THE INDUSTRY COMMISSION'S REPORT ON PRIVATE HEALTH INSURANCE IN AUSTRALIA

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Private health insurance has a significant but ambiguous role within Australia's health care system. It is a voluntary facility for private funding of mainly hospital care, sitting alongside a compulsorily tax-financed public system ('Medicare') that is available to all. It is also constrained by regulations designed to maintain the sort of open, non-discriminatory access — at least for those who can afford to pay — which the public system was established to provide on a universal basis.

The system comprises around 50 health benefits organisations, most of which are not-for-profit mutual societies. The largest organisation and the only one with a national presence — Medibank Private — is owned and run by the Commonwealth Government.

All up, the private health insurance industry accounts for around one-tenth of Australia's total health care expenditure and one-fifth of hospital funding (most of which is directed at private hospitals and is their main source of income).

Although ostensibly a private system, it is enveloped by a thick mantle of social regulation, much of which is designed to sustain 'community rating' and the risk equalisation transfers among funds which underpin it.

In recent years, this 'mixed system' has been in trouble (**see slide 1**):

- PHI premiums have been rising on average at rates three times faster than the consumer price index;

- affordability has been declining;

- and membership has been steadily falling. By the time of our review in mid-1996, barely one-third of the population had some form of PHI — down from one-half only a decade before.

As a consequence, the demands on a public system already beset by funding difficulties have increased.

Governments have responded to these developments with a number of initiatives intended to stem the decline in membership. The most recent of these was a financial carrot and stick for lower and higher income households respectively, which is being implemented this financial year. But in the meantime, premium increases have continued — eroding the financial inducements and raising community concerns which triggered our inquiry.

Some were surprised that the Industry Commission was chosen to conduct a review of PHI, given the important social dimensions. (Indeed, press reports suggested that this surprise was shared by the Minister for Health, who was overseas at the time.)

The Commission has traditionally advised governments mainly on matters to do with industry policy and economic regulation. But in recent years, its ambit has widened to include such topics as Workers Compensation, Public Housing and Charitable Organisations. The Commission's independence, its statutory obligations to take an economy or community-wide view on the policy issues referred to it, and the openness of its processes, make it an effective vehicle for achieving a better understanding of both the economic and social issues in such areas, and the tradeoffs involved.

Meeting the multiple objectives of health policy in a cost effective and sustainable way requires a good understanding of how people and institutions

respond to incentives. Indeed, neglect of such fundamental forces is at the heart of many of the problems with which governments are currently grappling in health, education and other areas of social policy.

The Commission's ability to make a broader contribution on the health system was, however, limited by its terms of reference. While being asked to assess the 'state of PHI', its structure and efficiency, the cost pressures facing it, and what changes may be required to enhance its contribution, the Commission was also told to conduct its inquiry 'against the background' of the Government's policy to retain Medicare and community rating.

Many saw this as obliging the Commission to ignore key sources of the problems facing PHI. In practice, while the Commission's recommendations clearly complied with these constraints, its report was also able to shine some light on the wider systemic issues.

Consumer surveys consistently — and unsurprisingly — show that the key reason why people drop out of PHI (or decide not to enrol) is their assessment that it represents poor value for money — an assessment made, it should be noted, against the availability of the 'free' public system.

Understanding why and for whom PHI represents 'poor value for money' was therefore basic to our deliberations on ways of improving the system.

The Commission's study provided a first systematic attempt, using a consistent methodology, to determine why PHI costs what it does and why premiums have been rising so rapidly.

The answer has several dimensions. One important contributor to the current cost of PHI is the fact that Governments had in earlier years pulled out or cut back some important subsidies. We estimated that removing the bed-day

subsidy to private hospitals and the subsidy to the reinsurance (cost equalisation) pool in the few years after Medicare was introduced, accounted for about one-third of existing premium levies.

But this pre-dated, and in itself couldn't explain, the rampant *growth* in premiums through the 1990s.

Some attributed this to increasing inefficiency or market power within the PHI system. But as we showed, the facts are inconvenient to such an interpretation. While the regional or State markets are relatively highly concentrated (in most States the top two funds have at least half the market between them) there are no effective barriers to entry or expansion of a discriminatory kind — and there are plenty of players across the country who could readily establish in a different State or region.

A key point that tended to be neglected, which distinguishes this industry from many others, is that costs incurred by the industry consist overwhelmingly of benefits paid to the industry's consumers. In the most basic sense, premiums to members are rising fast because *payouts* to members (collectively) are rising fast.

The major direct contributors to this in the 1990s were found to be:

- First, and most important by far, a rise in the proportion of PHI members using private hospitals (at full private rates) rather than public hospitals (at subsidised public rates). This in turn has reflected several 'push' and 'pull' factors — particularly problems of access to public hospitals (partly policy-induced through funding decisions) and a consequent enhancement in the capacity and capabilities of private hospitals.

- Of secondary importance — although often mistakenly seen as the main cause — has been increased private hospital admission charges, as a result of changes in medical technology and clinical practice.

- A third contributor to rising premiums was an increase in the incidence of hospital admissions by private patients, partly reflecting a change in fund composition towards older and sicker members.

Behind this, and indeed a number of the cost drivers, is 'adverse selection' — poorer risks joining the PHI community while better risks leave. Our calculations suggested that adverse selection may have contributed around 17 per cent of the real increase in premiums in the 1990s. Its relative significance is likely to increase in the future.

Adverse selection is a common problem in insurance markets, but its effects in the PHI market in Australia have been heightened by community rating regulation in circumstances where members can enter or leave at will, with Medicare as a backstop.

This has contributed to what has become a vicious circle of falling membership (**slide 2**) in which:

- premiums rise as payouts rise (for the reasons just identified);

- lower risk members drop out first;

- this creates a riskier, diminished pool of PHI members, which means that average payouts rise;

- which compounds other cost pressures, leading to higher premiums again (**slide 3**)

- and the downward spiral continues.

The Government's attempts to arrest declining PHI membership through a combination of rebates for lower income households and tax-based levies for high income households, was seen by the Commission as having at best a temporary effect. This has been borne out thus far, with fund membership stabilising for only one quarter, before resuming its downward trend.

What this reveals is an inherently unstable interaction between the public and private systems in Australia. That in turn reflects important tensions in the role of PHI within Australia's health system.

Some see PHI, in the context of a 'universal' public health system, as simply funding optional extras (like more comfort or choice) — a 'supplementary' role. Others see it as providing a desirable alternative or 'complement' to public funding and provision. But these roles have quite different regulatory implications, as the CEO of one major fund made clear during our inquiry:

> 'if private health insurance is truly supplementary then I don't see any impediment whatsoever to full risk rating and underwriting for people who elect to pay something extra. That doesn't happen, which suggests to me...there's an implicit acceptance that it's complementary, and if it is complementary then you are going to need a range of regulations ... which will ensure that there is equity of access...and that it is part and parcel of the funding of health in Australia. I think you've got to make one or the other conclusion, and we're in the process of being a little bit pregnant right now' (*Private Health Insurance*, p.24).

Australia remains a little bit pregnant still, despite the Commission's emphasis on the need to resolve this fundamental issue.

While the Commission was constrained by the terms of reference from making suggestions about the wider system, we did need to consider the larger design issues if we were to provide sound policy advice about the PHI component.

From the views of inquiry participants and other sources, we distilled three broad systemic options for the funding and delivery of health care that have some measure of internal consistency:

- One involves predominantly *public* funding and delivery — a public system. (It would of course require more funding than the current public system and also some design improvements).

- A second model is a predominantly *private* market for provision, funding and intermediary services — what might be characterised as a US-style model.

- The third approach is a mixed system — but with *coordinated* public and private involvement. One variant, known as 'managed competition', separates health care delivery from financing, and groups of providers and intermediaries compete in a managed market for tax-funded dollars. In another variant, access to the public system would be restricted to low income households, with others compulsorily insuring privately.

None of these approaches is necessarily a perfect system, measured against governments' multiple policy objectives. But each would avoid the instability and tensions inherent in Australia's current mixed (some might call it mixed-up) system.

Clearly the role of PHI and how it should be regulated would differ considerably under these different systems. It was of course not our call as to

which system would suit Australia best, but consideration of the options helped us assess how the workings of the current system might be improved, without getting in the way of wider and potentially more beneficial changes.

The most important need we identified was to reduce the destabilising effect of adverse selection — the combined result of voluntary community rated PHI and the fallback of the 'free' public hospitals.

Ruling out any significant change to the voluntary nature of PHI (beyond the recently introduced financial penalty on higher income households without PHI) the only avenue available is to make greater allowance for risk in pricing or access to PHI.

Regulatory changes over the past few years have done this through the back door to some extent, by allowing some exclusions in policies, as well as front-end deductibles. These initiatives have essentially enabled members to self-select a lower risk category, according to their expected state of health and financial circumstances. Such 'cream skimming' is normally undesirable in insurance markets. But in the case of Australian PHI it has probably helped to moderate instability. (In economics this is called a 'second best solution' — existing distortions justify additional ones.) However it has done so at the cost of inducing a bewildering array of products and tables.

In any case, the scope to effectively target different risks remains constrained by the reinsurance arrangements, whereby the costs of the elderly and chronically ill are equalised among funds regardless of their membership profile.

A major problem with the current version of community rated private health insurance is that it is a voluntary 'pay as you go' scheme. Younger people finance the health care needs of the currently sick and elderly, and rely on a yet

to be born generation to fund their own health care when they have aged — an increasingly bad bet given recent trends (**see slide 4**). In this sense, the current community rating scheme in the Australia system is subject to the same risks as pyramid selling schemes.

To help ameliorate this problem, the Commission recommended a form of 'lifetime community rating' which would penalise late entry into PHI — essentially levying late entrants for not having contributed their share to the funding needs of older people. It retains the core non-discriminatory principle of community rating, however, in that an older contributor would still only pay the same premium as a younger one who had entered PHI at the same age.

This system has obvious advantages in deterring late and 'strategic' entry into health insurance. It is thus much fairer to existing and long-term members, as well as in time producing a more balanced pool of risks and thus lower premiums.

The Commission flirted with the idea of an actuarially pure, 'funded' scheme, in which people pool reserves within their age cohort over their lifetime, but given transitional complexities and potential to constrain broader reform opportunities, opted for an unfunded scheme in which the level of premiums in a given year depends on the composition of members in that year.

Such a scheme need not create any inequities. It could be arranged such that no existing member would be adversely effected, with a grace period provided so as not to disadvantage intending entrants. Indeed, it would be much more equitable than current arrangements, in which older, long-standing members are increasingly being driven out of PHI when they need it most, because of the diminishing scope for cross-subsidy from younger members.

The Government announced on receipt of our report that it favoured our recommendation, subject to further consideration of the potential effects. It has apparently commissioned an actuarial firm to assist its deliberations, but has yet to announce a decision.

A second source of inequity as well as instability is the adverse selection that arises through short waiting periods for cover of 'pre-existing ailments' under Australia's PHI regulation. For example, at the time of our inquiry the waiting period for obstetrics cover was a (convenient) 9 months; that for any obvious existing ailment 12 months and a uniform 2 months applies in all other cases. These generous entry requirements facilitate and indeed encourage 'hit and run' behaviour, to the cost of existing members. One well-known Australian politician commented, in his submission to our inquiry:

> I compare the status of today's private health insurances to that of a bookmaker who is required to continue to bet on a race after it has concluded. (*Private Health Insurance*, p.336)

The Commission recommended that the Government, in consultation with the health funds, prescribe longer maximum waiting periods for those conditions where opportunistic behaviour is a source of instability. The Government has now extended the waiting period for obstetrics to 12 months — which will no doubt also reduce the alleged incidence of premature births — but has thus far made no other changes.

From a brief look at a VHI guide to its healthcare plans, the need to avoid these sources of adverse selection in private health insurance have been better understood in Ireland than Australia.

As noted, community rating in Australia has been supported by a set of pragmatic risk-pooling arrangements —misleadingly called reinsurance —

which spread the costs of the old and chronically ill among all funds. Reinsurance financially polices community rating by lowering the incentives for funds to cream skim low risk consumers.

Unfortunately current arrangements also appear to reduce the incentive to reduce unit costs and utilisation in the high risk categories, because part of the benefits flow automatically to less efficient funds. And they may generate an excessive insurance loading on products offering lower benefits to consumers, such as FEDs, as well as on genuine 'catastrophic' insurance products.

The Commission reviewed the various alternatives and concluded that the objectives of reinsurance would be most effectively met by changing to 'composition-based' schemes which adjust better for differences between funds' risk profiles, possibly complemented by arrangements whereby the contribution of any policy to the reinsurance pool was more closely related to the benefit it provides (proportional reinsurance). However the Commission also recognised that changes to reinsurance arrangements can have significant financial repercussions on individual funds, and has emphasised the need to phase in any significant changes.

These complicated matters are currently under review by the Government, with any changes partly depending on what happens to our lifetime community rating proposal.

While the need to reduce destabilising adverse selection was perhaps the most important focus of our work, our report also made a range of other recommendations. These were directed at:

- *enhancing competition*, by making the mutual societies less immune to (hostile) takeovers — a potentially important entry strategy for new players — and by creating a competitively more neutral position for

Medibank Private (including its separation from the public systems' administration, which the Government has now implemented).

- *improving the cost effectiveness of health care*, by among other things, allowing funds the freedom to contract with a selection of hospitals, without paying a 'default benefit' to others. (Not accepted by Government.)

- *alleviating regulatory burdens*, such as the requirement for funds to seek approval for premium increases. This served no useful purpose and could actually be counterproductive in endangering solvency or encouraging price collusion. (Broadly accepted, although funds now must synchronise their premium increases annually!)

- *reducing transaction costs for consumers*, including by pushing for integrated billing arrangements which avoid the need for multiple claims through Medicare and a private health fund. (Accepted.)

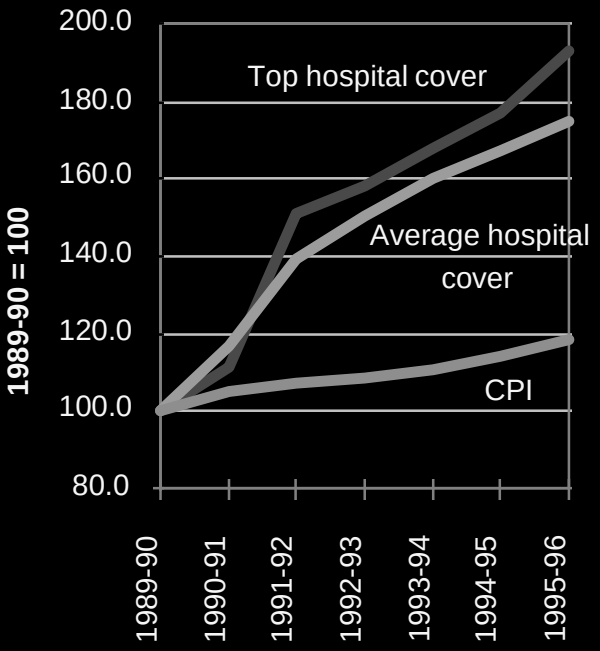
Although significant in their own right, the Industry Commission's recommendations were of necessity incremental in nature and designed to alleviate some of the problems of the health insurance industry in the short term. They may serve to improve the stability of the private health care system and alleviate some of the pressure on the public system. But their implementation will not resolve the inherent and ongoing tension between universal access under Medicare and voluntary community-rated private health insurance.

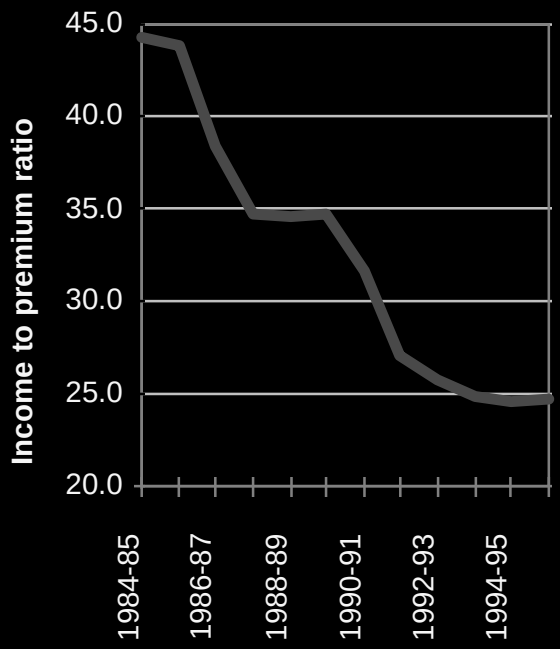
A long-term solution will thus require more. Using the Commission's oft-quoted analogy:

> Private health insurance is like a cog in a machine. One can burnish the gears of that cog, but ultimately its performance and functioning depends on the rest of the machine.

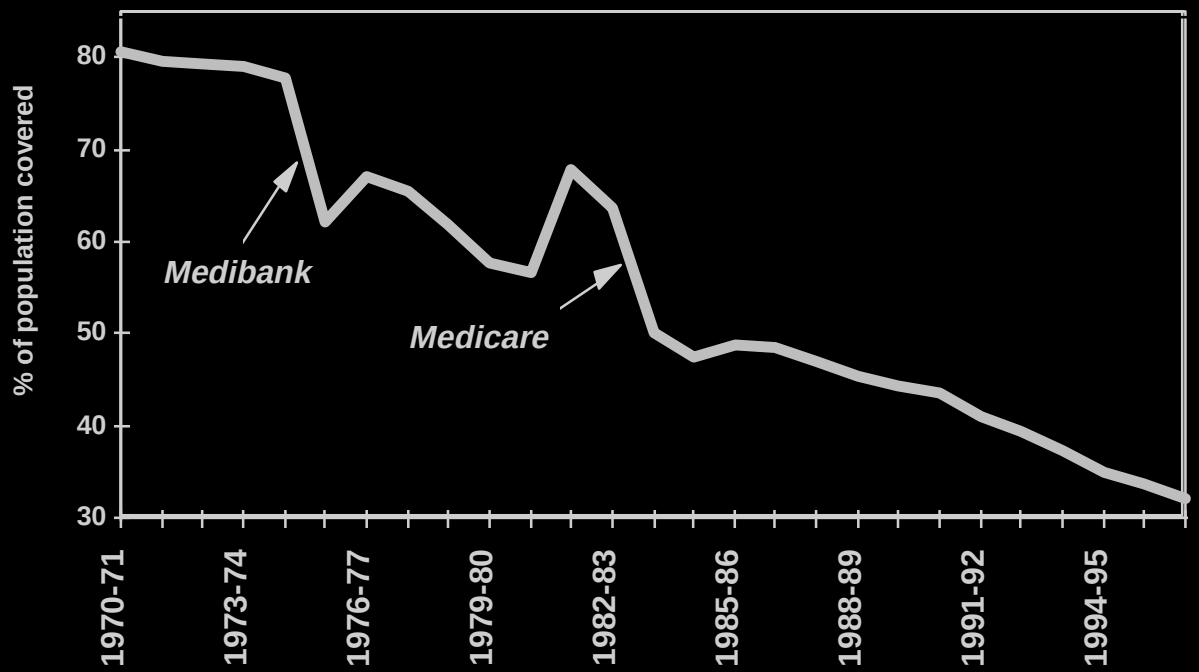
An important lesson from our inquiry is that it is impossible to define the most appropriate role of PHI without determining how the wider system is intended to function. For that reason, our final recommendation was that there should be a broad public inquiry into Australia's health system.

Premiums rising... affordability falling

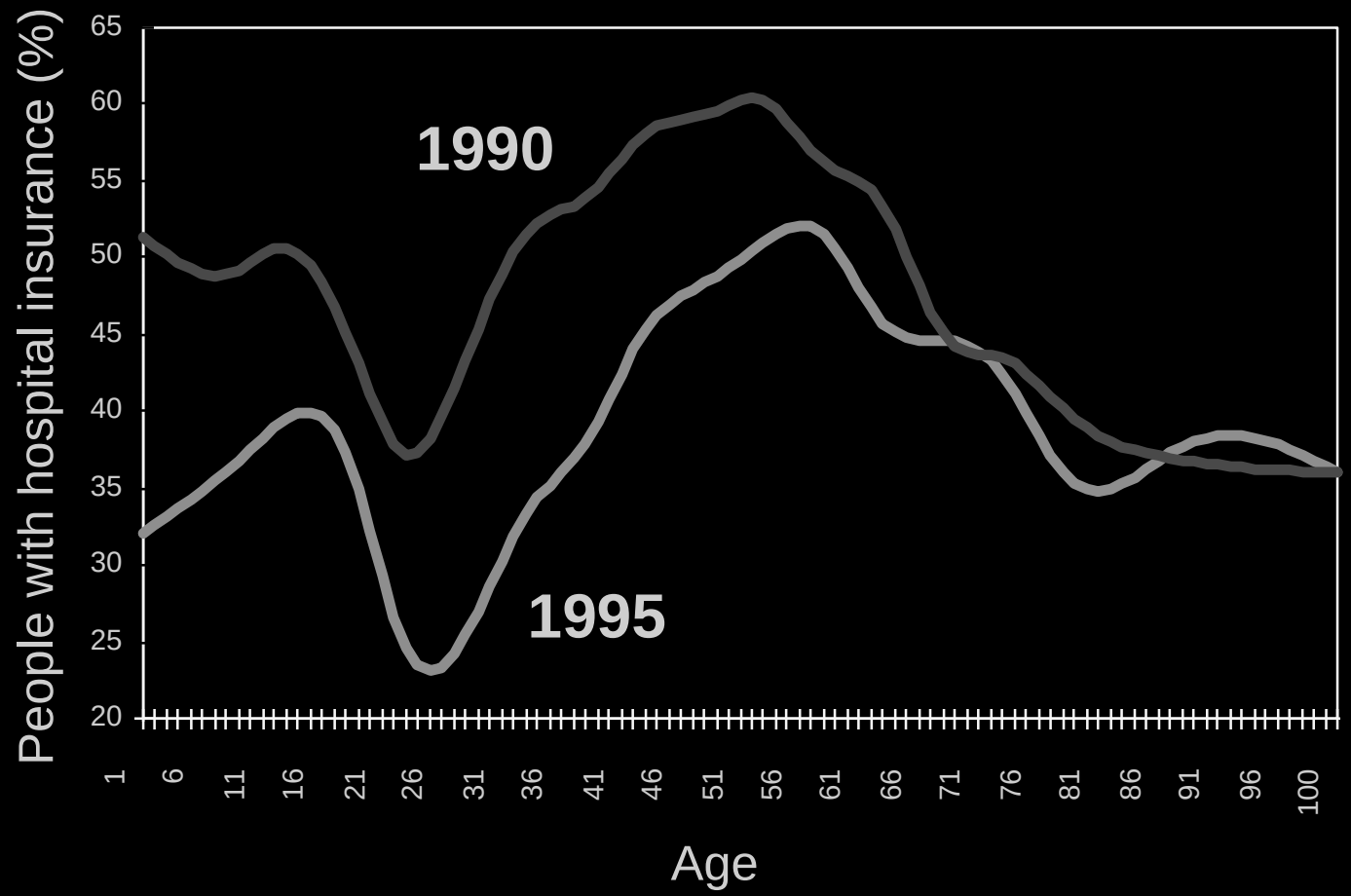




Membership in decline



Adverse selection at work



Source: ABS Health Surveys

Vicious circle