants in certain circumstances.

A second example concerns limitations on the amount of *advertising* practitioners can undertake. Members of the medical professions are generally prohibited from undertaking comparative advertising and from making any unsolicited approaches to consumers or potential users of their services. They are also prohibited from advertising specialist expertise knowledge. Furthermore, press advertisements are subject to size restrictions.

A third example concerns permissible organizational structures. For example, both medical practitioners and dental practitioners are not permitted to practice through limited liability corporations or by way of multidisciplinary practices.

As the Authority works through each professional sector dealt with in the Report, it will publish draft Recommendations for public comment.[24] On conclusion of the overall process, the Authority may:

[23] The Report can be downloaded from – *www.tca.ie*.

- Seek changes to existing practices, present recommendations and where appropriate issue best practice guidelines to Government, relevant regulators, professional bodies and others with a view to the removal of unnecessary impediments to competition;
- Publish information about markets or practices that improves knowledge and understanding of, or stimulates and improves competition generally in some or all of these sectors;
- Offer a clean bill of health;
- Make recommendations for regulatory reform.

The key factor informing the Authority's perspective is the principle of proportionality. That is, only those restrictions or regulations that achieve their objective in the most efficient and non-distortionary fashion should be retained. Where more effective and non-distortionary alternatives are available, these should be implemented.

6 HEALTHCARE - COMPETITION POLICY GOING FORWARD

The notion of competition is often perceived as not relevant to health care markets:

- In principle, because it is somehow 'sacrosanct' ("healthcare is different/unique");
- In practice because markets often do not exist, or the information asymmetries and principal-agent problems are too severe; and
- In law because public regulation may often act to prevent it.

However, resources – people, time, facilities, equipment and knowledge – are scarce and, naturally, decisions must be made on how best to allocate them. Economics is the study of the allocation of scarce resources among alternative uses and its tools may usefully be brought to bear on many problems facing the health sector, not least of which is the need to get value for money.

[24] More information on the Professions Study can be downloaded from - *www.tca.ie*.

The role of competition advocacy therefore, is to persuade the relevant legislators and public bodies either that the presence of markets and the competitive pressures that go with them can improve outcomes, or that regulations which confer market power on producers should be removed or replaced by measures less restrictive of competition.

The Authority is at present drafting a Discussion Paper for publication, focusing on actual and potential health care markets and the role of competition therein. At present, our attention is focusing on the following issues:

- Collective action by professionals and their associations and professional bodies;
- The Retail Pharmacy Sector and Drug Pricing;
- Health Insurance markets; and
- Anti-competitive restrictions in the Medical Professions, as part of the Authority's ongoing study of competition in the provision of professional services.

7 CONCLUSION

I've tried in a relatively short time to give you a flavour of what the health system in Ireland looks like, what the overall problems and issues appear to be and, in particular, how competition law and policy might be relevant to these debates. I certainly have the strong impression, though, that, while our National systems, cultures and approaches to healthcare may be somewhat different, the competition issues that we face are strikingly similar. This is hardly surprising, really, since although institutions may differ, people are the same the world over.

Thank you very much.