

**INDUSTRY COMMISSION**

**PRIVATE HEALTH  
INSURANCE**

REPORT NO. 57

28 FEBRUARY 1997

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### **Acknowledgments**

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Commissioners would also like to express their appreciation for the sustained efforts and commitment of their research team, who assisted in the preparation of this report against severe time constraints.

### ***Forming the Productivity Commission***

*The Industry Commission, the former Bureau of Industry Economics and the Economic Planning Advisory Commission have amalgamated on an administrative basis to prepare for the formation of the Productivity Commission. Legislation formally establishing the new Commission is before Parliament.*



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28 February 1997

The Honourable Peter Costello MP  
Treasurer  
Parliament House  
CANBERRA ACT 2600

Dear Treasurer

In accordance with Section 7 of the *Industry Commission Act 1989*, we have pleasure in submitting to you the Commission's final report on Private Health Insurance.

Yours sincerely

Gary Banks  
Executive Commissioner  
(Presiding)

Helen Owens  
Commissioner

Brendon Kearney  
Associate Commissioner

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## ABBREVIATIONS

ABA	Applicable benefits arrangement
ABS	Australian Bureau of Statistics
ACA	Australian Consumers' Association
ACCC	Australian Competition and Consumer Commission
ACHCA	Australian Catholic Health Care Association
AIHW	Australian Institute of Health & Welfare
AHA	Australian Hospitals Association
AHIA	Australian Health Insurance Association
AHSA	Australian Health Service Alliance
ALOS	Average length of stay
AMA	Australian Medical Association
AN-DRG	Australian National Diagnosis Related Group
APHA	Australian Private Hospitals Association
COAG	Council of Australian Governments
CCU	Critical care unit
Department	Commonwealth Department of Health and Family Services
DRG	Diagnosis related group
ESP	Elective surgery product
FAI	FAI Health Benefits
FED	Front end deductible
FTE	Full time equivalent
HBA	Hospitals Benefits Association (operated by National Mutual)
HBF	Hospital Benefit Fund of WA

HCF	Hospitals Contribution Fund of Australia
HCoA	Health Care of Australia
HIC	Health Insurance Commission
HIRMAA	Health Insurance Restricted Membership Association of Australia
HMO	Health maintenance organisation
HPPA	Hospital purchaser-provider agreement
ICU	Intensive care unit
ISC	Insurance and Superannuation Commission
IT	Information technology
MBF	Medical Benefits Fund of Australia
MBS	Medical Benefits Schedule
MPPA	Medical purchaser-provider agreement
NHA	National Health Act 1953 (as amended)
NHTP	Nursing Home Type Patient
NIB	NIB Health Funds Ltd
NMHI	National Mutual Health Insurance Pty Ltd
PA	Practitioner agreement
PBS	Pharmaceutical Benefits Schedule
PEARs	Pre-existing ailment rules
PHIAC	Private Health Insurance Administration Council
PHICC	Private Health Insurance Complaints Commissioner
RMO	Restricted membership organisation
SEU	Single equivalent unit
SGIC	SGIC Health (now operating as SGIO Health)



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## GLOSSARY

Ad valorem	Expressed as a percentage of the price or value.
Adverse selection	The process whereby higher risk people purchase insurance — lower risk people do not join (or they leave) to avoid subsidising the higher risks.
Ambulatory patient	A patient who is treated out of hospital.
Ancillary cover	Covers services such as dental, prescribed optical appliances, physiotherapy, chiropractic, hearing aids, and speech therapy. These services do not require referral from a medical practitioner for health fund cover.
Applicable benefits arrangement	An arrangement that a health fund enters into with some or all contributors under which the contributors are covered wholly (or partly) for liability to pay fees and charges for hospital and medical services.
Asymmetric information	Two parties to a (potential) transaction have different information about the attributes of the service or product. For example, a doctor has more medical knowledge than the patient.
Average length of stay	The average (or mean) number of days of stay in hospital for a group of patients.
Capitation	Payment per head of population.
Case payment	Casemix based (episodic) payment system.
Casemix	Describes the mix and types of patients treated by a hospital, according to their medical conditions.
Clinical protocol	Practice guides designed to assist practitioners make optimal decisions about health care intervention.
Coordinated care	Coordination of care of patients between different health programs or sectors of the health system usually by the assistance of care coordinators or managers.

Copayment	Portion of the cost of an insured health service met by the user — usually a fixed amount, or proportion of the fee, specified in advance.
Community rating	This principle guarantees access by all members of the community to private health insurance. Health funds are not able to discriminate between people on the basis of age or health status, for example.
Cream skinning	Adapting a service or product to appeal most to those people from whom the greatest return can be obtained by the provider (usually the lower risks).
DRGs	Diagnosis related groups. A convenient way of classifying hospital in-patient casemix, which has a direct relationship to resources used. The criteria for developing groupings are that they are clinically meaningful and involve similar resource use.
FED	Front end deductible — generally refers to an excess payment required from the health fund contributor.
Gap	Describes the difference between the MBS fee and the Medicare rebate. The gap for in-hospital services can be covered by a health fund. Where MPPAs exist, funds can also cover any difference between the MBS fee and the actual service charge.
Health status	Health condition of the population.
‘Hit and run’	The phenomenon of an individual joining a health fund to receive benefits for medical expenses which are known to be looming — and then leaving after those benefits are obtained. A form of adverse selection.
HPPA	Hospital purchaser-provider agreement. Describes a contract between a health fund and a hospital, under the provisions of the 1995 Amendment Act. These include: a single bill for all accommodation expenses; provision of casemix data in a specified form; and no out-of-pocket expenses, or an agreed level of out-of-pocket expenses, for the contributor.



Lifetime community rating	An insurance arrangement in which premiums rise with the age of entry.
Managed care	Refers to any system whereby the payer for health care seeks to exercise some control over the care provided, in terms of cost, quality, and appropriateness of care, and even choice of the provider.
Managed competition	Refers to competition among health care plans and among health care providers within a comprehensive government regulated framework. In Australia, this could involve private health insurers covering a more comprehensive range of health services (such as all pharmaceutical and medical services). Also can refer to arrangements where someone (eg a general medical practitioner), is assigned by the payer to organise, negotiate, and possibly pay, for a range of health services which an individual may require.
MBS	The Commonwealth Medical Benefits Schedule specifies fee levels for medical services. Medicare rebates are set on the basis of the MBS, although many doctors charge more than the MBS fee.
Medicare Agreements	Agreements between the Commonwealth and the states and territories about public hospital treatment and funding.
Memberships	The number of either single or family memberships of a health fund. (Used interchangeably with ‘contributors’.)
Moral hazard	The effect of incentive on behaviour — for example, an individual with health insurance may take less care of their own health.
MPPA	Medical purchaser-provider agreement. Describes a contract between a health fund and a doctor, under the provisions of the 1995 Amendment Act. A fund can negotiate with medical providers and establish an agreement where there are no out-of-pocket expenses or an agreed level of out-of-pocket expenses for the

	patient. The fund can pay benefits above the scheduled fee where such an agreement exists.
Open membership fund	A health fund which must take all persons who wish to join, subject only to pre-existing ailment rules and waiting periods.
PEARs	Rules specifying the maximum time that people with pre-existing ailments must wait before private hospital insurance benefits.
PHIAC	The Private Health Insurance Administration Council. Established under amendments to the National Health Act in 1989. Responsibilities include ensuring health funds meet minimum solvency requirements as defined in the Act, and the administration of the reinsurance arrangements.
PA	Practitioner agreement. An agreement between a hospital and a doctor, under the provisions of the 1995 Amendment Act.
‘Reinsurance’	A system for sharing the hospital costs of high risk members among health funds.
Reserves	Health funds are required to keep reserves of at least \$1 million or two break-even contribution months, whichever is the greater. When a fund falls below the requirement, it must make application for an exemption.
Restricted or closed membership organisation	A health benefits organisation whose membership is restricted, for example to certain industry or employment groups. Pre-existing ailment and waiting period rules apply as for open funds, and participation in reinsurance is required.
Self-insurance	The payment by an individual for their hospital care on an episode-by-episode basis.
SEU	Single equivalent unit. Calculated by multiplying family memberships by two, and adding the number of single memberships. The new membership categories of couples and single parent families also count as two single equivalent units.

Sovereign risk                      The unforeseen costs of a change in government policy.

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## OVERVIEW

- Private health insurance occupies a significant but ambiguous position within Australia's health care system.
  - It is a voluntary facility for private funding of hospital care and ancillaries, sitting alongside a compulsory tax-financed public system (Medicare) that is available to all.
  - It is also constrained by regulation designed to pursue similar non-discriminatory access objectives to those in the public system.
- Given the existence of 'universal' public health care, some participants argued that the logical role of private health insurance was just to fund 'optional extras' (additional comfort, choice). Others saw it as providing a desirable alternative to public funding and provision.
  - In practice, it plays both roles: providing top-up funding for additional services and amenities, as well as displacing the need for public funding for services available under Medicare.
- But this 'mixed' system is in trouble:
  - premiums for private health insurance are rising rapidly, fewer people can afford to choose private health insurance and fund membership is falling;
  - demand pressure is consequently growing on a public system beset by funding difficulties; and
  - private health insurance's 'safety valve' function for the public system is deteriorating.
- The need to alleviate budgetary pressures, among other objectives, has led to a series of government initiatives in recent years intended to stem the decline in private health insurance;
  - including a range of regulatory changes and, most recently, financial inducements from July 1997 to improve its attractiveness.
- But in the meantime premium increases have continued, raising community concerns that have led to this inquiry.

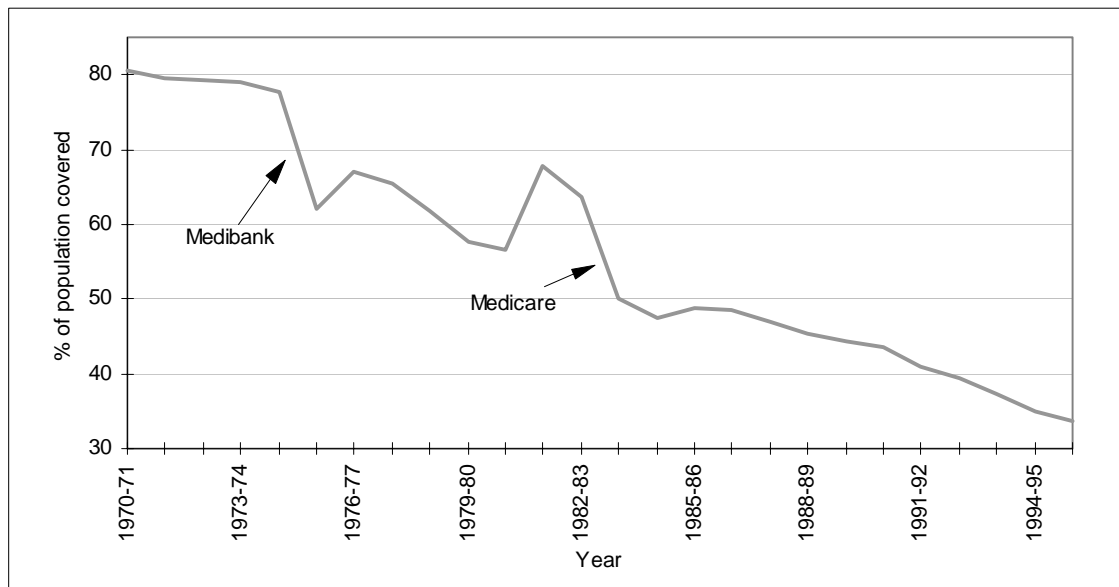
## State of the industry

- Since the introduction of Medicare, private health insurance has diminished considerably in terms of its coverage of the population, but has maintained its contribution to the funding of health care.

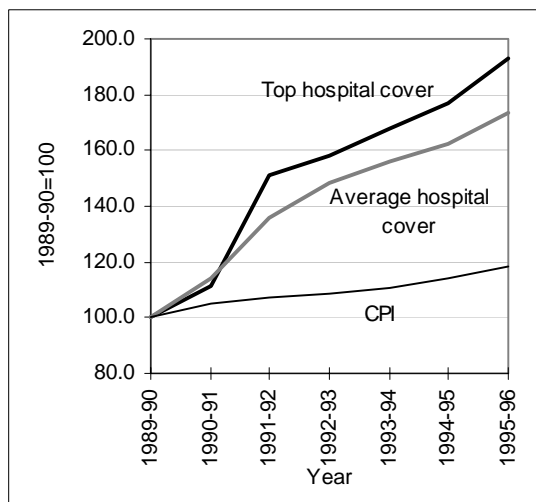
### **Box 1: Some facts about private health insurance**

- It is a \$4.5 billion industry  
accounting for 11 per cent of total health care expenditure  
and about 18 per cent of hospital funding.
  - It covers around 6 million people or one-third of the population  
who are on average wealthier, older (and apparently in better health) than the  
rest of the community  
the majority of whom have ‘top cover’ at premiums averaging around \$1230  
for individuals or \$2460 for families (equivalent to around 8½ per cent of  
average weekly earnings after-tax).
  - It comprises 48 health benefits organisations  
but the six largest have nearly 80 per cent of total membership, and  
in most states the top two funds have at least half the market between them.
  - Only three organisations operate ‘for profit’  
most are ‘mutuals’  
the largest (and only national one) is a Commonwealth non-profit body.
- 
- Membership of hospital insurance has fallen at a steady rate, reaching over  
five per cent per annum in the last three years. It now covers a third of the  
population, compared to about 50 per cent in mid-1984.
    - Simple extrapolation of the membership trend would have it  
bottoming out at 10–12 per cent; but Queensland’s longer experience  
with a free public hospital system suggests that the low point could  
be double that.
    - How low membership falls will depend largely on community  
perceptions about the value of private health insurance compared to  
service under Medicare, and how policy measures affect that  
comparison.

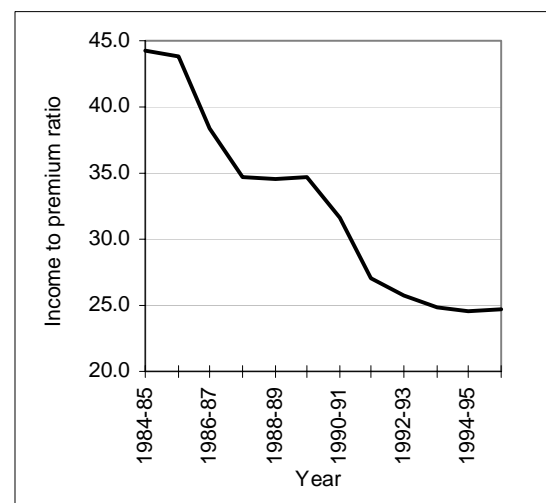
## Fund membership has fallen...



## ... premiums have risen



## ...and affordability has declined



- The price of private health insurance has been rising inexorably, at a rate averaging 3½ times CPI inflation since 1990.
- The attractiveness of private health insurance has also been diminished by unpredictable 'out-of-pocket' expenses associated with hospital treatment, which can be large:
  - and this is compounded by the uncoordinated proliferation of doctors' bills.

- The complexity of the product has meant that many consumers are unaware of the exact nature of the benefits to which they are entitled until they need to claim — and then they are unpleasantly surprised.

**Box 2: Consumers speak out**

‘My wife and myself are 67 years of age and at this time, where probably more than ever before we need to belong to a health fund, it may be necessary to discontinue our membership because of increasing charges.’

‘Believing all the advertising I had seen regarding private health cover, I simply assumed that I was covered for all expenses. Much to my dismay, on discharge I found that I needed to find some \$350 extra for the hospital bill and a further \$600+ for the specialist.’

‘We have found that some of the health funds’ policies, in their fee structures and excesses, make it almost impossible to make an informed choice.’

‘Comparison shopping for private health insurance is a nightmare for consumers. An absolute disgrace!’

‘I arrived home in a very disturbed and weak state and within days was back in hospital with post operative amnesia. *Then the bills arrived.* Surgeons’ bills. Anaesthetists’ bills. Pathologists’ bills. Doctors’ bills. Unknown doctors’ bills. Chemists’ bills. Ambulance bills. Claiming from [a major private fund] and Medicare became a nightmare.’

‘Whilst receiving treatment as a private patient in a public hospital, the person in the next bed was a public patient and received the same treatment by the same medical practitioner, yet was not faced with any out-of-pocket costs.’

‘The fund’s huge cost is an outrage, yet I don’t dare drop it only because I know that private insurance, in this democracy, gets you into hospital faster. My wife might be in desperate need for it some day, so I hang on, bleeding money. It’s that unfair priority, rather than superior service, that keeps many of us in.’

*Source:* A selection from among over 75 submissions received from individuals and families.

- The bewildering and expanding array of ‘tables’ being offered by the funds is in part a (perverse) manifestation of competitive activity driven by the constraints of the regulatory framework.
- The major regulatory influence on the industry’s performance are the rules giving effect to the Government’s policy of ‘community rating’.
  - This concept has never been clearly defined, and has become elastic in interpretation, but essentially means that funds are not to

discriminate between people in setting premiums or benefits on the basis of expected claims risk.

- Together with the supporting ‘reinsurance’ pool arrangements — which serve to even out differences in the burden of claims resulting from older or chronically ill members — community rating of private funds in circumstances where members can enter or leave at will (with Medicare as a backstop) has created some perverse effects. It has:
  - dulled the incentive for funds to reduce costs, especially in those risk categories covered by reinsurance;
  - led to a proliferation of products designed to target particular groups (while precluding development of some products that would be in demand); and
  - heightened ‘adverse selection’, whereby lower risk people have been leaving (unwilling to pay the actuarially excessive premiums needed to ‘pay for’ higher risk people) and those expecting to make claims have been joining (some of whom ‘hit and run’).
- These effects have created an inherent instability in the industry. They add to what has become a vicious circle, in which rising premiums lead to the lower risk members dropping out first (see box 3). This not only shrinks the pool of insured but raises its overall riskiness, leading to higher pay outs and higher premiums again.

### **Why are premiums rising so fast?**

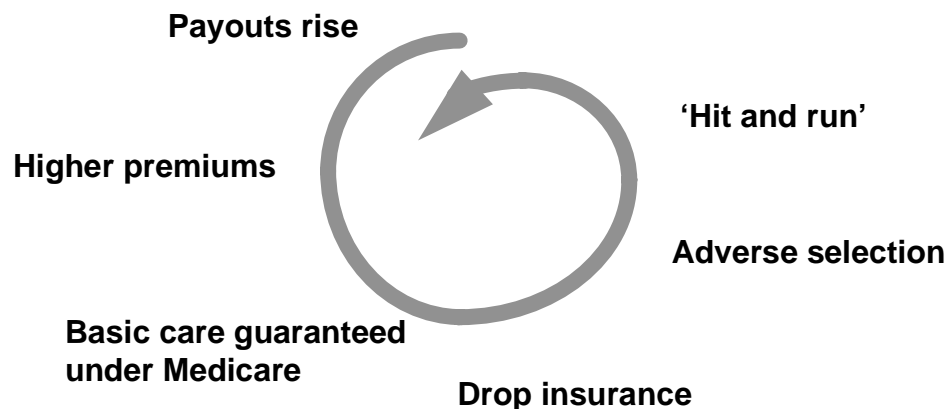
- The rapid growth in premiums has been interpreted by some as showing that the private system is either increasingly inefficient or anti-competitive, or both. But the facts are inconvenient to such an interpretation.
- The degree of competitive pressure on funds is greater than the relatively high level of concentration within state markets would suggest, and has been increasing.
  - There are no effective regulatory barriers, of a *discriminatory* kind, to the entry of new firms (or to the interstate expansion of existing ones). There are, however, major regulatory constraints on *all* players — notably through community rating — which make the industry unattractive to enter and limit choice within the market.
  - In the latter respect, key regulations relating to private health insurance would require further examination under the Competition



Principles Agreement. But this is essentially precluded by the Commission's terms of reference.

- There also appear to be few significant economic barriers to new entrants, other than low expectations of profitability and the impregnability of the mutual funds to 'hostile' takeovers.

**Box 3: The vicious circle of falling membership**



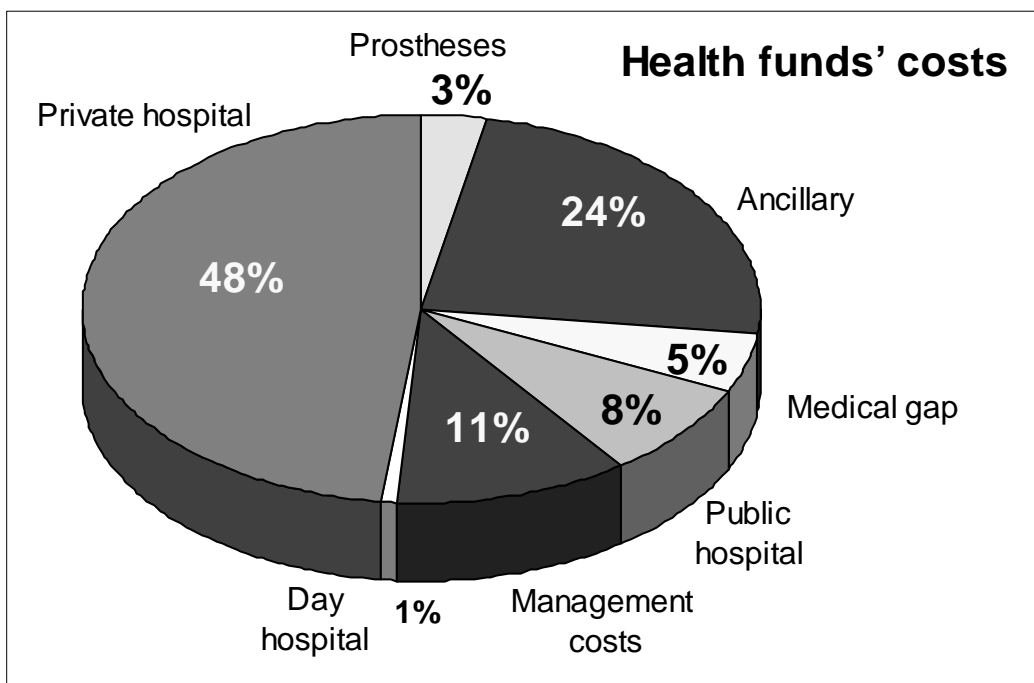
(Diagram derived from ICA/LISA, Sub. 161, p. 7.)

'In our opinion these price increases are a natural result of an inherently unstable funding system ... This instability results from the cost increases beyond inflation which are an inherent part of health insurance under the current structure. As premiums increase, progressively more and more members with lower expected health insurance costs will give up their health insurance, with membership reducing until only the most costly members survive, supported by heavy government controls and subsidies.'

(Australian Institute of Actuaries, Sub. 141, p. 2)

- To understand why premiums have been rising, the first thing to be aware of is that the costs incurred by funds consist overwhelmingly of benefits paid to members. In the most basic sense, therefore, premiums are rising fast because payouts to members are rising fast.
  - Funds are not making excessive surpluses or profits (indeed many are losing money); and

- while administrative costs have been rising, their share of total fund income has not and, in any case, remains small relative to payouts (although scope remains for administrative savings).

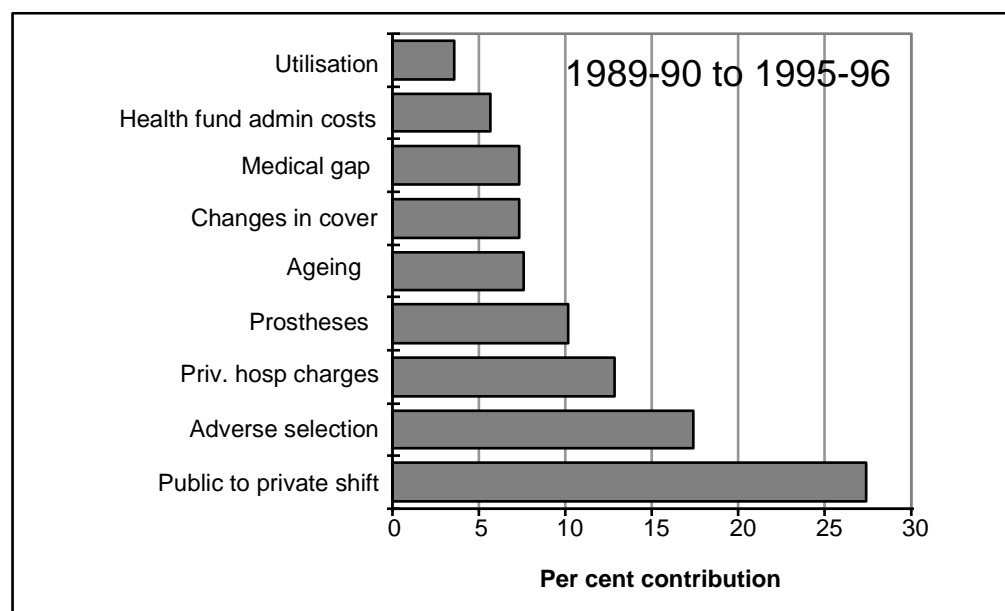


Source: PHIA 1996a.

- A second key point is that a large proportion of the rise in premiums since Medicare was first introduced has been policy induced — involving the withdrawal of a range of subsidies to private funding and provision.
  - This factor has been estimated to account for around 30 per cent of the current level of premiums;
  - though its effect largely pre-dates the 1990s, which have seen further substantial premium rises.
- The major contributors to the rise in premiums (above general inflation) since 1990–91 were found by the Commission to be:
  - a substantial rise in the proportion of fund members using private rather than public hospitals (the formers' charges being about twice the subsidised public rates):
    - this factor dominated all others, especially in 1995–96;

- the shift has reflected several ‘push’ and ‘pull’ factors, among which public hospital access problems (partly policy-induced via Medicare Agreements), and a consequent enhancement of private hospital capability, have been influential;
- an increase in average private hospital admission charges, due primarily to changes in technology and clinical practice;
- an increase in average hospital admissions by private patients:
  - with the net effect on average utilisation of services being largely offset by reductions in average length of stay;
  - and the rising admissions partly reflecting a change in fund composition towards older and sicker members as community coverage dwindles (‘adverse selection’).
- Indeed adverse selection is a significant underlying contributor to a number of the cost drivers. Available evidence suggests that it may have contributed around 17 per cent to real premium increases in the 1990s.
  - In the future, as other influences such as the public-private shift diminish, it will become more dominant as an underlying force for premium increases.

#### Key contributors to increased hospital insurance premiums in the 1990s



- Lesser contributors over the last six years included the costs of prostheses (which were relatively small but have been growing fast), medical gap

payments, public hospital charges and the introduction of ‘100 per cent’ cover.

- The most important cost drivers behind premium increases are thus not under the *direct* control of the funds. They reflect decisions by governments, doctors, patients and hospitals about what treatment occurs, where it takes place and at what price. And they are influenced by ongoing shifts in the risk profile of the diminishing pool of members under community rating.
  - This is not to say, however, that the funds are powerless to influence some of these cost drivers.

### **Recent policy initiatives**

- Faced with adverse budgetary implications of the fallout from private insurance, governments have made changes to the regulatory framework and announced financial incentives for membership.
- The main regulatory changes in recent years include:
  - legislation to facilitate contracting between funds, doctors and hospitals, that would allow greater certainty about fees and scope to moderate cost increases:
    - these have been partly successful, but only with private hospitals and, in allowing 100 per cent cover, have exacerbated cost pressures in the short term;
  - permission for funds to sell excess (or ‘front end deductibles’) policies as well as tables excluding certain treatments, so as to allow more affordable products, with consumers bearing some of the risks:
    - these have become increasingly popular as full cover premiums have risen, but they have also led to so-called ‘cream skimming’ as lower risk existing members self-select lower cover, at some cost to higher risk groups;
  - the categories of members for community rating purposes have been extended from singles *vs* family (with the family rate having to be twice the single rate) to a fourway split containing two new family categories — couple and single parent — with no restrictions on pricing relativities among them:
    - together with policies which exclude certain medical conditions, this recent change gives funds greater scope to provide more targeted products at lower prices; but the

extent to which it encourages new entry as opposed to the ‘cannibalising’ of members among funds is unclear.

- The Government has also announced financial incentives to apply from July 1997, consisting of (a) rebates for members below certain income ceilings and (b) a Medicare levy surcharge for those with incomes above specified thresholds (see box 4).
  - The rebates provide a high rate of assistance, especially on the cheaper tables;
  - they are likely to have a moderate, but predominantly short-term impact on membership levels (unless the subsidies were to increase in line with premiums);
  - while this will bring some savings in public health expenditure, the fact that the bulk of the rebates will go to *existing* fund members, means that the net budgetary effects will be negative.

#### **Box 4: The private health insurance incentives**

- From 1 July 1997, single people earning less than \$35 000 a year, and couples and families earning less than \$70 000, will be eligible for private health insurance rebates. The income threshold for families will rise by \$3000 for each additional child.
- The rebates will be paid as follows:

Singles:	\$100 for hospital cover, and \$25 for ancillary cover;
Couples:	\$200 for hospital cover, and \$50 for ancillary cover;
Families:	\$350 for hospital cover, and \$100 for ancillary cover.
- Higher income earners will face a Medicare levy surcharge of 1 per cent from 1 July 1997 if they do not take out private health insurance. This applies to single people earning more than \$50 000 and families earning more than \$100 000.

#### **Need for systemic reform**

- In undertaking reforms, governments have had a number of objectives, some of which are incompatible. They include:
  - easing the budgetary pressure on publicly funded health care and encouraging people to take up and retain private health cover, while providing universal access to free health services;

- ensuring that access to the private system is generally available at prices which do not discriminate against high-risk groups, while allowing funds greater scope to provide products which meet the specific needs of particular (low-risk) groups.
- Ad hoc and piecemeal reforms to a complex, interactive system can have some beneficial effects, but also can create further tensions and the need for additional government interventions.
- The outcome is a system which, despite numerous policy changes, has inherent and unresolved tensions, the most fundamental being the unstable interaction between private health insurance and the public system.
- Policies for private health insurance need to be informed by an understanding of how the overall system can most effectively operate.
  - This raises issues beyond the assigned scope of this inquiry, but getting some understanding of the larger design problems and reform models was seen as a pre-condition for providing sound policy advice in the specific areas identified by the terms of reference.
- Health policy is complicated by the necessity for multiple objectives and in the range of mechanisms and institutions that can play a role in achieving them.
  - Important objectives include consumer choice, efficient and high quality service delivery, equitable and efficient allocation of services and ensuring overall stability and coherence in the system.
- Many participants (and others) had views about broader systemic reforms that were needed in health care financing and delivery, often tied to their perspective about the appropriate role of private health insurance. From these and the wider literature it is possible to distil three somewhat stylised models:
  - (a) more emphasis on *public* funding and delivery (with improvement in system design);
  - (b) a predominantly *private* market for provision, funding and intermediary services;
  - (c) a *mixed* system, 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 is restricted to lower income households, with others compulsorily insuring.

**Box 5: Participants on the 'bigger picture'**

Perhaps the greatest immediate problem nationally is that reform is proceeding in a piecemeal manner. We lack a clear vision of the objectives of health care financing, and the principles and policy settings which will move us toward attainment of the objectives. (Healthscope Limited, Sub. 190, p. 1.)

The policy processes in health care perhaps are best called 'muddling through' or 'disjointed incrementalism' — a decision-making process in which:

'decision makers consider only incremental alternatives at any one time, together with a limited number of alternative means. Solutions will be considered only if they are realistic or, in other words, appropriate to the available means. There is no clearly defined problem, no one decision; problems are never "solved".' (Ian McAuley [also citing Hall 1980], Sub. 13, p. 3)

There are design features in Medicare which, quite apart from their effects on the performance of the public system itself, hamper the development of greater efficiency in the private health insurance industry. (Peter Carroll, Sub. 9, p. 25)

Any useful inquiry must study the health system and interfaces in entirety ... the actual insurance is at the summit of a cumbersome, ridiculously costly, system ... (Robert Green, Sub. 143, p. 1)

- Each model has strengths and weaknesses (there is no perfect system) and each implies quite different roles for private health insurance and its regulation.
  - Private insurance would effectively become peripheral under a strengthened public system (and community rating would have no place in private insurance). Yet it would dominate under a primarily private health care system or in systems in which near complete opting out was sanctioned or mandatory.
  - Under managed competition models, the role of insurers (as fund holders) would also be far more significant, although the main funding source would be a 'capitation' payment from government rather than the consumer (who nevertheless could 'top up' for extra cover).

- The critical lesson from a quick review of even such simplified models of health care reform is that the role of, and problems faced by, private health insurance cannot be separated from the system as a whole.
- The Commission has nevertheless considered the scope for policy changes, within the limits of its terms of reference, which would improve community welfare, without getting in the way of wider and potentially more beneficial changes.

### **Reducing ‘adverse selection’**

- Adverse selection — good health risks leaving, bad risks coming and staying — is the combined result of community rating regulation and the fallback of free public hospitals. Its effects could be moderated — helping to stabilise the overall system — by some changes to regulations, without undermining the broad principle of community rating.

#### *‘Lifetime’ community rating*

- The most effective mechanism — raised by a cross-section of participants — would be a form of ‘lifetime’ community rating, which introduces penalties for later aged entry to insurance.
  - For example, a 65 year old who had entered insurance at age 35 would pay a much lower premium than one who had entered at say 60 years of age — and would pay the same premium as someone entering today at the age of 35.
- 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 producing a more balanced pool of risks and thus lower premiums.
- In its pure form, lifetime community rating is a ‘funded’ scheme, in which people pool reserves within their age cohort to meet their health costs in old age. Premiums are set to meet expected costs over the remaining years of life.
  - While relatively effective in addressing adverse selection, such a system is likely to require complex and costly transitional arrangements and could remain vulnerable to or impede broader changes in the health system.
  - Until a wider review of the health system takes place, such radical restructuring of community rating may be counterproductive.



- These difficulties are largely avoided with an *unfunded* lifetime community rating scheme, which essentially imposes higher premiums on those who enter insurance later in life. Contrary to a funded approach, the level of premiums would depend on the composition of the membership pool in a given year.
  - The Commission also considered a ‘non-price’ variant of this form of lifetime community rating, which would involve longer eligibility waiting periods for late joiners. Such a scheme could be combined with the premium-based one, but this would be confusing. In choosing between the two, the Commission has been attracted to the price variant because of some advantages in efficiency and community acceptance.
- The Commission considers that introducing unfunded lifetime community rating would not create inequities:
  - no existing member would be adversely affected (indeed pressure on their premiums would be reduced); and
  - a grace period would ensure that intending members were not disadvantaged.

### *Pre-existing ailments*

- Issues of age aside, many insurers have argued that the regulated maximum waiting periods for pre-existing ailments are too short and facilitate ‘hit and runs’, to the detriment of existing members.
  - The Commission considers that lengthening waiting periods would be a positive step for obstetrics and conditions particularly subject to strategic entry.

### *No claim bonuses?*

- One way of reducing the incentive for good risks to leave private health insurance would be to allow provision of no claim bonuses in premiums. These would also mitigate ‘moral hazard’ effects (overuse of services because of insurance).
  - On closer examination, however, the Commission considers that, despite the moderating influence of reinsurance, no claim bonuses would inevitably lead to higher premiums for the sick (against the principle of community rating) and there is significant potential for cost shifting (back) to the public system.

## Facilitating innovative products

- The extent of innovation is constrained by various regulations and institutional arrangements.

### *Product regulations*

- Funds currently cannot offer some products and are at the same time *obliged* to offer others, providing fewer options for consumers wanting more selective service cover.
- The Commission has considered participants' views on the rationale for requiring funds to offer cover in all products for in-hospital psychiatric, rehabilitation and palliative care (but for no other categories of care). While there may be some justification in the case of psychiatric care — subject to appropriate admission criteria — the Commission found no compelling reason for singling out rehabilitative and palliative care in this way.

### *Changing reinsurance*

- Historically, reinsurance has constituted a set of pragmatic risk pooling arrangements among funds, in support of community rating. The current arrangements have a number of deficiencies. These are partly a legacy of previous data constraints, which are rapidly vanishing.
- There is a need to revise reinsurance arrangements so that:
  - funds which are effective at containing unit costs or utilisation do not subsidise those which are not;
  - the effect of family and membership composition differences is equalised more systematically;
  - there is more scope for funds to target products to attract lower risk members, as long as community rating is not destabilised; and
  - out-of-hospital care can be included.

#### **Box 6: Understanding 'reinsurance'**

Reinsurance consists of a common pool for two groups of bad risks (the aged and chronically ill) into which all funds compulsorily contribute. Funds with a greater proportion of lower risk people (the young) pay into the reinsurance fund, while those with a greater proportion of higher risks (the old and those with hospitalisation of 35 days or more) receive transfers from the fund.

The function of reinsurance is to remove disincentives to recruitment of older and sicker people — it financially polices community rating by lowering the incentives for funds to ‘cream skim’ the low risk consumers.

Reinsurance has some adverse side effects. For example:

- it decreases any single fund’s incentives to manage the costs of the elderly and the sick, since most of these costs are pooled with other insurers;
- it increases the insurance loading on products offering lower benefits to consumers such as front end deductibles and exclusion products, thus making these less attractive to consumers; and
- it also reduces the attractiveness of introducing genuine ‘catastrophe’ insurance products.

- The Commission considers that these objectives would be best met by ‘composition based’ reinsurance schemes, which adjust for differences between funds’ risk profiles and (sometimes) coverage.
- There is also a case for complementing such changes with ‘proportional’ reinsurance arrangements, subject to their workability. The current system imposes the same liability on any policy, regardless of the benefit it offers. Under proportional reinsurance, the contribution by any policy to the reinsurance pool would be proportional to the benefit rate provided by that policy. This would facilitate cost-effective innovation, including cheaper products, and have some positive equity implications, although there could be some trade-off in higher premiums for full cover policies.

## **Enhancing competition**

- While the Commission’s judgment is that there is a reasonable degree of competitive pressure on the private health insurance industry (a major underlying source being the Medicare system itself), there are also a number of ways in which it could be enhanced. These would complement other regulatory changes designed to improve incentives to reduce costs and innovate.

## **Governance**

- Most of Australia’s private health insurers are ‘mutuals’. They exhibit a number of different governance structures, but most lack strong accountability to members.

- One issue is how this may be improved in a way that provides greater discipline on performance.
- In particular, it would seem desirable that mechanisms to facilitate (hostile) takeovers be considered, as under current arrangements this important source of competitive pressure is virtually irrelevant in the health insurance industry.
- Mutual funds have an apparent advantage over for-profit competitors in that they do not pay income tax. There appear to be some impacts on pricing and output, but the Commission's assessment is that the distortions are relatively small.

### *Medibank Private*

- The existence of a dominant government-owned insurer, initially introduced to enhance competition and bring a national presence to the industry, also raises questions about competitive neutrality. At face value, the co-location of Medibank Private and Medicare would seem to bring advantages unavailable to other insurers. And the Commission is unsure to what extent Medibank Private's relatively low administrative costs represent cost shifting to Medicare, rather than greater technical efficiency (or economies of scope).
  - At a minimum, there is a case for allowing funds to act as Medicare retail agents (which would also simplify billing transactions for consumers):
    - and for examining the desirability of separating Medibank Private from the Health Insurance Commission.

### **Improving cost effectiveness of health care**

- The Australian health care system has traditionally combined fee-for-service medicine with payment of the largest part of health care bills by a third party — the government (taxpayers) or private insurers. Inherent in the system is a tendency for overuse, where patients receive services which they value at less than the cost of provision. This is compounded by the information imbalance between doctors and patients.
  - These factors work against containing excessive costs within the system and providing private health insurance members with value for money.

- The problem compounds as technology makes feasible an ever increasing range of procedures which are high cost, but sometimes of questionable additional clinical worth.

### *Contracting*

- In addition to proposals already made, there is some scope to improve incentives within the contracting framework.
- In particular, the Commission considers that health funds should be free to choose which private hospitals to contract with and for what services (subject to members being adequately informed):
  - this implies eliminating the requirement for a specified default benefit for private hospitals.
- Health funds should not be obliged to pay full hospital benefits for nursing home type patients in acute hospitals for up to 35 days. They should be free to negotiate with hospitals about an appropriate rate or with other providers about treatment on a nursing home basis.
- The Commission also considers that the speedier and widespread adoption of *proper* episodic case payment contracts between funds and hospitals will be facilitated by a number of its recommendations.
  - Allowing doctors to write contracts with hospitals at above the MBS fee where proper case payment contracts are in place will assist in this respect.

### *Other mechanisms*

- Case payment contracts can help influence unit costs, but won't necessarily influence the *number* of episodes.
- Health funds already pursue options to counter adverse volume incentives, including 'step down' contracts with hospitals (specifying lower payments after a certain number of treatments), copayments per service received and, for expensive procedures, products with benefit ceilings and/or exclusions.
  - Proposed changes to the current reinsurance arrangements will enhance the funds' incentives to act.

## Alleviating other regulatory burdens

### *Price regulation*

- The funds are required to notify the Department in advance before implementing rule changes, including premium changes. The *National Health Act* provides for the Minister to disallow changes where they: breach a condition of registration; adversely affect the rights of contributors; or affect a fund's financial stability.
- When applied to price controls, these conditions essentially relate to solvency, anti-competitive behaviour and equity. In the Commission's view, none of the arguments withstand critical examination.
  - For example, solvency is best addressed by a direct instrument related to reserves: a 'belt and braces' approach is not needed.
  - Given the variety of funds, and the absence of significant barriers to entry, effective collusive behaviour seems unlikely (if anything, 'price approval' processes can encourage it) and there is also little scope for monopoly pricing.
  - Given the benefit-driven nature of pricing, there is little the Government can achieve by attempting to suppress prices (other than endangering solvency).
- Price regulation — even if informal and infrequently applied — can also act as a deterrent to entry of new organisations into the market and thus detract from incentives to be efficient.
- The Commission considers that the Government should neither control nor screen price *changes* of health insurance products.

### *Reserve regulation*

- With the aim of protecting contributors, funds are currently required to maintain a minimum of \$1 million, or two break-even contribution months of reserves, whichever is greater. Compliance is monitored by the Government through a statutory agency (PHIAC) reporting to the Minister.
  - The Commission doubts whether the current administrative structure ensures sufficient independence for PHIAC and proposes that its powers be vested in an independent Board.
- The Commission found a number of problems with existing reserve management, including:

- some ambiguity about what happens when a fund breaches the minimum reserve requirements; and
  - limited requirements regarding liquidity of assets held as reserves.
- There should be a clear protocol for breach of reserves, and clearer guidelines as to what constitutes acceptable liquidity and diversification of reserve assets.
  - Reserves should be set at appropriate levels (which should be differentiated by fund categories) and funds not meeting them closed down.

## **Other consumer needs**

### *Integrated billing*

- Currently contributors face a proliferation of bills after private hospital treatment, requiring multiple claims through Medicare and their health fund. The system inefficiencies and (hidden) costs to consumers are considerable.
- The benefits to consumers (and ultimately the whole sector) of ‘single billing’ are widely recognised. They include reduced transactions (including a single copayment) and greater certainty about charges. Work underway to achieve billing reforms, and to facilitate informed financial consent, should be completed as quickly as possible.

### *Comparing products*

- Consumers and experts alike face a daunting task in deciding what level of cover (‘table’) to take up and in comparing the offerings of different funds.
- To some extent, product complexity has been a side effect of attempts to allow innovation within community rating constraints. The ultimate ‘solution’ therefore involves systemic considerations beyond the scope of this inquiry. In the meantime, the Commission does not see a net pay off to the community from government measures to improve consumer information, beyond those already available through PHIAC and the Complaints Commissioner.

**‘Maximising the value of the incentives’**

- Many of the above proposals are directed at making private health insurance ‘better value’ for consumers. They would allow a wider range of products and (ultimately) lower premiums. And they would be more equitable.
  - In these ways, they would also enhance the value of the rebate.
- There was early confusion as to how the administration of the rebate would work. A working party has now been set up to deal with implementation issues:
  - administrative arrangements need to be clarified and compliance costs kept to a minimum.
- There need to be phasing provisions in the rebate and levy, to reduce the currently extreme marginal tax peaks at ceiling /threshold income levels:
  - which otherwise could have adverse employment incentives and lead to strategic behaviour.
- The Commission considers that money set aside for the rebates on ancillaries may be better spent by giving additional encouragement for hospital cover.
- The Commission considers that the rebate/levy arrangements are likely to have some effect on membership levels in the next few years, but that they have more questionable effects in terms of other objectives. The underlying longer term instability of the system will remain.

**Impact of proposed reforms**

- The Commission’s proposals will enhance community welfare as well as the performance of the private health insurance industry. In particular, the proposed reforms will:
  - reduce the destabilising effects of adverse selection;
  - strengthen incentives for cost effectiveness, both within funds and in hospital care;
  - provide greater scope for development of innovative products; and
  - over time, lead to lower premiums.
- While placing pressure on providers and funders to perform better, the Commission considers that no community group would be unfairly disadvantaged by its proposals, especially if the suggested transitional



strategies (phasing, grace periods) were adopted. This includes aged members and those who are ill or are just bad health risks.

- Overall, by improving the attractiveness of private health insurance, the Commission's proposals would also serve to reduce pressure on the tax-funded public system.
  - In encouraging early entry and (after a grace period) penalising those who only choose to buy private insurance when they anticipate high claims, some people will inevitably make greater use of Medicare (as, of course, is their right).
  - But this could be avoided only by perpetuating destabilising arrangements for private health insurance which would end up imposing a much greater burden on the public system.
- Nevertheless, the Commission emphasises that its proposals are essentially incremental in nature and designed to alleviate the problems of the health insurance industry in the short term. A long-term solution will require more. Private health insurance is a cog in a machine. One can burnish the gears of that cog, but ultimately its performance and functioning depend on the rest of the machine. There are grounds therefore for looking at other aspects of the health system through a wider public review.

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## RECOMMENDATIONS

*The following listing of recommendations is drawn from chapter 10 of the report.*

### **Recommendation 1**

The Commission recommends the introduction of (unfunded) lifetime community rating for private health insurance, under which people entering insurance late, for example after the age of 30 years, would pay higher premiums than those who enter early.

### **Recommendation 2**

The Commission recommends that community rating principles be examined as part of a wider review of the health system.

### **Recommendation 3**

The Commission recommends that community rating no longer apply to ancillary cover.

### **Recommendation 4**

The Commission recommends that *changes* in the price of health insurance products no longer be subject to disallowance.

The Commission also recommends that premium *changes* not be subject to monitoring or screening.

### **Recommendation 5**

The Commission recommends that guaranteed cover should be limited to psychiatric care which meets appropriate hospital admission criteria — with a short phasing-in period to develop these criteria.

If, however, this innovation fails to control costs and utilisation within two years, the Commission recommends that mandated cover be reviewed.

### **Recommendation 6**

The Commission recommends that compulsory coverage for in-hospital rehabilitative and palliative care no longer be required in every hospital table.

### **Recommendation 7**

The Commission recommends that the current restriction on no claim bonuses be maintained.

### **Recommendation 8**

The Commission recommends that pre-existing ailment rules be examined as part of any review of community rating.

### **Recommendation 9**

The Commission supports in principle the extension of maximum waiting times for conditions commonly subject to ‘hit and run’ behaviour (such as obstetrics), and recommends that appropriate arrangements be devised by the funds and the Department of Health and Family Services.

### **Recommendation 10**

The Commission does not recommend implementation of national reinsurance. However, any review of community rating should include consideration of this issue.

## **Recommendation 11**

The Commission recommends that new reinsurance arrangements be devised which meet the following criteria:

- differences in costs among funds due to the demographic characteristics of their membership (such as age, family size and gender) should be equalised;
- funds with lower unit costs and utilisation should not have to subsidise funds with poorer cost efficiencies;
- there should be some scope for funds to target new products at lower risk groups to recruit new members, as long as community rating is not destabilised;
- out-of-hospital care should be eligible for inclusion as part of any reinsurance arrangement.

The Commission considers that a composition based reinsurance scheme would best meet these criteria:

- subject to introducing additional age brackets for the elderly, so that funds with a greater proportion of very old members are not disadvantaged; and
- with appropriate transitional arrangements so that the impact on funds disadvantaged by the changes is spread over a number of years.

The Commission also considers that:

- proportional reinsurance, while entailing some risks, may be a useful complement to the above changes. It should be examined for its workability; and
- reinsurance will need to be adapted if unfunded lifetime community rating is introduced.

## **Recommendation 12**

The Commission recommends that arrangements be developed to allow ‘hostile’ takeovers of mutual health funds.

Detailed consideration should be given to proposals which:

- allow members or nominated representatives to accept or reject (via mechanisms such as a plebiscite) a hostile takeover;
- ensure transparency to members of the terms and conditions of such takeovers; and

- include appropriate monitoring of takeover bids in accordance with standard commercial arrangements.

### **Recommendation 13**

The Commission recommends that the transition of a health insurance fund from a tax exempt to a taxable entity be eased by making appropriate legislative amendments to the National Health Act.

### **Recommendation 14**

The Commission recommends that private health funds be allowed to act as retail agents for Medicare, subject to:

- satisfactory privacy arrangements;
- suitable apportionment of the relevant costs; and
- competitive neutrality with the arrangements applying for Medibank Private.

The Commission recommends that, depending on the findings of the current Treasury review, detailed consideration be given to separating Medibank Private from the HIC.

### **Recommendation 15**

The Commission recommends that:

- a clear protocol for breach of reserves should be developed;
- flexibility should be introduced into reserve requirements for funds facing different levels of risk; and
- clearer guidelines of what constitutes acceptable liquidity and diversification of reserves assets should be produced.

### **Recommendation 16**

The Commission recommends that the existing council be disbanded and the powers of PHIAC be vested in an independent Board, including a Commissioner and two to four other individuals independent of both the Department and the industry.

**Recommendation 17**

The Commission recommends that work towards achieving billing reforms, and facilitating informed financial consent, be completed as quickly as possible.

**Recommendation 18**

The Commission recommends that funds no longer be required to:

- pay benefits for NHTPs at the acute rate for the first 35 days; and
- pay a non-contracted private hospital at any specified minimum default bed rate (including emergency admissions and psychiatric care).

The Commission recommends that where doctors and hospitals contract under practitioner agreements, the funds be able to offer full coverage for medical fees above the MBS, as long as proper case payment contracts between funds and hospitals exist.

The Commission recommends that the proposed wider review into the health system examine supply constraints in the medical market.

**Recommendation 19**

The Commission recommends that, in the context of the next Medicare Agreement, the Commonwealth negotiate with the states and territories about introducing full economic charging for public hospital services for private patients.

**Recommendation 20**

The Commission recommends that the rebates for ancillary insurance be abandoned. If there was a concern to maintain the overall size of the package of subsidies to private health insurance, the relevant amount could be added to the rebates for hospital cover.

**Recommendation 21**

The Commission recommends that smoother phasing provisions be introduced in both the rebate and the levy surcharge arrangements.

## **Recommendation 22**

The Commission recommends a broad public inquiry into Australia's health system. Such an inquiry should encompass:

- health financing, including state/federal cost shifting incentives;
- integrated health systems and coordinated care (including assessment of the role of private insurers);
- the role of copayments;
- competitive neutrality between players in the system (for example between public and private providers, between untaxed not-for-profit private hospitals and taxed private hospitals, and taxed and untaxed health insurance funds);
- market power exerted by players in the system, including supply constraints in the medical market;
- community rating, including assessment of pre-existing ailment rules;
- information management in health care (such as transferable patient records and use of information in quality assurance); and
- progress of protocol development.

In the event that a broad strategic inquiry is considered unmanageable, a number of specific inquiries could be undertaken, focusing on themes such as financing issues, quality of health care, and competitive neutrality.

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# 1 INTRODUCTION

This inquiry about the private health insurance industry covers:

- its structure and conduct;
- issues relating to its efficiency and competitiveness; and
- aspects of its institutional and regulatory environment.

This chapter explains the background to the inquiry, outlines the scope of the report, describes the inquiry process and sets out the report structure.

## 1.1 Background

In its 1996 Budget, the Commonwealth Government announced measures to encourage families and individuals to maintain, or take up, private health insurance. These measures had been foreshadowed by the Coalition before the 1996 federal election.

- From 1 July 1997, incentives of up to \$450 a year for families, and \$250 a year for individuals, will be provided to low and middle income people with private health insurance.
- In addition, a Medicare levy surcharge will apply from that date for high income earners without private insurance. (For details, see box 1.1.)

The Minister for Health and Family Services has stated that the Government is committed to ‘implementing effective measures to keep private health insurance within the reach of ordinary Australians’ (Wooldridge 1996). An underlying objective of the incentives, however, is to switch demand from public to private health care, thus taking pressure off the public hospital system and public funding of health care (see section 2.3). In recent years, private health insurance membership has fallen significantly, with a greater treatment and funding load placed on the public system — see figure 1.1.

One of the reasons for this inquiry was concern that the announced financial incentives could lose some effect because of increases in health fund premiums. In fact, several funds announced such increases between the time of the Budget and the Prime Minister’s announcement of the reference on 30 August 1996. And more funds have implemented or announced increases since this inquiry commenced.

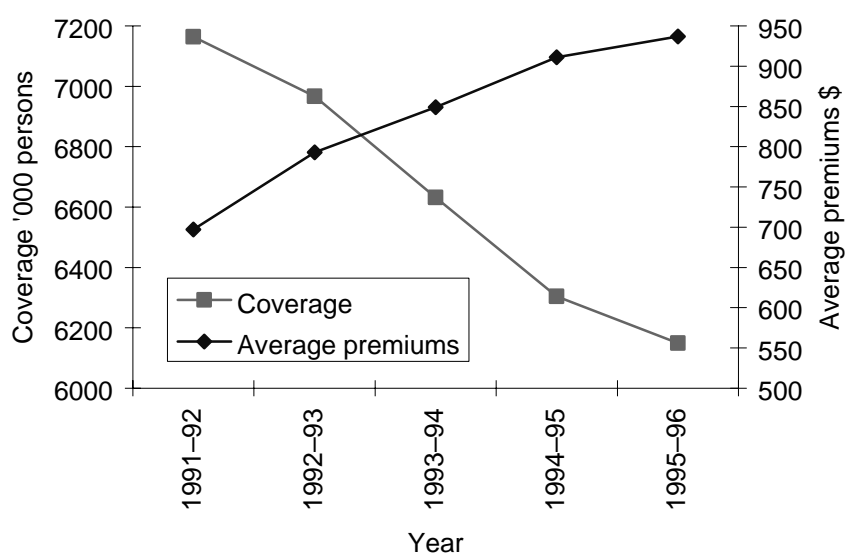


### Box 1.2: The private health insurance incentives

- From 1 July 1997, single people earning less than \$35 000 a year, and couples and families earning less than \$70 000 will be eligible for private health insurance rebates. The income threshold for families will rise by \$3000 for each additional child.
- The annual rebates will be:  
Singles: \$100 for hospital cover, \$25 for ancillary cover, \$125 for combined hospital and ancillary cover;  
Couples: \$200 for hospital cover, \$50 for ancillary cover, \$250 for combined cover;  
Families: \$350 for hospital cover, \$100 for ancillary cover, \$450 for combined cover.
- People can choose to have the rebate paid directly to their health fund in return for a guaranteed reduction in premiums, or they may choose to receive the payment as a tax rebate after the end of the financial year.
- Higher income earners will face a Medicare levy surcharge of 1 per cent from 1 July 1997 if they do not take out private hospital cover for themselves and all their dependants. This applies to single people earning more than \$50 000 and families earning more than \$100 000.

*Source:* Private Health Insurance Incentives Bill 1996 and Explanatory Memorandum, Medicare Levy Amendment Act (No. 2) 1996 and Explanatory Memorandum.

Figure 1.2: Private health insurance coverage and premiums



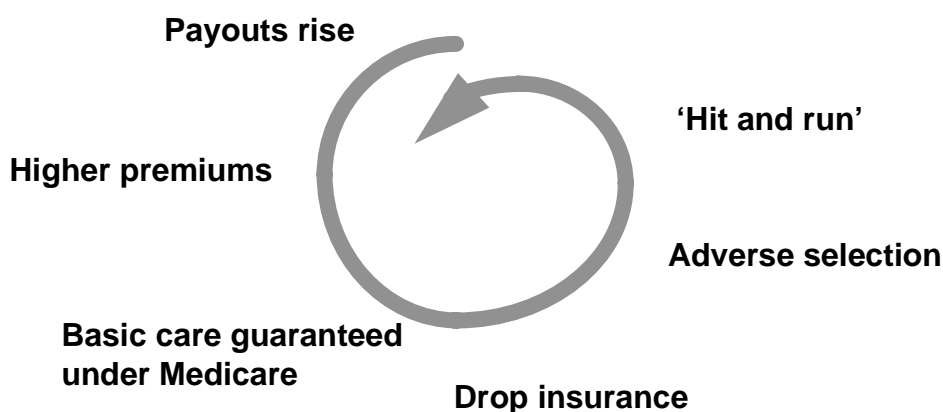
*Source:* PHIAC, Sub. 90, table 1.1.1(B) for hospital insurance coverage, and table 1.1.3(F) for average income per single equivalent unit.

The terms of reference for the inquiry also reflect more general concerns about the current state of the private health insurance industry, its falling membership, and the cost pressures it faces. Falling membership and increasing costs create difficulties for the funds themselves, as well as for public health provision and funding.

Several factors have led to premium rises: for example, some switching by private patients from public to private hospitals, and increasing private hospital usage and costs — in turn reflecting a number of factors which are analysed in this report.

As premiums rise, many contributors have dropped out of private cover, relying on ‘free’ access under Medicare to public hospital treatment. A vicious circle reinforces the process — see box 1.3. If this process were to continue then the industry — and the health sector generally — could ultimately face severe problems.

**Box 1.4: The vicious circle of falling membership**



*Source:* Adapted from ICA and LISA, Sub. 161, chart 4.

Legislative changes made in 1995 under the previous Government — the so-called Lawrence reforms — sought to improve the attractiveness of private health insurance to consumers. The changes aimed to limit out-of-pocket expenses by facilitating contracts between funds and hospitals, and between funds and doctors, at agreed charges. With contracts in place, funds can offer tables with 100 per cent cover, both for hospital treatment and for the medical services associated with that treatment. An important element was to allow funds to contract with doctors to provide rebates beyond the schedule fee. To

date, 100 per cent hospital cover is widely available, but there is very limited 100 per cent medical cover available (involving no out-of-pocket expenses). However, the availability of 100 per cent hospital cover is one factor leading to increasing health fund premiums.

The 1995 changes continue a long tradition of institutional and regulatory change in the private health insurance area. Insurers have been, and continue to be, subject to a myriad of government controls. These cover registration of funds, their rules, premium levels, the products offered, levels of financial reserves and even mergers and takeovers. In addition, 'reinsurance' arrangements redistribute money between funds to share the burden of higher cost members.

Many of these controls are intended to reinforce requirements for 'community rating' by health funds. This concept predates the introduction of Medicare and has never been precisely defined, but essentially means that a fund cannot discriminate its premiums or benefits on the basis of age, sex, health status or claims experience. In other words, community rating provides for 'equal' access to private health insurance for all members of the community.

## **1.2 Scope of the inquiry**

The terms of reference, dated 17 September 1996, focus on private health insurance and the private health insurance industry, rather than on broader issues such as the financing of the health care system generally, or improving the quality of health care. Matters under reference include:

- the current state of the private health insurance industry;
- the cost pressures on the industry;
- the most effective means of ensuring that contributors receive the maximum benefit from the Government's financial incentives;
- options to encourage innovative and price competitive insurance products; and
- an appropriate regulatory framework within which funds should set reserves and premiums.

The Commission also examines the institutional and regulatory framework of private health insurance more generally.

The terms of reference specify that the inquiry be conducted '*against the background of the Government's policy to retain Medicare, bulk billing and*

*community rating, and to provide financial incentives for families and individuals with health insurance’.*

The reference also specifies that, in making recommendations, the Commission ‘*aim to improve the overall economic performance of the Australian economy*’.

The Commission has been asked to identify groups which would benefit from, or be disadvantaged by, any proposed measure, and to consider relevant implementation strategies. The reference also specifies a number of other matters to which the Commission must have regard, including the intergovernmental Competition Principles Agreement (see chapter 5) and reforms being developed within the COAG process (see box 1.5).

### **Box 1.6: COAG and health system reform**

In February 1994, the Council of Australian Governments (COAG) endorsed the need for reform of health and community services. At further meetings in 1995 and 1996, COAG agreed to broad directions for such reform and an approach to implementation.

According to the June 1996 Communique:

‘there is an urgent need to shift the focus of health and community services from programs to people, through a partnership between the Commonwealth and the States. This will involve building a system that: provides quality care responsive to peoples’ needs; provides incentives for preventive health and cost effective care; gives better value for taxpayers’ dollars; more clearly defines roles and responsibilities; and retains the benefit of universal access to basic health services through Medicare’.

COAG agreed to several key elements for the longer term: working towards arrangements which place all health and related community services, including the MBS and the PBS, under the umbrella of a single multilateral agreement, with bilateral arrangements covering funding and outcome measures; exploring long-term global funding arrangements; and exploring options for a nationally consistent information and payments system. In the interim, COAG agreed to steps to consolidate and rationalise a number of existing arrangements, including consideration of transfer of responsibility for managing aged care programs to the States. COAG agreed that further work will also be undertaken on the ongoing role of private sector funding.

Part of the ongoing work under the auspices of COAG includes trials in ‘coordinated care’. (See chapter 9 for further information.)

*Source:* COAG Task Force on Health and Community Services, *Meeting people’s needs better*, January 1995; COAG Meeting, *Communique*, 11 April 1995; COAG Meeting, *Communique*, 14 June 1996.

The full terms of reference are set out in Appendix A. The Commission was required to report to the Government by 28 February 1997. The reference notes the Government's intention to respond to the Commission's report as soon as possible thereafter, at which time it will be publicly released.

### **1.3 The inquiry process**

The inquiry process was designed to facilitate participation by all interested groups and individuals and to allow the maximum degree of public scrutiny within the time available. (Appendix B lists the names of organisations and individuals participating in each of stage of the inquiry process.)

- Informal visits and discussions were held with organisations and individuals with a range of interests and perspectives — about 40 organisations and individuals were consulted.
- An issues paper was sent out in late September to assist those wishing to make submissions.
- A roundtable discussion was held in Canberra on 1 October to encourage an interchange of ideas among key participants with different interests and perspectives on the issues.
- Submissions were invited from the public — 191 were received before the Discussion Draft was released for public comment. These included submissions from industry organisations, health funds, and medical and consumer groups. Over 75 of the submissions were from individuals and families commenting on their experiences in the medical and hospital system, and as health fund members.
- The Discussion Draft was released on 18 December 1996 for public comment. Under the terms of reference, the Commission was not required to produce a draft report. Nevertheless, the Commission saw considerable benefits in exposing its preliminary analysis and findings to public scrutiny and comment, so that its report to Government could be as well-informed as possible.
- A further 97 submissions were received in response to the Draft, and 19 organisations or individuals participated in public hearings on 28, 30 and 31 January 1997. This final report takes those responses to the Draft into consideration.

## 1.4 Structure of the report

Chapter 2 examines the role of private health insurance, and the importance of private provision of health services, in the context of the Australian health care system. It is important to understand the constraints imposed on the private health insurance industry by policies such as Medicare, bulk billing and community rating. This chapter explains the Commission's approach to the inquiry, given the Government's support for those policies expressed in the terms of reference.

Regulation is covered in chapter 3. The chapter describes the complex web of regulatory requirements, and assesses their effects. It includes participants' comments about regulatory issues.

Chapters 4, 5, 6 and 7 look at the characteristics and operations of the private health insurance industry. Its structure, conduct and performance are covered in chapter 4. The nature and extent of competition within the industry are covered in chapter 5. Chapter 6 covers users of health insurance: it examines the characteristics of those people with private cover, the reasons why people take out or drop health insurance, and likely future trends in membership coverage.

Cost pressures are examined in some detail in chapter 7. It includes examination of those matters referred to in the reference:

- the impact of declining membership levels;
- increasing health care costs, including the relationship between private health funds and hospitals;
- usage of private hospitals;
- the impact of reforms allowing the setting of premiums for 100 per cent private cover; and
- the different costs to the industry of hospital beds in private and public hospitals.

Chapter 8 discusses the incentives facing health funds, hospitals and medical providers, and considers the scope for improvements to encourage cost containment and efficiency.

As a backdrop to examining the scope to make beneficial policy adjustments within the current terms of reference, chapter 9 looks at different models of health system reform.

Chapter 10 examines various policy options for private health insurance, and develops the Commission's findings and recommendations. (This is the key

chapter for readers anxious to get quickly to the reasoning behind the Commission's main findings and recommendations.) Chapter 11 discusses the likely effects on various groups of implementing those recommendations, as well as implementation strategies.

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## 2 THE ROLE OF PRIVATE HEALTH INSURANCE IN AUSTRALIA

In addressing issues relating to the private health insurance industry, it is important to understand the role of private health insurance in the context of the Australian health care system. In turn, this requires familiarity with that system, and why and how governments take such an active part in it.

This chapter firstly provides a brief overview of health care services provision and funding in Australia. It provides information on the size and make up of the sector, as well as on the significance of private health insurance. It then considers the role of private health insurance in the Australian context, both as envisaged by the Government and participants, and as it operates in practice. The chapter concludes by presenting the Commission's approach to the issues, given the Government's support for Medicare, bulk billing and community rating expressed in the terms of reference.

There are both equity and efficiency reasons for some government intervention in health systems (see box 2.1). While this report does not provide any detailed assessment of the rationales for government intervention in the health sector generally, it does describe the nature and extent of government involvement in private health insurance, examines whether that involvement is appropriate, and looks at ways to improve the regulatory and institutional environment in which private health insurance operates.

### 2.1 Overview of the Australian health care system

In Australia's federal system, responsibility for health care is divided between different levels of government. Governments make decisions about public and private health care *provision*, public and private *funding*, and about *regulation*.

Significant changes have been made to Australia's health care arrangements over the years as different governments have brought different views about the need for government intervention, about the appropriate balance between public and private provision, and public and private financing, and about the appropriate nature and extent of regulation.



**Box 2.2: Rationales for government involvement in health care**

Governments intervene in many areas of the economy in a number of ways and for a variety of reasons.

In health care, government intervention takes the form of regulation, provision of services, and funding of services. Reasons for intervention include:

- equity: concern that low income should not preclude members of the community from (at least basic) health care; and
- efficiency: there are problems with asymmetric information (consumers have difficulty in judging their own best interests), and adverse selection and moral hazard in insurance arrangements.

These characteristics arise in other areas of the economy as well, and government solutions are not always necessary. However, the characteristics combine rather uniquely in health care activity.

The difficult questions are to decide what form the intervention should take and how much government intervention is appropriate. Different community groups — and policy analysts — bring different perspectives to these issues.

One important distinction is between government *provision* of services and government *funding*. Justification for government funding need not imply justification for government provision.

The underlying objectives of government intervention could be summarised as seeking to obtain:

- an ‘improved’ distribution of health services among community members;
- the ‘right’ overall level of health service provision; and
- good health outcomes.

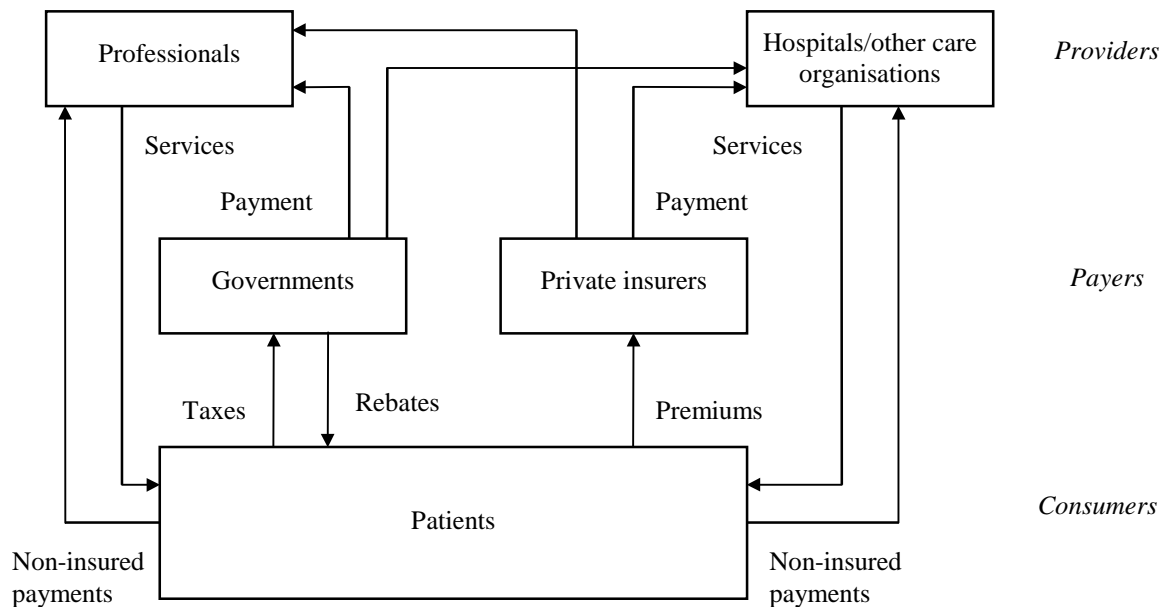
These objectives acknowledge that health care expenditure cannot be unlimited — expenditure on health care displaces resources available for other community needs and wants.

Some key features of Australia’s system are listed below (see also figure 2.1, which attempts to capture some of the main linkages between health care funders and providers):

- private and public supply of both medical and hospital services coexist;
- many medical services are provided on a fee-for-service basis;

- the Commonwealth Government funds both medical and hospital services (from the Medicare levy and general tax revenue);
- state government provision and funding of health services is significant;
- services such as dental care, physiotherapy, and ancillary services are mostly privately provided and funded, although there is some public provision;
- many pharmaceuticals are subsidised;
- voluntary private hospital and ancillary ‘insurance’ is available, with ‘community rating’ applying; and
- regulation is extensive.

Figure 2.2: Linkages between health care consumers, payers and providers



Source: Adapted from KPMG.

## Provision

Medical care in Australia can be provided by private fee-for-service or salaried medical practitioners. Out of hospital, private providers predominate. In public hospitals many services are provided by salaried doctors, including specialists, but there is significant provision of services by doctors under contract or under fee-for-service. In private hospitals, fee-for-service medical provision predominates.

The majority of hospital services (both in terms of provision and funding) are provided by public hospitals under the jurisdiction of state and territory governments. These public hospitals still predominate for acute care, and in medical cases requiring hospitalisation. However, in the last few years the range and sophistication of services available at private hospitals have increased substantially. Some of these now offer complex surgical procedures, and accident and emergency facilities. Particular private hospitals offer psychiatric care, and some provide care for nursing home type patients.

## **Funding**

Funding for health care provision in Australia comes from a number of sources. The majority comes from government revenue, with significant contributions from individuals and private insurance (see figure 2.3). Some government revenue is sourced from the Medicare levy — this, however, raises less than 10 per cent of health expenditure overall, and less than 20 per cent of Commonwealth expenditure on health.

The Medicare arrangements channel Commonwealth Government funds (including the levy) into payment for medical and hospital services:

- For medical services provided out of hospital, patients can receive a rebate of 85 per cent of the schedule fee set under the Commonwealth Medical Benefits Schedule (MBS). If the medical practitioner ‘bulk bills’, being prepared to accept the 85 per cent rebate, the patient pays nothing.
- In-hospital medical procedures are free to public patients in public hospitals, and subsidised to 75 per cent of the MBS fee in other cases.
- Under the Commonwealth–State Medicare Agreements, the Commonwealth also makes funds available to the states and territories for public hospitals, subject to a number of conditions set out in the *Health Insurance Act 1973*. The agreements are underpinned by the Medicare Principles which, in summary, provide for choice, universality and equity (see box 2.3).

The current agreements cover the 1993–1998 period. As well as receiving revenue through the Medicare arrangements, public hospitals receive some income from private patients (see below).

**Box 2.4: Medicare Principles**

[As set out in the *Health Insurance Act 1973*, sect. 26.]

The Commonwealth and the States are committed to the following principles in the provision of public hospital services:

Explanatory Note: The Principles focus on the provision of public hospital services to eligible persons, but operate in an environment where eligible persons have the right to choose private health care in public and private hospitals supported by private health insurance.

**Choices of services**

Principle 1: Eligible persons must be given the choice to receive public hospital services free of charge as public patients

Explanatory Note 1: Hospital services include in-patient, out-patient, emergency services (including primary care where appropriate) and day patient services consistent with currently acceptable medical and health service standards.

Explanatory Note 2: At the time of admission to a hospital, or as soon as practicable after that, an eligible person will be required to elect or confirm whether he or she wishes to be treated as a public or private patient.

**Universality of services**

Principle 2: Access to public hospital services is to be on the basis of clinical need

Explanatory Note 1: None of the following factors are to be a determinant of an eligible person's priority for receiving hospital services:

- whether or not an eligible person has health insurance;
- an eligible person's financial status or place of residence;
- whether or not an eligible person intends to elect, or elects, to be treated as a public or private patient.

Explanatory Note 2: This principle applies equally to waiting times for elective surgery.

**Equity in service provision**

Principle 3: To the maximum practicable extent, a State will ensure the provision of public hospital services equitably to all eligible persons, regardless of their geographical location

Explanatory Note 1: This principle does not require a local hospital to be equipped to provide eligible persons with every hospital service they may need.

Explanatory Note 2: In rural and remote areas, a State should ensure provision of reasonable public access to a basic range of hospital services which are in accord with clinical practices.

## Private insurance

In the past, private insurance was a more significant element in the funding of health care than it is at present, covering a wider range of medical services as well as hospital and ancillary services. However, its service coverage has diminished since Medicare was introduced in 1984. Further, as noted elsewhere in the report, the proportion of the population covered by private health insurance has been in decline since that time. Even so, private health insurance cover for hospital services still plays a greater role in Australia than in most other OECD countries.

Under present arrangements, private health insurance funds are allowed to offer cover for:

- up to 100 per cent of the charges levied by public and private hospitals, for services such as accommodation, theatre fees, etc. There now is no Medicare rebate for these services;
- up to 25 per cent of the MBS fee to cover the Medicare gap for medical services provided in hospitals, whether private or public;
- medical cover beyond that 25 per cent gap if a contract exists between the fund and the doctor specifying the fees to be charged; and
- ancillary services including dentistry, optical, and physiotherapy. These services do not require referral from a medical practitioner to qualify for cover from a fund.

A fund member with hospital insurance is still able to choose to enter a public hospital as a public patient. In this case, no charge is incurred either for the hospital services or medical services rendered while in hospital. However, if the patient chooses to enter a public hospital as a private patient, hospital and medical charges will be incurred and can be covered by health funds.

If a fund member with private hospital insurance enters a private hospital, no credit or rebate is given for the Medicare levy paid. (The Government's financial incentives to apply from 1 July 1997 will provide a rebate on premiums paid to private health funds.) Table 2.1 and figure 2.4 show, in different ways, how private health insurance can appear unattractive under present arrangements compared with the Medicare alternative.

Figure 2.5 illustrates how the full costs of hospital care, not merely the costs associated with additional services, have to be paid by a person receiving private treatment. According to the submission from the Insurance Council of Australia and the Life, Investment and Superannuation Association of Australia:

The [private health insurance] premiums have to cover the full cost of hospital care but the benefit is the value of choice of doctor, lower waiting times and the additional amenities offered by private hospital or being treated as a private patient in a public hospital. This excess of costs over benefits would not exist in a fully private system and is used by the government to shift the cost of entitlements to service under Medicare on to the privately insured. (Sub. 161, p. 6)

**Table 2.2: One participant's comparison of private health insurance vs Medicare**

<i>Key variable</i>	<i>Private health insurance</i>	<i>Medicare (ie public health funding)</i>
Hospitalisation	Yes — full payment	Yes — full payment
Surgeon fee	Probably out-of-pocket expenses — can be large	Yes — full payment
Pre/post hospital doctor visits	Not available for cover	Yes
'Hospital' in the home	Not available for cover	Yes
Choice of surgeon	Yes — if consumer is aware	Partial — depends on referral pattern
Choice of hospital	Choice of private or public hospital — if consumer is aware	Choice of public hospital — if consumer is aware
Waiting time for electives	A few weeks	Often much longer, particularly in key specialities
Ancillary cover	Dental, glasses, exercise, physio — with limited payouts	Very limited
Cost	\$2000 per family — additional to Medicare levy and tax	Medicare levy and tax

*Source:* Adapted from a submission from Chappell Dean Pty Ltd (Sub. 18, p. 1).

### **Control of costs**

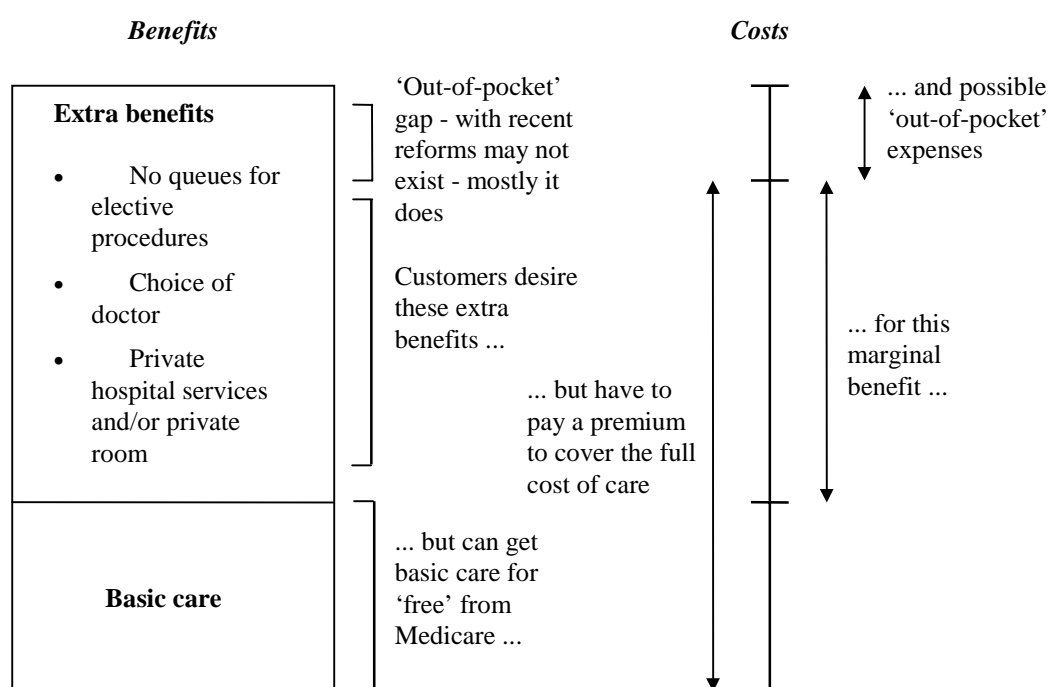
In recent years, a number of measures have been introduced in an attempt to reduce the rate of growth of government health care expenditure:

- For medical services, these measures have included reductions in the Medicare rebate, and control over MBS fee levels. Special arrangements have been introduced for diagnostic services such as pathology and radiology.

- Patient copayments for pharmaceuticals under the PBS have risen, although no medical copayment is required for medical services which are bulk billed.
- With respect to public hospitals, overall funding growth has been slowed or stopped. Public hospitals continue to operate at close to 100 per cent capacity, and considerable waiting times may exist, particularly in some specific areas such as orthopaedics and ENT surgery. Measures such as output-based funding using casemix classifications have been introduced for public hospitals in some states to improve technical efficiency.

Waiting times are lower in the private hospital sector for elective services, although many private hospitals now also operate at high capacity utilisation and, for particular hospitals, there may be some wait. Casemix arrangements are also being introduced into the private hospital sector (see chapter 3).

Figure 2.6: Another participant's weighing up of the costs and benefits of private health insurance

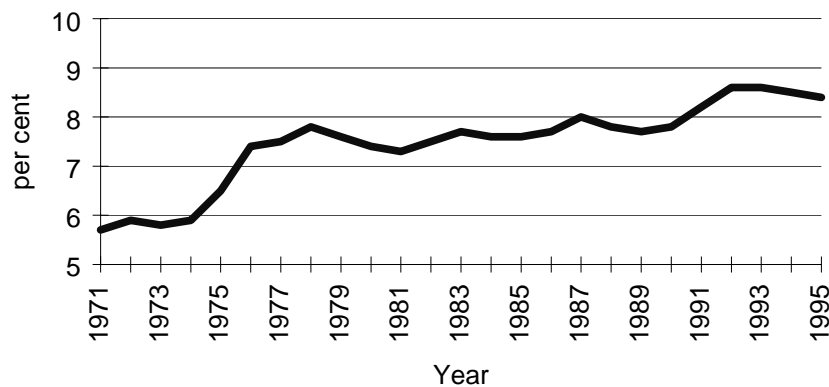


Source: Reproduced from ICA and LISA, Sub. 161, p. 6.

## 2.2 Expenditure on health care

Until recently, Australia's health care expenditure had been steadily growing as a proportion of GDP, but with some fluctuation from year to year. Over the 1971 to 1995 period, for instance, the ratio of health care expenditure to GDP grew from 5.7 per cent to 8.4 per cent (see figure 2.7). The 25-year unweighted average is 7.5 per cent. Health care expenditure as a proportion of GDP peaked in 1992 and 1993 at 8.6 per cent and has since declined marginally.

Figure 2.8: Australia's health expenditure as a proportion of GDP



Source: AIHW, *Health Expenditure Bulletin*, Number 12, table 21.

There are difficulties in comparing health care expenditure between countries. While the data in table 2.3 may not be fully comparable, it suggests that Australia's health care expenditure (as a proportion of GDP) is higher than in some OECD countries, and lower than in others. The United Kingdom and Japan have consistently had the lowest expenditure, with the United States the highest. The table also shows that Australia's health care expenditure as a proportion of GDP has increased, as it has in the other countries shown, with the possible exception of Sweden.

Peter Carroll commented on the 'powerful nature of the demographic forces that are likely to influence health care expenditure in Australia' in the coming years (Sub. D213, p. 1). On certain assumptions, he estimated that health expenditures in Australia, as a percentage of GDP, could grow to over 10 per cent in 20 years, and over 15 per cent in 50 years.



Table 2.4: Health services expenditure by country as a proportion of GDP (%)

<i>Country</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>
Australia	7.6	7.8	8.4
Canada	8.5	9.2	9.5
France	8.5	8.9	9.9
Germany	8.7	8.3	9.6
Japan	6.7	6.0	7.2
New Zealand	6.4	7.4	na
Sweden	8.9	8.6	7.7 <sup>a</sup>
United Kingdom	5.9	6.0	6.9
United States	10.7	12.7	14.5

a Not comparable with earlier years.

Source: AIHW, *Health Expenditure Bulletin*, Number 12, table 21.

In dollar terms, Australian health care expenditure continues to grow significantly (see table 2.5), with the real rate of growth fairly steady. This growth has been due to increases in price and in the volume (and quality) of services supplied.

Table 2.6: Growth in Australia's health care expenditure

<i>Year</i>	<i>Amount</i>		<i>Growth rate over previous year</i>	
	<i>Current prices</i>	<i>Constant prices<sup>a</sup></i>	<i>Current prices</i>	<i>Constant prices<sup>a</sup></i>
	<i>\$ million</i>	<i>\$ million</i>	<i>%</i>	<i>%</i>
1982–83	13 239	20 673	..	..
1984–85	16 546	22 862	10.6	4.1
1989–90	28 795	28 795	10.2	3.9
1994–95 (prelim.)	38 479	33 905	5.4	4.0

a Deflated to 1989–90 prices using specific health deflators.

Source: AIHW, *Health Expenditure Bulletin*, Number 12, table 1.

In line with this growth in total costs, expenditure per head of population has also increased, as table 2.7 shows. Figure 2.9 compares health care expenditure per head of population in Australia with that in selected OECD countries. Australia ranked in the middle of the countries shown.

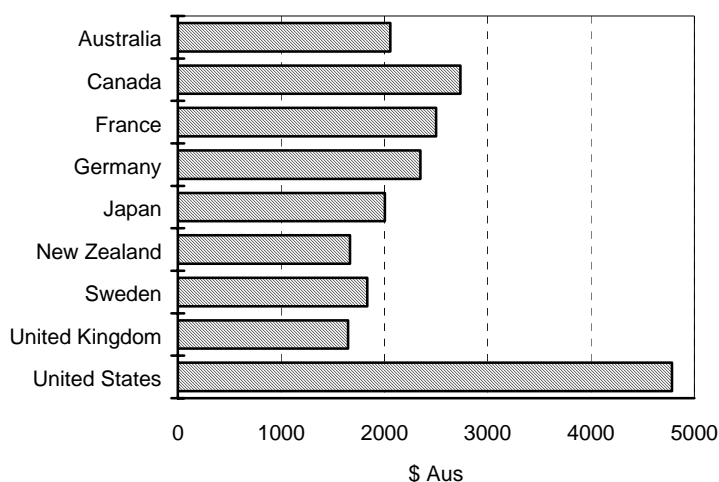
Table 2.8: Australia's health expenditure per person

Year	Expenditure per person		Growth rate over previous year	
	Current prices	Constant prices <sup>a</sup>	Current prices	Constant prices <sup>a</sup>
	\$	\$	%	%
1982–83	866	1 352	..	..
1984–85	1 055	1 458	9.2	2.8
1989–90	1 700	1 700	8.6	2.3
1994–95 (prelim.)	2 145	1 890	4.3	2.9

a Deflated to 1989–90 prices using specific health deflators.

Source: AIHW, *Health Expenditure Bulletin*, Number 12, table 2.

Figure 2.10: International comparison of expenditure per person, 1993



Source: AIHW, *Health Expenditure Bulletin*, Number 12, table 20.

Health expenditure is spread among a range of services and goods (see table 2.5). In Australia:

- Public hospitals are the largest individual area of expenditure. In 1993–94, they accounted for about 26 per cent of total expenditure.
- Medical services made up the next highest area of expenditure.
- Expenditure on private hospitals accounted for only 6.4 per cent in 1993–94. By comparison with 1991–92, however, the share of expenditure accounted for by private hospitals increased (from 6.0 per cent), whereas that for public hospitals declined (from 27.4 per cent).

Table 2.9: Selected areas of expenditure (current prices)

Area of expenditure	1991–92		1993–94	
	Value	Proportion of total	Value	Proportion of total
	\$ million	%	\$ million	%
Recognised public hospitals	9 090	27.4	9 512	26.1
Private hospitals	1 983	6.0	2 333	6.4
Nursing homes	2 613	7.9	2 647	7.2
Medical services	5 928	17.9	6 884	18.9
Dental services	1 652	5.0	1 831	5.0
Benefit paid pharmaceuticals	1 627	4.9	2 282	6.2
Other (including capital items)	10 241	30.9	11 006	30.2
Total recurrent expenditure	33 134	100.0	36 495	100.0

Source: AIHW, *Health Expenditure Bulletin, Number 12*, tables 23 and 25.

Individuals directly bear only a small proportion of total expenditure on health services, although they bear a greater proportion of the total than do the private health funds (see figure 2.11 and table 2.10). The Commonwealth and states fund over 80 per cent of expenditure on public hospitals, medical services and benefit paid pharmaceuticals.

Figure 2.12: Expenditure by source of funds 1993–94

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Source: AIHW, *Health Expenditure Bulletin, Number 12*, table 25.

Table 2.11: Expenditure by source of funds 1993–94

<i>Area</i>	<i>Commonwealth</i>	<i>State and local government</i>	<i>Health insurance funds</i>	<i>Individuals</i>	<i>Other<sup>a</sup></i>	<i>Total</i>
<u>\$ million</u>						
Public hospitals	4 661	4 169	493	-	189	9 512
Private hospitals	168	-	1 867	140	159	2 333
Medical services	5 700	-	208	683	294	6 884
Benefit paid pharmaceuticals	1 887	-	-	396	-	2 282
Total <sup>b</sup>	16 435	8 255	4 078	6 017	1 710	36 495
<u>% of total</u>						
Public hospitals	49.0	43.8	5.2	-	2.0	100.0
Private hospitals	7.2	-	80.0	6.0	6.8	100.0
Medical services	82.8	-	3.0	9.9	4.3	100.0
Benefit paid pharmaceuticals	82.7	-	-	17.3	-	100.0
Total <sup>b</sup>	45.0	22.6	11.2	16.5	4.7	100.0

a Includes workers compensation and third party motor vehicle insurance.

b Total includes other areas of health expenditure not shown in this table.

Source: AIHW, *Health Expenditure Bulletin*, Number 12, table 25.

In contrast, private health insurance funds bear about 80 per cent of expenditure on private hospitals. The funds also bear a small share of expenditure on public hospitals (in respect of private patients) — about 5 per cent in 1993–94, and on medical services (coverage of the gap).

Although private health insurance membership has been declining as a proportion of the population, the share of hospital expenditure covered by private health funds has increased (see table 2.12). However, private health insurance still only contributes about 11 per cent to the community's total health expenditure.

Indicators of price changes in health services all show reasonably consistent trends, with the exception of the hospital and medical services CPI which has grown much faster (see table 2.13). Whereas the other indicators reflect changes in prices irrespective of whether the additional costs are borne by governments,

health funds or consumers, the health CPI specifically reflects changes funded by consumers. That is, it reflects changes in all out-of-pocket expenditure by consumers, rather than changes in the price of health services overall.

**Table 2.14: Health fund expenditure**

<i>Year</i>	<i>Total health expenditure</i>	<i>Total health fund expenditure</i>	<i>Share covered by health fund</i>	<i>Total hospital expenditure</i>	<i>Health fund expenditure on hospitals</i>	<i>Share covered by health fund</i>
	<i>\$ million</i>	<i>\$ million</i>	<i>%</i>	<i>\$ million</i>	<i>\$ million</i>	<i>%</i>
1991–92	33 134	3 796	11.5	12 149	2 200	18.1
1992–93	34 910	3 979	11.4	12 464	2 320	18.6
1993–94	36 495	4 078	11.2	12 675	2 365	18.7

*Source:* AIHW, *Health Expenditure Bulletin, Number 12*, tables 23 to 25.

**Table 2.15: Indicators of price changes**

<i>Year</i>	<i>Total health price index (AIHW)</i>	<i>Total GDP implicit price deflator</i>	<i>Government expenditure on hospital and clinical services index</i>	<i>Private final consumption index of total health expenditure</i>	<i>Private final consumption index of expenditure on doctors</i>	<i>Hospital &amp; medical services CPI</i>
1975–76	32.3	32.5	32.1	32.6	32.0	na
1979–80	46.6	46.5	46.5	46.5	45.9	na
1984–85	72.4	70.4	72.8	71.5	71.5	50.7
1989–90	100.0	100.0	100.0	100.0	100.0	100.0
1994–95	113.5 (prelim.)	109.6	112.4	115.4	114.5	155.6

*Source:* AIHW, *Health Expenditure Bulletin, Number 12*, tables 12 and 14.

## 2.3 Role of private health insurance

Many participants considered that before discussing policy prescriptions for the private health insurance industry there was a need to define more clearly its role in the Australian health care system. For instance, the NSW Government commented that:

the terms of reference for the inquiry should consider the role of private health insurance in relation to broader Government objectives for the health care system. These include objectives such as maximising the effectiveness of the

health system in delivering improved health for the Australian community and caring for those with chronic poor health; ensuring equity in the delivery and financing of health services; and improving the efficiency of individual health service providers as well as the industry as a whole. (Sub. 180, p. 2)

Although the Commission must respond to its terms of reference, it accepts that it is important to examine how health care is provided and funded in Australia, and the role of private health insurance in the system.

There was considerable debate about these issues at the Commission's October Roundtable (see box 2.5); and many participants canvassed them in their written submissions. Participants noted considerable ambiguity, both in the underlying objectives for the health care system and for private health insurance, and in the way in which the objectives translate into practice.

The debate centred around the respective roles for public and private service provision, and for public and private funding of health services.

In respect of the present inquiry, the most important issue is that of funding, rather than whether a particular service is obtained in the public or private sectors. The remarks in this section of the report thus concentrate on the question of funding and access to services.

Some confusion arises in discussing issues to do with the role of private health insurance because different participants use different terminology in their arguments. Words such as 'complementary', 'supplementary', 'substitute' and 'competitive' were used by different participants in different ways, sometimes with opposite meaning. However, the core issue is the extent to which private funding should be seen as, or in fact is:

- *replacing* public funding (eg private patients in private hospitals); or
- *topping up* public funding to provide extra dimensions of service (eg doctor of choice, or private room).

This section of the report firstly examines the Government's objectives for private health insurance, concentrating on its funding role for hospital services.

It then summarises participants' comments about the role for private health insurance in Australia. Drawing on these comments, the Commission provides an assessment of the current role of private health insurance and its approach, given the terms of reference, to the wider question of what role private health insurance should play.

**Box 2.6: Roundtable remarks on the role of private health insurance**

**John Evered** (HIC): ‘private health insurance isn’t what it used to be. It was one thing and now it is becoming — if it hasn’t already become — an entirely different thing. It was an arrangement which provided access to limited services in private hospitals because private hospitals, by and large, only provided limited services. It also provided easy access to public hospitals as a private patient ... But now it is more about access to an increasingly complex and sophisticated private hospital sector which offers a very viable alternative to a very large degree to what the public sector provides, and inevitably that is going to be a more expensive service’ (p. 27)

**Garry Richardson** (NHMI): ‘my view is that the health insurance industry will be what it is allowed to be ... I don’t think it knows what it is allowed to be, or what the government wants it to be’ (p. 11)

**John Deeble**: ‘private health funds offer a means of mobilising ... funds to make it easier for those people who place a high value on private health care delivery ... But it also offers a way in which people can escape the almost inevitable constraints ... in a public system’ (p. 19)

**Jeff Richardson**: ‘there is an important distinction between what is the [current] role of private health insurance ... and what should it be ... So I think the answer to the “what is” is highly fluid — it is a matter of politics as much as anything ... And so unless there is significant structural reform to private health insurance, I think ... the answer to the “should be” question is that it should be relatively small, a safety net for those people who don’t like the public system’ (pp. 10–11)

**Francis Sullivan** (ACHCA): ‘I think from the start it was meant to be complementary in structure ... it was meant to provide access ... people are buying to queue jump ... it is an access mechanism now basically to high tech surgical’ (p. 20)

**Brent Walker**: ‘in fact private health insurance is both supplementary and complementary in Australia’ (p. 28)

**Clive Ashenden** (MBF): ‘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 therefore 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 to the complementary system, 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’ (p. 39)

*Source:* Roundtable transcript.

### **The Government's objectives**

The Government's objectives for private health insurance, and the private health insurance industry, are set against its more general policies for the health care system as a whole. Important elements of those policies are set out in the Commission's terms of reference:

- retain Medicare;
- retain bulk billing; and
- retain community rating.

These policies were also covered in the Coalition's health policies in the lead-up to the last Federal election. One of the 'guiding principles' was that the Coalition in government would:

maintain a successful balance between public and private health care, with Medicare being retained in its entirety in tandem with a strong and viable private health system, with private insurance a realistic option for all Australians wishing to have that choice.

In an October 1996 speech, the Minister for Health and Family Services commented on the Government's approach:

Essentially, our policy approach — and especially the role of the private health insurance incentive scheme — recognises the essential role of the private sector in our health system as a complementary structure to the public sector, and seeks to capitalise on the strengths of both the public and private systems in building a better health system for Australia. The previous Government claimed they saw the private system as supplementary to the public system. An additional amenity for those who wanted it. (Wooldridge 1996)

The Minister, in his second reading speech on the Private Health Insurance Incentives Bill 1996, stated that:

Medicare ... was never designed to stand alone. It was originally devised as Medibank by John Deeble and Richard Scotton in the context of being complemented by a robust private health care system, primarily funded through a private health insurance system partially assisted by government through measures such as the private hospital bed day subsidy and Commonwealth contributions to the private health insurance fund reinsurance pool. (House of Representatives 1996, p. P8005)

According to the Department of Health and Family Services:

Private health insurance is sometimes portrayed as competing with Medicare, and sometimes as complementing Medicare. In a sense it plays both roles. Members of private health insurance are still eligible to receive public insurance benefits ... Private health insurance products complement these benefits in various ways ... where the service is provided [in the private system] no differently to that



available under Medicare, private health insurance is competing with Medicare but with a lower public subsidy. (Sub. 175, pp. 2–3)

It is clear that budgetary and public resource considerations play a significant part in the Government's attitude towards private health insurance. In its pre-election policy, the Government stated that 'tackling waiting lists [in public hospitals is] ... the basic rationale behind our private health insurance incentive initiative'. In his second reading speech, the Minister commented that the incentive scheme:

is the centrepiece of the Government's strategy to assist Medicare from collapsing under the weight of demand for publicly funded hospital and medical services. (House of Representatives 1996, p. P8005)

In Budget documents the Government stated that its insurance incentive measure 'takes the pressure off the public hospital system and, also, indirectly provides additional health dollars to the States and Territories that the Federal Government will not claw back'. The Coalition noted that 'if the private health system did not exist, this would ... add billions of dollars to the annual public health bill'.

Another aim of the Government is to assist low and middle income families to maintain private health insurance. Indeed, the private health insurance incentives are set in the context of the Government's family tax initiative. The Minister has commented on the Government's commitment to:

keep private health insurance within the reach of ordinary Australians, including those of high need and low income, many of whom scrimp and save desperately to ensure their cover is maintained. (Wooldridge 1996)

In summary, the Government's objectives for private health insurance are set against its support for Medicare, bulk billing and community rating. Particular objectives include:

- relieving pressure on public funding;
- encouraging private funding;
- providing choice of public and private service provision, especially for low and middle income families; and
- assisting families to keep private insurance.

### **Participants' views on the role of private health insurance**

Participants had a range of views on the role of private health insurance and about current weaknesses. As noted, there was also widespread agreement that

the role of private health insurance should not be examined in isolation from the wider health care system generally.

Ian McAuley commented on difficulties caused by the ‘absence of a consistent health policy framework’:

there has rarely been any consistency in or even a clear statement of [health] policy, and individual decisions appear to be driven more by immediate budgetary objectives or by impending crises. (Sub. 13, p. 3)

Peter Carroll considered that ‘design features in Medicare ... hamper the development of greater efficiency in the private health insurance industry’ (Sub. 9, p. 25). MBF said that:

Attracting a large enough number of Australians back to private health insurance is impossible while the current Medicare system remains in its present form providing the fallback of ‘free’ health services ... (Sub. 29, p. 1)

The APHA commented on ‘the currently damaging incentives arising from community rated health insurance competing with free Medicare’ (Sub. 51, p. 48). And the AMA said that ‘many of the problems in the private health insurance industry are related to the nature of Medicare and its effects on health care provision and financing’ (Sub. 130, p. i).

A number of participants — including consumer organisations — considered that, under Medicare, the role of private health insurance was to fund *supplementary* services (optional extras) to those provided by the public system. The Australian Nursing Federation said:

if Medicare’s universality and integrity are to be preserved, then the private health system cannot be regarded as an alternative to the public health system — it can only be regarded as supplementary. (Sub. 22, p. 2)

The Consumers’ Health Forum of Australia considered that:

the role for private health insurance should be defined by the Commission in terms of offering choice to consumers and as supplementing, rather than complementing [ie rather than substituting for], Medicare. (Sub. 64, p. 7)

According to the Council on the Ageing:

private health insurance should be an affordable option for older people if they want it although it should not be seen as a requirement for people on low incomes who should have guaranteed access to all forms of treatment through the public system. (Sub. D246, p. 1)

And the Australian Consumers’ Association said that ‘private health insurance should complement and add value, in terms of a private room for example, and not be seen as a substitute for Medicare’ (Sub. 77, p. 7).

Other participants, however, considered that, at least in practice, private hospital care was a *substitute* for care in the public system. The APHA considered that:

The public and private health sectors in Australia form complementary and supporting roles ... it is also clear that private and public sectors are interdependent. (Sub. 51, p. 50)

According to the APHA, private health insurance is ‘merely one payment mechanism’ for private hospital care: ‘any other viable scheme which meets government determined social objectives would be equally suitable’ (Sub. D217, p. 7). The APHA also recognised private health insurance as supplementing public funding in regard to public hospital care.

The view of private hospital care as a substitute was generally held by medical and private hospital interests, as well as the funds. For example, the AMA considered that:

Waiting lists and, more importantly, long waiting times have provided a strong incentive for patients to seek to have elective procedures in the private sector. Is ‘elective surgery’ the surgery you elect to have done privately? (Sub. 130, p. 20)

The Australian Catholic Health Care Association considered that the main aim of Catholic health care is to:

enhance the distribution of health care resources allocated by governments and further meet community health care needs which are not touched by the public health care system. In essence, Catholic health care providers aim to ensure timely access to essential services for as many people as possible. (Sub. 150, p. 3).

According to Health Care of Australia, ‘access to private health care has become an equity issue’ (Sub. 128, p. 2). This would imply a substitute role for private hospital care, as would the suggestion from the AHIA that a major role for the private hospital system was to relieve pressure on public funding of health care.

## **The Commission’s approach**

Private health insurance is used by consumers to gain access to extra dimensions of service, such as quicker treatment and choice of doctor. When treatment occurs in private hospitals, private health insurance replaces public funding entirely (for at least the hospital component). When private treatment occurs in public hospitals, public funding is still involved — this is topped up through payments from the health funds.

Thus, at present, private health insurance clearly serves a dual role. It provides a source of private funding for health care which:

- replaces public funding in some areas of service; and
- tops up public funding in others.

The replacement role is significant, as the private health insurance industry currently funds nearly one-fifth of total hospital expenditure in Australia. If that source of funding were to decline significantly, considerable pressure would be placed on public provision of health services and consequently on public funding. As the Commonwealth Minister has observed ‘every time someone drops out of private health insurance it puts an extra burden on a state or territory health budget’ (Wooldridge 1996). The NSW Government commented that ‘for every 1 per cent decrease in private health insurance coverage, on average approximately \$30 million is added to the costs of the NSW public health system’ (Sub. 180, p. 4). According to the South Australian Government, public hospitals in that state received 35 per cent less (in real terms) in 1995–96 than in 1990–91 from private patients: ‘This loss has been steadily growing and has been absorbed by the public hospital sector’ (Sub. D193, p. 19).

Through supporting private health insurance, and by providing financial incentives in response to this pressure, the Government is endeavouring to switch health funding from the public sector to private sources. This process is also aided by the expenditure constraints imposed on the public health system in recent years, reflected in constrained access to public hospitals.

At the same time, Government policy supports universal access under Medicare, and private health insurance remains voluntary.

As a consequence, the dual role currently being served by private health insurance poses some difficulties for its regulation:

- the objective of displacing public funding under Medicare can be seen as providing justification for some form of community rating of private health insurance; but
- the objective of merely topping up Medicare funding (with optional extras), would seem to provide little justification for community rating of private health insurance.

There is, at present, an inherent tension between the policies of support for universal access under Medicare, and support for voluntary, community rated, private health insurance.

Resolution of such conflicts would seem to require changes to the overall settings for health care policy in Australia. As a backdrop to examining the scope to make more limited policy adjustments, chapter 9 considers some ‘big picture’ changes which have been variously proposed.

The Commission recognises that, in the longer term, significant changes may be required in health care policy in Australia to enhance equity, efficiency, and improve health outcomes. For this reason, in considering options for private health insurance within the constraints of the current terms of reference, the Commission has been careful not to cut off potentially more beneficial longer term options for the Australian health care system.

This approach was supported by many participants in response to the Discussion Draft. MBF, for example, said that:

... worthwhile changes can be made within the constraints of the current terms of reference ... [but] such changes will always be of secondary importance to the changes that are possible and desirable in relation to the total health care system.  
(Sub. D203, p. 3)

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### 3 THE REGULATORY AND INSTITUTIONAL ENVIRONMENT

This chapter describes the environment in which the private health insurance industry operates in Australia. It also comments on some of the effects and implications of the current regulatory and institutional environment, drawing on participants' comments. Chapter 10 discusses policy options for dealing with some shortcomings of the present arrangements.

The existing framework is complex, involving many interrelated aspects which take their underlying rationale from community rating. Box 3.1 provides a brief overview of the key components. This chapter also covers the Government's financial incentives and some competitive neutrality issues relating to Medibank Private.

Many of the requirements imposed on health funds are set out in the *National Health Act 1953* (subsequently referred to as 'the Act'), and associated regulations. The provisions of the constitution, articles of association and the rules of the fund have to be consistent with them. There are also a number of provisions in the *Health Insurance Act 1973* that govern the conduct of health funds. Box 3.2 briefly summarises the responsibilities of the two main regulatory bodies, the Department of Health and Family Services ('the Department') and the Private Health Insurance Administration Council (PHIAC). As well, a Complaints Commissioner commenced operations in 1996. The Health Insurance Commission is to have a role in administering the private health insurance incentives.

Any examination of the regulatory and institutional environment must confront the impenetrability of the legislation and the associated regulations — in particular, of the National Health Act. The Department agreed that:

that part of the Act that relates to the registration and operation of health benefits organisations is extremely complex and difficult to understand ... It is proposed that the legislation should be rewritten in plain English. (Sub. 175, p. 26)

Other participants commented on the need for better regulation. For example, the ICA/LISA considered that:

The development of clear, transparent and, as far as possible, simple regulations on prudential requirements, on community rating, on what can and cannot be covered, and on the power to negotiate with both public and private providers would improve the efficiency of the system. (Sub. 161, p. v)

**Box 3.3: Overview of regulation**

Access provisions:	Access to private health insurance for all members of the community is guaranteed, with no discrimination in premiums and benefits on the basis of factors such as age and health status
Reinsurance:	Health costs of certain high cost categories of member are redistributed across all health funds
Registration:	Health funds must be registered — specified terms and conditions apply
Products and benefits:	Funds must offer some types of product and benefit, but cannot offer others
Waiting periods:	A maximum initial waiting period of two months applies, except for obstetric conditions and for members with pre-existing ailments, for whom there are longer specified maximum waiting periods
Premiums:	Changes are subject to government screening
Reserves:	Minimum levels of financial reserves are specified
Complaints:	The Private Health Insurance Complaints Commissioner mediates disputes between health funds and their members
Contracting:	Controls apply to contracting between health funds and hospitals, between health funds and doctors, and between hospitals and doctors

Medibank Private called for regulation to be ‘informed, useful and minimal, targeted to achieve specific outcomes and administered with minimum cost to the industry’ (Sub. 168, p. 9).

The Commission endorses this call for regulatory reform, although it would emphasise that the priority is to get the policy aspects settled first; simplicity and transparency should follow.

### 3.1 Community rating

Community rating has long been a central tenet of Government policy for private health insurance. At its most basic, it ensures access to private health insurance for all members of the community (see box 3.4), and provides the

rationale for much of the current regulation of the private health insurance industry.

### **Box 3.5: The regulators**

The *Commonwealth Department of Health and Family Services* administers the regulation of health funds under the *National Health Act 1953*. It advises the Minister and Secretary about their powers under the Act — which include the registration of health funds, and the oversight of their rules — and provides policy advice on health matters.

The *Private Health Insurance Administration Council* (PHIAC) is a Commonwealth statutory authority that is funded by industry. It monitors the reserves of all registered health insurers, administers the reinsurance arrangements, and provides information to consumers. It will also be involved in monitoring the private health insurance incentives. The powers of PHIAC are vested in the Commissioner, who is required in decision making to take into account the views of advisers who include an independent actuary, three industry representatives, and a representative of the Department. However, the Commissioner is not obliged to follow their advice.

The term itself is not precisely defined in the Act, nor in the conditions of registration of health funds. However, according to the Department:

The core of community rating is that persons should not be discriminated against in obtaining health insurance on the basis of their health risk. Accordingly the requirements in the Act forbidding premium discrimination on the basis of age, health status and claims experience have been maintained. (Sub. 175, p. 34)

Apart from specified maximum waiting periods, including for those with pre-existing ailments (see section 3.2), there are no barriers to entry by individuals to private health insurance — whether to hospital cover or to ancillary cover. In particular, while access to benefits can be delayed, it cannot be denied on the basis of pre-existing ailments.

### **Box 3.6: Community rating**

Under the National Health Act, funds must accept all applicants, within certain membership categories. In setting premiums, or paying benefits, funds cannot discriminate (in relation to a contributor or his/her dependants) on the basis of health status, age, race, sex, sexuality, use of hospital or medical services, or general claiming history (National Health Act, section 73ABA and Schedule 1, paragraph m). The principle is also supported by the reinsurance arrangements.



The Department noted that for many years the community rating principle was also interpreted as requiring funds not to discriminate on the basis of the number of people covered by a membership, except that single memberships paid one-half the rate of all other memberships. This control was recently changed (see box 3.7).

**Box 3.8: Recent changes in the interpretation of community rating**

Under changes taking effect from 1 October 1996:

- the previous two membership categories of single and family have been replaced by four categories of membership: single, couple, single parent family, and family;
- the requirement for the family membership premium to be twice the single membership premium has been removed: there is now no specified relationship between the premiums charged for different categories of membership;
- although the relativity of premiums between categories was removed, it is still a requirement that all members of a table within each category must be charged the same premium (for instance all single memberships of a table must pay the same, all couple memberships of a table must pay the same and so on); and
- the requirement to offer all tables to all categories of membership has been abolished.

In notifying these changes to the health funds, the Department advised:

‘Organisations should note the Minister’s concern that these changes do not result in increased premiums for families with children. The Department will be monitoring premiums to ensure that families with children are not paying relatively more. If it transpires that premiums for this group are rising in relative terms the previous system of single and family memberships will be restored.’

*Source:* DHFS 1996c.

## **Implications and issues**

### *Adverse selection*

Community rating ensures access by all members of the community to private health insurance. But in effect, community rating (underpinned by the reinsurance arrangements — see section 3.3) institutionalises cross subsidies from fund members who make relatively little use of health care services to fund members who have relatively high use of those services. However, as explained in box 3.9, this can create incentives for lower risk members to drop

out of private health insurance. This, in turn, weakens risk profiles, leading to higher costs for the funds. Consequent higher premiums reduce still further the perceived value of private insurance for low-risk members, and the 'vicious circle' continues (see box 1.2).

In recent years, with the decline in health fund membership, a downward spiral has been evident, with a diminishing proportion of the community taking out voluntary private health insurance.

### **Box 3.10: APHA on the effects of community rating**

The effect of community rating is twofold:

- the social objective of limiting premiums for high-risk members is met; but
- health insurance is more expensive than necessary for low-risk members.

The problem is the latter effect. Health insurance premiums are based on the average risk of all members. As such, premiums for low-risk members include an element of cross-subsidisation for the high-risk members. This means that the perceived value of health insurance is low for low-risk members and there is a consequential incentive not to take out, or to drop, hospital cover.

Furthermore, low-risk people are aware that they are entitled to free care in a public hospital if they do happen to need hospital treatment. This further increases the incentive to avoid private health insurance.

Community rating has a secondary effect for the well informed members of the community. Those people who are high-risk and do not wish to use the public hospital system can join a health insurance fund in the knowledge that their premium is subsidised by the remaining low-risk members. Conversely, people who assess their risk as low can defer taking up private health insurance until such time as they assess their personal risk of ill health as having increased to the point that insurance is desirable.

The cumulative effect of these individual decisions is to worsen the risk profile of health insurance, thus increasing the average benefit outlay per member. This in turn is a major cost pressure on premiums. Increased premiums then drive out more of the low-risk members which further exaggerates cost pressures. The spiral is inexorable.

*Source:* Sub. 51, pp. 25–6.

MBF said that:

community rating ... has underpinned health insurance ... for nearly half a century but is now collapsing ... The community rated 'community' is now largely made up of older and sicker Australians ... (Sub. 29, p. 3)

HIRMAA commented that ‘the decline in participation has meant that the “community” for health insurance purposes has become unrepresentative of the general community’ (Sub. 71, p. 21). And Ian McAuley commented that: ‘the healthy and ignorant have subsidised the ill and informed, but such cross subsidisation cannot last forever’ (Sub. 13, p. 15).

Alan Brown considered that:

It can be shown that the community rating principle is the basic cause of the cost pressures facing private health insurance, and until the stance on this issue is modified, all the other measures taken will fail to protect the ‘old and the sick’.  
(Sub. 34, p. 2.2)

### *Excesses and exclusions*

Even before the recent changes (see box 3.11), the strict application of the principles of community rating had been watered down, for example through tables with ‘excesses’ and ‘exclusions’. In addition, considerable ‘discounts’ are being offered by some funds to attract (lower risk) corporate membership.

MBF considered that such ‘innovative’ arrangements could reduce the access of higher claiming members to the benefit entitlement they needed:

Unless ‘innovative’ packages attract previously uninsured people and the contribution paid contains a subsidy component for higher claiming members, the main effect is to reduce the funding available from standard cover participants. Over time, the prices of cover for those people most likely to need hospital care will rise to levels such that an increasing number of people cannot afford to maintain membership for the benefit entitlement they need — and the problems for Medicare will grow larger. (Sub. 29, p. 8)

The AMA considered that exclusionary and excess policies, although responding to members’ needs and concerns had ‘hammered another nail into the coffin of community rating’ (Sub. 130, p. 34). Some participants went as far as to suggest that community rating had effectively ceased. SGIC Health (now SGIO Health) considered that to be so for a number of reasons — see box 3.12.

### *Recent changes*

The evidence available to the Commission suggests that, so far, some health funds have not yet introduced the new membership categories allowed under the October 1996 changes to the interpretation of community rating (see box 3.13). Even where they have been introduced, the premiums for families remain at double the rates for singles. In some cases, premiums for the couples and single parent family categories are identical to those for the family category, and in others they are a little lower. In these latter cases, the premium for couples is

sometimes below that for single parent families, and sometimes the opposite is the case.

However, the October 1996 changes could ultimately have significant implications for community rating. PHIAC commented that:

The new categorisation increases the opportunity for funds to tailor products to target niche markets and offer a greater range of choice and price within community rating, the efficiency benefit will be a better matching of users with payers. However, this runs the significant chance of implementing risk rating by default. (Sub. 90, p. 95)

### **Box 3.14: SGIC on community rating in practice**

We do not have ‘community rating’ in Australia:

- it is the insured community that is rated — an ever decreasing percentage of the population;
- recent decisions pertaining to couples, single and family memberships together with exclusion type products are clearly outside the principles of community rating;
- discounts (up to 40 per cent) offered by some private insurers to large corporate bodies also interfere with the concept of community rating; and
- registration conditions for health funds which allow funds to restrict membership to particular industries, etc is a questionable practice under a community rating system.

If our health insurance arrangements are to be built on a community rating foundation, then it should be consistently applied. The current approach appears to be one of everyone saying how important community rating is then seeing how far it can be stretched. All closed funds in Australia effectively breach the community rating principle.

*Source:* Sub. 26, p. 8.

Further weakening of community rating under the new categories would have significant effects on premium levels. The AIHW has estimated, using November 1995 data, that an average risk based premium for hospital cover per person is about \$465. But there are significant differences between categories: single – \$788, couple without children – \$576 (per person), sole parents – \$344 (per person), and couple with children – \$303 (per person). According to the AIHW, the reason for the ‘higher estimated risk based premium associated with belonging to a family without children is the relatively higher proportion of older people in these family types’ (Sub. D207, p. 4).

The impact on premiums facing the aged could be even greater if the health funds were to use exclusions and excess arrangements to adapt particular tables to appeal to persons in particular age and health status categories. As the Health Benefits Council of Australia commented (in relation to new funds — but the remark holds true for existing funds as well):

[funds] can enter the market, offer a singles-only product and — through targeted marketing and other positioning — effectively exclude the more costly groups such as the elderly. (Sub. D265, p. 17)

MIRA pointed out that the new provisions require funds only to community rate *within* membership categories, rather than, as before, *across* categories. This gives scope for health funds to choose significantly different rate structures. It commented that:

one must expect that different health funds will choose different rating strategies. It is hard to predict what the rate structure would look like for different funds, although market forces would probably force some convergence between the different funds' rate relativities. The clash between the remaining community rating regulation (which only prescribes community rating within membership categories), and a reinsurance arrangement designed to support community rating across membership categories will inevitably provide opportunities for health funds to 'play the system'. (Sub. D239, pp. 6–7)

MIRA considered that the Government should clarify its preferred approach.

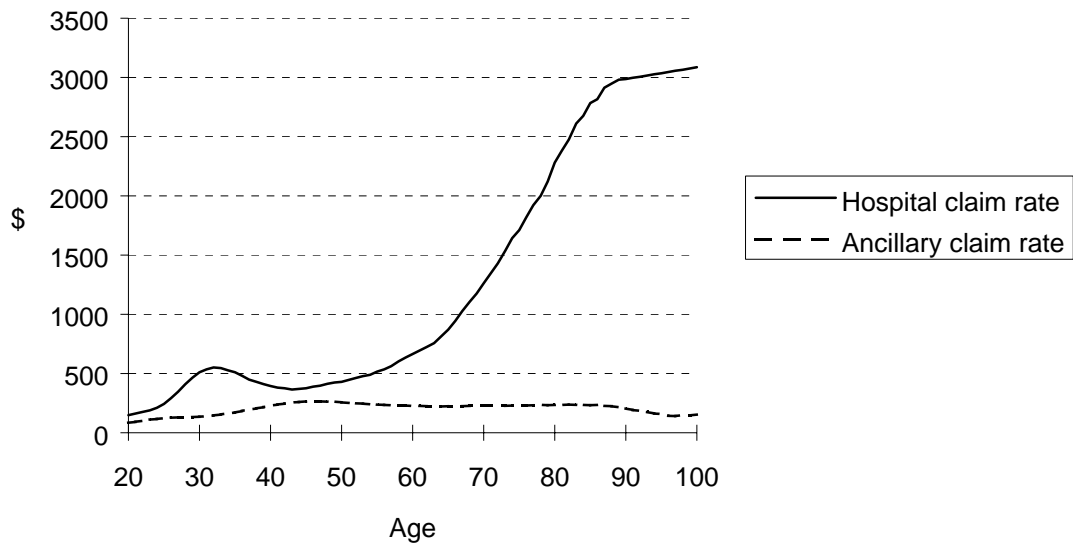
### *Ancillary tables*

At present, community rating applies to both the hospital tables and ancillary tables. Medibank Private queried the purpose of applying community rating principles to ancillary products, which are excluded from the reinsurance pool calculations (Sub. 168, p. 10). SGIO Health believed that community rating has no application for ancillary cover (Sub. D237, p. 3). Peter Carroll advocated abolishing community rating for ancillary insurance:

The cross subsidies involved are small, and not related to income or age. This might well lead to price reductions for many less affluent and older consumers. (Sub. 9, p. 34)

Figure 3.1 illustrates the claims experience of NMHI for hospital and ancillary cover. It shows a much greater rise with age for hospital claims than for ancillary claims — indeed the latter tend to decline with age after about 45.

Figure 3.2: Hospital and ancillary claim rates (per SEU), by age



Source: Data obtained from NMHI.

Several participants, however, considered that, given the small cross subsidies involved, there could only be limited effect from abolishing community rating for ancillaries. For example, HIRMAA stated that:

community rating of ancillary cover is not of significance, however if this was to be amended it may result in unnecessary complexity for consumers. (Sub. D204, p. 2)

And NMHI stated that it does not believe there is ‘a significant advantage to be gained by applying a risk-rated premium to ancillary products’ (Sub. D210, p. 4).

The Department did not support the removal of community rating for ancillary cover either. It considered that:

As funds are not required to maintain separate pools for different products, a combination of judicious cross-subsidy and differential ancillary premiums would permit the fund to offer apparently significantly lower combined premiums to young people: a defacto form of risk rating. (Sub. D277, p. 3)

Even if market forces were to permit this outcome, as discussed above the October 1996 changes to community rating (together with exclusions and excesses) already give the health funds considerable scope to set premiums to differentiate between categories of member.

### *The future for community rating*

Though membership has been declining, community rating principles (together with the reinsurance arrangements) still act to bring about significant redistributions of health costs. Thus, community rating still has considerable effect.

That said, it must be acknowledged that the application of community rating has weakened over time. To some extent, this has been inevitable, as universal access to public health services under Medicare has reduced the incentive for low health risk members of the community to take out private health insurance. As noted in chapter 2, there is at present inherent tension between the policies of universal access to a ‘free’ public system and community rating for private health insurance.

In responding to the declining attractiveness of private health insurance, flexibility has been shown by adapting community rating to allow for policies with excesses and exclusions, and through the recent expansion of membership categories. In seeking to make private health insurance more attractive to low-risk people in this way, high-risk people may face higher premiums. However, the reality is that in the absence of such changes their position would be under threat anyway.

Despite the present difficulties with community rating and its impacts on private health insurance, many participants supported continuing access to private insurance by all members of the community, whatever their age and health status. For example, the AHIA commented that:

While community rating may need some refinement — to protect it — the alternative, risk rating, is totally inappropriate. (Sub. 108, p. 12)

Many participants made suggestions for changes which they considered would support community rating, an important one being *lifetime community rating*. These suggestions are considered in chapter 10, with a discussion of alternative rating schemes given in appendix C.

### *Need for clarity*

As noted previously, there is no clear definition of community rating. This has created considerable uncertainty for the funds about what they can and cannot do. Medibank Private commented that ‘there are no documented clear definitions or application principles of community rating, with the result that definitions are influenced by the views of [the Department]’ (Sub. 168, p. 63).

Alan Brown commented that ‘community rating is so loosely defined that nowhere is it written down’ that premium rates can differ between states (Sub.

D231, p. 10). And he queries whether premium rates for a table can or should be allowed to vary by locality within a state.

As noted, MIRA called for the Government to clarify its approach to community rating. Other participants also saw a need for better definition of community rating. For example, the Institute of Actuaries commented that:

Any policy reform requires a statement of the objectives of community rating, the recognition of age-related risk and the application of actuarial principles within the context of achieving desired social outcomes. (Sub. D218, p. 2)

And SGIO Health considered that ‘if community rating is to remain as the backbone of our health insurance arrangements, it must be clearly defined and apply to a much higher proportion of the community ...’ (Sub. D237, p. 2).

### **3.4 Reinsurance**

Registered funds must participate in what are known as ‘reinsurance’ arrangements for the cover under their hospital tables. The purpose is to underpin community rating by sharing the hospital costs of the chronically ill and the aged. If there were no such arrangements, instability could develop in the industry: funds with a higher proportion of individuals with high claims would be forced to charge relatively high premiums; this would drive out members to other funds — especially members with low health claims — which would drive up premiums further, and so on. Appendix D gives more detail about the reinsurance mechanism and its effects.

Under the arrangements, administered by PHIAC, the hospital claims of all people aged 65 years and over, and those with more than 35 days of hospitalisation in any one year, are to a large extent shared by all health funds. Over 48 per cent of total claims costs are now covered by the reinsurance arrangements. Out-of-hospital costs (and ancillary costs) are not included in reinsurance.

Health funds with above average claims for those people in the specified categories receive a compensating amount from the health funds with below average claims. Settlements are made quarterly. One result is that claims costs for older established funds with a more elderly membership are shared by newer funds or funds with a restricted and younger membership, such as those with an employee base.

The reinsurance arrangements operate on a state basis. The ACT is included in the NSW pool, but the NT is treated separately. Thus, a fund operating in more



than one state is treated as a series of separate state funds for the purposes of reinsurance.

In the past, the private health insurance reinsurance pool was subsidised by the Government (taxpayers generally). In some years, the subsidy, which was phased out between 1984 and 1988, had been as high as \$100 million. The AMA estimated that this would have been worth about \$220 million in 1994–95 (Sub 130, p. 7). This subsidy served to reduce all health fund premiums.

## **Implications and issues**

### *Large money flows*

Reinsurance results in large transfers among funds, as the arrangements redistribute costs of the two high cost groups of members more evenly among health funds in each state. It could be expected that the attitude of a particular health fund to reinsurance would depend, at least partly, on whether the fund was a net recipient or net contributor to reinsurance. As the AHIA observed:

Attitudes to reinsurance differ between funds and, as they involve financial transfers, are dependent on their assessments of the benefits/disadvantages of differing schemes. (Sub. 108, p. 66)

In 1995–96, hospital benefits paid by the private health funds totalled over \$2.83 billion. Of this, some \$1.37 billion related to members over 65 years of age, and those with more than 35 days of hospitalisation. In line with current arrangements, 79 per cent of this amount —some \$1.08 billion — was reallocated among funds.

The value of transfers can be very large for some funds. In 1995–96, for example, MBF in NSW received about \$36 million from the reinsurance pool, whereas NIB contributed about \$16 million. In Victoria, HBA received about \$21 million, and Medibank Private contributed about \$21 million.

Reinsurance arrangements have changed from time to time. Such changes can have a significant effect themselves. A submission from Brent Walker pointed to the 1989 changes which added the over 65 age category to the arrangements. He compared payments made in 1987–88, the last full year of the previous arrangements, and 1989–90: MBF's receipts jumped from \$7.8 million to \$32.5 million, whereas Medibank Private's payments rose from \$8.2 million to \$29.8 million (Sub. 73, p. 4).

### *Outcomes*

The current reinsurance arrangements have a number of consequences, not all necessarily desirable:

- Only two high-risk groups are recognised. This means that some funds are still disadvantaged if they have a higher representation of certain riskier groups not covered by reinsurance, for example, expectant mothers.
- States have their own reinsurance pools, so that there are no cross subsidies among states, notwithstanding pronounced demographic variations (for example, between South Australia and Northern Territory).
- Reinsurance weakens incentives to control costs associated with the elderly, because most of these costs are pooled. It particularly weakens the incentives to select cheaper out-of-hospital treatments, since they do not enter the pool.
- It similarly reduces incentives to use ambulatory care, rather than hospital care.
- It also discourages funds from seeking care options that keep people from spending more than 35 days in acute hospitals (the chronically ill).
- It weakens the ability of funds to produce cheaper products for consumers who are willing to pay front end deductibles or copayments, or to accept exclusions. This is because each product bears a fixed reinsurance liability, and the impact on prices is much greater for cheaper products. This also reduces the ability of the funds to develop mechanisms to avoid moral hazard and cost inflation in the health system.
- The possibility of specialisation in insurance products is effectively eliminated, as even specialised products bear a full reinsurance burden.

Although some equalisation arrangements appear necessary to support community rating (particularly given the October 1996 changes), many participants raised questions about the nature and extent of current reinsurance.

### *Efficiency*

Some participants recognised some trade off between supporting community rating through reinsurance, and encouraging efficiency. For example, the NSW Government commented that:

The reinsurance arrangements, which support the effective operation of the community rating principle by equalising the costs of bad risks across insurers, still creates a disincentive for insurers to maximise cost control measures and from attracting good risks. (Sub. 180, p. 18)

Peter Carroll suggested that systematically reducing the scope of the reinsurance pools would reduce the scope for cost shifting in the private health insurance industry (Sub. 9, p. 35). The Australian Health Management Group (which includes the Government Employees Health Fund, and runs a number of health plans for specific employers) recommended that reinsurance be reformed to provide incentives for cost containment strategies (Sub. 81, p. 12). And Westfund considered that reinsurance ‘rewards inefficiency’ and should be wound up immediately (Sub. 133, section 18).

### *National vs. state pooling*

NMHI considered that national rather than state-based pooling should apply:

Anomalously, reinsurance pooling or equalisation operates on a regional (state-by-state) basis, while marketing and selling activity, and registration and minimum reserves regulations now operate nationally. In the context of a national health insurance industry and policy, and a community service obligation that is imposed nationally [ie community rating], this regionalisation of reinsurance makes little sense. (Sub. 140, pp. 50–51)

Medibank Private stated that ‘on balance, and subject to further development of the concepts [it] supports national reinsurance arrangements which recognise state differences [arising from state government policies]’ (Sub. D242, p. 3). It considered that the arguments against national reinsurance are ‘not very strong’, and that differences arising from state government policies ‘could be handled by adjustments while maintaining the advantages of the larger reinsurance pool’ (Sub. D242, att. 1, p. 3).

There was considerable opposition to national pooling from a number of other funds, both in initial submissions and in response to the Discussion Draft. This is understandable as many of them are beneficiaries of the present state-based approach. The HBF of WA, for example, considered that a national pool would have a ‘catastrophic effect’ on that state (Sub. 33, p. 18). In supporting continuation of state pooling, the HBF said that:

Health insurers are still permitted to set different contribution rates in each state, recognising that for many reasons, other than risk, there are different cost structures. Differences between states in terms of public health policy, insurance products and insurer relationships with providers impact far more than different risk profiles between states ... Each state exercises control over the number of private beds or facilities which it licenses, and the interrelationship between these elements has an effect on the cost of health care in each state. (Sub. 33, p. 19)

HBF’s submission in response to the Discussion Draft contended that:

Community rating by funds takes place at state level. Those insurers who operate in more than one state set a different contribution rate in each state. With a national pool, a single rate cannot be set nationally (because the product can be changed by each state). It would be anti-competitive to have a national pool and state contribution rates. (Sub. D228, p. 4)

NIB Health Funds considered that:

A national pool would see existing inequities further exacerbated. There are considerable differences between states in respect of population profiles, health policies, cost structures and charging systems. (Sub. D236, p. 3)

According to HIRMAA, ‘there are far too many real structural differences within the private health environment of individual states to allow for the accommodation of national pooling’ (Sub. D204, p. 4).

One of the potential reinsurance ‘winners’ from national pooling, SGIO Health, did not support change: ‘we firmly believe that there are sufficient differences in cost drivers within each state to warrant the maintenance of separate reinsurance pooling’ (Sub. D237, p. 7).

The Department considered the present arrangement to be satisfactory:

There are considerable differences in benefits between states reflecting differences in private hospital costs and subsequent charges and the proportion of private hospital beds to public hospital beds rather than differences in fund membership. (Sub. 175, p. 20)

Moving to national pooling would have substantial financial implications. Table D.4 in appendix D shows that there would be gross flows between states of about \$200 million. Fund members in NSW, WA, Tasmania and the NT would be the losers.

### *Restricted vs. open funds*

Another area of contention related to the differential effects of the reinsurance arrangements between the restricted membership funds and the open funds (see section 3.5). The restricted funds, as a group, are significant payers into reinsurance. HIRMAA argued that:

The reinsurance scheme has unfairly affected the restricted funds to such an extent that the system effectively discriminates against funds that actively seek to improve their age or risk profile. Independent studies [by MIRA consultants] have concluded that the reinsurance system arrangements have resulted in unfair results for many funds, and ultimately their members, who have to finance the inflated contributions that have resulted. (Sub. 71, p. 26)

However, the Department considered that the changes advocated by the restricted funds would have little effect:

initial estimates by PHIAC of the effects of Mixed-1 [ie the arrangements favoured by the restricted funds] show that payments to and from the reinsurance pool would be largely unaffected. Mixed-1 is also complex to administer ... Nevertheless, the Department intends to seek legislative change so that Mixed-1 or other improvements in the reinsurance arrangements can be introduced from time to time without the need for legislation. (Sub. 175, pp. 19–20)

PHIAC also commented that Mixed-1 is not very different from the existing Mixed-2 scheme which ‘is simple to administer and reduces opportunity for gaming which could occur in a more complex system (Sub. D262, p. 4).

### *Costs to be pooled*

The Australian Unity Friendly Society suggested that the proportion of pooled costs equalised among funds should be increased from 79 per cent to 85 per cent. This is aimed at ‘merely restoring the former level of support to the retired population who choose to remain in private health insurance’ (Sub. 163, p. 59).

The HCF made another suggestion. It considered that the proportion should be recalculated each quarter for each state in which it is applied, with its ‘calculation methodology’ recognising that it would be applied to benefits for both the under 65s and over 65s (Sub. D225, p. 4).

### *Basis of reinsurance*

Changes to the application of community rating could necessitate changes to reinsurance arrangements as well. In this regard, the Institute of Actuaries commented that the current reinsurance arrangements limit the ‘potential advantages’ of the October 1996 changes to community rating (Sub. 141, p. 9). Brent Walker suggested changes which would be commensurate with those new community rating arrangements. He suggested changing the basis of reinsurance to ‘risk equalisation’ across all age groups — rather than basing it on benefits paid to high cost groups — with the initial risk weights corresponding to the hospital cost weights in the Medicare Agreements (Sub. 73).

In response to the Commission’s Discussion Draft, a number of other participants suggested changes to the basis of the reinsurance arrangements. Suggestions for change in the basis of reinsurance are considered in appendix D, and in chapter 10.

## **3.6 Registration requirements**

Only organisations registered under the National Health Act are lawfully able to carry on the business of health insurance. Penalties are available to enforce the

conditions of registration, and to take action against unregistered organisations which carry on business which is deemed to be health insurance. Indeed, action has been taken in a number of instances to prevent sale of certain types of health-related insurance by non-registered organisations (see section 3.7). Such organisations have the obvious advantage of not being bound by community rating and reinsurance.

The conditions of registration cover such matters as: categories of membership, waiting periods for benefits, transfer arrangements between tables and funds, the types and levels of benefits, and requirements about contracting with hospitals and doctors. (Some of these matters are discussed in other sections of this chapter.) The registration requirements enable the Government's regulatory authority over the funds. Box 3.15 gives more detail about the requirements.

### **Box 3.16: Registration requirements**

- Registration can be as an 'open membership organisation', or a 'restricted membership organisation'. Membership of restricted funds can be limited to an employment group, professional association or union.
- Health funds are permitted to carry on other business activities. However, there are some restrictions on which types of diversified asset can be included in the health insurance solvency calculations.
- In the past, registration exemptions had been possible for employers or employer organisations funding health expenditure or health insurance cover for their employees. However, the 1995 Amendment Act effectively prohibited company self-insurance schemes from 1 October 1995, unless registration was obtained. Only one employer fund, covering certain employees of BHP, obtained such registration.
- Most registered funds operate on a not-for-profit basis, and are not liable to pay company tax under the Income Tax Assessment Act. However, there is no specific regulatory bar against for-profit funds. Further, it is possible for an existing fund to convert to for-profit status through a (complex) process of establishing a new for-profit fund, and gaining Ministerial approval to merge its existing operations with the new fund.
- The 1995 Amendment Act enabled organisations to obtain national registration, ending the previous requirement for an open fund to maintain a separate fund for every state in which it operates. This change placed open membership organisations on an equal footing with restricted membership organisations, by enabling them to conduct a single health benefits fund covering all members with a single reserve pool. (However, the reinsurance arrangements continue to operate under state pools.)

The Act contains provisions for the judicial management, or the winding up, of funds which encounter financial difficulties (see later section). As well, funds can apply to the Minister for permission to merge.

## **Implications and issues**

### *Restricted vs open funds*

Medibank Private considered that the presence of restricted funds appeared ‘inconsistent’ in an environment where competition between health funds was encouraged. Further, it considered that restricted funds received advantages through their lower risk profile and indeed that their very existence breached community rating principles. Such funds can take advantage of lower risk profiles to expand membership beyond their core groups if membership restrictions are loosely enforced. Medibank Private proposed a number of options in regard to the restricted membership funds: they should be targeted in industry rationalisation (in particular their takeover by open funds should be made easier); their membership should be more tightly regulated; or they should be forced to operate as open funds.

In contrast, the HIRMAA considered that its group of restricted funds ‘stand out with respect to both efficiency and effectiveness’ (Sub. 71, p. 4), and that ‘the argument seems stronger for increasing the number of [restricted funds] rather than reducing them’ (Sub. D204, p. 10). HIRMAA pointed out that restricted funds abide by community rating requirements and contribute significantly to the reinsurance pools. Further, it considered that:

It is indeed abhorrent that such accusations should be raised by funds who compromise their position by openly offering significantly discounted products to corporate groups, a move which clearly breaks the principle of community rating. (Sub. D204, p. 10)

The Department proposed changes to reserve requirements (see section 3.8) which would ‘allow more small employer, craft and union groups to establish themselves as funds’ (Sub. 175, p. 24).

As already noted, the existing community rating arrangements, supported by reinsurance, are far from ‘perfect’ in providing equal treatment to all irrespective of age, sex, health status and claims experience. There are many different types of products, including products with exclusions and excesses, and many funds operate on a restricted regional or state basis. In such an environment, it is unlikely that the existence of restricted membership funds significantly weakens community rating, especially as they take part in the reinsurance arrangements.

### *Not-for-profit vs for-profit funds*

At present, most registered health funds are not liable for income tax: only three operate on a for-profit basis — see chapter 4.

As noted in box 3.17, there is no specific regulatory barrier against for-profit funds. And it is possible for funds to convert from not-for-profit to for-profit status. In the Department's view there are no registration requirements that prevent the entry of any other entities such as banks or life insurance companies into the market, except the overarching premise that, historically, health insurance has been conducted on a not-for-profit basis (Sub. 175, p. 25). However, the Department suggested legislative amendment to the registration conditions to clarify the fact that for-profit funds are permissible and so encourage new entrants to the market. SGIO Health commented that, as a health fund that has just been through the conversion process under the existing requirements of the Act, it 'would certainly support' this suggestion (Sub. D237, p. 14).

Many health funds considered that there were important reasons why the private health insurance industry should continue to operate on a non-profit basis, not subject to taxation. For example, Medibank Private stated that:

Not-for-profit status enables private health insurance funds to preserve the community need, social justice and equity aspects of health care in a for-profit service delivery environment. (Sub. 168, p. 13)

Manchester Unity explained that health fund members contributed:

to ensure that they have adequate coverage to meet expenses that may occur in medical and hospital related instances, and any form of taxation could only drive up their contribution rates. (Sub. D245, p. 1)

According to the Health Benefits Council of Victoria, 'the not-for-profit model ... maximised sensitivity to community need, social justice and equity aspects of health insurance' (Sub. D265, p. 5).

Westfund also considered that it is in the community's interest for the private health insurance industry to be non-taxed.

Some participants opposed these views, in particular, health funds operating on a for-profit basis. NMHI considered that:

The fact that the majority of health insurers are mutuals no more justifies tax exemption than it does for other mutuals such as life insurers, credit unions or others providing equally socially valuable services. (Sub. 140, p. 48)

And Peter Carroll stated that:



Unequal tax of health insurers, based entirely on ownership, has no rational economic justification and imposes a competitive disadvantage on enterprises who wish to access capital through the equity markets. There is no counterpart elsewhere in the insurance industry. (Sub. 9, p. 34).

Appendix E discusses issues associated with health benefits organisations and taxation. Relevant issues include:

- the rationale for exemption from income taxation;
- economic effects — in particular, on competitive neutrality; and
- effects on corporate culture and efficiency of operation.

Some brief comments are set out below.

#### *Rationale for exemption*

Apart from their specific exemption under Section 23(eb) of the *Income Tax Assessment Act 1936* (ITAA), mutual health funds could be exempt from income tax under the ‘mutuality principle’ of common law. According to the Health Benefits Council of Victoria:

The essence of the mutuality principle is that an organisation is not taxable on the profits or surplus made from its dealing with its members, and its members will not be taxable on the income or benefits received by them as members of the organisation. (Sub. D265, p. 10)

The Council considered that one reason for the specific exemption under the ITAA is that health funds:

encourage voluntary community and personal endeavour towards socially or economically desirable or responsible goals, for other than individual or ‘corporate’ gain. (Sub. D265, p. 7)

But NMHI commented that the rationale that it is not appropriate to tax organisations which have a fraternal (rather than commercial) focus is outdated:

It is no longer applicable to the health insurance industry of today, which is dominated by large-scale businesses dealing with the general public in competition with each other. (Sub. D210, p. 9)

#### *Competitive neutrality*

In regard to competitive neutrality, an important issue is whether exemption from tax allows the not-for-profit funds to compete on more favourable terms than do the for-profit funds.

The majority of participants commenting on this issue clearly believed so. For instance, the AHIA considered that any tax impost ‘would, of course, increase

contribution rates for members' (Sub. 108, p. 45). The Hospital Benefit Fund of WA stated that 'any new or additional tax would be passed on to members in the form of higher prices' (Sub. D228, p. 19). Medibank Private said that: 'funds ... view their members as "shareholders" for whom the delivery of lower prices is a "dividend" (Sub. 168, p. 13).

To the extent that the tax exemption permits lower premiums, then its removal could lead to increased health fund premiums. NMHI's solution to this would be to return the tax proceeds to the private health insurance system, 'for example as part of a resumed government contribution, at the national level, to the reinsurance pool' (Sub. 140, p. 48).

Of course, the magnitude of any possible competitive advantage to not-for-profit funds needs to be taken into account. Appendix E suggests that it is not large on an annual basis. Nevertheless, as SGIO Health pointed out, 'there is probably close to \$1 billion that the funds have accumulated as reserves, primarily over the last 40 years' (Sub. D237, p. 9) — this has accumulated from the non-taxed surplus of the funds. SGIO contended that as the population grows and inflation increases premiums, the levels of reserves required will continue to increase, and the taxation advantage to not-for-profit health funds will continue.

Medibank Private estimated that, over the five years to June 1996, industry taxation would have been equivalent to 1 per cent of contributions (Sub. D242, p. 4). It pointed to the increased management expenses which would be incurred by health funds if they were taxable.

#### *Corporate culture and efficiency*

The Health Benefits Council of Victoria considered that 'there is no evidence that mutual funds are less well-managed or efficient than the for-profit funds' (Sub. D265, p. 18). It compared the management costs of NMHI, the largest for-profit fund, with those of not-for-profit funds, noting that the former are substantially higher than the average for restricted membership organisations, significantly higher than the industry average, and marginally higher than the average for the open membership organisations. Of course, management costs alone are not complete indicators of efficiency (see chapters 4 and 8).

PHIAC commented that the available data show that, non-profit status and fund size are not 'indicators of efficiency' (Sub. D262, p. 3).

## *Mergers*

The Act provides for mergers and takeovers of funds. Some of its provisions apply specifically to funds facing difficulties, for example those not maintaining minimum reserves (see section 3.9). However, unless they agree to it, mutuals and closed funds are not easily taken over — there is no ‘shareholder’ pressure on management to seriously consider any such offers that are made.

SGIC commented on the lack of opportunity for ‘the more efficient funds to take over the less efficient in the same or different state’ (Sub. 26, p. 3). It proposed (as SGIO Health) a detailed mechanism, modelled on Corporations Law, which could be used to deal with ‘hostile’ takeover offers (Sub. D237, pp. 12–14). It recommended that a working party be set up to report to the Minister on a set of procedures and rules which should be followed in a hostile takeover of a mutual health fund.

Medibank Private also considered that there should be:

A regulatory mechanism to facilitate ‘hostile’ takeovers ... as a fair and equitable process for industry rationalisation and to ensure that inefficient, uncompetitive health funds are not ‘bailed out’ by the industry. (Sub. 168, p. 34)

Its proposed mechanism would open up the final decision to a plebiscite of the fund’s members. If they rejected a suitable takeover offer, the fund would be cut off from industry support (for example, there would be no industry-wide levy in support — see section 3.10) if it failed financially within a period of, say, two to three years. The procedure would operate under the Act.

Other participants opposed mechanisms to facilitate hostile takeovers. For example, the AHIA ‘strongly opposed’ it (Sub. D221, p. 5). It queried whether a hostile takeover could provide any benefit to contributors:

It would certainly not be based on a desire to provide high-risk contributors with better benefits: more likely it would arise from a desire to access the assets and reserves of the fund targeted: it is dubious whether this would be in the public interest. (Sub. D221, p. 5)

The Government Employees Health Fund pointed to the difficulty members would face in assessing the takeover offer:

the assessment of value is extraordinarily difficult because it entails competing cover. We are not dealing with a share price, neither do members care about a theoretical reserve backing. (Sub. D220, p. 6)

## **3.11 Requirements about products**

Funds are now able to offer a wide range of hospital tables, including those which cover all costs (except some medical gaps), share costs with members

(copayments and excesses) or limit coverage (exclusionary tables). There is increasing competition between products offered within a fund, as well as competition between funds.

There are nevertheless restrictions on the products which funds can, and cannot, offer under hospital tables (see box 3.18). For example, funds must offer:

- at least a minimum specified level of benefit (ie the basic or default benefit), for all public and private hospitals for all conditions covered in the policy taken out by the fund member;
- cover in every (ABA) policy for in-hospital psychiatric, rehabilitation and palliative care, at least at the default level; and
- cover for nursing home type patients (NHTPs) at ‘acute rates’ for the first 35 days in hospital.

### **Box 3.19: Product coverage and the 1995 amendments**

Until October 1995, the Commonwealth Government defined a set of benefits that all health organisations had to pay as a minimum when an insured person was treated in any recognised (public) hospital, or licensed private hospital (including day hospital facility). This set of benefits included basic table hospital costs, as determined by the Minister for Health and Family Services. Health funds could also offer supplementary cover for the additional costs for treatment in a private hospital (or a single room in a public hospital). The level of supplementary benefits was not regulated.

From 29 May 1995, however, health funds were able to negotiate different agreements with different hospitals. Applicable Benefits Arrangements (ABAs) came into existence. This term describes an arrangement between a health fund and its contributors under which contributors are covered for fees and charges related to hospital treatment (including medical charges). ABAs are more flexible than the basic and supplementary table system.

ABAs, when they were fully implemented on 1 July 1996 for both the private and public hospital sectors, provide cover ranging from all services in all hospitals, public and private, to a limited number of services in a limited number of hospitals. /cont’d

**Box 3.8: continued**

The use of the basic table for private hospitals has not been possible from 1 October 1995 unless Hospital Purchaser-Provider Agreements (HPPAs) are in place (see below). Where there is no HPPA, default benefits have applied (see below). Under contracts with individual hospitals (ie HPPAs), the funds can agree to continue with existing basic and supplementary tables, or enter into some other arrangement. The basis of payment under the HPPAs can be per diem, casemix, or some other method.

The use of the basic table ceased on 1 July 1996 for public hospitals unless there was an HPPA in place. As, in fact, there were no HPPAs between funds and public hospitals, the basic table for public hospitals has now effectively ceased and the default benefit applies. (However, as the minimum default benefit, as determined by the Minister for Health and Family Services, mirrors the basic table, the level of benefits is effectively the same.)

Some HPPAs between funds and private hospitals carry on the basic and supplementary tables arrangements, as an interim measure. The basic and supplementary tables will cease on 1 July 1997 — from then, all cover will be under ABAs.

As from 1 July 1996 default benefits apply where funds and hospitals (public and private) do not have HPPAs in respect of some or all hospital services:

- the default only applies to services covered by the health fund's policy (see below);
- the default benefits must be at least at the level specified by the Minister; and
- for each service covered by the policy, the default level of benefit for emergency treatment in a (public or private) hospital with which the fund does not have an HPPA must be at least the average level of benefit for that service paid in hospitals with which the fund does have HPPAs.

Hospital treatment relating to palliative care, rehabilitation and psychiatric care is a compulsory inclusion in all ABAs. Benefits must equal or exceed the default benefits for non-emergency treatment in non-HPPA hospitals.

Every fund must offer at least one table that covers all services, but the level of benefit is not mandated.

Prostheses can be excluded: for example, a table offering only obstetric care need not cover artificial hips. But a table covering hip replacements would not be able to exclude the prosthesis. However, the fund could negotiate with the hospital/doctor about which particular prostheses were covered.

*Source:* Based on advice from the Department.

The minimum default level of benefit is determined by the Minister for Health and Family Services. It varies across states, but is currently set at about \$200 per day. Higher default benefits may apply for members of funds admitted to hospital in an emergency.

Funds cannot offer, for example:

- no claim bonus discounts in premiums;
- discounts for non-smokers and other low-risk groups;
- nursing home cover;
- cover for the patient copayment for in-hospital PBS pharmaceuticals;
- any gap cover for out-of-hospital medical services covered by Medicare; or
- insurance for any gap above the MBS for in-hospital medical services, unless there is a contract between the fund and the doctor — funds can cover the 25 per cent gap between the Medicare rebate and the MBS fee even if there is no contract.

Essentially, hospital tables offer cover for hospital treatment and associated medical gaps — coverage for services provided out of hospital needs to be under ancillary tables. These can also offer cover for ancillary services, such as physiotherapy, when provided in hospital.

The regulatory requirements are less strict for ancillary tables than for the hospital tables. Funds have more discretion in regard to the nature of coverage, deductibles, excesses and copayments, waiting periods and so on. However, state government licensing and regulation can affect the provision of ancillary care.

## **Implications and issues**

Apart from concerns about the possible effect on community rating (see above), participants generally accepted that the development of products with excesses, exclusions, and so on had been positive for the industry. The AHIA commented that:

there are a relatively wide range of niche products developed within community rating, aimed at maintaining or expanding membership by providing customers with choices which make the product more appealing to them. The only real constraint on 'new' products is ... 'cannibalisation' — ie attracting existing members who had no intention of changing their insurance status until the new product was introduced, as distinct from retaining members who would otherwise leave. (Sub. 108, p. 63)

In the past, the constraints had been greater on these type of products. MBF pointed out an anomaly that no longer applies — a requirement that a deductible on a family table had to be twice that on a single table had led to many couples without children taking out two single memberships rather than a family membership.

However, there were a number of concerns about remaining restrictions on what coverage the health funds had to offer, and what coverage they were not permitted to offer. Further, there was concern that funds had not taken up opportunities to reduce costs, by changing the nature of their coverage. These issues are taken up briefly below, and considered further in chapters 8 and 10.

### *Default benefits*

The AHIA and many health funds supported the removal of the default benefit arrangements. For example, the AHIA contended that the existence of a minimum benefit weakened the health funds' negotiating position with hospitals and could lead to reductions in quality of care (Sub. 108, pp. 31–4). It considered that, there was no need for statutory default benefits (Sub. 108, App. II, p. 2).

NMHI commented that, because of the default arrangements, 'an insurer cannot choose to offer the services of only a certain range of hospitals and related providers' (Sub. 140, p. 33).

Furthermore, the AHIA contended that the emergency default payments encouraged private hospitals to erect accident and emergency facilities to 'capture' patients.

Private hospitals, however, opposed removal of the default arrangements. The APHA considered that 'the consequences of abolishing the default benefit would be [the] effective end to consumer choice in selection of private hospital' (Sub. D217, p. 30). It suggested that the level of default be effectively doubled to about 85 per cent of average benefits. Similarly, HCoA considered that by removing choice, part of the 'advantage of private health insurance and therefore its attractiveness to consumers' would be lost (Sub. D248, p. 5).

There was some questioning about whether removal of the (non-accident & emergency) default benefit would have any practical effect. The AMA commented that:

since the default benefit is already set at less than 50 per cent of current private hospital charges, its abolition is unlikely to produce any impact on overall costs. (Sub. D223, p. 1)

And the ACA said that ‘it is unclear how the default benefit is actually weakening the contracting regime in practice’ (Sub. D238, p. 4). It considered that funds should be required to continue to pay for emergency treatment in any private hospital.

The Department considered that:

the default provision should remain while the industry develops expertise in contract negotiations, and the level of the default should be set at a level that provides an incentive for hospitals to contract. It may be appropriate to phase the default benefit out over time. (Sub. D277, p. 19)

However, there could be an effect on public hospitals if the default were removed. The Tasmanian Minister for Community and Health Services considered that ‘to safeguard public hospital revenues in a market where public hospitals have a weak negotiating position, the minimum default benefit needs to be retained’ (Sub. D272, p. 2).

In regard to the (higher) default for emergency treatment, the Private Hospitals Association of Queensland contended that the AHIA’s statement (see above) misunderstands completely the drivers for private hospital development over the past five years:

private hospitals [see] their future as providers of a comprehensive range of services to any patient they treat — this model must include such facilities as critical care and accident and emergency units. (Sub. D232, p. 3)

Thus, a range of issues surrounds the general and the accident and emergency default benefits: whether they ‘bite’, the effect on competition and contracting, the appropriate level, and effects on consumers. These issues are considered further in chapters 8 and 10.

### *Psychiatric, rehabilitation and palliative care*

In their initial submissions, a number of health funds were critical of the requirement mandating coverage (at least to the minimum default level) for psychiatric, rehabilitation and palliative care in every table. Funds such as NMHI considered that they should have the freedom to decide whether or not to cover psychiatric and rehabilitation treatment. But some participants considered that mandating coverage was justified. For example, the National Community Advisory Group on Mental Health commented:

The extent of mental illness is not well understood or accepted by the community. Members and potential members of health funds are likely to seriously underestimate their risk in requiring psychiatric treatment. Therefore, psychiatric care is not an appropriate form of treatment to be excluded from insurance products. (Sub. 49, p. 2)



The Group commented that some funds were interpreting the regulations to require that they only cover at least one of psychiatric, rehabilitation and palliative care, rather than all three areas. Further, the Group considered that the default level of benefit was too low, and that a ‘more realistic’ coverage should be provided (Sub. 49, p. 2).

These sentiments were supported by some other participants, including the Royal Australian and New Zealand College of Psychiatrists which considered that ‘blatant discrimination against those suffering from mental illness must be addressed if people are to be encouraged to retain or purchase private health insurance’ (Sub. 102, p. 1).

In response to the Discussion Draft, many participants amplified the arguments for and against compulsory coverage in every table. These are summarised in appendix F — they relate to the reasons for singling out these forms of care, whether adequate care is available through public hospitals, whether funds would provide such cover if it was not required, and whether consumers would take it out.

There was some concern expressed that in-hospital care was not always most appropriate for these conditions. The Eastern Metropolitan Palliative Care Provider Group, for example, highlighted the lack of insurance cover for palliative home care clients, and proposed a funded program, case managed by an approved palliative care service (Sub. 62, p. 1) (also see section below on ‘reducing costs by expanding coverage’). The APHA supported the development of ‘appropriate admission criteria’ and the limitation of the requirement to cover psychiatric, rehabilitation and palliative care to programs which apply those criteria (Sub. D217, p. 23). Relevant issues relating to psychiatric care are currently being considered by a special taskforce which is to report to the Minister for Health and Family Services early in 1997.

### *Pharmaceuticals*

MBF considered that funds should be able to pay benefits in respect of the presently required in-hospital copayment for PBS pharmaceuticals. It considered that the copayment does not provide any price signal to the patient, and served ‘no purpose other than to increase the dissatisfaction of health fund members, or potential members’ (Sub. 29, p. 12).

The APHA agreed with this proposal recognising, however, that there would be some effect on health fund premiums (Sub. D217, p. 16). The Private Hospitals Association of Queensland also was concerned about the possible impacts on premium levels (Sub. D232, p. 4).

### *Reducing costs by expanding coverage*

Participants suggested a number of ways in which the private health funds could reduce their costs through expanding the range of services on which benefits were paid.

Some such as Fit for Work, Macquarie Home Healthcare, the Motor Neurone Disease Association, the Victorian Association for Hospice and Palliative Care, and Tony Wade & Associates (in respect of psychiatric care) considered that costs could be reduced if an appropriate range of out-of-hospital care were covered by the funds. These participants considered that often such care was cheaper, with better health outcomes.

The Federation of Natural and Traditional Therapists, and the National Herbalists Association of Australia, considered that funds should provide adequate cover for natural and traditional therapists, as the 'primary emphasis of health care should be prevention' (Sub. 17, p. 2).

Others also considered that health funds should place more emphasis on prevention, rather than cure. The Public Health Association, for instance, considered that it would make 'economic sense' for the private health insurance industry to play a more proactive role in health promotion and disease prevention (Sub. 84, p. 3).

The Government Employees Health Fund pointed out that out-of-hospital care is 'discouraged' by the reinsurance arrangements (Sub. D220, p. 6). Nevertheless, health funds pointed to a number of initiatives intended to reduce costs while promoting health outcomes (other examples are given in section 4.4):

- NMHI has piloted an alternative cancer therapy program in conjunction with a major Victorian private hospital. The program allowed patients to receive appropriate treatment and supported care in the home, rather than in hospital (Sub. D210, p. 5).
- Through care coordination measures, the Government Employees Health Fund has saved 242 bed days in six months through shortened length of hospital stay involving 59 people. A saving of \$82 200 was achieved by spending \$11 000 on other services (Sub. D220, p. 6).
- And the HBF provides a number of products and services to its members. These include, for example, 'Bundle of Joy' which encourages early release from hospital for new mothers by providing free home care services, and a 'Health at Work' program.

And the Government Employees Health Fund, the HBF and some other health funds donate to relevant health related institutions and fund research.

The AHIA considered that reinsurance should be extended to appropriate non-hospital services which would allow reductions in length of stay in hospital and reduce total costs per episode of care (Sub. D221, p. 3). There could, however, be some difficulties in defining what substitute services should be included in reinsurance, and monitoring claims from the health funds.

### *Acute care for Nursing Home Type Patients*

The Acute Care Advisory Committee suggested a number of ways in which costs imposed on health funds by NHTPs could be reduced. The Committee pointed to low disincentives for funds to endeavour to reduce acute care for NHTPs to below 35 days — care of more than 35 days is covered by the reinsurance arrangements.

At present, the first 35 days in hospital of NHTPs have to be covered at full rates, irrespective of the treatment needs of the patient. At issue is whether a lesser period for full cost coverage might be more appropriate or, indeed, whether any particular period need be specified.

The AHIA and many health funds supported removal of this requirement. And the Department commented that:

As nursing home type patients cannot be considered acute patients it is inappropriate to pay at an acute care rate for any period. (Sub. D277, p. 18)

There was opposition from the APHA, however, as ‘assessment of all patients would involve very high administrative costs’ (Sub. D217, p. 34). The APHA considered the issues of appropriate benefits could be dealt with through existing contract arrangements. Further, the ACHCA ‘strongly endorsed’ the present system, noting that ‘private hospitals have been called on to fill the aged services gap left through the inadequate resourcing of the aged care system’ (Sub. D215, p. 5).

Under the existing regulations, health funds are unable to offer coverage for care in nursing homes. However, the Institute of Actuaries noted that a recent government decision enables means tested entry fees to be levied on admission to nursing homes — previously care was provided on a needs basis by the social welfare system. It considered that there was now a rationale to allow the development of insurance products to cover the ‘long-term care costs of people in advanced age’ (Sub. D218, p. 4).

### *Ancillary services*

State-based regulations affect what funds can provide in their ancillary tables. The NSW Health Funds Association argued that:

The efficacy of private health insurance in the provision of medical and ancillary medical care is directly influenced by the plethora of Acts regulating the providers of such care. It is argued that these Acts have the practical effect of: a) restricting the supply of certain services to high cost providers and so denying consumers the choice of varying price and service quality combinations; b) allowing higher costs and prices than would occur in a more competitive market; c) protecting inefficient service providers and practices; d) preventing more productive methods of service delivery. (Sub. 57, attached paper, p. 1)

Representatives of dentists commented on the coverage offered by the private health insurers for dental work. The Victorian Branch of the Australian Dental Association considered that 'for most contributors there is no economic benefit in joining ancillary funds as they are presently structured' (Sub. 59, p. 1). Indeed, Dr Leone Hutchinson stated that private dental practitioners 'actively discouraged' patients from joining health funds (Sub. 60, p. 2). According to the Australian Dental Association:

Rebates for dental care are low in relation to usual and customary fees ... it is important that the funds preserve the level of dental benefits available directly to their clients and do not use these premiums for other purposes. The provision of costly infrastructure of clinics is not seen as an efficient use of these funds. (Sub. 50, p. 2)

Dentists were also concerned about moves towards contractual arrangements and managed care.

Physiotherapists and speech therapists considered that coverage from funds for their activities was not adequate, either for in-hospital or for out-of-hospital care.

### *Medical gap coverage*

In commenting on out-of-pocket expenses faced by consumers, some providers commented on the relativity between the MBS fees and the costs of service provision. Out-of-pocket costs would be reduced, and the attractiveness of private health insurance increased, if funds were allowed to offer coverage beyond the MBS, without the necessity for MPPAs to be agreed between funds and providers.

According to the AMA, private health insurers should be entitled to provide medical insurance up to 'reasonable fee levels' without individual contracts (Sub. 130, p. 41).

The Royal Australasian College of Radiologists indicated that in 91 out of 115 private hospitals the equipment is owned by private radiological groups. But:

Medicare rebates are applicable only for office type practice. There is no so-called after hours fee to cover work performed out of hours, or any allowance for the added cost structure of private hospital radiology. (Sub. 35, p. 4)

Similar points about the adequacy of the MBS fee levels were made by the Australian Society of Anaesthetists, the Australian Association of Surgeons NSW, the Urological Society of Australia, the Australian Association of Private Radiation Oncology, and the National Association of Specialist Obstetricians and Gynaecologists.

The Australian Cancer Society pointed to perverse incentives in radiology. While admission to hospital ensures insurance coverage of the gap to the MBS fee level, at least, someone receiving radiotherapy as an outpatient would have a daily gap payment, often for six weeks.

### *No claim bonuses and 'discretionary' risk*

Although many participants supported some form of loyalty bonus to encourage health fund membership, there was general opposition to no claim bonuses. The Department, for example, considered that as no claim bonuses are a form of 'experience' rating, they would represent 'a major departure from the community rating system' (Sub. D277, p. 9).

Questions of equity were raised. For example, Diabetes Australia considered that no claim bonuses are 'unacceptable because they are an unfair concept for those who become chronically ill through no fault of their own' (Sub. D267, p. 1).

According to the AHIA, 'if a person chose to defer health treatment for fear of losing their no claim bonus the outcome could be unfavourable for the patient and insurer alike' (Sub. D221, p. 5).

And no claim bonuses could have an effect on premium structures. As the APHA commented:

If funds offer no claim bonuses, members would expect premiums for non-claimers to reduce. This, however, requires premiums for claimers and new entrants to be increased. With a higher entry price, funds are likely to have even greater difficulty in attracting new low-risk members. (Sub. D217, p. 24)

As well, the APHA pointed out that there would be an incentive for health fund members to either pay their own way for smaller charges, or attend hospital as a public patient for more expensive care (Sub. D217, p. 24).

There was also some concern about allowing higher premiums for people subject to 'discretionary' risks, arising from smoking for example. The Council on the Ageing submitted that:

many such behaviours should not be regarded as discretionary. For example, may older people became addicted to smoking in an era when the health risks of smoking were not widely acknowledged and when there was a high level of encouragement for people to take up smoking. (Sub. D246, p. 4)

As well, there could be considerable practical difficulties in implementing and enforcing such arrangements.

### *Catastrophe and trauma products*

Finally, some participants were concerned about alternative forms of cover, such as catastrophe and trauma insurance, offered outside the regulated community rating of the National Health Act.

The AHIA considered that some forms of trauma product directly compete with health insurance:

This type of product is simply risk and age rated insurance which discriminates against the elderly and the chronically ill, and is no substitute for health insurance. (Sub. 108, p. 42)

Participants, including NMHI and Medibank Private, considered there was a need to define more precisely what was ‘health insurance’ and what was not. Medibank Private, for instance, said ‘the status of trauma products in the private health insurance industry is currently unclear and requires review’ (Sub. 168, p. 62).

Harrington Associates Limited indicated that life insurance companies sell forms of sickness and accident and trauma policies ‘which can complement or even act as alternatives to health fund membership’ (Sub. 56, p. 1). In contrast to traditional health insurance which is ‘open-ended ... where the liability to pay a cost is underwritten’ the other products are ‘closed or capped’ and based on actuarial assessment of the likely loss (Sub. 56, p. 12).

Harrington has been associated with Citicorp in devising a product — Silver Cross — which would have provided lump sums on diagnosis of illnesses requiring hospitalisation. It contended that Silver Cross was ‘designed as a continuous disability product’ under the *Life Insurance Act 1995*:

As such it: does not qualify for government tax rebates; is not classified as ‘health insurance business’ as defined ... under the National Health Act 1953; would not receive any relief from the increased Medicare levy liability. (Sub. D201, p. 3)

Indeed, Harrington submitted correspondence from the Assistant Treasurer, which stated that the Insurance and Superannuation Commission had advised Harrington that Silver Cross complies with the definition of a continuous disability product under the Life Insurance Act.

However, the product has not been brought to market. According to Harrington, ‘in an attempt to block the sale of Silver Cross the Department of Health modified a regulation ... with the specific purpose of trying to outlaw products which provided competition in the market’ (Sub. D201, p. 5). Harrington contended that the Department has chosen to selectively apply the regulation:

by ignoring some products [from Harrington’s competitors] which may not appear to be competitive, whilst applying it to a single product [Silver Cross] which the [health insurance] industry regards as ‘too competitive’. (Sub. D201, p. 5)

The underwriter was reluctant for the product to proceed to market while ‘there is confusion about the Department’s ability to apply a regulation under the National Health Act to a ‘legal life policy’ (Sub. D210, p. 5).

Harrington considered that there is no ‘insurance’ component in the health fund ‘business’ (Sub. D210, p. 2), and so believed that products classified under the Life Insurance Act should not be subjected to regulations under the National Health Act.

### **3.12 Waiting periods and transfers**

Maximum waiting periods for hospital cover are specified in the Act, and are part of the requirements for registration. A maximum of two months generally applies, with higher maximum periods specified for pre-existing ailments and illness, and obstetric conditions — see box 3.20.

#### **Box 3.21: Waiting periods for hospital cover**

Waiting periods are required not to exceed:

- 12 months in relation to an ailment or illness, the signs and symptoms which, in the opinion of a medical practitioner appointed by the fund, existed at any time during the 6 months preceding the member joining the fund (or upgrading cover).
- nine months for an obstetric condition; and
- two months in any other circumstances.

No minimum periods are specified. Funds often waive the two months waiting period as part of marketing campaigns to attract new members.

Members upgrading hospital cover with their existing fund may also be subject to the same waiting periods for the additional cover.

Waiting periods for ancillary services are more flexible.

People transferring between funds must be given credit for any equivalent waiting period that they had served with their previous fund. This applies to ancillary cover as well as hospital cover.

### **Implications and issues**

Several participants considered that the existing waiting periods were inadequate. For example, MBF said that the waiting periods were originally intended to protect members, but now act as an incentive for some people to ‘hit and run’ at the expense of members (Sub. 29, p. 11). MBF commented:

Nine months minimum for obstetrics means that many families actively planning parenthood can ensure coverage even though the expense was planned well before joining. The pre-existing condition rule permits members who have not previously been members to qualify for full benefit for expensive surgery by paying the annual contribution and simply waiting twelve months: often a shorter period than the wait for treatment in a public facility. (Sub. 29, p. 11)

There is nothing to stop such members leaving the fund once the service has been obtained and the fund benefits paid. Nor is there any way to prevent them rejoining later, if they need further treatment.

Peter Carroll commented that ‘as much as 80 per cent of the new business of the industry is effected by customers who know at the time of purchase they will be making a specific claim on the insurer’ (Sub. 9, p. 14). Available data about the extent of this problem are provided in chapter 7.

Clearly, the ‘hit and run’ phenomenon can be a pernicious form of adverse selection. There are a number of ways in which it could be ameliorated. Obviously, waiting periods could be increased for previously existing ailments. Although many health funds supported this approach, the APHA opposed extending maximum waiting periods — except for obstetrics — because it would cause confusion and ‘complicate any determination of whether a problem existed before taking out insurance’ (Sub. D217, p. 12).

The Department commented on an ‘anomaly’ in the 12 month waiting period introduced by the 1995 Amendment Act — that is, the amended requirement relates only to an ‘ailment or illness’. However, ‘there are a number of treatments such as cosmetic surgery that do not relate to an ailment or an illness’ (Sub. 175, p. 23). The Department indicated it would support amending the Act to reintroduce the term ‘condition’ into the requirement.

Chapter 10 discusses the question of waiting periods in more detail.



### **3.13 Approval of rules (including premiums)**

Each fund must have a constitution, articles of association and set of rules outlining conditions of membership, benefits and premiums. These are subject to regulatory oversight under section 78 of the Act. The rules of a fund are defined to include premiums.

Under the Act, rule changes are to be notified to the Department no later than 7 days in advance, in the case of premiums, and 60 days in advance for other changes, unless the Minister determines a lesser period.

With the announcement on 29 August 1996 that changes to fund rules affecting contribution rates would be approved by the Minister for Health personally in consultation with the Prime Minister and the Treasurer, 21 days notice has been requested by the Department (HBF Circular 461, 11 September 1996). This is not, however, a formal requirement under the Act. The Department noted that there have 'already been a couple of instances where this request has not been complied with' (Sub. 175, p. 22).

Rule changes are not formally approved by either the Minister or the Department. However, the Minister has the power to disallow changes where they:

- could breach a condition of registration or other section of the National Health Act;
- impose an unreasonable or inequitable condition affecting the rights of any contributor; or
- adversely affect a fund's financial stability (Sub. 175, p. 21).

A declaration by the Minister is reviewable by the Administrative Appeals Tribunal.

No application for a premium increase has been formally disallowed for many years.

### **Implications and issues**

According to the Department:

The rationale for government scrutiny of rule changes [including premium changes] is to protect community rating by ensuring that rule changes do not enable funds to discriminate against bad risks and to protect contributors by ensuring the changes do not threaten the financial stability of the fund. (Sub. 175, p. 22)

However, the Department recognised that applications for premium changes stood apart from other rule changes:

there are few circumstances in which premium increases might contravene the Act, and ... in many cases funds must take prompt action to increase premiums to address emergent financial circumstances. (Sub. 175, p. 22)

The Department supported continued ‘screening’ of price changes — that is, the continued scrutiny of proposed premium changes, before implementation, to ensure that the activity of funds falls within the legal requirements of the National Health Act. However, it accepted the ‘need for improvement’ in the existing process (Sub. D277, p. 6).

The ACA considered that there was a ‘clear need for funds to be accountable for premium rises’ (Sub. D238, p. 5). But it called for transparent monitoring by a government department or independent authority with regular reporting to health fund members and key stakeholders.

The industry generally considered that the requirements were, at best, unwieldy and unnecessary. The AHIA commented that:

Assumptions that health insurance should be a low cost commodity are unrealistic. The question should not be the price of health insurance per se, but ensuring that the price is no higher than necessary to ensure the purchase of quality care. (Sub. D221, p. 1)

It considered that the ‘existence of an extremely competitive health insurance marketplace ensures premium prices are kept to a minimum’ (Sub. 108, p. 11). Australian Unity considered that price competition is fierce for two reasons: any increase in price will cause a drop in membership; and fund members can move to another fund with no loss of entitlement. Thus ‘it is difficult to see what is achieved by government oversight of premiums’ (Sub. 163, p. 64). Further, ‘we are not aware that the Department has ever used this power to reject a proposed increase’ (Sub. 163, p. 64).

The Institute of Actuaries considered that:

If the regulator is closely regulating the solvency of each organisation, there is no need for premiums to be regulated by the regulator. If each insurance fund was required to have an actuary appointed, the actuary could be responsible for approving the premium rates for each product. (Sub. 141, p. 20)

MBF noted what it saw as a further serious drawback with the regulations relating to premium changes (and reserves requirements). There was:

a potential contradiction between the responsibilities of Directors under Corporation law and some health insurance regulations which limit the ability of Directors to respond appropriately to commercial realities. (Sub. 29, p. 10)

On at least one occasion in the past, regulation of premiums has caused difficulties for the health funds. PHIAC noted that:

in 1978 prior to an election, price increases for private health insurance funds were not permitted. Immediately after the election contribution rates soared and it became clear that a number of funds had been pushed close to zero reserves. Government involvement in price had an adverse effect that still affects the outlook of the industry as a whole. (Sub. 90, p. 104)

Premium restraint has recently been urged on the health funds by the Government and community. It has been reported that during the September 1996 quarter alone, the funds collectively suffered a loss of some \$65 million — this compared with a deficit of some \$80 million for the whole preceding financial year.

In responding to media reports that the Government might require all funds to adjust premiums simultaneously once a year, Medibank Private raised a number of objections: funds would shore-up larger reserves, price competition would be reduced, product launches would have less advertising impact, and premium increases could be overstated to ensure fund viability (Sub. D242, p. 12).

At a minimum, the requirements about rule changes, including premiums, add to the difficulty and uncertainty of doing business as a registered health benefits organisation. Further, there is a question as to the effect of the existing requirements relating to premium changes on the ‘financial stability’ of a fund.

### **3.14 Reserves**

Certain reserve requirements are imposed on funds under the National Health Act to ensure that contributors are protected from financial loss arising from funds being unable to meet their commitments.

Currently funds are required to maintain a specified minimum of \$1 million or two break-even contribution months of reserves, whichever is the greater. (A break-even month is the amount of monthly income a fund requires to operate at a break-even level by meeting its average benefit payments and management expenses.) This requirement now operates on a national basis. Before the introduction of the provision for national registration in 1995, open organisations were obliged to maintain minimum reserve requirements on a state-by-state basis.

Not all categories of asset can be counted for reserve requirement purposes — any assets that represent investments or loans to prescribed companies may be excluded. In addition, the Minister has power, after taking advice from PHIAC,

to exclude certain assets (eg goodwill) from the calculation. Such assets would generally not have a realisable value in the event of an organisation winding up its operations.

When a fund falls below the reserve requirements it must make application for an exemption, indicating the corrective action that will be taken to restore the required minimum reserves. Exemption applications are usually required to be accompanied by a report from an actuary. The Minister, after consulting PHIAC, may grant an organisation an exemption from the minimum reserves requirement.

Data about the number of funds in breach of the requirements and operating under exemption are set out in chapter 4.

If a fund collapses or is wound up, the National Health Act allows for a levy to be imposed on other registered organisations to meet these liabilities, proportionate to the size of their membership. It is, in effect, an industry-wide solvency guarantee. (Also see material on mergers and takeovers, above.)

In October 1995, the Department circulated a discussion paper on solvency and diversification issues to the industry. Following responses, the Department has developed the following preferred approach set out in box 3.22, which has been put on hold pending the outcome of the Commission's inquiry.

## Implications and issues

### *Need for specific requirements*

Some inquiry participants considered that special regulation of the reserves of private health insurers was not needed. For example, HIRMAA (supported by the Naval Health Benefits Society) considered that:

the most appropriate mechanisms for solvency are those that operate within the general business community and ... there is no need for additional and separate impositions within health insurance legislation. (Sub. 71, p. 9)

#### **Box 3.23: The Department's preferred approach to solvency and diversification**

- Maintain current requirements for open funds, but with trigger points for action by PHIAC with provision for automatic wind up or merger should reserves fall below 1 contribution month.

- Allow restricted funds to register with less than the current monetary requirement (\$1 million) to allow small employer, craft and union groups to establish themselves as funds.
- Require funds to keep one month's reserves in liquid form.
- Restrict diversified activity within the fund to health services or health related activity.
- Only diversified activity within the fund to count for solvency purposes.
- No restriction on diversified activities conducted through separate companies with funds being allowed to use reserves above the minimum requirement to engage in diversified activities.

*Source:* Sub. 175, p. 17.

MBF considered that:

The level of reserves required for prudent operation depends not on an arbitrarily established figure but on the capital needs and claims exposure of a fund and these vary from fund to fund. (Sub. 29, p. 12)

Others considered that a change of regulator was warranted. SGIC considered that health insurance should be regulated by 'a specialist team within the ISC' (Sub. 26, p. 6). As SGIO Health, it commented that the ISC has the 'necessary legal structure to create the legal independence, but also more importantly, has the culture that is independent' (Sub. D237, p. 17). And Peter Carroll considered that 'the industry is regulated as if it were an extension of social security rather than part of the financial system' (Sub. 9, p. 30). He called for the prudential regulation of the industry to be placed with the ISC, and 'prescriptive controls on product design, pricing and reserving' to be replaced with 'appropriate actuarial certifications' (Sub. 9, p. 34).

The Institute of Actuaries strongly supported the view that:

governance structures for the regulator should establish independence as its key feature and the regulator should: be clearly separated from the policy making bureaucracy; exclude representation by stakeholders in the management of the regulator; and hire or acquire the specialist skills needed to oversee regulatory compliance. (Sub. D218, pp. 4–5)

PHIAC noted that the Commissioner is independent from policy makers, and that, although the Commissioner is obliged to consult the Council (which includes industry representation), the Commissioner is not obliged to follow its advice (Sub. D262, p. 4).

### *Reserve levels and enforcement*

From those participants supporting prudential regulation under PHIAC, there was general agreement that some levels of minimum reserves should be specified, but that, as at present, there should be no controls over maximum levels of reserves. There was also a general view that the minimum reserve requirements should be specified as ‘trigger points’ at which certain specified actions would need to be taken. Participants proposed different trigger points and different actions to be taken.

At present, funds can receive exemptions from the specified requirements and continue to trade. The Department commented that there could be difficulties if an exemption were not granted: ‘a refusal to grant an exemption ... would probably lead to a costly and drawn out legal process’ (Sub. 175, p. 17). However, the fact that several funds have managed to continue under exemptions for some considerable time suggests that the present requirements may be inappropriate for those funds.

The AHIA considered that a step down approach should be applied equally to all funds, large and small. It considered that once a fund reached the final step (which it considered should be one month’s reserves), PHIAC should have the power to act; but an automatic closing down of a fund should not be triggered. HIRMAA argued against automatic windup or compulsory merger as directors’ responsibility and the Corporations Law should prevail (Sub. D204, p. 6). PHIAC considered that some flexibility should be preserved (Sub. D262, p. 3).

Other participants, including the Department, considered that if a fund breaches the final trigger point it should be closed down or merged. NMHI considered that:

It is more beneficial to the industry, consumers and government for members of funds that are unable to regulate their own levels of reserves, or ensure that their solvency margin is protected against unexpected crises, to be wound up or absorbed into more efficiently managed funds. (Sub. 140, p. 46)

### *Assets*

Requirements about reserves are specified to protect members of health funds. This has implications for the categories of assets which should be allowed to count towards the requirements.

NMHI stated that the current treatment of assets was inequitable because hospitals it operates are prescribed (because of their ownership structure), whereas similar investments by other major insurers are able to be counted for solvency purposes. (Sub. D210, p. 12).

PHIAC considered that the rules should be consistent for all registered organisations, with like assets treated in the same way, and the matter handled via regulation or guidelines, rather than legislation. Further it argued that it is important that the solvency rule take account of ‘the quantum and mix by type of both assets and liabilities’ (Sub. D262, p. 2).

### **3.15 Complaints Commissioner**

The *Private Health Insurance Complaints Commissioner* (the Complaints Commissioner) has operated only since early 1996. The Complaints Commissioner’s role is to deal with consumer complaints about matters associated with private health insurance arrangements, to publish aggregate data about complaints, to make recommendations to the Minister and the Department of Health and Family Services about regulatory and industry practices, and to promote the Private Patients Hospital Charter (Complaints Commissioner, 1996 *Annual Report*, p. 5).

The Complaints Commissioner is funded by appropriation which is recouped by the Commonwealth via an industry levy based on each fund’s membership. Some additional funding has been provided by the Department for publications and office accommodation.

The Complaints Commissioner’s powers to investigate complaints are limited. Health fund records and rules can be examined in order to investigate the practices and procedures of funds, but there are no powers to interview staff or make or request copies of records. Remedial action is limited to making recommendations to health funds, practitioners and hospitals.

In a submission to the Commission’s inquiry (Sub. 80), the Complaints Commissioner indicated concern over the lack of express powers to interview staff and obtain information from health funds. She considered that she needs to be provided with the statutory powers to interview health fund staff, obtain information, direct that specific action be taken by funds, and enforce sanctions on funds which fail to act on her recommendations. The Department (Sub. D277, p. 18) supported consideration of extending the powers of the Complaints Commissioner ‘to include an investigatory and conciliatory role and to changing the name to one which is less negative’.

Complaints received by the Complaints Commissioner are typically a consequence of lack of understanding by fund members of the products they have purchased. There are also complaints about misleading advertising, and

about how changes are communicated to members — see box 3.24. These are similar to concerns conveyed to the Commission — see chapter 6.

The Complaints Commissioner considered that a complete review of the pre-existing ailment provisions of the Act and of associated fund rules was necessary to clarify the rules about undiagnosed pre-existing conditions.

In relation to the information problems identified by the Complaints Commissioner, she considered that funds should develop plain English rules and make them available on request to their members.

She also considered that funds should provide membership guides containing information specific to the product purchased by the member and an industry-wide set of key information features. All significant changes to benefits and premiums should be notified by personalised letter, in advance as far as practicable. The ACA considered that the Commissioner should develop guidelines for health insurance advertising jointly with the Federal Bureau of Consumer Affairs and the industry.

The Commissioner considered that there was a need for an effective disputes resolution scheme to resolve disputes between hospitals and health funds about HPPAs.

### **3.16 Negotiation between funds, hospitals and doctors**

According to the Department, one of the objectives of the 1995 Amendment Act was to:

reduce the cost of private health insurance premiums and reduce the ever increasing cost of private health hospitalisation and treatment. (Sub. 175, p. 1)

The reforms were intended to formalise contractual arrangements between health funds and providers. They encourage funds to shop around, using their bargaining power to negotiate lower prices and more comprehensive services with their preferred hospital and medical providers, by establishing the total cost of an episode of treatment for a patient in a hospital or day hospital facility.

**Box 3.25: Complaints about health insurance received by the Complaints Commissioner**

**Waiting Periods.** Often, interpretation of the rules about waiting periods causes dispute. For example, premature births have led to disputes when funds have claimed that the nine month waiting period for such claims has not been completed. Disputes also arise



when funds refuse claims on the basis that a pre-existing ailment or illness was present in the six months before the contributor joined or upgraded cover.

**Benefit Entitlements.** Changes to benefit entitlements at short notice often cause disputes. Fund members who rely on fund brochures and benefit information provided when they first joined their health fund can sometimes have substantial unexpected out-of-pocket expenses when such changes occur.

Excesses cause problems when, for example, two periods of hospitalisation only shortly apart occur, but in different calendar or membership years.

Other complaints relate to the payment of claims for services provided in states/territories different from the contributor's usual residence — benefit levels may differ and consumers find they face unexpected out-of-pocket expenses. Limitations on benefits paid for ambulance use have arisen when funds have disputed whether the ambulance trip was really for emergency reasons.

Disputation can also arise about ancillary cover: for example, some funds will only pay ancillary benefits if the health service provider is registered with them.

Treatment at private hospital accident and emergency departments is not generally covered by private insurance, although many consumers are not aware of this fact. Although health funds can cover such treatment under ancillary cover, very few do so.

**Information and Advertising Complaints.** The common complaints are: concerns over the comprehensiveness and availability of information provided in fund brochures; advertising relating to tables with '100% hospital cover'. This statement has led some consumers to believe that all charges are covered, when in fact only hospital accommodation charges are. Some advertised 'waiver' of waiting times offers are in fact only offers to waive the 2 month standard waiting period for new members and not the longer waiting periods for obstetrics and pre-existing ailments.

**Acute Care Certificates (ACC).** Without an ACC issued by a treating doctor, a patient in hospital for more than 35 days continuously is automatically classified as 'a nursing home type patient' which attracts a lesser level of benefit than the acute care rate. The review of such certificates and subsequent reclassification of some patients long after the treatment has caused concerns to consumers, and the arrangements are being reviewed by the Department.

*Source:* Complaints Commissioner, Sub. 80.

Although the changes facilitate 100 per cent hospital cover, funds in both South Australia and Victoria had offered this prior to 1995. An important feature of the 1995 legislation is that it allows funds to offer coverage for in-hospital medical charges above the MBS if there is an MPPA in place between the fund and the doctor.

The forms of contractual arrangement permitted under the Amendment Act are set out in box 3.26.

Chapter 8 presents comments and covers issues relating to contracting.

### **Box 3.27: Forms of contractual arrangement**

*Hospital Purchaser-Provider Agreements* (HPPAs) may be made between health funds and hospitals (public and private) and/or day procedure centres. Apart from any patient copayment, which must be specified in an HPPA, the hospital or day hospital facility must accept the HPPA price in full payment by the fund covering the episode of care for eligible contributors. Some further information about HPPAs is set out in box 3.28.

*Medical Purchaser-Provider Agreements* (MPPAs) are between funds and doctors, relating to the provision of medical services to contributors in hospitals and day hospital facilities.

If an MPPA is in existence, a fund is able to pay medical benefits in excess of the MBS, thus enabling the elimination of out-of-pocket expenses for patients or set pre-determined copayments. (Where no MPPA exists, the fund is restricted to paying medical benefits up to a maximum of the amount between the Medicare rebate and the MBS fee.) Any pre-determined copayment must be identified in the MPPA.

As with the hospital contracts, up-to-date lists of the names of doctors who have entered such agreements must be made available by funds to their contributors.

Another form of medical agreement is a *Practitioner Agreement* (PA) between hospitals and doctors. These agreements do not enable reimbursement to fund contributors of medical expenses beyond the MBS rates.

The 1995 Amendment Act treats public and private hospitals equally: that is, it seeks to facilitate negotiations between funds and public hospitals on an equivalent basis to negotiations between funds and private hospitals. However, so far this ‘equivalence’ has not operated. This is because:

- health funds have limited incentives to negotiate with public hospitals — because of the Medicare Agreements their contributors cannot receive any preference in public hospitals (eg in terms of waiting times), and there is thus little reason for the funds to offer public hospitals more than the minimum default payment level; and
- public hospitals have limited incentives to negotiate with the funds — there is concern that payments higher than the minimum default levels would be ‘clawed back’ by the Commonwealth.

Submissions from NSW, Queensland, South Australia and Tasmania commented on these issues. The Tasmanian Minister for Community and Health

Services, for instance, considered that Medicare Principle 2 — which ensures access to public hospitals only on the basis of clinical need — may need to be relaxed. Further, any intention to claw back the extra revenue:

should be dropped, otherwise the incentive to increase fees in public hospitals towards the levels charged in the private sector may be reduced or removed if the additional revenue raised is simply to be handed back to the funds. (Sub. 182, p. 3)

The South Australian Government pointed out that in providing emergency treatment to private patients, public hospitals are entitled (under the 1995 Amendment Act) to higher fund benefits than would usually apply (see box 3.29). However, it was also concerned that the Commonwealth would claw back any amount above the minimum default paid in respect of non-emergency treatment.

Further, the potential claw back of amounts above the minimum default paid by the health funds to public hospitals would have an effect on competitive neutrality within the hospital sector. The South Australian Government considered that:

the system of state subsidies for private patients treated at public hospitals will continue under the reforms, and will likely remain around the same level as at present, in real terms. This places the state in a dubious position with regard to any obligations under the National Competition Policy to provide an ‘even playing field’. (Sub. D193, p. 21)

The Commonwealth Department also commented on the equivalence issue. It stated that:

there is merit in considering full economic charging of public services for private patients and replacement of the implicit subsidy to public hospital use by private patients with a transparent subsidy to the reinsurance pool. Such consideration should be made on the basis of a clear agreement between the Commonwealth, the states and the insurers: not unilateral action by a state government. (Sub. D277, p. 21)

The Department saw discussion taking place in the context of negotiating the next Medicare agreement.

The provisions of the Trade Practices Act also have an effect on how contract negotiations between funds, hospitals and doctors can proceed (see box 3.30).

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**Box 3.31: The Trade Practices Act**

Part IV of the *Trade Practices Act 1974* (‘the TPA’) is designed to prevent anti-competitive conduct, thereby encouraging competition and efficiency.

The National Competition Policy reforms provided, amongst other things, for the universal application of the 'competitive conduct rules' of the TPA to all sectors of the economy including the health care sector. The ACCC administers the Act and has been active in promoting information on the effect of the competition reforms on the health care sector. (In 1995, the ACCC produced a *Guide to the Trade Practices Act for the Health Sector*, which was designed to assist health care professionals and organisations to identify their rights and obligations under the provisions of the TPA.)

As a result of the introduction of the competition reforms, the contractual arrangements entered into by health professionals, hospitals and health funds are now monitored by the ACCC in order to 'determine whether their conduct promotes or hinders patients' interests in being able to choose among a variety of service and price options according to their needs'.

As the focus of the rules is on preventing price agreements as a result of collusion or joint negotiation positions, and on preventing a reduction of competition, the formation of health funds, hospitals, and doctors into groups for the purposes of negotiation is not generally allowed, unless it can be demonstrated that the reduction of competition this involves is in the public interest. Some smaller health funds have been able to group together as the Australian Health Service Alliance for the purpose of negotiating with hospitals and doctors.

The 1995 Amendment Act was also intended to achieve the development of aggregate billing arrangements by 1 July 1998. Under such arrangements, patients would receive only one bill covering all hospital and related medical services, rather than the many bills possible at present. Although the Advisory Committee allowed for under the Act has not been established, an informal Ministerial taskforce has been studying relevant issues. The Minister announced on 13 February 1997 that voluntary trials of simplified billing procedures would shortly begin, and would include supporting payment mechanisms together with procedures for informed financial consent for patients (Wooldridge 1997).

At the Mersey Community Hospital in Tasmania, HCoA is trialing an aggregate billing arrangement for medical and accommodation costs in cooperation with Medibank Private (Sub. D 248, p. 4).

A September 1996 Senate Committee report reviewed the changes made under the 1995 amendments. The Committee found that the legislation has not been successful in meeting many of its objectives, and made 24 recommendations for improvement. The Department stated that:

The Government is currently considering the recommendations from the Committee with the view to introducing legislation to overcome the most serious

flaws in the legislation. The Government intends to consult widely with the industry to develop specific suggestions for legislative change. (Sub. 175, p. 2)

Some of these issues are discussed further in other chapters of the report, particularly in chapter 8.

### **3.17 Rebates and levy**

As noted in chapter 1, in its 1996 Budget the Government announced financial measures to operate from 1 July 1997 to encourage people to maintain, or to take out, private health insurance.

The measures consist of rebates for families, couples and singles below specified income ceilings, who take out or maintain private health insurance, and a Medicare levy surcharge for those above (higher) specified income thresholds without private patient hospital cover (see box 1.1). For example, a family with less than \$70 000 annual taxable income can receive up to \$450 (taken as a reduction in premiums, or as a tax rebate) if it takes out or maintains private health insurance. And if a family with more than \$100 000 taxable income does not take up private patient hospital cover, a levy surcharge of 1 per cent of taxable income would apply.

The Commission has been asked to report on ‘the most effective means of ensuring that contributors receive the maximum benefit’ from these incentives.

As noted in chapter 2, the financial measures, set in the context of the Australian health care system generally, appear to have a number of objectives:

- relieving pressure on public funding;
- encouraging private provision;
- providing choice of public and private service provision, especially for low and middle income families; and
- assisting people to keep private insurance.

### **Participants’ comments**

#### *General comments*

The AHIA considered that the proposed incentives represented ‘the most effective way’ of targeting assistance to low income groups and to couples and families who are most likely to have difficulty in affording private health insurance (Sub. 108, p. 10).

A number of other participants supported the thrust of the AHIA's comments. For example, NMHI considered that the initiatives have good prospects of arresting and reversing the decline in membership. 'Moreover, they appear likely to make a net positive contribution to public budgets even if only moderately successful ...' (Sub. 140, p. 16).

Medibank Private, however, considered that the incentives 'may be uneven in their application as the target groups are those least likely to purchase private health insurance' (Sub. 168, p. 60). Queensland Health considered that the incentives 'will reward, by default, inefficiency in the industry and not allow it to compete on open terms' (Sub. 176, p. 9). The NSW Government considered that:

as the vast majority of these funds will be directed to the 34 per cent of the Australian population who already have private health insurance, it is considered that the incentives will do little more than stabilise the rate of drop-out from private health insurance, thus resulting in only marginally increased revenue or reduced demand for the public hospital system. (Sub. 180, p. 2)

Australian Unity remarked that: 'there is considerable doubt about the ability of these incentives by themselves to stabilise, let alone reverse, the decline in health fund membership' (Sub. 163, p. 34). Both Australian Unity and Medibank Private referred to research by TQA indicating the difficulty of encouraging people to take out private health insurance:

Encouraging people into private health insurance will be extremely difficult. Effective price reductions of around 25–30 per cent would be required, combined with a guaranteed cap on out-of-pocket expenses. (TQA 1995, p. 222)

### *Premium increases*

In responding to concerns that premium rises would reduce the benefit of the Government's incentives, the AHIA considered that fund members would still benefit from the rebates:

While AHIA acknowledges the price of health insurance must rise with general inflation and health care inflation, a competitive marketplace should ensure that rises will be minimal. Therefore the current incentive arrangement ensures a direct dollar reduction in the price, whatever it may be, will flow directly to those targeted. (Sub. 108, p. 10)

### *Longer term impacts*

However, the South Australian Government considered that the effect of the incentives would erode in the longer term:

unless the rebates are indexed to increases in operating costs of the funds, their value will erode with time and the fall in coverage will resume, albeit at a slower

rate than at present. Alternatively, the upward pressure on operating costs needs to be reduced to enable unindexed rebates to retain their relative value for a longer time. (Sub. 193, p. 24)

The APHA stated that there was no government commitment to extend the incentives past 20 June 2000, and that ‘the removal of the subsidy is likely to cause a significant and immediate reduction in membership’ (Sub. D217, p. 19).

### *Suggested improvements*

Individual health funds made a number of suggestions which they considered would improve the effectiveness of the incentives. For example,

- MBF considered that their value should depend on the level of cover and the members’ use of deductibles (Sub. 29, p. 7).
- Australian Unity Friendly Society suggested the replacement of fixed dollar amounts with a percentage discount on premium; and considered that the income cut-off points for the rebates and the Medicare surcharge should be aligned.
- The APHA supported smoothing arrangements to remove the marginal taxation effects at the income thresholds for both the rebates and surcharge (Sub. D217, p. 19). The Consumers’ Health Forum also suggested a form of phasing in of the surcharge (Sub. D254, p. 5).

In regard to rebates for ancillary cover, the APHA commented that there appears to be little justification for them. And NMHI stated that it would not object to the rebates on ancillaries being abandoned, with the resources concentrated on hospital products.

### *Administration*

Australian Unity commented that consideration also needed to be given to administrative matters such as the issue of periodic payment of contributions and the possibility of termination of insurance during the year. Medibank Private was concerned about the possible cost of administration. The Commission notes that the relevant bills have now been introduced into Parliament, and that a working party has been established to consider relevant administrative matters. HIRMAA outlined two areas of dissatisfaction with the proposed arrangements: the need for claimants to register with health funds annually (rather than only once initially); and arrangements for reimbursement to health funds for reductions in premiums (funds may carry some of the cost of the rebates for some considerable time) (Sub. D273, pp. 1–2).

### *Alternative approaches*

There were some suggestions for different means entirely of encouraging private health fund membership. These included improving the attractiveness of the product by: means testing public hospital provision; allowing age-related premiums through lifetime community rating; extending tax concessions to individuals or employers. For example, the National Association of Nursing Homes and Private Hospitals supported means testing of access to the public hospital system (Sub. D227, p. 2). And the Australian Catholic Health Care Association considered that:

A more sensible and targeted program would be the direct rebate for utilisation of private hospital services by the elderly, chronically ill and low income people. (Sub. 150, p. 1)

Indirectly, this would improve the attractiveness of private health insurance. Similarly, the AMA considered that the incentives should be targeted at those who use the private health system by providing a benefit at the time of use of the service. HCoA also supported directing funding to utilisation in private hospitals.

Some participants supported directing the funding towards the public hospital system. The NSW Government considered that ‘the investment of \$500 million in the public hospital system would produce more public benefit than the family incentives package’ (Sub. 180, p. 2). Similarly, the Council on the Ageing considered that the incentives are ‘poorly targeted’ and the funds could be better allocated to improvements in public hospitals (Sub. D246, p. 5).

The Institute of Actuaries thought ‘a better use’ would be a direct contribution to the reinsurance account ‘thereby alleviating, to some extent, the age-related cross subsidies’ (Sub. 141, p. 2).

However, the AHIA considered that other systems such as payments to reinsurance, direct subsidies to health funds, bed day subsidies, and grants to individuals conditional on hospital admission would be less effective in assisting low income earners. In its submission, the Department compared a number of possible alternatives to the incentives, and considered there were shortcomings in all of them.

### *Employer issues*

A submission from the Employers Health Group queried the application of the rebates in cases where employers paid health insurance premiums for their employees:



Employers are anxious to maintain health cover for employees but ... could not justify continuation (either economically or on the grounds of equity between employees) where certain of their employees gain tax relief on premiums not paid by those employees. (Sub. 91, p. 9)

It proposed the optional direction of the rebates to employers in that situation (negotiated between employees and their employer on an 'all in/all out' basis) (Sub. D219, p. 3). However, the Department has indicated (in correspondence with the Commission) that, if an employer pays private health insurance premiums on behalf of its employees, that employer is entitled to receive a reduction in premiums in respect of those employees that are eligible to participate in the scheme. The employer will need their eligible employees to register with their health fund, in order to receive a reduction in premium. It should be noted that, unlike individuals claiming the rebate, employers will not be able to claim the payment on behalf of their employees in the form of a tax rebate at the end of the year.

### *Self-insurance*

Several participants raised the question of those who self-insure. Those people who fund their own treatment in the private hospital system also save public healthcare expenditure. ACA stated that:

Consumers should have a choice of whether they want health insurance funds to handle the health services they desire to complement Medicare and not be discriminated against because they choose to save (something the coalition Government would certainly want to encourage) and self-insure. (Sub. 77, p. 13)

This was opposed by the AHIA and some other participants, including the Department. According to the AHIA, the incentives are intended to encourage the take up of insurance, and providing them to the uninsured negates that intention (Sub. D221, p. 4).

## **Implications and issues**

In assessing the incentives a number of issues arise:

- whether the incentives are likely to encourage private insurance;
- whether there will in fact be a saving in public finances, bearing in mind the \$600 million annual cost of the incentives;
- the overall community benefit, given that the incentives would shift costs from the public to the private sector;
- the structure of the incentives;

- inclusion of ancillary cover;
- administrative issues; and
- treatment of those who self-insure.

*Likely impact on membership, and budgetary effects*

The rebates can provide quite high rates of assistance (see table 3.1). For a family, with ‘top cover’, for example, the rebate of \$350 for hospital cover can represent about 25 per cent of the premium, with about 15 per cent of the ancillary premium covered by the additional \$100 rebate. On cheaper tables, because the rebates do not distinguish between levels of benefit, they would offer much higher rates of assistance. Because premiums vary significantly between states, the rates of assistance can also vary significantly.

As the rebates are not indexed, these rates of assistance will decline if health fund premiums continue to increase. For example, if hospital cover premiums were to continue to increase at about the present rate of 10 per cent per year, then the rate of assistance for top hospital cover for families would decline from the 25 per cent shown in table 3.2 to about 23 per cent in the second year, and 21 per cent in the third. To provide equivalent rates of assistance in the third year, total rebates would need to be set at about \$730 million.

The Medicare surcharge can provide even larger incentives to take out or maintain private cover. The minimum surcharges of \$500 for singles and \$1000 for families compare with maximum financial rebates of \$125 and \$450, respectively. Indeed, those amounts of surcharge would often more than pay for basic private patient hospital cover.

Table 3.3: Rates of assistance provided by the rebates (% of premium)

<i>Type of cover</i>	<i>Singles</i>	<i>Couples</i>	<i>Single parent families</i>	<i>Families</i>
<u>Hospital</u>				
Blue ribbon	14	14	25	25
Blue ribbon excess (level 1)	17	17	30	30
Blue ribbon saver (level 2)	24	26	48	42
<u>Ancillary</u>				
Super extras	7	7	15	15
Special extras	10	10	21	21
First choice	14	na	na	na

Note: As premiums vary significantly between states, the rates of assistance can similarly also vary significantly.

Source: Estimates based on tables and rates shown in Medibank Private's December 1996 brochures for New South Wales/ACT.

The rates of assistance in table 3.4 are expressed in terms of current premiums. However, it is possible that changes in the composition of membership brought about through the rebates — and the surcharge — could have an effect on fund expenses and premiums. The Department considered that:

- it is likely that the new membership due to the incentives will be of worse health risk than the population at large, but probably not as poor a health risk on average as those currently insured; and
- the Medicare surcharge is likely to attract new members with better than average health risk, and certainly better than those currently insured (Sub. 175, p. 47).

Although the AIHW commented that it may be the young and healthy who are attracted to health insurance as the result of the incentives, it considered there is some evidence to suggest that the old and the sick may be equally, if not more, attracted to private health insurance:

- the elderly have been holding onto private health insurance as the price has increased more than people in younger age groups, suggesting that it is of more value to them; and
- the perception of longer waiting lists in the public health system for treatments common for the elderly may also encourage them to purchase private health insurance with the aid of the incentives (Sub. D202, p. 6).

Set against this, though, the rebates appear to offer more assistance to the young with children than to older singles and couples. The former group are more likely to have saver-type products (with rates of assistance of 40–50 per cent), and the latter top cover products (with rates of assistance of about 15 per cent).

Further, MBF Healthwatch survey data (reproduced in table 3.5), show that the rebates are more likely to influence younger people to take out or retain private health insurance than older people.

**Table 3.6:** Survey data on the likely effect of the health insurance rebates, November 1996 (percentage of respondents agreeing)

<i>Effect</i>	<i>16–24 age group</i>	<i>25–34 age group</i>	<i>35–49 age group</i>	<i>50+ age group</i>	<i>Total</i>
Encourage retention of private health insurance	81	72	64	58	64
Encourage to obtain private health insurance	49	44	31	25	36
Encourage return to private health insurance	64	43	29	21	29

*Source:* CATI 1996.

Whatever the net effect on premiums of changes in membership composition, it is unlikely that such large financial rebates and surcharges would not have a positive effect on private health insurance membership levels. In terms of the Government's objectives, however, one important question is whether the retention and take-up of membership, and the consequent shifting of cost from the public to the private sectors, would exceed \$600 million per year.

The Department's submission estimates that the rebates/surcharge arrangements could increase the participation rate of the community in private health insurance by June 1998 to about 35.5 per cent. This compares with an estimate for June 1997 of 32 per cent under current arrangements. Thus, the arrangements are expected by the Department to increase participation by a minimum of 3.5 percentage points — about 640 000 persons. Of this, the Department anticipates that 2 percentage points (366 000 persons) is due to the rebates, and 1.5 percentage points (275 000 persons) to the extra Medicare levy.

The former figure represents a departmental estimate of the likely response to the price changes arising from the rebates. The latter estimate for the surcharge was derived by simply assuming that two-thirds of those falling within the

relevant income categories without private health insurance at present would take it out rather than face the Medicare surcharge.

However, the Department's estimates imply that without the Government's measures, participation would have continued to decline in 1997–98 at the expected 1996–97 rate of about 1.7 percentage points. Thus, the total effect of the measures (using the Department's figure) could amount to about 5.2 percentage points — about 950 000 persons. Of this, about 3.7 percentage points (or 677 000 persons) could be due to the rebates, and 1.5 percentage points (or 275 000) to the surcharge.

This initial positive effect is likely to be one-off in the sense that increases in premiums in future years are likely to adversely affect fund membership. As a rough generalisation, annual participation rate falls of about 2 per cent have been associated with average annual premium rises of about 10 per cent.

Apart from the Department, no other participants provided quantified estimates of the likely effects of the measures. Some, including the AHIA, commented that the incentives would do no more than stabilise membership — this implies an effect of about 2 per cent in terms of participation rate.

The Commission notes that the Department's estimates of the possible effects of the measures are not based on hard information or analysis. Indeed, the Commission considers that estimating these possible effects on membership with any degree of precision is not feasible:

- there is no reliable Australian information available about the responsiveness of consumers to the price of private health insurance;
- the measures will give a 'large' change in price — up to 100 per cent in the case of the surcharge, but most assessments of consumer responsiveness relate to relatively small changes;
- available assessments relate to premium increases, rather than decreases — but the effects may not be symmetrical. Ian McAuley commented: 'it is speculative but I would suggest that there is some degree of hysteresis in demand and income elasticity' (Sub. D193, p. 3);
- not all consumers are eligible for the rebates, nor subject to the extra levy;
- private health insurance is extremely heterogeneous in the number of different products it offers — and the measures will provide widely differing assistance on different products, and in different states;
- the October 1996 changes to membership categories, and the cessation of requirements about premium relativities, further complicate this situation;

- the ‘quality’ of cover can change — for example, 100 per cent cover has become more widely available; and
- it is possible that the declining participation trend may bottom out of its own accord.

Thus, the Commission can neither endorse the Department’s estimates, nor provide any firm estimates of its own. It can be concluded, however, that although the Government’s incentives are likely to encourage people to maintain or to take out private health insurance, and will result in Medicare savings, it is unlikely that there will be net budgetary savings, taking into account the costs of the incentives. Box 3.32, based on the Department’s estimates of the possible change in membership, indicates that the net budgetary cost of the incentives is likely to be quite large.

### *Allocative efficiency*

The incentives will have the effect of further shifting the balance of health financing and health provision from the public to the private sector. In terms of service provision, an important issue is the relative efficiency of the two sectors.

For a number of reasons, however, comparing the relative efficiency of the public and private hospital sectors is fraught with difficulty. For example:

- different institutional arrangements apply in the two sectors;
- average data may disguise differences in treatment complexity;
- averages disguise ‘best practice’; and
- the situation is dynamic, with constant change in medical technology, and ongoing cost efficiencies, for example, in response to the incentives of casemix funding in the public sector.

Detailed study of whether transfer of service provision from the public to private sectors increases or reduces efficiency overall is beyond the scope of the inquiry.

**Box 3.33: Estimating the possible budgetary savings and costs of the rebates/surcharge arrangements**

Assume that those transferring to private hospital fund membership have the average hospital experience of those persons aged under 65 who are already privately insured.

For each 1000 lives covered, insured people each year use on average 155 public hospital bed days (as private patients), and 442 private hospital bed days (Sub. 158, p. 12, data for 1996).

- The revenue gain to Medicare for the transfer of 155 patient bed days in public hospitals from public to private status is about \$31 000, assuming the average contribution per day is \$200.
- The cost saving to Medicare from a transfer of 442 patient bed days out of the public system to private hospitals is about \$221 000, assuming the average bed day cost in a public hospital is about \$500.
- Thus, for each 1000 people transferring to private insurance, the total saving to Medicare would be about \$252 000 (excluding any net change in medical costs).

**Rebates**

Total annual savings from transfer of 677 000 persons = \$171 million

Total annual cost (including running costs and any extra Medicare costs) = \$600 million approx.

**Levy surcharge**

Total annual savings from transfer of 275 000 persons = \$69 million

Total annual revenue from extra levy = \$40 million net

**Combined effect**

Total annual savings = \$240 million

Total annual cost = \$560 million

**Estimated net annual budgetary cost = \$320 million**

This estimate is relatively invariant to changes in assumptions. For example, if the rebates were to increase membership by 2.7 percentage points (or by 4.7 percentage points), rather than 3.7, the estimate for net cost would increase (decrease) by only about \$30 million. This is because the change in public hospital costs is partly offset by the change in the cost of the rebates. Further, any additional hospital cost saving arising from a greater take-up of private health insurance due to the surcharge would be offset by the reduction in extra levy revenue.

*Source:* Commission estimate, using the Department's estimate of possible membership changes — see Sub. 175.

### *Incentive structure*

Obviously, much of the Government's rebate would be paid to families and individuals who already have private health insurance. Leaving aside consideration of whether the rebate should properly be seen as some recompense for the Medicare levy already paid by those who use private facilities, this suggests that more targeted measures might be better in meeting the Government's objectives overall.

The incentives operate quite differently for those in different circumstances. Table 3.7 illustrates the way the incentives will work for families:

- There is a range of income for which there is to be no rebate, and no levy surcharge.
- The structure of the incentives for singles, and for couples, is also very uneven.
- And there are no separate rebate arrangements for single parent families (they count as families), although that category can now be separately covered by the funds (see section 3.18).

**Table 3.8: Financial incentives for families**

<i>Family income</i>	<i>Rebate</i>	<i>Levy surcharge</i>
Less than \$70 000 (rising by \$3000 for each additional child)	\$350 for hospital cover \$100 for ancillary cover	Nil
Between \$70 000 and \$100 000	Nil	Nil
In excess of \$100 000	Nil	1 per cent of taxable income (if no private health insurance)

A number of further comments can be made about the structure of these incentives on the basis of tables 3.9 and 3.10:

- rebates:
  - are not related to premiums charged by the funds; thus the subsidy effect varies;
  - do not vary between funds which charge different premiums for similar benefits;
  - are not related to the coverage obtained, that is, there are no differences for tables with excesses or deductibles;
  - do not vary within the eligible income range;



- contain no phasing provisions, so that, for example, at a family income of \$69 999 a rebate of \$450 can be obtained — but with an extra dollar of income, no rebate is available;
- levy:
  - also contains no phasing provisions, so that with a family income of \$100 000 no surcharge is payable, but with an extra dollar of income a levy of \$1000 will apply.

Thus, apart from any effects on health insurance participation, the incentives will have quite different marginal tax effects at different income points, with quite severe effects at the income break-points of \$70 000 and \$100 000 for families, and \$35 000 and \$50 000 for singles. This, in turn, is likely to generate strong incentives for strategic behaviour by some income earners (and employers), for example, to package salaries so as to gain the rebate, or to avoid the levy.

### *Ancillary cover*

Rebates are also available for ancillary cover — even if hospital cover is not held — albeit at lower levels and rates than those available for hospital cover.

In comparison with hospital services and payment, most ancillary services are already provided by the private sector, and funded privately. Thus, an increased take up of ancillary cover in response to the incentives may not help much in terms of the Government's objective of moving health expenditure off the public budget.

Given that rebates for hospital cover are likely to have much greater success in terms of that objective than those for ancillary cover, the money set aside for the ancillary benefits might be better spent in that respect by giving additional encouragement to hospital cover.

### *Administrative issues*

People can choose to have the rebate paid directly to their health fund in return for a guaranteed reduction in premiums or they may choose to receive the payment as a taxation rebate after the end of the financial year. Bills introduced into Parliament late in 1996 set out broad details of the proposed administrative arrangements.

It is important that the working party set up to consider detailed administrative issues clarifies exactly how the rebates will work in practice. Attention should be given by the working group and the Department to minimising administrative

and compliance costs as far as possible. As noted by SGIO Health, adequate time needs to be given for the health funds to implement the required computer software and other system changes needed (Sub. D237, p. 21).

### *Self-insurance*

Some participants considered that government assistance should be extended to those who self-insure. (MBF considered that these people are more correctly termed ‘uninsured’ (Sub. D203, p. 12). Those people pay for their own private treatment and save taxpayers the expense of providing public treatment.

However, those who self-insure may not necessarily be significantly disadvantaged relative to those who take out private health insurance. Although many of this latter group will be eligible for the insurance rebates, all taxpayers, whether self-insured or not, are eligible for the medical expenses income tax rebate. For the 1996–97 income year, this will provide a rebate of 20 cents in the dollar for expenditure in excess of \$1430 on a range of health services.

By definition, those who self-insure would have (on average) much larger out-of-pocket hospital charges to meet than those who are covered by private health insurance, and so are likely to take greater advantage of the medical expenses income tax rebate. Set against this, however, the insurance rebates will be available each year, whereas, for most people, hospital treatment is infrequent.

## **3.19 Issues relating to Medibank Private**

Medicare Private was established in 1976. According to the AHIA, the Government provided it with significant ‘seed’ money which allowed the fund to expand into the market in ‘an aggressive manner’ (Sub. 108, p. 47). However, Medibank Private stated the claim that it had been advantaged by seed money was incorrect (Sub. D242, p. 9).

Medibank Private has expanded to become the largest private health fund — it operates in all states and territories.

The AHIA commented that the number of funds had reduced from 92 at the introduction of Medicare in 1983, to 76 in 1995 (before the introduction of national registration).

Medibank Private stated that its influence within the industry had been positive. It had introduced products which were ‘ahead of the market’ and had ‘added value to members and the industry’ through these innovations (Sub. 168, pp. 29–30).

Some participants, however, considered that Medibank Private had marketing and cost advantages not available to other funds.

According to SGIC Health, part of the reason for Medibank Private being the only true national fund is that it is the sole agent for Medicare: ‘anyone making a claim at a Medicare branch is inundated with advertising for Medibank Private’ (Sub. 26, p. 5). Together with funds such as NMHI and Westfund, SGIC called for all health funds to be allowed to be agents for Medicare.

The Department indicated that this possibility was being considered by the Ministerial taskforce examining simplified billing arrangements (Sub. D277, p. 15). Medibank Private submitted details of the additional costs which it considered allowing funds to act as Medicare agents would entail — they could be up to \$22 million for initial set-up, and annual ongoing costs of about \$46 million (Sub. D242, p. 11). In response, HCF (for example) recognised that there would be costs, as well as benefits, and these would have to be weighed up (Sub. D278, p. 3).

There were claims that Medibank Private enjoyed cost advantages. For example, the Australian Unity Friendly Society considered that ‘co-location means that Medibank Private enjoys prime commercial sites at a significantly lower cost than any other fund would face for the same location’ (Sub. 163, p. 59).

Some participants queried why Medibank Private should remain in government ownership. The AHIA commented that: ‘the Commonwealth has no more role in operating a private health insurance organisation than in running an airline’ (Sub. 108, p. 68). NMHI stated that it is not clear ‘in terms of competitive neutrality principles, why the Commonwealth needs to own a health insurance business at all’ (Sub. 140, p. v). It considered that Medibank Private should be de-linked from Medicare and privatised, or at a minimum, fully commercialised (including being subject to tax or tax equivalent payments along with other insurers). Australian Unity commented that Medibank Private:

provides no significant community service obligations or primary infrastructure. It operates in a highly competitive market and is subject to no direct government support, other than the indirect commercial advantage of shared accommodation costs with Medicare retail service outlets. (Sub. 163, p. 60)

It considered that Medibank Private could be first corporatised, and then ultimately privatised:

the privatisation of Medibank Private should be considered as a means of attracting a new operator into the health insurance market, with sufficient scale to drive overall industry efficiency and productivity through competitive endeavour. (Sub. 163, p. 60)

However, Medibank Private commented that:

Medibank Private operates on a competitive neutral basis with its competitors, with minimal change being required to meet every one of the competitive neutrality principles ... (Sub. D242, p. 9)

And in regard to the possible separation of Medibank Private from the HIC, Medibank Private commented that this would:

in time only add to objections [from other funds] about us as a competitor, with greater freedom for imaginative and innovative products, both of which have been the hallmark of Medibank Private, leading to further gains in our market share. (Sub. D 242, p. 10)

In entering the Competition Principles Agreement of April 1995, all Australian Governments undertook to introduce nationwide reforms to competition policy. Part of the agreement relates to 'competitive neutrality': meaning that government business activities should not enjoy net competitive advantages over their private sector competitors simply by virtue of public sector ownership.

A process of implementation of the agreement is now under way. A competitive neutrality task force, under the chairmanship of the Treasury, is currently considering issues relating to Commonwealth entities, including the Health Insurance Commission (which operates Medibank Private). The task force is due to report by March 1997.

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## 4 STRUCTURE AND PERFORMANCE OF THE INDUSTRY

Declining membership, particularly among the young and healthy, has led to concerns about the longer term viability of private health insurance. Some see a crisis developing in the industry.

The Tasmanian Minister for Community and Health Services said:

This Government recognises the crisis in private health insurance and has concerns relating to the drop in contribution [membership] rates to private health insurance. (Sub. 182, p. 1)

The Royal Australasian College of Surgeons was concerned about the broader ramifications:

We believe it to be essential that the number of insured people is increased to ensure the viability of a private health service ... (Sub. 27, p. 1)

This chapter supplies information about the organisations providing private health insurance and the range of products they offer. It examines the operations and performance of these organisations.

Chapter 5 assesses the nature and extent of competition within the industry, while chapter 6 examines the characteristics of health insurance members and the factors determining the demand for health insurance.

### 4.1 Structure of the industry

#### Nature and number of organisations/funds

There are 48 registered health insurance organisations (box 4.1). Of these, 30 are potentially open to anyone to join, while the remaining 18 are restricted membership organisations (RMOs), operating as ‘closed funds’. With only three exceptions, funds are operated on a ‘not-for-profit’ basis.

The three organisations now operating on a ‘for-profit’ basis are National Mutual Health Insurance Pty Ltd (NMHI), FAI Health Benefits Ltd (FAI) and SGIO Health Pty Ltd (since 1 January 1997). FAI’s health insurance business has only a very small share of the market (0.2 per cent of members). With the change in status for part of NMHI business to for-profit from 31 December

**Box 4.2: Health insurance organisations<sup>a</sup>**

<b>Registered names</b>	<b>Total members</b>
Health Insurance Commission (Medibank Private)	889 474
Medical Benefits Fund of Australia	660 270
National Mutual Health Insurance Pty Ltd#	396 110
Hospitals Contribution Fund of Australia Ltd	291 395
Hospital Benefits Fund of Western Australia (Inc.)	267 646
NIB Health Funds Ltd	186 238
Australian Unity Friendly Society	125 378
Government Employees Health Fund*	91 913
New South Wales Teachers' Federation Health Society*	51 667
SGIC Health Pty. Ltd <sup>b</sup>	43 068
Army Health Benefits Society*	41 047
Manchester Unity Independent Order of Oddfellows Friendly Society in NSW	40 765
Geelong Medical and Hospital Benefits Association Limited	35 785
Commonwealth Bank Health Society*	31 637
IOR Australia Pty Ltd	26 741
Queensland Teachers Union Health Society*	17 755
Health-Partners	17 046
St Luke's Medical & Hospital Benefits Association	15 194
Latrobe Health Services Inc.	14 701
Railway & Transport Employees' Friendly Society Health Fund*	14 364
CUA Members' Benefits Friendly Society	13 349
Grand United Friendly Society	12 702
Health Insurance Fund of W.A.	12 553
Australian Health Management Pty Ltd	12 097
Naval Health Benefits Society*	11 660
Independent Order of Odd Fellows of Victoria	10 346
Western District Health Fund Ltd	10 134
Transition Benefits Fund Pty Ltd*	9 866
Mildura District Hospital Fund	9 226
FAI Health Benefits Ltd#	8 350
MIM Employees Health Society*	7 436

**Cont'd****Box 4.1: Cont'd**

Goldfields Medical Fund (Inc.)	6 716
Phoenix Welfare Association Ltd*	5 843

Lysaght Hospital and Medical Club*	5 782
Yallourn Medical and Hospital Society	4 836
South Australian Police Employees' Health Fund Incorporated*	4 811
United Ancient Order of Druids	4 386
CPS Health Benefits Society	4 218
AMA Health Fund Ltd*	3 944
ACA Health Benefits Fund*	3 722
Health Care Insurance Ltd*	3 226
Transport Friendly Society*	3 106
Reserve Bank Health Society*	3 054
Healthguard Health Benefits Fund Limited	2 805
Queenstown Medical Union Health Benefits Fund	2 553
United Ancient Order of Druids Registered Friendly Society Grand Lodge of NSW	2 395
CDH. Benefits Fund	1 372
'The Sydney Morning Herald' Hospital Fund*	1 222
a	Registered names of organisations operating during 1995–96 and membership at 30 June 1996.
b	SGIC Health Pty Ltd converted to a new for-profit licence in a new company, SGIO Health Pty Ltd from 1 January 1997. SGIO Health Pty Ltd operates as SGIC Health in South Australia and SGIO Health in Western Australia.
Notes:	* Restricted membership organisations.
	# Organisations registered under subsection 68(2A) of the National Health Act (ie. may be carried on for the purpose of profit or gain to the individual members or shareholders).
Source:	PHIAC 1996a.

1995, and from 1 January 1997 for SGIC Health, the for-profit sector has increased in significance and now represents almost 13 per cent of members nationwide.

The number of organisations offering private health insurance has declined through the 1990s (table 4.1). While there are fewer organisations, it appears some have expanded their operations by entering into other states, as evidenced by the rise in the number of funds from 67 (June 1989) to 91 (June 1995).

The 1995 Amendment Act introduced national registration, removing the requirement for health insurance organisations to have a separate fund for each state in which they operated. (This placed open funds on an equal footing with the RMOs.) Thus, the number of funds has declined from 91 at 30 June 1995 to 48 at 30 June 1996.

Table 4.1: Changes in the number of health organisations and funds

<i>At 30 June</i>	<i>Number of organisations</i>			<i>Number of funds</i>		
	<i>Non-profit</i>	<i>Profit</i>	<i>Total</i>	<i>Non-profit</i>	<i>Profit</i>	<i>Total</i>
1989	56	4	60	62	5	67
1990	55	4	59	70	5	75
1991	52	2	54	71	2	73
1992	51	2	53	70	12	82
1993	49	2	51	76	12	88
1994	47	2	49	79	12	91
1995	47	2	49	79	12	91
1996	46	2	48	46	2 <sup>a</sup>	48 <sup>b</sup>

a From 1 January 1997, the number of for-profit funds increased to 3, with SGIC Health Pty Ltd converting to a new for-profit licence in a new company, SGIO Health Pty Ltd.

b The introduction of national registration meant that the number of funds operating was effectively reduced to 48 at 30 June 1996.

Source: PHIAC annual reports.

The Commission estimates that private health insurance organisations employed around 5700 persons at 30 June 1996.<sup>1</sup> There are no available data on trends in employment. AHIA has indicated that for a small subset of AHIA funds, there has been a decline in employment of around 30 per cent over the period from 1991 to 1996.

## Market shares

The Australian private health insurance market – for both hospital and ancillary cover – comprised around 3.4 million members, covering over 7.4 million people (equivalent to 5.3 million SEUs) at 30 June 1996. The six largest organisations (shown in table 4.2) accounted for 78 per cent of this market, while thirty-five organisations shared less than 10 per cent.

Together the three largest health organisations provided private health insurance cover for well over half of all members:

<sup>1</sup> This estimate is based on employment data obtained from nine of the larger private health organisations and a small number of restricted membership organisations (accounting for 85 per cent of membership). The national employment figure has been extrapolated from this, on the basis of membership numbers. However, this figure may be overstated because of the less labour-intensive nature of many of the smaller RMOs.



- Medibank Private, operated by the Health Insurance Commission (HIC) — a Commonwealth statutory authority — is the largest private health insurer in the country. Under its establishing Act of 1975, it is required to operate in all states.
- Medical Benefits Fund of Australia Ltd (MBF) is the second largest insurer and the largest privately managed health fund, operating in all states except WA (where it has no branches but some limited membership).
- NMHI is the third largest health insurer. It operates in Victoria and South Australia under the names of Hospital Benefits Association (HBA) and Mutual Community, respectively.

Table 4.3: Membership and market shares of major health organisations, 30 June 1996

<i>Organisation</i>	<i>Membership</i>	<i>National market share</i>	<i>Cumulative market share</i>
	<i>no.</i>	<i>%</i>	<i>%</i>
Medibank Private	889 474	25.9	25.9
Medical Benefits Fund of Australia	660 270	19.2	45.1
National Mutual Health Insurance	396 110	11.5	56.6
Hospitals Contribution Fund of Australia	291 395	8.5	65.1
Hospital Benefit Fund of WA	267 646	7.8	72.9
NIB Health Funds	186 238	5.4	78.3
Other open organisations	436 716	12.6	90.9
Restricted membership organisations	312 055	9.1	100.0
<b>National total</b>	<b>3 439 904</b>	<b>100.0</b>	

Source: PHIAC 1996a.

### State and regional distribution

For open organisations, table 4.4 shows the proportion of members accounted for by the three largest insurers in each state and the Northern Territory. Two or three organisations cover the bulk of membership for private health insurance in each state and territory.

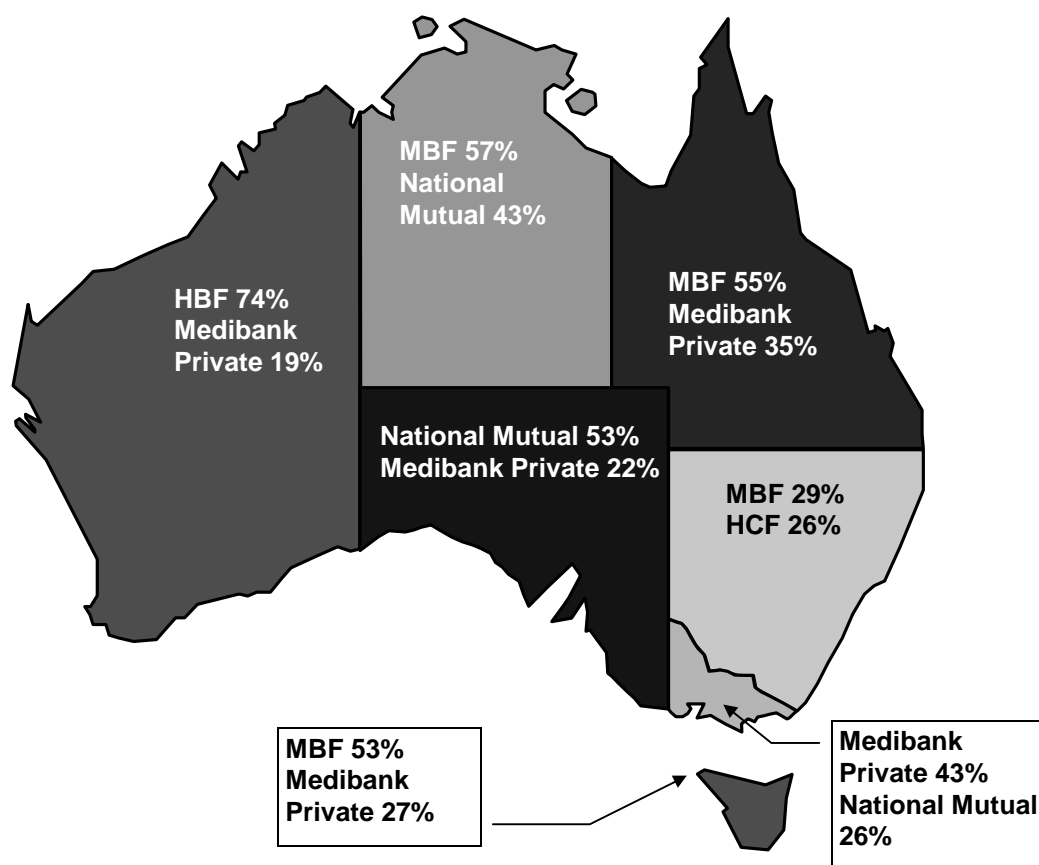
In five of these seven market segments (see table 4.5), a single insurer covers more than 50 per cent of members. In the other two — namely, Victoria and New South Wales — more than half the market is shared between two insurers. The major insurers and their share of members for each state and territory are indicated in Figure 4.1.

**Table 4.6: Degree of seller concentration for open funds by state/territory, 30 June 1996**

<i>State/territory</i>	<i>Largest insurer % of membership in state/territory</i>	<i>Largest two insurers % of membership in state/territory</i>	<i>Largest three insurers % of membership in state/territory</i>
Northern Territory	57	100	na
Western Australia	74	93	97
Tasmania	53	80	97
Queensland	55	90	93
South Australia	53	75	88
Victoria	43	69	86
New South Wales (including ACT)	29	55	76

Source: PHIAC 1996a.

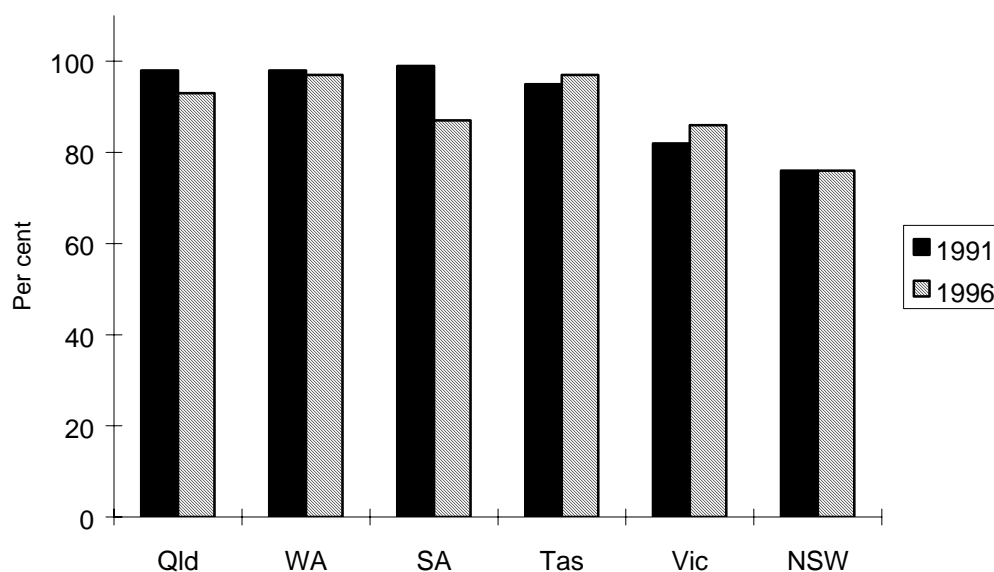
**Figure 4.2: Major insurers' share of members by state/territory, 30 June 1996**



Source: PHIAC 1996a.

Changes in the dominance of the three largest insurers for each state (expressed as a share of members), are shown in figure 4.3. The experiences of the states are mixed. The dominance of the three largest insurers declined in South Australia, Queensland and (marginally) in Western Australia between 1991 and 1996, but increased in Tasmania and Victoria.

Figure 4.4: Concentration (as per cent of members) of three largest insurers by state, June 1991 and June 1996



Source: PHIAC 1996a, 1991.

There are also a number of dominant regionally based funds. These include Yallourn Medical and Hospital Society, Goldfields Medical Fund, Latrobe Health Services Inc. and Mildura District Hospital Fund. They typically have close relationships with local hospitals, both public and private, and other medical services in the region. While covering a large proportion of local members, these four organisations provide health insurance cover for just 1 per cent of all members.

Overall, therefore, despite the large number of insurers operating in Australia, there is a high degree of seller concentration at the state level. For some states, notably Victoria and Tasmania, this has increased since 1991. Chapter 5 draws on this information in assessing the degree of competition within the industry.

## Changes in structure

There have been only three cases of large-scale new entrants into the private health insurance market since the mid 1970s:

- Medibank Private was established by the Commonwealth Government in 1975.
- NMHI entered the market in 1991 through the acquisition of two large mutual organisations (Mutual Community and HBA), which were in danger of becoming insolvent.
- SGIC (now SGIO) entered the South Australian market in 1991, with backing from the South Australian Government.

Box 4.3 outlines the mergers, acquisitions and closures that have occurred since 1989. Only one fund was closed over the period. There have been eleven instances where the operations of a health organisation have been transferred (through merger or takeover) to another. According to the Commonwealth Department of Health and Family Services (the Department), most of these transfers were for financial reasons, with funds getting into unsustainable situations and being merged or taken over by a stronger partner (Sub. 175, p. 13). The Commission understands there are other mergers currently in train.

## 4.2 Nature of the ‘product’

Individuals are unable to predict the time and magnitude of many events that may profoundly affect their well-being. Insurance is a means of mitigating the influence of uncertainty, by sharing the risk of an unexpected occurrence among many people (by a process of pooling).

But private health insurance has some unusual characteristics.

### Broad characteristics of services

Under the community rating regulations, the major role of private health insurance organisations has been one of claims processing and payment — essentially what some have described as a passive payer of bills.

According to the Australian Consumers’ Association:

In the past private health insurance funds, have simply acted as an expensive financial intermediary that hasn’t added much value to health care. It is in essence, a very expensive and elaborate bill paying system. (Sub. 77, p. 14)

**Box 4.4: Mergers, acquisitions and closures**

- PA Health Benefits (operated by the Over 50s Friendly Society) merged with Australian Unity Friendly Society on 1 February 1996.
- The business of Mutual Community Ltd was transferred to NMHI from 31 December 1995.
- The business of the Grand United Friendly Society (in Victoria, QLD, SA, WA and Tasmania) was transferred to the funds operated by NIB Health Funds Ltd from September 1994.
- Funds of the Australian Natives' Association and Manchester Unity Independent Order of Oddfellows in Victoria Friendly Society merged on 22 September 1993 to form a new fund known as Australian Unity Friendly Society.
- Rosebery Health Benefits Society, operating in Tasmania, merged with Medibank Private on 11 November 1993.
- The funds conducted by ACC Health Limited were transferred to NMHI from 1 January 1992.
- The Cheetham Hospital Benefits Fund, based in Victoria, ceased operating from 1 October 1991.
- The fund formerly conducted by Grand United Order of Oddfellows Friendly Society was transferred to Grand United Friendly Society from 9 August 1991.
- The fund conducted by the Order of Sons of Temperance in Victoria was transferred to the Independent Order of Odd Fellows of Victoria from 1 January 1991.
- The fund conducted by the Queensland District, No 87, Independent Order of Rechabites was transferred to IOR Australia Pty Ltd from 1 January 1991.
- The fund formerly conducted by the Hospitals Benefits Association Ltd in Victoria was transferred to Mutual Community Ltd in December 1990, without a name change.
- The funds formerly conducted by Switzerland Australia Health Fund Pty Ltd were transferred to the Health Insurance Commission from 1 October 1990.

*Sources:* PHIAC annual reports. PHIAC (Sub. 90, p. 70).

However, the complex nature of the 'health' product, the range of products now available, and changes that have been occurring within the industry – including in its regulatory framework – have seen the private health insurance organisations evolve. These organisations are now beginning to act as financial intermediaries between individual consumers and providers of hospital and

medical services. The move to ‘100 per cent cover’ for hospital services has meant they have taken on the role of negotiating with providers. Further, they have had to assume a greater role as information providers to their members.

### **Types of cover**

While having a broader coverage prior to the introduction of Medicare, private health organisations currently provide only hospital and ancillary cover.<sup>2</sup>

- *Hospital insurance* provides benefits towards the costs of fees charged for accommodation and medical treatment as a private patient in a public or private hospital. Cover for up to 100 per cent of the charge for hospital treatment is available. For medical treatment, 75 per cent of the MBS fee is covered by Medicare, and the health organisations can cover the remaining 25 per cent. Coverage for medical fees above the MBS level is currently only permitted where the organisation and the medical practitioner have entered into a contract.
- *Ancillary insurance* provides a level of coverage for many services offered by health professionals other than medical practitioners, usually (but not always) outside hospitals. It includes dental, chiropractic and physiotherapy services as well as a range of aids and appliances, such as spectacles and hearing aids. There is no requirement for a doctor’s referral. Ancillary table membership may be held without any hospital table membership.

Broadly, there is provision for six types of health insurance in terms of services and charges (see box 4.5).<sup>3</sup>

Funds are now developing new types of policies. Some provide full cover for medical and hospital charges. Others require members to meet part of the costs of any services received in exchange for lower premiums. These innovations are discussed later in this chapter.

All forms of product offer only ‘indemnity cover’, where the amounts claimed are limited to the actual amounts charged by health care providers.

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<sup>2</sup> Details about the characteristics of those covered for hospital and ancillary insurance are contained in chapter 6.

<sup>3</sup> All six types of cover can be sold with an excess component. (However, in practice, ancillary cover usually involves a copayment.) Under an excess policy, the member pays lower premiums and will pay an excess charge only when making a claim — either annually or per hospital visit.

**Box 4.6: Types of cover**

- *100 per cent* cover for hospital and medical services from those hospitals and doctors with agreements with health funds.
- Full hospital cover with *partial medical cover*. Insured patients have to pay for doctors' charges that exceed the MBS fee.
- *Exclusionary* cover which excludes or reduces benefits for certain treatments such as heart surgery and joint replacement (designed for the young and fit) and obstetrics (designed for those past child-bearing age) in return for lower premiums.
- *Specified copayment* cover, where contributors pay lower premiums in return for bearing some of the costs of either the hospital, the doctor, or both when hospitalised. The specified copayment may relate to all hospital or medical services or, in the case of exclusionary cover, for only selected hospital treatments and the related medical services.
- *Unspecified copayment* cover which provides fixed benefits per day. This cover pays all the hospital charges as a private patient in shared accommodation in a public hospital or pays some or all of the accommodation charges for a private hospital. It also pays benefits — 25 per cent of the MBS fee — for in-hospital medical services.
- *Ancillary* cover, much of which involves copayments, automatically reducing excesses etc.

Source: PHIA 1996b.

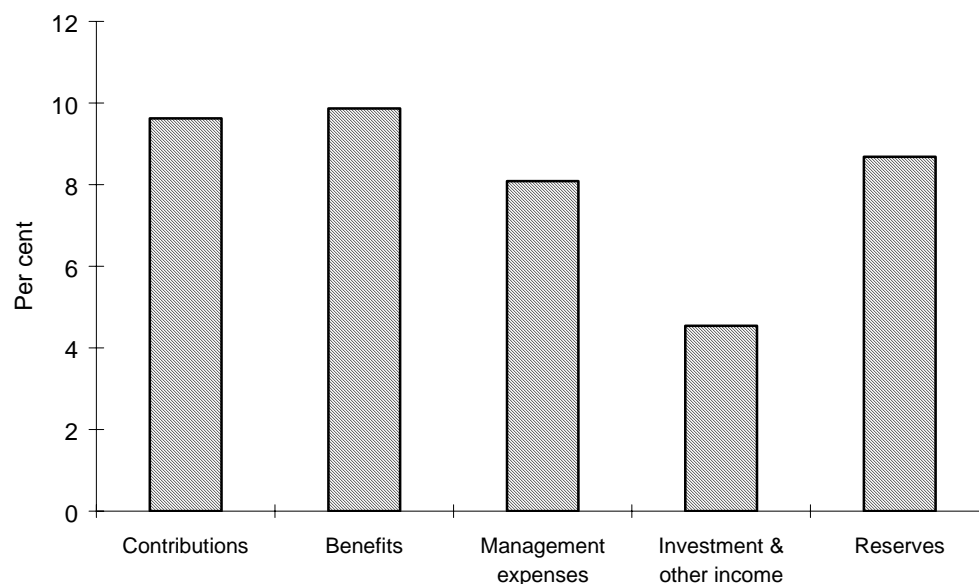
**4.3 Financial performance**

This section looks briefly at the broader picture for the industry in terms of the key financial indicators — contribution income, benefits paid, profitability, reserves, management expenses, investment and other income.

**Financial overview**

Health organisations receive income from two sources: members' contributions (the major source) and returns on their investments. They must balance their income against expenses, comprising benefits paid to members and the management expenses incurred in running the business. The trend rates of growth in these measures since 1984–85 are shown in Figure 4.5.

Figure 4.6: Trend rates of growth in financial indicators of registered health insurance organisations, 1984–85 to 1995–96



Note: Benefits also include provision adjustment, reinsurance liability and state ambulance levy paid by the funds.

Source: PHIAC 1996a.

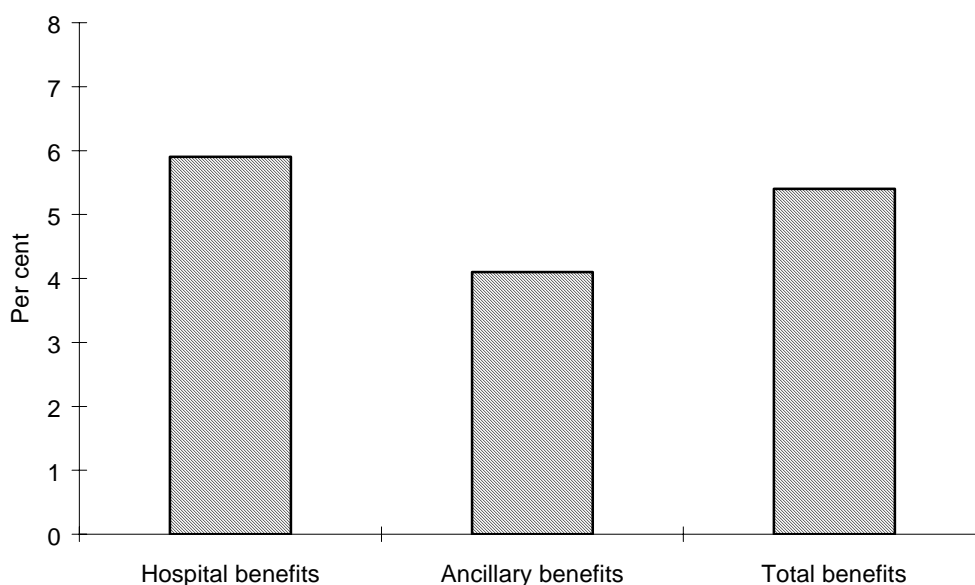
Health insurance organisations paid benefits amounting to 94.6 per cent of contribution income in 1995–96, an increase from 90.4 per cent in the previous year. With one exception, this was the highest ratio of benefits paid to contribution income recorded since 1984–85 and reflects the increasing claims on health insurance organisations.

The health insurance industry paid \$3.9 billion in hospital and ancillary benefits in 1995–96. Nearly three-quarters of this was for hospital benefits. The trend rate of growth in hospital benefit payments is close to 2 percentage points higher than for ancillary benefit payments (see figure 4.7).

While membership of funds continues to decline, benefits paid for hospital and medical services have increased, particularly in the last two years. The move to 100 per cent hospital insurance cover, the switch by the insured to being treated in private rather than public hospitals, and advances in technology, are among the factors contributing to these increasing costs (see chapter 7).



Figure 4.8: Trend rates of growth in benefits paid, 1989–90 to 1995–96



Source: PHIA 1996a.

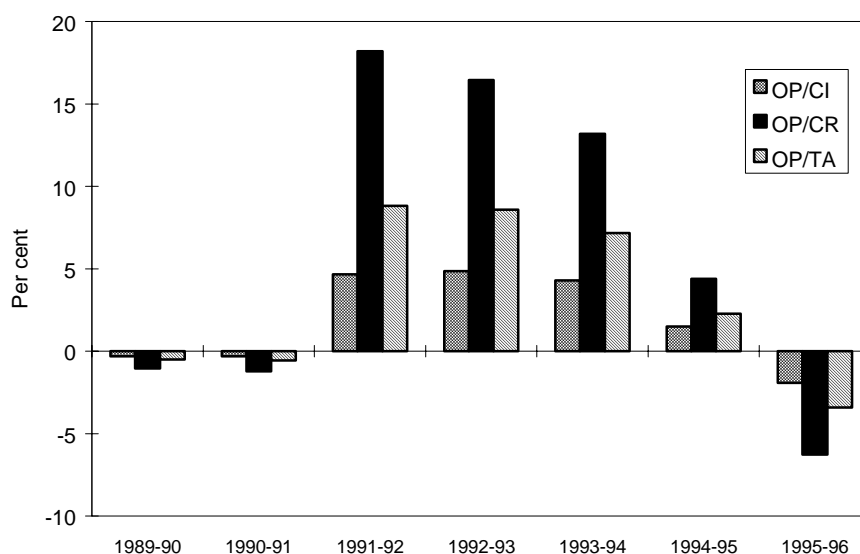
### Profitability

The profitability of all health insurers is reported in figure 4.9 in terms of three indicators — operating profit/loss expressed as a ratio of contribution income, reserves and total assets.

During the relatively favourable three-year period 1991–92 to 1993–94, profitability was modest — operating profits averaged around 5 per cent of contribution income, and around 8 per cent of total assets.

However, fund profitability has deteriorated consistently since 1991–92, to the point where the health insurance organisations reported a combined operating loss of \$81.3 million in 1995–96. The trend has worsened, with newspaper reports suggesting the organisations suffered a combined operating loss of \$65 million in the September quarter 1996 — while traditionally a loss-making quarter, this was substantially above the loss incurred in the September quarter of the previous year.

Figure 4.10: Profit/loss ratios of health insurance organisations



Notes: (OP) is operating profit/loss expressed as a ratio of contribution income (CI), reserves (CR), and total assets (TA).

The data presented relate to operating profit/loss before abnormal and extraordinary items in PHIAC reports (from 1994–95) and operating surplus/deficit before abnormal and extraordinary items in PHIAC reports (for earlier periods).

Source: PHIAC annual reports.

## Reserves

Health insurance organisations cannot precisely predict the timing of their payouts. They accordingly need to maintain reserves to meet unexpected demand and to ensure their solvency.

The reserve position of the funds is highly regulated. As noted in the previous chapter, all registered health insurance organisations are required to maintain minimum reserves of \$1 million or two contribution months, whichever is greater. If funds fail to meet this requirement, they need to apply for exemptions to continue to operate.

Health funds base their decisions about reserves on a number of considerations, apart from the need to conform with minimum statutory requirements. According to the AHIA (Sub. 108, p. 39), these are:

- to meet prudential requirements of their own boards, which may believe that the circumstances require higher margins than required by statute (these decisions will vary according to the size of the fund and the assessments of its directors);

- to provide a buffer allowing for the introduction of new products that are untested and to allow deferment of rate rises should costs increase; and
- to provide investment income, which can be used to offset management expenses or contribution rates or both.

HCF (Sub. 158, p. 24) said that strong reserves are needed to: smooth adverse fluctuations in the underwriting cycle without the need to increase contributions; replace major capital assets; provide capital for investment in new member services or business expansion; to shield contributors from rising costs associated with an ageing membership and changes within the hospital mix; and to enable HCF to react to strategic moves in relation to competitors' pricing, benefit or marketing strategies.

Funds can lose reserves quickly, especially when the risk profile of the insured population deteriorates and cost pressures increase. Among other participants, PHIAC (Sub. 90) noted that reserves are slow to build up but can quickly diminish.

### *Reserve position*

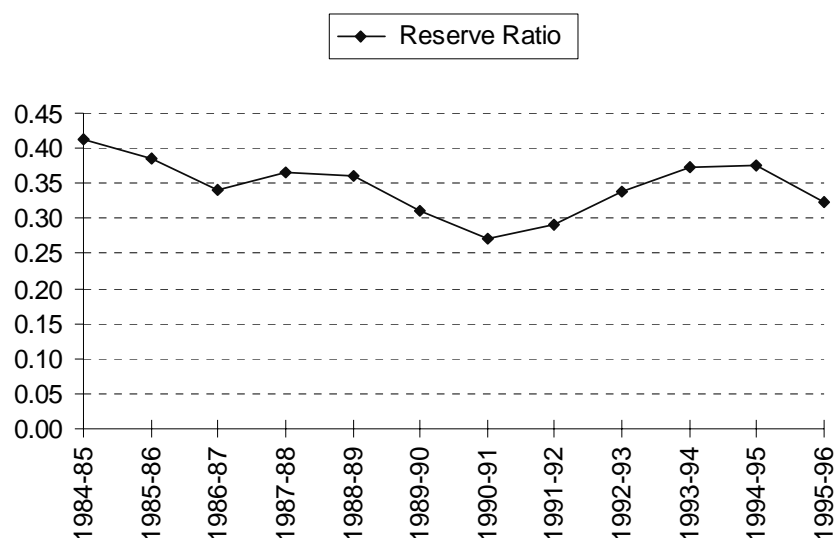
Total reserves of the private health insurance industry have increased from \$520 million in 1984–85 to \$1.3 billion in 1995–96. The trend growth rate is 8.7 per cent per annum (see figure 4.3).

The ratio of total reserves to benefits payable for the industry has fluctuated over the past decade, but was significantly lower in 1995–96 than in 1984–85 (see figure 4.11).

Reserves for statutory requirements equalled 3.7 contribution months (\$1.36 billion) in June 1995, declining to about 3 months (\$1.18 billion) in June 1996 (PHIAC annual reports). This industry average masks individual differences, due to such factors as fund size, risk profile, level of contributions, benefit payouts and management decisions.

Table 4.7 shows June 1996 data on the distribution of reserves by number of contribution months and organisation size. Six organisations are shown as having reserve levels equivalent to less than the required two contribution months. As at February 1997, there were seven organisations with reserves under two contribution months. Of these, six are currently on exemptions and one has requested exemption.

Figure 4.12: Reserve to benefits ratio, 1984–85 to 1995–96



Source: Based on PHIAC 1996a.

Table 4.8: Industry reserves by number of contribution months and organisation size, June 1996

Organisation size (total contributors)	Contribution months					Number of organisations
	Less than 2.0	2.0-2.99	3.0-3.99	4.0-4.99	5+	
0 – 10 000	2	9	5	4	5	25
10 001 – 40 000	2	8	1	1	2	14
Over 40 000	2	2	3	2	0	9
Total	6	19	9	7	7	48

Source: PHIAC 1996a.

As at February 1997, there were five organisations with reserves below the \$1 million requirement. All are currently on exemptions. These are mainly small funds. The Department said that ‘to maintain \$1 million in reserves would price their products out of existence. These funds have been required to obtain actuarial reports setting a benchmark higher than two contribution months’ (Sub. 175, p. 25). According to PHIAC, the relevant benchmark is about four contribution months.

At June 1996, there were seven organisations with reserves equivalent to more than five contribution months. Five of these are small organisations and two are

medium-sized. The data indicate that small health organisations generally tend to hold greater reserves (in terms of contribution months) than large ones. In this context, PHIAC said:

For the smaller funds, reserves can operate as a buffer as they are far more susceptible to large fluctuations in benefit payments. The volatility of a small insurer's business is likely to be greater than a large entity. (Sub. 90, p. 37)

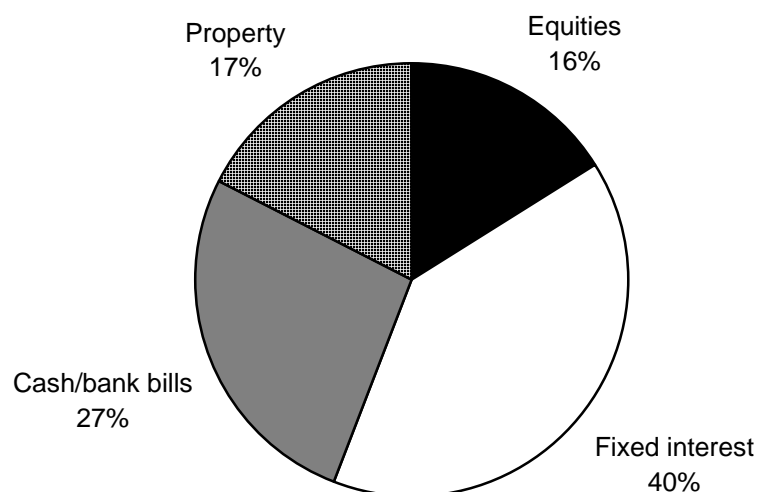
Further details on the reserves requirements can be found in chapters 3 and 10.

### *Investment of reserves*

There are a range of options for funds to invest their reserves. They include equity investments, term deposits, and properties. Figure 4.13 shows the investment portfolio of HCF.

The National Health Act does not restrict the nature of investments. However, as noted in the previous chapter, it excludes certain assets from solvency calculations. This means that health funds are relatively free to invest, although some liquidity must be maintained to accommodate regular claim payments and unforeseen events. There is no legislated requirement that assets be held in liquid form (DHFS 1996b). However, PHIAC uses as a guideline a 1:1 ratio (total readily realisable assets/total short-term liabilities) as being the minimum desirable ratio which should be maintained (Sub. D262, p. 2).

Figure 4.14: HCF's investments, 1996



Source: Sub. 158, p. 26.

Some funds keep reserves in the form of fixed assets such as hospitals and nursing homes, a proportion of their assets which clearly lack liquidity. But not all funds can include such assets in their solvency calculation. This depends on whether or not they are classified as ‘prescribed company assets’. In this context, AHIA said that:

there is a current anomaly in that if a fund ‘diversifies’ within the health fund (eg runs a hospital) the fund ... may count the business towards reserves, but if the business is a separate company, then ... it is excluded from reserve calculations. (Sub. 108, Appendix 1, p. 3)

For instance, NIB owns another company which owns hospitals, but such assets are excluded from NIB’s solvency calculation. In contrast, MBF has its own hospitals and they are counted towards the reserve calculation due to its differing structure.

Nevertheless, PHIAC said that when managing their reserves, funds take into account short term liabilities and, accordingly, most investments tend to be short term (Sub. 90, p. 76). It noted further that most registered organisations are conservative investors.

According to the Department (Sub. 175), the overall rate of return on investments for individual organisations varied from 3 to 17 per cent in 1994–95, with an average of 10 per cent. Table 4.9 compares rates of return by different categories of health insurance organisations.

Table 4.10: Return on investments for different categories of health insurance organisations, June 1995

<i>Fund grouping</i>	<i>Rate of return (per cent)</i>
The top seven	10
Other open funds	8
HIRMAA	12
National funds	10
State based funds	9
Regional funds	10
<b>Industry average</b>	<b>10</b>

Note: Fund groupings are not mutually exclusive.

Source: DHFS, Sub. 175, p. 15.

## Management costs

This section examines the management costs of health insurers, which many participants have seen as excessive. It includes a comparison with general insurers and Medicare, examines the composition and relative importance of management costs and finally evaluates the differences among funds in management costs as a proportion of contribution income.

### *Health insurance vs general insurers*

The share of private health insurance administration costs in relation to contribution income is around 12 per cent (including both open and closed funds).

A number of submissions noted that these administration costs compare favourably with general insurers. For example, HCF (Sub. 158) reproduced data from the KPMG 1996 Insurance Survey showing that the health insurance administration expense ratio of 12 per cent compares with over 24 per cent for general insurance and 16 per cent for life insurance. HCF said that:

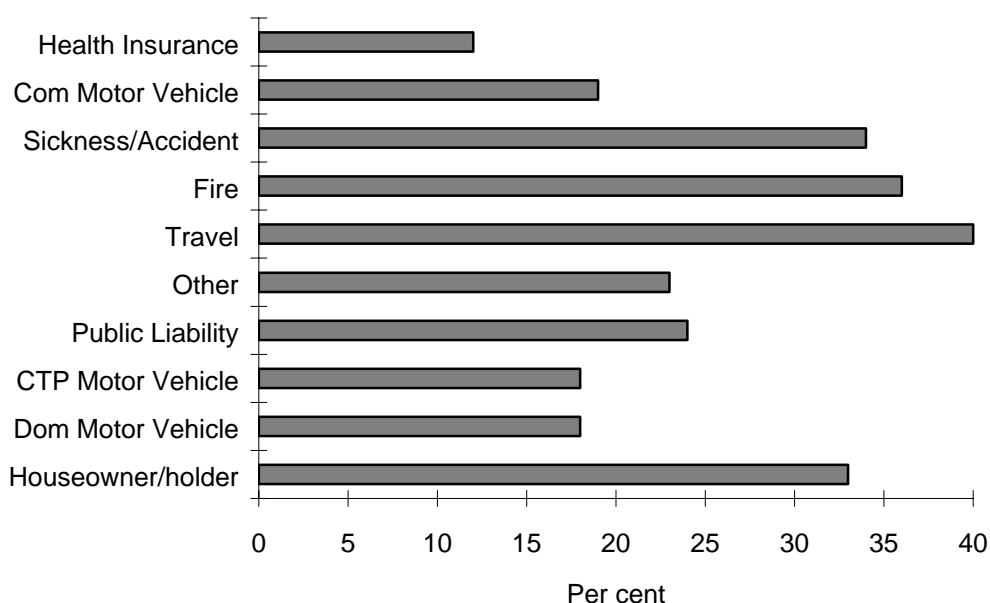
Health funds are efficient when compared with other insurers ... The decline in the number of persons insured, the general trend for consumers to choose lower priced products and fund decisions to contain price increases is holding the absolute growth in contribution income down. *This puts constant and unrelenting pressure on funds to seek efficiency gains.* (Sub. 158, p. 19)

The AHIA also compares health fund administration costs with those of other insurers (figure 4.15). This only provides a general indication of relative performance, however, as circumstances are not strictly comparable. For instance:

- PHIAC noted that ‘underwriting costs in general insurance are not present in health insurance’ (Sub. 90, p. 58).
- General insurers operate their businesses on a risk rated basis, which involves actuarial costs.
- The Department also observed that comparative efficiency is difficult to gauge from administrative costs because health insurers ‘very rarely face litigation over contested claims’ (Sub. 175, p. 29).

Nonetheless, private health insurance administration costs do not compare as favourably with those incurred by Medicare. Ian McAuley commented that even when the costs of the Australian Taxation Office are added in, the comparison is around 4 per cent for Medicare and 12 per cent for private health insurance (Sub. D194, p. 4).

Figure 4.16: Operating expenses of general insurance and private health insurance (per cent of income)



Source: AHIA, Sub. 108, p. 38.

### *Composition of management costs*

Management costs of health insurance organisations are influenced by a number of factors, including their size, branch structure, number of claims, data management techniques, marketing and communication strategies. Figure 4.17 provides a breakdown of typical management costs for open funds: labour and advertising are the largest cost components, accounting for half of the total.

### *Management cost ratios*

Turning from the structure of management costs to their importance measured as a ratio of contribution income, substantial variation is apparent among funds. In seeking to explain why these differences might arise, it is useful to first look at the distinction between open and closed funds.

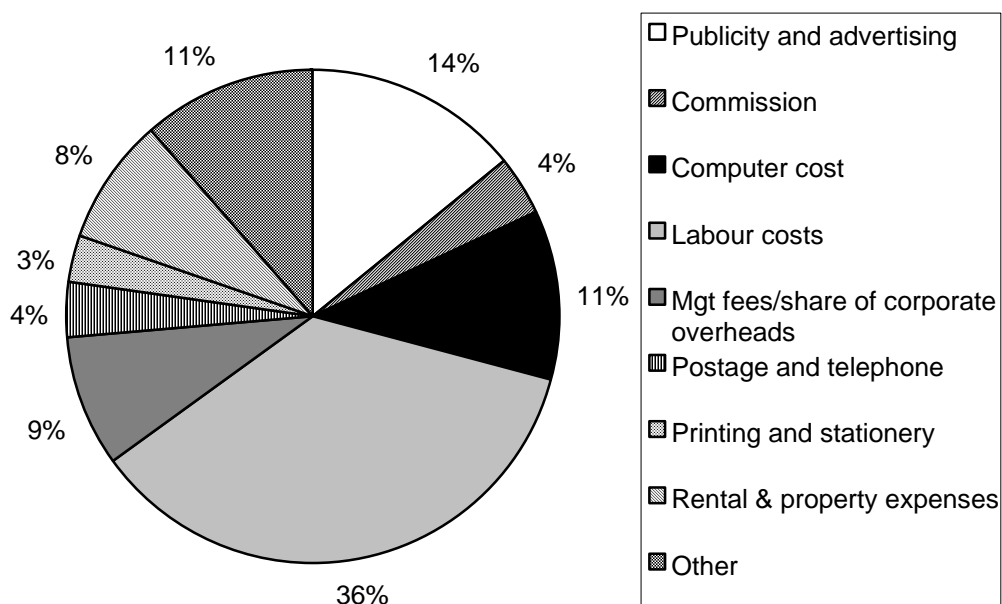
### *Open vs closed funds*

Management costs as a ratio of contribution income might be expected to vary depending upon whether particular funds are 'open' or have restricted membership. As shown in figure 4.18, RMOs generally have lower management cost ratios than open funds. For instance, in 1995–96, the average management



cost share for RMOs was 8.2 per cent, whereas the corresponding figure for open membership organisations was 12.3 per cent.

Figure 4.19: Typical management costs for an open fund



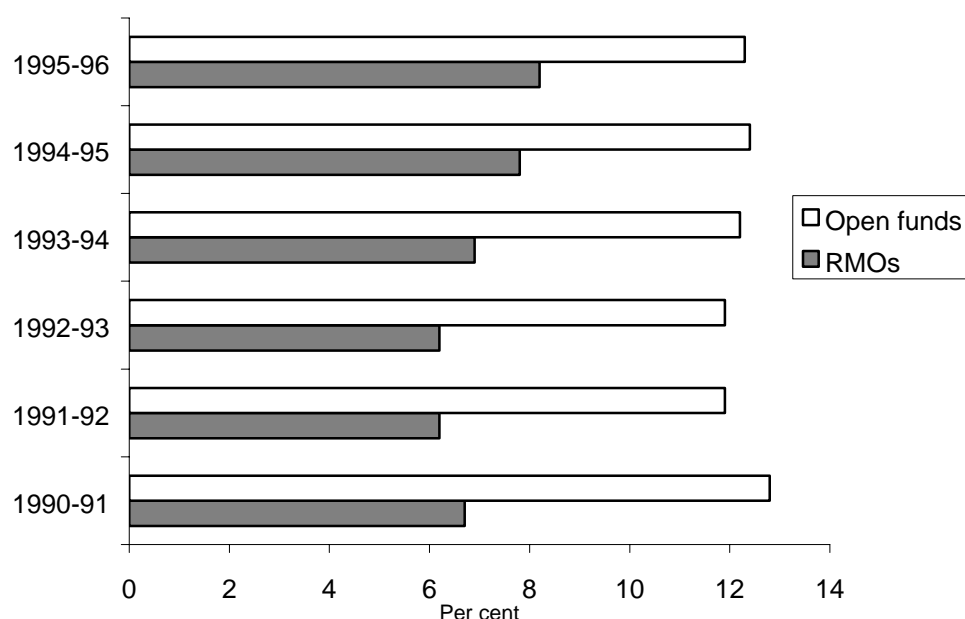
Note: Other category includes depreciation & amortisation, financial taxes & charges and other.

A number of factors help explain the difference. For instance, some RMOs may benefit from non-cash subsidies from employers (for example staff, postage and other assistance), operate from a central office or share computer facilities. In commenting on this issue, the AHIA (Sub. 108) said that RMOs are often able to share overheads with employers.

The Naval Health Benefits Society noted that cooperative ventures such as the HAMBS computer company and the Australian Health Service Alliance (AHSA) provide significant administrative efficiency for the fund (Sub. 72, p. 4). The Health Insurance Restricted Membership Association of Australia (HIRMAA) said:

The majority of HIRMAA funds ... generally operate from a single national office, without major use of expensive shopfronts, rather using technology and fast claims turnaround, minimising the costs of administration. ... (Sub. 71, p. 3)

Figure 4.20: Management costs as a proportion of contribution income: comparative performance between open and closed funds



Source: PHIAC annual reports.

Moreover, closed funds generally have a more easily targeted pool of potential members, thereby reducing marketing costs, which can be sizeable for open funds. The AHSA noted that:

Many restricted membership organisations ... have lower costs [than open funds] because they are employer or association based and as such, enjoy greater member loyalty. This loyalty translates into steadier membership base and therefore lower operating costs. These funds do not have expenses that larger funds incur to protect their membership base, eg. advertising and distribution costs. (Sub. 44, p. 9)

#### *Differences among open funds*

There is significant variation in management costs among open funds, as the selection in table 4.11 indicates. This variation may be caused by a variety of influences, not all of which reflect on efficiency. AHIA said:

These [different levels of management costs] are largely a function of competition ... different funds wish to present themselves to their markets in different ways, develop different distribution systems ... Some advertise extensively, some do not ... What should be noted is the existence of considerable diversity in how funds do administer their operations and their public presence. (Sub. 108, pp. 53-4)

Product mix can also affect management costs. For instance, the Commission's own analysis reveals that a fund paying out a greater share of benefits as ancillaries, faces significantly higher management costs per member. Other key factors explaining variation in management costs are membership size and age of operations (see appendix G). But, there are still marked differences in management costs per member not explained by such factors. These residual effects are likely to partly reflect variation in the relative efficiency of the funds.

The influence of age of fund, size of fund (scale economies) and branch structure on management costs are considered in turn.

Table 4.12: Management costs of selected insurers, June 1996

<i>State</i>	<i>Selected insurers</i>	<i>Contributor numbers</i>	<i>Year of establishment</i>	<i>Management cost per member (\$)</i>	<i>Per cent of contribution income</i>
Queensland	CPS	4 218	1976–77	77.3	6.0
Queensland	MBF	257 530	1950	137.6	10.4
Queensland	NIB	7 551	1993	138.9	10.3
WA	HBF	267 646	1941	103.8	8.7
WA	Medibank Private	67 756	1976	132.3	13.3
WA	NIB	993	1993	184.7	18.6
NSW	HCF	291 395	1933	148.1	13.9
NSW	MBF	320 368	1946	148.9	12.6
NSW	Medibank Private	231 149	1976	127.4	11.7
VIC	Medibank Private	334 116	1976	108.9	9.7
VIC	MBF	17 801	1989	383.3	29.3
VIC	NMHI	201 870	1991	188.5	13.2
SA	NMHI	165 431	1991	193.8	13.4
SA	MBF	10 919	1993	298.7	22.6
SA	Medibank Private	68 599	1976	125.3	12.5
<b>National total</b>				<b>145.7</b>	<b>11.9</b>

Note: National total (management cost per member) is a weighted average number.

Sources: PHIAC 1996a and information provided by funds.

#### AGE OF FUND — THE INFLUENCE OF 'NEWNESS'

Management cost ratios tend to be higher among newer funds. Because there are fixed costs associated with establishing a greenfield operation, a fund with an

initially small membership base is likely to have a relatively high management cost ratio, which should fall as the number of contributors grows over time. For example:

- During MBF's first year of operation (1993–94) in South Australia, its management cost ratio was 188 per cent and management cost per member \$1380. By 1995–96, however, the corresponding numbers had dropped to 22.6 per cent and \$299 respectively.
- When NIB started operating in Queensland in 1992–93, its management cost ratio was 109 per cent and management cost per member \$476. By 1995–96, the cost ratio had fallen to about 10 per cent.

In both cases, significant increases in membership numbers and hence contribution income resulted in a large fall in the management cost ratio.<sup>4</sup>

#### SIZE OF FUND — THE INFLUENCE OF SCALE ECONOMIES

From table 4.13, it is apparent that Medibank Private, the largest health insurer, has among the lowest management costs (expressed on a per member basis, or as a percentage of contribution income). According to Medibank Private, these outcomes demonstrated its 'efficiency in this area' and that it has 'actively sought to maintain management expenses to a minimum' (Sub. 168, p. 47).

The Australian Medical Association (AMA) said that Medibank Private has a lower cost of processing claims due to the use of information technology (Sub. 130, p. 17). However, a number of participants noted that this may also partly reflect the company's network sharing arrangements with Medicare. For instance, the Australian Unity Friendly Society said:

The shared payment of the lease by Medicare ensures that Medibank Private's expenses are significantly lower than private funds in most states. (Sub. 163, p. 59)

Similarly, NMHI commented that:

Medibank Private has an advantage in cost terms over other insurers by sharing facilities with Medicare. The fact that Medibank Private and Medicare operate out of the same shopfronts, offering a 'one stop shop', also gives Medibank Private an unfair marketing advantage over its competitors. (Sub. 140, p. 48)

The Commission undertook an econometric analysis to test whether Medibank Private had lower costs than the other major players, after accounting for scale, age of operations and product mix effects. It found that after controlling for

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<sup>4</sup> In fact, once size and product mix are controlled for, newer funds tend to have lower management costs per member than established ones (see appendix G).

these other effects, Medibank Private did have lower costs than the average, but the difference was not statistically significant (see appendix G). This means that there is some uncertainty about whether Medibank Private genuinely enjoys cost sharing advantages.

More generally, therefore, how important is the size of an organisation as an influence on management cost ratios? On the one hand, the Department said that:

For larger organisations, some efficiencies could be gained through economies of scale that are not necessarily available for smaller organisations.  
(Sub. 175, p. 28)

But in contrast, PHIAC reported that:

There is ... no evidence that bigger is better or that economies of scale apply in the private health insurance industry ... Niche marketing can be and is competitive, as evidenced by regional and restricted membership organisations.  
(Sub. 90, p. 58)

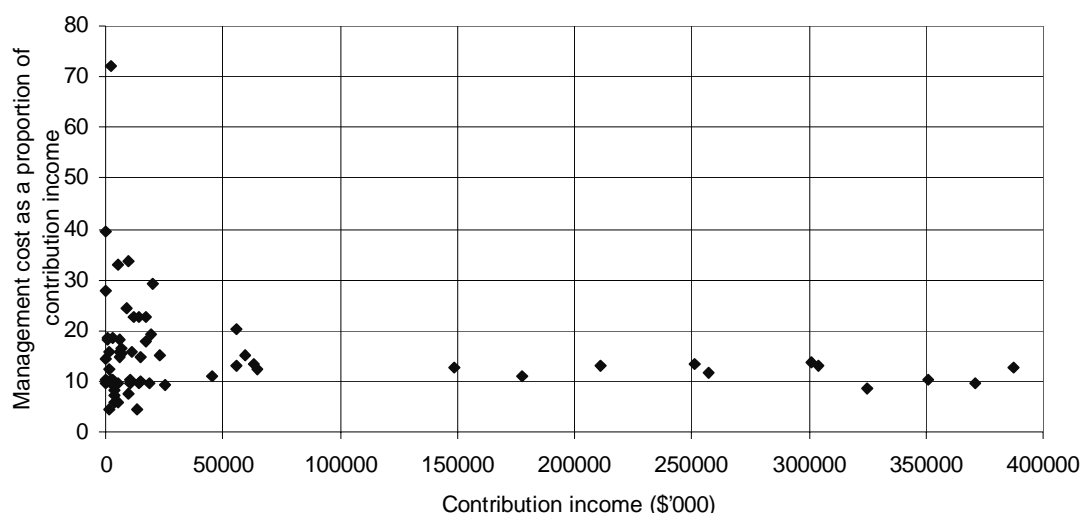
Ian McAuley (Sub. 13) examined the correlation between the administrative expenses ratio and premium income for 77 open funds for 1994–95, and found no significant correlation. A similar approach is undertaken here for 1995–96 (see figure 4.21).

This appears to show that, apart from some variation among funds with contribution income less than \$25 million (where the ‘newness’ factor is also at work) there is strikingly little variation in cost ratios as the level of contribution income rises. (The statistical measure of correlation is insignificant.)

However, it should be noted that partial correlations can be misleading. This problem is accentuated if insurance funds with very different operating procedures are compared with each other. Accordingly, the Commission undertook an analysis of a group of major funds which adopted similar technologies. It found that economies of scale were present for these funds (every doubling of membership was estimated to provide a 20 per cent reduction in management costs per member) but scale economies were not very important for niche players.

This is not surprising as large funds generally incur considerable costs in establishing new operations (for example, on branch networks, advertising campaigns and computer facilities). Reductions in management cost ratios can be achieved if these fixed costs are spread over higher membership numbers. In contrast, small funds generally confine their business to particular segments of the market and incur lower costs in establishing and operating their businesses.

Figure 4.22: Management costs and premium income for open funds, 1995–96



Source: Based on PHIAC 1996a.

The results imply that large absolute changes in membership are required to generate cost reductions after a fund reaches substantial size. Further details about scale economies and management costs can be found in appendix G.

Scale economies might also be important in areas that involve contract negotiations between health funds and health service providers. The Commission was told by some funds that contracting with hospitals on a case payment basis, and other strategies to contain health costs, require sophisticated data management and other skills. They add to the complexity of funds management and generate high fixed costs which could be lowered by increasing membership.

#### BRANCH STRUCTURE AND MANAGEMENT COSTS

As noted earlier, management costs are influenced by the size and number of branches. Many funds operate branch networks and these remain an important channel of service and product delivery. The number of members serviced per branch can vary significantly among health insurers. For instance, information received from eight big (open) funds indicated that, in 1995–96, fund members per branch (excluding agents) ranged from 3300 to 19 100.

Whether such a network justifies the cost is an issue that requires some examination. A number of participants considered that rationalising branch structures would affect funds' ability to serve as well as retain customers, many of whom expect the personal attention provided by branches. The AHSA said

that while rationalisation of branch networks may generate some savings, such an important decision is best left to individual funds to determine depending upon their strategic and economic imperatives. It added:

A forced rationalisation will distort the competitive positioning of health funds, has the potential to disenfranchise a customer base, one which funds have invested substantial resources to retain. (Sub. 44, p. 10)

Also many funds with a branch network sell health insurance alongside other financial products such as investment bonds, building society products and life insurance. In this way, the cost of the branch network is shared among several product groups.

The complexity of the Australian system, with the multitude of products and the interaction between private and public cover, may also lead people to seek such greater assistance.

The AHIA argued that the existence of a large branch network need not increase costs significantly. For instance, branch office staff not only deal with customers but also process claims which in other funds may be handled in a central office. It said:

A fund may deliberately choose to site branches at places where it believes it will recruit more customers. Others may wish to develop other systems to provide member services. Market forces determine what customers want ... Cost savings in management expenses could well reduce the fund's capacity to service members and create membership attrition. (Sub. 108, pp. 53–4)

Nonetheless, the issue of branch networks and management costs is akin to the banking sector. For instance, a number of other participants indicated that there may still be scope for greater uptake of electronic payments, lodgement and processing of claims. In NMHI's view, payment methods such as direct debit and EFTPOS have the potential to reduce processing costs by facilitating a reduction in the number of expensive 'shop fronts' (Sub. 140, p. 44). According to the AMA, funds have clung to expensive 'paper trails', and payments based on cash and cheque refunds requiring relatively expensive shop fronts. It added:

There is undoubtedly scope for significant savings through the introduction of electronic lodgement and processing of claims, interfaces to enable billing details to be captured electronically from hospital and doctor computers, and electronic fund transfers to effect payments. (Sub. 130, p. 17)

The Department said:

complex branch structures are likely to increase management costs, suggesting that rationalisation of branch structures may reduce some of the larger funds' operating costs. (Sub. 175, p. 28)

It should be noted that some rationalisation has already occurred. For instance, HCF has closed 15 branches and moved 20 to better locations (Sub. 158, p. 21). It said:

HCF continued to rationalise the branch and agency network, on the basis of member usage and convenience. (HCF 1996, p. 24)

Nevertheless, the Commission has insufficient evidence to suggest that the existence of branch networks is a major source of inefficiency. The degree of competitive pressure (chapter 5) should determine the appropriate outcome in this regard. It is reasonable to expect that the number of branches will reduce over time as the funds embrace other technologies (see below).

#### **4.4 Product and service innovation**

There has been considerable innovation in the types of products and services on offer by the health funds. The diverse products available, each with a particular range of benefits, target specific market segments and attempt to differentiate one fund from another. Indeed, the array of products and the complexity of their conditions has made informed consumer choice difficult, as discussed later. The extent of contract negotiation with health service providers is also examined.

##### **Product innovation**

###### *100 per cent cover*

While a few funds had already negotiated contracts with hospitals to allow 100 per cent hospital cover (in Victoria and South Australia) well before the 1995 Amendment Act, their use was not widespread. The legislation formalised this process and most health funds now provide 100 per cent cover at a number of hospitals.

If a health fund has an agreement with the doctor (MPPA), the legislation permits the fund to pay benefits in excess of the MBS fee for medical treatment in hospital. Otherwise, if the doctor charges more than the MBS fee, the insured still has to pay the excess amount. (The extent to which agreements have been reached with hospitals and doctors is addressed below.)

###### *Front end deductible/excess policies*

Following the removal of regulatory restrictions in 1985, most funds began offering policies where contributors pay lower premiums but meet part of the costs. In front end deductible (FED) tables, an up-front excess is payable when a



hospital stay is claimed. The excess varies but is commonly between \$150 and \$300 for single contributors or between \$300 and \$600 for family contributors. Some funds, such as MBF and NIB, offer tables where the excess can range up to \$1000 for single cover and \$2000 for a family. Excess amounts apply per membership per calendar year.

Some organisations, including HCF and NMHI, have products with an automatically reducing excess (described by HCF as a loyalty entitlement) depending on the length of membership.

On 13 August 1996, the Minister for Health and Family Services signed a directive allowing increased flexibility for front end deductibles and excesses within the industry (see box 4.7). The ministerial direction also promotes greater use of day surgery facilities when medically indicated, by allowing funds to either waive or halve the excess for day surgery (Sub. 175, p. 31).

**Box 4.8: Front end deductibles and excesses**

A health organisation may:

- apply the FED or excess in two stages: half applies for the first episode of hospitalisation before benefits are payable, the remaining FED or excess applies to a subsequent episode of hospitalisation in respect of a year; and
- apply the FED or excess for each episode, or multiple episodes, of hospitalisation, but in any one year the total of such FED or excess payments for the episode or episodes of hospital treatment in that year must not exceed \$2000 in respect of that year.

*Source:* The Department, HBF Circular 461.

***Exclusionary cover***

In order to attract young singles or young couples not planning to have children, funds developed cheaper policies by excluding certain conditions such as heart surgery, cataract surgery and hip replacement and offered better cover for dental services, physiotherapy, and fitness club memberships. This cheaper cover also excludes obstetrics and assisted reproductive services. HCF and other funds offer exclusionary cover with an excess targeted at young singles.

**Management/technology innovation**

Funds have also innovated in modes of service delivery, giving consumers some choice in how they conduct business.

Consumers may have the option of paying their health fund contributions electronically from their bank or other account, by automatic payroll deduction, using a personal computer from home, at any Australia Post outlet, at branches of most major banks and at many pharmacies (Subs. 44, 158, 163).

Most of the larger funds maintain a branch structure. However, many of the smaller health organisations, particularly the RMOs, have devised other methods for the processing and payment of claims. For example, the Government Employees Health Fund, which operates nationally, provides for contributors to have claims processed by phone. Linked with payment into a nominated account it provides access to reimbursements within 24 to 48 hours. In addition to a telephone service, the Naval Health Benefits Society provides fax and bank claim services which enable the crediting of benefits direct to bank accounts the same day a claim is sent (Sub. 72, p. 3).

The AHSA stated that:

Health funds have also been creative in advancing the single bill concept, where doctors' fees are bundled together with other fees relating to an episode of care. (Sub. 44, p. 6)

Despite such advances in dealing with contributors, claims processing remains an area where procedures could be improved. For example, the Australian Unity Friendly Society pointed out that claims processing still involves a high degree of labour-intensive data entry. The state of play in billing reform is covered in chapter 3.

The New South Wales Government commented that there is some scope for the introduction of electronic data interchange (EDI) to reduce the costs of claim processing across the industry and to improve general service levels to consumers (Sub. 180, p. 19). Medibank Private noted that EDI is being implemented within the industry (Sub. 168, p. 21).

Australian Unity Friendly Society claimed that:

The big leap forward in productivity gains will come when there is an industry-wide end-to-end EDI/FT system linking hospitals, funds and Medicare.

... it is generally expected that the establishment of a linked system will generate industry-wide efficiency gains and reduce operating expenses by at least 5 per cent. (Sub. 163, pp. 23–4)

Implementation of electronic commerce will clearly transform how information is exchanged between hospitals and health funds. Hospitals will be able to transmit electronically details of patient treatment and costs to funds. Health funds already have details of the pricing arrangement with hospitals, as the contract is stored on their computer disk. It is anticipated there will be cost

savings once the system is in place. However, despite the success of a pilot electronic interchange between a fund and a hospital, the industry has still to make the necessary investment and resolve outstanding issues (Sub. 44, p. 20).

### **Contracts with service providers**

As discussed in the previous chapter, the 1995 Amendment Act facilitated contract negotiations between funds, hospitals and doctors. It was also noted that some funds had negotiated such agreements (in particular with hospitals) prior to the above legislation.

The extent of successful contract negotiation between health funds and service providers can be seen as a performance indicator for the private health insurance industry, although individual funds do not have full control over such contracts. Medibank Private said:

Industry efficiency can only be achieved through enhanced negotiation outcomes with private providers; primarily hospitals, medical specialists and ancillary providers. (Sub. 168, p. 69)

Contracts with providers can also help funds to keep costs down. For example, HCF noted that its experience in NSW was that private hospital charges had been increasing by two to two-and-a-half times the rate of inflation prior to 1993, but by 1995, the rate of increase had slowed. According to HCF, this was attributable to negotiating charges and benefit levels (which the company commenced late in 1993) with private hospitals (Sub. 158).

However, general conclusions can not be drawn at this stage owing to a lack of data.

### ***Contracts between funds and hospitals***

Contracts between health funds and hospitals (HPPAs) can allow health insurers to offer nil or known out-of-pocket hospital expenses to contributors. Many funds have now negotiated such contracts.

As at 30 September 1996, there were 9701 HPPAs — 4215 agreements were entered into by restricted funds and 5486 by open membership organisations. Table 4.14 provides a breakdown of HPPAs by state. Nearly two-thirds (65.3 per cent) of hospital contracts were made in NSW (including ACT) and Victoria.

Illustrations of the extent of HPPAs include:

- By July 1996, Medibank Private had 343 HPPAs, representing 73 per cent of all private hospitals, day surgeries and free standing clinics (HIC 1996).

- By June 1996, HCF had achieved agreements with 78 private hospitals in NSW and ACT. These agreements covered 95 per cent of all private hospital beds and 97 per cent of all HCF patient admissions in NSW and ACT (HCF 1996).
- As at 1 September 1996, Australian Unity Friendly Society had agreements with 98 registered hospitals, comprising 57 private hospitals in the greater Melbourne metropolitan area, 18 in country Victoria, 22 day surgeries and 1 birthing centre (Sub. 163).

Table 4.15: Number of HPPAs by state, 30 September 1996

<i>State/territory</i>	<i>Total HPPAs<sup>a</sup></i>	<i>Percentage of total</i>
New South Wales and Australian Capital Territory	3 302	34.0
Victoria	3 039	31.3
Queensland	1 490	15.4
Western Australia	252	2.6
South Australia and Northern Territory	1 364	14.1
Tasmania	254	2.6
Total contracts	9 701	100.0

a HPPAs include all private hospitals including day surgeries.

Source: Information provided by the Department.

Smaller funds have formed an alliance called the Australian Health Service Alliance (AHSA) to provide management services to its member funds. The AHSA has entered into HPPAs with 300 private hospitals (Sub. 44, pp. 3–4).

### *Contracts between funds and doctors*

The contractual arrangement between health insurance funds and medical practitioners is known as a Medical Purchaser Provider Agreement (MPPA). Under MPPAs, funds can potentially offer full (or at least defined) cover for in-hospital medical expenses and thereby provide greater financial certainty and value for money for their members.

However, there has been very limited progress in agreements between doctors and health insurers. Information provided by the Department indicates that, as at September 1996, only two out of 48 funds had agreements with doctors and the

total number of MPPAs was 89.<sup>5</sup> Table 4.16 shows contract numbers and their proportions by state. Most contracts were negotiated in Victoria and South Australia/Northern Territory.

**Table 4.17: Number of MPPAs by state, 30 September 1996**

<i>State/territory</i>	<i>Total MPPAs</i>	<i>Percentage of total</i>
New South Wales and Australian Capital Territory	16	18.0
Victoria	30	33.7
Queensland	13	14.6
Western Australia	2	2.2
South Australia and Northern Territory	25	28.1
Tasmania	3	3.4
Total contracts	89	100.0

*Source:* Information provided by the Department.

### **Providing consumer information and services**

Health funds can provide a range of services to their customers which contribute to more informed decisions and containing health costs. They may include:

- provision of information on the level of cover, likely costs of treatment (including out-of-pocket expenses), benefit entitlements and changes to fund rules;
- programs designed to prevent illness and to reduce future health costs; and
- direct provision of selected ancillary services (for example, dental or optical clinics).

The provision of clear consumer information is potentially an important performance measure for health insurers. However, objective indicators are not possible in this area.

Consumers often do not have adequate information to compare funds or even to know what their insurance covers, due to the complexity of products. A number of submissions noted that considerable confusion exists among consumers about the level of cover, benefits, changes to benefit entitlements and waiting periods. The Australian Consumers' Association said:

<sup>5</sup> Similarly as at 30 September 1996, only one practitioner agreement (hospital-doctor contract) had been completed — in Victoria.

Buying private health insurance products is a bewildering experience for consumers with many different tables and rates to compare. (Sub. D266, p. 6)

In this context, the Department said:

confusion may relate to either too much product diversity or poor communication from the funds about the products themselves, or both. (Sub. 175, p. 32)

The Private Health Insurance Complaints Commissioner said that most complaints relate to benefits, including changes to benefit entitlements. The Commissioner noted that many funds provide advice to members about changes to their cover and premiums in letters and newsletters, but:

Due to the frequency and way funds notify changes, many members find it difficult to keep up to date. In addition, not all changes are notified to members. New conditions of registration require health funds to advise their members in writing of changes. (Sub. 80, p. 11)

NMHI argued that the private health insurance industry provides quite comprehensive information with respect to its products and services and that increased information is most needed for health care itself. For example, it said:

in the case of incipient prostrate cancer, early surgical intervention carries pronounced risks, and it is not clear that in the past patients with this condition have been provided with sufficient information to allow them to make the most appropriate choice. (Sub. 140, p. 22)

Effective measures of prevention can reduce future health costs. Examples of some preventive and other services provided by Australian health funds are noted below. Other examples are given in chapter 3.

- MBF has a number of preventive health care programs including MBF 'health check' and 'know your heart'. MBF's 'private access' information service also provides members access to information on a broad range of health and well-being issues. MBF also operates a service which enables members to learn the likely cost of their hospital stay, the schedule fee for each procedure and other associated costs (MBF 1995b).
- HBF of WA members have access to health and medical information services through its 'private line' and the 'HBF life club'. The life club line endeavours to help members (over 65 and with 20 or more years of membership) in the reduction of hospital costs. HBF also provides community health checks as a preventive and early detection mechanism for the general public through promotional and shopping centre displays (Sub. D270).
- The Government Employees Health Fund provides services such as 'Healthtrac' and 'Health Awards Club'. The former analyses information

obtained through a questionnaire filled in by members every six months, helping to reveal health risk factors for members. The latter program is similar to a frequent flyer plan. Members earn points for doing healthy things such as joining the gym. The fund rewards members when they have earned enough points. It has also established a Medical Research Fund that contributes to the prevention of diseases, covering both basic and clinical research. The fund observed that, 'these are typically projects which the National Health and Medical Research Council has been unable to fund but has judged as meritorious' (Transcript, Canberra, p. 155).

- The Australian Health Management Group supports members in their recovery after hospitalisation by appointing a registered nurse to manage a support program. It said that this has generated cost savings and provided psycho-social support for its members during recovery (Sub. 81).

Some health funds also directly provide health services to members to reduce costs. For instance, HCF operates dental clinics in Sydney and Parramatta. It said that the average out-of-pocket cost for HCF Dental Centre patients is less than a third of that incurred by members who attend private practitioners (HCF 1995).

The nature of information and services provided by funds can vary significantly. They are not easily comparable. It is difficult to determine the extent to which health funds are providing these services and whether or not they are adequate.

PHIAC's booklet *Insure? Not sure?* provides information to consumers on a range of public and privately funded health services. This can assist them, for example, to choose whether to have Medicare cover alone or to go for a combination of Medicare and private health insurance. Information contained in the booklet is of a general nature and does not attempt to guide consumers in their choice of funds or products. NMHI considered that the booklet needs to be built upon to increase consumer access to information about health insurance and, more importantly, health care choices (Sub. 140, p. 22).

The Department considered that because of the number and diversity of products, it would be difficult for anyone to provide a meaningful comparison between products. It went on to say that:

Requiring PHIAC to provide comparisons between products would be even more problematic because of its links to industry. (Sub. 175, p. 32)

On the contrary, the Australian Consumers' Association recommended that PHIAC be responsible for delivering comparative information on private health insurance products for consumers (Sub. 77, p. 14).

This issue is examined further in chapter 10.

## 4.5 Governance

The private health insurance industry comprises a mixture of organisations, including friendly societies, funds based around particular industries (some of the restricted membership organisations) and the large mutual funds. As noted earlier, there are also three for-profit organisations and the government-owned Medibank Private, which is overseen by the Health Insurance Commission.

These organisations are incorporated under a variety of different statutes: friendly societies under the various state acts; companies under the Corporations Law; life insurance companies under the Life Insurance Act and various special federal or state based organisations incorporated under their own acts (table 4.18). The manner in which these organisations are set up will influence their behaviour and method of operation.

Table 4.19: Structure of private health insurance organisations,  
December 1996

<i>Structure of the private health insurance organisations</i>	<i>Number of organisations</i>
Friendly society	16
Public company limited by guarantee	15
Public company limited by shares	6
Association incorporated	6
Unincorporated	3
Credit union	1
Commonwealth statutory authority	1
<b>Total</b>	<b>48</b>

*Source:* Information provided by the Department.

For those health funds operating as friendly societies, each state is working towards introducing legislation prior to 1 July 1997, that will bring the regulation of friendly societies under the Financial Institutions Scheme. Under these new arrangements, the Australian Financial Institutions Commission will be the body responsible for establishing national standards, with each state having their own supervisory authorities (Sub. 175, p. 14).



## **Mutual funds**

A large proportion of the industry (comprising 87 per cent of membership) is operating on a not-for-profit basis. The mutual nature of most of the industry means any surpluses generated must remain within the fund and be used for the benefit of contributors. This can be achieved by allowing the surplus to be incorporated in the fund's reserves or using it to finance part of future increases in benefits or operating costs. Mutual funds are unable to pay dividends to shareholders, in accordance with the terms of their registrations, and have income tax free status.

In contrast, the three corporate groups that own registered health insurers through shareholdings, namely NMHI, FAI and SGIO Health, are profit-making operations and liable for income tax.

Some submissions questioned whether this was the most appropriate structure. For example, Peter Carroll argued that:

The mutual nature of most of the industry, with an absence of shareholder disciplines or any systematic requirement to account for the use of capital, reduces the profit incentive and encourages the pursuit of non-profit objectives. (Sub. 9, p. 16)

SGIC Health considered that:

the only element driving management is to maintain a solvency position above the minimum set out in the Health Act. (Sub. 26, p. 3)

In addition, SGIC stated:

The mutual funds do not have access to the equity markets, which limits their ability to finance the expansion into other markets and to invest in new products and systems. (Sub. 26, p. 3)

The question of the payment of tax by the non-profit sector is discussed in chapters 3 and 10.

The mutual nature of most of the industry acts as a deterrent to 'hostile' takeovers. Essentially, they can occur only when a fund (or rather, its management) agrees to be taken over. A number of submissions argued that rationalisation in the industry should occur more easily and that there should be more scope for more efficient funds to take over less efficient ones. (This issue is discussed further in the next chapter.)

An advantage of moving away from the mutual structure is that it would exert pressure on the industry to be more commercially focussed. The Department argued that:

it is likely that ... the introduction of more for-profit health funds could lead to a more competitive and professional corporate culture within the industry. (Sub. 175, p. 25)

In comparison, the Australian Unity Friendly Society stated that:

Our tradition and heritage as a friendly society means that our members are exceptionally more powerful than the 'customers' of a profit-driven commercial organisation. Our members directly elect the Board of Directors and the Managing Director. Friendly societies are formed 'of the members, by the members, and for the members'. (Sub. 163, p. 27)

## **Accountability**

The Consumers' Health Forum of Australia called for more accountability of the industry to consumers, and greater transparency of administrative costs, including the proportion of contributors' funds spent on marketing and management (Sub. 64, p. 1). This was supported by the Australian Consumers' Association, which recommended that funds be made more accountable to members for their expenditure. The Association said that funds should provide members with a financial summary at year's end, detailing expenditure on health care, advertising, shop fronts and management expenses (Sub. 77, p. 14).

Another submission from J. R. Ferguson argued for annual reports to be provided to members and for information about the operations of the funds (such as financial information, efficiency of the fund and the names and experience of directors/management) to be contained within the fund's brochures (Sub. 149, p. 1).

The extent to which contributors to health funds have a say in the election of office holders and consequently the running of the organisation is also relevant.

The Australian Nursing Federation stated that the accountability of the funds required consideration:

Currently, it seems that members of funds have little or no rights regarding the management of the fund. If dissatisfied with management issues, their only option is to resign and move to another fund. (Sub. 22, p. 6)

In contrast, HIRMAA stated that:

The funds have a close affinity with their members and in the main have Boards of Directors composed of persons elected by the members ... (Sub. 71, p. 3)

This is the case, for example, for members of the Australian Unity Friendly Society who directly elect the Board of Directors and the Managing Director (Sub. 163, p. 27) and the NSW Teachers Fund where the Board is made up of contributors.

MBF instituted new governance arrangements from 1 July 1995, which involve a Council including some selected consumer representatives. The role of the council includes approving appointments to the Board of Directors and nominating candidates for the position of director. However, while contributors can attend and be heard at AGMs, they are not entitled to vote (unless they are council members). Details are outlined in box 4.9.

HCF stated that contributors are now able to elect four of their nine non-executive directors (Sub. 158, p. 21). Box 4.6 contains details of HCF's governance arrangements.

However, it would appear that, with the exception of the restricted funds and a small number of open funds, members generally do not have the ability to vote for individuals forming the Board of the fund.

To the extent that governance arrangements affect the efficiency of the funds, this issue is of less significance if funds are operating in a competitive external environment. This issue is addressed in the following chapter.

**Box 4.10: MBF's revised governance arrangements**

The arrangements introduced from 1 July 1995 include:

**Governors (3)**

Selected by the directors from among eminent persons; of clear independence from the directors. Governors hold office for 3 years, and receive payment for expenses only.

**Council (75 to 100 members)**

Includes all members from time to time of state boards of advice, the directors and selected contributor representatives (who are selected by the directors with the approval of the governors). Members usually hold office for 5 years and have expenses paid. Their role includes nominating candidates for the position of director and electing directors.

**Board of directors (usually 4–11, includes at least 2 registered medical practitioners; currently 10, including 2 medical practitioners)**

Directors must be contributors and members of MBF; they usually hold office for 3 years with remuneration determined by council. At each AGM, one-third of directors must retire. Their role includes responsibility for the management of the affairs of the company and appointing a chairman.

**Nomination committee**

Comprised of at least 6 persons; must include the chairman of the board of directors and chairmen of the state boards of advice. Its role is to assist the directors with:

- developing selection criteria for casual appointees to the board of directors and recruiting new directors; and
- selecting contributor representatives on the state boards of advice and contributor representatives on the council.

**State boards of advice (currently 3, with a total of 20 members at 1 July 1995; one board of advice in the states of NSW, Queensland and Tasmania)**

Comprised of medical representatives (9), elected by a postal ballot, by medical members and contributor representatives (11), appointed by the directors with the approval of the governors. The directors are obliged to form a state board when the number of contributors in that state exceeds 50 000. Members serve a maximum of 3 terms of 3 years each; remuneration and expenses are determined by directors. At the AGM, one-third of both medical and appointed contributor representatives must retire. Their role is advisory.

*Source:* MBF 1995b.

### Box 4.11: HCF's governance arrangements

**Board of Directors** (10 directors – the maximum permitted under its Articles of Association – 9 of these, including the Chairman, are non-executive directors. The Board can appoint the Chief Executive Officer, who is the only executive director.

Directors must be financial contributors to HCF and usually hold office for 3 years. The Chairman of the Board should be independent of health service providers.

**Functions** of the Board include:

- overseeing the company's business including setting the strategic direction;
- establishing goals and policies for management; and
- monitoring compliance with them together with all regulatory obligations.

There are 45 constituent hospitals and corporations (listed in HCF 1996 Annual Report) that provide representatives, who are entitled to attend and vote on motions and resolutions at AGMs. These representatives must have HCF cover.

HCF's Memorandum and Articles of Association provide that 4 of the constituent hospitals/corporations, namely:

- Catholic Health Care Association of NSW (1);
- Health Services Association of NSW (2);
- University Teaching Hospitals Association (Industrial) in NSW (1); and
- Private Hospitals Association of NSW Inc (1)

can appoint 5 directors to HCF's Board. These appointed directors have historically been office bearers or consultants to the constituent corporations appointing them.

The other 4 non-executive directors are elected by eligible contributor voters (those contributors that have registered to vote and who have held continuous hospital insurance cover for not less than one year).

Candidates for election must have continuous HCF hospital cover for not less than one year and require the support of 25 eligible contributor voters, who must sign the nomination form. The adult partner of the contributor (the person who signed the HCF enrolment form) is entitled to stand as a candidate and vote if given the written permission of the contributor.

*Source:* HCF 1996 and information supplied by the fund.

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## 5 COMPETITION IN HEALTH INSURANCE

### 5.1 Introduction

This chapter builds on the discussion of the structure and performance of the private health insurance industry carried out in chapter 4, by drawing out the implications for competition within the health insurance market. Broader issues, such as competition within the private hospital sector and between public and private hospitals, are discussed elsewhere (chapter 8).

The terms of reference for the inquiry require the Commission to have regard to the legislative review provisions of the Competition Principles Agreement (set out in box 5.1). The reference also identifies sections of the *Health Insurance Act 1973* (dealing with payments for hospital services) and the *National Health Act 1953* (dealing with private health insurance).

**Box 5.1: Legislative review provisions of the Competition Principles Agreement**

Under the Competition Principles Agreement between the Commonwealth and the states and territories, each jurisdiction is to review all existing legislation that affects competition by the year 2000. According to the Agreement, the guiding principle is that legislation (including Acts, enactments, Ordinances or regulations) should not restrict competition unless it can be demonstrated that: (a) the benefits of the restriction to the community as a whole outweigh the costs; and (b) the objectives of the legislation can only be achieved by restricting competition.

A review of legislation should: (a) clarify the objectives of the legislation; (b) identify the nature of the restriction on competition; (c) analyse the likely effect of the restriction on competition and on the economy generally; (d) assess and balance the costs and benefits of the restriction; and (e) consider alternative means for achieving the same result including non-legislative approaches.

*Source:* National Competition Council 1997.

The broad intent of the legislative review process is to eliminate anti-competitive regulation, or replace it with alternative measures, unless it can be shown to be in the public interest. The Commonwealth's review program is also concerned with regulation that may be costly to business. In responding to the

legislative review requirements, however, the Commission has been constrained by its terms of reference to take into account the Government's policy to retain Medicare, bulk billing and community rating.

A detailed analysis of the regulatory and institutional environment in which health funds operate was provided in chapter 3, and further discussion is given in chapter 8. In this chapter, the ways in which the regulatory framework affects competition are examined.

Health funds can compete in a variety of ways — here their behaviour in relation to price, product, marketing and contracting is examined. Because the question of market definition is important to any consideration of competition issues, the relevant market in which health funds compete is also considered, together with the degree of seller concentration. Finally, a key feature of market structure that is likely to influence competition — the height of barriers to entry — is then discussed, noting in particular whether the regulatory environment discriminates against potential new entrants.

## **5.2 Participants' comments on competition**

Participants submitted a range of views on the degree of competition in the health insurance industry. Some saw a highly competitive market. For example, the Australian Health Insurance Association Ltd (AHIA) commented that:

The existence of an extremely competitive health insurance marketplace ensures premium prices are kept to a minimum commensurate with constraints on the capacity of insurers to restrain volume. (Sub. 108, p. 11)

Similarly, the Australian Health Service Alliance Ltd (AHSA) stated that:

the private health insurance industry has demonstrated a high degree of resilience, innovation in product design and is as competitive as it can be under the current regulatory environment. (Sub. 44, p. 5)

On the other hand, SGIC Health Pty Ltd (SGIC) pointed to a lack of competition:

Currently each state has two or three competitors in the market, one of which is the national insurer, Medibank Private. ... This gives rise to a lack of competition with the established fund names in each state creating a natural barrier to new competitors. (Sub. 26, p. 3)

Similarly, the Australian Private Hospitals Association Ltd (APHA) stated that:

There is a lack of real competition between health insurance funds in most states. ... This lack of competition dilutes competitive pressures which could encourage

health fund efficiency. The situation is exacerbated by a strict regulatory environment which discourages product innovation. (Sub. 51, p. 10)

Gaining some understanding of the extent to which funds face competitive pressure is important, as it also provides an indication of the incentives facing funds to keep costs and premiums as low as possible. However, as AHSA's comment indicates, the extent to which competitive pressure can be translated into efficiency is influenced by the regulatory environment.

### **5.3 How do health insurance organisations compete?**

Participants indicated a variety of ways in which private health insurance organisations compete. PHIAC's view was that:

The scope for competition and innovation in the private health insurance industry is defined by statutory requirements for community rating, stringent conditions of registration, price control and solvency. Schedule 1 of the National Health Act defines the conditions of registration which effectively limits the range of products offered, defines categories of membership and coverage and waiting periods for benefits etc. ... Within this context, competition revolves around service and price. (Sub. 90, p. 58)

The AHIA stated that:

Health funds compete on the basis of price, service, benefits and product mix. (Sub. 108, p. 45)

#### **Price competition**

Two aspects of pricing behaviour in the industry are: first, the pricing of different products within a given fund; and second, the pricing of similar products between funds. Participants commented on both aspects.

The AHIA (Sub. 108) stressed that it should not be assumed that there is little emphasis on price in health funds' competitive strategies — funds often promote their price advantages. Australian Unity also shared that view:

Price competition in the health insurance industry is fierce for two reasons. First, the elasticity in the market means that any increase will cause a drop in membership. ... Secondly, fund members can pick up their contributions and move to another fund for no loss of entitlement, and many do, to take advantage of marginal savings. (Sub. 163, p. 64)

But the degree of product complexity makes it difficult for consumers to make fully informed price comparisons between competing products offered by different funds. As PHIAC noted:



Product definitions as advertised make it difficult to compare and therefore hard for consumers to decide. However, if consumers first decide on the type of cover needed [broad category of insurance], price difference is likely to become a major factor in consumer choice. (Sub. 90, p. 59)

The Health Insurance Commission (HIC 1996) argued that health funds *do* compete on price, and that any similarity between fund prices is due to:

- similarity between fund products, with funds setting prices based on expected membership liability; and
- lack of significant variation in membership liability.

In contrast, the AHSA indicated that the prices of different products offered by funds can vary significantly, because the products offer different benefits. For example, they observed that among the three major funds in Victoria, the price difference between products offering budget-price and top-of-the-range cover was as high as 63 per cent for ancillary cover and 50 per cent for hospital cover.

The AHSA also argued that any differences between funds (in a given state) in prices charged for similar products were indicative of industry competitiveness:

Taking 100 per cent cover as a benchmark, because this product offers the most homogeneous level of benefits by most funds — but ignoring some of the unique features that differentiate products between funds — we observe a price difference of up to 30 per cent. ... This difference in products and prices is the true indication of competition. (Sub. 44, p. 8)

There are several reasons why price levels for similar products might vary between funds — such as demographic profile, location, services available, and marketing decisions (PHIAC, Sub. 90, p. 59). But it is a moot point as to whether price differences within markets, rather than price similarities, are an indication of competition. It could be argued that it is only particular features of the demand for private health insurance — such as product complexity, consumer ignorance, importance of brand names, and consumer inertia — that could allow price differences of (say) 30 per cent to exist in a competitive market. Contrary to the AHSA claim, therefore, a smaller difference in price for otherwise similar products is likely to be a truer indication of competition than a larger difference.

In relation to the most recent pricing responses of some incumbents, Ian McAuley commented that:

The ‘crisis’ which precipitated the present inquiry provides an illustration of the way in which insurers work. No firm with a competitive mentality would raise prices on the eve of a big marketing opportunity developing. But this industry is exhibiting the behaviour of one with a ‘cost-plus’ mentality. (Sub. 13, p. 8)

But it might also be suggested that the industry has limited scope to do anything else, since ‘costs’ are largely outside its control and funds are required to maintain minimum reserve levels and obviously seek to stay in business. (The previous chapter noted that the industry recorded a sizeable loss in the September quarter 1996.)

The extent to which price differences exist between similar products offered by different funds is difficult to assess because of the problem of identifying products with similar benefits. While bouts of price rivalry have been observed from time to time, funds have limited scope to engage in price competition for a number of reasons: first, funds can readily get themselves into trouble by putting their required reserve levels in jeopardy; second, as noted above, the major part of their costs are influenced by factors outside their control; third, the lower prices may well attract a disproportionate number of customers who claim; and finally, mutuals cannot draw on other sources of capital to fund the price reductions.

In short, there are substantial downside risks to health insurance funds engaging in vigorous price rivalry. But there is also no evidence that prices are excessive relative to costs, as illustrated by the recent losses incurred in the industry (see chapter 4).

### **Product competition**

As noted in chapter 4, health funds offer a wide range of products that provide different benefits and are targeted at specific market segments. But as discussed in chapter 3, there are some product areas where funds don’t compete because they are prevented from doing so by regulation. For example, under current arrangements funds cannot or have limited incentive to provide catastrophic cover, limited elective surgery products, or gap insurance for out-of-hospital medical care.

Similarly, funds are constrained in the types of products they can offer because of the community rating principle. But as Peter Carroll noted, the industry has displayed considerable ingenuity in coping with community rating:

Many products are designed to appeal disproportionately to specific good risk groups and, if the design is effective, deliver a portion of the benefit back to customers through lower prices. Devices such as clever use of deductibles and copayments, restriction of particular covers and targeted marketing and distribution strategies are used as proxies for the underwriting methods commonly used elsewhere to control insurance costs. (Sub. 9, p. 16)

The Department of Health and Family Services (the 'Department') pointed out that the marketing of 'niche' products to particular groups of potential members has led to a proliferation of products and may have led to greater consumer confusion (Sub. 175, p. 26).

But as the AHSA commented:

product diversity is a symbol of a customer responsive, competitive and innovative market. Product diversity is demanded by consumers and therefore, from a health fund point of view, is defensible. (Sub. 44, p. 8)

The conclusion is that funds appear to engage in product competition and innovation within the constraints imposed by the regulatory environment. It is notable that whenever product regulations are eased (such as allowing front end deductibles) there tends to be a flurry of activity, as funds attempt to match the behaviour of rivals with similar new product offerings.

But given the complexity and diversity of products available, it is very difficult for consumers to make an informed assessment of the relative merits of competing products offered by different funds. This tends to reduce competitive pressures, because in such circumstances consumers are more likely to stick with their existing funds (although they always have the option of dropping insurance in favour of Medicare).

## **Marketing and distribution**

As noted by Coopers & Lybrand (Sub. 58), insurers compete through marketing campaigns to attract customers, and by establishing distribution outlets that can deliver convenient service. Advertising is also used to promote fund services and 'image'.

The AHIA reported considerable diversity in how funds administer their operations and their public presence. It attributed the different ways in which funds present themselves to their markets, and develop different distribution systems, as largely a function of competition:

A fund may deliberately choose to site branches at places where it believes it will recruit more customers. Others may wish to develop other systems to provide member services. Market forces determine what customers want. (Sub. 108, p. 54)

Several participants thought that Medibank Private had an unfair marketing advantage through its relationship with Medicare. For example, National Mutual Health Insurance (NMHI, Sub. 140, p. 48) and SGIC (Sub. 26, p. 5) argued that all health funds should be able to act as agents for Medicare, to enable them to

be on a more competitive footing with Medibank Private (see chapters 3 and 10).

### **Contracting with hospitals**

One competitive strategy that has been increasingly followed in recent years is for funds to negotiate contracts with health providers (mainly hospitals) in order to provide financial security for members receiving treatment in those hospitals. As the AHSA noted:

to provide consumers with financial security, funds are under pressure to have contracts with as many hospitals as is possible. More hospitals under contract means greater coverage and minimum inconvenience to members. ... Without a contract, the value of the health insurance is diminished if members face uncertainty about out-of-pocket costs. (Sub. 44, p. 14)

As noted in chapter 4, in the period since the first fund — Hospital Benefits Association (HBA) — negotiated contracts with hospitals, and particularly after the 1995 legislation facilitating such contracts, other funds have had to respond by also entering into agreements, so as not to be placed at a competitive disadvantage. One reason why 31 small-to-medium sized funds formed the Australian Health Service Alliance was to facilitate contract negotiation with private hospitals and other health care providers.

But the APHA argued that whether the fund-hospital contracting process promotes competition between funds depends on consumers being fully aware of the hospitals with which the particular funds have negotiated contracts. In this respect, the APHA suggested that:

There appears to be little information provided to members on hospital contract status. This dulls the competition between funds in attracting consumers but also eliminates any pressure on funds to contract with appropriate hospitals. (Sub. D217, p. 25)

Richard Scotton (Sub. D234) argued that the regulatory environment had encouraged funds to have a ‘pass-through’ attitude in relation to fees charged by health care providers, rather than a strong bargaining approach. In his view, funds have tended to accept benefit/fee levels and utilisation rates as given, and set contribution rates so as to cover outgoings plus management costs and accumulation of reserves (Sub. D234, pp. 2–3). The issue of the relative bargaining power of funds compared with hospitals in negotiating agreements is discussed in chapter 8.

## **Summing-up on funds' competitive behaviour**

This brief review suggests that health insurance organisations compete in areas where they are best able to. Particular features of funds' cost structures mean there is only limited scope for them to compete on price, but at the same time there is no evidence that prices are excessive relative to costs. Similarly, product regulations dictate the types of health insurance products that funds can offer. But the wide variety of products that are available coupled with the information difficulties that consumers face in making informed comparisons between products, can lead to consumer inertia and weaken competitive pressures. Overall, it appears that the main ways in which funds compete are in the areas of marketing and contracting, and constrained product variation, rather than price.

Because the behaviour of funds is influenced by features of the competitive environment in which they operate, it is necessary to look at the nature of the relevant market in which they actually compete to draw any further conclusions about the degree of competition.

## **5.4 Market characteristics**

In assessing competition issues, the relevant concept of the 'market' is the area of close competition between firms — taking account of substitution possibilities on both the demand and supply sides of the market. Markets are multi-dimensional, having product, space, function and time dimensions (see IC 1996, chapter 2). In this section, the focus is mainly on the geographic space dimension of the health insurance market.

In the case of private health insurance, it is appropriate to think of the geographic market as being narrower than the Australia-wide industry.

The AHIA noted that:

Market penetration varies widely between organisations, and some restrict their activities to particular employment groups (RMOs), some to particular regions, some to states, and some operate, or plan to operate, nationally. (Sub. 108, p. 29)

It would seem that the most workable concept of the market is on a state basis. According to Peter Carroll:

the private health insurance market in Australia is effectively segmented into separate markets in each of the states and the Northern Territory. Competition within each segment is far more intense than it is across segments, because the products offered in one state or territory are not easily substitutable for those in another. (Sub. 9, p. 9)

There are a number of factors which have contributed to this geographic market segmentation:

- differences in the hospital and medical systems, managed or regulated by the various state and territory governments;
- until recently, regulation of private health insurance on a state and territory basis, with reinsurance still based on separate state/territory pools;
- different consumer cultures in the various segments, reflecting differences in historical developments in health care provision (for example, a stronger consumer preference for private hospitals in Victoria compared to New South Wales); and
- the importance of ‘local’ brand names — such as NMHI operating under the brands of HBA in Victoria, Mutual Community in SA, and Territory Mutual in the NT; and the dominance of the Hospital Benefits Fund of Western Australia in WA.

Because of this geographic market segmentation, it is appropriate to examine seller concentration on a state-by-state basis. As indicated in chapter 4, the degree of seller concentration by state is much higher than at the national level — the largest three funds in each state and territory cover three-quarters or more of members in each region. Such concentration at the state level would appear high enough to confer market power on funds, if supported by significant barriers to the entry of new firms.

But it should also be noted that from a product dimension viewpoint, the relevant market is broader than just the health insurance funds competing among themselves — it would also include Medicare. This is because there is a point where consumers can perceive the price of private health insurance to be ‘too high’ and choose the ‘free’ alternative (Medicare), since there is a significant degree of substitution in services (see chapter 2).

## **5.5 Relative ease or difficulty of entry**

The threat of potential competition from new entrants can be an important constraint on the exercise of market power even in highly concentrated markets. The importance of such a threat depends on the height of barriers to entry. When entry barriers are low, excessive price increases by incumbents — whether reflecting cost-padding or profit-taking — might be expected to induce outsiders to seek profitable opportunities and enter.

New entrants are most likely to come from three areas:

- an existing participant seeking to enter the market in another state;
- other insurers seeking to enter the health insurance industry; and
- foreign insurers seeking to enter the domestic industry.

There was a range of views on the extent of barriers to *new* entrants into the private health insurance industry. At one extreme, the AHIA commented that:

If ... the industry was 'inefficient' one would reasonably expect new entrants who could compete against existing players, especially as there are relatively few real barriers to entry. The existence of regulation, rating schemes, etc, should not be a deterrent to any operator who genuinely believed their own managerial efficiency outweighed that of current players. It is an excuse rather than a reason. (Sub. 108, p. 47)

On the other hand, Mercantile Mutual argued that:

The structure ... shows an industry dominated by a few major players with barriers to new competitors entering the market. These barriers take the form of regulation that stifles innovation and competition combined with a specific regulatory system unknown outside the industry. (Sub. 142, p. 9)

Similarly, the Australian Medical Association Ltd (AMA) stated that:

The private health insurance industry has been rendered less competitive by government overregulation. There is a small number of competitive players in the relevant markets and lack of entry and exit over the last ten years. (Sub. 130, p. ii)

In considering factors influencing the decision to enter the industry, it is useful to distinguish between:

- features of the regulatory environment that apply equally to all firms;
- features of the industry which confer competitive advantages on incumbents and discriminate against entrants; and
- other features of the industry which render it sufficiently unattractive that new firms might choose not to enter.

It is only barriers to entry of the second kind (that impose a differential cost on entrants) that have consequences for market power.

## Possible regulatory barriers

### *Registration requirement*

As discussed in chapter 3, an organisation can operate a private health insurance fund only if it has obtained registration for that purpose under the National Health Act.

The Department considered that the only regulatory requirement that might be a barrier to entry is the requirement for funds to have a minimum level of reserves (but this is an industry-wide requirement). It commented that:

Apart from this monetary requirement there is nothing in the [*National Health*] Act or its regulations which prevent banks, life insurance companies or anyone else from becoming registered health benefits organisations. (Sub. 175, p. 25)

Until recently, registration was state based and reserves had to be held in accordance with activity in each state. But those conditions no longer apply (refer chapter 3).

But the Department also mentioned that that part of the Act covering the registration and operation of health benefits organisations is extremely complex and difficult to understand. This may be a disincentive to enter the market, particularly for those planning to enter with for-profit status:

While the Act does not prevent particular corporate entities from becoming registered health benefits organisations, it is based on the fundamental premise that health funds are not operated on a for-profit basis. [The] convoluted route [for existing funds to convert to for-profit status] gives the clear message that for-profit status is not welcome. (Sub. 175, p. 25)

On balance, while there are no aspects to registration that actually prevent new entry, there are particular aspects which may act as a deterrent.

### *Community rating*

Community rating was seen by some participants as an obstacle to new entrants. The Commission's informal discussions, as well as a number of submissions, suggest that it deters new players, particularly from life or general insurance areas, from entering the health insurance market. For example, AMP Financial Services (AMP) commented that:

current interpretations of community rating lead to a poor risk pool with selection against health funds, poor consumer information on health options leading to increased incidence and severity of claims and poor alignment of incentives along the care continuum. (Sub. 159, p. 2)



But because community rating impinges on all firms (incumbents as well as new entrants), it is not a factor that would allow incumbents to exercise market power.

### *Reinsurance pooling arrangement*

Westfund (Sub. 133) considered the reinsurance pooling arrangements to be a major impediment to any new entrant. Coopers & Lybrand also commented on the likely consequences of reinsurance for entry:

[It] will ... act as a significant barrier to entry for new funds and restrict the profitability of funds with younger, healthier members. It might be expected that new funds have the ability to market younger, healthier members but would nevertheless be forced to make a payment to the reinsurance pool. (Sub. 58, p. 34)

NMHI discussed the impact of reinsurance pooling on competition. It pointed out that because reinsurance operates on a state basis, the competitive position of insurers will be affected (due to the level of private hospital utilisation and the age profile varying considerably across states):

Health funds with large memberships in states with lower private hospital utilisation and a more favourable age profile ... face lower aggregate claims costs and are thus able to offer lower premiums. (Sub. 90, p. 51)

But a new entrant to a particular state market could also gain access to these advantages once its membership built up. Furthermore, because competition tends only to take place within state markets, reinsurance pooling would have little broader impact on price competition between funds in different states.

## **Factors creating possible competitive disadvantages for new entrants**

### *Tax advantages of not-for-profit incumbents*

As noted above, all but three of the 48 organisations involved in private health insurance operate on a not-for-profit basis, and are exempt from income tax. This tax advantage may allow incumbents to price at levels that would only achieve below-normal profits for a potential taxable entrant.

Peter Carroll argued that both the current reserve requirements and taxation differences in the industry disadvantage new (for-profit) entrants in a way which is discriminatory:

Most of the established players are mutuals set up before there were minimum reserve requirements, and have accumulated their reserves from untaxed earnings over many years. A new entrant to the market today is required to meet the

minimum reserve requirements immediately business is written, or to suffer an intensive level of regulatory scrutiny. Furthermore, for a new entrant financed through equity capital, reserves must be established from after tax earnings. (Sub. D213, p. 3)

The potential effects of non-taxable and taxable status on premiums are examined in appendix E. It is shown that in response to an increase in membership (or any factor which increases required reserve levels), a for-profit fund would need to raise premiums by a greater amount to achieve a target level of reserves than would be the case for a not-for-profit fund — with the higher premiums placing the for-profit fund at a price disadvantage.

While income tax exemption for not-for-profit incumbents can therefore constitute an entry barrier to for-profit organisations, to the extent that it operates through allowing not-for-profit funds to offer lower prices, it is not necessarily a concern from the perspective of consumers of health insurance products.

### *Brand loyalty*

To the extent that brand names are important, a barrier to entry can be created through potential entrants having to incur higher marketing costs and pricing disadvantages in order to overcome established brand names and consumer loyalties.

As PHIAC commented:

anecdotal evidence suggests a high degree of brand loyalty amongst high claiming contributors, with price elasticity more evident amongst low claimers. (Sub. 90, p. 58)

This constitutes an entry barrier to the extent that it involves sunk costs that incumbents can spread over larger membership numbers than a potential new entrant would initially be able to attract.

There are other features on the demand side of the market which affect competition. As noted in chapter 4, some funds offer products that confer benefits (for example, a reducing excess) depending on the length of continuous membership. These rewards tend to ‘lock-in’ consumers with a particular fund and inhibit switching. As Brent Walker commented:

One of the things the funds did back in 1975 when they developed the ancillary tables was they tacked on loyalty bonuses into their benefits. ... All these things gave the perception to the public that there was benefit in staying with that organisation and not moving around all the time. .. The ploy was [to] lock the people in [and] try and create some loyalty. And I think that has tended to work. (Roundtable Transcript, p. 100)

On the other hand, it should be noted that existing members can transfer freely between funds and enjoy continuity of membership for the same level of benefits without incurring any waiting periods that would apply to a first time applicant. This degree of flexibility *facilitates* competition among funds. As the Department commented:

Transfer provisions also provide a more competitive environment for funds. Funds know that there has to be a reasonable comparability of products or risk losing market share. (Sub. 175, p. 24)

But to what extent do existing members actually switch between funds? As background, it should be noted that the majority of members have been with their current fund for a relatively long period of time — according to TQA survey data for 1995, around 70 per cent of members had been with the same fund for seven years or longer, and around one-third for at least 20 years (see TQA 1995, table 13.3).

At the other extreme, around 14 per cent of members in 1995 had joined their current fund only in the last two years, and around 30 per cent of these had switched from another fund in the same state. Around one-half of those members who switched reported price (cheaper/lower cost) as the main reason for changing funds, and a further 25 per cent reported better benefits/more cover (TQA 1995).

The overall importance of fund-switching behaviour is best gauged as the proportion of all persons with private hospital cover who switch funds. The TQA survey data reveal the proportion to be quite small — generally only around 4 per cent in any year. But there are differences between states, with fund-switching being more common in Tasmania (9 per cent in 1995) and SA (8 per cent) than in NSW (3 per cent) or WA (1 per cent).

Brand loyalty and member inertia are therefore more likely to act as a barrier to entry in states where the proportion of members switching funds is very low, insofar as that is indicative of the potential market share that might be captured by a new entrant.

### *Economies of scale*

The question of the extent to which access to scale economies by the larger incumbents can give them a cost advantage over potential entrants was discussed in chapter 4 (see also appendix G). A relationship was found between the management cost ratio and size of organisation among major funds. But the fragmented nature of the industry into regional and occupational markets means that scale economies are not crucial for small niche players which confine their business to segments of the market with a geographic or occupational focus.

And in these regional and restricted membership markets, the local or closed fund often has greater market penetration than the larger organisations.

New entrants might also be deterred from entry because of the advantages achieved by large, long-established funds, in negotiating contracts with hospitals and other health service providers. But the AHIA (Sub. 108) noted that regional and other small funds have recently formed buying alliances to provide them with purchasing capacity more in line with that of larger funds.

On balance, scale economies constitute a barrier to entry only if a new fund seeks to enter the market with the aspiration of being a major player.

### **Other factors making new entry unattractive**

#### *Low average profitability of incumbents*

The recent profitability experience of the industry was discussed in chapter 4, where it was shown that funds overall have recorded operating losses in three of the past seven years. The AHSA considered the poor profitability of the industry to be the most important deterrent to entry:

The greatest barrier preventing new entrants from participating in the private health insurance industry is the poor profitability, caused by the high level of regulation of the industry. Investors will employ capital in markets that offer returns on investment commensurate with the risks involved. (Sub. 44, p.12)

The Department argued along similar lines by suggesting that the continued decline in the private health insurance participation rate has not made entry into the industry by banks, life insurance companies or anyone else an attractive proposition.

Some participants thought that the mutual status of most participants was likely to reduce the profit incentive and encourage the pursuit of non-profit objectives (Peter Carroll, Sub. 9, p. 16). SGIC noted that:

In a normal market with shareholders and investors determining the allocation of resources, only the strongest and most efficient firms survive. There are few, if any, market forces in the health insurance market. Because of the mutual or closed nature of a majority of the Funds, the only element driving management is to maintain a solvency position above the minimum set out in the Health Act. (Sub. 26, p. 3)

But the low profitability of the industry as a whole is likely to reflect the interaction of a host of other features of the industry as well as characteristics of individual funds, as evidenced by the wide variation in profitability across different funds (refer Coopers & Lybrand, Sub. 58, p. 16).

*Regulation and uncertainty*

Another deterrent to entry mentioned by participants was the high level of uncertainty in the industry, associated with general market instability and continual regulatory changes. The AHIA considered that the uncertainty created by changes to health financing arrangements made corporate planning difficult (Sub. 108, p. 66). The Insurance Council of Australia Ltd and the Life, Investment and Superannuation Association of Australia stated that:

The regulatory environment covering health insurance and the health industry has been uncertain. This reduces greatly the incentive to make up-front investment to enter the health insurance market and for insurers already in the market to expand. Insurers seek a more certain environment that is free from unexpected government intervention. ... [T]he present instability of the health system act[s] as a deterrent to innovative insurance products. The system is certainly a disincentive to any degree of imaginative promotion, long-term product development and customer relationship marketing. (Sub. 189, pp. 1–2)

Price regulation was raised as a particular concern. If funds are not free to make pricing decisions, this poses a problem for profit-making companies with Boards and shareholders. For example, SGIC commented that:

The private health insurance industry is one of a few, if not the only, industry where a Minister of the Federal Government is required to approve all pricing/product matters. No fund can amend their prices (premiums) without the approval of the Minister of Health and Family Services, and now the approval of the Prime Minister and Treasurer is also required. ... We believe the best control and regulator of premium levels ... is in the market place. (Sub. 26, p. 6)

Similarly, Clive Ashenden of Medical Benefits Fund of Australia Ltd (MBF) stated that:

I'm having to get price increases agreed through Government. ... [T]here is absolutely no rationale in the private enterprise environment for that happening. (Roundtable Transcript, p. 90)

Effective deregulation is long overdue to remove excessive Government interference in the day to day operations of funds, particularly in key areas such as pricing. (MBF, Sub. 29, p. 4)

But in relation to whether the Government can actually control prices, Andrew Podger (the Department) indicated that:

The legislation is a very interesting piece of legislation. We don't approve, we just have certain powers to disallow under three criteria ... [which] ... are extremely limited. (Roundtable Transcript, p. 91)

Some other participants considered that problems with the current health care system as a whole — such as the wrong economic incentives, and fragmentation

in terms of funding arrangements, care provision and information — made entry into private health insurance unattractive (AMP, Sub. 159).

### **Conditions of exit/takeover**

Because of the brand name advantages of incumbents, together with member inertia, the takeover of an existing organisation may well be a preferred entry strategy rather than the establishment of a new fund. But failure is rare and 'hostile' takeover is precluded by the mutual structure — a fund must agree to be taken over.

SGIC commented on the implications of this feature:

The mutual nature of participants makes it difficult for interstate competitors to acquire smaller state based funds and build market share on the basis of that name. ... If the market were made up of companies, it would be possible for a new Fund or an interstate Fund to buy one or more of the smaller funds, and build a market share to become a significant player. (Sub. 26, p. 3)

It is likely, therefore, that the mutual status of participants *is* an obstacle to greater competitive pressure.

### **International competition**

One particular feature of the industry is that it has not attracted entry by foreign insurers. Peter Carroll attributed this to the uncertainty created by general market instability and continual regulatory changes, and noted that:

A number of major international insurers such as Cigna and Aetna, based in the US, and Norwich Union, based in the UK, have entered the health insurance markets in New Zealand and South Africa but have avoided doing so in Australia. (Sub. 9, p. 12)

However, there is the possibility that in the future the industry will face direct competition from overseas companies. For example, Tom Karp (Deputy Commissioner, Insurance and Superannuation Commission) told the Commission that the ability to purchase insurance via the Internet has just commenced in the USA, and when international standards for insurers are introduced this should make it more popular, as consumers will have greater confidence in the soundness of offshore insurers. Of course, the ability of offshore insurers to service local customers and pay claims will be some brake on this competition, but this will vary with the type of policy and its likely claim frequency.

### **Summing-up on conditions of entry**

A key element of market structure which influences the extent of competitive pressures is the height and nature of barriers to entry. There are some economic barriers which tend to give incumbents competitive advantages over new entrants, such as the importance of brand names, and member inertia. The not-for-profit status of most participants may give them a slight price advantage over new rivals who enter with for-profit status. Scale economy barriers appear not to be of significance if new funds seek to target particular niche markets rather than attempt to compete more broadly with the established majors in the industry.

But there are also common regulatory and other features of the industry which affect incumbents and new firms alike. High on the list of regulatory factors which participants reported as rendering the industry unattractive are community rating and reinsurance. Perhaps the main feature of the industry which deters entry is low profitability — there are other areas of the economy where firms perceive the return on investment to be better than in health insurance.

### **5.6 Concluding comments**

The private health insurance market is geographically segmented on a state basis, with each market characterised by a very small number of participants. This high degree of concentration suggests the possibility that incumbents might possess market power and that competitive pressures might be weak.

But in assessing the degree of competition in the health insurance market, it is not just the number of actual competitors which is relevant. Rather, observed behaviour is also influenced by other factors, including the threat of potential competition, and features of the broader competitive and regulatory environment in which health funds operate.

Health funds seek to compete on the basis of price, product, marketing, and contracting, but their behaviour in some of these areas is constrained by regulations and other factors. In particular, it appears that funds are more effective at competing in marketing (and service), while product and price competition are tempered by regulatory constraints, most notably community rating and reinsurance. There are also certain features of funds' cost structures which limit their ability to engage in vigorous price rivalry. At the same time, there is little to suggest that prices are excessive in relation to costs.

Given that consumers can choose the free alternative (Medicare) if they perceive the cost of private health insurance to be ‘too high’, Medicare itself constitutes a major source of competitive discipline facing private health insurance funds.

In relation to potential rivals, there appear to be few entry barriers that give incumbents a competitive advantage over new entrants. Brand loyalty or information-related consumer inertia — combined with the impregnability of mutual funds to ‘hostile’ takeovers — and the mutual funds’ exemption from income tax are the only ones of any significance (the Commission addresses these in chapter 10). There are other factors which render the industry unattractive and thereby deter entry — most notably, community rating, reinsurance, and low overall profitability. But these are burdens on the incumbents as well.

The Competition Principles Agreement stipulates certain requirements for carrying out reviews of legislation — any restriction on competition should be identified, likely effects on competition analysed, an assessment made of whether the restriction is justified, and consideration given to alternative means that might achieve the same result. Community rating is perhaps the main feature of the regulatory environment that affects health fund behaviour. The Commission finds that neither it nor other regulations are *discriminatory* restrictions in the sense of favouring incumbents over potential new entrants.

Rather, the regulations in place — in relation to access to private health insurance, and products and benefits offered — influence the *nature* of price and product competition among funds. They do have a restrictive effect on choice in the market as well as imposing costs on business (see chapters 3 and 10). But the Commission has been constrained by its terms of reference from assessing the justification for these effects. What it has done, in taking community rating as given, is examine ways of achieving a better outcome for the community.

In conclusion, there appears to be a reasonable degree of competition among health insurance funds, more so in some areas than in others, but behaviour and performance are constrained by regulations that affect incumbents and potential entrants alike. A number of proposals are put forward in chapter 10 to address these issues.



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## 6 USERS OF HEALTH INSURANCE

### 6.1 Introduction

If there is a general perception of a crisis in health insurance it arises because of the cumulative actions of many individuals. We observe that large numbers of people are relinquishing private insurance, that the shrinking pool of the insured tends to be older and higher users of health services, that muted price signals may expand the demand for health care, and that there are opportunistic users of insurance who enter and exit during times of medical need while avoiding contributions to insurance at other times. The collective impact of these myriad of individual behaviours puts pressure on premiums and this in turn weakens the attractiveness of insurance — creating a vicious circle of declining membership and escalating premiums.

To understand why these processes are at work we need to look closely at the patterns of insurance usage and at the users (and potential users) of private health insurance — their age, health, income and other socioeconomic characteristics — and their behaviour (such as their responsiveness to price, quality, queuing times). We also need to have this information to assess the likely impact of various policy options (who will leave or enter? what will be their health costs? what equity implications are there?).

### 6.2 An overview of health insurance membership

#### Hospital insurance

In June 1996, there were just under 2.9 million contributors to hospital insurance covering just over 6.1 million people (or 33.6 per cent of the population). About 45 per cent of these contributors were memberships covering just one person, while the remaining 55 per cent were family memberships — covering an average of just over 3 persons per policy.

Coverage of the population varies markedly by state, with a 12 percentage point variation between maximum and minimum coverage (table 6.1). The Northern Territory, with only a quarter of people privately insured, has the lowest coverage, but this likely reflects its younger demographics, its substantial aboriginal population and the greater proportion of people living in rural

locations.<sup>1</sup> Queensland also appears anomalous with a much lower share of people covered (30.9 per cent) than any other state. Notably, Queensland has had a long-term policy of free public hospitals for all residents (for many years before the advent of Medicare). For this reason, some inquiry participants saw the Queensland situation as a natural experiment which, in the absence of counteracting policy changes, established the long-run membership share of private health insurance.

Table 6.1: Membership<sup>a</sup> of hospital insurance, June 1996

	<i>NSW</i>	<i>VIC</i>	<i>QLD</i>	<i>SA</i>	<i>NT</i>	<i>WA</i>	<i>TAS</i>	<i>AUST</i>
<i>Membership (no. of contributors)</i>								
Single ('000)	478	346	200	119	7	117	38	1305
Family ('000)	565	378	276	127	12	174	44	1576
Total ('000)	1044	724	476	246	19	291	82	2881
<i>Persons covered</i>								
Number of persons covered ('000)	2218	1518	1038	504	46	650	176	6149
Share of state population covered (%)	34.1	33.5	30.9	34.1	25.6	36.9	37.1	33.6

a Membership is defined as the number of policies. There may be more than one person covered per policy.

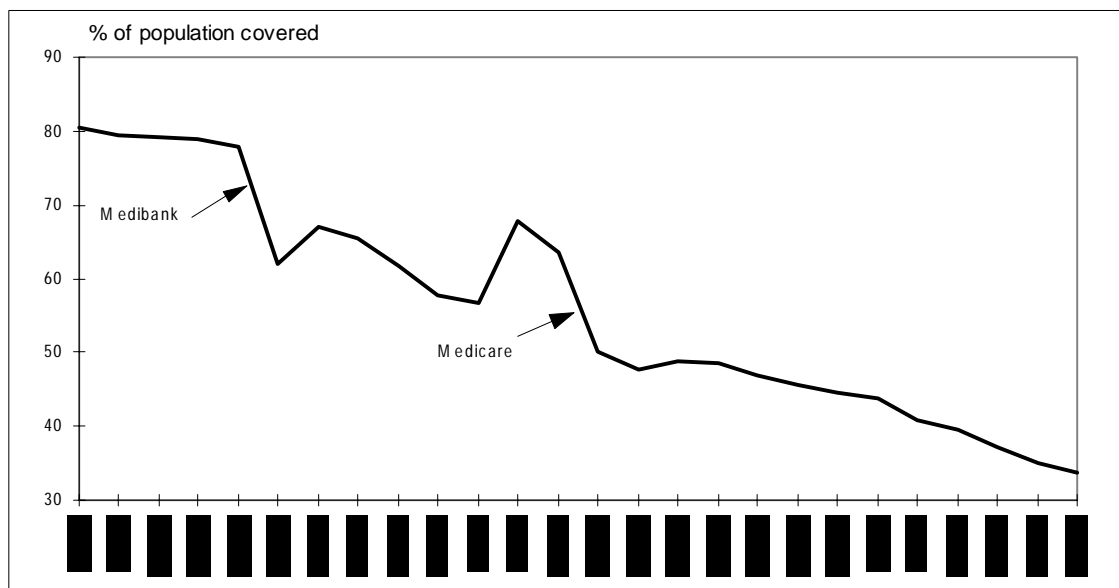
Source: PHIAC 1996a.

Demand for most goods is stable, shifting slowly year by year. The demand for private health insurance is quite different. There have been marked changes in membership numbers and coverage of the population over time — reflecting abrupt changes in the regulatory and institutional regimes that embrace most aspects of the industry.

Figures 6.1 and 6.2 depict the pattern of demand for health insurance for Australia and by each state, across radically different policy regimes — indicating that consumers' demand *can* respond rapidly to changes in incentives to insure.

<sup>1</sup> Health insurance tends to have lower take-up in rural areas given weaker availability of private hospitals.

Figure 6.1: Share of people covered by hospital insurance (per cent)



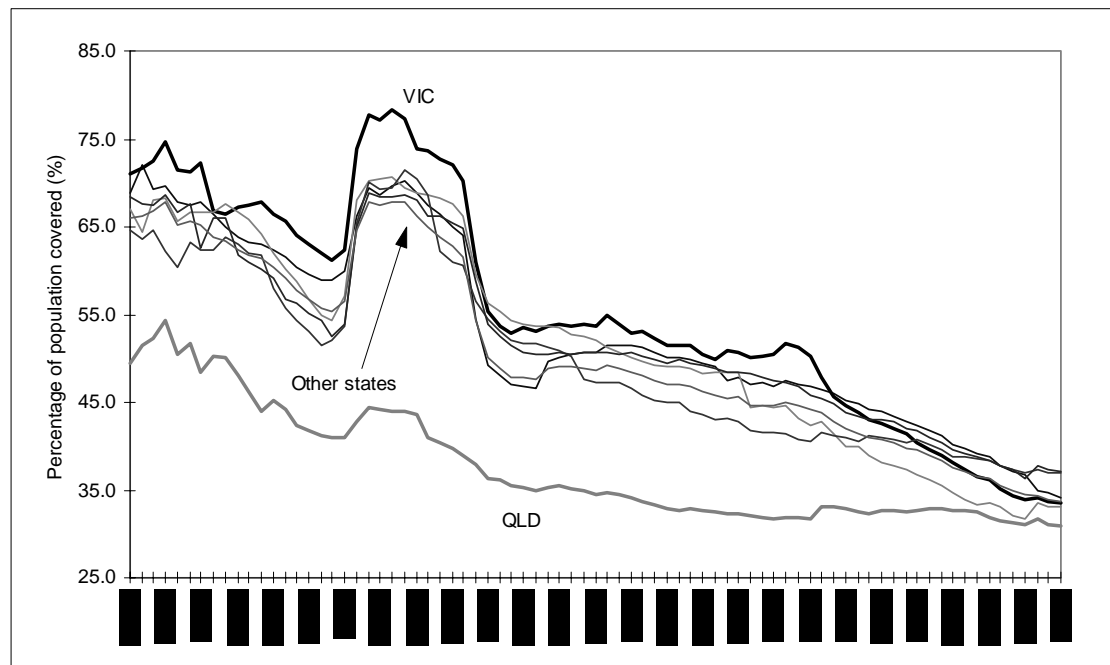
Source: PHIAC data for the year ending June from 1971 to 1996.

Some of the critical changes in the policy and regulatory regime, which explain the large shifts apparent in the pattern of demand are:

- The introduction of Medibank in 1975 reduced incentives for private insurance, reducing demand by about 18 percentage points in one year.
- A contingent 2.5 per cent levy on taxable income was introduced in October 1976. The levy was payable if a person wished to receive free public care but was waived if private insurance was purchased. This pushed up demand by around 5 percentage points.
- Further declines in health insurance took place after the abandonment of the levy in late 1978, pushing coverage of private health insurance down by around 10 percentage points over a four year period.
- In 1981 a series of initiatives either placed downward pressure on premiums or otherwise provided encouragement to take out insurance: incentives for *medical* insurance were introduced in late 1981; the government subsidy to the reinsurance pool roughly doubled in 1980–81; and bed day subsidies in private hospitals increased substantially in mid 1981, while at the same time basic hospital cover attracted a tax rebate of 32 per cent. The net impact of these measures increased coverage by 11 percentage points in one year.
- The tax rebate for private health insurance was abolished in July 1983, while in early 1984, Medicare was introduced. These measures cut demand for

health insurance by around 14 percentage points, so that less than 50 per cent of the population was covered.

Figure 6.2: Share of people covered by hospital insurance, by state (%)



Source: PHIA data covering the period from June quarter 1976 to June quarter 1996.

Policy changes since the inception of Medicare have been less abrupt or significant and, accordingly, have had less pronounced impacts on demand. Even so, the gradual removal of Commonwealth subsidies to reinsurance and cessation of private hospital bed day subsidies placed further upward pressure on premiums and generated associated contractions in demand. The rebate initiatives announced by the Government in 1996 can be seen as partly reversing the previous withdrawal of support.

Since June 1984 (just after Medicare), private health insurance coverage has declined from 50 per cent of the population to 33.6 per cent. The rate of decline has accelerated over time. In the first three years after Medicare, there was little change in the coverage of private health insurance (table 6.2) — partly reflecting the NSW doctors' dispute. In the next three years (June 1987 to June 1990), it fell by a trend rate of nearly 3 per cent per annum. In the subsequent three years it fell by 4.7 per cent per annum, while in the most recent three year period it fell by 5.5 per cent per annum. Altogether over the five years from 1991–92 to 1995–96, insurance coverage dropped by about 1.4 million or an average of nearly 800 people (net) per day.

Table 6.2: Trend growth rates in shares of people covered by state, June 1984 to June 1996<sup>a</sup> (per cent)

	<i>NSW/ACT<sup>b</sup></i>	<i>VIC</i>	<i>QLD</i>	<i>SA/NT</i>	<i>WA</i>	<i>TAS</i>	<i>AUST</i>
June 84 to June 87	3.0	-0.1	-1.8	-3.4	-5.2	-1.3	0.0
June 87 to June 90	-3.4	-1.8	-2.1	-3.9	-3.8	-2.0	-2.9
June 90 to June 93	-3.9	-8.7	0.9	-6.8	-0.6	-4.5	-4.7
June 93 to June 96	-7.2	-6.7	-2.3	-3.6	-3.2	-3.9	-5.5
June 84 to June 96	-2.8	-4.3	-1.0	-5.0	-2.9	-3.1	-3.3

a The trend growth rates are annualised trend growth rates, estimated by regressing the log value of the membership share against a time trend.

b The NSW doctors' dispute occurred during the first period, and may explain why uptake of insurance actually rose during this time.

Source: Data provided by PHIAC.

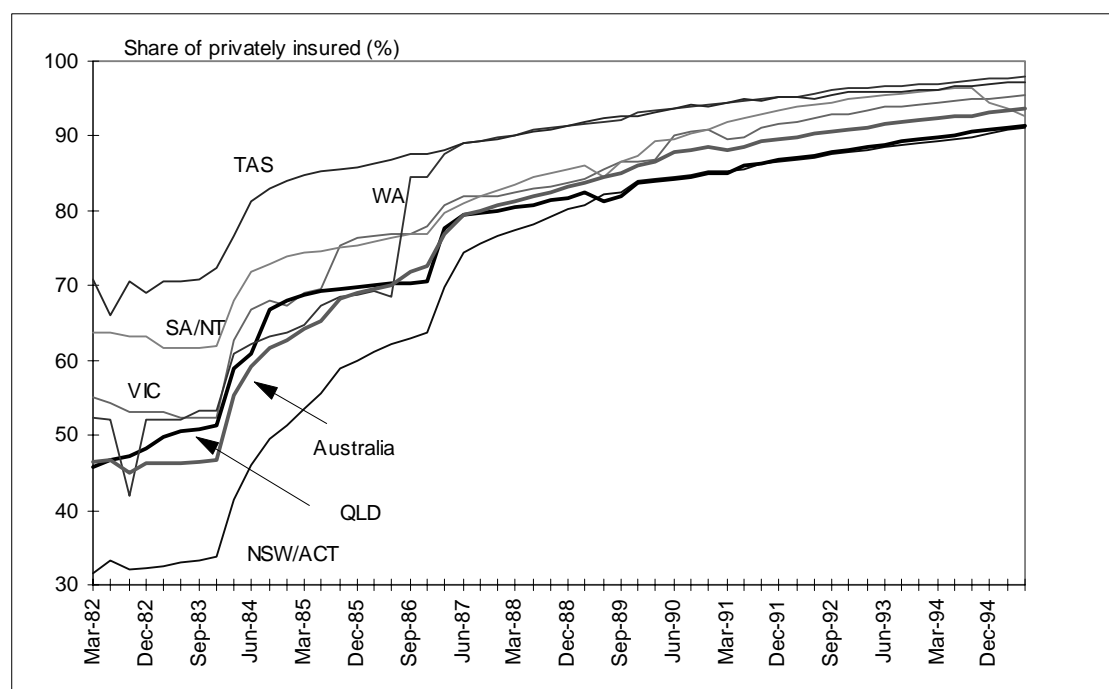
There are large differences in the membership attrition rates in different states. Queensland, as already noted, has much lower rates of decline than other states. South Australia and Northern Territory have recorded consistently high attrition rates. Victoria had modest decreases in the first six years after Medicare, but has since recorded such substantial falls in membership that, over the whole period since Medicare, it has experienced the second highest attrition rate.

While there has been an erosion in the proportion of people covered by private health insurance over the past decade, there has also been a steady shift in the *type* of insurance policy purchased (figure 6.3 and table 6.3). In 1982, only about 46 per cent of privately insured people purchased supplementary cover (which typically entitled the insured to high levels of hospital cover in private hospitals as well as basic cover in public hospitals). By June 1995, this had risen to around 94 per cent of the insured population.

The large upward shift in the incidence of supplementary insurance after Medicare was introduced is likely to largely reflect exits from private health insurance of those with basic hospital insurance, rather than an increased preference for supplementary insurance by those insured.<sup>2</sup>

<sup>2</sup> The Commission does not have the detailed 'transition' data to confirm this. To examine this question rigorously requires data on people who *migrate* from basic to supplementary (and vice versa), on previously uninsured people who *enter* basic or supplementary tables and on people who *exit* from basic and supplementary tables out of insurance altogether. Some of the patterns seen in the aggregate data would be consistent with people with basic tables migrating to supplementary tables, and for people in supplementary tables exiting altogether. However, such a series of flows appears to be highly implausible — it seems far more

Figure 6.3: Share of privately insured with supplementary cover, by state, March quarter 1982 to June quarter 1995 (per cent)



Source: Data provided by PHIAC.

Table 6.3: Shifts in type of insurance, March quarter 1982 to June quarter 1995 (per cent)

	Share of population with basic only (B)	Share of population with supplementary (S)	Share of insured with supplementary insurance ( $S/[B+S]$ )
Mar-82	36.2	31.3	46.4
Jun-86	14.6	34.2	70.0
Jun-90	5.5	39.0	87.6
Jun-94	2.8	34.4	92.4
Jun-95	2.3	32.7	93.5

Source: Data provided by PHIAC.

For example, in the March quarter 1984, 24.3 per cent of the population had basic only insurance, a drop of 8.4 percentage points from the previous quarter. Thirty per cent of the population held supplementary policies, up only 1.2

credible that the general trend reflects the exit from insurance of many people with basic insurance.

percentage points on the previous quarter — suggesting that substitution between the two forms of insurance was weak during this period.

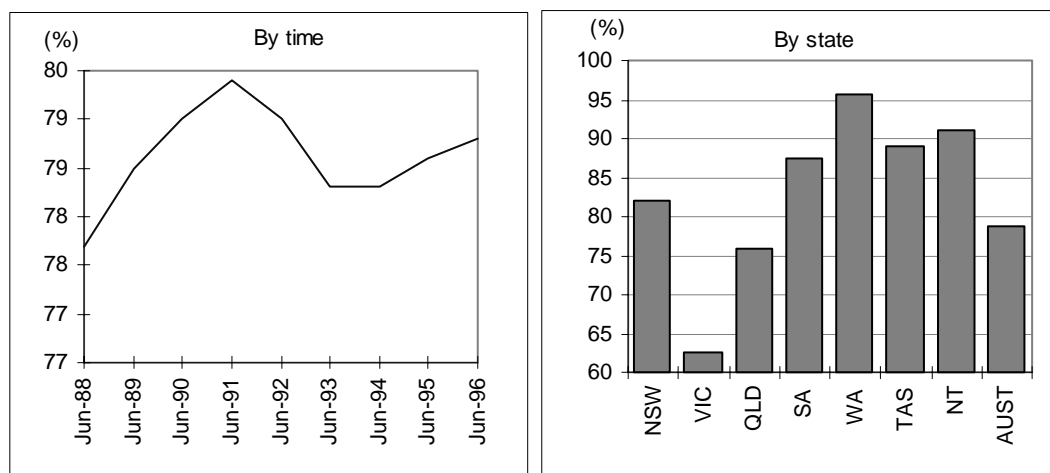
However, while the long run trends are consistent with this view, there have been instances, sporadic for most of the states, but occurring over a much longer period in Queensland, when the reduction in basic-only coverage probably represented migration to supplementary insurance, rather than out of insurance.

### Ancillary insurance

Ancillary insurance covers people for a set of non-hospital costs — mainly dental, optical and physiotherapy.<sup>3</sup> Most contributors holding health insurance policies hold ancillary insurance. A small group (16 per cent in June 1996) hold ancillary policies only.

Demand for ancillary insurance has been relatively stable — in contrast to hospital insurance — but its uptake in various states is much more variable than hospital insurance (figure 6.4).

Figure 6.4: Share of people with health insurance having ancillary cover (per cent)



Sources: PHIA 1996a, AHIA, *Private Health Insurance Industry Statistics*, June 1996.

<sup>3</sup> Dental comprised 53 per cent of ancillary benefits in 1995–96, while optical and physiotherapy accounted for 15 per cent and 7 per cent respectively.

For example, whereas around 95 per cent of West Australians with health insurance have an ancillary policy, only around 60 per cent of Victorians do.

The use of ancillary insurance has a different character to that of hospital insurance:

- It is not really insurance in the proper sense, in that purchasers expect to claim every year, and large, catastrophic, expenditures are not covered. The product usually has limits on yearly rebates for given complaints.
- The coverage typically relates to medical services involving no referral. The patient self-refers to a practitioner — for example, a dentist.
- Copayments are much more significant as a proportion of treatment costs. For example, a typical policy offers consumers around 60 per cent rebates on expenditure on dental treatment. The existence of large copayments likely reflects the otherwise high risk of moral hazard (overuse) if there is near or complete insurance of an oft recurring and self-referred medical expenditure.<sup>4</sup>

Given the stark differences in the characteristics of the service and its use by consumers, the perplexing feature of ancillary insurance is why it is so routinely purchased as a bundle with hospital insurance. It contributes little to total premium rises, and consumers can buy it separately from private hospital insurance. The rest of this chapter focuses on hospital insurance.

## Self-insurance

The private health insurance *industry* is an intermediary, providing consumers with risk and resource pooling opportunities to gain access to health care supplementary to the public system. But there is one, sometimes ignored, alternative to either hospital insurance or the tax funded public system: ‘self-insurance’.

Private health insurance protects against two broad types of uncertainty: the uncertain *treatment costs* during a lifetime and uncertain *timing* of these costs. Usually self-insurance is sub-optimal because the greatest uncertainties relate to the lifetime costs — for example, we do not expect our house to burn down during our lifetime, but there is a small probability that it may. However, much of private health insurance covers expenditure items which are likely to occur

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<sup>4</sup> The AIHW (Sub. D202) noted that the demand for ancillary services was much higher for the insured than the uninsured, although it was unable to assess to what extent this reflected income differences between the two groups or moral hazard.



over a lifetime, but whose exact timing is unknown (for example, confinement costs). Thus individuals have a capacity to at least partly match private health insurance by saving. The stock of savings can then be used to smooth expenditures over time.

However, the term 'self-insurance' is widely used to cover all cases where individuals decide to meet the full costs of an episode of care, regardless of whether they make provision to meet lifetime costs via savings in any systematic way.

Self-insurance (in either form) is interesting from a public policy viewpoint for three reasons.

- It lies outside community rating regulations. To the extent that an insurance policy protects against the unknown *timing* of health costs, rather than uncertain *magnitude* of costs, then younger, healthier people wishing to gain access to the private hospital system or choice of doctor in the public system may well find it optimal to self-insure rather than insure through the regulated private intermediaries. For example, by self-insuring, a young male loses some risk pooling abilities but gains an average \$500 per annum in reduced obligations to others through community rating.
- There is a tax credit of 20 per cent for every dollar in excess of \$1430 expenditure (rising to \$1500 in 1997–98).
- To the extent that public policy on private health insurance is intended to supplement aggregate health funding, self-insurance is as effective a mode of achieving this as private health insurance. Yet public policy has largely ignored the role of self-insurance.

The significance of self-insurance is uncertain. In 1994–95, 18.4 per cent of separations from private hospitals involved people who were not privately insured (table 6.4). However, based on past data, many of these will have been funded by workers' compensation, so that this share represents an upper limit. In 1991–92, when data on patients separated the uninsured from compensable and other patients, the uninsured represented around 7 per cent of separations from private hospitals.

Table 6.4: Proportion of separations by insurance status, private hospitals, 1991–92 to 1994–95 (per cent)

<i>Year</i>	<i>Insured</i>	<i>Uninsured</i>	<i>Compensable/ other<sup>a</sup></i>	<i>Not stated<sup>b</sup></i>	<i>Total without insurance</i>	<i>Total</i>
1991–92	81.9	7.2	10.3	0.5	18.1	100
1992–93	82.9	4.9	8.4	3.8	17.1	100
1993–94	81.7	...	11.7	...	18.4	100
1994–95	81.5	...	15.6	...	18.4	100

a Comprises contract, Repatriation or Department of Veterans Affairs beneficiary, Defence Forces and compensable. From 1993–94 onwards, this category was not reported.

b A number of hospitals were unable to provide information on the uninsured/compensable/other dissection.

Source: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years.

### 6.3 Outlook for demand

If the trends continue at their long run historical rate, then only around 11 per cent of Australians would have private health insurance by the year 2030 (table 6.5). On the other hand, if current trends continue, about 22 per cent of Queenslanders will be covered at that time. It is incongruous that the state with the smallest current coverage would have double the Australia-wide average in the long run. It seems much more likely that rates of attrition will slow in other states so that their long run position is similar to Queensland.

Table 6.5: Long run trends in membership shares by state, 2000 to 2030 (per cent of population)

	<i>NSW/ACT</i>	<i>VIC</i>	<i>QLD</i>	<i>SA/NT</i>	<i>WA</i>	<i>TAS</i>	<i>AUST</i>
Jun–2000	30.4	28.2	29.7	27.2	32.8	32.8	29.5
Jun–2005	26.4	22.7	28.2	21.2	28.3	28.1	25.0
Jun–2010	22.9	18.3	26.8	16.5	24.5	24.0	21.3
Jun–2015	19.9	14.7	25.5	12.8	21.1	20.6	18.1
Jun–2020	17.2	11.8	24.3	10.0	18.2	17.6	15.3
Jun–2025	14.9	9.5	23.1	7.8	15.7	15.1	13.0
Jun–2030	13.0	7.7	21.9	6.1	13.6	12.9	11.1

Source: Based on extrapolation using the long run exponential trend rate evident from June 1994 to June 1996.

## 6.4 Determinants of demand

A wide variety of socio-economic factors drive the demand for health insurance, from income and price to age, ethnicity and location. In this sense, there is nothing special about health insurance — the demand for all goods and services varies with such factors.

But two factors are special to insurance services and explain their existence: the role of risk aversion and risk pooling (box 6.1). We examine these fundamental factors first, and some perverse features of the demand for health insurance, before considering the more typical determinants.

### Fundamental determinants

#### *Risk aversion*

Risk aversion captures the idea that people are willing to pay to avoid uncertainty. If there is a one in a hundred chance of a treatment costing one thousand dollars, then the risk averse person will prefer to forgo at least \$10 to insure against that risk, a risk neutral person is willing to pay only \$10 and a risk loving person will prefer the gamble to the \$10 premium. Since there are always costs of providing insurance (such as hiring actuaries, financial systems, billing and so on — called the ‘loading’ fee), full insurance cannot be offered at the actuarially fair price. All other things being equal, this implies that only the risk averse insure at premiums that are actuarially ‘unfair’.<sup>5</sup>

#### *Risk pooling*

Some rare illnesses are catastrophic — they involve treatment costs beyond the purchasing power of many individuals and, if untreated, even greater costs (including death). In this case it is no longer valid to look at the trade-off between an unlikely payment for treatment and a certain insurance amount, but rather between the cost of *not treating* the illness and the premium. People who were risk neutral or even risk loving might take out actuarially unfair policies to pool risks.

In an Australian context, risk pooling probably plays a more minor role in consumers’ minds than risk aversion because of the existence of a universal ‘free’ system. On the other hand, for some groups — such as the old on lower incomes — risk pooling may be a stronger factor (recalling that there can be

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<sup>5</sup> The term ‘actuarially unfair’ is used by actuaries to describe a situation where the expected value of the benefits of insurance is smaller than the premium. This is not to suggest that the outcome is unfair.

protracted delays in Medicare treatment for some disabling elective operations like hip replacements).

**Box 6.1: An illustration of risk pooling and risk aversion**

First, imagine a person, say K, with an annual income of \$25 000. In K's world you are either well (with probability of  $p$ ) or you acquire an illness (with probability  $1-p$ ) which costs \$30 000 to treat. If you leave the illness untreated, it costs you \$45 000 in lost earnings, pain and disability. Unfortunately, you can't borrow readily to finance current health care costs. How will K behave? For the moment suppose that K is new to the workforce so that she has not accumulated savings which could avert such a crisis. She therefore has only one choice: to insure or not. Say  $(1-p)$  is 0.0001 or one in ten thousand. In this case, if K is uninsured then the expected cost is \$4.50. Say that an insurer offers a policy at \$3.20. K will take the policy even if she is risk neutral. In fact she will take it unless she actually enjoys risk so much that it offsets the risk pooling advantage offered by the insurer.

Now suppose that another person, L, earns \$80 000 a year and that she can meet all her tax and subsistence needs with \$30 000 leaving \$50 000 of disposable income. L has a choice that her poorer counterpart did not: she can self insure because she has adequate income to cover the cost of treatment. If she is risk neutral then the insurer must offer a policy at less than \$3.00 — which is clearly actuarially impossible. Of course, if she was risk averse, it may well be worth paying out for the \$3.20 policy.

This very simple and contrived example indicates that there are two forces at work in the demand for insurance: risk pooling for people like K who in adverse states of the world could not even afford the treatment, and risk aversion for people like L who are happy to pay a premium to avoid risk.

Why do these two concepts matter?

- First, they explain why health insurance is economically valuable. Insurance offers consumers ways of either pooling resources for unlikely contingencies or to avoid uncertain events.
- Second, they are useful in explaining the uptake of insurance by different groups. Some submissions to the inquiry characterised the young insured as irrational because the price of their policies exceeded expected benefits, judged from risk neutral grounds. But with either risk pooling or risk aversion, it may be perfectly rational to still take out insurance.

## **Perverse features of demand for insurance**

Not only are there some unique drivers for insurance, but some uniquely perverse behaviours that are activated by insurance, particularly within a regulated environment.

### *Moral hazard*

As price falls people demand more. Under insurance, the prices of health care services are either zero or very low, so that people demand more. This can mean that people buy too much health care, because they buy more than they really would be willing to pay for if they actually had to bear the full cost. The extent to which they buy 'too much' is known as moral hazard (Besley 1989).

However, because the demand for health care is typically price inelastic, moral hazard problems are likely to be small for most, *but not all*, health services. There are few studies for Australia, and those that exist examine a small range of procedures (for example, a study by Cheah et. al. 1994 of demand for barium meal radiology found a welfare loss from moral hazard of around 1.5 per cent of health insurance rebates).

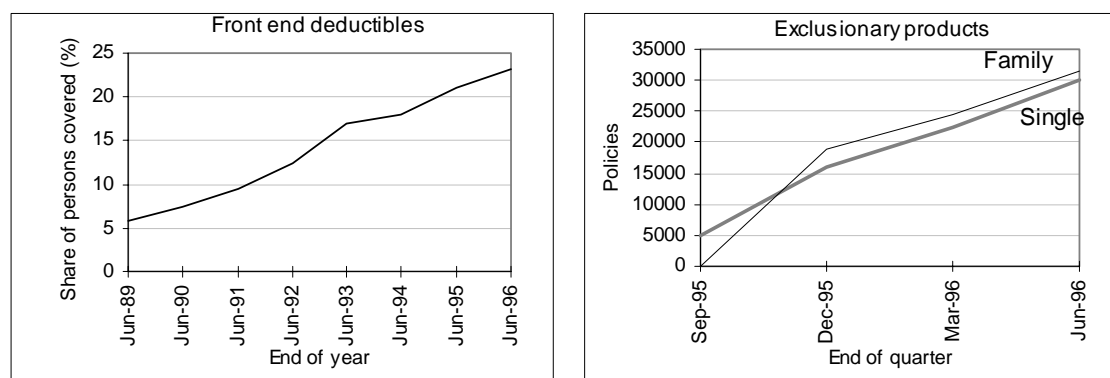
Insurers develop antidotes for moral hazard by using a variety of cost sharing mechanisms such as:

- Front end deductibles, where a person pays an initial amount towards the cost of care. These policies have expanded rapidly in Australia, from around 6 per cent of persons covered by insurance in June 1989 to nearly a quarter by the end of June 1996 (figure 6.5).
- Ad valorem copayments, where a person actually meets a fixed share of costs. These are customarily used in ancillary policies, where individual expenditures by consumers are relatively small, and moral hazard problems arguably the greatest. They are not used in hospital insurance where individual expenses can be very large, and moral hazard problems more muted.
- Benefit limits which impose a limit on total cover.

### *Adverse selection*

Adverse selection occurs because the true risk level of any individual is not discernible to an insurer (Culyer 1994). Insurers set premiums based on *average* risks within any broad risk group. These are actuarially attractive to the riskiest people in that group, and not attractive to the least risky group. The least risky group then find it worthwhile to self-insure or, in the Australian context, use Medicare instead.

Figure 6.5: The uptake of specialised insurance products



Source: PHIAC 1996a.

Adverse selection is minimised in either:

- full risk rated insurance systems, because there are many different risk groups, and insurers have strong incentives to assess risk. They can also design policies, such as front end deductibles, or exclusionary products, to create incentives for honest disclosure of low risk. Such products are based on the principle that only a lower risk individual would seek to use them; or
- a compulsory system of private health insurance.

In the Australian context, a *voluntary* system of *community rating* intensifies adverse selection — this is what Logan (1995 p. 11) identifies as the system's 'built in self-destruct mechanism'. Voluntary community rating amplifies adverse selection for two reasons:

- There is just one big risk group — the 'community', used as the basis for setting premiums. As shown later, this leads to premiums well in excess of expected benefits for the young and healthy, and very favourable to the old or sick.
- Its voluntary nature means that the lower risk groups can exit, leaving a pool of people with higher risk. Premiums then rise, reflecting the higher risk, and the cycle begins again.

In the Australian setting adverse selection is manifested in two other ways:

- 'Hit and runs'. These occur when people opportunistically take out insurance ahead of a known episode of illness in order to receive care, and then leave insurance. Hit and runs are borne of the regulatory system (chapter 3 and chapter 10), which regulates waiting periods for pre-existing ailments. A typical hit and run is an obstetrics case. A woman takes out insurance just before conception, with the intention of having her baby in a private hospital,

and then leaving private health insurance. The premium for top cover hospital care is around \$750. The average cost of confinement in a private hospital is around \$3500<sup>6</sup> — the ‘hit and run’ represents a loss to the insurer (or more to the point, enduring members of health insurance) of \$2750. The incidence and impact of ‘hit and runs’ is hard to assess — but probably accounts for no more than 2 per cent of benefits paid (appendix H).

- ‘Hit and stays’. These occur when people delay entry to health insurance until they reach a time of their lives when health costs are expected to be higher (say around age 60).

Adverse selection is a critical feature of the Australian system and its empirical basis is examined in later sections of this chapter and in chapter 7.

### *Cream skimming*

Insurers also behave strategically, and they develop products which try to discriminate between the risk classes of different users of health insurance. They offer specialist products, such as exclusionary policies (where, for example, hip replacements may be excluded) to try to identify the young or well — and which can still be priced lower than other products even in a community rating setting. This is called, for obvious reasons, ‘cream skimming’.

Cream skimming, moral hazard, and adverse selection are all properties of the Australian health insurance market — and their presence and impact is magnified by our regulatory regime. They have far-reaching consequences for users’ demand for insurance, the prices they face, and the products they can buy.

## **Socio-economic determinants**

Empirical work identifies a wide range of conventional socio-economic factors explaining the demand for private health insurance in Australia. These interacting factors include:

- income;
- age;
- ethnicity;
- health status and habits;
- family type; and

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<sup>6</sup> HCF 1995, p. 27.

- location.

One of the major difficulties in looking at the demand for any good or service is disentangling the influence of the factors which act simultaneously. For example, as people grow old, their disposable income tends to fall, and often they move, they get sicker, and their partners die. Ignoring that these changes often coincide (and confound each other) can lead to misinterpretation of the impact of any one factor. One might, for instance, mistakenly view the decline in health insurance proclivity after age 65 as purely an age effect, when in fact there is strong evidence that income and other variables really explain this drop.

For this reason, we present both:

- information on how uptake of private health insurance is associated with a given socio-economic characteristic (such as income or age) *without* controlling for the influence of other variables; and
- information on the impact of each important variable on the demand for health insurance, *holding everything else constant* (based on the regression models developed by the ABS 1995 and Schofield 1996 using the 1989–90 ABS Health Survey).

### *Income*

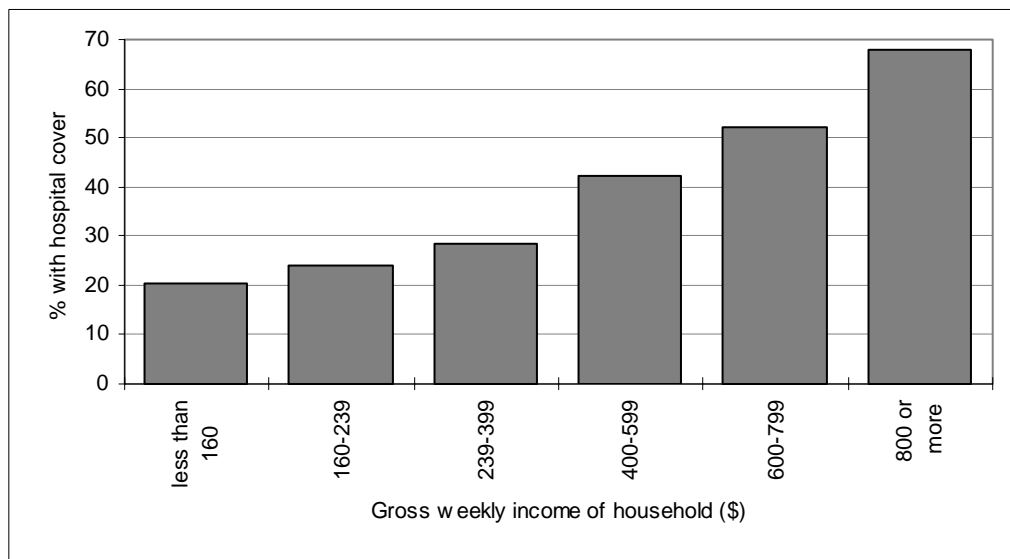
The uptake of private health insurance increases sharply with income (figure 6.6).

Only 20 per cent of the lowest income households held hospital insurance in 1992–93. An even smaller proportion held ancillary insurance. In contrast, nearly 70 per cent of households in the top income bracket held private hospital insurance and just over 62 per cent held ancillary insurance.<sup>7</sup>

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<sup>7</sup> The ABS's 1993–94 *Household Expenditure Survey* (Cat. No. 6535.0) records expenditure on hospital, medical and dental insurance. The Commission obtained data on those households recording expenditure on health insurance. The results are similar: less than 30 per cent of households in the bottom income quintile had some health insurance while 72 per cent of the top income quintile had some health insurance.



Figure 6.6: Uptake of hospital insurance by income group, 1992–93<sup>a</sup>

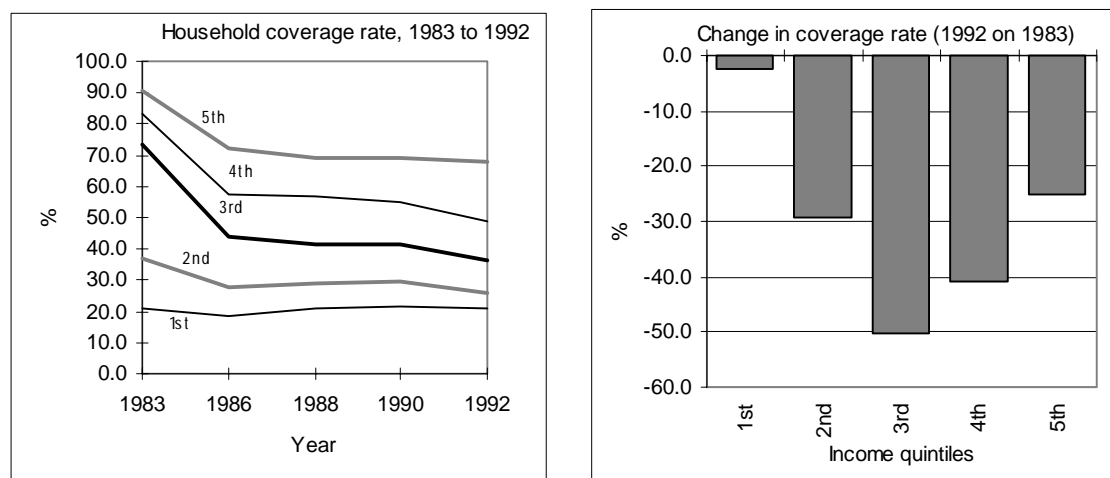
a About 3 per cent of those who were privately insured were not sure of the type of insurance policy. We have distributed these across the other categories of insurance in proportion to the importance of the different types of policy. The data is based on information provided by 'contributor units'. A contributor unit refers to the person who contributes to private health insurance either solely on their own behalf or both for themselves and other family members.

Source: ABS, *Health Insurance Survey, Australia*, June 1992, Cat. No. 4335.0.

The decline in membership since 1983 has not been uniform across households in different quintiles. Households in the fifth (the richest) and first two (poorest) income quintiles have shown the least proportionate decrease in hospital insurance coverage (figure 6.7).

It seems surprising that the poorest households have shown so little response, given that premium increases will have had the greatest impact on affordability for them. One possible resolution of this paradox is suggested by the demographic characteristics of the lowest income groups. These groups have the highest representation of older people, and older people have a much higher propensity to insure (figure 6.8).

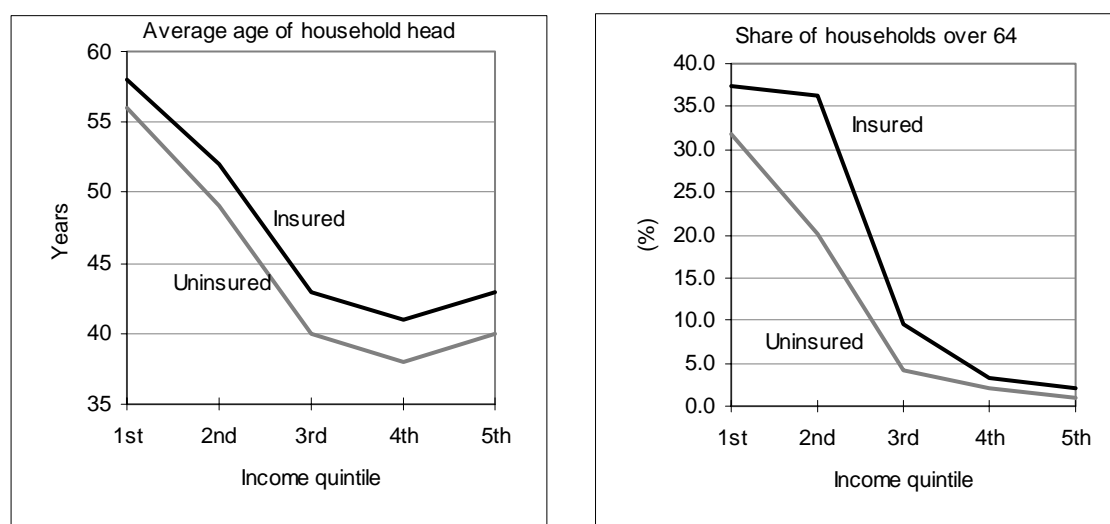
The ABS (1995) found that, *controlling for other factors*, a household on gross income of \$70 000 or more per year in 1989–90 had a five times higher likelihood of having insurance than a household with less than \$10 000 in annual income. Of course, gross income is a static, often poor, measure of real income which should, in theory, include capital gains on assets and changes in the future expected value of labour income.

Figure 6.7: Hospital insurance coverage rates by income quintile<sup>a</sup>

a These data are based on sorting households from lowest to highest income, and then calculating insurance membership in the bottom 20 per cent of households, the next 20 per cent, and so on — so-called income quintiles. The poorest 20 per cent of households are in the 1st income quintile, and the highest income households in the 5th income quintile. As the ABS Health Survey data were not based on quintiles, average health insurance coverage for each quintile group was estimated by piecewise linear interpolation.

Source: ABS, *Health Insurance Surveys*, 1983 to 1992.

Figure 6.8: Age characteristics of insured and uninsured by income quintile, 1993–94



Source: Unpublished data from the ABS, *Household Expenditure Survey*, 1993–94.

Other influential variables, such as occupation and eligibility for a health concession card, also affect the demand for private health insurance — and these probably pick up omitted income effects. Thus, a person eligible for a health concession card not only has low current income, but also assets below a certain threshold and is more likely to be retired or out of work — so that future labour income is expected to be low too.

The importance of income as a determinant of private health insurance is significant for public policy for a variety of reasons:

- It indicates something about the potential income distributional impacts of different government policies towards private health insurance. For example, non-targeted tax rebates to the privately insured represent net distribution away from typically lower income people (without private health insurance) to typically higher income people. This effect would be accentuated as the pool of the insured contracts to higher income groups, as has occurred in recent years.
- The results imply that reductions in a person's income will tend to result in forfeiture of insurance. This is particularly problematic if the reduction in income coincides with a period of increased risk of morbidity (for example, unemployment or retirement). The Commission received a number of submissions from people who were forced to relinquish their insurance because of its lack of affordability after a lifetime of payments (box 6.2).
- The evidence on the drop out rate of the elderly seems mainly attributable to income effects. While most elderly people own their own house<sup>8</sup>, another potential source of buying power, there is limited evidence of equity withdrawal by the elderly in Australia — other than some (tax penalised) trading down. This may reflect the fact that (a) instruments have only recently become available to do this, and (b) re-mortgaging the home is not an attractive prospect for the current elderly cohort.
- The results imply that large copayments associated with the medical gap of a prolonged or expensive illness may influence demand for private health insurance via an income effect. Thus an elderly person who contracts an expensive medical condition — for example, some cancers — may find copayments associated with the medical gap insupportable on their incomes. They will typically leave private health insurance. This income effect has the interesting implication that, for people below a certain income threshold,

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<sup>8</sup> About 93 per cent of people aged over 65 with private health insurance own their dwelling outright or are buying it. Access to housing equity is strong even in the group of aged without private health insurance — with 74 per cent of this group owning/buying a dwelling.

there is an effect opposite to standard adverse selection — sick people with low incomes (while facing an actuarially attractive product under community rating) will tend to leave health insurance as premiums rise, actually improving the average ‘health quality’ of the remaining pool. Overall, though, the evidence points to adverse selection as the dominant effect.

**Box 6.2: Consumer submissions relating to affordability of insurance during old age**

‘My yearly premium is now \$943.80, an increase of 287 per cent in 12 years ... if ... my premium is increased I will have no option but to cancel my membership, because as a pensioner I can ill afford even the present premium.’

‘We are concerned that as retired people, now part-pensioners, we may be compelled, along with many other people in a similar position, to cease our contribution to the fund, because of the steep increases in subscriptions during the past few years.’

‘My wife rightly points out that just when contributors need private health insurance the most, they are least able to afford it in their old age.’

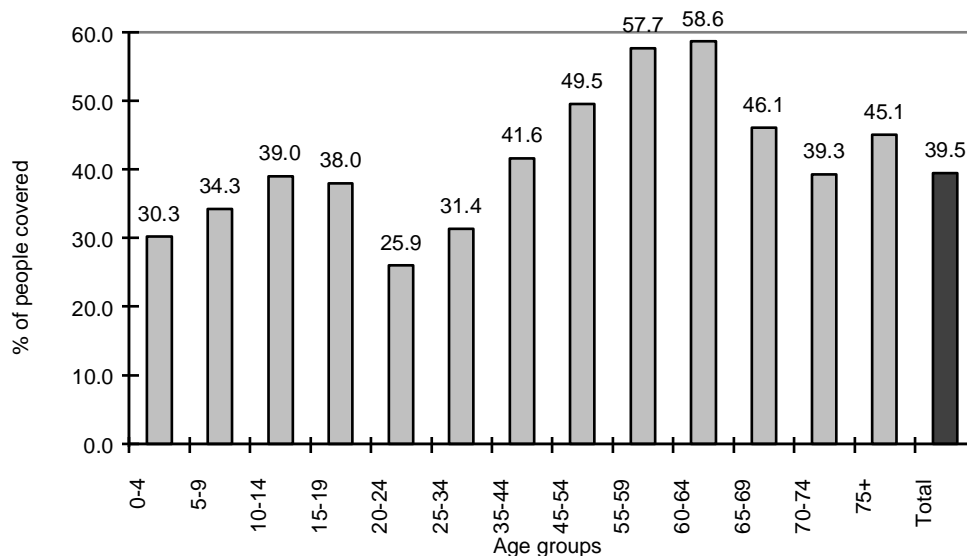
‘My wife and myself are 67 years of age and at this time where probably more than ever before we need to belong to a health fund it may be necessary to discontinue our membership because of increasing charges.’

‘I have been a pensioner for eight years (am 68) and after two or three years found I could not afford it.’

## *Age*

Cross sectional data on membership of private health insurance by adults follows an inverted U shape (figure 6.9). Young adults have the lowest participation with about one quarter of those aged 20–24 privately insured in 1992–93. Maximum participation is reached by people in ages just prior to retirement (around 60 per cent of those aged 60–64). There is then a sharp decline in membership to around 40–45 per cent for people aged 65 or more.

Figure 6.9: Age distribution of membership of hospital insurance, 1992–93<sup>a</sup>



a The AHIA data are indicative only because they do not cover all of the funds. The AHIA submission included data for 1995 but we have not used them here as they are based on a less reliable sample of the funds.

Sources: Insurance membership from the AHIA (1995, p.17) and demographic data from the ABS.

This is likely to reflect a variety of influences:

- Young people are much healthier than others, and have lower income. Under the existing community rating regime, they pay the same as an older person with higher probabilities of illness. For many, private health insurance is actuarially too unattractive to buy: it is seen as ‘poor value’. For example, a person aged 20–24 years pays more than three times the actuarially fair price for their private insurance, whereas a person aged 75 years and over pays less than one-third of the actuarial price (figure 6.10). This reflects the fact that a person aged 20–24 years makes claims which are one-tenth of those of a person aged 75 years and over. Therefore, for the young, private health insurance becomes a ‘luxury’ good — and this is reflected by the income levels of the young people who take it up. The gap between the relative incomes of the insured and the non-insured is greatest for the very young (figure 6.11).
- The oldest groups have the highest incidence of morbidity and, all things being equal, have the greatest incentives to insure under the existing community rating regime. However, income levels fall dramatically after

retirement<sup>9</sup> so that insurance becomes less affordable (figure 6.15). The pattern of usage by age suggests that many people terminate insurance after retirement as they find it too expensive given their lower budgets. If these people have been enduring members of insurance funds, they have effectively paid a substantial premium during their pre-retirement years, only to forfeit the implicit accumulated benefits at a time when their expected health costs will be highest.

Figure 6.10: Actuarial attractiveness<sup>a</sup> of private health insurance by age group

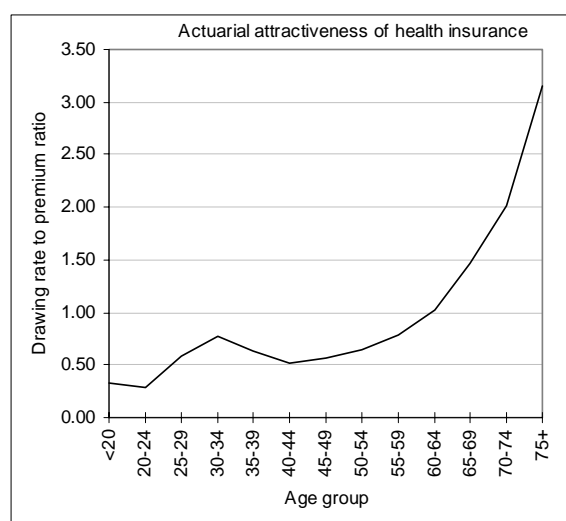
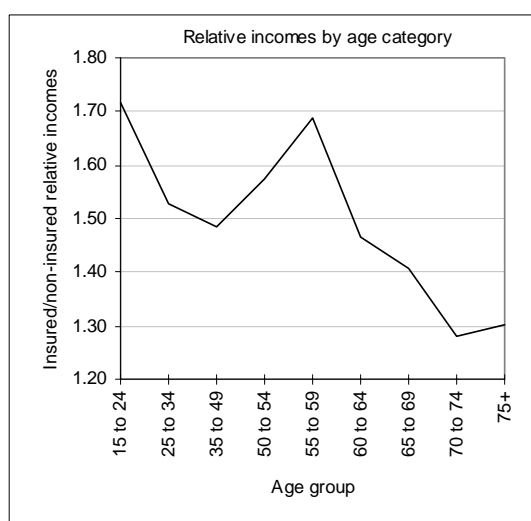


Figure 6.11: Relative incomes of insured /non-insured



a This is calculated as the ratio of the average benefits paid per person (or drawing rate) to the premium.

Sources: Alan Brown (Sub. 34, p. 4.3) and unpublished data from the ABS, *Household Expenditure Survey*, 1993–94.

- It is possible that *some* of the differences apparent in the cross-sectional data between the propensity to insure at different ages represents generational rather than lifecycle effects. Thus the fact that 50 year olds have higher insurance than 20 year olds may reflect the fact that the group of people born

<sup>9</sup> For example, the average weekly household income of a married couple with no dependants and with a reference person aged 55–64 years falls from \$533.80 to \$356.90 for a couple with a reference person aged over 65 years (or a drop of 33 per cent). The reference person is the ‘head’ of the household, defined by the ABS to be the male partner in couples and families. The 1984 ABS Health Survey is also consistent with the hypothesis that it is probably income and not some other life cycle variable underlying the abrupt decline in membership around retirement age. The 1984 survey was based on wage and salary earners alone — and so excluded aged people who had ceased to work. The proportion of contributor units which is insured is constant at around 70 per cent for units headed by people aged 50–59, 60–69 and 70+.

in 1946 (the 1946 cohort) have a different predilection for insurance than the 1976 cohort, not just that 50 year olds in general have higher insurance rates than 20 year olds. It is important to develop data-sets which can accurately discriminate between these generational and lifecycle effects — for example, a longitudinal study.

This age distribution of the insured is at least partly mimicked by patterns of use by age in the private hospital system (table 6.6). The median age of a patient in the private system is 49 years compared to 44 years in the public system — reflecting far fewer very young patients and more people aged 45 to 64.

Table 6.6: Age of patient by hospital sector, 1994–95 (per cent)

<i>Age of patient</i>	<i>Share of public bed days</i>	<i>Share of private bed days</i>	<i>Share of public separations</i>	<i>Share of private separations</i>
0-14	10.5	4.4	13.8	6.3
15-44	27.4	28.1	36.7	36.7
45-64	19.4	23.1	21.9	28.2
>65	42.7	44.3	27.6	28.9
All ages	100.0	100.0	100.0	100.0

*Source:* Department of Health and Family Services 1996d.

The age profile of the insured has been shifting away from the young (and healthy) and towards the old (table 6.7 and figure 6.12). For example, prior to the introduction of Medicare, about 70 per cent of the households with a head aged between 25 and 34 years were insured — that has now declined to about 30 per cent, representing a 60 per cent reduction in the membership ratio. In contrast, there appears to have been only a slight reduction in the coverage of older households.

Thus, notwithstanding the policy turbulence that has affected private health insurance, the proportion of those aged 65 years or more with private health insurance has stayed within a narrow band (figure 6.12 and figure 6.13). For example, from 1981–82 to 1991–92, the proportion of people aged 65 years or more with insurance *increased* by just over 1 per cent. In contrast, the proportion of people of all ages with insurance *decreased* by about 40 per cent over the same period. In the subsequent four years, there has been a slight reduction in the insurance coverage of those aged 65 years or more, but this has been modest compared to the continuing attrition apparent in membership as a whole.

Table 6.7: Uptake<sup>a</sup> of health insurance by age group, 1979 to 1995<sup>b</sup>  
(per cent)

Age group	1979 <sup>c</sup>	1980 <sup>c</sup>	1981 <sup>c</sup>	1982	1983	1984 <sup>d</sup>	1986	1988	1990	1991 <sup>e</sup>	1992	1993 <sup>e</sup>	1995 <sup>e</sup>
15–24	50.8	45.9	41.4	58.9	55.1	39.2	29.8	30.7	30.3	28.0	29.1	28.0	22.0
25–34	67.3	62.3	57.1	73.0	71.4	56.3	46.9	43.7	40.7	38.9	35.7	34.7	29.7
35–49	73.2	69.0	65.6	78.0	76.6	65.6	55.9	54.5	52.6	50.5	46.6	45.1	38.6
50–59	69.5	66.8	65.0	74.8	72.2	69.9	57.0	57.1	55.6	45.3	52.2	45.8	42.6
60–69	46.6	44.1	43.9	46.3	45.7	71.1	42.2	44.0	45.1		45.5		
70+	37.1	35.1	35.0	36.9	36.4	68.3	31.8	35.5	36.8		36.4		
Total	60.0	56.0	52.9	64.7	62.8	56.5	44.6	44.3	43.8	42.0	40.5	40.0	36.0

a Uptake of insurance is measured as the proportion of people heading a contributor unit with insurance. A contributor unit with private health insurance consists of a contributor plus all persons in the same family who are covered by the health insurance arrangements of the contributor. The age data relate to the head of the contributor unit. For couples and families, the ABS data define the head of the contributor unit as the male partner.

b Some people did not know what sort of insurance they had. Researchers have had different approaches to allocating this unknown form of insurance. The AIHW (1996) have included all of unknown as hospital insurance — not unreasonably since most insurance is hospital insurance. Wilcox (1991) excluded it altogether. The unfortunate consequence of these differential practices is that data sometimes collated for several years are based on different methods for allocating the unknown amount (for example, AIHW 1996, p.131 and the AHIA 1995, Feb, p.15). In collating the data above we have adjusted all data so that the unknown form of insurance is allocated to insurance types in proportion to the number of contributors holding those insurance types. The surveys from 1979 to 1983 and in 1986 were undertaken in March, the 1984 survey was undertaken in May, and the surveys in 1990 and 1992 were undertaken in June. The TQA surveys in 1991, 1993 and 1995 were undertaken in August.

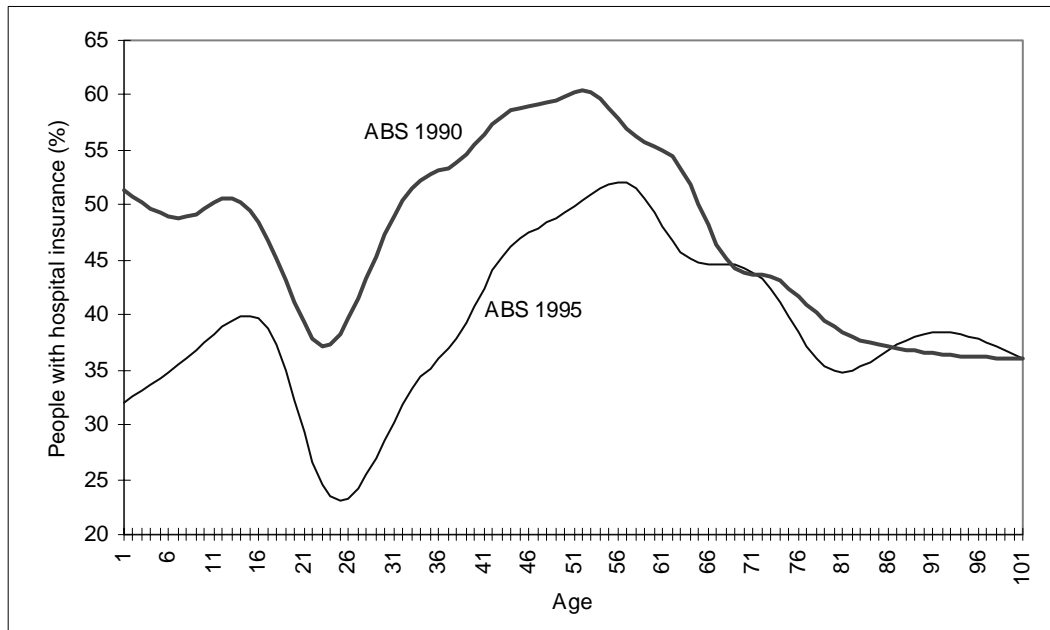
c The earlier ABS surveys categorise the old differently. The ABS provide data on people aged 60–64 and 65+ whereas later surveys have data on those aged 60–69 and 70 or more. We converted the earlier categories to the new categories with the following approximation. Let  $P_a$  denote the proportion of the population insured in age group  $a$ . From the ABS data for 1983 and 1984, we found that  $P_{6069} = 1.25P_{70+}$ . By definition  $P_{60+} = w_{6069} P_{6069} + (1-w_{6069})P_{70+}$  where  $w_{6069} = \text{POP}_{6069}/\text{POP}_{60+}$  with POP denoting the population within a particular age bracket. Therefore  $P_{70+} = P_{6069}/(1 + 0.25 w_{6069})$  and  $P_{6069} = 1.25 P_{70+}$ .

d This survey was based on wage and salary earners only. The survey may give biased estimates of insurance coverage for the population as a whole. This is because the incidence of insurance varies according to the work status of a person. This may generate particularly large biases for those aged over 65 as labour participation rates are very low for persons aged 65 and over. On the other hand, the data are probably indicative for other age groupings.

e These data are based on a survey conducted by TQA Research. Unfortunately, not all their age groupings matched those of the other data. TQA have data on the coverage of insurance for the following age groups: 15–25, 26–49, 50–64 and 65+. Using the nomenclature and methodology of note c, we found that  $P_{3549} = P_{2549}/(1 - 0.23 w_{2534})$  and  $P_{2534} = 0.77 P_{3549}$ . The data for people aged 50 or more years were calculated by appropriately weighting the two other age groups' data.

Sources: Data for 1979 to 1988 are based on the ABS *Health Insurance Surveys*, as are data for 15–24, 25–34 year olds and totals for 1990 and 1992. The data for the remaining age groups in 1990 and 1992 come from AIHW (1996) but are adapted to our methodology using data from the ABS *Health Insurance Surveys* for those two years. The data for 1991, 1993 and 1995 are from TQA Research (1995).



Figure 6.12: Membership of hospital insurance by age, 1990 and 1995<sup>a</sup>

a The original data set contains information on the insurance participation of about 20 discrete age groups. The data were centred within the age bracket of each age group, and then estimates of insurance rates by age were obtained by using the natural cubic spline interpolation technique (Burden and Faires, 1985).

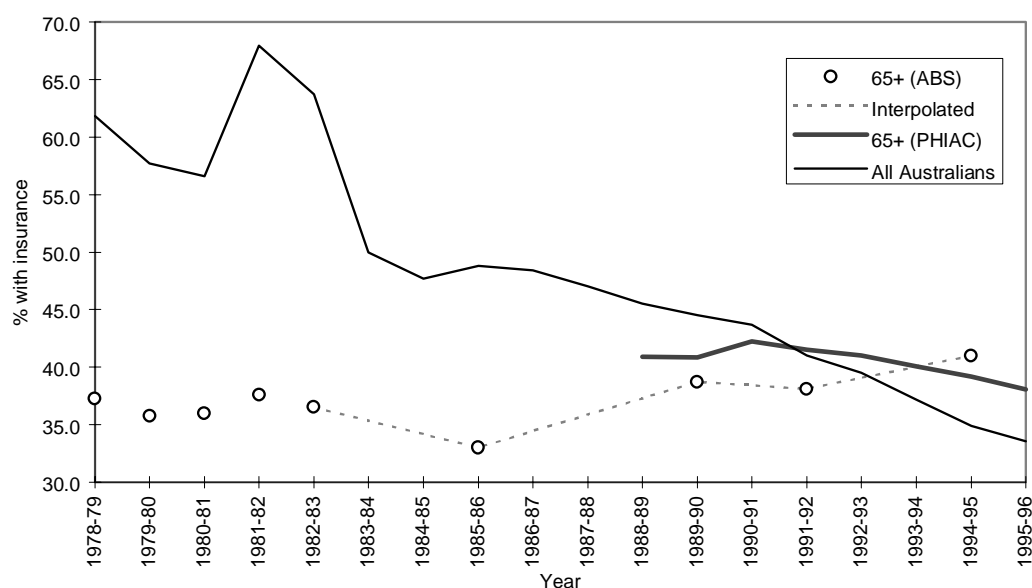
Source: ABS, *Health Surveys*.

The age distribution data suggest that people aged 65 years and over are relatively unresponsive to either favourable or unfavourable shifts in policy compared to younger groups. In contrast, younger groups, particularly those in age groups 15–24 and 25–34, have been most responsive to either negative or positive incentives to insure.

If income and other potentially confounding variables *are held constant*, the relationship between age and proclivity to insure is more pronounced. Older people are much more likely to buy private health insurance. The ABS found that, *all other things being equal*, people aged 70 or more have nearly seven times the likelihood of having private health insurance as a contributor aged less than 20 years.<sup>10</sup>

<sup>10</sup> Schofield (1996) finds an important but much weaker age effect. This reflects differences in the model specification.

Figure 6.13: People covered by hospital insurance by age, 1978–79 to 1995–96<sup>a</sup>



a The PHIAC data relate to the proportion of people aged 65 and over who have hospital insurance while the ABS data relate to the proportion of contributor units headed by a person aged 65 and over who have hospital insurance.

Sources: ABS, *Private Health Insurance Survey* (various issues) and data provided by PHIAC.

But as apparent from table 6.7, the elderly do not have very high rates of insurance — reflecting the influence of other, counteracting, factors. In particular, there are significant changes at retirement which depress the propensity to insure:

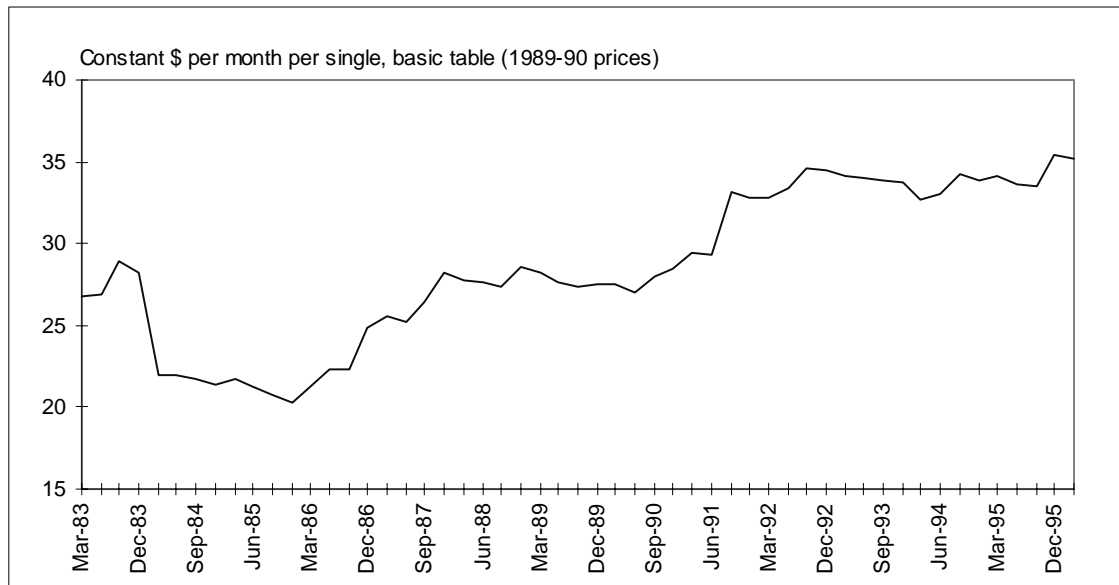
- Lower income is likely to be the most important.
- Out-of-pocket expenses associated with insured episodes of illness are likely to have a particularly strong impact on the old because they have poorer health and an inability to increase income by varying working hours.
- Access to health concession cards decreases the incentive to insure.
- Changes in family status from couples to singles when one spouse dies can make insurance less attractive.

## Price

This inquiry was sparked by concern over rising private health insurance premiums. From June 1984 to March 1996, prices of a basic policy for a single

person have risen by a trend rate of 4.8 per cent above the rate of inflation — that is, a 60 per cent increase in real prices over the 12 year period (figure 6.14).

Figure 6.14: Real premiums for a basic hospital insurance policy, single person (monthly contribution rate, 1989-90 prices)



Sources: Information supplied by funds and by the AHIA. The 8 capital cities weighted CPI (ABS) was used to calculate real prices.

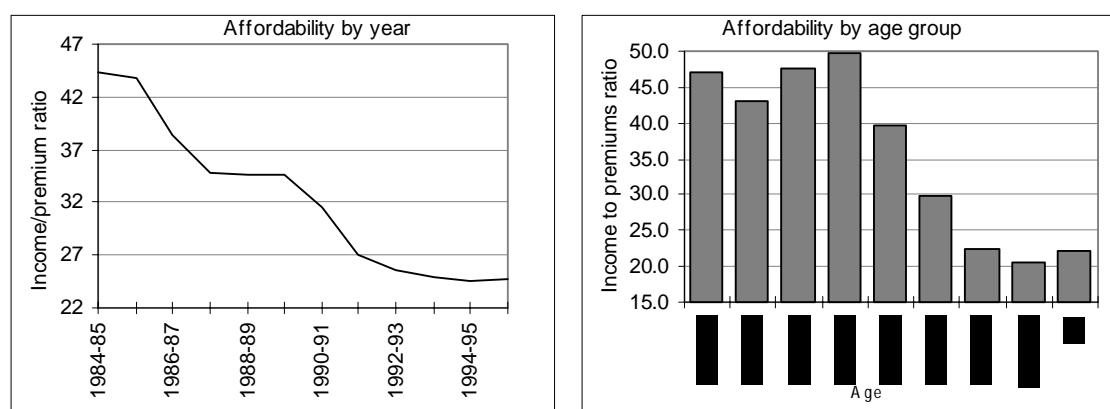
There are few recently estimated price elasticities for private health insurance in Australia. TQA Research (1995) have undertaken marketing analysis of the price responsiveness of consumers to price changes, but the results are hard to interpret as strict elasticities. It is likely, however, that the price responsiveness of consumers is low.<sup>11</sup> Doessel (1990) provides some, now somewhat dated, estimates of the price elasticity of demand for private health insurance using Queensland data. The results confirmed that insurance membership was negatively related to the price of insurance per se (measured as the ratio of insurance loading to benefits paid) and to the price of the medical services that insurance purchases. The overall results imply an elasticity less than unity — or an inelastic response by consumers to changes in premiums.<sup>12</sup>

<sup>11</sup> US studies (cited in Jacobs 1991, p. 110) point to a relatively inelastic demand for insurance — but the US system does not provide universal cover as an alternative. Consequently, their estimates are likely to underestimate the responsiveness of demand to price in the Australian context.

<sup>12</sup> In one of the preferred equations, Doessel found that  $ENR = -3.02 - 1.40 \text{ PINSPE} - 0.34 \text{ NPCASE} - 0.26 \text{ PTGINS} + 0.67 \text{ INC} - 0.07 \text{ D8488}$  where ENR is the proportion of the Queensland population holding basic private hospital insurance, PINSPE is the ratio of

The combined impact of income and premium changes has seen a dramatic reduction in the affordability of private health insurance for all classes of households. ‘Affordability’ (the income-to-premium ratio) has roughly halved over the period from 1984-85 to 1995-96 (figure 6.15). Schofield, Fischer and Percival (1996) report that affordability has declined most for people in the first (poorest) income quintile.

Figure 6.15: Private health insurance affordability, by year<sup>a</sup> and by age<sup>b</sup>



a A weighted premium measure was estimated as the total health insurance contributions divided by the population (using PHIAC data). An affordability measure was then constructed as the ratio of household disposable income per capita to the average premium. The premium data include ancillaries, as the PHIAC data on contributions include all policies — not just hospital cover. This should have little impact on the overall pattern seen here.

b These data relate to 1993-94 only. The affordability measures were estimated in several stages. First, the typical price of a single person's insurance policy for top private hospital cover only, with no excess, was established for 1993-94. Second, we controlled for differences in family structure. This is necessary because some age groups have more couples with dependent children than others — with implications for average household premiums. Families, regardless of their size, pay twice the premium of a single person. Using this, we derived the total premiums paid by households in every age bracket — and then determined average household premiums. Finally we formed the ratio of average gross income to average premiums for each age group. There is no correction for tax paid by households.

Sources: PHIAC 1996a. Other data supplied by PHIAC. ABS, *Australian Economic Indicators*, December 1996 (Cat. 1350). Reserve Bank of Australia, *Bulletin*. ABS, unpublished data from the *Household Expenditure Survey*, 1993-94.

It seems highly likely that real premium increases have been the fundamental driver of the high attrition rates of private health insurance membership

administrative costs to benefits paid, NPCASE is the net price per case of private medical insurance, PTGINS is the price of total government insurance, and INC is per capital disposable income. The overall impact of premium changes on the membership ratio is captured by PINSPE and NPCASE, with the latter dominating.

witnessed over the past decade. However, the underlying price elasticities for different groups are probably very different. The aged (who tend to fall into the lowest income quintile) have not been very responsive to changes in affordability — notwithstanding the fact that they may well have faced the largest effective decrease in affordability. On the other hand, they have the greatest motivation for insurance and receive an actuarially advantageous price. Younger households on more moderate incomes appear to be the most price responsive. For them, affordability has declined by about 50 per cent, and they face a price for insurance which far exceeds expected benefits.

### Health status

The nexus between health status and the propensity to insure is subtle. It is certainly not true that health funds cater particularly for the sick — as some extreme models of adverse selection might predict. Non-smokers, lighter drinkers and people reporting better health status, are much more likely to be insured than their smoking, heavy drinking, and, self-reportedly, ill counterparts. This remains true even after confounding income and other effects are taken into account. Yet, paradoxically, other indicators of morbidity, such as a hospital visit in the last 12 months or the number of chronic conditions people have, produce a positive, if small impact on the probability of private health insurance (table 6.8).

Table 6.8: Impact of health status on likelihood of insurance, 1989–90<sup>a</sup>

<i>Self-assessed health status</i>	<i>Probability of holding private health insurance</i>	<i>Number of chronic conditions</i>	<i>Probability of holding private health insurance</i>
	%		%
Poor	43.7	None	51.3
Fair	53.9	One	52.6
Good	62.8	Two	53.9
Excellent	67.6	Three	55.2

a The probabilities are calculated using Schofield's logit model (1996) of insurance choice. The calculations show how the probability of insurance changes as we vary health status variables, holding all other variables constant. To provide a yardstick for comparison, we define a reference person, and then vary a single variable to see the impact on the probability of insurance.

Sources: Schofield 1996. Commission estimates.

Utilisation of hospitals by the two groups may be a useful indicator of relative morbidity of the insured compared to the uninsured. Unfortunately, there are

considerable inconsistencies and gaps in data on bed days in different institutions by the insurance status of the person. However, complete data are available for 1991–92. The data suggest that insurance-covered hospital bed days per 1000 insured is around 35 per cent less than hospital bed days per 1000 uninsured (table 6.9). This implies that the insured are less sick. But there are two complications:

- A privately insured person may elect to be treated in a public hospital as a public patient.<sup>13</sup> For example, this would be customary in emergencies, which may often involve long stays. To the extent that the privately insured patients are treated as public patients, then the measure of relative morbidity will be understated. On the other hand, only the insurance-covered hospital bed days matter for the financial viability of the private health insurance funds – and to this extent, the insured are *effectively* less sick than the uninsured.
- After adjustment for casemix variations, the duration of hospital stays is greater in private (typically) insured hospitals than public hospitals. For example, an obstetrics case will involve an earlier release in the public system. To this extent, it seems likely that the measure somewhat overestimates the relative morbidity of the insured to the uninsured.

Other estimates<sup>14</sup> over a longer time span suggest that the ‘morbidity gap’ between the insured and the uninsured is closing (table 6.10). This is consistent with adverse selection of the sick. Thus while the insured appear to be less sick than the uninsured, the least sick of the insured (the young) have tended to exit insurance, leaving a sicker pool of people behind.

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<sup>13</sup> Data from the Department of Health and Family Services suggest that *at least* 11 per cent of public patient separations in public hospitals are privately insured patients who elect to admit themselves as public patients. This may underestimate the actual share as information on insurance status is not always recorded.

<sup>14</sup> The estimates ignore psychiatric hospitals and make a range of assumptions.

Table 6.9: Bed days for the insured compared to the uninsured, 1991–92<sup>a</sup>

	<i>Bed days ('000)</i>			<i>Population ('000)</i>	<i>Bed days per 1000</i>
	<i>Private hospitals</i>	<i>Public hospitals</i>	<i>All hospitals</i>		
Privately insured	4195	2999	7194	7164	1004
Non-insured	820	15452	16272	10325	1576
Total	5015	18451	23466	17489	1342

a Private hospitals cover private acute and psychiatric hospitals and free standing day hospital facilities. Public hospitals include all acute public hospitals, hospitals operated by the Department of Veterans' Affairs and public psychiatric hospitals. Non-insured bed days are those which are not claimed as insured with existing private health insurance funds. They include all public patient bed days in public hospitals (including privately insured patients who elect to be treated as a public patient), veterans' bed days, days for people ineligible for Medicare (for example, diplomats), the self-insured and workers' compensation cases. Insured bed days are those claimed by people with registered health insurance funds.

Sources: Data on insured bed days and the insured population are from PHIAC, while the remaining data are from ABS, *Hospitals, Australia, 1991–92* (Cat. 4391.0).

Table 6.10: Bed days for the insured compared to the uninsured, by year<sup>a</sup>

	<i>Insurance covered bed days per 1000 insured</i>	<i>Non-covered bed days per 1000 uninsured</i>	<i>Ratio of insured to uninsured</i>
1989–90	928	1409	0.66
1990–91	938	1333	0.70
1991–92	966	1271	0.76
1992–93	972	1254	0.78
1993–94	972	1234	0.79
1994–95	977	na	na
1995–96	980	na	na

a The data exclude psychiatric bed days and will not match the results in the previous table.

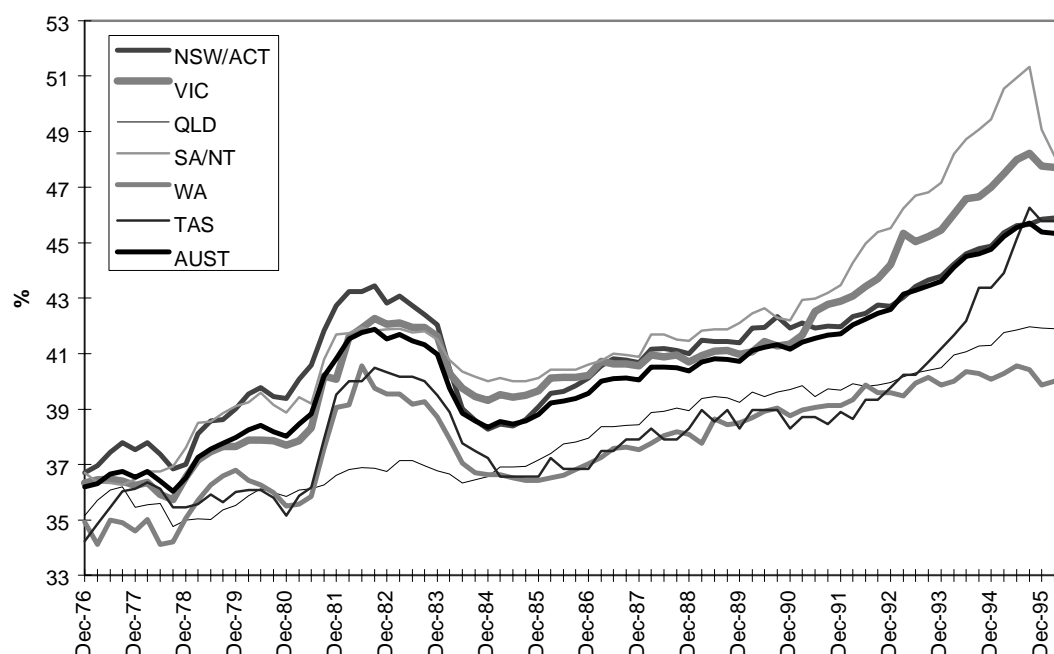
Sources: Calculations by the Commission using data from the ABS (Cat 4390.0, various issues), PHIAC, and information provided by the Department of Health and Family Services.

## Family status

Until changes announced in September 1996 there were only two categories of membership of private health insurance: single membership and family membership, with the premium for the latter set by regulation at twice the single rate, regardless of family size. Single members were far more favourably responsive to the amendments to insurance introduced by the Fraser

Government in the early 1980s and adversely responsive to the introduction of Medicare by the Hawke Government in 1984 (figure 6.16). Since then, family members have exhibited the greater responsiveness to premium rises, deserting private health insurance in great numbers, particularly from 1991 to 1995 and particularly in South Australia and Tasmania.

Figure 6.16: Single memberships as a share of insured contributors



While family status appears to be an influential factor underlying demand, its impact is much weaker when income, age and other confounding variables are taken into account.

### Other factors

There are numerous other associations between insurance choice and other demographic and socio-economic variables, some of which are summarised below (table 6.11). However, none of these explain how people rationalise their choices for and against private health insurance — this is examined next.



Table 6.11: Other determinants of health insurance status

<i>Description of factor</i>	<i>Comments</i>
Gender	There is only a slightly higher propensity for women to insure than men, despite the fact that the product is <i>much</i> more actuarially attractive to women who are higher users.
Ethnicity	38 per cent of people speaking a language other than English at home were insured compared with 55 per cent of those who did use English (this may pick up underlying income effects, and possible lack of information).
Health card recipient	People with a health card have a 40 per cent lower probability of having private health insurance compared to non-recipients — even after controlling for income. This may reflect uncounted income and wealth effects.
Location of person	Those in metropolitan areas have a higher probability of being insured. Also some higher probabilities of insurance in some states. For example, a person in South Australia has around twice the likelihood of being insured, after controlling for other influences.

*Sources:* ABS (1995) and Schofield (1996).

### *Why do people insure?*

The dominant reason for health insurance appears to be people's desire for 'security' or 'peace of mind' — reflecting risk aversion (table 6.12). In 1992, the last year for which official data are available, 40 per cent of the insured nominated motivations of these kinds.

People nominate choice of doctor as the second major reason for health insurance. While people have a limited capacity to directly exercise choice of doctor, private health insurance does allow the consumer to delegate choice of doctor to their GP — though notably, this motivation for health insurance has been waning rapidly.

Access to the private hospital system, avoidance of waiting lists and benefits for ancillary services are other major motivating forces. Interestingly, the desire to avoid queuing has become an increasingly important rationale for choosing insurance — despite evidence that actual waiting times for public patients have been declining. The importance of this factor is also underscored by other, more

general, surveys of Australians, which nominate waiting lists as the most pressing concern about the public health system.<sup>15</sup>

Table 6.12: Why do people insure?<sup>a</sup>

<i>Reason given</i>	<i>Share of contributors which nominate a given reason for insuring (%)</i>			
	1986	1988	1990	1992
Choice of doctor	43.3	39.5	37.4	31.7
Allows use of private hospitals	41.0	33.8	34.8	28.6
Benefits for ancillary services	na	33.7	32.6	27.1
Shorter wait/concern over public hospital waiting lists	na	24.9	25.7	28.4
Financial reasons	na	20.9	20.0	14.1
Always had it/parents had it/ condition of job	na	na	19.4	16.2
Security/protection/peace of mind	na	44.9	40.4	40.0
Other	76.5	6.4	4.9	5.1

a People could give more than one reason for choice, so rows do not add to 100 per cent.

Source: ABS, *Private Health Insurance* (various issues).

### *Why do people give up insurance?*

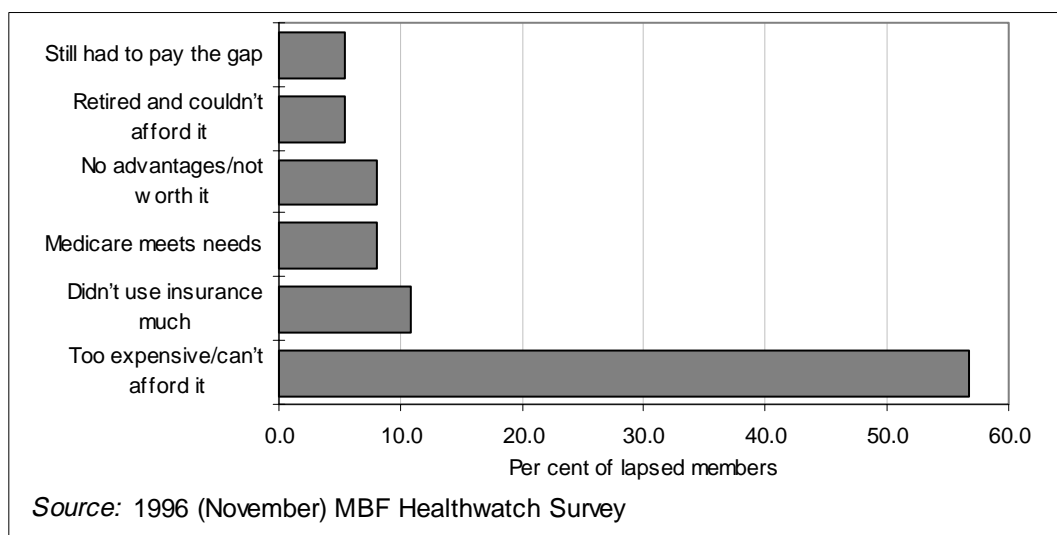
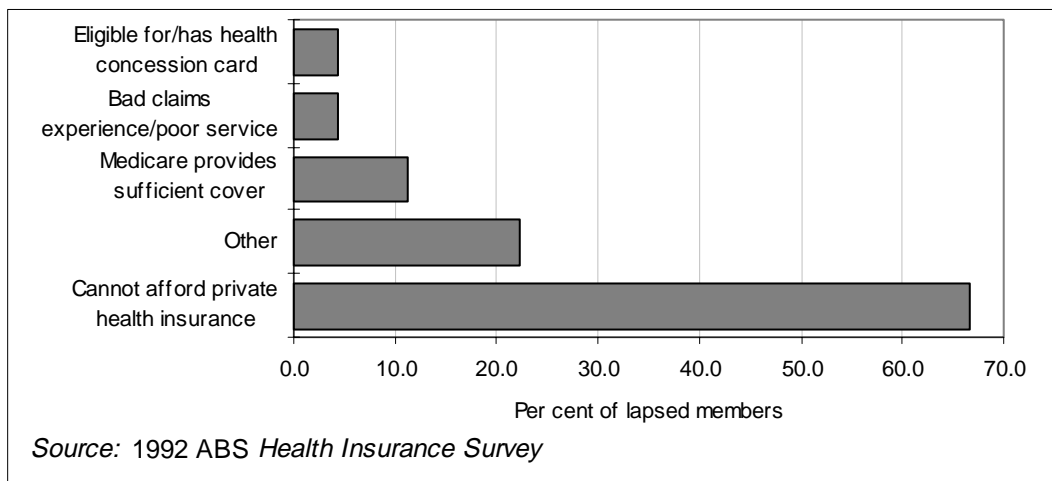
Surveys reveal that a whole range of factors make people relinquish insurance (figure 6.17). Lack of affordability is perceived to be the most important reason for giving up insurance — consistent with the substantial decline in affordability over the last decade. But other factors were also important, such as:

- the existence of a ‘free’ substitute service, Medicare;
- a perception of poor value; and
- frustration with the uninsured gap.

The next section summarises the concerns of consumers who made submissions to the inquiry.

<sup>15</sup> For example, the MBF Healthwatch Survey of November 1996 suggested that 34 per cent of Australians expressed concerns over waiting lists — more than three times the level of concern of any other factor raised.

Figure 6.17: Why do people leave health insurance?



### Consumer concerns

A number of submissions from consumers to this inquiry outlined a wide range of concerns with the current private health insurance arrangements. The most significant related to:

- a lack of value for money;
- large and often unexpected out-of-pocket costs;
- complexity, resulting in difficulties when comparing funds and tables;
- cumbersome billing arrangements; and
- the rebate.

Box 6.3 sets out a selection of comments on these issues.

In addition, consumers raised concerns relating to the lack of affordability of insurance when old (box 6.2), subsidisation of families by singles (under the previous arrangements), lack of schedule fees for ancillary providers, increased medical charges, level of benefits for dental treatment, and a general inflexibility of fund rules.

**Box 6.3 “Dear Commissioner”... Consumers speak out****Unexpected or large out-of-pocket costs**

‘The hospital gap and also that of 22 doctors totalled over \$50 000, despite my being a “Foundation Member” with top cover, of Medibank Private, who only covered intensive care for six days.’

‘Believing all the advertising I had seen regarding private health cover I simply assumed that I was covered for all expenses. Much to my dismay on discharge I found that I needed to find some \$350 extra for the hospital bill and a further \$600+ for the specialist.’

‘After all of the operations and worry the bills started coming in, I was nearly flattened with all of the extras I had to pay that Medicare or the \_\_\_ did not cover. After nearly going bankrupt, I had to write to all involved and work something out in paying these bills.’

‘I want no out-of-pocket expenses. I want genuine 100 per cent cover. After my recent experience ... I am seriously considering leaving private health insurance.’

**Tax rebates of no help**

‘We consider that the incentives announced by the government in the budget are of little benefit to people in our situation.’

‘The government’s incentive plan of a rebate for those who are fortunate enough to be able to afford private health insurance will have no effect on our options. I don’t know what income bracket the government is targeting, but if they are aiming for ours, THEY MISSED.’

‘Any assistance the Budget might have offered to some, would no doubt be more than outweighed by the costs likely to be incurred by people who use the government dental service which is now to be eliminated.’

**System confusing and not user friendly**

‘We have found that some of the health funds’ policies, in their fee structures and excesses, make it almost impossible to make an informed choice.’

‘The system of private patient status and the situations you can find yourself involved in and the complicated choices and expense involved often makes you feel confused.’

‘Trying to find information for private health insurance funds is a nightmare, particularly on their refunds and conditions etc.— they have books 100 mm thick.’

‘Comparison shopping for private health insurance is a nightmare for consumers. An absolute disgrace!’

### **Billing system confusing and cumbersome**

‘Subsequently a string of bills arrived ... The procedure for paying was cumbersome, confusing and time wasting for all concerned.’

‘I arrived home in a very disturbed and weak state and within days was back in hospital with post operative amnesia. *Then the bills arrived.* Surgeon’s bills. Anaesthetist’s bills. Pathologist’s bills. Doctor’s bills. Unknown doctor’s bills. Chemist’s bills. Ambulance bills. Claiming from \_\_\_\_ and \_\_\_\_ became a nightmare.’

‘To give some practical idea of the impracticality of this paper-fuelled system ... statements of accounts, claims, receipts, statements from both private funds and Medicare etc. There were SEVENTY-NINE pages in all this accumulated guff. All this had to be found, or duplicate copies sought, when different organisations all demanded the same original documents.’

‘Once home supposedly to recuperate, I had to deal with an avalanche of accounts, with confusing, multiple procedures (in both number and kind) for payment and reimbursement. For instance, most of these accounts will make seven (that’s SEVEN) passes, or trips through Australia Post, before they can be finalised.’

### **Private health insurance not value for money**

‘Whilst receiving treatment as a private patient in a public hospital the person in the next bed was a public patient and received the same treatment by the same medical practitioner yet was not faced with any out-of-pocket costs.’

‘In a two tier system, such as Australia has in practice, the benefits accruing must be commensurate with the cost to the consumer. In our view this is not the case with the current arrangements for private health insurance.’

‘The fund’s huge cost is an outrage, yet I don’t dare drop it only because I know that private insurance, in this democracy, gets you into hospital faster. My wife might be in desperate need for it some day, so I hang on, bleeding money. It’s that unfair priority, rather than superior service, that keeps many of us in.’

‘Why is it that a non-insured patient who is bulk-billed will have exactly the same service billed at far less than the insured patient is required to pay?’

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## 7 WHY ARE PREMIUMS RISING?

### 7.1 Introduction

Health insurance premiums have risen at rates well above the rate of inflation in recent years. These price increases have contributed to the steady exodus from health funds. In turn, declining health fund membership has put pressure on the public hospital system. The Commonwealth Government announced in its 1996 Budget that it would provide financial incentives for health fund membership from July 1997. In the meantime, however, a further substantial rise in premiums has taken place.

The combination of these factors led to this inquiry. A critical question is why the health funds have had to raise premiums by so much — particularly in the context of diminishing demand for the product. If membership is falling, why can't health funds halt the flow by lowering premiums? Does the apparent failure to restrain premium increases indicate inefficiency or excessive market power by the health funds — or by the private hospitals that dominate health fund benefit payouts?

This chapter helps tackle these issues by quantifying the cost pressures that have led to higher premiums in the 1990s (as required by the terms of reference for the inquiry). A summary of the Commission's findings is contained in box 7.1.

Identifying the underlying cost factors contributing to higher premiums is not only useful for explaining *past* events; it may also indicate what measures might assist in minimising *future* increases in health insurance premiums.

Most of the statistics used for the analysis of cost pressures and premium increases are publicly available data published by PHIAC and the ABS. Other key data were obtained from the Department of Health and Family Services, the AIHW and some of the major health funds. Finally, specific information from a number of submissions was used to supplement the analysis.

The cost methodology has been elaborated since the Discussion Draft — most notably through the assessment of real rather than nominal premium changes, the use of a numerical integration technique so that impacts add to 100 per cent and a different approach to estimating demographic impacts and adverse selection. Details of the cost methodology are contained in appendix I.

**Box 7.1: Summary of factors underlying increases in hospital insurance premiums**

- Average hospital insurance premiums increased by around 75 per cent (9.8 per cent pa) between 1989–90 and 1995–96. The CPI increased by 18.7 per cent (2.9 per cent pa) over the same period, leaving a *real* increase in premiums of around 46 per cent.
- A *shift by the insured in obtaining treatment in (non-subsidised) private hospitals rather than public hospitals* is one of the most important factors behind increased premiums. It accounted for 27 per cent of the real increase in premiums in the 1990s and close to half of the increase last year (1995–96).
- *Private hospital benefits paid per bed day* contributed around 40 per cent overall of the rise in real premiums. This consisted of three major components. Rising private hospital *admission charges* accounted for 13 per cent; changes in the *average length of hospital stays* for 20 per cent; and *changes in insurance cover* for 7 per cent.
- Public hospital bed day charges are regulated and have actually had a slight negative impact on premiums. However, adding the impact of shorter lengths of stay resulted in *public hospital benefits* contributing 4.5 per cent of the increase in premiums.
- *Day hospital charges* accounted for 1.8 per cent of the premium rises.
- Increased *hospital utilisation* accounted for only 3.6 per cent of real premium rises since 1989–90 — acute and day hospitals each contributing 1.8 per cent. For *acute hospitals*, rising admissions per insured person covered placed a substantial demand on hospital benefits paid by the health funds (40 per cent contribution). However, this was largely counteracted by the trend for shorter hospital stays (-30 per cent contribution). Furthermore, the recent steep decline in persons covered by hospital insurance has resulted in fewer hospital claims (-8 per cent contribution).
- *Medical gap payments* for in-hospital services contributed a little over 7 per cent of the increased premiums since 1989–90. Benefits paid for surgically implanted *prostheses* have grown rapidly and accounted for over 10 per cent of the premium rise — largely reflecting a significant increase in the volume of items implanted.
- Two important underlying factors — *ageing and adverse selection* — were at work which, by changing the composition of membership, contributed to the changing usage patterns and higher bed day benefits. Ageing of the health fund membership contributed around 8 per cent of the rise in premiums between 1990 and 1995, while adverse selection is likely to have contributed around 17 per cent over the same period.
- *Health funds' management expenses* have accounted for almost 6 per cent of the rise in hospital insurance premiums since 1989–90.

## 7.2 Background to recent premium increases

### Trends

Average hospital insurance premiums are estimated to have increased by around 75 per cent (nominal terms) between 1989–90 and 1995–96, compared with a CPI increase of 18.7 per cent.

There is a diverse range of hospital insurance products and a variety of premiums across the 48 health funds. Indeed, individual health funds can have markedly different premiums in different states for the *same* type of cover.

There are two convenient indicators of trends in hospital insurance premiums:

- The first is an average measure estimated from industry-wide data on health fund membership, hospital benefits and contribution income.<sup>1</sup>
- The second is an actual premium for ‘top hospital cover’ in one of the major health funds — this is fairly reliable for judging premium trends as the nature of the top cover product has been stable since the late 1980s.

Recent trends in hospital insurance premiums clearly depict growth well in excess of general price inflation (figure 7.1). While the level of top cover premiums is obviously higher, the same directions and degrees of change are generally evident for both measures.

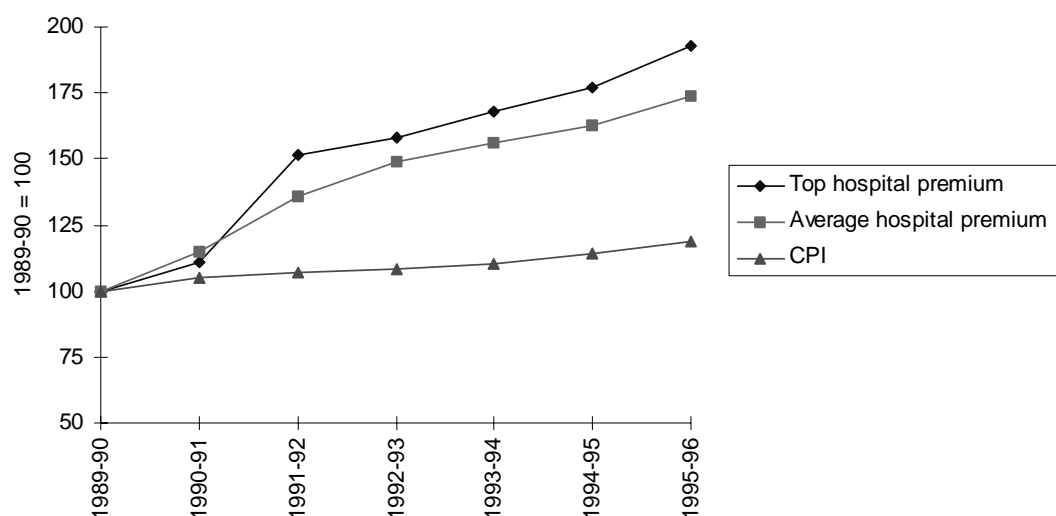
However, some differences exist. The premium for top hospital cover increased by 93 per cent (11.6 per cent per annum) over the 1989–90 to 1995–96 period, while the average premium rose by around 75 per cent (9.8 per cent per annum).<sup>2</sup> The rate of increase for both measures has been relatively stable in the last few years following an acceleration in the early 1990s. Indeed, the higher rate of increase for top cover premiums since 1989–90 is essentially attributable to a 36 per cent jump in 1991–92.

<sup>1</sup> Published industry data on contribution income are not split into hospital and ancillary cover. However, unpublished data provided to the Commission by PHIAC give the 1995–96 relative shares of hospital and ancillary contributions for many of the health funds. While these data indicate significant variety between the funds, a reasonable estimate is that the hospital component averages around two-thirds of total contribution income.

<sup>2</sup> The health insurance price index — a sub-component of the CPI — also shows premiums increasing by 77 per cent over the same period (AIHW, Sub. 178, table 3).



Figure 7.1: Hospital insurance premiums, 1989–90 to 1995–96



Notes: The average hospital premium is estimated using PHIAC data. The top hospital premium is a time series of the family monthly contribution rate for NMHI Victoria's (HBA) 100 per cent hospital table, which was introduced in 1989. The premiums selected are those applicable at December of each year.

Sources: PHIAC annual reports and unpublished data. ABS Ausstats. NMHI published rates.

These premium changes compare with a CPI increase of 18.7 per cent (2.9 per cent per annum) since 1989–90. In other words, the average price of hospital insurance in the 1990s has risen at a rate approximately three and a half times CPI inflation. This amounts to a real increase in premiums of about 46 per cent.

The analysis in this chapter relates to the factors underlying these *real* increases in premiums between 1989–90 and 1995–96 (with nominal prices deflated to 1989–90 prices).<sup>3</sup>

### Premium levels are cost driven

The Australian Unity Friendly Society provided an insight into the 'real world' premium setting process for individual health funds. The fund's review process in setting premiums occurs annually and involves three main steps: actuarial modelling, budget review and rate review (box 7.2).

<sup>3</sup> The contribution of inflation to annual changes in nominal premiums is described in table I.3, appendix I. Over the 1989–90 to 1995–96 period it is estimated that inflation accounted for 30.7 per cent (and real factors, 69.3 per cent) of the rise in nominal hospital benefits per SEU (a close proxy for premiums).

### Box 7.2: How a health fund sets its premiums

The Australian Unity Friendly Society's annual review process in setting premiums involves the following steps:

- *Actuarial modelling*

All historical and projected key operating data, including claims experience and membership trends by different types of cover, are updated in an actuarial model for the health fund. Various cases are then simulated based on different sets of bases and assumptions on a host of operating variables (including timing and quantum of rate changes). This process of projections begins around March/April.

- *Budget review*

The outputs from the actuarial model are incorporated in the health fund's annual budget, which includes management expenses, investment income and the health fund's trading position. The budget review and approval process takes place between April and June with the budget being approved by June/July.

- *Premium review*

The review of premiums in terms of timing and amount of change takes place after the fund's budget is approved by its board. The review considers the impact of premium changes on the financial viability of the different cover types and on the health fund's competitiveness relative to other funds.

*Source:* Australian Unity Friendly Society (Sub. 163, p. 18.)

Price setting in the health insurance industry is largely cost driven. In the long run, premiums are principally determined by the benefits paid by the health funds to meet members' claims — on average, health funds pay out close to 90 cents in the dollar to meet claims.

Accordingly, their premium options are severely constrained by their need to have sufficient contribution income to meet these liabilities. If higher costs are incurred — through meeting members' claims — the health funds will inevitably look to premium increases.<sup>4</sup>

Factors other than contribution income and benefits payable — principally changes in reserve levels and investment income — can have significant impacts on premium levels on a year-to-year basis. Over longer periods,

<sup>4</sup> However, this does not mean the health funds are powerless to contain the costs of claims. For example, contracting with hospitals and medical practitioners now provides the means by which the funds can influence such costs (see chapter 8).

however — such as 1989–90 to 1995–96 — these factors have virtually no impact on premium changes.<sup>5</sup>

The example in box 7.2 suggests the health funds are left with some choices about the structure of premiums for the different products on offer (including taking into consideration possible demand effects). Nevertheless, in the longer term, if the funds are to balance their books and maintain adequate reserves, *average* premium levels are principally dictated by membership trends and the volume and amount of claims (benefits payable).

### 7.3 The major cost components

The cost-driven nature of premium increases requires an understanding of the health funds' cost structure. What are the health funds' major cost components — how do they spend their contribution income?

#### Hospital, ancillary and management costs

At the broadest level, health funds' costs have only two components — benefits payable for members' claims and the costs of management/administration. Benefits payable can be split into hospital and ancillary, which reflect the two main types of health insurance cover available.

Hospital insurance accounts for the major share (65 per cent) of health fund expenditure (figure 7.2). The shares have been fairly stable in recent years, although hospital benefits have increased slightly at the expense of ancillary benefits and management expenses. In 1989–90, the respective shares were 61 per cent (hospital), 26 per cent (ancillary) and 13 per cent (management).

The cost pressures underlying hospital and ancillary cover are, for the most part, quite different. *The remainder of this chapter focuses on the factors contributing to higher real hospital insurance benefits and premiums in the 1990s:*

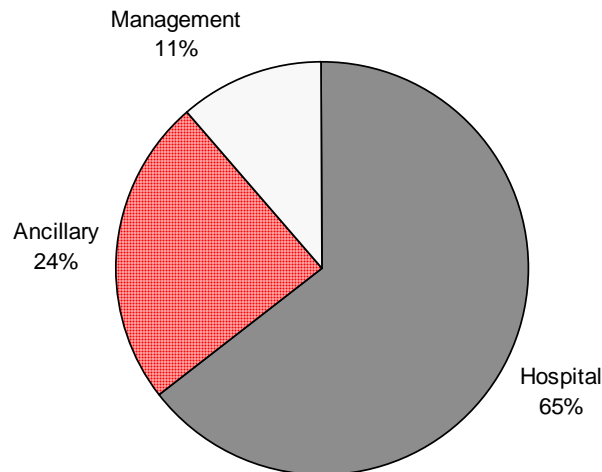
- the inquiry's terms of reference generally deal with hospital-related questions; and
- the major cost pressures on the health funds are in the hospital area, not ancillaries. Not only did hospital benefits represent almost three-quarters of

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<sup>5</sup> See appendix I for a discussion of the relationship of these and other factors to premium changes.

total benefits payable by the health funds in 1995–96, they have been increasing at a significantly higher rate than ancillaries.

Figure 7.2: Health fund expenditure — hospital, ancillary and management costs, 1995–96



Note: Total amount of hospital and ancillary benefits and management expenses was \$4398 million.

Source: PHIAC 1996a.

### Hospital insurance cost components

Hospital insurance benefits paid by the health funds in 1995–96 totalled around \$2.8 billion. This expenditure is categorised by PHIAC under five major benefit items: private hospital, public hospital, free standing day hospital,<sup>6</sup> medical gap, and listed prostheses.<sup>7</sup> The relative magnitudes of the five benefit categories are shown in figure 7.3:

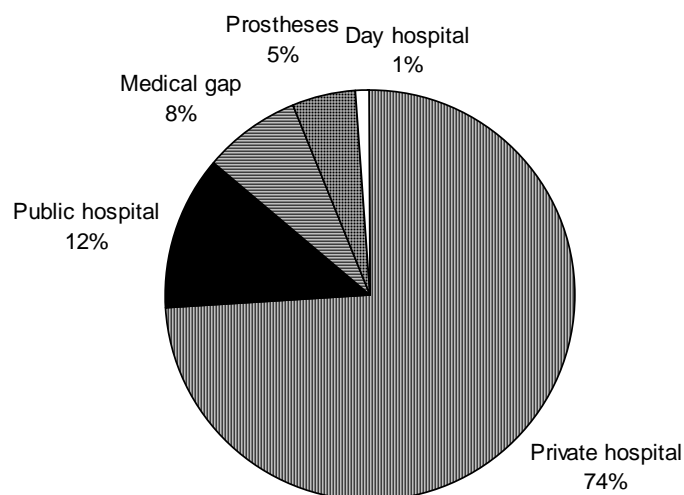
- Acute hospital care clearly dominates, with private hospitals accounting for around three-quarters of hospital benefits paid — followed a long way back by benefits paid to private patients in public hospitals (12 per cent).

<sup>6</sup> Free standing day hospitals, by definition, exclude ‘day hospitals’ and ‘day surgeries’ within acute hospitals.

<sup>7</sup> Nursing Home Type Patient (NHTP) is sometimes used as a separate category in industry statistics. But as the benefits paid for NHTPs are small and falling over time, relevant data have been included under public and private hospital benefits (as appropriate) throughout this chapter.

- Free standing day hospitals, while expanding rapidly, still only account for 1 per cent of health fund benefits and have an insignificant impact on overall cost pressures and premiums.

Figure 7.3: Hospital insurance benefits paid, by major category, 1995–96



Note: Total amount of hospital benefits paid was \$2834 million.

Source: PHIAC 1996a.

Medical gap benefits are payments made by the health funds to medical practitioners. The health funds have been restricted by regulation to paying only 25 per cent of scheduled fees for medical services provided in hospitals — although this limit was lifted by the 1995 Amendment Act, provided a contract is signed by the fund with the doctor. Prostheses benefits are benefits paid for surgically implanted prostheses, with the Commonwealth determining which items qualify and the benefit levels.

At the state level, NSW and Victoria together account for around 60 per cent of national hospital insurance benefits — with the former having a slightly greater share (appendix I, table I.5). The proportion of benefits paid to public and private hospitals varies significantly between the two states. In 1995–96, 18 per cent of hospital insurance benefits in NSW were paid for treatment in public hospitals. This contrasts with a figure of only 10 per cent in Victoria (and a similar proportion in other states).

## 7.4 The major cost drivers

### The overall picture

From the viewpoint of cost pressures, the main interest is in recent *changes* in the five major benefit components (table 7.1). Just as private hospital care dominates hospital insurance benefits in any one year, so do changes in these benefits account for the bulk of total annual changes. This has been particularly noticeable in the past three years, when very strong private hospital contributions have been only partially offset by negative contributions from public hospital benefits. *Overall, between 1989–90 and 1995–96, benefits paid by the health funds for private hospital admissions accounted for 96 per cent of the increase in total benefits payable (\$783 million in real terms).*

Table 7.1: Contributions of hospital benefit categories to real annual changes in overall hospital benefits (SEU basis), 1989–90 to 1995–96 (per cent)

<i>Year</i>	<i>Private hospital benefits</i>	<i>Public hospital benefits</i>	<i>Free standing day hospital benefits</i>	<i>Medical gap benefits</i>	<i>Prostheses benefits</i>
1990–91	78	5	2	8	7
1991–92	84	0	1	8	7
1992–93	81	-2	2	9	10
1993–94	132	-60	3	10	17
1994–95	125	-51	2	9	14
1995–96	106	-38	13	4	15
1989–90 to 1995–96	96	-18	4	8	11

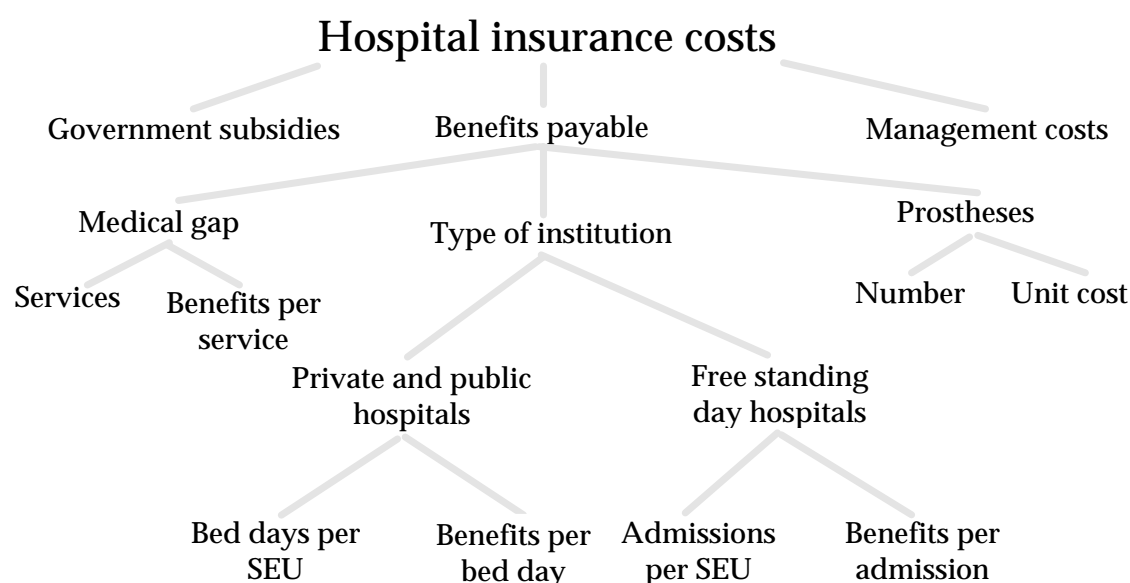
Note: Components may not add to 100 per cent due to rounding.

Source: PHIAC annual reports.

### The underlying factors — hospital usage and unit costs

A framework for analysing the factors contributing to changes in hospital insurance costs is shown in figure 7.4. At the aggregate level, the bulk of health funds' hospital insurance costs are a direct result of (a) their members' utilisation of hospital services and (b) the prices set for private health care delivery (unit costs).

Figure 7.4: Decomposition of hospital insurance cost pressures



Thus, each of the five broad benefit components contributing to changes in hospital insurance costs — shown in table 7.1 — has a usage element and a unit cost element. And for any increase in benefits for a particular category, it is also possible to calculate how much of this change was due to greater (or lesser) *use* and how much was due to higher *unit costs*.<sup>8</sup> The premium increases analysed in this chapter are principally explained under these two broad categories.

Increases in private hospital benefits have been identified as the most significant of the health funds' expenditure components — and the dominant contributor to recent benefit increases. However, given that much of what is occurring in terms of private hospital benefits is intertwined with health fund members' declining use of the public sector, these two categories need to be examined together (and, for completeness, with free standing day hospitals). This examination forms the bulk of the sections to follow.

The remaining two principal hospital insurance cost components — medical gap and prostheses — are examined later (section 7.7). In addition there are

<sup>8</sup> At its simplest, this involves holding unit costs constant and asking what would be the effect on benefits paid over a defined period if just hospital usage had changed (and vice versa). This 'decomposition' method — as it is termed — is the basic approach for analysing health fund cost changes in this chapter. A mathematical explanation of the method is demonstrated in appendix I.

underlying factors, relating to the changing composition of health fund membership, behind both bed day use and costs. These factors — ageing and adverse selection — affect the funds' risk profile and simultaneously affect aspects of both hospital usage and unit costs. The treatment of ageing and adverse selection in this chapter (section 7.8) represents an improvement over the Discussion Draft — due to a refined methodology and the availability of better data.

The remaining sections of the chapter examine the influence on premium rises of management costs, reserves and government policy changes which have effectively transferred costs to the private sector. However this latter discussion is relatively brief as the analysis focuses on the period 1989–90 to 1995–96 — when the picture was not significantly affected by cost transfers.

The methodology used to calculate individual hospital insurance cost pressures produces outcomes measured in terms of hospital benefits per SEU.<sup>9</sup> In the long run, the contribution of various factors to changes in hospital benefits per SEU closely approximates their contribution to changes in average premiums.<sup>10</sup> This is demonstrated by the comparison of individual components' contributions to hospital benefits per SEU and premiums in table 7.22 at the end of this chapter.

## **7.5 Impact of changes in hospital *usage***

### **Overview**

In analysing changes in hospital benefits, utilisation is measured in terms of the number of bed days required by fund members — or more specifically, the number of insured bed days per SEU.

There are several influences at work which combine to produce a net bed day usage impact (figure 7.5). The key utilisation factors for public and private hospitals which have been directly affecting health fund benefits are:

- the number of admissions;
- the average length of hospital stays (ALOS); and
- health funds' membership coverage.

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<sup>9</sup> Single Equivalent Units (SEUs) are a standard membership measure used in the health insurance industry. The number of SEUs for the industry at a point in time equals the number of single memberships plus the number of family memberships multiplied by two.

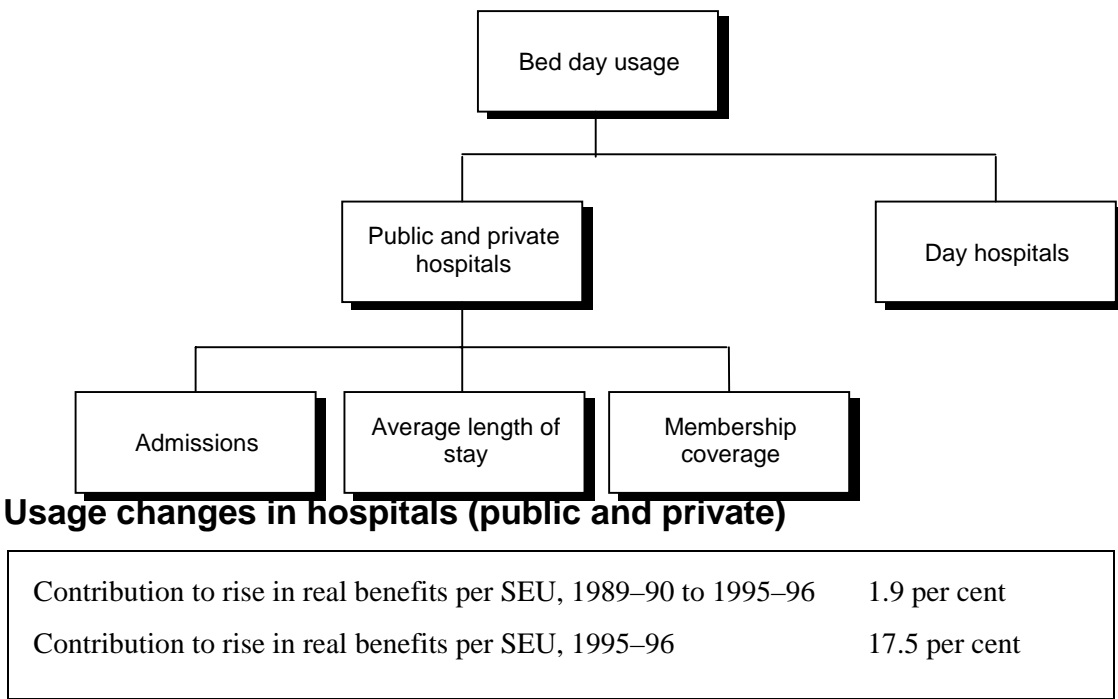
<sup>10</sup> See appendix I for a mathematical explanation.



In addition, increased utilisation of free standing day hospitals has contributed to overall bed day usage.

These factors are discussed below, including estimates of their contributions to recent increases in hospital insurance benefits.

Figure 7.5: Decomposition of changing hospital usage



In aggregate, insured hospital bed days *declined* by around 1 million (or 14.5 per cent) between 1989–90 and 1995–96. However, on an SEU basis, falling health fund membership resulted in insured bed days per SEU actually rising slightly over the same period (2.1 per cent).

The impact of this modest additional hospital utilisation on health fund benefits can be estimated by disaggregating the higher bed days per SEU into three separate effects — changes in admissions per insured person covered, bed days per admission and insured persons covered per SEU.

The results of this decomposition, and overall impact, are shown in table 7.2. The analysis underlying these data is explained in the following sections.<sup>11</sup>

<sup>11</sup> The principal data source for hospital admissions was Medicare hospital statistics supplied by the Department. However, while the data on insured patients in public hospitals

Table 7.2: Impact of changes in public and private hospital utilisation (insured bed days per SEU) and its components on hospital insurance benefits, 1989–90 to 1995–96 (per cent)

<i>Year</i>	<i>Impact of changes in admissions per insured person covered</i>	<i>Impact of changes in bed days per admission</i>	<i>Impact of changes in members per SEU</i>	<i>Net contribution of changes in bed days per SEU to real increase in hospital insurance benefits per SEU</i>
1990–91	33.3	-22.6	-6.3	4.4
1991–92	44.2	-39.6	-6.8	-2.2
1992–93	32.3	-10.4	-9.9	12.0
1993–94	35.3	-62.1	-15.5	-42.2
1994–95	66.9	-54.5	-12.3	0.1
1995–96	47.1	-25.7	-3.8	17.5
1989–90 to 1995–96	42.4	-32.2	-8.3	1.9

Note: The large negative contribution of changes in bed days per SEU to the increase in hospital benefits in 1993–94 appears to be an anomaly. It is explained by a *decline* in bed days per SEU occurring at the same time as only a very modest rise in hospital benefits per SEU.

Sources: PHIAC annual reports. ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years. Information supplied by the Department of Health and Family Services using data obtained from Medicare hospital statistics. Commission estimates.

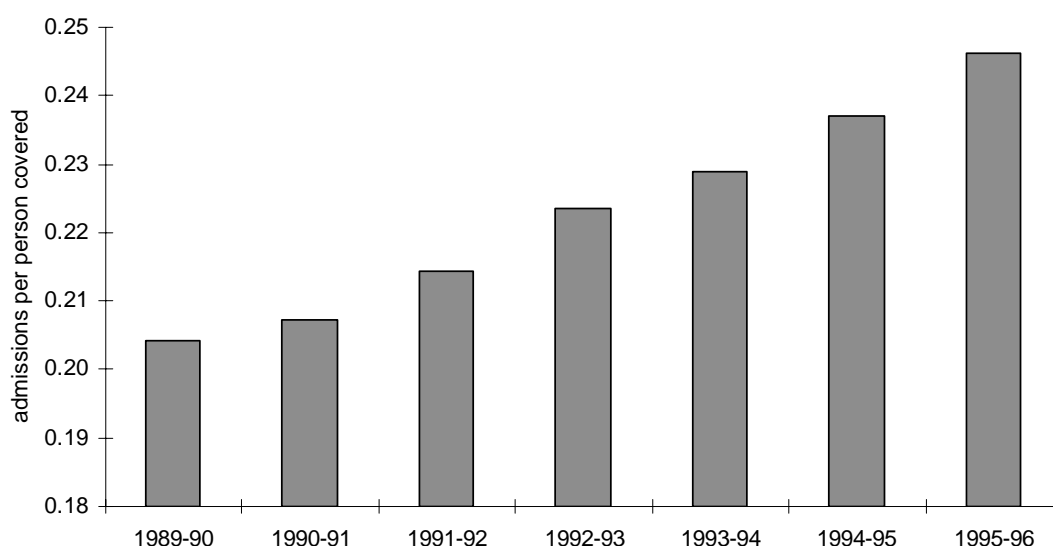
### *Hospital admissions*

The major *longer term* effects behind the rising levels of hospitalisation are the ageing of the population and increases in hospital capabilities. Elderly people tend to go to hospitals more often and stay in them longer than young people. At the same time, increasing technological capability is creating its own demand for hospital treatment. While this is not particular to the private sector, it appears to be at the forefront of utilising technological change to raise its capabilities. This has obvious implications for the health funds.

appeared robust, there are concerns about the accuracy of some of the annual private hospital admissions (and ALOS) data. These concerns include discrepancies between the Medicare data and data from the ABS private hospital survey. Accordingly, the Commission produced its own trend estimates of private hospital admissions by the insured and ALOS in private hospitals. These trend estimates affect the contribution of changing hospital usage to changes in hospital insurance benefits through changes in admissions per insured person covered and bed days per admission (ALOS) — but not membership coverage. While the use of a trend rate requires estimated *annual* contributions to be regarded with some caution, it can be expected that *long-run* estimates will be close to the real values.

From the health funds' perspective the interest is in the additional demand for hospital services by the insured. In recent times this has been subject to several opposing effects. The number of private hospital admissions has been increasing (by an estimated 28 per cent between 1989–90 and 1995–96) while the number of private admissions in public hospitals has fallen sharply (by an estimated 42 per cent). The net result has been virtually no change in insured hospital admissions (1.7 per cent decline between 1989–90 and 1995–96). But while total hospital admissions by the insured have remained fairly stable, health fund membership has fallen substantially. *The net result has been a significant increase in hospital admissions per insured person covered* (figure 7.6).

Figure 7.6: Public and private hospital admissions per insured person covered, 1989–90 to 1995–96



Sources: PHIA annual reports. ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years. Information supplied by the Department of Health and Family Services using data obtained from Medicare hospital statistics. Commission estimates.

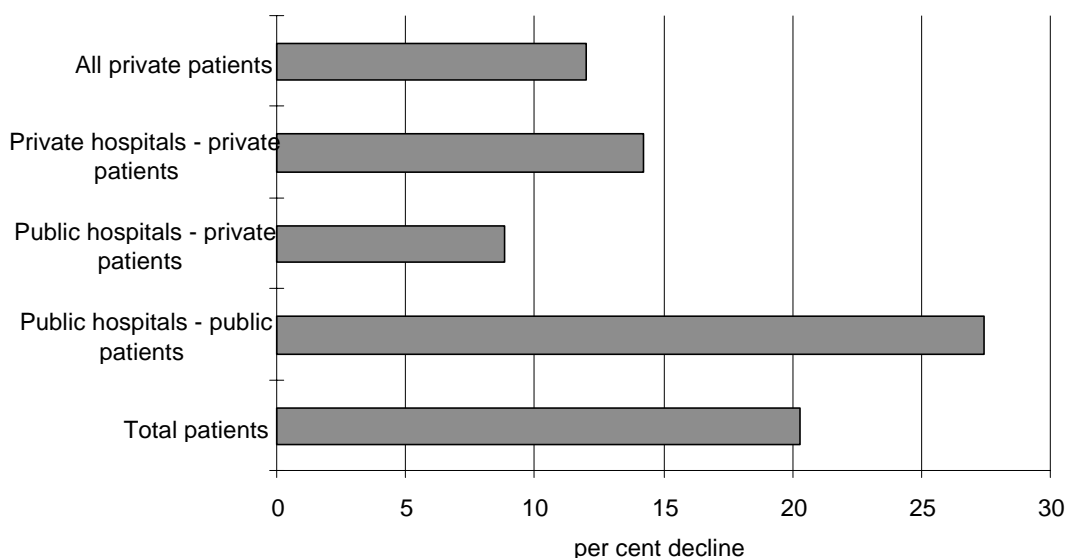
The steep decline in fund membership and persons covered has outweighed the small decline in hospital admissions — implying rising service usage per person. In fact, between 1989–90 and 1995–96, hospital admissions per insured person covered increased by around 20 per cent.

*Average length of stay (bed days per admission)*

Although insured bed days have fallen by around 15 per cent since 1989–90, hospital admissions for the insured have declined by only 1.7 per cent. This clearly indicates that substantial changes have been occurring in the average length of hospital stays (ALOS).

Departmental data show the extent of the ALOS declines in the 1990s (figure 7.7). For ‘all patients’ ALOS has declined from 5.4 days in 1989–90 to 4.3 days in 1995–96 (a 20 per cent decline). The average length of stay of all private patients (in both private and public hospitals) fell by around 12 per cent. The most significant change has occurred with public patients in public hospitals (27 per cent decline).

Figure 7.7: Reductions in average length of stay, public and private hospitals, 1989–90 to 1995–96 (per cent)



Note: 1995–96 data are provisional.

Sources: Information supplied by the Department of Health and Family Services using data obtained from Medicare hospital statistics.

There are several factors contributing to decreasing average lengths of stay in hospitals. Queensland Health observed that:

These include technological and capital intensification of procedures which have led to greater efficiencies, the increase in day-only procedures and the shift towards community-based aftercare. (Sub. 176, p. 5)

Several submissions addressed the increasing trend towards day surgery (and greater usage of free standing day hospitals). Medibank Private (Sub. 168), for example, saw the increase in average bed day benefits for day surgery as reflecting increasing emphasis on technology in day procedures.

Departmental data confirm a *general* trend in hospitals towards day-only stays:

- the proportion of day-only admissions in acute hospitals virtually *doubled* between 1989–90 and 1994–95 (from 21 per cent to 38 per cent); and
- the proportion of private patients in public and private hospitals using day surgery rose from 21 per cent to 35 per cent over the same period.

The Commission estimates the ALOS for insured patients fell by around 12 per cent between 1989–90 and 1995–96 — and made a negative contribution of around one-third to the increase in hospital insurance benefits per SEU.

### *Health funds' membership coverage*

The final way in which changing hospital utilisation by the insured can influence hospital insurance benefits is through changes in membership coverage. If the average number of persons covered associated with the standard membership measure, the SEU, declines over time, this will result in a tendency for fewer claims, lower benefits payable and reduced pressure on premiums.

The recent decline in health fund membership — measured in SEU terms — has in fact been accompanied by a steeper decline in persons covered (table 7.3). This basically reflects a greater loss of family memberships than single memberships, particularly from 1991 to 1995 (see chapter 6). While the resulting fall in persons covered per SEU appears fairly modest (-3.6 per cent), it may still have a significant impact on hospital utilisation and benefits per SEU (especially in individual years).

Table 7.3: Changes in health funds' membership coverage, 1989–90 to 1995–96

<i>Year</i>	<i>Hospital insurance, SEUs</i>	<i>Hospital insurance, persons covered</i>	<i>Membership coverage (persons covered per SEU)</i>
	<i>'000</i>	<i>'000</i>	<i>ratio</i>
1989–90	5 325	7 617	1.43
1990–91	5 323	7 568	1.42
1991–92	5 211	7 356	1.41
1992–93	5 047	7 066	1.40
1993–94	4 886	6 799	1.39
1994–95	4 677	6 468	1.38
1995–96	4 514	6 227	1.38

*Source:* PHIA annual reports.

### *Overall public and private hospital utilisation impact*

Rising hospital admissions per insured person covered have served to place a greater demand on insurance benefit payouts, but this has been substantially counteracted by the general trend in recent years for shorter lengths of hospital stays. As health insurance membership declines, the remaining health fund members are going into hospital more often — but once admitted are staying there for shorter periods than in the past. Furthermore, the health funds have also experienced a downward pressure on the demand for hospital services due to a decline in membership coverage (average number of persons covered per SEU).

The net impact of the three utilisation factors on benefits per SEU — shown in the final column of table 7.2 — has varied widely from year to year since 1989–90. For the most part the outcome has depended upon the extent to which the additional benefits payable associated with greater admissions have outweighed the ALOS impact.

Over the entire 1989–90 to 1995–96 period, the savings to the health funds flowing from the ALOS and membership coverage factors virtually cancel out the impact of higher admissions. The net result is that greater utilisation of public and private hospital beds by the insured contributed only around 2 per cent of the rise in hospital insurance benefits per SEU.

### Utilisation change in free standing day hospitals

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	1.9 per cent
Contribution to rise in real benefits per SEU, 1995–96	4.3 per cent

Changes in the use of free standing day hospitals by health fund members has had little bearing on overall health fund benefits and premiums, although this may change in the near future.

Table 7.4 depicts the estimated impact of increased utilisation of free standing day hospitals by the insured on hospital benefits per SEU. Following a 50 per cent rise in 1990–91, bed day usage grew steadily in the first half of the 1990s before again experiencing a large (30 per cent) rise in 1995–96 — resulting in a contribution of 4.3 per cent to hospital insurance benefits in that year. Over the 1989–90 to 1995–96 period, the utilisation contribution of free standing day hospitals to benefits averaged out at around 1.9 per cent.

**Table 7.4: Impact of changing usage of free standing day hospitals on hospital insurance benefits, 1989–90 to 1995–96**

<i>Year</i>	<i>Bed days (per 1000 SEU)</i>	<i>Change in bed days</i>	<i>Impact of changes in bed days on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	<i>no.</i>	<i>no.</i>	<i>\$</i>	<i>%</i>
1989–90	7.5			
1990–91	11.3	3.8	0.6	1.8
1991–92	13.4	2.2	0.3	0.9
1992–93	16.2	2.8	0.5	1.3
1993–94	18.1	1.9	0.3	2.0
1994–95	19.5	1.3	0.2	1.1
1995–96	25.0	5.6	1.3	4.3
1989–90 to 1995–96		17.5	3.2	1.9

Note: Constant (1989–90) prices.

Sources: PHIAC annual reports. Commission estimates.

Benefits paid by the health funds for these facilities amounted to just \$39 million in 1995–96, about 1.4 per cent of total hospital benefits. However, strong growth in this sector suggests that day hospitals will contribute increasing amounts to annual changes in hospital benefits and premiums.

### Summing up on hospital usage

Hospital use by the insured has increased only marginally in recent years (on an SEU basis). At the aggregate level, bed day use by insured patients in public and private hospitals actually declined by over 1 million between 1989–90 and 1995–96.

But this fall masked very different patterns occurring in the utilisation equation. A strong rise in public and private hospital admissions per insured person covered — placing an upward pressure on hospital insurance benefits — was largely neutralised by a decline in the average length of hospital stays. A fall in membership coverage also assisted in reducing the pressure on benefits.

The overall effect was a very modest contribution from additional private and public hospital utilisation to increases in benefits per SEU between 1989–90 and 1995–96 (1.9 per cent) — although the impact in the most recent year was much higher at 17.5 per cent. Increased usage of free standing day hospitals contributed a further 1.9 per cent of rises in benefits per SEU since 1989–90.

Overall, increased hospital usage is estimated to have contributed 3.8 per cent of hospital insurance benefit increases since 1989–90.

## 7.6 Impact of changes in hospital *bed day benefits*

### Overview

The other broad factor, apart from hospital usage, determining movements in hospital insurance benefits is the change in benefits paid per hospital bed day — the ‘unit price’ aspect of the total hospital benefits payable. It is important to recognise that the ‘price’ in this context is examined *from the perspective of the health funds*. The amount the health funds pay on behalf of their members (that is, *benefits paid* per bed day) will not necessarily be the same as the hospital *charges* for the day. Nor will it be the same as the *economic or resource costs* involved in treating fund members (especially so in the case of public hospitals).

Bed day benefits have exerted far stronger cost pressures on the health funds since 1989–90 than changing usage patterns (although these differences narrowed somewhat in 1995–96). *Between 1989–90 and 1995–96 rising hospital bed day benefits accounted for just over three-quarters of health funds’ overall benefit increases.*

There are four major reasons for the significantly higher benefits per hospital bed day in recent years (figure 7.8):



- a *shift* by the insured in obtaining treatment in private rather than public hospitals;
- *increases* in hospital admissions charges;
- *changes* in types of health fund hospital cover; and
- *reductions* in the average length of hospital stays.

This section analyses these and the other components — shown in figure 7.8 — underlying the increases in hospital benefits per bed day paid by the health funds.

### Shift in usage from public to private hospitals

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	29 per cent
Contribution to rise in real benefits per SEU, 1995–96	49 per cent

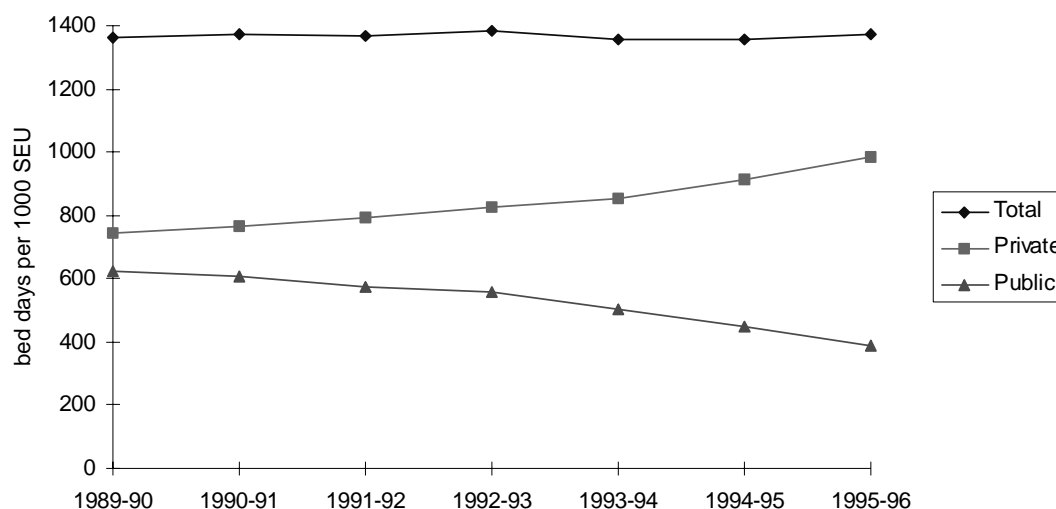
The changes in acute hospital utilisation discussed in section 7.5 mask different stories for utilisation in private and public hospitals. Health fund members have in fact been spending a lot more time in the former and a lot less time in the latter (figure 7.9).

Interestingly, the decline in the use of public hospitals by health fund members is broadly equivalent to the increase in the use of private hospitals (on an SEU basis). But the savings to health funds flowing from less use of public hospitals are greatly outweighed by the amount they have to pay for greater use of private hospitals. This is due to the much higher bed day benefits in the latter — around two and a half times greater than public hospitals — reflecting the fact that, unlike public hospitals, they are not subsidised by governments.

There are several, mutually reinforcing, forces underlying the changes in private and public hospital usage. Some are acting to ‘push’ the privately insured away from treatment in public hospitals, while others ‘pull’ the insured towards attending private hospitals.



Figure 7.9: Annual insured bed days (per 1000 SEU) by hospital type, 1989–90 to 1995–96



Source: PHIAC annual reports.

Amongst the ‘push’ factors mentioned in submissions are:

- the 1993 Medicare Agreements;
- budgetary constraints on public hospital services by state governments;
- queuing or perceptions of long waits in public hospitals; and
- public sector limits on doctors charging above the scheduled fee and corresponding freedom to do so in the private sector.

‘Pull’ factors mentioned in submissions include:

- eased technical capability in the private sector, which affects both usage and charges;
- increased availability of 100 per cent hospital cover;
- co-location of private facilities on public hospital sites;
- the development of ‘private’ wards in public hospitals; and
- better amenities in private hospitals.

HCF (Sub. 158, p. 14) argued that the 1993 Commonwealth/State Medicare Agreements<sup>12</sup> provided substantial incentives for the states to increase their public patient throughput. In HCF's opinion, these agreements 'would be the single major reason for the accelerated shift in hospital sector market share.' HCF said that an additional factor behind the shift could be the sustained criticism of the public hospital system over the past 12 months. The AMA (Sub. 130, pp. 11–12), on the other hand, believed the health funds had done too good a job in selling 100 per cent cover and promoting private hospitals.

It would be very difficult to calculate the individual impact on health fund benefits of these various, interrelated influences. However, it is possible to estimate their *combined* effect. This is shown in table 7.5.

Table 7.5: Impact of changes in public and private hospital usage on health insurance benefits, 1989–90 to 1995–96

<i>Year</i>	<i>Private hospital share of health fund members' use of hospital beds</i>	<i>Excess of private bed day benefits over public bed day benefits</i>	<i>Structural change impact on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	%	\$	\$	%
1989–90	54	155	na	na
1990–91	56	170	3.4	10.7
1991–92	58	191	5.0	13.3
1992–93	60	204	5.0	14.9
1993–94	63	217	9.2	57.3
1994–95	67	227	12.3	57.0
1995–96	72	233	14.8	48.6
1989–90 to 1995–96	–	–	49.7	29.0

Source: Commission estimates based on PHIAC annual reports.

<sup>12</sup> The Medicare Agreements sought to create an incentive to increase, or at least maintain, the ratio of public to private services in each state. This incentive initially operated through the Annual Adjustment Pool, from which states drew funds if the public share increased — and into which states paid funds if the public share declined. This arrangement operated for 1993–94 and 1994–95 only. In 1995–96 new adjustment pool arrangements were implemented which set a baseline for minimum public patient activity, with potential loss of funds if activity fell below the agreed target (but no extra funding being provided for achievement over the target).

Over the 1989–90 to 1995–96 period, it is estimated this structural change in hospital usage raised hospital benefits per SEU by nearly \$50 — equivalent to around 29 per cent of the overall increase in hospital insurance benefits.

The impact of the shift from public to private hospitals has been particularly pronounced in the last three years. Over half (54 per cent) of the increase in hospital insurance benefits between 1993–94 and 1995–96 can be explained by the trend for the insured to be treated in private rather than public hospitals.

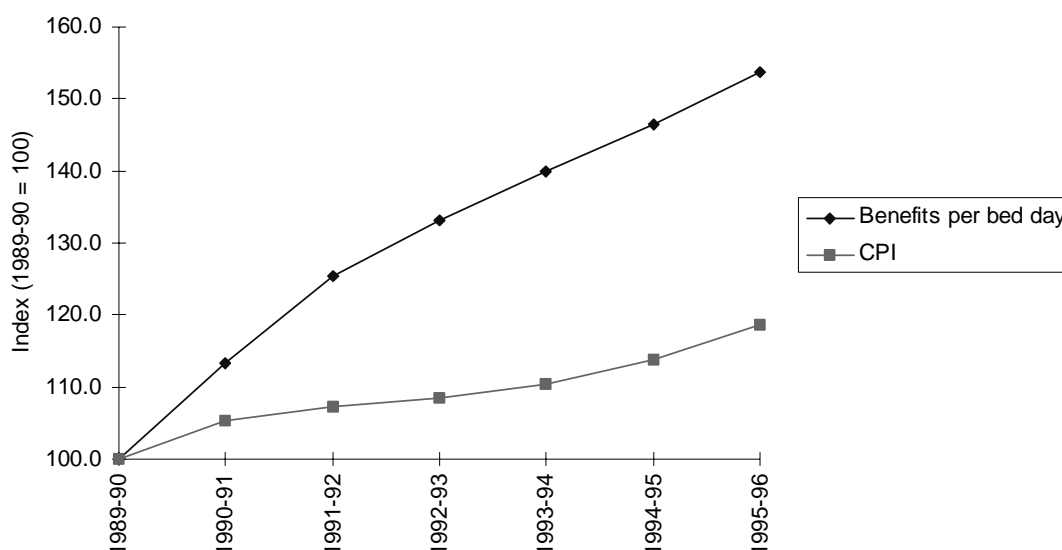
### Private hospital bed day benefits

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	42 per cent
Contribution to rise in real benefits per SEU, 1995–96	8 per cent

#### Overview

Average benefits paid by the health funds for each private hospital bed day have risen from \$307 in 1989–90 to \$471 in 1995–96. This amounts to a 53 per cent increase over the period and compares with general inflation of around 19 per cent (figure 7.10). Taking out the CPI effect leaves the real increase in bed day benefits at around 29 per cent.

Figure 7.10: Increases in private hospital benefits paid per bed day and CPI, 1989–90 to 1995–96



Sources: PHIA annual reports. ABS Ausstats CPI data.

At the state level, substantial variations from the national trend have occurred. In the 1990s, NSW (and ACT) private hospital bed day benefits (real terms) have increased at twice the rate of Victoria (41 per cent and 21 per cent respectively). South Australia has experienced the smallest increase in private hospital bed day costs overall (16 per cent) since 1989–90 (appendix I, table I.13).

From the health funds' perspective, there are three broad factors determining changes in private hospital bed day benefits:

- hospital admission charges;
- the impact of changes in the average length of hospital stay; and
- the extent of hospital charges covered by insurance cover.

These are discussed in the following sections.

#### *Increases in private hospital admission charges*

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	13.5 per cent
Contribution to rise in real benefits per SEU, 1995–96	-4.5 per cent

The principal component determining the level of private hospital bed day benefits is hospital admission charges. As charges data were not generally available on an industry-wide basis between 1989–90 and 1995–96, charges were estimated by the Commission using data on the number of insured bed days, patient revenue per bed day and the average length of hospital stays.<sup>13</sup>

Data on changes in real private hospital admission charges and their estimated impact on hospital insurance benefits are presented in table 7.6. Between 1989–90 and 1995–96, charges are estimated to have increased by around 9 per cent in real terms, accentuated by a 4 per cent rise in a single year (1992–93). Since 1992–93, however, charges have remained virtually unchanged.

<sup>13</sup> As noted in the analysis of hospital utilisation (section 7.5), the Commission produced its own trend estimates of private hospital admissions by the insured and ALOS in private hospitals — due to concerns over the accuracy of some annual data. For bed day benefits, these trend estimates affect changes in charges per admission and bed days per admission (ALOS). While the use of a trend rate requires estimated *annual* contributions to be regarded with some caution, it can be expected that estimates over the 1989–90 to 1995–96 period will be close to the real values.

This apparent recent moderation in charges is supported by evidence from HCF (Sub. 158, p. 7). HCF noted that its own experience in NSW was that private hospital charges were increasing by two and a half times the rate of inflation prior to 1993, but by 1995 the rate of increase had slowed (which it attributed to negotiations between HCF and private hospitals).

Between 1989–90 and 1995–96, it is estimated that rising private hospital admission charges contributed an average 13.5 per cent to the increase in hospital insurance benefits. The real decline in charges in the past year is reflected in a negative contribution to the increase in benefits.

**Table 7.6: Changes in real private hospital admission charges and impact on hospital insurance benefits, 1989–90 to 1995–96**

<i>Year</i>	<i>Charge per admission</i>	<i>Change in charge per admission</i>	<i>Impact of changes in admission charges on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	%	\$	%
1989–90	1 608			
1990–91	1 644	2.2	5.4	16.5
1991–92	1 679	2.1	6.0	15.1
1992–93	1 746	4.0	12.5	34.4
1993–94	1 757	0.6	2.2	12.6
1994–95	1 757	0.0	0.0	0.0
1995–96	1 750	-0.4	-1.6	-4.5
1989–90 to 1995–96		8.9	23.2	13.5

Note: Constant (1989–90) prices.

Sources: PHIAC annual reports. ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years. Information supplied by the Department of Health and Family Services using data obtained from Medicare hospital statistics. Commission estimates.

The factors underlying changes in private hospital real admission charges can be approached from two angles:

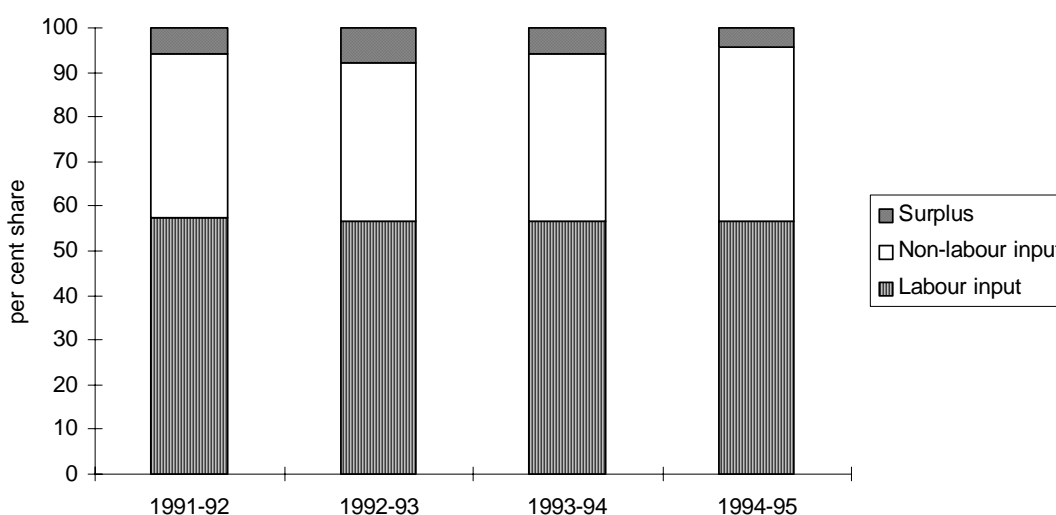
- The first is to treat admission charges as the accounting aggregate of labour costs, non-labour costs and a surplus — and to assess the influence of each.

- The second is to explain changes in real admission charges in activity terms as a greater intensity of resources per bed day — due to increases in casemix intensity and changes in technology and clinical practice.

*Factors underlying increased private hospital admission charges — changes in input contributions*

Data restrictions prevent a detailed analysis of hospital expenditures and allow only for a snapshot of changes occurring between 1991–92 and 1994–95. Nevertheless, it is possible to give a broad picture of the significance of labour and non-labour inputs (and their contributions to rising bed day benefits). By adding the hospital surplus element to this analysis, we can fully decompose the admission charges. The broad relativities are demonstrated in figure 7.11.

Figure 7.11: Private hospital expenditure and surplus element, 1991–92 to 1994–95 (per cent shares)



Note: The labour input shares do not generally include payments to doctors. However, ‘salaried medical officers and other diagnostic health professionals’ — around 4–5 per cent of private hospital staff — are included.

Sources: ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years. Commission estimates.

Wages and salaries (labour input) accounted for 57 per cent of private hospital admission charges in 1991–92 and remained at this proportion throughout the period to 1994–95. The expenditure associated with non-labour inputs<sup>14</sup>

<sup>14</sup> Non-labour hospital costs in 1994–95 comprised interest, depreciation and contract services (31 per cent), drug, medical and surgical supplies (29 per cent), administrative



increased at a faster rate than wages and salaries over the period (21 per cent as opposed to 12 per cent). As a result, non-labour costs contributed slightly more to admission charges at the beginning of the period than at the end. The surplus element — the difference between operating expenditure and patient revenue — fluctuated but ended the period at its lowest share (4.3 per cent).<sup>15</sup>

The rising proportion of non-labour costs in private hospital expenditures shows up more clearly in the contributions of the three components to annual *increases* in admission charges (table 7.7). In the latter two years in particular, increases in non-labour costs have been the major drivers behind rising real hospital costs. The ‘profit’ share has apparently been declining and therefore having a negative effect on charges per admission.

**Table 7.7: Contribution of expenditure components and surplus element to real increases in private hospital admission charges, 1991–92 to 1994–95 (per cent)**

<i>Year</i>	<i>Labour input contribution</i>	<i>Non-labour input contribution</i>	<i>Surplus contribution</i>
1992–93	35	1	64
1993–94	71	178	-149
1994–95	49	127	-75
1991–92 to 1994–95	46	71	-16

Note: Components may not add to 100 per cent due to rounding.

Source: Commission estimates based on data in ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years.

The largest component of non-labour costs is ‘interest, depreciation and contract services’. Although only increasing at the same rate as average operating costs in the 1990s, this could be set to change in the near future. Capital expenditure by private hospitals has risen rapidly in recent years, mainly as a consequence of new hospital facilities being opened. Significantly, the 41 per cent real increase in capital expenditure per bed day between 1991–92 and 1994–95 is derived mainly from a 170 per cent increase by the private for-profit hospitals. The religious and charitable hospitals increased capital expenditure by just 20 per cent over the same period.

According to the ABS data, the component classified as ‘drug, medical and surgical supplies’ has been the fastest growing non-labour input cost (36 per

expenses (22 per cent), food supplies (6 per cent), repairs and maintenance (6 per cent), and other domestic services (6 per cent).

<sup>15</sup> The overall ‘surplus’ will be slightly higher when non-patient revenue is included.

cent real rise per bed day between 1991–92 and 1994–95). The other major components all grew by around 10–11 per cent. The APHA said that the substantial increase in the cost of medical supplies reflects both a change in casemix and a change in surgical methods:

Laparoscopic surgery started to become more popular in 1992 and involves large quantities of disposable items. Similarly, single use items have become more commonplace to address infection. Drugs that are not available under the Pharmaceutical Benefits Scheme have also dramatically increased in price. Together, these factors have led to much higher cost increases than can be accounted for purely by analysing input costs. (APHA, Sub. 51, p. 17)

While non-labour costs have been growing the fastest, the labour component is still the most significant in absolute terms. APHA pointed out that contributing factors to increased staffing costs could have been a move to a 38 hour week for nursing staff and increases in the number of staff per occupied bed. In addition, APHA noted there has been a shift to more expensive clinical staff over the period — as private hospitals moved into more complex surgery and more intensive medical care. The contribution of changing complexity to higher private hospital admission charges is discussed below.

There are some interesting variations among states in input contributions to rising private hospital admission charges (appendix I, table I.16). A notable feature over the 1991–92 to 1994–95 period is the absence of any labour contribution to cost increases in Victoria — approximately two-thirds of the increase in admission charges is attributed to non-labour input cost increases and the remainder to higher surpluses. The Victorian situation is unique in two respects — the absence of a labour contribution and a positive contribution from the surplus factor. Another notable feature of the state data is the very high (214 per cent) non-labour contribution in Western Australia, which was ‘balanced’ by a similarly large negative contribution (189 per cent) from the surplus element.

*Factors underlying increased private hospital admission charges — changes in the complexity of treatment*

Part of the story behind higher private hospital benefits per bed day has been attributed to the increasing complexity of procedures now being undertaken in private hospitals. Increasing complexity might mean higher hospital spending on drug, medical and surgical supplies. In addition, more complex procedures mean more high-tech equipment and more highly qualified (and better paid) nursing staff — all of which affect hospital expenditure.

Both Medibank Private (Sub. 168) and the AMA (Sub. 130) note that whereas private hospitals once provided relatively simple medical services, they now

provide more advanced surgical procedures supported by intensive care facilities.

The Medibank Private submission includes a table summarising the growth in private hospital facilities and showing the increasing sophistication of services available. A more simplified and updated form of this table, based on ABS data, is reproduced as table 7.8.

**Table 7.8: Private hospitals with selected specialised units, 1994–95**

<i>Specialised units</i>	<i>Private hospitals with units</i>	<i>Increase in number of hospitals between 1991–92 and 1994–95</i>
	<i>no.</i>	<i>%</i>
Neonatal ICU	39	95
Separate ICU	21	91
Separate CCU	11	267
Combined ICU/CCU	28	65
High dependency unit	68	6
<b>Sub-total ICU/CCU/HDU</b>	<b>167</b>	<b>45</b>
Cardiac surgery	9	125
Neurosurgical unit	4	300
Major plastic/reconstruction	3	200

Note: ICU: Intensive Care Unit; CCU: Critical Care Unit; HDU: High Dependency Unit.

Source: ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years.

Medibank Private observed that:

The increase in ICU/CCU/HDU units, as well as the emergence of cardiac and neurosurgical facilities, is evidence of the increased capability of private hospitals, especially associated with high cost health care services. (Sub. 168, p. 43)

HCF noted that investment in private hospital capability has been substantial, with one consequence being an increase in benefits paid by the health funds. Its submission provided the following specific example:

HCF categorises private advanced surgery hospitals as AA (Level 1 ICU — capable of cardiac surgery) or A (Level 2 ICU). In 1992 HCF paid benefits to two AA private hospitals and nine category A private hospitals. In 1996 there are nine AA category hospitals and eight A category hospitals, an increase of 54 per cent in advanced surgery capability generally and a quadrupling of cardiac surgery capability. In one year, from 1994–95 to 1995–96, benefits paid by HCF to these 17 hospitals have increased by 17 per cent. (Sub. 158, p. 9)

It is possible to gain a broad insight into the impact of increasing complexity on the cost of private hospital treatment using two methods:

- by analysing ABS private hospital data on patient types; and
- by analysing Departmental partial data on the average cost weights of private hospital separations.

Interestingly, rather than confirming the picture drawn above, they tend to throw some doubt on the notion that complexity is increasing overall.

More advanced surgical patients naturally tend to be more costly to a hospital and can attract both a higher daily accommodation charge as well as higher theatre fees. Evidence showing a significant rise in the proportion of advanced surgery being undertaken in private hospitals would lend support to the argument that increased complexity is adding to input costs and charges.

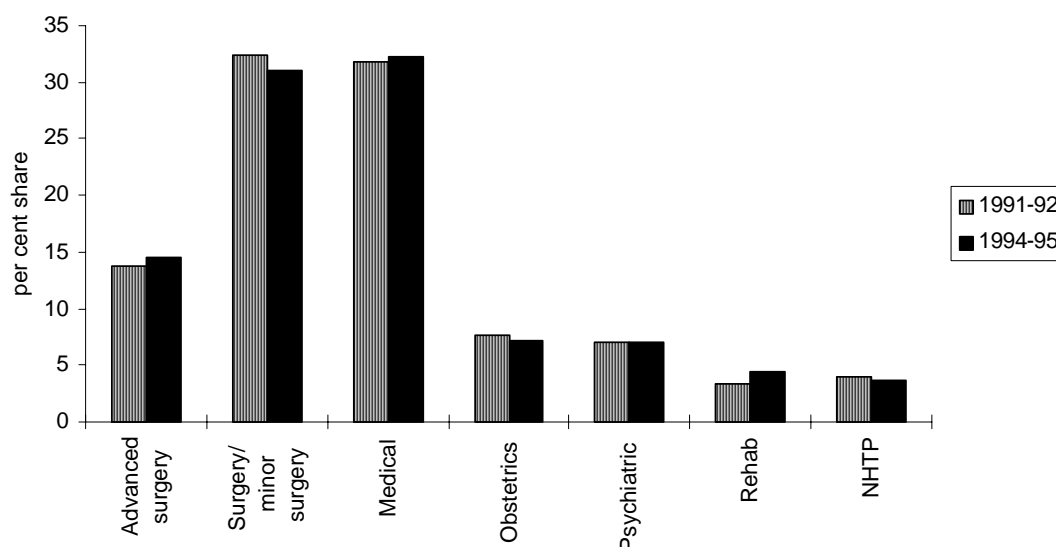
The changing relative shares of various patient classifications for private acute hospitals are shown in figure 7.12.<sup>16</sup> Advanced surgery patients accounted for 14.5 per cent of bed days in 1994–95, up from 13.8 per cent in 1991–92. This category of patient in fact grew the most over the 1991–92 to 1994–95 period. The data show advanced surgery and medical patients increasing slightly at the expense of other (less complex) surgery patients. That is, there appears to be some movement towards greater complexity in private hospitals, but perhaps not enough to explain a significant increase in hospital costs.

Information obtained from the Department addresses the relationship between changing complexity and costs. The data enable us to contrast the casemix weighted averages of private hospital separations in New South Wales and South Australia between 1991–92 and 1994–95 (table 7.9).

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<sup>16</sup> The data are shown on a bed day basis in view of the wider discussion which is seeking to explain rising bed day benefits. Using separation data makes little difference to the results.

Figure 7.12: Private acute hospital patient types, by occupied bed days, 1991–92 and 1994–95 (per cent share)



Notes: 1. Same day patients are each counted as having a stay of one day.  
 2. The surgical and medical patient classifications are as defined by the Department of Health and Family Services. From 1 November 1996, advanced surgery includes surgical procedures with an MBS fee greater than \$626.30. Medical includes all admitted patients not included elsewhere.

Source: ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years.

The data are split between episodes which include or exclude same day separations. In 1994–95, day only separations were responsible for 53 per cent of all private acute hospital separations in NSW (up from 46 per cent in 1991–92) and for 35 per cent in South Australia (up from 25 per cent). For all separations (that is, including same day separations) there is no casemix-based evidence that, on average, patients in private hospitals were any more costly to treat in 1994–95 than they were in 1991–92 (private national cost weight of 0.96 against 0.97). If same day separations are excluded from the total separations a different picture emerges. This shows that private patients were (on average) 7.3 per cent more costly to treat in 1994–95.

*The implication of these data seems to be that private hospitals are undertaking more complex procedures (as evidenced by the non-same day data), but these are being outweighed from an overall cost perspective by the increasing share of cheaper same day separations.*

Table 7.9: Separations and average cost weight (private national) per separation, AN-DRG Version 3.0, private acute hospitals, NSW and SA, 1991–92 to 1994–95

Year	NSW		SA		Total (NSW and SA)	
	Number of separations	Average cost weight	Number of separations	Average cost weight	Number of separations	Average cost weight
<b>Excluding same day separations</b>						
1991–92	144 902	1.22	85 442	1.23	230 344	1.23
1992–93	184 801	1.25	86 742	1.29	271 543	1.26
1993–94	219 323	1.23	86 479	1.32	305 802	1.26
1994–95	207 491	1.30	85 318	1.37	292 809	1.32
% change 1991–92 to 1994–95	43.2	6.6	– 0.1	11.4	27.1	7.3
<b>Including same day separations</b>						
1991–92	267 447	0.93	114 520	1.07	381 967	0.97
1992–93	359 621	0.92	121 177	1.08	480 798	0.96
1993–94	441 188	0.90	123 759	1.09	564 947	0.94
1994–95	444 133	0.92	130 763	1.09	574 896	0.96
% change 1991–92 to 1994–95	66.1	– 1.1	14.2	1.9	50.5	– 1.0

- Notes:
1. An AN-DRG cost weight is a measure of the mean cost of one AN-DRG relative to the cost of other AN-DRGs. The 'average cost weight per separation' is equal to the sum of total separations for each DRG multiplied by the cost weight for the DRG, all divided by the number of total separations. It should be noted that the average cost weight is a measure of casemix complexity and not a measure of the cost of health delivery.
  2. Separate cost weights exist for the private and public sectors, reflecting major differences in the range of costs. Table 7.9 uses private cost weights while table 7.10 uses public cost weights.
  3. Private hospital data include free standing day hospitals.
  4. Episode types other than 'acute' are excluded. Deaths or discharges/transfers to other acute hospitals are treated as overnight stays.
  5. The 1991–92 and 1992–93 data do not represent complete coverage of private hospital activity in NSW in those years.

Source: Department of Health and Family Services, unpublished data. Table derived from the data set used to produce the *Australian Casemix Report on Hospital Activity*.

It is illuminating to compare data for private hospitals with public hospitals (table 7.10). These suggest that in 1994–95 public hospitals had a higher level of casemix complexity than their private hospital counterparts. This is particularly the case for private patients in public hospitals — who were, in casemix terms, 21 per cent more costly including same day separations and 15 per cent more costly excluding same day separations.

**Table 7.10: Average cost weight (public national) per separation, AN-DRG v3.0, private and public acute hospitals, NSW and SA combined, 1994–95**

<i>Patient type</i>	<i>Excluding same day separations</i>	<i>Including same day separations</i>
Private hospitals	1.17	0.86
Public hospitals	1.26	1.01
— public patients	1.22	0.98
— private patients	1.35	1.04

Notes: 1. National public sector cost weights used to enable comparison of private and public hospital activity.  
 2. The public hospital data used in this table exclude public psychiatric hospitals, repatriation hospitals not at the time part of the state hospital system, and ‘recognised hospitals’ identified as non-acute facilities by the relevant state authority.  
 3. See notes for table 7.9.

Source: Department of Health and Family Services, unpublished data. Table derived from the data set used to produce the *Australian Casemix Report on Hospital Activity*.

Overall, the casemix data reproduced in tables 7.9 and 7.10 suggest complexity has probably added only negligible amounts to private hospital costs (and bed day benefits). Average cost weights per separation in private hospitals — when same day separations are included — have remained stable (or might even be falling). The data also suggest that private hospitals are attracting relatively less complex cases than public hospitals. At the same time, the fact that private hospitals have been undertaking more complex episodes when day surgery is excluded, implies they have required more investment and capital equipment to do so.

*Factors underlying increased private hospital admission charges — changes in technology and clinical practice*

The principal activity leading to increases in private hospital admission charges through a greater intensity of resources per bed day — see figure 7.8 — is a broad collection of components that affect hospital practices and costs. Most of these can probably be summarised under the impact of new technology and changing clinical practices.

Improvements in the use of current technologies and the development of new ones are placing substantial pressures on hospitals to increase technology uptake. In most cases, this seems more likely to add to costs than reduce them.

The intensity of hospital resource use — including technology — is also affected by the ageing population. The Royal Australasian College of Surgeons observed that:

As the population ages there is a very dramatic increase in the use of health care resources for degenerative diseases and cancer. Major examples are in the area of cardiac disease (and cardiac surgery); joint disease (with joint replacement) and degenerative changes in the eye (cataract surgery).

As people age the incidence of cancer increases, causing an increased use of technology for diagnostic purposes; increased numbers of patients needing surgery, radiotherapy and chemotherapy; and there is an increasing need for palliative care, for intensive care beds and for high dependency nursing. (Sub. 27, p. 3)

Changes in clinical practices in private hospitals may also occur for endogenous reasons. For example, the attitude of doctors to ordering tests and X-rays will have a bearing on the level of hospital resources devoted to individual patient episodes. Also, ‘drug, medical and surgical supplies’ have been the fastest growing non-labour input cost in private hospitals — and much of this increase is probably attributable to changes in surgical methods.

It is only possible to estimate the combined impact of these effects on hospital charges by assuming they equal the *residual* amount — that is, the amount of admission charges left over once the complexity impact is taken out. On this basis, it is estimated that changes in technology and clinical practice may account for virtually all of the increase in private hospital admission charges between 1989–90 and 1995–96.

#### *Impact of reductions in average length of stay*

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	21 per cent
Contribution to rise in real benefits per SEU, 1995–96	19 per cent

The impact of reductions in the average length of hospital stays (ALOS) was discussed earlier (section 7.5) as one of the factors contributing to hospital *utilisation* changes. But the amount of private hospital benefits paid per bed day is also affected by the length of stays (see figure 7.8).

As the ALOS of patients falls — other things being equal — the hospital benefit paid per bed day will increase. However, this apparent increase in benefits is an



artificial one in the sense that bed day benefits will rise faster than the benefits paid per episode. Nothing has occurred which has added to hospital charges for accommodation or theatre. But because patients are staying in hospital for shorter durations, it has the same effect as an increase in charges.

The principal reason for the increased benefit payments on a bed day basis is that shorter stays mean non-accommodation charges are spread over less days. This is a particular feature of surgical procedures. The APHA described it thus:

[a] source of overestimation of charge increases arises from the reducing length of stay. Some of this may reflect changes in casemix but, in other cases, there has been a reduction in length of stay for particular types of patients through changes in clinical practice. Where this occurs for surgical patients, charges related to the initial procedure (eg theatre, high cost pharmaceuticals, disposables) are spread across fewer days, thereby increasing the apparent daily charge. (Sub. 51, p. 18)

A significant factor in this analysis is the relative decline in ALOS for private patients in public and private hospitals. ALOS in private hospitals has fallen at a greater rate than ALOS for private patients in public hospitals. Combining this information with the large usage shift by health fund members from public to private hospitals, means that while the number of private ‘stays’ has expanded, the average length of stay has fallen — with the effect of inflating the overall benefits paid per bed day by the health funds.

Commission estimates of the impact of declining ALOS in private hospitals on hospital insurance benefits are shown in table 7.11.

**Table 7.11: Impact of ALOS changes in private hospitals on hospital insurance benefits, 1989–90 to 1995–96**

<i>Year</i>	<i>Impact of ALOS changes on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	%
1990–91	11.3	35.2
1991–92	10.2	27.3
1992–93	-0.8	-2.4
1993–94	1.8	11.1
1994–95	7.3	33.7
1995–96	5.8	19.2
1989–90 to 1995–96	35.6	20.8

*Sources:* ABS *Private Hospitals, Australia* (Cat. No. 4390.0), various years. Information supplied by the Department using data obtained from Medicare hospital statistics. Commission estimates.

Apart from 1992–93, the reductions in length of stays at private hospitals have made significant annual contributions to increases in benefits paid on a bed day basis (and to overall hospital benefits). Between 1989–90 and 1995–96, the ALOS effect is estimated to have contributed around 21 per cent to increased hospital insurance benefits per SEU.

*Changes in types of hospital insurance cover*

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	7.8 per cent
Contribution to rise in real benefits per SEU, 1995–96	-7.1 per cent

In attempting to decompose increases in benefits paid per bed day in private hospitals since 1989–90, we have so far accounted for the effects of increasing costs per admission and decreasing lengths of stay. The residual amount is attributable to changes in the types of hospital cover held by health fund members (see figure 7.8).

There are two broad changes in cover types which have influenced bed day benefits:

- Enhanced forms of cover — especially the move to 100 per cent hospital accommodation cover — have *increased* benefits paid per bed day due to the fact that health funds are paying for a higher proportion of hospital charges.
- At the same time the increasing take-up of hospital insurance cover with front end deductibles (FEDS) will tend to work in the opposite direction, *reducing* the amount of benefits paid by the health funds.<sup>17</sup>

Assuming hospital charges remained unchanged, enhanced hospital cover reduces the gap between the charges per bed day and the benefit paid per bed day (and reduces copayments by an equivalent amount). In other words, an increasing level of cover increases the amount the health funds pay out in benefits — irrespective of any changes in bed day *charges* made by the hospitals. On the other hand, an increasing number of members taking out FEDS cover has an opposite effect — it increases the gap between charges and benefits (due to higher copayments). Accordingly, any calculations of the impact of changes in cover *must* take into account both enhanced cover and FEDS.

<sup>17</sup> Types of hospital insurance cover, including 100 per cent products and FEDS, are discussed in chapter 4.

A number of submissions discuss the impact of 100 per cent cover on health fund benefits. The AMA (Sub. 130), for example, claims there is anecdotal evidence that 100 per cent cover premiums have been underpriced and are driving up benefit pay outs — through strong demand for private hospital accommodation. Evidence of a substantive kind was provided — on a confidential basis — by one of the major health funds. It made the observation that 100 per cent hospital cover has been most attractive to ‘high’ claiming members and has thus incurred high claims cost since its introduction.

The move to 100 per cent cover interacts with increasing private hospital use. With reduced financial disincentives for health fund members staying in private hospitals, it is likely that 100 per cent cover has played some part in the changed hospital usage patterns.

The AHIA (Sub. 108) stated that 100 per cent cover may have accelerated the shift from public to private hospitals, but did not start the trend. It points out that *de facto* full hospital cover has been around since the 1980s, in the sense that members were only required to contribute a very small amount (say \$10 a day) to hospital accommodation charges.

A method for estimating the impact of changes in health insurance cover was suggested by the AIHW (Sub. 178). The contribution of cover changes to rising benefits paid per bed day is estimated by comparing growth in patient revenue per bed day<sup>18</sup> with growth in benefits paid per bed day by the health funds. The reasoning is that if health funds are paying a higher proportion of private hospitals’ patient revenue, this must mainly reflect the fact that more members have top hospital cover.

The results of this exercise (table 7.12) suggest that the net impact of 100 per cent cover and the introduction of front end deductibles has been an upward pressure on health fund benefits.<sup>19</sup> Changes in the types of cover taken up by health fund members are estimated to have contributed around 8 per cent to increases in hospital benefits per SEU between 1989–90 and 1995–96.

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<sup>18</sup> The AIHW uses total revenue per bed day.

<sup>19</sup> The AIHW submission notes that the estimated impacts of 100 per cent cover using its method should be treated with caution. First, the calculations are sensitive to small changes in the input parameters. For example, the use of Medicare Agreement data on the number of private hospital bed days produces significantly different numbers as compared to the ABS Private Hospitals Survey. Second, the results will not apply to any particular state as the timing of the move to 100 per cent cover was different in each state.

Table 7.12: Impact of changes in hospital insurance cover on hospital insurance benefits, 1989–90 to 1995–96

<i>Year</i>	<i>Private hospital patient revenue per bed day</i>	<i>Benefits paid per private hospital bed day</i>	<i>Ratio of benefits to charges</i>	<i>Impact of cover changes on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	\$	ratio	\$	%
1989–90	348	307	0.882	na	na
1990–91	373	330	0.884	0.7	2.3
1991–92	395	358	0.906	6.6	17.7
1992–93	410	377	0.919	4.1	12.3
1993–94	415	388	0.936	5.9	37.0
1994–95	424	394	0.931	-2.0	-9.1
1995–96	429	397	0.926	-2.1	-7.1
1989–90 to 1995–96				13.3	7.8

Notes: 1. Patient revenue per bed day for 1989–90 and 1990–91 derived by assuming it accounts for 95 per cent of total hospital revenue.

2. Constant (1989–90) prices.

Sources: Commission estimates based on data in PHIAC annual reports, ABS *Private Hospitals, Australia* (Cat. No. 4390.0) and AIHW (Sub. 178).

The pressure on benefits appears to have been greatest between 1991–92 and 1993–94, peaking in the latter with a contribution of over one-third to the benefit rise in that year. Since then the effect of changing cover preferences appears to have worked the other way — a greater tendency towards FEDS and fewer top hospital cover memberships has had a downward impact on hospital benefits and premiums.

### Public hospital bed day benefits

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	4.8 per cent
Contribution to rise in real benefits per SEU, 1995–96	-5.3 per cent

Unlike private hospital bed day benefits — which are negotiated between the health funds and private hospitals — public hospital bed day benefits have been determined by the Commonwealth. Under these arrangements, public hospitals were constrained from charging more than the amount prescribed by the

Commonwealth Government under the Basic Table of Benefits. However, this has recently changed. The use of the basic table ceased on 1 July 1996 unless there is an HPPA in place. As there are no HPPAs between public hospitals and the funds currently in place, the default benefit applies.<sup>20</sup> Effective from July 1996, the public hospital charge in most states for private treatment in a shared ward is \$210 per day.

Changes in public hospital benefits per bed day for insured patients can be decomposed into benefits paid per admission and the impact of changes in the average length of stay.

Benefits per admission paid by the health funds fell in real terms between 1989–90 and 1995–96 (table 7.13). This is the result of real benefits declining for the past three years, following increases in the early 1990s. The contributions of changes in public hospital admission benefits to hospital insurance benefits mirror these trends. Thus, positive contributions in the early 1990s have been replaced by negative ones from 1993–94 onwards. Over the entire period these factors balance out so that the net impact on hospital insurance benefits is virtually non-existent (-0.2 per cent).

The impact of reductions in the average length of hospital stays (ALOS) was discussed earlier as one of the factors contributing to hospital utilisation changes and to higher private hospital bed day benefits. Commission estimates of the impact of declining ALOS in public hospitals on hospital insurance benefits are shown in table 7.14.

As is the case with private hospital bed day benefits (table 7.11), reductions in ALOS for private patients in public hospitals have placed upward pressures on bed day benefits. However, the impact is significantly less due to the relatively small role played by public hospital benefits.

Overall, the effect of changing ALOS for private patients in public hospitals on bed day benefits is estimated to have contributed around 5 per cent to increased hospital insurance benefits per SEU between 1989–90 and 1995–96 (compared to 21 per cent for private hospitals).<sup>21</sup>

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<sup>20</sup> However, the default benefit, as determined by the Minister for Health and Family Services, mirrors the basic table so that the level of benefits is effectively the same. See chapter 3 for further information on HPPAs.

<sup>21</sup> Comparisons of the effect of ALOS changes in public and private hospitals should be treated with caution, due to the fact that the latter include estimates based on trend data. Private hospital ALOS data, actual and estimates, are depicted in figure I.2, appendix I.

Table 7.13: Changes in benefits per public hospital admission and impact on hospital insurance benefits, 1989–90 to 1995–96

<i>Year</i>	<i>Real benefits per admission</i>	<i>Change in real benefits per admission</i>	<i>Impact of changes in benefits per admission on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	%	\$	%
1989–90	809			
1990–91	868	7.3	6.7	21.0
1991–92	881	1.5	1.4	3.8
1992–93	889	1.0	1.0	2.8
1993–94	845	-5.0	-4.7	-29.3
1994–95	810	-4.1	-3.4	-15.7
1995–96	795	-1.9	-1.3	-4.3
1989–90 to 1995–96		-1.8	-0.3	-0.2

*Sources:* PHIAC annual reports. Information supplied by the Department of Health and Family Services using data obtained from Medicare hospital statistics. Commission estimates.

Table 7.14: Impact on hospital insurance benefits of ALOS changes for insured patients in public hospitals, 1989–90 to 1995–96

<i>Year</i>	<i>Impact of ALOS changes on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	%
1990–91	-2.1	-6.7
1991–92	3.2	8.7
1992–93	1.8	5.5
1993–94	4.0	24.8
1994–95	1.8	8.4
1995–96	-0.3	-0.9
1989–90 to 1995–96	8.5	4.9

*Sources:* Information supplied by the Department of Health and Family Services using data obtained from Medicare hospital statistics. Commission estimates.

## Free standing day hospitals

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	1.8 per cent
Contribution to rise in real benefits per SEU, 1995–96	8.3 per cent

The growth in *usage* of free standing day hospitals was discussed in section 7.5 — higher usage contributed 1.9 per cent to hospital insurance benefit rises between 1989–90 and 1995–96. The impact of changes in their admission charges on hospital benefits over the same period — at 1.8 per cent — is approximately the same (table 7.15).

The small annual impact on hospital benefits per SEU followed a gradually rising trend until 1995–96, when it appears to have changed dramatically. The data indicate that free standing day hospitals accounted for over 8 per cent of the increase in hospital benefits in 1995–96.

**Table 7.15: Changes in benefits per bed day for free standing day hospitals and impact on hospital insurance benefits, 1989–90 to 1995–96**

<i>Year</i>	<i>Benefits per bed day</i>	<i>Change in benefits per bed day</i>	<i>Impact on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	\$	\$	%
1989–90	148			
1990–91	151	3	0.02	0.1
1991–92	161	10	0.13	0.3
1992–93	166	5	0.07	0.2
1993–94	171	5	0.09	0.5
1994–95	180	9	0.16	0.7
1995–96	294	114	2.53	8.3
1989–90 to 1994–95		32	0.47	0.4
1989–90 to 1995–96		146	3.00	1.8

Note: 1. Constant (1989–90) prices.  
2. The benefits data for 1995–96 were collected on a different basis from earlier years. Accordingly, a more accurate picture of the longer run contribution of day hospital charges to rising hospital insurance benefits might be obtained by the change over the period 1989–90 to 1994–95 (rather than 1989–90 to 1995–96).

Sources: PHIAC annual reports. Commission estimates.

However, the reason for this large turnaround is owed to PHIAC reporting changes. Prior to July 1995, theatre fees and some other charges raised by free standing day hospitals were separately collected and were not included as part of the 'benefits paid' for their patients. But as the 1995–96 data now include theatre fees there appears to have been a massive rise in benefits paid compared to previous years. This is not the case.

A more accurate picture probably emerges by aggregating the contribution of free standing day hospital admission charges between 1989–90 and 1994–95. This shows a contribution of only around 0.4 per cent to increases in hospital insurance benefits per SEU.

### **Summing up on bed day benefits**

Increases in benefits per bed day have been the dominant source (78 per cent) of rising hospital insurance benefits in the 1990s. At the head of the list is the cost pressures caused by the shift by the insured from public to private hospital treatment. This is estimated to have been responsible for almost 30 per cent of the benefit rise between 1989–90 and 1995–96. In the last of these years it was the single most important factor, contributing almost 50 per cent of the benefit increase.

Private hospital bed day benefits contributed 42 per cent overall of hospital insurance benefit increases in the 1990s, but this consisted of three different factors:

- Reductions in the average length of stay in private hospitals — which have the effect of spreading non-accommodation charges over fewer days — accounted for half (21 per cent) of the rise in bed day benefits.
- Admission charges contributed a further 13.5 per cent, due primarily to changes in clinical practice patterns and the increasing utilisation of high cost and high technology equipment. Changing patient casemix appears to have had a negligible impact on private hospital admission charges in the past few years. There is no direct evidence of higher surpluses/profits being behind the higher private hospital admission charges — the surplus share appears to be relatively stable and even falling of late. Non-labour inputs have apparently been the main component explaining the increased charges (although labour costs still make up the greatest share of private hospital costs).
- The final component of rising private hospital bed day benefits — changes in types of health fund cover — is estimated to have contributed approximately 8 per cent of hospital insurance benefit increases.



The other elements of hospital bed day benefits — public and free standing day hospitals — are estimated to have made only small contributions to hospital insurance benefits since 1989–90 (4.8 per cent and 1.8 per cent respectively).

## 7.7 Medical gap and prostheses

### Medical gap benefits

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	7.7 per cent
Contribution to rise in real benefits per SEU, 1995–96	3.7 per cent

Medical gap benefits for in-hospital services remained stable in the first half of the 1990s at around 8–9 per cent of total hospital benefits, although this fell to 6 per cent in the last year. Benefits paid by the health funds for medical gap services amounted to \$223 million in 1995–96, 24 per cent higher in real terms than the amount paid in 1989–90.

The impact of medical gap benefit payments on hospital insurance benefits is detailed in table 7.16. The data reveal a fairly stable contribution from year to year and an average contribution to benefits per SEU of 7.7 per cent between 1989–90 and 1995–96.

Figure 7.13 decomposes the growth in medical gap benefits in the 1990s into the volume and price effects. This reveals mixed outcomes from year to year, but with service use having the dominant impact overall. Over the entire period the usage effect accounts for around 85 per cent of the medical gap contribution to benefit increases.

In fact growth in the average fee per service over the period was not very much greater than CPI growth (28 per cent and 18.7 per cent respectively). The scheduled fees for medical services under the basic table, which are set by the Commonwealth, have been effectively frozen in the last few years. This has helped to keep the rate of increase for in-hospital medical services within inflation. And, while doctors are free to charge above the scheduled fee in the supplementary tables, the out-of-pocket costs for patients may have acted as a deterrent on charging practices.

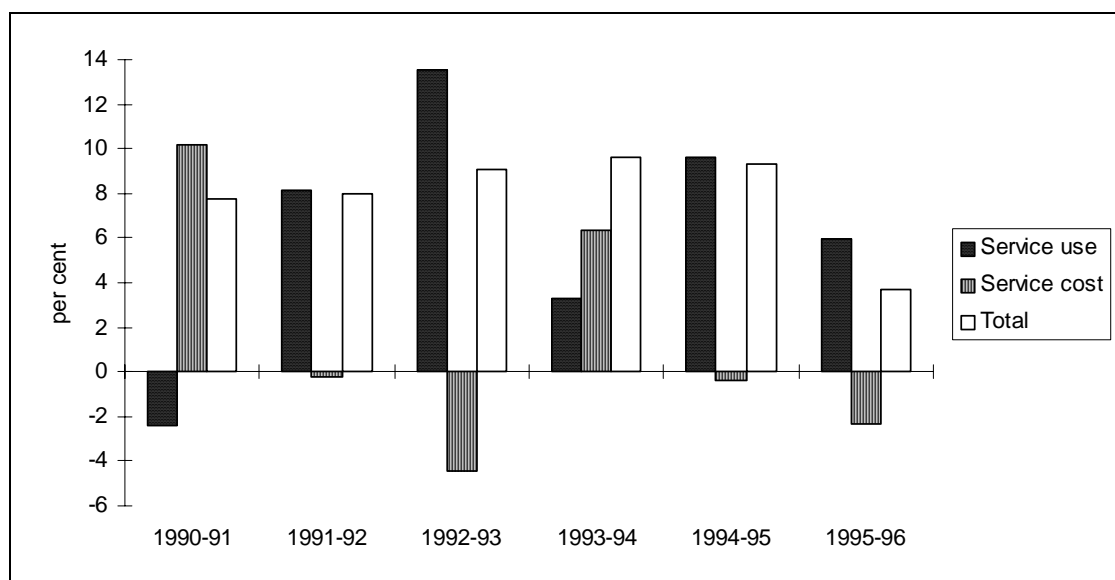
Table 7.16: Changes in medical gap benefits and impact on hospital insurance benefits, 1989–90 to 1995–96

<i>Year</i>	<i>Medical gap benefits per SEU</i>	<i>Impact on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	\$	%
1989–90	28.43		
1990–91	30.91	2.5	7.7
1991–92	33.89	3.0	8.0
1992–93	36.96	3.1	9.1
1993–94	38.50	1.5	9.6
1994–95	40.51	2.0	9.3
1995–96	41.62	1.1	3.7
1989–90 to 1995–96		13.2	7.7

Note: Constant (1989–90) prices.

Sources: PHIAC annual reports. Commission estimates.

Figure 7.13: Impact of changes in medical gap service use and cost on changes in hospital insurance benefits per SEU (real terms), 1989–90 to 1995–96 (per cent contribution)



Source: Commission estimates based on PHIAC annual reports.

The increase in the volume of medical services in the 1990s (15 per cent rise since 1989–90) has occurred in a climate of rapidly declining health fund membership and a loss of around 1 million insured bed days. This reflects a rapid increase in the number of in-hospital medical services per insured person — up by around 40 per cent since 1989–90.

The reasons for this increase are partially tied up with increased admissions per insured person covered. Although occupied insured bed days and health fund membership have recently declined, admissions per insured person covered still increased by over 20 per cent between 1989–90 and 1995–96 (see section 7.5). In addition, the shift in insured patients from public to private hospitals may also have played a role. The data would seem to indicate that patients in private hospitals are more likely to receive a greater number of in-hospital medical services per episode than they would as private patients in public hospitals.

The APHA commented it is likely that this phenomenon reflects charging practice rather than clinical practice:

In public hospitals, hospital employed medical practitioners are available for some of the surgical assistance and consultation roles. These doctors may provide these services without billing the private patients. In private hospitals, however, staff doctors are not available for these roles. (Sub. D217, p. 29)

However, it seems unlikely that charging practices alone would totally explain the greater number of medical services per episode in private hospitals.

### **Prostheses benefits**

Contribution to rise in real benefits per SEU, 1989–90 to 1995–96	10.9 per cent
Contribution to rise in real benefits per SEU, 1995–96	15.1 per cent

Benefits for surgically implanted prostheses were introduced in 1985. The Department controls the list of eligible items — currently over 4500 — and the benefits paid by the health funds for each procedure.

The significance of prostheses benefits in total hospital benefits has increased during the 1990s — from a 1.7 per cent share in 1989–90 to a 4.7 per cent share in 1995–96. The impact of growing prostheses claims on hospital insurance benefits is shown in table 7.17. The decomposition of this impact into service use and cost is depicted in figure 7.14.

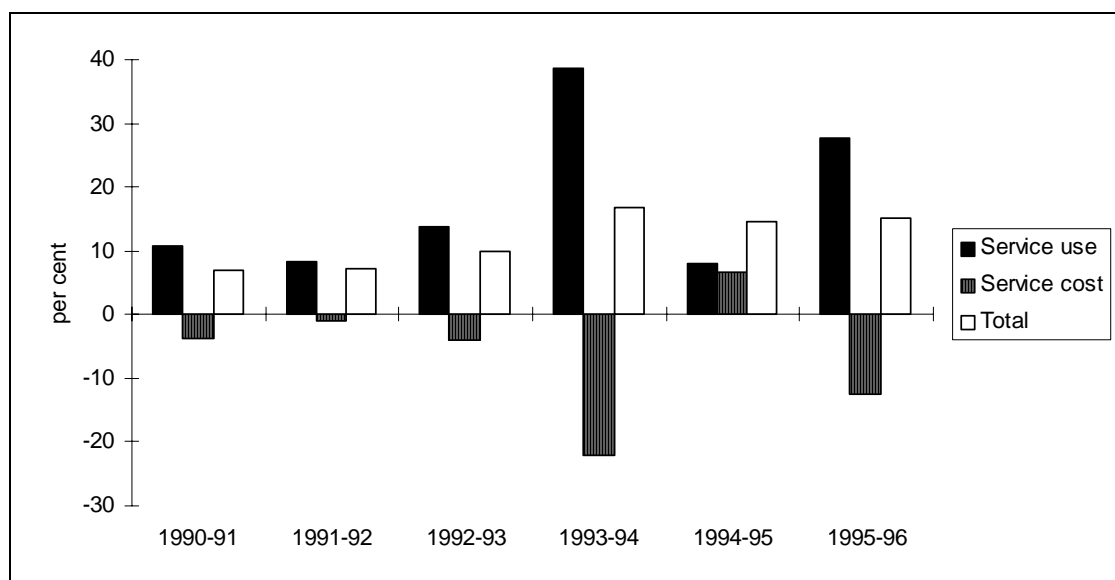
Table 7.17: Changes in prostheses benefits and impact on hospital insurance benefits, 1989–90 to 1995–96

<i>Year</i>	<i>Prostheses benefits per SEU</i>	<i>Impact on real hospital insurance benefits per SEU</i>	<i>Contribution to real increase in hospital insurance benefits per SEU</i>
	\$	\$	%
1989–90	6.2		
1990–91	8.4	2.2	6.9
1991–92	11.1	2.7	7.1
1992–93	14.4	3.3	9.8
1993–94	17.1	2.7	16.7
1994–95	20.2	3.1	14.5
1995–96	24.8	4.6	15.1
1989–90 to 1995–96		18.6	10.9

Note: Constant (1989–90) prices.

Sources: PHIAC annual reports. Commission estimates.

Figure 7.14: Impact of changes in prostheses service use and cost on changes in hospital insurance benefits per SEU (real terms), 1989–90 to 1995–96 (per cent contribution)



Source: Commission estimates based on PHIAC annual reports.

The contribution of prostheses to *changes* in hospital benefits averaged around 11 per cent between 1989–90 and 1995–96. Over the past three years the contribution has been averaging over 15 per cent, with the rise in the *volume* of items implanted being the main driver. In fact, only in one year (1994–95) did prostheses *costs* make a positive contribution to rising benefits (figure 7.14).

Over the period 1989–90 to 1995–96, the number of prostheses items implanted grew five-fold — compared with a real decline of around 45 per cent in the average benefit paid per item. The decline in unit costs probably reflects a change in the mix of prostheses items towards the cheaper end of the spectrum, rather than falling prices per item.<sup>22</sup>

The increased utilisation is also somewhat misleading as it reflects rapid growth in the number of prosthetic items added to the eligible list — rather than an increased demand for a given number of items.

APHA indicated (Sub. 51, p. 24) that the greater number of prosthetic items being implanted each year is likely to be a reflection of advances in medical technology and that ‘as such, the trend can be expected to continue in spite of any attempts to “increase efficiency” in hospitals’.

## 7.8 Other underlying factors

In the previous sections, rising hospital insurance benefits have been explained in terms of changes in four broad factors: hospital utilisation, benefits paid per bed day, medical gap and prostheses. The estimation methodology ensures that the sum of the contributions of these factors to increases in hospital insurance benefits per SEU in any particular period will equal 100 per cent.

However, there are other significant elements at work influencing hospital insurance benefits that have so far not been discussed. The reason is that their effects cut across a number of areas simultaneously, making it impossible to isolate impacts on hospital usage, bed day benefits or other factors.

These other elements can be classified as changes in membership composition that alter the funds’ risk profile. First, there is an impact on health fund benefits due to members gradually getting older (‘ageing’ impact). Second, there is the impact arising from people exiting the health funds (or not joining) and worsening the funds’ risk profile by leaving it top heavy with the older and sicker members (‘adverse selection’).

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<sup>22</sup> There can also be an enormous variability in costs for the same item. Thus, a hip prosthesis currently can cost between \$800 and \$5000.

### Ageing of the insured population

The cost impact of an ageing health fund membership is best demonstrated by assuming that each group in the population has a propensity to insure — for example, 25 per cent of people aged 20–25 might have health insurance — and that this remains *fixed*. But while this is fixed, both the insured and uninsured population is ageing. This has two effects:

- As health fund membership gets older, the average age increases, and this results in increases in the benefits paid per SEU.
- As the general population ages, there may actually be an increased *overall* participation in health insurance as the population weights of those who have higher propensities to insure increases.

The first effect is the largest. Even if total health fund membership remained unchanged from one year to the next, the benefits payable by the funds would be expected to rise due to all the members getting one year older.

### Adverse selection

Lower participation by the general population in health insurance worsens the funds' risk profile and effectively raises benefits payable (and thus premiums). As premiums increase, there is a further drop out of healthier members and the 'vicious circle of falling membership' — described in chapter 1 — continues.

In analysing age impacts, it was assumed that the propensity to insure remained fixed. With adverse selection, the propensities to insure *change*. The good health risks leave (or do not join in the first place) and the bad risks join and stay. For example, imagine that everyone was stuck at their current age — perpetually 25, 50 or some other age. But the propensity to insure for the younger, healthier people was falling. And, at the same time, the propensity to insure for 'sicker' people may actually rise a little — certainly this could be true for some risk groups such as women planning a family.

An increasing proportion of members in the older age categories has significant implications for health fund costs. The usage and cost of hospitalisation is very much higher for older age groups and with fewer low claim, low cost contributors (the young and healthy) to compensate, the more likely the health funds will be faced with higher pay outs on claims.

The health funds then face being left with a greater proportion of high cost elderly members, while losing the contribution income of low claiming younger members. In order to be able to meet the continuing claims of remaining members, the funds must increase premiums to raise more contribution income.

### **Estimated impacts of ageing and adverse selection**

The AMA (Sub. 130, p. 15) lists several reasons why ageing and adverse selection may be significant factors behind increases in health fund benefits:

- The insured population is ageing faster than the population at large.
- Ageing has a much larger impact on hospital outlays than on medical outlays.
- The impact for females is larger than the impact for males because females have a longer life expectancy, older females use more bed days, and private health insurance coverage of females aged 65 and over is higher than the coverage for males.

HCF (Sub. 158, p. 15) illustrated the impact of ageing health fund membership by examining the share of bed days used by the elderly as their share of total membership increases. It concluded that for every 1 per cent increase in the proportion of members aged 65 and over as a share of total membership, there is a 3 per cent increase in their share of bed days.

The *broad* impact of ageing and adverse selection on health funds can be observed through the share of hospital benefits directed to the reinsurance pool. Around 1990, reinsurance benefits for the elderly accounted for 35 per cent of total hospital benefits, but by 1995–96 this share had increased to 43 per cent.

The Commission's estimates of the effects of ageing and adverse selection on hospital insurance benefits are illustrated below (tables 7.18 and 7.19). Two methods are adopted.<sup>23</sup> The first method relies on PHIAC data and is therefore able to produce annual estimates — however, it suffers from only being able to assess impacts for two broad age groups (under and over 65). The second approach uses ABS Health Survey and population census data, and actuarial data provided by Alan Brown (Sub. 34). This enables variables such as the propensity to insure to be associated with every year of age. But estimates of impacts are confined to the change over the entire 1990–1995 period.<sup>24</sup>

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<sup>23</sup> Technical details of the adverse selection and ageing methodology are contained in appendix I.

<sup>24</sup> Detailed statistics and analysis on ageing and the propensity to insure can be found in chapter 6.

**Table 7.18: Impact of changing age composition and adverse selection on hospital insurance benefits, 1989–90 to 1995–96**

<i>Year</i>	<i>Share of population aged 65 and over</i>	<i>Share of insured aged 65 and over</i>	<i>Impact of ageing on real hospital insurance benefits per person covered</i>	<i>Impact of adverse selection on real hospital insurance benefits per person covered</i>	<i>Contribution of ageing to real increase in hospital insurance benefits per person covered</i>	<i>Contribution of adverse selection to real increase in hospital insurance benefits per person covered</i>
	%	%	\$	\$	%	%
1989–90	11.0	10.0	na	na	na	na
1990–91	11.2	10.6	0.8	2.2	3.5	9.2
1991–92	11.4	11.3	1.2	3.4	4.0	12.1
1992–93	11.6	11.9	1.3	2.9	4.8	11.0
1993–94	11.7	12.4	1.4	2.7	10.0	20.0
1994–95	11.9	13.1	1.1	3.6	6.2	20.2
1995–96	12.0	13.5	1.0	2.8	4.2	12.0
1989–90 to 1995–96			6.7	17.6	5.0	13.2

Sources: PHIAC annual reports. Commission estimates.

**Table 7.19: Impact of changing age composition and adverse selection on hospital insurance benefits over the period 1990 to 1995**

<i>Year</i>	<i>Average age of Australian population</i>	<i>Average age of insured population</i>	<i>Impact of ageing on real hospital insurance benefits per person covered</i>	<i>Impact of adverse selection on real hospital insurance benefits per person covered</i>	<i>Contribution of ageing to real increase in hospital insurance benefits per person covered</i>	<i>Contribution of adverse selection to real increase in hospital insurance benefits per person covered</i>
			\$	\$	%	%
1990	33.97	34.33				
1995	34.94	37.35				
1990 to 1995			8.8	20.1	8.1	18.5

Sources: PHIAC annual reports. ABS National Health Survey, unpublished data. ABS Population Census data. Alan Brown (Sub. 34). Commission estimates.



Tables 7.18 and 7.19 both demonstrate the growing disparity between the age composition of the insured vis-a-vis the general population. However, the effects of these changes vary to a significant degree. The change in demographics between 1990 and 1995 (table 7.19) suggests that ageing contributed 8 per cent and adverse selection around 19 per cent to rising hospital benefits in the first half of the 1990s. This compares with around 5 per cent and 13 per cent respectively using annual PHIAC data.

The implication of this comparison is that the usual method adopted by analysts for estimating ageing and adverse selection — using PHIAC data — *underestimates* their impact on hospital benefits and premiums. This is due to the limitations presented by being only able to divide the population into two age groups. The detailed demographic data used to calculate the results in table 7.19 enables a much more accurate picture to be painted.

Neither of the methods for estimating adverse selection capture the cost impacts of ‘hit and runs’. The Commission was unable to obtain data that would allow an accurate assessment of *changes* in hit and runs and the effect on *changes* in premiums. However, estimates of the impact of hit and runs on hospital benefits in any one year are contained in appendix H.

## **7.9 Health fund management costs**

Trends in management costs, including matters relating to efficiency, were discussed in some detail in chapter 4. Between 1989–90 and 1995–96, aggregate management costs increased by 29 per cent, to \$504 million. This increase was considerably lower than the 49 per cent increase in hospital benefits over the same period, but higher than the increase in the CPI (18.7 per cent).

A more meaningful picture emerges if changes in management costs are considered on an SEU basis to take account of the declining health fund membership. Over the period since 1989–90, management costs per (hospital insurance) SEU increased by 52 per cent or around 7.3 per cent per annum. In real terms the corresponding figures are 28 per cent and 4.2 per cent per annum.

However, health funds are in the business of providing ancillary insurance as well as hospital insurance. Accordingly, it would be inappropriate to allocate all of the increases in management costs to hospital insurance premiums. Management expenses need to be shared between the two — but there are different approaches to how this should be done.

Some analysts allocate costs on the basis of benefit shares, but this seems too arbitrary. A sounder approach is to use data on the proportion of administrative

duties undertaken by health funds — such as claims processing, inquiries — that are related to hospital insurance. Information obtained from a survey of some of the major health funds indicates that ancillary insurance dominates administrative duties. The number of hospital accommodation claims tends to account for only 5–15 per cent of all health fund claims.<sup>25</sup>

Accordingly, one approach would be to assume that a maximum of 15 per cent of annual management cost increases should be allocated to hospital insurance costs (and premiums). This would mean that management costs have perhaps contributed only around 2 per cent to hospital insurance premium increases between 1989–90 and 1995–96.

However, this is likely to be a considerable underestimate. While the proportion of *claims* is strongly biased towards ancillary products — which might particularly affect labour and computer costs — some *other significant administration expenses* lean more towards allocation to hospital insurance, for example, the publicity and advertising budget. In addition, although the major funds tend to include the processing of medical gap claims as ancillaries, there is obviously a case for allocating these (in-hospital services) to the hospital product.

The Commission surveyed a sample of the health funds — including the major players — regarding how they allocated administrative overheads to hospital and ancillary products (in 1995–96). The survey results produced quite a diverse range, but averaged out at 49 per cent hospital and 51 per cent ancillary (with ‘hospital’ including any medical gap overheads). Adopting an even allocation between hospital and ancillary, the Commission estimates the contribution of management costs to recent real hospital premium increases to be around 6 per cent (5.7 per cent between 1989–90 and 1995–96).<sup>26</sup>

Some of the reasons behind these contributions by management expenses to real increases in premiums are discussed in chapter 4 and appendix G.

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<sup>25</sup> Not all of the remaining proportion of claims are ancillary claims. Many funds classify claims as ‘hospital’, ‘ancillary’ and ‘medical gap’. The latter accounted for 10–35 per cent of claims.

<sup>26</sup> The contribution of management cost increases to premium changes in any particular year can be volatile, depending on changes in the other variables which determine premium levels (see appendix I).

## 7.10 Reserves

It was noted in section 7.2 that premium levels are influenced in broad terms by the statutory requirement for health funds to maintain members' reserves at two months of break-even contributions. In practice, the reserve levels of the funds fluctuate significantly from year to year and the effects of this accumulation (or de-accumulation) of reserves can be traced through to an impact on premiums.

For example, if the health funds go through a period of running down reserves, this will tend to have a downward impact on premiums — the funds forestall premium rises by digging into reserves. On other hand, when reserves are increasing, an upward pressure is placed on premiums — the funds are 'forcing' premium rises by a desire to build up reserves.

In broad terms, the health funds have been building up reserve levels again in the 1990s, following the relatively low levels experienced in the second half of the 1980s. To what extent have changes in reserve levels since 1989–90 led to premium increases?

One way of estimating this is simply to compare the change in annual reserves with the health funds' contribution income — and then derive the implied income effect on an SEU (or premium) basis. This is the method adopted by APHA (Sub. 51, p. 39), who found that the premium effect of the change in reserves was fairly small over the 1991–92 to 1994–95 period.

The method adopted by the Commission focused on the annual reserves/benefit ratios of the health funds rather than the reserve levels. This recognises that reserve levels are going to fluctuate naturally in line with annual changes in benefits. Holding fixed the reserves/benefit ratio at the previous year's level provides a more accurate indication of how the health funds' policy towards reserves is impacting on premiums.

The results of this analysis are shown in table 7.20. In 1995–96, for example, the data indicate that a relatively low increase in premiums was financed by running down reserves. On the other hand, a building up of reserves in 1992–93 and 1993–94 had the effect of adding to premium levels. Since 1989–90, the accumulation of reserves by the health funds has added an overall 1.3 per cent to premiums.

In sum, premiums in the 1990s appear to have been a little higher than strictly necessary for the purposes of paying out benefits. But the amount added to premiums is relatively small. And in any case there are sound prudential reasons to take into consideration with respect to the building of reserves by the health funds.

Table 7.20: Changes in health fund reserves and impact on premiums, 1989–90 to 1995–96

<i>Year</i>	<i>Reserves</i>	<i>Change in reserves</i>	<i>Reserves/benefits ratio</i>	<i>Impact of changing reserves/benefit ratio on premiums</i>
	<i>\$'000</i>	<i>\$'000</i>		<i>%</i>
1989–90	861 630		0.31	
1990–91	850 976	(10 654)	0.27	– 3.6
1991–92	991 312	140 336	0.29	1.9
1992–93	1 205 391	214 079	0.34	4.3
1993–94	1 350 058	144 667	0.37	3.1
1994–95	1 408 982	58 924	0.38	0.4
1995–96	1 295 327	(113 655)	0.34	– 4.7
Change 1989–90 to 1995–96				1.3

*Source:* Commission estimates based on PHIAC annual reports.

## 7.11 Government policy and cost transfers

Recent government policy towards the health insurance industry was discussed in detail in the discussion of regulatory and institutional matters in chapter 3. Numerous submissions addressed the various ways in which changes in government policies had affected the health insurance industry in general.

Several submissions also estimated the impact of these changes on health fund costs and premiums. These showed some variation in the estimates of the cost impact of government policies — for the most part because the submissions have differing views on which government decisions had a significant effect.

However, the most common ‘big ticket’ items addressed related to:

- the requirement for health funds to cover the medical gap for private in-patient care (1985–86);
- the removal of the bed day subsidy for private hospital utilisation (1986–87); and
- the removal of the Commonwealth Government subsidy to the reinsurance pool, which commenced with a \$100 million government contribution (phased out between 1983–84 and 1987–88).

The AHIA (Sub. 108) and the AMA (Sub. 130) both provided estimates of the on-going cost impact on the health funds resulting from these (and other) government policy changes (table 7.21). The AMA inclusions and calculations indicate a slightly higher figure than the AHIA.

**Table 7.21: AHIA and AMA estimates of the impact of earlier government policy changes on health fund costs, 1994–95 (\$ million)**

<i>Government measures</i>	<i>AHIA estimates</i>	<i>AMA estimates</i>
<b>Common items</b>		
Private hospital bed day subsidy removal	154.0	235.0
Change in medical gap to 25% of MBS for in-hospital medical services	215.8	216.0
Cessation of contribution to reinsurance pool	100.0	220.0
<b>Other items</b>		
Requirement to cover prostheses costs as part of basic cover	109.3	–
Public hospital charges above the CPI	133.0	–
Transfer from public to private hospitals	–	175.0
<b>Total</b>	<b>712.1</b>	<b>846.0</b>
Impact expressed as a proportion of 1994–95 premiums	27 per cent	30 per cent

Notes: 1. Annual cost to health funds, 1994–95 dollars.  
2. AHIA estimate of reinsurance impact not indexed. Estimates based on 1994–95 hospital usage. AHIA impact is additional cost per SEU, which may vary slightly from the impact on premiums.

Sources: AHIA (Sub. 108), AMA (Sub. 130).

For the three common items in the table, the AMA obtains higher numbers except for the medical gap (which is the same). For the reinsurance pool, the AHIA has used the original government contribution in the 1970s (\$100 million) as its basis for estimating the loss to the health funds. The AMA, on the other hand, notes that it estimates the higher figure of \$220 million by maintaining the reinsurance contribution at the real levels of 1982–83 (when the government subsidy was at its peak).

The impact of the loss of the bed day subsidy is complicated by the fact that the amount used to vary according to three categories of private hospitals. The AHIA calculated an average figure which it then applied to current bed day utilisation, whereas the AMA stated that:

maintained, [the bed day subsidy] would have been worth \$235 million per annum by 1994–95 on the most modest of assumptions. (Sub. 130, p. 7)

The overall impact of government policy changes is calculated by the AMA to be equivalent to around 30 per cent of current hospital premiums, and by the AHIA to be equivalent to around 27 per cent of current hospital benefits per SEU (similar to premiums).

The gradual removal of Commonwealth subsidies to reinsurance, the cessation of private hospital bed day subsidies and the requirement for the funds to cover the medical gap undoubtedly placed upward pressure on premiums. However, while these and other measures have added to health fund costs and premiums, this largely occurred prior to 1989–90. Although premiums today are higher than they would have been if government subsidies had remained in place, little of the *growth* in premiums in the 1990s — the subject of this chapter — can be attributed to these changes.

## **7.12 Impact of cost drivers on premiums**

Recent increases in hospital insurance premiums were one of the factors that led to this inquiry. This chapter has sought to quantify the cost pressures in the health insurance industry and explain why premiums have risen so much.

The relative contributions of hospital insurance cost drivers to premium increases in the 1990s are summarised below in table 7.22. The results clearly show the similarity between contributions to premium changes and contributions to changes in hospital benefits per SEU. In fact they only differ due to the inclusion of management expenses in premium changes.<sup>27</sup>

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<sup>27</sup> This will not always be the case. The relationship between increases in premiums and hospital benefits per SEU is also influenced by such factors as investment income and changes in reserves, especially on an annual basis. However, over a longer period these factors tend to reduce to zero — which is precisely what occurs over the 1989–90 to 1995–96 period. See appendix I for a further discussion of these issues.

Table 7.22: Key contributors to real increases in hospital insurance benefits and premiums, 1989–90 to 1995–96 (per cent)

<i>Component</i>	<i>Contribution to increase in hospital benefits per SEU, 1995–96</i>	<i>Contribution to increase in hospital benefits per SEU, 1989–90 to 1995–96</i>	<i>Contribution to increase in hospital insurance premiums, 1989–90 to 1995–96</i>
<b>Utilisation (bed days per SEU)</b>	<b>21.9</b>	<b>3.8</b>	<b>3.6</b>
<i>Public and private hospitals</i>	<i>17.5</i>	<i>1.9</i>	<i>1.8</i>
— changes in admissions	47.1	42.4	39.9
— changes in average length of stay	-25.7	-32.2	-30.3
— changes in membership coverage	-3.8	-8.3	-7.8
<i>Day hospitals</i>	<i>4.3</i>	<i>1.9</i>	<i>1.8</i>
<b>Unit costs (benefits per bed day)</b>	<b>59.3</b>	<b>77.6</b>	<b>73.2</b>
<i>Shift from public to private patients</i>	<i>48.6</i>	<i>29.0</i>	<i>27.4</i>
<i>Private hospital bed day benefits</i>	<i>7.6</i>	<i>42.1</i>	<i>39.7</i>
— changes in admission charges	-4.5	13.5	12.8
— changes in average length of stay	19.2	20.8	19.6
— changes in health fund cover	-7.1	7.8	7.3
<i>Public hospital bed day benefits</i>	<i>-5.3</i>	<i>4.8</i>	<i>4.5</i>
— changes in benefits per admission	-4.3	-0.2	-0.2
— changes in average length of stay	-0.9	4.9	4.7
<i>Day hospitals</i>	<i>8.3</i>	<i>1.8</i>	<i>1.7</i>
<b>Other hospital benefits</b>	<b>18.8</b>	<b>18.6</b>	<b>17.5</b>
<i>Medical gap</i>	<i>3.7</i>	<i>7.7</i>	<i>7.3</i>
— service use	6.0	6.6	6.2
— service cost	-2.3	1.1	1.1
<i>Prostheses</i>	<i>15.1</i>	<i>10.9</i>	<i>10.2</i>
— service use	27.6	16.0	15.1
— service cost	-12.5	-5.1	-4.9
<b>Management expenses</b>	<b>na</b>	<b>na</b>	<b>5.7</b>
<b>Other underlying factors</b>			
<i>Impact of ageing (1990–95)</i>	<i>na</i>	<i>8.1</i>	<i>7.6</i>
<i>Impact of adverse selection (1990–95)</i>	<i>na</i>	<i>18.5</i>	<i>17.4</i>

Note: For convenience it is assumed that increases in benefits and premiums occur in the same year.

Source: Commission estimates.

The cost element of hospital treatment — benefits paid per bed day — was the major driver of premium rises between 1989–90 and 1995–96 (responsible for almost three-quarters of the increases). Two main factors were behind these increasing costs — the switch by the insured to being treated in private rather than public hospitals (27 per cent), and private hospital bed day benefits (40 per cent). The latter can in turn be decomposed, which shows that private hospital charges were responsible for only around one-third of rising bed day benefits. The rest was due to changes in health insurance cover (especially the move to 100 per cent cover) and declining lengths of hospital stays.<sup>28</sup>

Increased hospital usage is estimated to have contributed only 3.8 per cent of hospital insurance benefit increases since 1989–90 — acute and day hospitals each contributing 1.8 per cent. It should be noted that the small hospital utilisation contribution to rising premiums is a net effect that masks significant, but counteracting, changes in hospital admissions and the average length of hospital stays. As health insurance membership has declined, the remaining health fund members have been going into hospital more often — but once admitted have been staying there for shorter periods than in the past.

Adverse selection is an important characteristic of health insurance that cuts simultaneously across a number of the other cost drivers — private and public hospital usage, bed day benefits and other factors (such as prostheses). As such, it underlies a significant proportion of recent premium increases. Furthermore, adverse selection is likely to become even more significant in relative terms as other leading cost drivers of recent years stabilise or decline in importance. For example, private hospital admission charges have become less important as a source of premium increases than they were in the early 1990s. Similarly, the switch from public to private hospitals may well moderate in the near future.

The relative importance of the key cost drivers in the 1990s stands out more clearly in figure 7.15.<sup>29</sup> The public-private hospital switch was easily the single most important contributor to premium rises, followed by adverse selection, private hospital charges and prostheses benefits. The remaining elements are all relatively insignificant as long-term cost drivers, including increasing hospital utilisation, which ranks near the bottom as a source of premium increases.

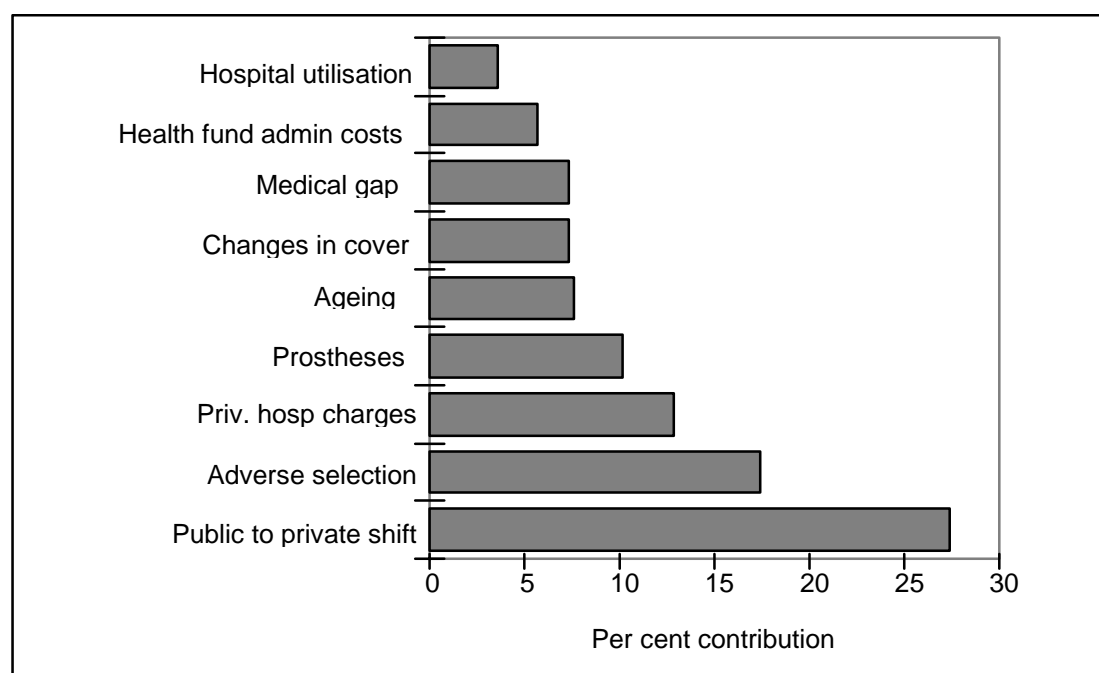
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<sup>28</sup> Note that the cost increasing impact on bed day benefits of reductions in the length of private (and public) hospital stays is offset by their cost reducing impact on utilisation.

<sup>29</sup> Comparisons between the Commission's findings on the key cost drivers and those contained in submissions to the inquiry can be found in appendix I.



Figure 7.15: Contribution of key cost drivers to increased hospital insurance premiums, 1989–90 to 1995–96



Note: Constant (1989–90) prices.

Source: Commission estimates.

The time period can make an important difference to the overall conclusions. This is broadly demonstrated by the comparison of contributions to changes in hospital benefits per SEU between 1989–90 and 1995–96, and for the most recent year, 1995–96 (table 7.22). Clearly, some factors are *currently* more (and some less) significant drivers of premium increases than previously.

Hospital utilisation, for example, plays a minor role in the longer term but accounted for 22 per cent of the rise in hospital benefits in 1995–96. The switch from public to private hospitals by the insured — the major cost driver between 1989–90 and 1995–96 — was even more significant in the past year (49 per cent of the hospital benefits increase). The growth in prostheses benefits has also accelerated rapidly and contributed 15 per cent of the benefit rise in 1995–96. On the other hand, 1995–96 saw *negative* contributions to benefit changes from private hospital admission charges and changing insurance cover.

In sum, no individual factor can be singled out as the underlying cause of recent increases in hospital insurance premiums (although the shift from public to private hospitals has clearly played a major role).

Importantly, there is no direct evidence of excess profits on the part of two of the major industry players — the health funds and private hospitals. A mix of factors, subject to numerous influences and individual actions, have worked together to raise industry costs and premiums well in excess of general inflation.

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## 8 IMPROVING EFFICIENCY AND CONTAINING COSTS

In recent times, governments have sought to improve *efficiency* within the public health system through casemix funding and other measures. They have also sought to control the public health care budget, with mixed success. This has included using their monopoly over purchasing to keep medical and pharmaceutical prices down; special arrangements for diagnostic services; and caps on funding and volume constraints, resulting in waiting lists for public hospital services.

Health fund contributors and private patients also have a direct interest in improved efficiency and lower costs in the private health care system. Chapter 7 examined the key cost drivers contributing to higher health insurance premiums. This chapter looks at the incentives facing health funds, hospitals and medical providers, and considers the scope for improvements to encourage efficiency and contain costs without compromising the quality of health care. Some changes fall within the ambit of this inquiry. But many of the major issues go beyond the current terms of reference.

### 8.1 Cost containment and efficiency

Efficiency in the health care system involves more than providing services at least cost. Consumers are also concerned with quality and levels of service — aspects like waiting times, convenience of facilities and the effectiveness of treatment. Improvements in these usually don't come without extra costs.

For the health care system, efficiency means achieving a balance between the cost of provision and the value patients place on the service, including all of these dimensions. Ultimately, it's about providing maximum value for money for consumers of health care services, including health fund members.

In examining the scope for improving incentives within the health care system, there are two broad elements to consider:

- incentives within health organisations to produce services using the fewest possible inputs (*technical* efficiency) and at minimum unit cost; and
- incentives for achieving an allocation of resources among different health services (and between health and other activities) that produce the combination which best meets patient and consumer demands (*allocative*

efficiency), and which therefore results in an efficient level of health expenditure overall.

## **8.2 Nature of the problem**

The Australian health care system has traditionally combined fee-for-service medicine with payment of the largest part of health care bills by a third party — the government (taxpayers) or private insurers. Inherent in the system is a tendency for overuse, where patients receive services which they value at less than the cost of provision. This is compounded by the information imbalance between doctors and patients.

Many submissions recognised this problem. National Mutual Health Insurance (NMHI) described it this way:

medical practitioners are much better informed than patients about what is needed to treat illness or injury. This creates a fundamental market imbalance in the purchase and sale of health care. (Sub. 140, p. iii)

Additionally, NMHI said:

there is an obvious incentive for medical practitioners to prescribe additional treatment that may be of benefit, even if the cost is large in relation to that benefit — so long as ‘the system’ picks up that cost. (p. iii)

In such cases, there also is little financial disincentive for patients to undergo additional treatment, even when it may be of marginal benefit.

These factors work against containing (excessive) costs within the system and providing private health fund members with value for money. The problem compounds as technology makes feasible an ever increasing range of procedures which are high cost but often of marginal additional clinical worth. The increasing tendency for litigation adds to the incentive for medical providers to prescribe additional procedures using the latest technology.

Part of the complex web of health care regulation is aimed at countering these incentives. For example, there are regulated MBS fees, restrictions on the number of doctors and private hospital beds, and constraints on the level of reimbursement by private health funds. But these and other elements of the regulatory structure can also constrain competition and flexibility within the system.

With growing recognition of the problems, there have been moves to introduce greater cost consciousness to the system. And there are signs of efficiency improvement within the existing system (Royal Australasian College of Surgeons, Sub. 27, p. 3):

- a general reduction in length of stay in hospitals and growth in the use of day care surgery (technical efficiency); and
- early discharge planning programs and domiciliary care initiatives (allocative efficiency).

### 8.3 Contracting arrangements

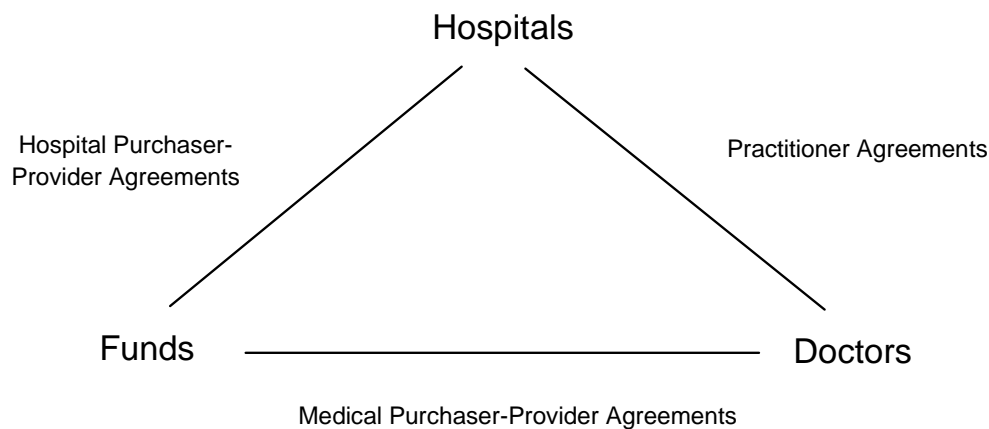
An important initiative aimed at both improving efficiency and containing unit costs has been the development of contracting between health funds, hospitals and doctors — a form of ‘purchaser-provider’ model.

The move towards contracting arrangements between health funds and hospitals began in Victoria and South Australia in the late 1980s and early 1990s. It was encouraged by changes to the reinsurance arrangements in 1989 and, according to funds in these states, the need to make health insurance more attractive to consumers. The 1995 Amendment Act added to this impetus by establishing an explicit contracting framework (see figure 8.1 and box 3.12 in chapter 3).

*Hospital Purchaser-Provider Agreements (HPPAs)* — between funds and hospitals (private or public) — facilitate the provision by funds of 100 per cent cover for hospital costs. The contracts can be based on per diem payments, per case payments or some other method. Funds can enter different contracts with different hospitals. While they can decide not to enter contracts with some hospitals, the grounds for doing so are restricted — for example, failure to contract can’t be based on the size of the hospital or its ownership. And, for treatment in non-contracted hospitals, funds are required to provide a specified minimum (‘default’) benefit. In effect health funds have to enter a contract, either explicitly or by default, with every hospital. (Chapter 4 details the growth of HPPAs.)

Under *Medical Purchaser-Provider Agreements (MPPAs)* — between funds and medical practitioners — funds can pay medical benefits above the MBS, potentially eliminating out-of-pocket expenses for medical services received by patients in hospital. But there has been little progress in achieving agreements to date (see chapter 4). In the case of *Practitioner Agreements (PAs)* — between doctors and hospitals — payments by health funds to hospitals for the relevant medical services are not permitted to exceed the MBS fees. This proviso has deterred such agreements.

Figure 8.1: The contracting framework



The contracting arrangements are aimed at reducing the unit cost of private hospitalisation and treatment, and providing better value for private health insurance. Some participants were, however, concerned with the administrative costs of the arrangements. For example, the Australian Doctors' Fund said:

such arrangements (multi-contractual provisions) can only result in a bureaucratic nightmare and the impost of an unnecessary cost burden on anyone who seeks to use a private health fund as a means of providing for their future health care financing needs. (Sub. 184, p. 1, see also Sub. D224)

Ultimately, their success will depend on the competitive pressures facing each group in the negotiating process. The effect on efficiency and costs overall will also depend on the responsiveness of service providers to the incentives of case payment and what happens to the utilisation of hospital and medical services.

## 8.4 Incentives within the system

There was a divergence of opinion among participants about the incentives at play within the health sector (box 8.1). While funds generally considered their market to be highly competitive, others pointed to the regulatory environment which constrains their operations (see chapter 5). Hospitals and doctors were concerned with the market power of the funds. In turn, funds considered that some medical specialists and private hospitals had considerable leverage. In practice, the bargaining power and the incentives facing each of the players also appeared to be affected by their particular circumstances (including their size and location).

### **Box 8.1: Competitive pressures — participants' views**

#### **Health funds**

‘Private health insurance funds ... have tended passively to accept increases in hospital and doctor charges and pass them on to consumers. They have been historically weak in the market place against powerful providers.’ (Australian Consumers’ Association, Sub. 77, p. 9)

‘Traditionally funds have been largely passive payers of bills generated by their contributors and have exerted little or no influence over the providers and the behaviours of contributors.’ (South Australian Government, Sub. D193, p. 4)

‘Reluctance and passivity has resulted in health funds shirking their responsibilities to their members particularly concerning the issue of medical costs.’ (Joe Nagy, Sub. 112, p. 1)

‘Due in part to the regulatory environment ... the health funds have a “pass-through” approach to health insurance, which they see as a cost plus operation ... This is not only the consequence of habit: it also reflects a philosophy of treating providers (hospitals and doctors) as clients to be served, rather than as trading partners to be bargained with.’ (R. B. Scotton, Sub. D234, pp. 2–3)

‘The regulation surrounding the private health insurance industry sacrifices consumer interest to producer interest ... the risk of collusive and monopoly seeking behaviour between funds and providers is real.’ (Queensland Health, Sub. 176, p. 9)

‘the bargaining power resides overwhelmingly with the health funds.’ (Church and Charitable Private Hospitals Association, Sub. 126, p. 2)

‘the health funds themselves arbitrarily dictate fees to the smaller hospitals and use their market power to set fees.’ (Blackwood and District Community Hospital, Sub. D212, p. 1)

‘The negotiating powers of the health insurance funds are very strong, with little option for independent private sector operators.’ (National Association of Nursing Homes and Private Hospitals, Sub. D227, p. 4)

#### **Hospitals**

‘a private hospital cannot afford, at the end of the day, to not have an arrangement with a major insurer ... The insurers may argue that they are in a similar position with the major, high profile hospitals or hospitals which are strategically placed in areas of high membership. However, it must be said that the ability of an insurer to demand a lower price is much greater than the ability of a hospital to refuse such a price.’ (Northpark Private Hospital, Sub. 82, p. 5) /cont’d

**Box 8.1: cont'd**

‘There is an incentive for private hospitals to maximise both the per-day bed (or unit) income and to maximise length of stay for each patient.’ (Australian Unity Friendly Society, Sub. 163, background information, p. 21)

‘Competition between private hospitals is pre-eminently competition for doctors’ and ‘in the hospital industry the reality is that one’s quality and price competitiveness is of negligible importance in gaining occupancy — it is one’s size and power that counts.’ (Fremantle Kaleeya Hospital, Sub. D199, p. 3 and Sub. 154, p. 1)

‘The lack of information about private hospital costs creates an advantage for these hospitals when negotiating with health insurers.’ (Medibank Private, Sub. D192, p. 19)

‘Private hospitals must be aware of health funds’ vulnerable position with regards to contracts and product integrity, because they constantly dictate terms.’ (Australian Health Service Alliance, Sub. 44, p. 14)

**Medical providers**

‘there is real competition between the 15 000 relevant medical providers and the 300 or more relevant private hospital providers.’ (AMA, Sub. 130, p. 4)

‘the registration and training of specialists [should] be taken away from the “Royal Colleges” so that either Universities or teaching hospitals will allow more specialists to be trained and meet the needs of our community and subsequently these excessive charges will be reduced’. (Clem Campbell MLA Qld, Sub. 86, p. 1)

‘If a global financial deal is struck between the hospitals and private insurers ... there is a high probability of a bias towards payments to surgeons and physicians. These are the people who control the major variable in the equation, the admission of patients to hospital beds.’ (Royal Australasian College of Radiologists, Sub. 35, p. 4)

‘A major factor in achieving agreements with doctors is the relatively low number of specialists who provide services. This position provides medical specialists with leverage and places them in a strong negotiation position, as their services cannot be purchased from alternative sources.’ (Medibank Private, Sub. D192, p. 59)

‘The moves that will help ... are for the College of Surgeons to have more vascular surgeons than [the] three being trained every year.’ (Doctors Reform Society, transcript, Melbourne public hearings, p. 70)

‘compared to the power of doctors, who dictate supply (and oversupply) — the phenomenon of medical sovereignty — the position of the private health insurers in the market place is weak.’ (Australian Nursing Federation, Sub. 22, p. 4)



## Competition in the health insurance industry

The greater the level of competition within the health insurance industry, the more the incentive for individual funds to act as effective purchasers of services on behalf of their members. But the greater the market power of a fund, the better placed it will be in negotiating with hospitals and medical providers.

As discussed in chapters 4 and 5, while there are nearly 50 health benefits organisations operating in Australia, in most states a few funds account for a large share of the market. The Senate Committee review of the 1995 Amendment Act found that:

on the evidence there is a market dominance of the funds vis-a-vis private hospitals. (SCALC 1996, p. 41)

As purchasers of services from hospitals, the major health funds in each state probably do have substantial negotiating power in that market. Failure to secure a contract with a large fund could significantly reduce a hospital's potential source of patients. Countering this, health funds are at a disadvantage to the hospitals in terms of information on the cost of procedures. The Australian Health Service Alliance (a service company belonging to 31 small to medium sized funds) said:

Many hospitals are reluctant to provide information that will in any way give funds an insight into their efficiency and profitability, for fear of it being used against them during the negotiating process. (Sub. 44, p. 16)

As providers of services to members, there appears to be a reasonable degree of competition among the funds, within the constraints established by the regulatory framework (see chapter 5). Of importance also is the competition from the free universal Medicare system and the option for people to 'self-insure' and still use the private system. The funds therefore do face incentives to contain costs.

However, the not-for-profit nature of most of the funds weakens this incentive. More importantly, community rating, and the range of regulations that underpin it, reduce the *outlets* for competitive behaviour among existing funds and from potential entrants. Legislation limits the range of products that can be offered, defines categories of membership and coverage, and specifies waiting periods. And the market for substitutes for health insurance (for example, certain trauma products and company self-insurance schemes) is stifled. In addition, until 1995 the reinsurance arrangements muted the incentive for funds to actively seek healthier members. They currently still weaken incentives to contain the costs associated with ailments of the aged. Reinsurance requirements also make cheaper front end deductible and copayment products less attractive to

consumers, as all products bear an identical reinsurance liability. Such deductible and copayment products have the potential to control some of the moral hazards present in the system.

### **Competition in the private hospital sector**

In conventional terms, there is nothing intrinsically anti-competitive about the private hospital sector. There are over 300 private hospitals and 100 day surgeries throughout Australia. Some may enjoy a geographic monopoly of sorts (in regional areas). But ownership is not concentrated and smaller hospitals account for over half the number in the industry.

In addition, the sector faces competition from public hospitals. Public hospitals can also enter HPPAs with funds, but haven't done so to date. Because they provide access to accident and emergency patients, public hospitals are often in a better position to have hospital-doctor contracts. This offers a better chance of developing either fixed copayment or no out-of-pocket contracts that will be attractive to the funds. However, full competition between public and private hospitals will require resolution of competitive neutrality issues, including 'equivalence' (see below).

Issues of competitive neutrality also arise *within* the private hospital sector, particularly in relation to taxation. Private hospitals (in terms of both numbers and beds) are roughly equally split between for-profit and not-for-profit operations (APHA, Sub. 51, p. 6). The exemption from income tax for not-for-profit operators is unlikely to lead to significant resource misallocation (see discussion of this issue in relation to health funds in appendix E). But where not-for-profit hospitals are exempt from fringe benefits tax and input taxes (for example, sales and property taxes), private hospital activity is likely to be distorted. The Commission has previously examined related issues in its inquiry into charitable organisations, although this did not specifically cover the hospital sector (IC 1995).<sup>1</sup> These taxation exemptions raise wider issues (see chapter 10).

Bed utilisation, which depends on both length of stay and patient turnover, is a major driver of profitability in the private hospital system. There is an incentive for private hospitals to maximise per day bed income and bed utilisation. There

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<sup>1</sup> The Commission recommended that the Commonwealth remove the fringe benefits tax exemption for public benevolent institutions. It also suggested that the Commonwealth and state/territory governments remove input tax concessions from activities of charitable organisations which clearly compete with for-profit firms and reimburse them directly to the extent that their for-profit activities contribute to their charitable work (IC 1995).

is also an incentive for private hospitals to contract with funds to help maintain the pool of privately insured patients and the hospital's level of usage.

Another element of competition is that private hospitals must compete for doctors in order to achieve patient referrals on which their incomes depend. This competition is based mainly on providing better facilities and equipment — what some have described as the hospital 'arms race' (NMHI, Sub. 140, p. 25). Private hospitals therefore are not just competing for patients, but for doctors to treat them.

One constraint arises from state government controls on the number of private hospital beds. A study undertaken for the Victorian Department of Human Services (Office of Regulation Reform 1996) found that:

The imposition of the bed cap has hindered the development of a balance between the supply of and demand for beds. This is evident from the existence of a bed market in which bed licences are traded between private hospitals and transferred between private hospitals within the same proprietary group. (p. v)

The potential efficiency gains obtained from deregulation, due to both the improved allocation and dynamic efficiency as hospitals have greater scope for innovation, could reduce the cost to private health insurance funds ... Overall, the proposed deregulation removes a constraint on the further development of the private hospital and day procedure centre sector. The removal of the bed cap and most of the planning controls will facilitate entry and exit from the industry as well as the expansion and reduction of existing hospital facilities. (p. vii)

While aimed at preventing oversupply, bed licensing can increase the cost of private hospital beds and reduce the extent of competition within the industry. For example, in Victoria, the price paid for bed licences traded since 1990 has ranged from \$7000 to \$33 000, with an average of over \$24 000 (Office of Regulation Reform 1996, p. v). Bed licensing may also encourage hospitals to allocate more staff and other resources to each patient to achieve the same patient throughput with fewer beds. This may reduce efficiency and add to costs (IC 1991, p. 82).

### **Competition among health professionals**

A range of supply side constraints applies to medical and other health care professionals. State governments regulate doctors and ancillary health care providers, and restrict advertising. The number of graduates from Australian medical schools is limited by student enrolment quotas and, over time, accreditation of foreign doctors has become more restrictive. The Commonwealth Government has recently introduced limits on the availability of

Medicare provider numbers and restrictions on new foreign doctors in response to concerns about an oversupply of general practitioners.

Of greater relevance to the current inquiry, there are also limits on the number of specialists trained in professional medical colleges. An earlier inquiry into the supply of medical specialist services in Australia (Baume 1994) found that there were not enough surgeons to meet reasonable standards of provision. The inquiry concluded that the Royal Australasian College of Surgeons and surgical societies exercised excessively tight control over the supply of trained surgeons and the numbers of surgeons in various specialties. It also found that, given existing training programs, there would still be a shortage by 2001. Such restrictions would be expected to raise medical fees and increase the bargaining power of doctors in the context of MPPAs (see box 8.2).

**Box 8.2: Charges for in-hospital medical services**

Charges for a wide range of in-hospital medical services for private patients (in private and public hospitals) exceed MBS fees. Data for 1994–95 indicate the extent to which average charges exceeded the average MBS fees.

- Specialist visits — 8 per cent
- Pathology — 11 per cent
- Diagnostic imaging — 5 per cent
- Obstetrics — 40 per cent
- Operations — 21 per cent
- Assistance at operations — 12 per cent
- Anaesthetics — 23 per cent
- Radio/nuclear therapy — 12 per cent
- Other — 7 per cent
- All specialist services — 17 per cent

The medical profession has expressed concern that MBS fees for many procedures do not reflect the cost of providing the service. Charges exceeding the MBS fees may provide an indication of the extent to which MBS fees are set too low. Alternatively, they may indicate potential supply constraints.

*Source:* Deeble 1996, p. 12 (data only).

Part of the regulatory framework aims to protect patients from incompetent practitioners and reduce costs of acquiring information about the quality of services offered. Some of the constraints have been put in place to counter the potential for over-servicing stemming from ‘supplier induced demand’. But there are also concerns that the regulations have been used to restrict competition within the medical profession and in ancillary health care. For example, the NSW Health Funds Association said:

The NSW HFA does not underestimate the importance of regulatory mechanisms to maintain standards of health care practice. These mechanisms serve to protect the community from incompetent and, at times, dishonest providers. However, there is concern that many of these regulations appear to go beyond what is necessary to maintain acceptable standards of service, quality and ethical practice. There is significant concern at all consumer levels that the regulations may operate more in the interests of members of health care professions than of their patients and the community generally. (Sub. 57, p. 1)

In its response to the Commission’s Discussion Draft, the AMA disputed the findings of the Baume Report and sought acknowledgment of:

the cooperative work done by the profession through the Government’s Australian Medical Workforce Advisory Committee and its predecessors to boost specialist numbers in identified specialties, the reliance on the public hospitals and through them the Governments, State and Federal, to fund training positions, the Government’s own strategy to limit overall access to the medical workforce and the inability of the Government to address the demand side of the equation. (Sub. D223, p. 10)

In contrast, the Australian Consumers’ Association regarded ‘supply side market failure — with restricted entry to specialist training colleges [as] a major area for action’ (Sub. D266, p. 4).

A complex range of factors are at work. Commercial-in-confidence information provided by a major health fund on its benefit claims in 1996, confirms that above-MBS charging of the extent illustrated in box 8.2 has continued. But relaxing supply-side restrictions while the MBS fee sets a price floor may lead to the perverse outcome of an oversupply of specialists.

Doctors have to date been reluctant to enter into contracts with health funds under the new arrangements. They have expressed concerns about the potential for clinical constraints, the ‘secrecy’ of contracts and the impact on medical fees. The AMA stated:

The medical profession has rejected contracts between health funds and doctors and will continue to do so. (Sub. 130, p. 3)

In contrast, the Royal Australasian College of Surgeons was of the view that:

it is possible, in a deregulated environment, to have agreements between doctors and health funds in regard to the amount of payment doctors will receive for specific items of care. Such agreements must prohibit interference in clinical decision-making. (Sub. 27, p. 5)

In submissions to the inquiry, health funds have been unanimous in the view that they are not seeking to interfere in clinical decisions. Rather, their aim is to ensure quality and cost effective treatment for their members. The Commission was also informed of the development of agreements expressly designed to address the main objections of doctors' organisations to contracting between medical providers and health funds (Sinclair Wornell and Associates, Sub. D264). However, doctors' groups still see it as the thin edge of the 'managed care' wedge.

The medical profession has an interest in ensuring the continued viability of the private health system. Under the current system, treating private patients is the only way for doctors to receive more than the MBS fee. Doctors have a significant say in where their patients are treated. They may have a greater incentive to sign contracts with particular private hospitals (than with funds) to ensure access to theatre time. Others may be willing to sign with hospitals in return for guarantees of income and access to patients. But offsetting these incentives is the legislative constraint on Practitioner Agreements which limits reimbursement to MBS fees. To date, there has been significant opposition by doctors to PAs.

The extension of the Trade Practices Act to the health sector in July 1996 may have some impact on the incentive for doctors to negotiate. For example, the Act precludes doctors competing in an area of specialisation from agreeing not to sign contracts with hospitals or funds, though they can individually choose not to negotiate.

## **8.5 Scope for enhancing efficiency**

There are competitive pressures in the health insurance, hospital and medical provider markets. However, constraints on competition and complex incentives inimical to efficiency are also evident.

There are no simple solutions to improving the incentives for efficiency and cost containment in the relationships between health funds, hospitals and medical providers. But there are three broad levels at which improvements could be considered:

- improving incentives for purchasers and providers within the existing contracting framework;

- changes to ensure that health funds face sufficient incentive to look after the interests of their members — changes to the regulations governing private health insurance recommended in chapter 10 would help; and
- improvements in the operation of the health system generally, which go beyond the terms of reference for the inquiry — for example, addressing supply side constraints will be important, although the effects would take several years to work through the system.

### **Changes within the contracting framework**

The contracting arrangements, and the legislation underpinning them, are relatively recent developments. While it is too early to judge their success in improving efficiency and containing costs, the AHIA noted some positive signs:

the rate of growth of hospital benefit payments has been slowed in those states (Victoria and South Australia) which have applied a negotiated benefit arrangement for some time. (Sub. 108, p. 25)

But, in addition, the AHIA pointed to problems:

The fact is hospital utilisation is up, capacity is up, but this has not yet translated into reduced insurance costs, largely because of the structural difficulties ... which weaken the capacity of insurers to extract price efficiencies. (p. 27)

Scotton also argued that there are structural barriers:

features of the present arrangements are almost cunningly designed to minimise the bargaining power of the insurers ... their inability to pick and choose the providers with which they will deal. (Sub. D234, p. 3)

Several changes could be made to the existing contracting arrangements to increase the likelihood of success.

### ***Default benefits under HPPAs***

Within the contracting framework, there are a number of restrictions on the freedom of health insurers to contract with hospitals. Since hospital costs account for the bulk of the costs of treatment, these restrictions may be a significant constraint.

- Insurers don't have to contract with all hospitals. But they are obliged to pay at least a legislated minimum default benefit for the treatment of a member in non-contracted hospitals (provided the member's policy covers that treatment). In effect, insurers cannot choose to offer the services of only a certain range of hospitals (and related medical providers). This could reduce

the pressure on hospitals to negotiate, depending on the level at which the default benefit is set.

- While insurers may contract for a limited range of treatments in a particular hospital, treatments not included in the contract but covered by members' policies are subject to default benefits. In addition, there are some services which funds cannot elect to exclude from coverage at all — psychiatric, rehabilitative and palliative care.
- Insurers are obliged to pay full hospital benefits for nursing home type patients in acute care hospitals for up to 35 days.

These requirements limit flexibility and mitigate the potential of the contracting arrangements to contain unit costs. Default benefits and benefits for nursing home type patients are discussed here. Issues related to psychiatric, rehabilitative and palliative care are discussed in chapters 3 and 10, and appendix F.

Participants' views on the benefits for nursing home type patients were reported in chapter 3. The AHIA and many health funds supported the removal of the 35 day rule. The APHA opposed its removal and noted the costs of acuity assessment. It commented that appropriate benefits for nursing home type patients could be addressed through the contracting arrangements. Significantly, the Department considered that nursing home type patients could not be regarded as acute patients and, therefore, it was inappropriate for benefits to be paid at the acute rate for any period.

The Commission agrees with the Department's assessment. The 35 day rule for nursing home type patients is inappropriate. It is even less desirable under the contacting arrangements, as funds are not free to negotiate with hospitals about an appropriate rate or with other providers about treatment on a nursing home basis.

Most health funds also supported the removal of the default benefit arrangements. For example, the AHIA considered that:

Funds' capacities to negotiate have ... been diminished by the existence of ... minimum guaranteed benefits to hospitals whether they have a contract with insurers or not. While this benefit is significantly less than posted charges it may nevertheless provide a hospital with profits at the margin if it can achieve significant volume from other insurers: thus a hospital may be able to strengthen its bargaining position by 'holding out' on some insurers. (Sub. 108, p. 27)



It also said:

The most important areas of potential cost containment involve a greater capacity for insurers to purchase health services in an open and competitive market, and removal of the existing situation in which insurers must underwrite the cost of all licensed beds. (Sub. D280, p. 1)

NMHI argued that:

freedom to contract is critical to the ability of insurers to deliver best value for money to their members ... It would give private health funds enhanced ability to influence the pattern of facility investment among hospitals in an area ... It would assist in achieving high utilisation [that is, higher occupancy rates in contracted hospitals] and discourage provision of excess capacity. And, it would enhance funds' ability to deliver to members, on better terms, access to the facilities and care for which they have purchased cover. (Sub. 140, p. 34)

Sinclair Wornell and Associates recommended that the default benefit be removed immediately. It considered that this would encourage greater competition and reduce private hospital unit costs through higher occupancy rates in contracted hospitals (Sub. D264, p. 8).

However, the ACHCA and private hospitals generally, as well as the ADF, opposed the removal of default benefits. Indeed, the APHA called for them to be increased to 85 per cent of average benefits. It said:

the extremely low level of the default benefit, well below the *cost* of hospital care, amounts to an irresistible contract acceptance imperative for private hospitals ... the consequences of abolishing the default benefit would be effective end to consumer choice in selection of the private hospital in which care is to be provided, together with the imposition of waiting lists and/or rationing of service availability. (Sub. D217, p. 30)

The Department sought continuation of the default provision while the industry developed its contracting expertise, perhaps with it phasing out over time (Sub. D277, p. 19). The medical profession was concerned that removing the default would reduce patient choice of hospital and doctor, and lessen the attractiveness of insurance. The ACA was uncertain whether the default was weakening the incentive to contract in practice (Sub. D238, p. 4). It sought continuation of the default for emergency treatment in private hospitals (see chapter 3).

The default benefit differs for emergency and non-emergency treatment. For emergency admissions, the default must be at least the average level of benefit paid by the fund for that service in its contracted hospitals. For non-emergency admissions, the default benefit must be at least equal to the level specified by the Minister. To date, this minimum has been set at around the level of the previous 'basic benefit' (see chapter 3).

For non-emergency admissions, the default benefit can therefore be substantially lower than contract prices. According to the Department, it is currently around 50 per cent of average benefits (Sub. D277, p. 18). This might suggest that the non-emergency default may currently not have much effect on the incentive for hospitals to contract. But the existence of the default has already led to pressure from hospitals for it to be increased. For some non-surgical hospitals or lower cost admissions (for example, some psychiatric and rehabilitation services), even the current level of the default benefit is a financially viable proposition. In other cases it may still exceed the marginal costs of treatment and be attractive to some hospitals, particularly in the short term if they have spare capacity. The long term attraction in such cases would be significantly less because of a hospital's need to cover its fixed costs.

The reduction in incentive for hospitals to contract is almost certainly greater in the case of emergencies. The minimum default benefit for emergency admissions is likely to be well above that for non-emergencies, and be an attractive proposition for most hospitals. The AHIA was concerned that the emergency default benefit encouraged private hospitals to develop accident and emergency facilities to 'capture' patients (see chapter 3). As no public hospital has entered into an HPPA to date, all of them are also potentially eligible for this higher default benefit for emergency admissions. This removes one of the incentives for public hospitals to seek HPPAs.<sup>2</sup>

Increasing the freedom of funds to contract (or not to contract), particularly with private hospitals, would increase competitive pressure within the system. When combined with other changes to the regulatory framework proposed in chapter 10, funds would be enticed to be more active as purchasers, seeking to contain costs and achieve higher quality care on behalf of their members. Where funds own hospitals, freedom not to contract would be an added bargaining chip in negotiations with other private hospitals. Removing the default may also lessen the need for state government limits on the number of private hospital beds and reduce the potential for inappropriate expansion of accident and emergency facilities. Benefits would only be payable where HPPAs are in place. As for consumer choice, removal of the default benefit would place more pressure on health funds to weigh up the consequences of not contracting with particular hospitals. While the fund may succeed in containing its costs, if its hospital coverage is inadequate its products will be less attractive to members and it will risk losing market share.

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<sup>2</sup> To receive the higher rate, a public hospital would first have to increase its charges for such admissions.

When the issue of equivalence between public and private hospitals has been resolved (see below), and HPPAs with public hospitals become a more realistic option, the default benefit for public hospitals could also be removed.

With the elimination of the default benefit, initially for private and later for public hospitals, the main requirement would be for funds to ensure that members are adequately informed of contract coverage. The 1995 Amendment Act already specifies this.

In relation to emergency admissions (for example, while travelling interstate where a fund may have no HPPAs), patients would have the fallback option of treatment at any public hospital as a Medicare patient. Health funds would also have the option of providing contingency cover for such cases. They may well see a marketing advantage in doing so. At present, many funds pay well above the minimum default rate for non-emergency admissions at most private hospitals for these reasons.

The Commission's specific proposals are detailed in chapter 10.

### *Changes to PAs*

Another constraint within the contracting framework stems from the limits placed on reimbursement of medical expenses under Practitioner Agreements. Unlike MPPAs, payment by the funds of medical expenses beyond the MBS fee is not permitted under PAs. This requirement reduces the incentive for doctors to contract with hospitals.

The ACHCA said:

Under current regulations, doctors have demonstrated little real commitment to contracts with health funds. The natural relationship for contracts would be between the hospitals and the doctors. (Sub. D215, p. 5)

At the public hearings, the Australian Association of Surgeons reiterated the concerns of doctors about the ethics of contracting. But it indicated less of a problem with PAs than with MPPAs (transcript, Melbourne public hearings, p. 61).

Both the ACHCA and the APHA supported changes to PAs to enable hospitals to contract with doctors above the MBS. Health funds had mixed views, with some endorsing such changes while others were worried about the effect on premiums.

The removal of the restriction on above-MBS charges in PAs would increase the likelihood of contracts being reached between hospitals and doctors, but could be expected initially to add to unit costs. This is one of the drawbacks of

attempting piecemeal reform in a complex and interdependent system. The impact on unit costs could, however, be limited by the existence of case-payment based contracts between the health funds and hospitals which embraced the full range of services, including medical services.

An option would therefore be to allow reimbursement for medical costs under PAs above the MBS fee where HPPAs based on per case payments (including medical services) are in place. The Department supported this approach (Sub. D277, p. 19). The development of such PAs would ultimately enable better control of costs on an episodic basis. It would assist in 'single billing' and enable simpler contractual negotiations between the funds, as purchasers, and hospitals and doctors as providers. It would also facilitate the adoption of clinical protocols and quality improvements (see below).

### *Conduct of negotiations*

Smaller hospitals and individual medical providers have expressed concerns about their unequal bargaining position, relative to the health funds, if they have to negotiate contracts unilaterally.

The Australian Competition and Consumer Commission (ACCC) has produced a guide to the application of the Trade Practices Act (TPA) to the health sector (ACCC 1995). Under the Act's price fixing provisions (section 45A), agreements *between competitors* are *deemed* to substantially lessen competition. In relation to contract negotiations in the health sector, the ACCC notes that:

- Individual negotiation by a medical provider with hospitals/health funds over fees is the only way to ensure no breach of the TPA. Agreements by the provider with colleagues (*who compete with them*) to collectively negotiate fees with hospitals/funds are *likely* to breach section 45A. (p. 13)
- Private hospital negotiations with funds need to be on an individual basis to guarantee no breach of the Act. Hospitals that *compete with each other, or are in a position to compete with each other*, cannot collectively negotiate with funds on price without *risking* a breach of the Act. (p. 15)

Joint negotiations by hospitals (with funds) or by medical providers (with hospitals or funds) *where they are in competition with each other* therefore risk breaching the price fixing provisions of the TPA. In practice, there would seem to be scope, for example, for a group of specialists *who are in competition with each other* to negotiate jointly on price, but still face sufficient competition from outside the group that no substantial lessening of competition would result. The price fixing provisions of the Act would, however, *deem* such joint negotiations to substantially lessen competition.

The existing provisions would appear to leave scope for a group of smaller hospitals from different regions, or of doctors specialising in different fields, for example, to negotiate jointly where they consider they *are not in competition with each other*. Whether joint negotiations involving such groups would breach the Act would depend on how the relevant market was defined and the particular circumstances of each case. Penalties available in the Federal Court for breaches of the Act are up to \$10 million for corporations and \$500 000 for individuals.

Provision exists within the Act for applications to the ACCC for authorisation of joint negotiations. The lodgement fee for applications is \$7500. For authorisation to be granted, the applicant must satisfy the ACCC that the benefit to the public would outweigh any anti-competitive effect (see box 3.13 in chapter 3). The ‘promotion of equitable dealings in the market’ has previously been recognised as one such potential benefit. To date this route has not been tested in the health industry.

Alternatively, where the concerns are about unequal bargaining positions, private hospitals and medical providers may be able to seek relief through recourse to the unconscionable conduct provisions of the TPA.

The types of concerns raised by private hospitals and medical providers are not unique to the private health sector. One of the aims of national competition policy was to apply the same set of trade practices rules throughout the economy. Modifying these solely for the private health sector is not a realistic option. It is also difficult to see how the ACCC’s existing guidelines could be improved in a way that would generate more certainty for joint negotiations by hospitals or doctors that consider they are *not in competition*. In its microeconomic reform stocktake, the Productivity Commission proposed a review of key elements of the national competition policy framework in 1998 and subsequent review of other elements of the TPA. The concerns raised, to the extent they are valid, would be more appropriately considered as part of a broader review.

The Private Health Insurance Complaints Commissioner also has jurisdiction to resolve disputes between hospitals and health funds about HPPAs. Whether this provision applies to disputes in pre-agreement negotiations is unclear. The Complaints Commissioner considered that:

there is very little [she] can do in this regard in the absence of any agreement about what constitutes fair play by health funds in the context of purchaser-provider agreements. Disputes of this nature currently have to be resolved in the context of legal principles relating to contract and trade practices law. (Sub. D259, p. 1)

As noted in chapter 3, the Complaints Commissioner considered that there was a need for an effective disputes resolution scheme. The Commission notes that a working party has been formed to develop guidelines for contract negotiations between private hospitals and private health insurers aimed at protecting patients' rights (Wooldridge 1997).

### *Public scrutiny of contracts*

Another issue raised in relation to contracting between funds, hospitals and medical providers is that of public scrutiny. The Australian Association of Surgeons, for example, said:

the potential for fee schedules and treatment protocols to be subject to undue influence by the funds clearly exists. The public has the opportunity to be vigilant only if agreements between purchasers and health care providers are readily available for scrutiny by the public — extending to financial incentives which may exist and which favour some treatments over others. (Sub. D209, p. 12)

The Complaints Commissioner was also concerned about the level of secrecy surrounding contracts.

Requiring HPPAs and MPPAs to be publicly available (with or without financial details) would be akin to requiring retailers to make public their contracts with suppliers. While governments often make public details of their contracts with winning tenderers, it would be highly unusual for such a requirement to be mandated for contracts between private sector entities. It would undermine the potential competitive advantage and hence the incentive to negotiate in the first place.

For a health fund member, the relevant contract is their health insurance policy with the fund. What matters is that the policy, benefit brochures and other information provided by the fund (for example, details of which hospitals are contracted) accurately reflect the product being offered. Proper disclosure of information by the funds is ultimately in the funds' own interests. In any case, disclosure is required by health and trade practices legislation.

### *Public hospital charging practices*

Under the Medicare Agreement, patients being admitted to public hospitals must be given the choice of being a public or a private patient, irrespective of their health insurance status or ability to pay. If patients opt for public status, they are treated free of charge.

The availability of this free alternative has effectively limited the amount that public hospitals can charge private patients to what they will receive from their

health insurance. In turn, health funds have set their benefits for private patients in public hospitals equal to the minimum default set by the Commonwealth (in effect, the previous ‘basic benefit’). If the public hospitals were to charge more, the required copayment would encourage patients to be treated as public patients (and the public hospital system would miss out on the contribution from the patient’s health fund).

As a result of these arrangements, charges for private patients in public hospitals do not reflect full cost recovery. This creates an advantage for public hospitals when competing for private patients, with public hospital charges currently around half of those in private hospitals. The Department estimates that the undercharging amounts to \$500 million per year (Sub. D277, p. 21). The extent of the advantage is, however, limited by differences in the standard of accommodation between public and private hospitals and the inability of private patients to ‘queue jump’ in public hospitals.

In the private hospital sector, St John of God Health Care System Inc. (Sub. 66, pp. 5–6), among others, sought public hospital charges being set to reflect actual costs, with the additional revenue re-directed to support the private health insurance industry. There were mixed views amongst the insurers. For example, MBF and NMHI agreed with full economic charging by public hospitals subject to enhancement of services to members. But while NMHI sought a subsidy to reinsurance (Sub. D210, p. 2), MBF preferred a more direct offset to consumers (Sub. D203, p. 11). SGIO Health considered that changes to public hospital charging practices should await a wider health system review (Sub. D237, p. 20). HIRMAA rejected full economic charging on the grounds that health fund members already pay the Medicare levy and general taxation, and that there is no distinction in care (other than choice of doctor) which would justify the additional cost (Sub. D204, p. 8).

Competitive neutrality between public and private sector enterprises is one of the requirements of national competition policy. Several state governments are currently examining their public hospital charging practices and commented on the issues in their submissions (see chapter 3). The Victorian Department of Human Services and Queensland Health have also released discussion papers which outline potential steps in the evolution of new charging arrangements (DHSV 1996 and QH 1997). Achieving competitive neutrality will not be a straightforward exercise — and there is more to it than just charging practices (for example, the taxation of public and private hospitals).

According to the Commonwealth Department, the 1995 Amendment Act ‘established the legal framework within which equivalence [between public and private hospitals] could operate’ (Sub. D277, p.21):

- insurers and public hospitals could enter into HPPAs; and
- state governments could remit the additional revenue back to the funds through the reinsurance pool.

An alternative to the latter would be for the Commonwealth to ‘claw back’ Medicare payments from the states and use them for the same purpose.

As noted earlier, to date no HPPAs have been reached between health funds and public hospitals. Under current arrangements, health funds have little incentive to negotiate higher prices with public hospitals. Similarly, public hospitals have little incentive to seek higher prices when they may be precluded from keeping the additional revenue. If the hospitals or state governments were able to keep the revenue, there may be offsetting changes to Commonwealth financial grants to the states.

Full economic charging by public hospitals would remove the current price distortion between public and private hospitals. But it would raise the equity concerns referred to by HIRMAA. In addition, any increase in public hospital charges would either encourage more private patients to be treated as ‘free’ public patients (if the additional cost was not met by health funds) or it would increase the cost of private health insurance. The Department has estimated that health insurance premiums could increase by 25 per cent and noted the need to redirect any additional revenue to avoid such an increase. It considered that any changes should be pursued via an agreement between the Commonwealth and the states in the context of the next Medicare Agreement (Sub. D277, pp. 21–2). To enable effective competition between the public and private systems, the relaxation of Principle 2 of the Agreement, which ensures access to public hospitals on the basis of clinical need, would need to form part of this process.

Replacing the current implicit subsidy of public hospital bed day charges by a subsidy to the reinsurance pool would improve transparency. Equivalence in this case would be viewed more in terms of cost neutrality for health insurers. Such an approach would have some drawbacks. ‘Clawback’ of all of the additional revenue raised would remove the incentive for state governments and public hospitals to pursue full economic charging in the first place. It would also add to administrative complexity and cost. And whether there were higher priority uses for the additional revenue raised, than subsidising private health insurance, would need to be considered. This last point underlies the scepticism of several health funds towards a subsidy to reinsurance. For example, SGIO Health said:

experience suggests that any subsidy to the reinsurance pool would quickly be removed in a subsequent budget resulting in a further cost shift from the public to the private sector. (Sub. D237, p. 20)



An alternative would be to pursue full economic charging by public hospitals in such a way as to provide both public hospitals and insurers with an incentive to enter into HPPAs. Permitting public hospitals to keep some or all of the revenue raised, as suggested by several states, would encourage them to pursue HPPAs. Funds would tend only to contract with public hospitals if those contracts were competitive. Alleviating the pressure for premium increases from such a change would rely on two effects. The first would be where public hospitals were cheaper and there was some reversal of the flow of private patients from the public to the private sector. The second would be where private hospital charges were reduced as a result of the increased competition. Conflicts with the Medicare Agreement would still need to be resolved.

The Commission's recommendations on public hospital charging practices are presented in chapter 10.

### *Case payment*

Output-based funding is increasingly replacing conventional global budgeting arrangements for Australia's public hospitals. The use of output-based funding, underpinned by 'casemix' classifications, aims to make hospitals more efficient by relating their revenue to the types and amounts of services they provide, rather than to the cost of inputs (see box 8.3). The results to date have been encouraging. For example, George Palmer considered that:

Funding for public hospitals on the basis of casemix is now well established or about to be introduced in most Australian states. This has followed from the general acceptance by state governments of the principle that casemix funding will promote the achievement of improved efficiency. (Sub. 61, p. 1)

With the development of contracting arrangements between health funds, hospitals and doctors, the use of episodic or per case payments based on appropriate casemix classifications (henceforth referred to as 'case payment'<sup>3</sup>) also offers the potential for greater efficiency within the private system.

#### **Box 8.3: Casemix classifications**

The term 'casemix' refers to the mix of cases treated by a hospital or health service. This mix is, in effect, the output of the hospital or health service.

A casemix classification groups similar episodes of care. The most widely used casemix classification is 'Diagnosis Related Groups' (DRGs). DRGs are used to categorise acute

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<sup>3</sup> This is usually referred to as 'casemix funding' in the public sector context. For the purposes of this discussion, the Commission has used the term 'case payment' to refer to payment on an episodic basis using casemix classifications, rather than per diem.

admitted patient episodes, according to the patient's principal diagnosis and other variables. A patient episode of care may initially be classified into one of more than 20 Major Diagnostic Categories based on the body's organ systems. The episode is further classified depending on whether it is surgical or medical, and on factors such as age, sex, the presence of complications and other co-existing illnesses. There are currently some 666 items in the Australian National Diagnosis Related Groups (AN-DRGs). (DHFS 1996a)

Casemix classifications can be used as a way of paying hospital or other health service providers on the basis of their outputs rather than inputs. Consider a simplified example. A health fund may negotiate a price with a hospital for each DRG, based on the average cost of the DRG across a number of hospitals. The price negotiated for a hip replacement may be \$10 000. This hospital may be able to do the operation for less or it may cost it more. In the latter case, to maintain business, the hospital would have a financial incentive to examine its cost structures and work practices. It may find that it can increase its efficiency and reduce costs. If it can't, it would have an incentive to leave this type of surgery to other hospitals.

The 1995 Amendment Act specifies that contracts between health funds and hospitals must be *described* on the basis of AN-DRGs by 1 July 1997. However, it does not stipulate the exact structure of the payment. This means that funds can pay on the basis of per diems, case payment, or a mixture of both (DHFS, Sub. D277, p. 19). While the legislation does not mandate (episodic) case payment, it does require the industry to collect data using AN-DRG casemix classifications as part of the Hospital Casemix Protocol (HCP) collection.

Competing views were expressed by participants on the merits of case payment and its extension to the private sector (box 8.4). Funds were generally supportive of a case payment approach. There were mixed views among private hospitals. Some, including the APHA, recognised the potential for efficiency improvements and were in favour of the extension of case payment, provided a cautious approach was taken. Others, particularly smaller hospitals, were critical of the administrative burden and cost of a case payment system. Parts of the medical profession were opposed to case payment, while others acknowledged some potential benefits but were critical of the AN-DRG classification system.

#### **Box 8.4: Competing views on case payment**

**Health funds**

AHIA ‘in general supports casemix based payments systems, and believes it is in the interests of both health funds and private hospitals to move as rapidly as practical to a system in which AN-DRG information is used as the basis of claims.’ (Sub. 108, p. 28). NMHI said ‘Experience has shown that the most effective method of paying hospitals for health services is the case payment or “casemix” system, as it links payments to outputs, whose quality can be specified and monitored, and obliges hospitals to manage their input costs against efficient benchmarks.’ (Sub. 140, p. iii)

Medibank Private commented on ‘the efficiencies and greater cost control associated with episodic based negotiations.’ (Sub. D242, p. 13)

### **Hospitals**

The APHA ‘supports the use of casemix based episodic payments in the private sector but emphasises that a cautious approach is required.’ It pointed to ‘some issues [which] need to be kept in mind about the difference between the [public and private] sectors:

- in the public sector, fixed costs are covered by grants;
- although all patients (in the relevant states) are funded on an AN-DRG episodic basis, such funding comprises less than half of each public hospital’s revenue; [and]
- the need for more conservative outlier or exceptional case policies in the private sector as all patients and almost all revenue would be included in episodic payments’. (Sub. D217, pp. 33–4)

HCoA ‘supports the extension of casemix payment’ (Sub. D248, p. 5) and considers that ‘cost efficiencies are possible through DRG funding’ (Sub. 128, p. 4). It pointed to efficiencies it had achieved from case payment arrangements with state governments in its public hospitals in Tasmania and Western Australia. It was also successfully trialing a case payment approach with health funds in one of its private hospitals.

Blackwood and District Community Hospital stressed the ‘rather onerous overhead in terms of costs, time and resources, in order to negotiate with each and every fund for specific items under casemix.’ (Sub. 212, p. 1)

Similarly, Fremantle Kaleeya Hospital said ‘Only those persons who have visited USA hospitals and their administrators can have any perception of the staffing, space, record keeping, management distractions, dispute resolution, audits, coding/casemix consultants, volume of contracts and paper, negotiation teams, medical distractions and complexities that follow on from casemix coding and payment systems.’ (Sub. D199, p. 5)

/cont’d

**Box 8.4: cont'd****Medical providers**

The AMA considered that 'pure case payment could only apply to a handful of DRGs where the volumes and consistency of costs are such as to favour the commercial risk involved' (Sub. D223, p. 9). In addition, it was concerned that 'such approaches can impact on patterns of care by disadvantaging high users (the aged and chronically ill) and causing hospitals to select against high cost cases' (p. 1).

The ADF sought 'evidence to support any claim that the US based casemix payment system is better equipped to increase productivity whilst maintaining the quality of surgical procedures, or that it will reduce total health costs, or that it will improve efficiency'. (Sub. D224, pp. 1–2)

The Australian Association of Surgeons considered that 'Clearly, the concept of casemix funding is sound but ... some quite different treatments are lumped together in the same group. The system is therefore difficult to adapt to changing circumstances ... Also, although the basis for the groupings was intended to be that all of the conditions in one group carried similar treatment costs, there are many examples of widely differing costs within a single group.' (Sub. 124, attachment, p. 8)

**Governments**

The Commonwealth Department 'supports speedier and widespread adoption of contracts between funds and hospitals based on so-called "proper" episodic casemix.' (Sub. D277, p. 19)

According to Queensland Health: 'Casemix funding is probably the single most powerful tool for generating greater efficiency gains and lowering costs in the private hospital sector. By paying hospitals on the basis of the number and complexity of cases treated, casemix provides strong incentives for cost containment compared with bed-day based reimbursement mechanisms.' (Sub. 176, p. 5)

*Progress with case payment*

There was general agreement that progress with the implementation of case payment in the private sector had been slow. Health funds and private hospitals typically blamed the other group for the lack of progress.

The AHIA, for example, said:

These moves have been slowed by a reluctance of some hospitals to invest in the necessary information systems to provide data (Sub. 108, p. 28).

Conversely, at the public hearings, the APHA argued that:

hospitals have moved forward perhaps rather further in their attitude to this form of payment than payers, in that it's actually not possible for a hospital to get an episodic based contract from any insurer. (transcript, Canberra public hearings, p. 43)

SGIO Health pointed to the risks involved for both funds and hospitals:

Whilst it may be preferable for speedier and widespread episodic casemix contracts, HCP data so far collected is unreliable and inadequate for both funds and hospitals to proceed at a rate that avoids cost blowouts to either hospitals or funds ... the industry [should be] allowed to proceed at a rate that allows for the proper consideration of the risks. (Sub. D237, pp. 18–19)

Medibank Private considered that:

The introduction of 'proper' episodic casemix is hampered by the unwillingness of private hospitals to accept the inclusion of costs associated with services other than those directly related to 'motel' costs, such as the inclusion of the cost of drugs associated with the patient's treatment. (Sub. D242, p. 13)

The Commonwealth Department commented on the slow progress and suggested some strategies for encouraging the process:

It needs to be borne in mind that the use of contracts and application of casemix episodic payment in the private sector is in its early stages ... The requirement for contracts to be described on the basis of AN-DRGs from 1 July 1997 will, in itself, provide some impetus for the industry to develop payment structures more akin to proper casemix episodic payment over time. Application of casemix episodic payment for all 666 AN-DRGs is not a feasible or practical option in the short term. It may be more appropriate ... [initially] to encourage the industry to negotiate proper casemix episodic contracts for the 20 or so common DRGs (eg normal birth, lens extraction, knee repair). The Department understands that some funds and hospitals have already begun to do this, and others have developed episodic payments for the common procedures carried out in day surgery. (Sub. D277, p. 19)

### *Assessment of case payment*

The Commission has not been in a position to undertake a detailed investigation of case payment in the context of this inquiry into health insurance. While evidence to date from the public system offers encouragement, it is not yet clear whether similar results can be expected in the private system:

The impact of casemix-based charging, however, may be less impressive for private hospitals than that of casemix funding of public hospitals in Australia. (Palmer et al, 1995, p. 9)

Data for the top 20 admission categories in 1994–95 indicate that there is a wider variation in average lengths of stay in private than in public hospitals.

This may suggest that costs are less predictable in the private sector and therefore that a case payment approach will be more risky. But it may also highlight the potential for case payment to reduce these variations.

Some parties clearly see such an approach as an avenue for improving technical efficiency in the private sector. A number of health funds are already pursuing the use of (episodic) case payments based on casemix classifications. If they prove successful, the pressure will be on others to improve their efficiency or risk the loss of business.

As well as improving technical efficiency, case payment has the potential to improve allocative efficiency and health outcomes through facilitation of out-of-hospital care. Some funds have already expanded the range of these services on which benefits are paid, but were critical that coverage of such services is discouraged by the reinsurance arrangements (see chapters 3 and 10).

The administrative costs involved for some, particularly smaller hospitals, are clearly high. There is therefore a need for a flexible approach both to data collection and form of case payment. The potential for the biggest gains rests with the most common forms of cases. Pursuing case payment for a limited range of cases as suggested by the Department is likely to be more cost effective for smaller players. The twenty most common AN-DRGs account for around 40 per cent of expenditure in private hospitals and the 100 most common for 78 per cent (NMHI, Sub. 140, p. 29).

Problems with the quality of classifications and the availability of data also mean that an increase in the use of case payment will take time and involve set-up costs. In certain areas, such as psychiatry and rehabilitation (in which some private hospitals specialise), robust classifications are lacking. However, in psychiatry, the Commonwealth is funding the development of more appropriate classifications.

More generally, information from the public health system is increasingly available and is also being collected from the private system under the 1995 Amendment Act. In addition, the Commission was made aware of private insurers' plans to institute a collaborative clinical coding audit aimed at improving the precision of diagnosis and procedure data in private hospitals (Hindle, Sub. D205, p. 3).

The Commission considers that its other recommendations should help to encourage case payment where it is appropriate and cost effective. In particular, changes to the reinsurance arrangements should provide greater incentives for cost containment and efficiency generally, by introducing case payments and other measures (see chapter 10). These changes should also encourage health

funds to pursue measures to ensure that quality of care is maintained under a case payment system (see below).

### *Protocols and quality of care*

Inappropriate practice variations and incentives under a case payment system for premature discharge were raised as issues by participants. International evidence indicates considerable regional variations in the delivery of health care (for example, in hospitalisation rates).<sup>4</sup> These variations are much less pronounced where the disease is easy to diagnose, there are few alternative treatments and the costs of non-intervention are high. Medical uncertainty appears to be a prime driver of this variation, rather than demographic, income, price or insurance variations.

Several participants argued that these problems could be addressed by the development of clinical protocols or guidelines (for example, by doctors through the NHMRC) for the treatment of particular conditions.<sup>5</sup> Don Hindle argued that ‘clinical protocols have the potential to increase control over errors of service provision (both excesses and omissions)’ (Sub. D205, p. 3). The Royal Australasian College of Radiologists noted that this will take resources and time:

Meaningful reform ... in this area requires consideration of cost-effectiveness data, utilisation rates, casemix funding/DRGs and quality management methods to ensure appropriate utilisation. Unfortunately, the measures and methods for each of these are as yet imperfect but they do exist and numerous bodies are trying to improve them. The aim in this regard should be a long term one, utilising in a limited way what evidence base and quality management techniques are available now and planning for the future. (Sub. D253, p. 2)

In commenting on quality issues, Qual-med Pty Ltd considered there was a need for funds:

to act on behalf of their contributors to ensure that hospitals with whom they contract actually have in place effective quality management programs. Such action will not only assist the cost effectiveness of the health benefit funds, but also, as a consequence, will enhance their appeal by more closely aligning the funds with the interests of their contributors. (Sub. 14, p. 5)

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<sup>4</sup> These cannot be explained by random variations. See, for example, Phelps (1992) for a review of the international, and particularly the US, experience. Phelps and Parente (1990) estimated an annual welfare loss in the US of around \$7 billion from cross-regional variations in hospitalisation rates alone.

<sup>5</sup> A number of guidelines have already been produced. These have included the management of early breast cancer, the treatment of depression in adolescents, surgical management of coronary heart disease, stroke prevention, acute pain management and unstable angina.

The Commission notes that issues relating to quality and clinical protocols were the subject of a report by the Taskforce on Quality in Australian Health Care in June 1996 (AHMAC 1996) (see box 8.5). It supported a non-punitive, systems approach to quality improvements. The Taskforce did not raise these issues specifically in the context of private health insurance. But the results of its study were from public and private hospitals and some of its observations are potentially relevant to HPPAs and PAs.

A number of funds have indicated a desire to have a greater role in achieving good clinical outcomes from contracting, without interfering in the doctor-patient relationship. For example, NMHI indicated it had joined other funds in commissioning a review to develop clinical guidelines for the payment of rehabilitation benefits. The process had involved a number of respected individuals with relevant expertise.

**Box 8.5: Taskforce on quality in Australian health care**

The major points from the report included:

- adopting practice guidelines (using evidence-based practice) and protocols can reduce inappropriate practice variations;
- guidelines and protocols would improve safety and quality but should *not* limit the exercise of professional judgment;
- guidelines provide a framework for clinicians to structure decisions and should support, but not direct, clinicians when developing appropriate management strategies for individual patients;
- a nationally coordinated approach was preferable but, where possible, existing guidelines from overseas should be adapted — this would speed up the process;
- guidelines can be promoted through funding arrangements (quality-adjusted case payments);
- intelligent use of information will drive quality improvement; and
- the desirability of a patient-centred computerised clinical information system linking providers (for example, hospitals and medical practitioners), and covering patient records, test results and quality indicators.

*Source:* AHMAC 1996.



HCF is seeking:

best practice protocols and guidelines developed by Australian doctors for Australian conditions which leave full discretion to each doctor to determine the treatment of their patient but enable funds to determine benefit policy and reimbursements on the basis of quality, effectiveness and efficiency. (Sub. 158, p. 16)

HCF said it was ‘working with providers to develop benefits based upon best clinical practice’ (Sub. D225, p. 1). In discussions with the Commission, it also raised the potential of using a fund’s database to track clinical outcomes on a statistical basis, in order to better monitor what happens to patients.

With a strengthened competitive environment, health funds will be under more pressure to pursue the role of purchaser on behalf of their members. The incentive for this role to evolve, from a focus on price to include appropriate clinical protocols and general quality of care provisions — where this is in the interests of the funds and their members — will also be enhanced.

### Containing overall costs

By encouraging improvements in technical efficiency, through providing better incentives for the handling of each episode of care, case payment aids unit cost containment. What it can’t do adequately is influence the *number* of episodes.

The AHIA alluded to this concern:

while episodic payments in the public sector should achieve efficiency gains which reduce queuing they will not necessarily have the same positive impact in the private sector. Reduction in cost per episode (and reduction of average length of stay) will certainly be beneficial, **but will not result in lower insurance prices if the number of episodes increases to fill in released capacity, especially if the overall payment systems (fee for service, production based hospital payments, guaranteed floor prices) produce incentives for increased activity.** (Sub. 108, p. 28 — emphasis in original submission)

Hospitals will still have an incentive to fill beds, provided their cost of treating patients is at or below the case payment, doctors will have an incentive to treat more patients, while patients may have little financial disincentive to undergo treatments which may be of marginal clinical benefit.

The Department viewed constraining unnecessary demand and inappropriate utilisation as issues to be addressed by health funds and providers, rather than by fund members:

the insurer cannot rely on the member to try to exercise any constraint on the service provider: the level of services and the costs involved need to be managed between the insurer and the provider directly. (Sub. D277, p. 20)

Health funds are already pursuing a range of options to counter potentially adverse volume incentives. Some are designed to influence the behaviour of their members, while others are directed more at providers.

- Funds offer products which share the risk with their members, for the trade-off of a lower premium. For example, front end deductibles and/or fixed dollar copayments provide members with some incentive to minimise claims. But the effect will vary depending on the nature of the payments required from members. Front end deductible products only provide an incentive to minimise patient length of stay when the deductible is high and the length of stay is relatively short. Some funds offer copayment products which require patients to contribute to the cost of each increment of service. These are likely to be more effective in containing demand and overall costs.
- Funds also offer products with benefit ceilings and/or exclusions for expensive procedures.
- At least one fund is pursuing ‘step down’ contracts with hospitals, specifying lower case payments after a certain number of treatments each year. This would provide hospitals with an incentive to control admissions. It wouldn’t preclude funds seeking supplementary contracts at the full price in the event of a large unmet demand from members. The APHA opposed step down contracts on the basis that they would lead to waiting lists and the rationing of private hospital services (Sub. D217, p. 35).
- Some funds actively monitor utilisation by particular classes of patient, for example, nursing home type patients, chronic medical patients and outpatient day procedures.<sup>6</sup>
- Others offer education and information programs which help members to reduce their risk factors and make better informed decisions about treatment options, quality and cost.

The coordinated care trials being conducted in the public sector (see chapter 9) present a further challenge for health insurers. For example, by better coordinating care across a range of settings, both frequency of hospitalisation and the length of hospital stays may be reduced. This offers significant potential benefits to health funds and their members by reducing the overall costs of care (see box 8.6).

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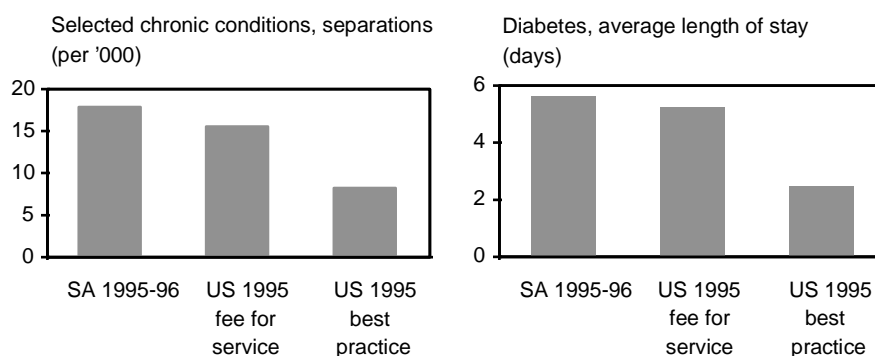
<sup>6</sup> Health funds in Australia have not, however, seen it to be in their interests (or that of their members) to introduce admission criteria or criteria for elective surgery, such as those adopted in New Zealand’s public health sector.

Contrary to the impression gained by some inquiry participants from the Discussion Draft, the Commission is not mandating any of these approaches. Rather, it is pointing to a range of options already being pursued by funds or elsewhere in the health system. Inevitably, funds will face trade-offs between the price of their products and product coverage (such as the extent of exclusions, size of copayments, range of hospitals and alternative care, and waiting times). Provided the market in which they operate is sufficiently competitive, the funds will be encouraged to pursue options which they regard as in their commercial interests and the interests of their members.

There is no legislative constraint to the development of step down contracts or to the alternative of funds seeking discounts for volume buying from individual hospitals (higher occupancy levels for selected private hospitals for a lower price). There is also nothing precluding health funds from enhancing their current range of deductible, copayment and exclusionary products.

### Box 8.6: Potential savings from coordinated care

Comparison of South Australian data, for public and private hospitals at an aggregate level, against US benchmarks (for selected DRGs) indicates that significant opportunities exist to reduce separation rates, average length of stay and bed days. The data show how different mechanisms can produce significant variations in utilisation. These include coordinated care plans for individual patients, to prevent or reduce hospitalisation, and appropriate discharge planning, as apply under US best practice.



Source: Unpublished information supplied by the South Australian Health Commission.

However, under the current reinsurance arrangements, such products are priced artificially high, as all hospital products bear an identical reinsurance liability. In addition, the arrangements discourage coverage of out-of-hospital care. And other elements of the regulatory framework lessen the field of competition within the industry and the scope for cost containment. Changes to reinsurance and other measures recommended by the Commission in chapter 10 should help to address these problems.

### **Health insurance regulation and more fundamental reform**

Chapter 3 highlighted the myriad of rules and regulations which apply to the operation of the private health insurance industry. Many of these, together with other aspects of the industry, affect the incentive for health funds to respond to consumer demands, including:

- community rating;
- reinsurance;
- price regulation;
- governance within the industry; and
- competitive neutrality.

The changes proposed in these areas in chapter 10 should increase the pressure on funds to pursue efficiency and quality improvements, and cost containment strategies.

Ultimately, encouraging greater efficiency — both technical and allocative — will require more fundamental reform of the health care system. This goes beyond the terms of reference for the current inquiry. The principal challenges confronting the health system and the broad directions in which it could evolve are the subject of chapter 9.

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## 9 THE BROAD POLICY CONTEXT

### 9.1 Introduction

The *next* chapter analyses policy proposals and develops recommendations, within specific requirements of the terms of reference. *This* chapter lays the foundations for that by looking at the ‘big picture’ in health policy, on the grounds that good policy is best achieved if a ‘general to specific’ policy making route is followed. That is, policy makers set out broad objectives for the system as a whole, and then derive policies for specific parts of the system, consistent with the whole.

While not able to make proposals about the wider system, the Commission considers that some understanding of available reform options is a necessary precursor to examination of private health insurance. At the very least, such an understanding can suggest whether a particular change to private health insurance is likely to generate wider benefits or be an obstacle to broader reform.

A number of participants commented on broad health policy issues and expressed opinions about alternative options for reform in response to the Discussion Draft (see box 9.2). Given the purpose of this chapter the Commission has not directly responded to those comments.

### 9.2 The broad policy context

The notion of a crisis in either Australia’s health care system as a whole or in private health insurance can be overplayed. Health outcomes, measured in terms of life expectancy and a myriad of other indicators, suggest that Australians are enjoying better health for longer periods of their lives than their predecessors (AIHW 1996).

John Paterson (1996, p. 1), for example, argues:

Health care is Australia’s largest industry, and one of our most successful. There are few places in the world where a person of modest means who is seriously ill will receive better treatment. We have a health workforce that is abundant and highly skilled by international standards. Australia’s medical research establishment is on a par with the world’s best.

To this, however, he adds:

So what's the problem? The problem is that bad systems beat good people every time.

Australia's \$40 billion per annum health system comprises a mosaic of complex arrangements, many of them ad hoc and opaque. It attempts to achieve a host of objectives through disparate, often poorly coordinated, public and private delivery and financing mechanisms. And it faces a plethora of sometimes contradictory regulations and institutions.

Thus, as the Australian Association of Surgeons commented: 'Australia's comparative international performance does not justify complacency in respect of the many existing and emerging problems throughout the system' (Sub. D209, p. 5).

### *An interactive 'system'*

Private health insurance is part of this 'system' and its functioning cannot be divorced from it. For example:

- The existence of a universally available, publicly funded system, which is 'free' at its point of delivery, clearly weakens the incentives for private health insurance.
- Budget caps on public hospital expenditure, on the other hand, create waiting lists for elective surgery which provide an impetus for private insurance. Similarly, little or no coverage of selective services (such as dental) by the public system create incentives for privately funded care.
- The system has set up expectations (for example, for free care) and conventions by funders, consumers and providers (for example, relating to the design of health programs and to the production, ownership, control and diffusion of medical information and billing) which affect the private system — limiting the role of information provision, consumer choice and the use of economic incentives.
- The initial referral system for specialists is a Medicare-subsidised and, increasingly, bulk billing GP.
- Public hospital charges for private patients are determined by government, rather than by underlying costs.
- Medicare reimburses the fees, up to a ceiling, for specialists used by the privately insured.

- There is an historically complex and ever-changing set of subsidy and tax transfers between the insured and the Commonwealth Government aimed at, but not always achieving, the goal of containing public health expenditures.
- Governments, state and federal, regulate the behaviour, standards, and entry of public and private providers, the costs of which are reflected in private health insurance premiums.

*Because private health insurance is a component of an interdependent system, piecemeal reform can be hazardous.* First, what constitutes an appropriate reform for private health insurance presuming that the status quo is preserved in the rest of the system, may be inappropriate in the context of a reformed system. Second, some changes to private health insurance are likely to be complex and difficult to reverse and may forestall broader and more beneficial reforms across the whole system.

A number of submissions to this inquiry urged a more fundamental examination of policy options in the health system because of these links (box 9.1). However, such an examination was precluded by the terms of reference and the time available for this inquiry.

### **Box 9.1 Reform to private health insurance: a ‘pimple on a pumpkin’?**

‘Many of the problems of the private health insurance industry are related to the nature of Medicare and its effects on health care provision and financing. Limiting the inquiry to the private health insurance industry is an artificial distinction which does not enable the real issues to be tackled.’ (AMA, Sub. 130, p. i)

‘There are design features in Medicare which, quite apart from their effects on the performance of the public system itself, hamper the development of greater efficiency in the private health insurance industry.’ (Peter Carroll, Sub. 9, p. 25)

‘Any useful inquiry must study the health system and interfaces in entirety ... the actual insurance is at the summit of a cumbersome, ridiculously costly, system ...’ (Robert Green, Sub. 143, p. 1)

Nevertheless, the Commission examined the principal problems that underlie the call for more widespread reforms, to see what implications these might have for private health insurance. As well, the Commission looked at some broader systemic reforms to:

- bring into relief the principal issues around which the good design of a health system needs to be organised;

- see what role they implied for private health insurance; and
- allow a better understanding of the implications of particular changes to private health insurance for the scope to undertake possible wider reforms.

### 9.3 Challenges faced by the health care system

There are symptoms of structural problems and disequilibria in the health care system. For example:

- Access to many publicly provided services is limited by queuing because of budget caps, yet overall cost control is becoming difficult (Scotton 1995).
- Ageing of the population and increasing technological sophistication suggest that health care costs will unavoidably rise in the future, with requirements for increased taxation revenue under the current system (Mercantile Mutual Sub. 142).
- Private health insurance, a safety valve for the public system, is meanwhile losing membership at an average of 800 members per day (net), increasing the budgetary pressures on the public system.
- There are incentives to cost shift, not only between the states and the Commonwealth, but also between private and public financiers and providers.
- Different health programs are not well coordinated, have different eligibility criteria and financing arrangements:

there is no Commonwealth 'health program'. Each of the 60 is a separate program ... Substitutability between services, even when clinically indicated, is often ruled out by legal, administrative or professional devices. Each of these 60 programs is a virtual island, isolated from the others by bureaucratically inspired rules that have nothing to do with clinical suitability, or even efficient service provision. The Australian health 'system' is pure Kafka. (Paterson 1996, pp. 14–18).

Reform of health systems is based on asking some fundamental questions about their goals, institutions and mechanisms, as depicted in figure 9.1.

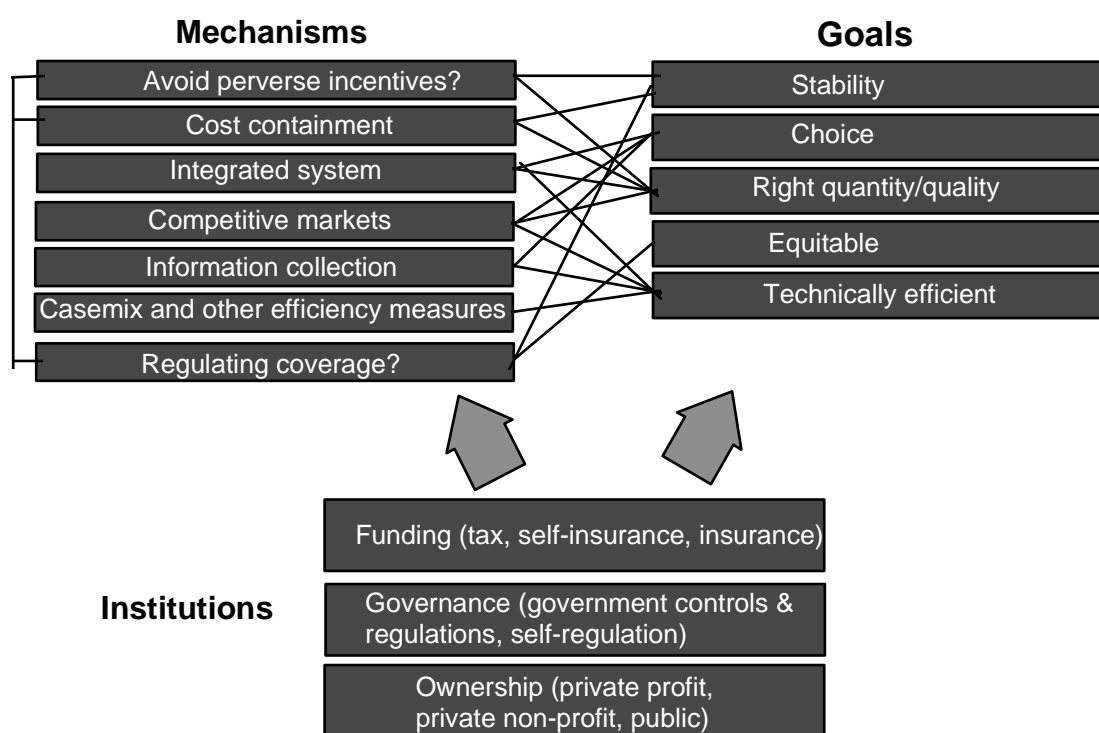
A health system has complex goals, including:

1. *Encouraging the most technically efficient provision of services.* Are providers, purchasers, funders and any other intermediary institutions or infrastructure (such as standards, information systems) using minimum inputs to maximise their outputs?



2. *Producing health care services most valued by people (consumer choice).*  
Command and control systems have to guess what and how much to produce to meet people's needs. Health is, however, different to many consumer goods because providers have such one-sided information advantages (so-called 'information asymmetries'). But are these taken for granted? Are there ways of (a) increasing the sovereignty of consumers through better provision of information and (b) providing improved and wider choices where information asymmetries are not so pronounced?
3. *Encouraging the production of the 'right' quantity and quality of services,* given competing uses of resources (that is, allocative efficiency), principally aimed at achieving better health outcomes.
4. *Determining equitable allocations of health care.*
5. *Ensuring the system is stable over time.*

Figure 9.1: Design criteria for a health system



A range of (linked) mechanisms and institutions can be used to achieve these goals:

- *Measures for integrating care arrangements*, both to improve health quality outcomes and consumer choice, and to discourage cost shifting.
- *Mechanisms for controlling problems of moral hazard and adverse selection*. These are aimed at objectives (2) and (3) above. They suggest attention to the role of copayments, deductibles, contracts between providers and purchasers, and payment mechanisms (such as capitation) as possible mechanisms to secure minimum cost quality health care.
- *Cost containment strategies*. These are really subordinate to objectives (3) and (5). The idea of cost containment is premised on faulty incentives in the health care system (such as the possibility of supply driven demand, or demand effects induced by a ‘free’ service). In some cases, it may well be optimal, however, to increase costs if this provides consumers with services that they value above the cost of their provision.
- *Mechanisms for collecting information* on the efficiency and effectiveness of the system, and on the comparative costs and clinical effectiveness of different health care arrangements and treatments.
- *Competition between players in the system* (providers, health system intermediaries), aimed at increasing technical and allocative efficiency (objectives 1 and 3 above).
- *Ownership arrangements* (state or federal governments, private for-profit and private not-for-profit).
- *Governance structures*, encompassing the operating rules and incentives of the organisations which control health care.
- *Funding arrangements*, including taxes (explicit and implicit), voluntary premiums, charitable donation, and self-insurance.

## 9.4 Systemic reform options

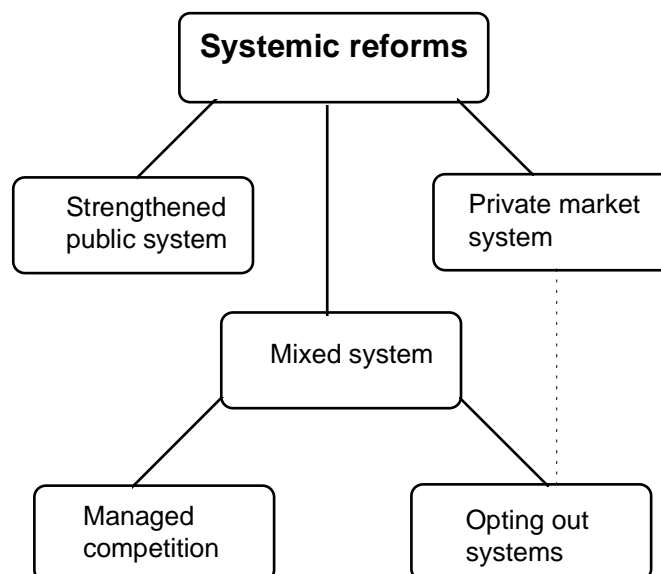
Many participants in the inquiry had views about how the whole health system should evolve, often tied to their perspective about the role of private health insurance. For example, consumer representative bodies — such as the Consumers’ Health Forum, the Health Issues Centre and the Australian Consumers’ Association (Subs. 64, 125 and 77) — advocated a free universally accessible public system, with private health insurance serving a relatively

minor role. Others, such as the Australian Private Hospitals Association, MBF, Peter Carroll, Mercantile Mutual Health and National Mutual (Sub. 51, 29, 9, 142 and 140) saw a major role for private financing and provision, and outlined a range of broader options — from managed competition to universal savings accounts.

From these, the Commission distilled three stylised alternative models, each with its own implications for the direction of the Australian health system (figure 9.2). The broad directions include:

- more emphasis on public funding and delivery (with improvement in system design);
- a predominantly private market for provision, funding and intermediary services; and
- a mixed system with coordinated public and private involvement, of which there are two principal variants:
  - in one variant, known as ‘managed competition’, health care delivery is separated from financing, and groups of providers and intermediaries compete in a managed market for tax funded dollars; and
  - in the other variant, access to free hospital coverage funded by the government is restricted to lower income households, with others compulsorily insuring.

Figure 9.2: Options for systemic reform



We briefly consider each in turn. Selected comments received from participants on these options in response to the Discussion Draft are set out in box 9.2.

**Box 9.2: Participants' comments on systemic reform**

Phillips Fox (Sub. D230, p. 2): Any proposal for comprehensive health care reform should include as its major goals: ... a basic package of core medical benefits to all Australians, the control of current continuing rising costs, ... an improvement in the quality of health care, ... preservation of some freedom of choice ...

Australian Pensioners' & Superannuants' Federation (Sub. D258, p. 2): we support a strengthened public system. ... We disagree with some of the disadvantages outlined — less consumer choice is not an inevitable feature of public systems. ... managed competition offers many possible advantages (as well as dangers). We are strongly opposed to 'opt out' options.

APHA (Sub. D217, pp. 36–7): public hospitals would need to be significantly expanded to provide sufficient capacity if the private sector was reduced to a purely supplementary role. ... A completely private market health care system could be unstable if the form of community rating requirement was inappropriate. ... APHA recommends serious consideration of the introduction of managed competition, and of the introduction of medical savings accounts accompanied by catastrophe insurance, in the context of a broader review of health financing options.

Marland Consulting (Sub. D196, pp. 2–3): I suggest that the Commission ... directly propose an option which would enhance the way the mixed system functions ... ie that a new private hospital insurance option be introduced to cover nominated events. A good starting point would be the kinds of events currently addressed in commercial Catastrophe and Trauma insurance policies.

Ian McAuley (Sub. D194, p. 5): the Commission still tends to refer to the public and private systems, rather than to the funding and delivery systems. ... universal publicly funded catastrophic insurance ... is a third, realistic alternative under the 'mixed system', and it could be achieved through evolutionary change ...

AHIA (Sub. D221, pp. 1–2): there should be no regulatory or legislative restrictions which prevent health funds entering into any financing with providers of care. ... If necessary the Health Insurance Act should be amended to allow Medicare entitlements to be provided via funds to those consumers who elect for such arrangements.

Australian Association of Surgeons (Sub. D209, p. 3): We are concerned at the current developments which are pushing private health insurance toward a managed care approach, particularly the potential for the exclusion of consumers and fund members from decisions taken on their behalf by health funds and other third parties.

Department of Health and Family Services (Sub. D277, p. 5): The department also agrees with the Commission that the actual purpose of the 'opting out' model is to overcome budget problems of funding the public system rather than trying to address systematically many other problems and design criteria for health care systems. The department considers that the appropriate direction for reform ... is to explore with the states more integrated systems of care, focused more on consumers and health outcomes rather than providers and inputs.

### **Strengthened public funding and provision**

Various suggestions for strengthening the public system have included:

- better coordination of state and federal health budget allocations to control cost-shifting;
- reduction in waiting periods for elective surgery by allocating more resources, for example, by increasing the Medicare levy;
- introduction of better mechanisms for coordinating care;
- increased information available to consumers about health care options (for example, Paterson 1996);
- extended application of casemix funding to all states and to out-of-hospital health care such as ambulatory services; and
- introduction of measures to better control moral hazard problems, while gaining more resources for health care, by introducing a more consistent approach to copayments. Currently, copayments are required for pharmaceuticals but not for bulk-billed medical care, optometry services or public hospital services. The costs of dentistry, physiotherapy, optical devices and a wide range of other health care services are principally met by individuals from their own funds.

Some of these features will be tested in coordinated care trials under the auspices of the health system reforms being considered by COAG (see box 1.3). Box 9.3 gives some information about these trials. At this stage, the private health funds are not taking an active part in the trials.

### ***Advantages***

The implementation of a strengthened public system would retain current advantages such as:

- generally high quality health outcomes available to all Australians;
- well developed cost-containment potential based on volume and financial caps;
- measures for efficiency promotion, such as casemix funding; and
- avoidance of adverse selection problems through compulsory participation.

It would also remedy, in part, some of the perceived difficulties facing the system (such as cost shifting between the states and the Commonwealth<sup>1</sup>, and waiting lists for certain elective procedures).

**Box 9.3: Coordinated care trials**

The Commonwealth, together with the states and territories, is exploring arrangements for the provision of more appropriate and effective health and community services.

Coordinated care trials will fund care coordinators who will be responsible for designing tailor-made care packages, in partnership with clients, and for assisting their clients to obtain the services specified in their care plans. The trials cover clients with a range of health and community service needs.

There are two major components new to this initiative — fund pooling and service substitution. Trials will be funded by pooling resources from a number of state/territory and Commonwealth programs. Amounts to be pooled will be based on estimates of the amounts of resources those clients would have been expected to use from these programs were they not participating in the trials. With service substitution, the care coordinator responsible for selecting the care package for the client will be able to select from a wide range of health and community services, and not be confined only to those services which are reimbursable under current programs.

Twelve mainstream coordinated care trials based in five states and the ACT are now undertaking their design and tracking phases, while two trials developed for Aboriginal communities in remote areas have now received Ministerial approval for funding for this phase.

It is expected that trials which are assessed as viable for funding for a 'live' phase will begin providing coordinated care arrangements for clients on 1 July 1997, with all funded trials finishing on 30 June 1999. There will be progressive evaluation of the trials.

*Source:* Information supplied by the Department of Health and Family Services.

**Disadvantages**

On the other hand, public systems inevitably limit consumer choice. For example, under Medicare people cannot elect a doctor of choice in a hospital, vary the speed with which they get elective surgery care, vary the quality of the accommodation services, or choose medical technologies whose marginal

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<sup>1</sup> Cost shifting in the public system between states and programs is akin to the problem of cream skimming by private insurers (see chapter 10).

clinical value is less than the marginal cost to the *typical* individual. A possible analogy to the public health system is a food delivery system that ensures that Australians have a healthy, nutritionally balanced diet — but which limits the associated trappings, variety and choice. Health care is more than obtaining desirable clinical outcomes, just as eating food is more than achieving healthy sustenance.

A further possible disadvantage goes to the heart of general criticisms that economists mount against centralised decision-making processes. It is argued that, relative to markets, centralised systems face profound difficulties in:

- *defining* the right levels of funding;
- *maintaining* levels of funding; and
- *allocating* scarce funds between thousands of competing uses.

The second critique is probably the most forceful. Governments do not have as much flexibility to vary budgets as consumers and producers within a decentralised market.

However, neither the first nor the last difficulties are confined to public systems. Market mechanisms also face difficulties in determining the right level of health care funding or in allocating budgets between competing uses effectively. These stem from the market power of providers and the pervasive information asymmetries between consumers and providers. The allocation and funding problems lie at the heart of what is so distinctive about health care: consumers cannot know all they need to know about competing health care options.

### *Impact on private health insurance*

If the government were to pursue a strengthened public system along these lines, a smaller pool of people would be privately insured, presumably those with the greatest income and risk aversion. Private insurance would tend to be peripheral to the system.

If the current two tier provider system remained, then the demand for private hospitals would fall too. This would create a more centralised hospital system with less diversity. On the other hand, higher income, more educated consumers diverted from the private hospital system may be more demanding of high quality care from the public system.

The long run role of private health insurance would partly depend on whether the regulatory regime was recast. If, for example, community rating were abandoned, the private insurance industry would be smaller, but more stable and likely more efficient. It could provide people with (potentially cheap) cover for

supplementary health care needs and could provide a valuable outlet for consumer choice. If, on the other hand, community rating were retained, then it seems likely that the vicious circle of adverse selection and rising premiums would persist, driving the industry into a corner.

### **A private market health care system**

Health care provision and funding would be fundamentally privatised under this approach, and regulations which have protected providers from competition (such as entry controls on specialists) would be eliminated. The role of government would be limited to three major, 'public good', roles:

- health care research;
- establishing an information infrastructure that allowed funders to collect information on comparative costs and clinical efficacy of different health care providers and techniques; and
- (non-hypothecated) transfers to low income and maybe chronically ill people.

Some regulation of insurers might also be required, for example prudential supervision of reserves.

The major real distinguishing feature of such a market system from other alternatives is that expenditure on health care is *purely voluntary*. People would elect the form and extent, *if any*, of private health insurance and would also decide if they wished to pay intermediaries to help them negotiate prices and health care arrangements on their behalf (as in say HMOs).

Such a fully privatised system is a radical option. No country has selected this option. Even the relatively free market US system funds a substantial share of total health care through taxes (Medicare and Medicaid) and has a morass of regulations governing health care financing and operations. In this sense, the US style 'market' system of health care, impeded as it is by tax distortions, complex regulations and the market power of providers, is not necessarily a guide to the outcomes of a genuinely market oriented health system.

Hurst (1991) and, more recently, Van de Ven (1996) in a wide-ranging survey of comparative health systems, found that no country is reducing the number of persons covered by *mandatory* health insurance, though in other respects there is increased use of market mechanisms for managing health care. Of course, the fact that others are not going down this path does not mean it is the wrong path — merely that there is little information about the impact of such a radical reform.



### *Advantages*

The market system has some clear advantages in terms of the criteria set up in section 9.3, particularly its ability to increase consumer choice and to allow people to choose between health care insurance, health care expenditure and other possible expenditures.

As well, it may have a number of other benefits:

- removal of financing constraints if there is under-funding in the public system. This in turn may have equity benefits if it allows the government to target scarce public funding at those genuinely in need;
- the possibility of penalties for discretionary risky behaviour, like smoking; and
- the potential for insurance contracts and payment mechanisms which temper moral hazard by consumers (selective copayments, front end deductibles, no claim bonuses, and discounts for 'healthy' behaviour).

The first point implies a critical distinction between the approaches of different health care systems. In most public systems, hospital care is 'free' and demand is potentially limitless. This, combined with concerns to counter the market power of providers, leads to budget caps to contain costs. But a blunt objective of containing costs may deny consumers services they would be willing to buy. Weaker cost containment might, in this case, be more of a virtue than a vice of a market system for organising health care. As noted by Van de Ven (1996) in the context of the Netherlands:

*if* additional health care can contribute to one's health, and *if* competition in health care yields more value for money, and *if* most people judge a good health care status to be the most important thing in life (more important than a good marriage, housing or job) — as does 60% of the Dutch population — then we cannot exclude the option that a competitive health care system yields both more efficiency (lower unit costs) and higher total costs (units of higher quality and more units).

### *Disadvantages*

The ability of a 'pure' market system to deliver good outcomes in health care is unknown. The efficiency of such a system relies on:

- weakening the power of providers to raise prices and generate services of marginal or questionable clinical value; and
- constructing insurance contracts which effectively limit moral hazard and adverse selection problems.

Its equity impacts are also problematic:

- A person may elect to 'self-insure' and then contract an illness beyond their means, for example, say leukemia or intensive care following a car accident. The government or charity would either have to step in and finance that care or the person would die. In a civilised society the government must act as an 'insurer of last resort' in such cases. This sets up a free-rider problem that will lead to sub-optimal insurance.
- People with higher probabilities of expensive illness acquired through no fault would, in many cases, not be able to afford insurance. Insurers would either set very high premiums or deny insurance altogether for people in whom a costly form of illness is indicated (for example, Huntington's chorea). Insurers would also require mandatory tests for expensive conditions. A person with a positive test would have little prospect of obtaining privately funded health care, requiring either charity or the involvement of publicly funded care.

The grounds, therefore, for some form of community rating are stronger on equity grounds if there is no, or only a weak, alternative publicly funded system. This issue is explored further in the next section.

### *Impact on private health insurance*

A fully privatised system would of course dramatically increase the role of private health insurance. Such a system requires sophisticated insurers who can:

- bargain knowledgeably with providers on behalf of consumers;
- produce diverse product types matching the needs of different sorts of consumers; and
- price and structure products to avoid perverse incentives.

Such a role offers the potential for significant efficiency gains. However, it took many years for sophisticated insurers, such as HMOs, to evolve in the US market. The risk of a transition to a private health system without associated reforms to anti-competitive features of the medical market is that costs could inflate dramatically, with equity problems and limited gains in health outcomes.

## Mixed systems

### (a) Managed competition

The observed evolution of health systems around the world eschews both the fully public and private models of organising health care, while incorporating features of both. There is an increasing tendency by many OECD countries to retain universal (compulsory) coverage of the population and a large measure of tax based funding of the health care system, *combined with* more competition and devolution in the purchasing and provision of services (Van de Ven 1996). These ideas have been realised in the Netherlands as a fully fledged system of ‘managed competition’.

In Australia, managed competition remains largely an idea, with Scotton as its prime advocate (see Scotton 1995).

While managed competition may have different expressions — and could even encompass ‘managed care’ (see below), it typically involves a number of common features:

- The financing for basic health care comes from taxes.
- There is disbursement of risk-related capitation payments to people who would be required to lodge them with health care fund holders.<sup>2</sup> For example, this means that a person who was 65 years old might get five times as much funding as a person aged 25 years. Risk-related capitation payments, combined with frequent revisions to capitation schemes, are designed to overcome cream skinning by fund holders.
- Entitlements could be held with one of a number of competing public or private purchasers (or ‘fund holders’) who would buy the full range of basic services (pharmaceuticals, nursing home care, medical specialty services, hospital care) on behalf of people covered. The requirement that all basic services be covered would eliminate the incentives for cost shifting prevalent in the current system (for example from nursing homes to private hospitals, or from private to public hospitals).
- The purchasers would write casemix contracts with providers, public and private, to secure least cost, appropriate quality, services for their customers.

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<sup>2</sup> Some variants, for example (Harding and Johnson, forthcoming), suggest the possibility that consumers could receive a rebate on part of any savings of this transfer and spend it on goods and services other than health care.

- Consumers could elect to supplement basic health care with their own funds to meet additional health care needs, such as doctor of choice, higher standard accommodation, certain procedures where the marginal benefits exceed the marginal costs for only a very few people, and more rapid service.

### *Advantages*

The main objective of managed competition is to promote efficiency by generating the right incentives to purchasers (avoidance of cost shifting) and providers (cost minimisation via casemix contracts). There are other advantages as well:

- It gives consumers broader choices. Consumers are effectively allowed to take their risk-related capitation payments and use them with the fund they think will best negotiate good health outcomes for them.
- It allows some potential gains in equity. Those electing for private insurance are no longer being asked to pay twice — once for the public system and again for the private system. They would receive full entitlement for their capitation payment and could simply add to it the amount of funding necessary to buy (at full cost) any additional services.
- It eliminates the requirement for elaborate regulatory machinery like community rating. This has no place in the presence of risk-related capitation payments, which avoids the problem of adverse selection.

### *Disadvantages*

Managed competition has, however, a number of disadvantages:

- Consumer choice is not as wide as that of a fully private system. Consumers can increase their cover, but they cannot decrease their cover below the mandatory floor. As well, consumers may be restricted to using certain providers which have contracts with fund holders.
- Since it does not allow rebates to consumers who wish to buy less than the basic cover, it may constrain the development of mechanisms for controlling moral hazard, such as front end deductibles, bonus schemes and variable copayments, which are customary in private insurance markets<sup>3</sup>.

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<sup>3</sup> Constraints on FEDs and other mechanisms for controlling moral hazard may be necessary to avoid another threat to the stability of managed competition: cream skimming. Insurers will always be looking for a way to identify which sorts of people are likely to be low risks *within* the risk groups underlying the capitation payments. However, they face two

- The capitation payments are based on assessments of risk which may be deficient until substantial databases have been formed.
- Since it caps budget allocations for the basic capitation payments, there is no guarantee that expenditure will be optimal – it could be either too much or too little. The pressure for smaller government outlays and ‘cost containment’ as an objective suggests that the level of basic cover might be too modest, or at least become so over time. This is particularly the case since it is likely that a shift to managed competition would require increased public funding unless sufficient copayments and/or front end deductibles were introduced.<sup>4</sup> Under-funding would raise the prospect of a two tier system: a poor quality system for those without the income to supplement their insurance and a high quality system for those on higher incomes. The advantage of the alternative, more private sector model, of targeting only those people on low incomes, is that the public sector budget required to provide a minimally satisfactory level of health care for those in need is less.
- It may involve complex transitional arrangements.

### *Impact on private health insurance*

The role of private health insurers (as fund holders) would be likely to increase in this model, as it would bring them full recognition as an integrated part of a health care system and decrease the financial penalties of joining them.

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obstacles. First, only around 20 per cent of the variation in health expenditure between individuals can be explained by observable characteristics of those individuals (such as age and sex). Second, even if they find some hitherto unknown observable characteristic associated with risk — the scope for this would fast disappear under Scotton’s regime of annual changes to the capitation formulas. Nor can insurers expect an honest answer to a question, such as ‘are you likely to use the system over the next year?’. But they *can* use uptake of front end deductibles and similar products as a filter which effectively asks this question, and elicits an honest answer! A person who is willing to purchase a front end deductible or who would like an insurance product with a no-claim bonus is exactly the person who is least likely to make a claim, regardless of whatever formal methods for determining risk related capitation payments are used. Thus, the problem with *voluntary* mechanisms to lower moral hazard is that they are exactly the mechanisms used by insurers to cream skim.

<sup>4</sup> This is because managed competition reimburses *all* people their risk related capitation payments, even if they elect to use a private fund holder. In the context of the current system this would be like allowing an average person not only to opt out of their Medicare levy but to opt out of their complete tax payments for health care.

*Managed competition is different to managed care*

Managed competition articulates a set of competitive incentives for cost efficiency and health quality outcomes, together with an associated set of funding instruments. 'Managed care' is a separate concept which need not be a major part of any particular managed competition arrangements.

There are many possible forms of managed care — ranging from the specification of the actual types of treatment permissible in specific areas, to application of admission criteria, to arrangements in which the care given to a group of patients, or provided by a group of health providers, is simply better coordinated. The ultimate aim of managed care is to achieve better health outcomes.

The coordinated care trials currently under way in Australia (see box 9.3) could be described as an embryonic form of managed competition, embracing some elements of managed care. The private health sector is not participating in the current trials.

**(b) 'Opt out' options, including means testing**

Some commentators see the financing problems of public systems as the chief difficulty and look to an explicit two tier system as the solution, of which there are many variants. Peter Baulderstone of the Australian Hospital Association notes:

there will only be significant expenditure savings to government, and revenue gains for public hospitals, if close to 50 per cent of the population are insured, and all insured patients are charged the full cost of their treatment ... I believe it is both inevitable and preferable to the increased service rationing that has accompanied budget cuts under the public funding model. (Baulderstone, 1996).

Under such approaches, consumers would be required to insure privately if their income was above a certain threshold. Alternatives may introduce contingent levies which people can avoid if they take out private health insurance. These were first applied during the Fraser Government. More recently, the announcement in the 1996 Budget of a contingent 1 per cent Medicare levy for singles on incomes above \$50 000 and families on incomes above \$100 000 also represents a move in this direction.

The implications of the opting out model are hard to assess because:

- they depend on the extent and nature of the opting out (table 9.1); and

- the central purpose of the model is to overcome budgetary problems of funding the public system, rather than trying to address systematically the many other problems and design criteria for health care systems.

If opting out were nearly complete, and other market reforms initiated, then the opting out proposal would be effectively identical to the ‘private’ market health care system — with its advantages and limitations.

### *Advantages*

The main advantage of the opt out model is its potential to relieve financial pressure on a cash strapped public system, depending on the extent to which a shift to private cover occurs.

Any move to a mandatory system of private insurance for most people (achieved by setting the income threshold at a low enough point *and* requiring private health insurance) limits the adverse selection problem currently facing private insurance.

**Table 9.1: Implications of the opting out approach**

<i>Minor opting out incentives</i>	<i>Major opting out incentives</i>
<ul style="list-style-type: none"> <li>• Limited public financing gains</li> <li>• Slight strengthening of basis for community rating</li> <li>• Limited impact on adverse selection</li> </ul>	<ul style="list-style-type: none"> <li>• Large public financing gains</li> <li>• If insurance is compulsory it eliminates adverse selection and creates a stronger basis for community rating</li> <li>• If means testing is used as the basis for opting out, then it can create ‘poverty traps’</li> <li>• Creates major incentives for cream skimming, requiring regulation</li> <li>• Does not address market power of providers, which could generate substantial service and cost inflation</li> </ul>

### *Disadvantages*

The major disadvantage of the opt out model is that, by itself, it represents limited reform. If major opting out options are considered, then it strengthens the basis for some form of community rating for equity reasons (covering for example, people with pre-existing ailments). This would then require limits on the voluntary uptake of certain products — such as front end deductibles and exclusions — which are used by insurers to cream skim. Such limits, while a

protective device for community rating, may also constrain the development of products which provide consumers with choice and incentives to avoid moral hazard.

As well, means tests can create employment disincentives for households with taxable incomes close to the threshold. For example, in the US, means testing is used as the basis for allocating public health subsidies. It has been estimated that up to one quarter of the approximately 4 million welfare recipients would enter the labour force if health insurance were available continuously (Cutler 1994).

Finally, *if* the system moved to one where most people were obliged to opt out, and *if* community rating were enforced, there may be pronounced distributional consequences. Community rating is a financing method in which all people pay the same premium, regardless of income. By contrast, under the current Medicare system, contributions are proportional to income. In other contexts, as noted by Pauly (1994), an implicit head tax (or ‘poll tax’), of which a community rated premium is a perfect example, is regarded as ‘regressive, inequitable and undesirable’. Whether it is actually regressive or undesirable in this context depends on:

- What happens in the tax system as a whole in response to the reduced requirement for direct tax funding of a universal health care system. For example, if the residual funds were distributed via rebates on premiums for lower income households, the distributional effects would be less than say a reduction in marginal tax rates.
- Assessments of what constitutes the optimal degree of progressivity of a tax system.

### *Impact on private health insurance*

The impact of the opt out model on private health insurance would depend on the determination of income thresholds in any means test or contingent levy. The lower the threshold, the more important private health insurance becomes as a substitute, and the stronger the basis for some form of community rating on equity and efficiency grounds.

### **Lessons from different reform options**

Each of these stylised options for systemic reform provides private health insurance with a different role, and a different need for accompanying regulation:



- Private insurance effectively becomes peripheral under a strengthened public system — and there is no basis for community rating.
- Private insurance dominates under a primarily private health care system, or in systems in which near complete opting out is sanctioned or mandatory — and here community rating has a role.
- Under managed competition models, the role of insurers (as purchasers or fund holders) can also be far more significant, although the main source of the funds is a capitation payment from government rather than the consumer.

The critical lesson from this thumbnail sketch of broader options for health care reform is that the role of, and problems faced by, private health insurance cannot be separated from the system as a whole.

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## 10 POLICY OPTIONS

### 10.1 Introduction

While there were many discordant voices over the importance and nature of the role of private health insurance (chapter 2), the Commission found there was general agreement among participants that the private health insurance industry *does* serve a useful role within the overall health system. It offers consumers greater access and choice, and serves as a financial safety valve to a capped public system.

But there was also widespread agreement that the industry suffered from major structural weaknesses and may experience long run instability given adverse selection (box 10.1). The Commission considered potential reforms to each of the major factors underlying these problems.

Against the broader backdrop of the previous chapter, and drawing on information and findings elsewhere in this Report, this chapter examines the scope for beneficial policy changes in private health insurance, including changes to:

- community rating;
- other price regulations;
- product regulations;
- reinsurance;
- governance and conduct of insurers;
- reserves;
- increase consumer satisfaction with insurance, including billing arrangements;
- costs; and
- rebates and other government transfers to private health insurance.

**Box 10.1: Problems affecting private health insurance**

Private health insurance is beset by a plethora of interrelated problems:

- premiums increasing at rates well above inflation (9.8 per cent per annum growth from 1989–90 to 1995–96);
- declining membership (down 3.8 per cent per annum over the last five years);
- adverse selection (the young and healthy are leaving, high users, often the elderly, stay in and opportunistic consumers are ‘hitting & running’);
- moral hazard (overuse of services due to weak price disciplines);
- a highly regulated industry (including regulations covering community rating, product and pricing approval, entry *and* exits, solvency, reinsurance, and maximum waiting periods);
- highly complex products which consumers find confusing;
- an onerous billing and claiming system for consumers;
- unpredictable ‘out of pockets’ for consumers;
- questions about the technical efficiency of the industry and its capacity for innovation reflecting its ‘mutual’ character and the regulatory web; and
- its role as a passive buyer rather than an active purchaser of services for consumers.

The impact of these recommendations are assessed in the next chapter, as well as implementation issues.

**10.2 Community rating**

The private health insurance industry is enveloped by a thick mantle of product and price regulations, of which community rating is the most controversial and important. As discussed in chapter 3, the regime of community rating, as currently applied in the private health insurance industry, is an ill-defined concept, without clearly articulated equity or economic objectives *given the system in which it is embedded*.

Community rating is premised on equalising premiums for high and low risk contributors to meet broad equity objectives of government. Probably the most important ways in which community rating is expressed are:

- its avoidance of age-related premiums;

- guaranteed acceptance — anybody must be able to *enter* a health fund, regardless of their health condition; and
- guaranteed renewability — anybody must be able to *stay* in a health fund, regardless of their health condition.

The equity basis for the third point, so long as the health risks are involuntary, appears to be strong. The equity basis for the first two points is weaker, especially against the backdrop of a universally available public system. For example, everyone knows they will get old. Many people could set aside as savings those amounts needed to meet risk-based age premiums (savings plans). Or they could contribute to a plan that demanded higher payments than actuarially required earlier, and lower payments than actuarially required later (so-called lifetime rating).

Within the context of the current system, equity arguments for community rating are largely a vestige of a health system pre-dating the universal coverage of Medicare. As noted by Peter Carroll:

Much of the detailed regulation of the private health insurance industry today dates from a time when the industry was regarded as virtually an extension of the social welfare system. (Sub. 9, p. 14)

When there is a free publicly funded health care system available to all, the equity grounds for community rating are weaker, since any individual can fall back on the public system for essential health care (box 10.2). The merit of community rating, therefore, depends on the role of private health insurance within the health system as a whole (chapters 2 and 9).

A second major flaw in the application of community rating is exposed by the *voluntary* nature of private health insurance. As reiterated by many submissions, community rating is not, in the long run, effective in a system in which lower risk contributors can leave (and use the free public system or self-insure). People with lower risks are increasingly exiting the funds, leaving a residual of increasingly higher risk groups. These in turn face rising premiums. This induces more departures, resulting in what Logan (1995, p. 11) has aptly termed ‘diminishing pool’ rating.

Moreover, this instability exposes younger members of private health insurance to risks. The current version of community rated private health insurance is an unfunded ‘pay as you go’ scheme. People aged under 40 years finance the health care needs of the currently sick and elderly, and rely on a yet to be born generation to fund their health care needs when they have aged — a bad bet if there are not enough young people interested in health insurance in thirty to

forty years time. In this sense, an unfunded voluntary community rating scheme is subject to the same risks as pyramid selling schemes.

Community rating incorporates other, incomplete, flawed and subordinate objectives such as income distribution. Thus, other than single parent families, community rating sets premiums for different sized families at the same rate. Since, on average, families with more children have less income per family member than those with less, this feature aids income distribution. However, it does so in an inefficient and incomplete way. First, some families with a greater number of children are richer than families with few children. Second, other income differences are ignored. For example, a single person on low income faces the same premium as a single person on high income.

**Box 10.2: A tale of two people**

Imagine a world in which there are full age-related premiums.

- Person A has a low income that makes contemplation of private health insurance impossible. She will get ready access to free and quality care for urgent medical cases in the public system, but will have to wait for elective care — and that can be distressing and immobilising. But the public system has budget caps and inevitably a choice has to be made about rationing supply for some medical procedures.
- Person B has higher income and is old. She could afford private health insurance in her old age under an age rated system *if* she had saved for it, but she has been short-sighted and has not done so. She too cannot afford private health insurance now, and like A will have to wait for elective surgery.

Community rating aims to deal with B's situation, but is not relevant to A's. Why should B's situation pose a policy problem and A's not, given that B has higher income?

These flaws are against a backdrop of other paradoxes and inconsistencies in the application of community rating:

- Community rating applies separately in each state, notwithstanding substantial inter-state variations in age (and therefore, risk) structures.
- Exclusion products have been selectively allowed that have increasingly 'cream skimmed' the insured — trying to identify lower risks and charge lower premiums for these groups — with full cover premiums rising as a consequence. However, the reinsurance arrangements partly ameliorate this.
- There are highly discounted corporate policies.

- The ‘community’ involved is no longer representative of the Australian community as a whole. Its typical member is more likely to be older, with higher income and of English speaking background.
- It creates incentives for perverse consumer behaviour. Those who choose risky activities (such as smoking, over eating, and substance abuse) pay the same premiums as those who avoid such risks.
- Some people who have contributed for many years, at a community rated premium well above their actuarial risk, find that medical gap copayments or premium levels are too high during retirement, and so have to forfeit insurance.
- Community rating also applies to ancillary services, notwithstanding the fact that they are radically different in nature to hospital services.

Despite these problems, successive governments have maintained a commitment to the principles of community rating. That commitment is reflected in the terms of reference for this inquiry. That being so, there are a number of different ways in which community rating could be organised which might ameliorate some of the flaws of the existing rating scheme.

### **New variants of community rating**

The Commission received many submissions from all quarters of the industry discussing the frailties of the existing community rating system and advocating amendments. These included National Mutual (Sub. 140, p. 67 and D210, pp. 3–4), the AHIA (Sub. 108, pp. 12–13 and D221, p. 3), the AMA (Sub. 130, pp. 32–37, p. 40 and D223, p. 8), the APHA (Sub. 51, pp. 42–43 and D.217, p. 10), the Institute of Actuaries of Australia (Sub. 141, p. 6 and D218, pp. 2–3), individual consumers (Sub. 47, 143, 149, and 171) and experts (for example, Sub. 9, pp. 34–35 and Sub. 4, p. 2.2). The Commission considered four variants of community rating:

- *funded lifetime community rating*. Unlike the current ‘pay as you go’ scheme, a funded lifetime rating scheme is based on people pooling reserves with their same aged peers, to meet both their current and future health costs. Rates of insurance are set to meet the expected costs over the remaining years of life. Late entrants pay more because they have to start accumulating reserves for approaching old age, whereas those of their age cohort who joined early have already accumulated the bulk of the required reserves.
- *unfunded lifetime community rating*. People entering at a younger age receive a discount on their premiums (or people entering late have to pay

more). It is still ‘community rating’ because people of different ages pay the same premium, so long as they entered at the same age. The difference between this scheme and pure lifetime rating is that it is still an unfunded scheme. No reserves are accumulated — the difference between the premium paid and the benefits received of any person is pooled with other surpluses and contributes to the costs of the sick.

- *differential age-related waiting periods*. This is the non-price version of the unfunded lifetime community rating scheme. People entering early can avoid longer waiting periods for treatment (or from an alternative perspective, late entrants face longer waiting periods than those entering early). The AHIA (Sub. 108) proposed a variant in which the waiting period penalty related to pre-existing ailments only.
- *bounded community rating*. This allows a prescribed degree of variation in premiums across age and, potentially, other risk categories. The scheme put forward by Peter Carroll (Sub. 9) advocates a 15 per cent upper and lower band around the ‘community rate’. Under such a scheme an old person would have to pay up to 35 per cent more than a young person. This represents a small shift towards risk rating.

As well, the Commission examined the advantages and disadvantages of ‘medical savings accounts’ (MSAs) as a way of financing private health costs. MSAs are similar to funded lifetime rating schemes, except that people do not pool risks with their age cohort, but simply spread their lifetime health risks over time by accumulating a savings buffer.

*These rating regimes are examined in detail in appendix C, including a review of participants’ comments — for and against the various options.*

The Commission established a broad set of criteria against which rating schemes could be judged (table 10.1). None perform perfectly against the criteria (table 10.2) — reform of rating schemes unaccompanied by changes to the overall funding of the health system is a palliative, not a cure of the ills affecting private health insurance.

### *Attract younger members and deter late entry?*

All of the variants are likely to attract new, younger entrants, and deter late entry, although the extent to which they do this varies and the mechanisms by which they achieve this are subtly different.

A bounded rating scheme attracts the young because premiums for the young would fall significantly below current levels. However, a person joining at a young age receives no loyalty bonus — and would face rising premiums as they

aged. Late entrants would pay more than they do now, and in that sense some may be deterred — but the product would remain actuarially very attractive to old entrants.

The intention under an unfunded lifetime community rating scheme and late entry waiting periods is to encourage early entry by imposing a penalty for late entry. Since no existing incumbent would be penalised (regardless of when they joined insurance), the current price of policies would not fall significantly, although the rate of expected premium increases would be reduced.

In contrast, the level of premiums for early entrants to funded lifetime rating and MSAs would be below current community rated premiums *and* late entry would be penalised.

Table 10.1: Criteria for assessing insurance rating schemes

<i>Principles</i>	<i>Purposes</i>
<b>Structural principles</b>	
Attract new, younger people	stability
Deter late entry	stability, equity for existing members
Deter 'hit and runs'	equity for existing members
Not adversely affect existing members	equity for existing members
Not discourage use of health insurance by the old/sick	
in the transition	equity, reducing tax burden
in the long run	equity, reducing tax burden
<b>Administrative principles</b>	
No lengthy or costly transition	feasibility, reducing tax burdens
Administratively feasible	feasibility
Portability possible	equity, promoting competition, consumer sovereignty
Robust to sovereign risk	feasibility, efficiency
Alright for sporadic users	equity, consumer sovereignty
No impediment to appropriate innovation	efficiency
Not create barriers to entry	efficiency, promoting competition



Table 10.2: How do different schemes rate?

	<i>Funded lifetime community rating</i>	<i>Unfunded lifetime community rating</i>	<i>Late entry waiting period</i>	<i>Medical savings accounts</i>	<i>Bounded community rating</i>
<i>Structural principles</i>					
Attract new, younger people	✓	✓	✓	✓	✓
Deter late entry	✓	✓	✓	✓	?
Deter 'hit and runs'	✓?	✓?	✓?	✓	x
Not adversely affect existing members	x ?	✓	✓	x ?	x ?
Not discourage use of health insurance by the old/sick					
in the transition	x ?	✓	✓	x ?	x ?
in the long run	✓	✓	✓	✓	x ?
<i>Administrative principles</i>					
No lengthy or costly transition	x ?	✓	✓	x ?	x ?
Administratively feasible	✓	✓	✓?	✓	✓
Portability possible	✓	✓	✓	✓	✓
Robust to sovereign risk	x	✓	✓	✓?	✓
Alright for sporadic users	✓	✓	✓	✓	✓
No impediment to appropriate innovation	✓?	✓	✓	✓	✓
Not create barriers to entry	x ?	✓	✓	x ?	✓

*Deal with 'hit and runs'?*

None of the proposed variants are very effective at dealing with 'hit and runs', with the exception of savings accounts. MSAs entirely eliminate incentives for hit and runs because each person is responsible for accumulating the funds for their own health care needs over a lifetime — the only person who can be 'hit' is oneself. This virtue, however, stems from a flaw in MSAs as an exclusive funding mechanism for health care — they are not real insurance.

Funded and unfunded lifetime community rating and late entry waiting periods do somewhat discourage hit and runs, because periods of lapsed membership are

penalised — and therefore still represent an improvement on the current regulatory environment. Bounded rating, on the other hand, provides no discouragement to strategic entry and exit by consumers.

*Impacts on existing members, the old and sick*

It is feasible to design unfunded lifetime community rating and late entry waiting period schemes with no impacts on existing members or the public purse. Any transition period could be very short. Because some people may have been planning to enter health insurance — it may be fairer to allow a grace period (of say 3 months) when people could join without penalty.

The APHA (Sub. D217, p. 12) was critical of the waiting period version on the grounds that it would disadvantage the old who were considering joining late. This goes to the heart of *any* scheme which penalises late entry:

- If the penalty deters effectively then it can only do so by disadvantaging a late entrant. The idea is to *avoid* having late entrants. And while late entry is costly to those old people who do join late, they are only being asked to bear the costs that hitherto longstanding members of insurance have had to bear on their behalf.
- If the penalty does not seriously disadvantage late entrants, then it is of questionable effectiveness and equity.

Unfunded lifetime rating or late entry waiting periods advantage one set of old people relative to another — they do *not* represent transfers to the young. Long standing old members gain, while future late entrants lose.

Bounded rating is more difficult to implement without adverse effects on the old. Its phased introduction may somewhat mitigate its negative impacts by spreading any increased premiums over a number of years and by allowing older people to accumulate savings to meet increased future premiums. For example, the band around community rating could be expanded by 3 percentage points a year for five years. However, in the absence of compensating subsidies, this would adversely affect existing members, particularly the old — and could lead to increased pressure on the public system.<sup>1</sup>

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<sup>1</sup> The *long run* impact of bounded rating on enrolment by the elderly in private health insurance depends on the extent to which they would anticipate and save for premiums that rise with age.

In both MSAs<sup>2</sup> and funded lifetime rating there is a tradeoff between impacts on (a) incumbents, (b) the cost to the taxpayer and (c) the complexity and duration of the transition period. Both of these variants require ‘bridging finance’, which must be met by someone over some period. The following examples are illustrative:

- In the extreme case, if taxpayers met the cost of a move to full lifetime rating, the cost could be nearly \$30 billion spread over a century (appendix C).
- Alternatively, existing incumbents could meet all of the costs — but these would be most pronounced for older members, many of whom may have been long term contributors, reasonably expecting to be cross-subsidised by the current young generation.
- Another variant might recognise long standing members of insurance funds, and penalise them less than more recent entrants.
- New entrants could pay their lifetime rate, plus a contribution towards the costs of the current pool of community rated people. However, by pushing up the lifetime rate, this would dampen the incentive for entry by the young, until all the people covered by community rating had died.
- Or, the burden could be spread differentially across the different groups.

Accordingly, while it is possible to share the burden of a shift to MSAs or a funded lifetime rating scheme evenly among taxpayers, new entrants, and incumbents, any arrangements are likely to be complex and protracted. To the extent that these variants placed any greater financial burden on existing elderly incumbents, there is a significant risk that in the interim (but *not* the long run) the old would use the public system instead. This would intensify pressure on an already strained system, and weaken the viability of the private health care system (whose current fortunes are, somewhat arbitrarily, tied to that of private health insurance).

### *Administrative problems*

While their solutions differ in complexity and nature, most of the schemes meet the remaining administrative criteria for a ‘well designed’ rating system. However, funded lifetime rating and, to a lesser extent MSAs, raise issues of sovereign risk. These schemes require long-term investments by funds and governments, and long-term understandings with consumers. But government

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<sup>2</sup> Of course, if MSAs were simply a component of a wider set of arrangements for funding health care (with, for example, complementary catastrophe insurance, as in Singapore), then the tradeoffs are attenuated.

policy is fluid — and health insurance only a part of a much bigger system. If the rules change in that bigger system, would funded lifetime rating necessarily still be the best arrangement? And if the costs of shifting from lifetime rating were considered high, might that prejudice broader reforms?

### **Which system of community rating for hospital cover?**

The current community rating system has a number of major drawbacks, of which adverse selection is the most extreme — the long-term prognosis for the industry under the current rating system is uncertain. However, the significance, in the *shorter run*, of this ‘vicious’ circle — or ‘diminishing’ pool rating — has probably been overstated. The fact that private health insurance is still active in Queensland after decades of a free public hospital care system suggests that adverse selection is countered by other forces (such as a desire to have a choice of doctor or to obtain elective surgery without prolonged waiting).

It is likely, therefore, that continuation of the current community rating system for hospital care in roughly its current form will not precipitate any *immediate* crisis for private health insurance. Until a broader inquiry into the health system takes place, which reviews the role of the public system, radical restructuring of community rating may be counter-productive.

Even so, adverse selection has significantly lowered membership by the young across Australia. Moreover, using a more elaborate methodology than in the Discussion Draft, the Commission found that adverse selection is having a much greater impact on premiums than previously thought (chapter 7). As the impact on premiums from the switch in usage from the public to the private sector wanes, adverse selection will become pre-eminent as a cost driver. This suggests that in the absence of a wider examination of the financing and functioning of the health system, interim measures are required.

The Commission recognises some advantages of funded lifetime community rating and MSAs compared to the current system, but cannot recommend their implementation because they are likely to involve complex transitions and are vulnerable to long-term broader changes in the health system.

However, a shift to an unfunded lifetime rating scheme or to late entry waiting periods may well be an effective interim measure for containing the worst aspects of adverse selection, while maintaining the broad objectives of community rating.

The Commission also believes that such schemes are equitable:

- no existing insured person is adversely affected;
- people who were planning to join insurance could still do so during a grace period; and
- they encourage early entry/deter late entry by consumers — this should over time somewhat balance the age distribution, thereby lowering premiums and making insurance more affordable for the old and young alike. This is also fairer to longstanding members who would bear less of the burden of late entrants.

Many participants favoured the unfunded lifetime community rating scheme. However, there was greater resistance to implementation of its non-price equivalent, the late entry waiting penalty scheme. This was primarily based on perceptions about the impact on elderly late entrants (see appendix C). The Commission does not accept that the arguments against differential waiting periods are sound.

However, unfunded lifetime rating and late entry waiting periods *do* affect late entrants differently. Under the first, late entrants can pay a price penalty to gain access to private hospitals, while under the second, they must pay a smaller surcharge (the premium during any waiting period) combined with a waiting period. Which of these variants constitutes the greatest penalty for late entrants will depend on consumers' preferences (their aversion to waiting) and their income.

- For example, if a waiting period variant were introduced, a late entrant who had a strong preference for rapid treatment might be forced to wait, even if they were willing to pay a larger surcharge which made immediate access financially attractive to the funds.

This suggests that both schemes could be introduced, with late entrants nominating which of the two penalty regimes they would face. However, this would probably be confusing for most consumers, and might pose some implementation difficulties (for example, in respect of reinsurance).

The Commission considers that, on balance, an unfunded lifetime rating scheme has some advantages over the non-price variant:

- usually there are efficiency losses when using queuing mechanisms (as in the above example) compared to price mechanisms; and
- from a pragmatic perspective, participants appear to better understand and accept the price variant.

The exact age at which late entry penalties should bind under an unfunded lifetime community rating scheme is a matter for further investigation. However, having a relatively young age (say 30–35 years) as the starting point for late entry penalties would serve to attract more young people into insurance.

**Recommendation 1**

The Commission recommends the introduction of (unfunded) lifetime community rating for private health insurance, under which people entering insurance late, for example after the age of 30 years, would pay higher premiums than those who enter early.

There is an inherent tension between the policies of support for universal access under Medicare and support for voluntary, community rated, private health insurance. Thus, while an unfunded lifetime rating scheme may deal with some problems affecting private health care financing in the shorter term, it still leaves many of the anomalies of the current system untouched.

**Recommendation 2**

The Commission recommends that community rating principles be examined as part of a wider review of the health system.

**Community rating of ancillaries**

The question of community rating for ancillaries is different from that applying to hospital services:

- Limited evidence suggests that demand for ancillaries is actually lower for older people — so that risk rating would, if anything, lower premiums slightly for the old. This is even implied by the reinsurance arrangements, which leave ancillaries out of the pool.
- Moreover, unlike hospital services, ancillaries are frequently purchased services. These include dental, optometry and physiotherapy services. As well, ancillaries involve much smaller outlays than typical hospital episodes, and insurance policies require significant copayments and expense thresholds. The typical consumer will *expect* to claim each year for ancillaries. In this sense, ancillaries are akin to standard consumption items,

like food or car expenses. Most Australians elect not to insure for ancillaries at all — ‘self-insurance’ is the norm.

There are, therefore, few grounds for community rating of ancillaries. As noted by Peter Carroll:

For ancillary insurance, full risk rating is unlikely to disturb prices greatly and is unlikely to have severe equity implications. Cross subsidies in this section of the market at present are small and under full risk rating the main drivers of prices for current products are utilisation of private dental and vision care services, which is relatively invariant by age and rises with income. (Sub. 9, p. 29)

On the other hand, any gains from eliminating community rating of ancillaries are also likely to be low given their demand characteristics.

### **Recommendation 3**

The Commission recommends that community rating no longer apply to ancillary cover.

### **Penalising discretionary risks?**

In theory there are good grounds for adapting current community rating to impose penalties for discretionary risks (such as smoking or substance abuse). However, the implementation of such penalties is complicated:

- it can be difficult to identify discretionary risks clearly; and
- the identified risk-taking groups may simply shift to the public system, without the desired deterrent effects. Putting a penalty on discretionary risk for users of private insurance, but not for users of the public system, is like taxing a product without taxing its close substitutes.

The Commission does not, therefore, endorse the use of such penalties within the current system.

## **10.3 Other price regulations**

The Commonwealth’s legislative power to control premium changes is limited, and no application for a premium increase has been disallowed for many years (chapter 3).<sup>3</sup> Even so, there are a range of controls exerted by the Commonwealth. Three principal arguments have been advanced for such

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<sup>3</sup> There is some question too over the constitutional basis for such a price control.

controls — solvency, avoidance of market power and equity (as noted in chapter 3). All have major limitations.

- *Solvency arguments* for price regulation ignore the existence of separate and more effective solvency rules targeted at the level of funds' reserves. These do not require subordinate controls which seek to influence the pricing decisions of the funds because they *may* have solvency implications. The principle here is one of regulators setting objectives, and then leaving firms with the freedom to achieve those objectives. Arguably, a fund, like any business, should have the autonomy to vary prices so as to trade out of looming difficulties. In fact, where premium increases have been constrained this has sometimes *precipitated* a solvency crisis (chapter 3).
- Arguments for price regulation based on the principle of *avoiding anti-competitive behaviour* by funds are also unconvincing. While the industry is concentrated, the scope for exercise of market power in pricing is limited (see chapter 5). If anything, collusive pricing can be encouraged by centralised price control. In any case, special purpose legislation dealing with potential breaches of competition policy is unnecessary, given the general legislative vehicles for dealing with such breaches.
- The Commission also notes that *equity* arguments for price regulation to protect the existing contributors of a fund are weak, given the portability provisions of health insurance. A fund which inappropriately increases premiums can be expected to lose members to other funds.

Price regulations — even if infrequently applied — can have another, perverse, impact. They could act as a deterrent to entry by new players used to operating in a market in which they don't have to seek government approval for the prices of their services. In this sense, price controls may deter those market oriented firms most likely to introduce innovative products and to be active in pushing for cost minimisation — thus keeping average premiums higher than necessary.

If premium increases were to be coordinated by government on an annual basis, a concern which has been raised by Medibank Private (Sub. D242, p. 12), then this would pose additional risks:

- Cost increases faced by funds occur randomly throughout the year. Funds would have to build larger reserves as a buffer for unpredictable cost shocks if they had to wait up to a year for a price increase. The only way in which that buffer could be built is through greater premium rises.
- The incentives for price collusion would be accentuated if insurers' price increases were dealt with simultaneously.



- Price discounts could not readily feature in recruitment drives and marketing other than at the appointed time, dampening competition.

The Department (Sub. D277, p. 6) acknowledged the possible perverse impacts of government pricing control. On the other hand, it maintained that ‘screening’ of premiums is necessary to ensure compliance with community rating. However, under the new system of community rating announced in 1996, there are no longer any required pricing relativities between single, couple, single parent and family tables. The only pricing requirement of community rating is that there should be no other price discrimination between people (for example on the basis of age, sickness, or ethnicity). Price *changes* do not have to be screened or monitored to ascertain compliance with this form of community rating.

#### **Recommendation 4**

The Commission recommends that *changes* in the price of health insurance products no longer be subject to disallowance.

The Commission also recommends that premium *changes* should not be subject to monitoring or screening.

## **10.4 Product regulations**

Funds have developed many different products over the last decade, including front end deductible, exclusion, and 100 per cent cover products. But they are not free from controls. Since all products are disallowable by the Commonwealth, funds face controls on any new products. In some categories the insurers are *obliged* to provide certain products; in other areas they must *not* provide them.

### **Products funds *must* provide**

Funds **must** cover psychiatric, rehabilitative and palliative care, at least at the default rate. These represent the last *explicit* product rules. There has been significant deregulation relating to product rules. For example, funds no longer have to include a common basic set of benefits in any hospital policy. Even so, the conjunction of these residual product rules with the reinsurance liability (see section 10.6) and the pre-existing ailments rule (section 10.5) has a greater impact on product choice than any single regulation by itself. They may, for

example, discourage funds from developing niche products which some consumers might prefer (box 10.3).

### **Box 10.3: Elective surgery products (ESPs)**

One of the major motivations for health insurance is the ability to avoid waiting lists for elective surgery (chapter 6). Yet insurers are unable to offer an ESP, say based on the top ten elective surgical procedures. If they were able to do so, they would (potentially) be able to market a product which offered older people a cheaper product than that required for full cover in a private hospital. Brian Collopy, Chair of the Advisory Committee on Elective Surgery in Victoria noted:

The majority of patients on the (waiting) list are non-urgent (category 3) and this number remains fairly constant at a little under 70 per cent. ... The vast majority of these patients have relatively minor disorders requiring limited treatment. ... Some examples ... would be arthroscopy, hernia repair, excision of skin lesions etc. Unfortunately many of these patients will have a long delay and some may not ever be treated as medical need will necessitate that the Category 1 and 2 patients have preference over them. ... This submission asks the Commission to consider a scheme to allow health insurance either for certain listed 'small' procedures ... or insurance up to a certain dollar amount eg \$5000. I believe that the introduction of such a health insurance scheme which is able to provide lower premiums should be attractive to both the young healthy citizens and the older members of the community. This should then in turn lead to a reduction in the total number of patients on public hospital waiting lists and a better utilisation of private health care facilities. (Sub. 185, pp. 1–2)

ESPs might increase the attractiveness of private health insurance for the elderly and help in turn to reduce public hospital waiting lists. Other niche products may also be attractive to consumers.

Niche products with too narrow a basis have one disadvantage for insurers — they potentially attract bad risks. For example, say a fund offered an ESP which provided cheap cover for only hip replacements. Under the current pre-existing ailment rules, the fund would attract opportunistic consumers who would hit the fund and run. This suggests that effective policies to increase the innovativeness and diversity of products for consumers require a set of mutually reinforcing regulatory changes. These include changes to allow niche hospital products, alteration of reinsurance and changes to the pre-existing ailments rule.

Whether ESPs and other niche products are feasible depends on whether such regulatory changes are introduced. That in turn depends on the *overall* consequences of such regulatory changes on private health insurance.

Selective cover has a number of possible advantages:

- Consumer choice. The current regulations are somewhat like requiring a consumer to buy a whole cow even if they only want one steak. Consumers wishing truly selective cover have few current options.
- Consumers can use the private system to purchase those services which are rationed, of lower quality or unavailable in the public system (for example, faster hip replacements, a single room etc) without having to pay premiums which cover services which are adequately provided in the public system.
- It can be partly used to filter lower risk from higher risk consumers ('cream skimming') which then generates lower premiums for low risk consumers compared to high risk consumers. As noted in section 10.6, *some* cream skimming may help to counter adverse selection, in the context of the current distorted system. In any case, reinsurance places a brake on the extent to which cream skimming can really force up premiums for the sick.
- The ability to tailor product cover — combined with freedom to determine which hospitals can provide care (see section 10.10) — increases the ability of funds to negotiate for appropriate cost effective care for their members.

On the other hand, selective cover is less consistent with any desire that the private health sector serve as a substitute provider of health care services rather than as an 'add-on' to the public system. In other words, the appropriate design features of private health insurance come back to the *desired role* of private health insurance in the wider health system.

Against the background of these different perspectives on the general role of selective products, the direction of policy has been towards liberalising rather than constraining consumers' choices within private health care. Does this suggest that the last restrictions relating to psychiatric, rehabilitative and palliative care should go?

The Commission undertook a detailed assessment of this question, taking into account the widely varying opinions of providers and funders (appendix F). The Commission finds that many of the arguments proposed by groups in favour of the existing mandated cover do not withstand critical scrutiny. Nevertheless, there remains some uncertainty over effective coverage of psychiatric illnesses were the mandated cover to be removed, reflecting in part the apparent stigma associated with mental illness. For this reason the Commission is not advocating cessation of mandated cover for psychiatric care, at least for the time being.

However, a number of key providers indicated problems associated with admission criteria and classification systems for psychiatric care (appendix F) — this suggests that mandated psychiatric cover should be limited to programs which meet appropriate criteria for admission, and that improvement of the classification system be given priority to facilitate case payment for psychiatric patients.

### **Recommendation 5**

The Commission recommends that guaranteed cover should be limited to psychiatric care which meets appropriate hospital admission criteria — with a short phasing-in period to develop these criteria.

If, however, this innovation fails to control costs and utilisation within two years, the Commission recommends that mandated cover be reviewed.

The Commission has also made a recommendation for cessation of default benefits (section 10.10), which should provide further incentives for providers of psychiatric services to maximise efficiency.

In contrast to the position of psychiatric services, no convincing arguments were provided that in-hospital rehabilitation and palliative care possessed similarly special qualities demanding attention over a whole range of other conditions.

However, the Commission does accept the concern of providers that in-hospital care is not always appropriate for palliative care (see chapter 3) — and has made a recommendation for changing the current adverse incentives posed by reinsurance for out-of-hospital care (section 10.6).

### **Recommendation 6**

The Commission recommends that compulsory coverage for in-hospital rehabilitative and palliative care no longer be required in every hospital table.

## **Products funds *must not* provide**

Funds **cannot** provide insurance for:

- PBS pharmaceuticals;
- the medical gap for out-of-hospital medical care;

- non-hospital based nursing home type care; or
- in-hospital medical costs above the Medical Benefits Schedule (except where an insurer has written a special contract with the doctor — so far, a rare occurrence).

These product regulations are a reflection of the uncoordinated and ad hoc way in which the health system as a whole has evolved over the years, and are intended to counteract perverse incentives that it generates:

- For example, the Commonwealth provides very large subsidies to provision of services. One ingredient in the attempt to contain costs is a copayment. The Commonwealth would bear the bulk of the costs of any increase in demand brought about by insurance of any gaps that it stipulates.

While Australia has its currently fragmented health care system, these product restrictions have the rational motive of deterring cost shifting. But they also affect the ability of insurers to cover all aspects of care (including out-of-hospital care) and to limit uncertain and potentially high out-of-pocket expenses faced by consumers. They should be reviewed as part of any wider inquiry into health.

Funds also **cannot** offer genuine no-claim bonuses. Theoretically, these restrict a potentially valuable way of addressing some moral hazard problems. While funds *are* allowed to offer products in which excess payments may be waived if a consumer has not made claims over a specified period, these ‘bonuses’ are only realised when the person ultimately gets sick, are not transferable between funds, and are only available on front end deductible products.

However, many participants responding to the Discussion Draft disagreed with the Commission’s proposal to permit no claim bonuses, arguing that:

- A system of no claim bonuses would discourage members from accessing the health system when they need it.
- The system will create incentives for some consumers to be treated in public hospitals to avoid possible loss of their no claim bonuses.
- Paying such a bonus would push premiums up for the sick — against the principle of community rating.

Selected comments from participants are summarised in box 10.4.

#### **Box 10.4: The introduction of a no claim bonus?**

There is very little support within the insurance industry for the concept of no claims bonuses. [They] are intended to deter the making of small claims: a very practical general insurance business method. However, if a person chose to defer health treatment for fear of losing their 'no-claim bonus' the outcome could be unfavourable for the patient and insurer alike. (AHIA, Sub. D221, p. 5)

If the no claim bonus offered was to operate in a similar way to car insurance it could have a detrimental effect by encouraging the postponement of the treatment of illness in order to accumulate or preserve the no claim bonus. Further, to the extent that those who receive a no claim bonus are able to save in premiums, other insured members ... would see their premiums forced up. (NIB, Sub. D236, p. 5)

a no claim bonus provides an incentive for a contributor to elect to be treated as Medicare patients rather than lose those non-claim bonuses. (HCF, Sub. D225, p. 6)

No-claim bonuses are in effect a form of experience rating. They would thus represent a major departure from the community rating system ... there would be significant risks ... for cost shifting to the Commonwealth ... possible loss of a no-claim bonus would lead many of those privately insured patients ... to elect to be treated publicly. While this would reduce costs to the funds, it would lead to further substantial revenue losses to the public system ... [No claim bonuses] may result in at least some people rejecting treatment that they may genuinely require ... [and] are likely to lead to substantially increased premiums for the elderly and for those joining insurance for the first time. (DHFS, Sub. D277, pp. 9–10)

In the current environment the introduction of no-claim bonus for hospital products would increase the cost to the elderly as the bonus would be more attainable by the younger members. (NMHI, Sub. D210, p. 9)

In the case of hospital treatment, the incentive of a no-claim bonus would work to shift the cost of treatment to the public system which offers free access to hospital care, not to forgo the cost of treatment altogether. (HCoA, Sub. D248, p. 3)

Consumers will benefit from the industry being able to offer wider product choices including ... no claim bonuses. (Medibank Private, Sub. D242, p. 12)

We cautiously support further consideration of no claim bonuses for health insurance contributors, as long as those bonuses are kept within a reasonable limit, so that premiums for people who do have to claim are not allowed to be substantially higher than no claims premiums. (The Consumers' Health Forum of Australia, Sub. D254, p. 4)

The Commission notes that every policy must bear its share of the reinsurance liabilities associated with the chronically ill and the old. This limits the scope for funds to use no-claim bonus products as a way of side-stepping community rating. Even so, premiums would rise for the sick and new entrants, and the scope for cost shifting to the public system might be significant.

**Recommendation 7**

The Commission recommends that the current restriction on no claim bonuses be maintained.

Finally, certain trauma products are not permissible. *Silver Cross* attempted to develop a product with insurance-like features which provided consumers with lump sum payments for certain illnesses — to some extent a valuable addition to product diversity. On the other hand, this product was arguably aimed at ‘cream skimming’ lower risk consumers: it would have escaped community rating and made no contribution to reinsurance.

There is, therefore, a tension between allowing any product diversity and, in the context of a system of community rating, controlling cream skimming initiatives both outside and inside the registered health insurance industry. Many products which cream skim *at the margin* have already been allowed. Reinsurance ensures that there are limitations on *any* attempt by a registered fund to cream skim. In this context, it is harder to argue for limitations on new products on the basis of their potential to ‘cream skim’. A consistent approach should be adopted.

## 10.5 Pre-existing ailment rules

As noted in section 10.2, a central feature of regulated private health insurance is guaranteed acceptance. That is, a person must be able to access private health insurance regardless of illness. The Act, however, recognises that *instant* access by anyone with a pre-existing ailment would destroy health insurance — a consumer would only pay a premium when they became ill. Accordingly the Act allows insurers to set certain (maximum) waiting periods after joining for pre-existing illnesses (chapter 3):

- Everyone must wait two months.
- A pregnant woman must wait (a convenient) nine months before being guaranteed coverage for the birth of her child.
- A person with an obvious pre-existing illness must wait twelve months before getting coverage of that illness.

But after these waiting periods, any person is guaranteed coverage. The Institute of Actuaries of Australia noted:

Guaranteed acceptance causes difficulty for insurers because, in a universal health insurance scheme like Australia’s, the guaranteed acceptance provision

bestows on persons who have no private insurance a right to obtain private insurance when they most need it, ie when they anticipate being heavy users of services covered by the private insurance. Hence, the guaranteed insurability provision has to be tempered with anti-selection mechanisms such as pre-existing exclusions and waiting periods. In Australia, however, the maximum permitted anti-selection waiting period provisions are quite insufficient ... the cost of private health insurance is increased significantly by these inadequate anti-selection provisions. (Sub. 141, pp. 5–6)

This raises the question: what is the appropriate waiting period for access to private health insurance for a pre-existing ailment? What are possible arguments for and against pre-existing ailment rules (PEARs)?

### **Arguments in favour of pre-existing ailment rules**

Many ailments are apparent in early life — for example, cystic fibrosis and diabetes. If the parents of a child with such a condition had not insured the family, then in a de-regulated environment it is unlikely that they would ever be admitted to private health insurance.

On the other hand, it should be noted that this argument does not require maintenance of the existing regime of PEARs. An alternative might be to allow guaranteed entry of such people, so long as they were under a particular age — say 25 years.

### **Disadvantages of pre-existing ailment rules**

Arguably PEARs are anachronistic features of the private health insurance system, given the ‘free’ public hospital system. Under the current health care system, people with ailments, however or whenever acquired, are covered by compulsory public insurance, although they may face significant waiting periods depending on their ailment. There seem to be few equity grounds for allowing typically richer people with pre-existing ailments the choice of advantaged access to the private system, as well as the usual access to the public system, while poorer people have access only to the public system. This is much the same argument against the equity claims for community rating developed in box 10.2.

If there are weak equity arguments for PEARs, there are strong efficiency *and* equity arguments against them. PEARs, together with community rating, contribute to the instability of private health insurance by encouraging ‘hit and runs’ by opportunistic consumers, as highlighted by some submissions:



I have compared the status of today's Private Health Insurers to that of a bookmaker who is required to continue to bet on a race after it has concluded. (Wilson Tuckey, Sub. 12, p. 3)

Qualifying periods protect existing members from unconscionable action by those who would join for a limited period simply in order to obtain benefits to cover immediate necessary treatment, and then abandon their contributions once they have received a 'clean bill of health'. (Australian Unity Friendly Society, Sub. 163, p. 65)

PEARs also:

- generate transfers from long-term contributors to late or temporary contributors — many see this as inequitable;
- discourage earlier, prudent membership of insurance, compounding the adverse selection problem; and
- reduce the ability of funds to cater to the needs of non-opportunistic consumers, including lower income elderly households — for example by limiting funds' incentives to develop elective surgery products (box 10.3).

Overall, by encouraging late entry of bad risks, PEARs reduce the capacity of private insurers to widen the risk pool on which community rating is based.

If PEARs were eliminated, insurers in a competitive market may of course still offer cover for pre-existing ailments, but on terms that reduced the perverse incentives.

In the Discussion Draft, the Commission sought comment on whether guaranteed access to private health insurance of a non-dependent *adult* with a pre-existing ailment is intrinsic to community rating. It further suggested that, subject to an exemption for guaranteed entry in early adulthood, the impact and desirability of removing pre-existing ailment rules be subject to broader review.

In response, MBF contended that 'deferred coverage for pre-existing ailments is not intrinsic to community rating' (Sub. D203, p. 7). It considered that 'decisions made by funds in this regard can become another, and very visible, competitive element' (Sub. D203, p. 7). However, other participants considered that PEARs should continue.

The Consumers' Health Forum, for example, stated:

Given the Government's commitment to a significant ongoing role for private health insurance, it follows that the private system will also be expected to continue to provide for long term chronically ill consumers. Any move to relax the regulations requiring funds to provide insurance to people with pre-existing conditions would be a significant step away from community rating ... (Sub. D254, pp. 4–5)

The Department also considered guaranteed access was intrinsic to community rating:

Community rating ... ensures that everyone is able to access private health insurance and that people are not discriminated against on the basis of age, sex or health status. Therefore, the department considers that guaranteed access by non-dependent adults with a pre-existing ailment after a suitable waiting period is intrinsic. (Sub. D277, p. 11)

On balance, the Commission considers that there is a case for maintaining some form of PEARs while community rating principles continue to apply. However, the Commission also considers that the PEARs should be included in any review of community rating.

### **Recommendation 8**

The Commission recommends that pre-existing ailment rules be examined as part of any review of community rating.

### **Adapting the current system**

Many insurers find the existing waiting periods associated with pre-existing ailments too short and have argued for extensions. For example:

MBF believes that waiting periods for very high benefit (procedures) should be more realistic. It is not the person who has elected not to be a member of a fund who needs protection when they change their mind; it is the people who have been members for some time and who have to pay extra costs borne by funds through 'hit and run' or other short term memberships. (Medical Benefits Fund of Australia Limited, Sub. 29, p. 11)

One possibility is to extend waiting periods for those ailments where 'hit and runs' have been most severe — for example in obstetrics (as noted by the Institute of Actuaries, Sub. 141, p. 6).

As well, the Department (Sub. 175, p. 23) has observed that the existing obstetric waiting period is also a source of 'disputes between members and funds as to whether a birth was premature or not'. The Department supported a

move to a 12 month waiting period for obstetrics cases. It also considered that there was a 'strong case' for extending the waiting periods for pre-existing ailments 'with age of entry to private health insurance' (Sub. D277, p. 11).

The APHA agreed that a nine month waiting period was too short for obstetrics. However, it noted that 'marriage and planning of a family are also key reasons to take out long term insurance' (Sub. D217, p. 17). It thus considered that extension of the waiting period to five years could discourage many people from taking out insurance, and proposed that a period of two years apply.

The Commission also supports the extension of waiting periods for other conditions commonly subject to 'hit and runs'. According to the AHIA, conditions 'particularly subject to strategic entry' include: psychiatric treatment, cardiac surgery, eye surgery, reproductive services, and joint replacement (Sub. D221, p. 3).

The Commission considers that the Department and the health funds should consult on appropriate maximum waiting periods for ailments where opportunistic consumer behaviour is a source of instability.

#### **Recommendation 9**

The Commission supports in principle the extension of maximum waiting times for conditions commonly subject to 'hit and run' behaviour (such as obstetrics), and recommends that appropriate arrangements be devised by the funds and the Department of Health and Family Services.

## **10.6 Reinsurance**

Reinsurance is inaptly named. It is not genuine reinsurance (appendix D), but rather a common pool for two groups of bad risks into which all funds compulsorily contribute. Funds with a greater proportion of lower risk people (the young) pay into the reinsurance fund, while those with a greater proportion of higher risks (the old and those with hospitalisation of 35 days or more) receive transfers from the fund. It is designed to protect community rating (chapter 3 and appendix D) by reducing the scope for cream skimming of low risk, younger consumers by health funds.

Arrangements have changed a number of times over the past decade, with the most recent changes being introduced in 1995 to remedy major design faults which were introduced in 1989. The reinsurance arrangements are contentious because changes can produce sizeable gains for some funds and sizeable losses

for others. Chapter 3 summarises the (often opposing) views of various insurers, while appendix D examines closely the functioning of reinsurance and a number of the competing schemes proposed to achieve its objectives.

Moreover, the impact of reinsurance has been growing as the age distribution of fund membership tilts towards the elderly — so that any flaws in reinsurance are magnified.

The current reinsurance arrangements have a number of potential drawbacks (chapter 3 and appendix C). They:

- reduce incentives to contain costs for the old;
- reduce incentives to use ambulatory care rather than hospital care, even where the former is cheaper than the latter;
- create some (very weak) incentives for longer term hospitalisation;
- increase the insurance loading on any products offering lower benefits to consumers such as front end deductibles and exclusion products, thus making these less attractive to consumers;
- substantially reduce the actuarial attractiveness of genuine catastrophe insurance products (which either cover selective, very expensive operations, or have very high excesses), so that such products are not available for consumers;
- effectively eliminate the possibility of specialisation in insurance products;
- do not equalise across all relevant risk categories, which still leaves room for funds to cream skim — which may erode the principle of community rating; and
- do not compensate states with older populations.

There are a number of possible responses to these perceived problems.

### **Eliminate reinsurance altogether?**

While this may be appropriate in a risk rated system or in a lifetime community rated system, the Commission notes that there would probably be major problems from abandoning reinsurance in the current community rating system (appendix C). It would most likely destroy community rating, because funds could then target the young and healthy with impunity by using selective products, leaving older, sicker people with relatively high premiums.

As well, reinsurance *may* play a potentially valuable role in any transition to another system (Brown, Sub. 34). For example, the reinsurance pool could be subsidised by government (as was done in the past) during such a transition.

### **Introduce stronger incentives for cost minimisation?**

Two features of the current reinsurance arrangements militate against funds introducing effective cost control (see appendix D for more details). First, funds which are effective at controlling utilisation and unit costs subsidise those which are not, reducing overall incentives to cost minimise. Second, funds do not face strong incentives to seek cheaper care options out of hospital because such benefits are not eligible for inclusion in the reinsurance pool.

#### *Effective funds subsidise ineffective funds*

This arises because the existing ‘Mixed 2’ scheme is a compromise between:

- a composition based scheme (in which funds’ contributions to the reinsurance pool are determined by the demographics of their membership — in this case the proportion of people over and under 65 years old). This provides strong incentives for cost minimisation, but with its very limited demographic categories, does not actually achieve risk equalisation between funds; and
- a usage scheme (which makes up for risk categories omitted under the crude composition scheme by partly compensating funds for actual benefits paid). This weakens cost containment incentives, but counters cream skinning.

The current arrangements only provide weak incentives for cost minimisation associated with the elderly, because nearly 80 per cent of these costs are pooled. A variety of remedies exist:

- A simple, but crude solution would be to lower the share of the costs associated with high risk groups which are pooled, say to 0.5 instead of 0.79. This would penalise funds with older people, but would increase incentives for cost minimisation.
- ‘Mixed-3’ or similar reinsurance arrangements could be introduced, as discussed by MIRA (1994; Sub. D239). The ‘Mixed-3’ arrangement provides incentives for funds to minimise unit costs, partly compensates funds for differing utilisation rates<sup>4</sup>, and compensates funds for varying family sizes or

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<sup>4</sup> If funds bore none of the costs of utilisation above the state average, this would diminish their incentive for conducting utilisation reviews and preventative health campaigns. On the other hand, if funds bore all of the costs of utilisation, this would encourage cream skinning (MIRA 1994, pp. 11–12).

membership composition (see appendix D). These arrangements require casemix data for the private hospital sector, and could not be implemented until adequate data were gathered. Older versions (such as 'Mixed-1'), which do not rely on casemix data, could be implemented immediately.

- A composition scheme could be introduced. A number of different versions have been proposed — the simple composition schemes examined by MIRA (1993) such as COMP-1 and COMP-2, the PROFILE scheme discussed by MIRA (1994, p. 21) and the proposal from Brent Walker (Sub. 73 and D197). The last two are the most promising. Walker suggested that hospital risks could be partially equalised between insurers using the cost weights from the Medicare hospital financing agreements between the Commonwealth and the states. This version partly compensates funds for varying family sizes and membership composition (with, as noted previously, the latter at a finer level of disaggregation than under the MIRA arrangements<sup>5</sup>). PROFILE calculates the overall drawing rate of a fund if it had the state membership composition, but its own drawing rates for each socio-demographic category. A fund with better utilisation rates and lower unit costs retains all the gains under both schemes. Neither composition scheme discriminates against old or other high risk demographic groups, but both generate disincentives for enrolment of sick people within any risk category. However, this is unlikely to be a major problem. Funds are not allowed to select between sick and well people, and so it is uncertain whether the incentive to select the well could be realised.
- Gross (1997) has proposed a long-run move to a system of reinsurance which takes account of the demographics of funds, but also of the assessed health status of its members (using a questionnaire). Looking at ex ante health status, rather than realised benefits paid to the sick, has the virtue that it maximises incentives to lower utilisation and costs, but completely eliminates incentives to recruit the healthy within any given risk class. Gross's approach also has the virtue that it may provide some of the information needed for a more systematic approach to preventative care for members (for example along the lines described by Owen, Sub. D208). Gross's model could be seen as a sophisticated compositional scheme, in which the age, gender, location, *and* the health status composition of membership is used as the basis for determining payments to and from the reinsurance pool.
- Proportional reinsurance (examined in more detail later) may also have complementary value when combined with the above schemes. First,

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<sup>5</sup> Some of what MIRA terms as differences in utilisation will in fact reflect underlying differences in membership composition. To that extent, the differences between the MIRA and Walker proposals are not that great.

proportional reinsurance facilitates insurance products with some form of patient copayment — which may reduce moral hazard. Second, funds with lower benefits per (age corrected) SEU will bear less of the burden of reinsurance than other funds, creating incentives for funds to manage costs effectively.

### *Disincentives for out-of-hospital care*

A number of participants pointed out that the scope to cover cheaper, more appropriate, out-of-hospital care should be increased (for example, the Royal Australian and New Zealand College of Psychiatrists, Sub. D260, p. 2 and the Motor Neurone Disease Association of Australia, Sub. D241).

The existing system of reinsurance reduces the incentives for out-of-hospital care, since benefits paid for such services are not eligible for pooling. Subject to ensuring that out-of-hospital care is a substitute, not an add-on to in-hospital care, there are grounds for including such care arrangements within reinsurance. Composition schemes do this automatically since they are like risk-based capitation payments to the insured — with fund holders unconstrained in their choice of treatment coverage.

### **Introduce proportional reinsurance?**

The current system imposes the same reinsurance liability on any policy, regardless of the benefit it offers. This may have adverse impacts on:

- *equity*. People buying a lower benefit table have to contribute far more to reinsurance as a percentage of the value of the insurance product than people buying a higher benefit table.
- *innovation*. A flat reinsurance levy per table may stop funds from providing niche products, such as ESPs discussed previously. It may also discourage specialisation of insurers in which consumers assemble (by themselves or through a broker) an insurance package that suits their needs.
- *incentives to reduce moral hazard* by consumers (and to contain costs by funds, as noted in the previous section). Front end deductible and other copayment insurance products bear a greater percentage liability towards reinsurance than 100 per cent cover products. This increases the relative price of products which provide incentives to reduce hospitalisation expenses.
- *stability* of private health insurance. As discussed in the next section, some cream skinning is optimal in the context of the current system, because it encourages recruitment of younger, lower risk members, who then cross-

subsidise the old and sick. Young people tend to buy low benefit tables which bear a disproportionate burden of reinsurance. This increases the price of such policies and lowers the attractiveness of insurance to just those people on whom the stability of community rating depends.

Mercantile Mutual (Sub. 142) proposed that a system of proportional reinsurance be used to address these limitations. Under proportional reinsurance, the contribution by any given policy to the reinsurance pool is proportional to the benefit rate provided by that policy.<sup>6</sup> If introduced, the prices of policies with full cover would rise, while prices of those which offered limited benefits would fall (box 10.5).

### **Box 10.5: The impact of reinsurance on catastrophe insurance**

If a policy offered a consumer private hospital cover for catastrophes (say health costs above \$5000) the expected benefits paid out to the policyholder will be low, because most hospitalisation episodes cost less than \$5000 and most people do not claim in any given year. Say that the expected benefits were around \$50 per policy-holder. Under the current system, the policy will also have to make some contribution to fixed management costs (say about \$45). But it also has to contribute fully to the reinsurance pool (currently around \$240 per SEU). This is slightly offset by the way reinsurance affects the benefits of the elderly in the fund. Overall, the policy will cost around \$300 or six times more than its value to a risk neutral consumer.

Proportional reinsurance would take account of the fact that the benefits on the catastrophe policy were roughly one tenth of those relating to full cover products. The cost of the product would be around \$100 under a proportional reinsurance arrangement, making it much more attractive to consumers.

While proportional reinsurance solves many of the problems posed by levying a fixed amount on every table, it has a number of potential drawbacks.

Many participants responding to the Discussion Draft saw proportional reinsurance as either complicated administratively, or in its simple forms, inimical to the principle of community rating (table 10.3).

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<sup>6</sup> Arguably the expected benefits paid should be calculated in relation to the whole population of insured, not just those who took up the policy. This is because of the risk selection problem. The people attracted to products with lower benefits are those with lower claims. If a proportional reinsurance system were based on *actual* average benefits paid, then this would incorporate two separable effects: (a) the fact that, for the whole population of insured, the product offered lower average benefits; and (b) that the product was able to select lower risk people. Within the constraints of community rating, it is arguable that only the first effect should be counted in a system of proportional reinsurance.



Proportional reinsurance would accelerate the further development of exclusion products, encouraging the breakdown of community rating. There would be significant difficulties in determining appropriate reinsurance contributions for the vast array of exclusion and copayment products. (National Mutual, Sub. D210, p.6).

Proportional reinsurance might push cream skinning beyond its optimal point. If premiums for those wanting full cover products (the old) rose too steeply, then pressures on the public hospital system might intensify. On the other hand, it is unlikely that *most* people would want insurance products with *high* front end deductibles or a *large* number of exclusions. If this is correct, then proportional reinsurance would allow some consumers the opportunity to buy these niche products, while not substantially affecting the prices of remaining tables (appendix D).

A move to proportional reinsurance also has to be assessed against other changes afoot in the system. The new insurance rebates will offset the disproportionate impact of the current system of reinsurance on lower benefit policies because they are specific, not *ad valorem*, subsidies. For example, a person buying a front end deductible product will get a bigger proportional reduction in premium than a person buying a full cover product.

### **Introduce more risk categories to reinsurance?**

The existing reinsurance arrangements recognise only two high risk groups (those aged over 65 years, and those with more than 35 days of hospitalisation), whose costs are subsidised by the remaining low risk group. The existing arrangement encourages funds to find lower cost groups within the lowest risk category. If more risk categories were introduced (for example, as advocated by Brent Walker, Sub. 73 or by Gross 1997) this would limit such cream skinning.

Table 10.3: Participants' views on reform of reinsurance

<i>Participant</i>	<i>National reinsurance</i>	<i>Proportional reinsurance</i>	<i>More risk categories</i>	<i>Out of hospital included</i>	<i>Persons covered not SEUs</i>	<i>Provide bigger cost minimising incentives</i>
AHIA (Sub. 108 & D221)	?			✓		
HBf (Sub. 33 & D228,	✗	✓				
HCF (Sub. D225 & D276)	✗	✗		✓	✗	✓ mixed 2 variant
HIRMAA(Sub. D204)	✗	?			✓	✓ mixed 1 and 3
MBF (Sub. D203)	✓	✓				✓
Med. Priv. (Sub. D242)	✓	✓				✓
MM (Sub. 142)		✓				
NMHI (Sub. D210)	✓	✗	✓	✓		✓ Brent Walker composition
SGIO (Sub. D237)	✗	✓	✗			✓ mixed 3 variant
Brown (Sub. D231)	✓	✓			✓	
Carroll (Sub. 9 & D213)	✗	✓				
Gross (1997)	✗		✓	✓	✓	✓ sophisticated composition
MIRA (Sub. D239)	✗	✗	✓		✓?	✓ mixed 3
Scotton (Sub. D234)		✓		✓		✓
Walker (Sub. D197 & 73)	✗		✓	✓	✓	✓ composition
APHA (Sub. D217)		✗				✓ a pure composition scheme
DHFS (Sub. D277)	✗	✗			✓	✓ mixed 1 and 3
PHIAC (Sub. D262)	?	✗				

What are the problems generated by cream skimming which would warrant intervention? In the context of a *closed (compulsory)* system of private health insurance, Van de Ven and Van Vliet (1992) identify three problems with cream skimming:

- Access to health care for the chronically ill may be hindered (because insurers will try to avoid contracts with providers with a good reputation for dealing with high cost ailments). Alternatively, premiums for this group will be raised (if, for example, top cover 'no excess' products are typically consumed by people with a higher probability of illness).
- It may distort efficiency priorities within funds so that insurers may make investments in cream skimming rather than make investments in minimising the costs of health care (such as better contracting).
- It is a 'zero sum game': while individual insurers gain from cream skimming, they only shift the costs of higher risks to other insurers or to high priced products.

Van de Ven and Van Vliet conclude that:

Therefore, an effective prevention of cream skimming is a necessary condition in order to reap the fruits of a competitive health insurance market with a regulated premium structure. (1992, p. 24)

On the other hand, with a *voluntary* system of private insurance, some cream skimming may be optimal. Why is this so? Community rating under voluntary private health insurance is unstable because the low risk consumers leave, pushing up premiums for the remaining higher risk consumers. This implies that there is a trade-off between:

- attracting some new (previously uninsured) low risk consumers with a competitively priced exclusion product or a front end deductible, so long as these partly subsidise higher risk consumers; and
- either poaching low risk consumers from one fund to another (a version of 're-arranging the deck chairs on the Titanic') or increasing the prices of products tailored to sicker consumers.

Thus while cream skimming is unequivocally inimical to the principle of community rating within a compulsory system, it can serve a partly protective role within a voluntary insurance system. Accordingly, while some expansion of risk categories may be worthwhile, this should be tempered by the need to recruit low risk consumers to private insurance — to widen the community rating pool.

### **Introduce national reinsurance?**

Currently, the principle of community rating stops at state borders. A state with many more older people (for example, Victoria) receives no contribution from states or territories with fewer old people (for example, the Northern Territory). An everyday example shows how this could be seen as inequitable:

Mrs Jones lives in Victoria, is 70 years old ... Because Mrs Jones is in Victoria, where 44 per cent of the over 65 year old population have private health cover, she enjoys less support through community rated premiums than does the average Australian (39 per cent of the over 65 are covered for Australia as a whole). (National Mutual, Sub. D210, p. 7)

A shift to *some* system of national reinsurance would appear logical within the broader context of community rating.

However, the simplest measures for achieving a national pool would have three undesirable effects:

- They would weaken incentives for cost minimisation by individual funds. The existing reinsurance formulae favour cost shifting by any single fund to the remaining funds in that state. However, currently each state has a few major players. They have much weaker incentives to cost shift because of their dominance. Within a national system, no single player is dominant — and cost shifting incentives would rise.
- They would result in sizeable transfers between states quite unrelated to the differential risk of the different populations. Different states have different average hospital costs, reflecting among other factors, the utilisation of (subsidised) public hospital bed days relative to private hospital bed days. For example, drawing rates for both the young and the old are significantly lower in NSW (appendix D).
- They would penalise funds which had sought to recruit young members. Some states appear to have a much smaller representation of young people in health insurance than the demography of the state would suggest (for example, Victoria).

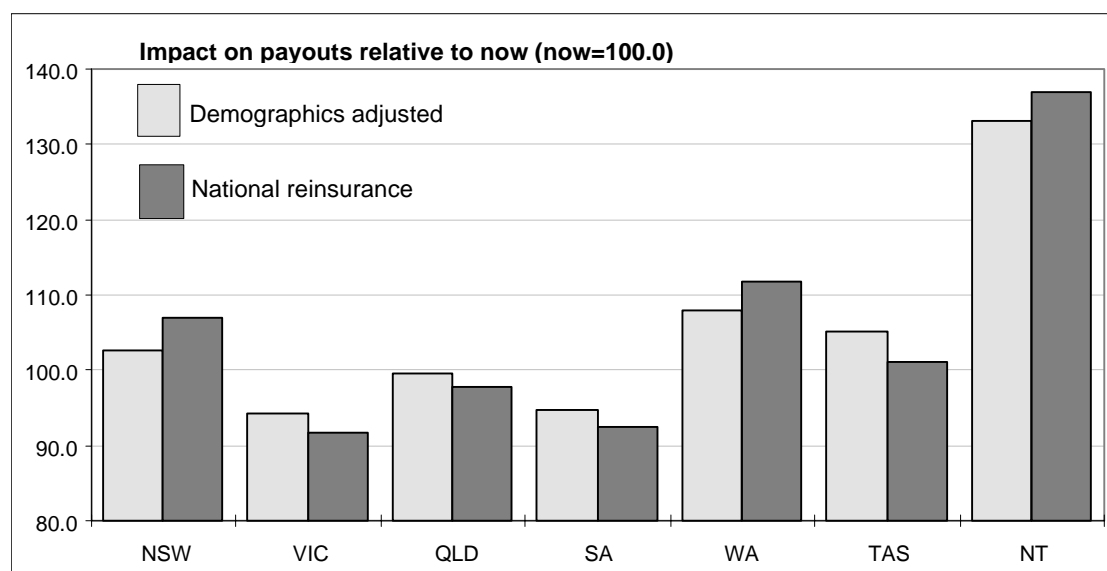
To assess the implementation of national reinsurance, the Commission:

- examined the magnitude of changes to payouts in each state which would ensue from adoption of national reinsurance; and
- calculated the hypothetical impact on payouts if the proportion of beneficiaries 65 and over in all states were set at the national average (appendix D).

Under the first scenario, states which have lower drawing rates than other states are penalised — whereas under the second scenario the various drawing rates applying in each state are taken as given and applied to a different membership base. The difference, therefore, between the two impacts<sup>7</sup> indicates the extent to which interstate variations in average drawing rates reflect demographics versus other determinants of costs (such as differential charges and utilisation rates for any given age group).

It was found that national reinsurance would substantially disadvantage some states by increasing payouts (and therefore premiums) — with payouts rising by over 30 per cent in the Northern Territory and over 10 per cent in Western Australia (figure 10.1). On the other hand, national reinsurance would create only modest pressure for premium declines in states which benefit.

Figure 10.1: Impacts of national reinsurance



Source: Appendix D.

However, in those states which would record the biggest changes, most of the increase would be attributable to demographic differences, not to drawing rate variations. Of course, the danger is that unless a national reinsurance scheme was carefully designed, it could sufficiently weaken incentives for cost

<sup>7</sup> In fact, there are some anomalies which somewhat complicate comparison when the difference is modest — while a national reinsurance scheme must balance flows in and out of states, the demographic adjustment technique does not ensure that flows balance (Appendix D).

minimisation that the flows between states would ultimately reflect ‘inefficiency dividends’ rather more than ‘demographic corrections’.

Thus, any move to national reinsurance would need to apply radically different formulae than the current arrangements in order to control cost-shifting incentives. Such a system may be hard to design.

All funds except three (National Mutual, MBF and Medibank Private) strenuously opposed any move to national reinsurance (table 10.3 and chapter 3). Generally, as in other respects, attitudes to national reinsurance are consistent with the self-interest of the funds concerned.

Ultimately, the issue of whether to adopt a system of national reinsurance depends on how far the government wishes to push the principle of community rating — a concept already riddled with anomalies. National reinsurance generates transfers from states with typically younger membership to those with typically older membership — it is a zero sum game between funds and their members. There are no efficiency gains. The disruption to membership in ‘young’ states from immediate implementation of national reinsurance would be large and the benefits in ‘old’ states small. As well, any benefits from shifting the burden of health costs from older to younger people would have to be set against any efficiency losses that might stem from flaws in the design of a system of national reinsurance.

#### **Recommendation 10**

The Commission does not recommend implementation of national reinsurance. However, any review of community rating should include consideration of this issue.

If the government *were* to introduce national reinsurance:

- it would need to be phased in over time to minimise disruption to states with younger age distributions; and
- it should also be designed to avoid incentives for cost shifting between states.

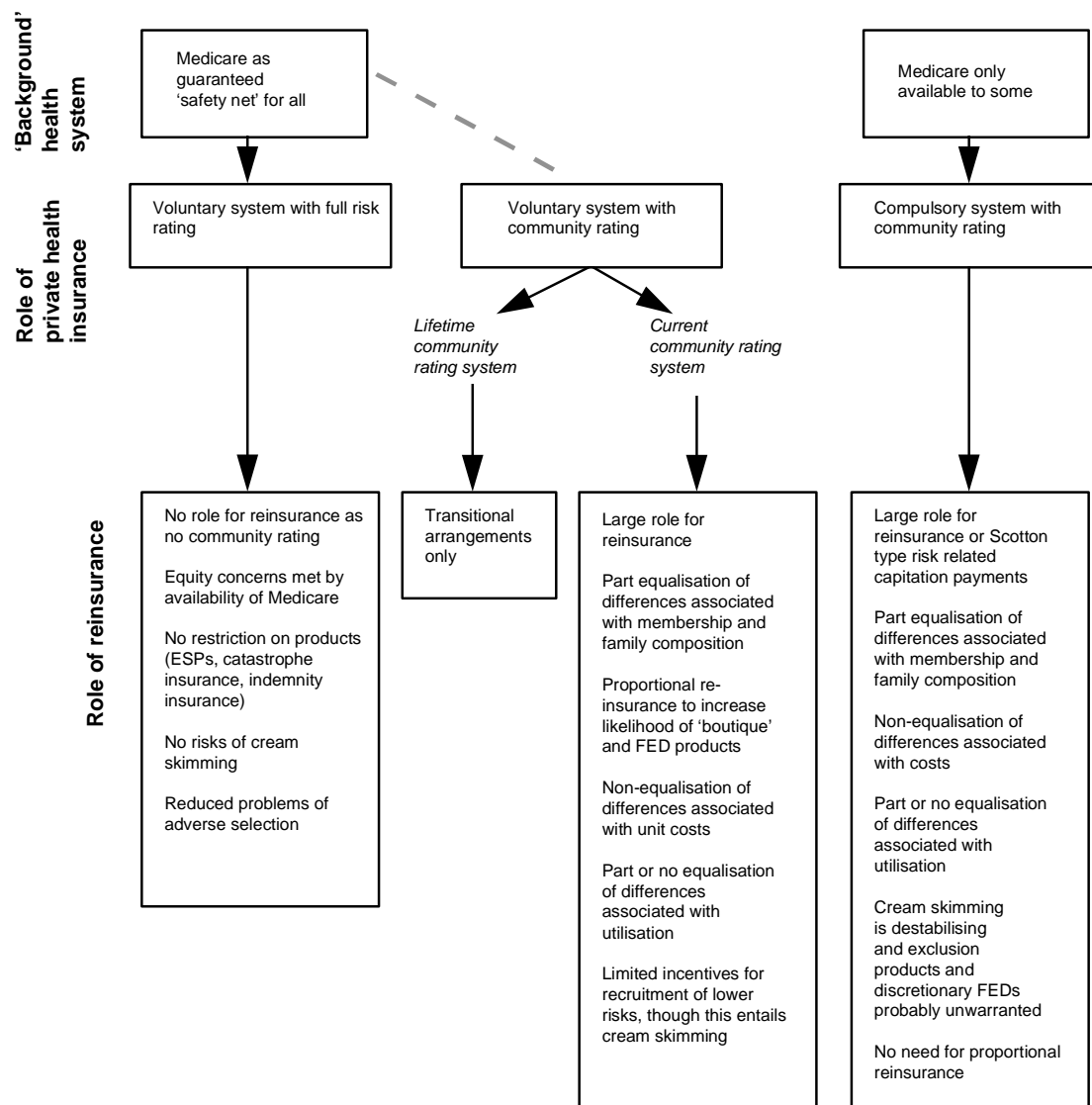
#### **Criteria for assessing any reinsurance proposal**

In historical terms, reinsurance has constituted a series of pragmatic arrangements for supporting community rating and, prior to the mid 1980s, a vehicle for government subsidisation of the worst risks. The sophistication of the arrangements has been tempered by inadequate data on fund membership

and casemix. These constraints are rapidly vanishing, so that more sophisticated arrangements are now feasible.

The Commission emphasises that the design of the reinsurance arrangements is inextricably linked with the role of private health insurance in the broader health system (figure 10.2). Its current, confused, role reflects the paradoxes associated with a voluntary system of community rated private health insurance.

Figure 10.2: The role of reinsurance in different systems



But what are the principles for designing a better system given the objectives of retaining a voluntary community rated private health insurance industry? The Commission identified four fundamental principles:

- *‘equity’* between people with different probabilities of becoming ill (the ‘community rating’ principle). The principle of community rating suggests that differences in premiums due to family sizes and membership composition should be equalised. There are grounds for more age/sex groups to be used as a basis in such equalisation than under the present system. Arguably, there are other applications of equity too. For example, it may be regarded as ‘fair’ that the liability associated with reinsurance should be proportional to the expected benefits paid out by policies.
- *stability of private health insurance*. Given the critical impact of adverse selection on the stability of the system, there should be some scope for funds to target new products at lower risk groups in order to recruit new members. There needs to be a tradeoff between re-balancing the demographics of the insured (and thereby strengthening community rating in the long run) and going too far with cream skinning so that prices for the old and sick rise too much (thereby undermining community rating). As well, the rules should not be open to ‘gaming’ by funds, as have various past versions.<sup>8</sup>
- *efficiency*. The efficiency consequences of reinsurance have two dimensions. First, funds with lower unit costs and utilisation (for example, obtained by negotiating better deals for consumers with providers, and in managing utilisation where appropriate) should not have to subsidise funds with poorer cost efficiencies. This suggests that reinsurance schemes should not be based on utilisation, but should be *composition* schemes (see appendix D). Second, reinsurance should create incentives for selecting the minimum cost, quality health care options for people — not just the ones which require in-hospital treatment. Reinsurance should not discourage product innovation or copayment products, since these are sources of efficiency gain to the health system.
- *administrative feasibility*. This includes a range of pragmatic considerations such as transparency and operational ease (subject to changing information availability and computer technology).

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<sup>8</sup> For example, under the arrangements in place from 1989 to 1995, funds had incentives to load as many members as possible into supplementary tables. They introduced new ‘supplementary’ tables which very slightly increased benefits payable to private hospitals above the basic table rate. Some funds re-enrolled all basic table members into such tables, gaining from the reinsurance while meeting the letter of the law.



The Commission notes firstly that any move to a new scheme may or may not involve sizeable changes to the transfers between funds. The magnitude of any changes in flows is not a good guide to any benefits from better incentives. For example, the Department (Sub. 175, p. 19) implied that the typically small changes in flows from implementation of 'Mixed-1' suggest few advantages from a shift from the current system. This ignores the potential benefits from creating better incentives to cost minimise in funds.

Secondly, more elaborate arrangements may encourage funds to distort the statistics on which the reinsurance calculations are based. This could be countered by an appropriate set of penalties and the application of risk management techniques in common use elsewhere (such as the ATO).

**Recommendation 11**

The Commission recommends that new reinsurance arrangements be devised which meet the following criteria:

- differences in costs among funds due to the demographic characteristics of their membership (such as age, family size and gender) should be equalised;
- funds with lower unit costs and utilisation should not have to subsidise funds with poorer cost efficiencies;
- there should be some scope for funds to target new products at lower risk groups to recruit new members, as long as community rating is not destabilised; and
- out-of-hospital care should be eligible for inclusion as part of any reinsurance arrangement.

The Commission considers that a composition based reinsurance scheme would best meet these criteria:

- subject to introducing additional age brackets for the elderly, so that funds with a greater proportion of very old members are not disadvantaged; and
- with appropriate transitional arrangements so that the impact on funds disadvantaged by the changes is spread over a number of years.

The Commission also considers that:

- proportional reinsurance, while entailing some risks, may be a useful complement to the above changes. It should be examined for its workability; and
- reinsurance will need to be adapted if unfunded lifetime rating is introduced.

## 10.7 Governance and conduct of health insurance funds

Australia's private health insurance industry is dominated by mutual funds, with governing structures different from other large corporate entities (chapter 4). The ownership structure of the industry raises a number of issues:

- governance;
- the scope for takeovers;
- equity raising;
- taxation; and
- competitive neutrality.

### Governance

Mutual funds are not for profit and, accordingly, do not have to generate returns to shareholders, nor be accountable to shareholders for management decisions or operating procedures. Directors are not usually elected by members (although there are member elections in HCF, MBF and some of the restricted funds).

Peter Carroll observed:

Control of the industry appears to be much more concentrated than its mutual nature would suggest. Contributors to many of the major insurers have very weak rights in relation to approval of financial statements, attendance at meetings or the election of directors. The largest insurer, Medibank Private, is controlled by the federal government, and the second largest insurer, MBF, is effectively controlled by the Australian Medical Association. .... Among many smaller insurers ... there is a greater degree of member control, but it is diffused and management of the organisations is not easily influenced. (Sub. 9, p. 8)

While the Commission is not in a position to assess any claims relating to particular funds, there is a potential for conflicts of interest and lack of accountability and transparency in some current governance arrangements.

To some fund members, the decision making of the funds seems remote and unresponsive:

To me they are in the nature of a secret society. (Sub. 116)

A lack of accountability has led to an unresponsive, self serving culture. (Sub. 112)

Members do not routinely receive information on the financial and management operations of the funds (Sub. 64, 77 and 149).

The Department noted that it:

... would see advantage in more public reporting in such areas as cost controls, cost of services provided, out-of-pocket expenses and improved information on products. (Sub. D277, p. 14)

The Commission sought to discover the impact of the mutual character of the industry on innovation, efficiency and service quality. However, the near domination of the industry by not-for-profit entities makes it virtually impossible to analyse the relative efficiency and conduct of mutual organisations and for-profit funds.

Analysis of the impacts of ownership and governance in other areas of the health sector does not provide clear guidance to the relative efficiency of non-profit and for-profit entities. For example, in the US, for-profit nursing homes have average costs 5 to 15 per cent lower than their non-profit counterparts. On the other hand, there is no unequivocal evidence of disparities in the relative costs of admission to for-profit and non-profit hospitals (Marmor et al 1987).

The governance structures in for-profit corporations are designed to minimise costs and to provide an efficient way in which shareholders can scrutinise management. Are there grounds (as Peter Carroll suggested) for requiring that all mutual insurers hold member elections of directors, hold general meetings and disclose their finances in a manner similar to publicly listed corporations?

The major barrier to implementation of corporate-like governance structures is potentially large transactions costs. Most for-profit entities have relatively few dominant shareholders, with the right incentives and resources to appropriately monitor management behaviour. Mutuals, by definition, have diffuse membership. There would be large transactions costs in providing all the relevant information to members, and it is far from clear that the financial stake of any single member is sufficient to create strong incentives to scrutinise managers for their effectiveness.

De-mutualisation (setting up conventional shareholder ownership) avoids these difficulties, but would raise other concerns about the administrative costs of any transition.

The Commission observes considerable variation in the governance structures, information dissemination and transparency of different funds (chapter 4).

The Commission considers that, within the scope of their particular legal form, mutual funds should seek to increase external and internal disciplines on their performance, including improved transparency and accountability of management and directors.

## The scope for takeovers

There is no scope for ‘hostile’ takeovers of badly performing mutual funds — directors of mutuals can only relinquish control voluntarily. As noted by Medibank Private:

there needs to be a mechanism whereby a ‘hostile’ takeover is possible. That is, a bid for takeover is not finished where a fund ‘simply’ rejects the offer of another and continues operation. (Sub. 168, p. 34)

Takeovers can have efficiency advantages if they enable an efficient fund to absorb an inefficient fund. It should be noted that existing arrangements for mergers only apply to funds which are actually experiencing a solvency crisis. A fund could be less efficient than another fund and not have any immediate solvency problems.

Moreover, takeovers are an important mechanism for increasing competitive pressures in an industry, by allowing a new entrant to achieve a sizeable foothold in an industry without having to build up market share slowly (see chapter 5). The Commission found evidence that a new player entering the market with the aspiration of being a major player will face a cost disadvantage relative to larger established incumbents, unless they can take over an existing player (appendix G).

Accordingly, there may be grounds for developing mechanisms that would allow members, or nominated representatives, the authority to accept a takeover, despite management opposition. For example, such mechanisms could include:

- a plebiscite of members or nominated representatives; or
- a mediating role played by an independent authority, such as PHIAC, as suggested by Medibank Private (Sub. 168) — this independent authority could gauge rejected takeover offers to see if it was appropriate to go to fund members for a re-assessment of the bids; and
- monitoring to ensure that disclosure to members by parties to a takeover are accurate and that reserves are not cannibalised by a predatory fund.

The SGIO (Sub. D237) also provided considerable detail on a possible mechanism (Box 10.6).

**Box 10.6: A takeover mechanism proposed by SGIO**

“An outline of the steps that should be followed in a hostile takeover is as follows:

1. The offeror should make an offer to the management of the target company in writing which is valid for, say, 2 weeks. The offer should be in a specified format which could be based upon the Part A statement in the Corporations Law.
2. At or prior to the end of the 2 week period the target would have to notify the offeror whether their offer is to be accepted. If the target’s management believes the offer is grossly unreasonable, for instance the offer is below net assets or members premiums are stated to rise dramatically after the offer is accepted or the offer will lead to a breach of the ACCC rules etc, the target should be able to refer the offer to the regulator. The regulator will have the power to either stop the offer at this point because it is grossly unreasonable or advise the target to continue the process.
3. If the offer is not accepted by the target’s management, then the offeror can either withdraw the offer or state that they wish to put the offer to the members of the Fund.
4. The Part A statement would need to be sent to the members of the target (how this is to work in practice is set out in point 6 below), at the cost of the offeror.
5. The target would have a period of 2 weeks from notification by the offeror that they wish the members to receive the offer, to prepare a statement setting out their views on the offer. This could, in keeping with the offeror’s requirements, be a document similar in content to a Part B statement under the Corporations Law.
6. Once the two statements are completed the target company must mail these out to the members, at the cost of the offeror. The target would be under a legal obligation to send these documents to all members within the specified time-frame. Included in the information sent to all members would be a notice of meeting to be held within say 6 weeks of the statements being sent out. The notice would need to cover a prescribed format, and in effect may be similar to the requirements for a demutualisation of mutual organisation.
7. The meeting would be held and the offeror and target’s management would address the meeting on the offer, and there may be a maximum time set that each has for this address. The members should be then able to ask questions with both the target and the offeror able to answer. Members would then vote on the proposal, with proxy or mail votes to be included. It may be set so that 75 per cent of the members that vote on the offer are required to vote in favour of the offer for it to be accepted. Prior to the meeting there would need to be a method devised for members to mail their votes to an independent party. The independent party may be the regulator and they may also have an observer at the meeting, with this to be to the cost of the offeror.” (Sub. D237, p. 13)

**Recommendation 12**

The Commission recommends that arrangements be developed to allow 'hostile' takeovers of mutual health funds.

Detailed consideration should be given to proposals which:

- allow members or nominated representatives to accept or reject (via mechanisms such as a plebiscite) a hostile takeover;
- ensure transparency to members of the terms and conditions of such takeovers; and
- include appropriate monitoring of takeover bids in accordance with standard commercial arrangements.

**Equity raising**

Mutual funds do not have access to equity funds (Sub. 26, p. 3) which may limit their ability to finance market or product expansion. By changing to for-profit status, a fund would be able to exercise that option. The important issue, then, is the ease of changing to for-profit status as raised by SGIO (chapter 3). The Commission notes that transition from a mutual to a tax paying entity is permissible under the existing registration arrangements, but that the process is tortuous.

**Recommendation 13**

The Commission recommends that the transition of a health insurance fund from a tax exempt to a taxable entity should be eased by making appropriate legislative amendments to the National Health Act.

**Taxation**

Most registered health benefits organisations are exempt from income tax. The Commission sought to examine the impact that exemption of mutual funds from tax has in an industry in which tax paying and exempt organisations compete. The idea that differential taxation generates a distortion is intuitively reasonable. However, that intuition has been challenged in a number of other areas: for example, in relation to income tax for government trading enterprises (EPAC

1995) and charities (IC 1995). *The issues and arguments of participants are examined in appendix E.*

The Commission finds a basis for the argument that there *is* a distortion, but considers that it is likely to be relatively modest. There are also some distributional effects. The distortion is likely to present some barriers to entry by for-profits into health insurance — and that in turn may reduce incentives for product innovation and cost minimisation.

On the other hand, the Commission found that changes to the taxation treatment of mutual funds would raise some implementation issues. If the removal of the exemption were considered by government, it would probably *not* be appropriate to levy tax at the corporate rate, because of the influences of dividend imputation (appendix D), but at a somewhat lower rate. The government would also need to determine whether any revenue collected was re-directed back into the industry (via reinsurance or some other mechanism) to avoid impacts on premiums.

Ultimately, the benefits from taxation equivalence would have to be set against the administrative costs of taxation collection, auditing and other transactions costs. These should be assessed prior to any change in the taxation regime faced by not-for-profit mutuals. The Commission considers that taxation arrangements relating to mutual health funds should be examined as part of a broader health review, as tax neutrality issues are pervasive within the health system.

### **Competitive neutrality**

Finally, the existence of a dominant government owned insurer, Medibank Private, leads to specific questions about competitive neutrality — a point raised by many submissions (chapter 3). A Treasury review of competitive neutrality is due to report in March 1997, including assessment of the Health Insurance Commission which operates Medibank Private. The Commission has not repeated the efforts of that review. Nevertheless, it notes:

- Medibank Private appears to have played a catalytic role in intensifying competitive pressures in the industry — and was the first genuinely national fund.
- Medibank Private shares its shopfronts with Medicare — and appears to derive significant market advantages unavailable to other insurers from their co-location. These advantages stem from easier billing arrangements for customers, and the ability to readily market their product to people applying for Medicare refunds. The first of these advantages may well be rendered

superfluous if hospitals, doctors and the private health insurance industry together adopt a better system of billing (see section 10.9).

- There are governance and competitive neutrality principles associated with the relationship between the Health Insurance Commission (HIC) and Medibank Private. Even after accounting for the impacts of product mix and scale, the Commission found that Medibank Private had lower management costs per member than some other large open funds (appendix G). However, the Commission is unsure to what extent this reflects a statistical artefact, genuinely higher technical efficiency or cost shifting to Medicare.

A number of submissions proposed that any registered fund be permitted to act as a shopfront for Medicare, so that all funds could have equal access to custom generated indirectly via Medicare.<sup>9</sup> The Commission notes that a precedent has already been set: some retail pharmacies in rural areas now act as Medicare agencies. Allowing health funds also to act as Medicare agencies could have a number of advantages:

- Consumers would benefit from better consolidation of billing when they used funds other than Medibank Private.
- With appropriate cost sharing arrangements, it would eliminate any competitive non-neutrality posed by the current system.

As noted in section 3.11, Medibank Private submitted details of the possible costs entailed in allowing other funds to act as Medicare agencies. In response, HCF (for example) recognised that there would be costs, as well as benefits, and these would have to be weighed up: ‘a commercial judgment would be required [by HCF] based on the complexity of the transaction process (including administration), the customer service effect and the level of remuneration being offered by HIC to act as its agent’ (Sub. D278, p. 3).

The Commission would not argue that all branches of all health funds *should* act as Medicare agencies — however, it does see advantages in health funds being given the opportunity to act as Medicare agents, on terms no less favourable than apply to Medibank Private, if they judge the benefits to them outweigh the costs.

Quite apart from the issue of the association between Medibank Private and the HIC, there are even more fundamental questions about the rationale for public

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<sup>9</sup> Acting as an agent for Medicare should not compromise the Medicare information system, which is a valuable tool for managing health care and avoiding abuses. Any fund would simply be tapping into the public asset, represented by this information system, rather than duplicating or fragmenting it.



ownership of a health insurer. These issues are currently under review by the Treasury.

The Commission has not been in a position to assess the case for and against the corporatisation or privatisation of Medibank Private. Among other matters, there is a question as to the feasibility of privatising Medibank Private given its ownership structure.

**Recommendation 14**

The Commission recommends that private health funds be allowed to act as retail agents for Medicare, subject to:

- satisfactory privacy arrangements;
- suitable apportionment of the relevant costs; and
- competitive neutrality with the arrangements applying for Medibank Private.

The Commission recommends that, depending on the findings of the current Treasury review, detailed consideration be given to separating Medibank Private from the HIC.

**10.8 Reserves**

Health insurance funds currently operate like simple banks. They collect premiums and pay out benefits. At any one point, premium income may not be sufficient to meet benefits — because of cost increases and random variations in claims. For these reasons, funds need to keep reserves as a basic matter of commercial prudence.

This raises two major questions:

- Are there grounds for prudential regulations and, if so, what form should they take?
- How should the regulator operate?

**The rationale for, and form of, prudential supervision**

One policy concern, more usually applied to the banking industry, is that in the absence of prudential requirements, the failure of any single imprudent insurer

would lead to the dishonouring of some claims, lower consumer confidence and other failures. But banks and insurers are different in one vital respect. A bank may fail, even if it is actually solvent, if consumers think it is not — its depositors withdraw their funds in a bank run. There is no obvious equivalent to a bank run in private health insurance.

Even if this argument lacks applicability to private health insurance, perhaps weakened consumer confidence would lead to lower membership in private health insurance.<sup>10</sup> In the absence of regulatory reserve requirements, markets would develop responses. Funds would want to signal their secure status to consumers. An insurance association might develop its own oversight of funds' reserves, because it would be in the collective interest of members to sustain consumer confidence. Consumers would probably tend to use larger, more established funds with a substantial capital base. Insurers of the insurers might spring up, offering consumers coverage of their health costs if their fund failed financially. Or a genuine reinsurance market might develop, in which smaller health insurance funds would seek to cover insurance risks via an intermediary.

These possible market responses, of course, bring their own dilemmas:

- If short sighted consumers failed to insure against the financial failure of their health fund, and their fund failed, they could be left with a bill of thousands of dollars for medical treatment which had already taken place. Of course this problem is not unique. Comprehensive car insurance is voluntary, as is housing and property insurance. There is inevitably a trade-off between the costs of compelling everyone to take out insurance for any given risk and the costs that are borne by those who elect to gamble, and lose. One possible regulatory option is compulsory insurance, but this brings with it another whole set of costs.
- If funds or consumers insure against insurance risk, they may be less scrupulous in managing risk (a 'moral hazard' problem). For example, the existence of such an insurance provision is seen as one of the causes of the savings and loans crisis in the US. Such moral hazard could be controlled partly by using a front end deductible for any such insurance policy.

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<sup>10</sup> There are a number of more minor *potential* problems. First, in a less than perfectly competitive industry, it may pay funds to have excessive reserves. Excess reserves can in *some* cases pose a deterrent to entry by newcomers as existing incumbents can then afford to price low (though only for a short period). The Commission found little evidence of excessive reserves, and it is not clear what 'rents' the funds would be protecting from new entrants. Second, the tax status of mutuals does not discourage accumulation of excess reserves, if these ever arise. If mutuals were taxed, then they would face a bigger incentive to lower premiums than to accumulate excess reserves.

There appear to be arguments both for and against unregulated arrangements. But these need to be balanced against the advantages and disadvantages of the regulatory approach. Under the current regulatory arrangements, funds are required to have reserves equivalent to two contribution months or \$1 million, whichever is the greater. A fund which falls below the minimum reserve requirement can gain an exemption and continue trading.

The approach has its own problems:

- *Questionable appropriateness of the \$1 million rule.* Some small funds have obtained longstanding exemptions from the requirement for a \$1 million reserve level, suggesting that this reserve requirement may have been inappropriate for them. Moreover, the current reinsurance arrangements include provision for pooling of most of the risks associated with conditions requiring more than 35 days of hospitalisation. This eliminates one of the major sources of insurance risk for smaller funds (long duration expensive conditions such as rehabilitation after an accident or burns). This also calls into question the appropriateness of the \$1 million reserve requirement. Of course, any change to reinsurance will require a fresh examination of measures to contain insurance risk.
- *Notionally inflexible reserve requirements.* The optimal reserve position for a fund will depend largely on the characteristics of the market in which it is operating and on the size of its membership. A small fund, for example, is more prone to random fluctuations in claims, and will typically require more contribution calendar months of reserves compared to a large fund. This suggests that a set floor to reserves will be too low for some funds and too high for others.<sup>11</sup> A 'one suit fits all' reserve requirement is likely to be inappropriate for:
  - Larger insurers, as these have less exposure to fluctuations in benefits.
  - For-profit funds, which aim to distribute any profits in excess of the commercially prudential reserve level to shareholders. In contrast, tax exempt funds, without the access to equity and debt finance of the for-profit sector, need greater reserve levels to finance business expansion.

On the other hand, the Commission notes:

- At the end of June 1996, 29 of the 48 funds had reserves in excess of \$1 million and were operating voluntarily at reserve levels of two and half

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<sup>11</sup> The Department (1996, p. 4) noted that a solvency expert advised it that one month's reserves would have a 99 per cent probability of allowing a fund to meet outstanding obligations — and that larger funds needed less reserves than smaller ones.

contributor months or more — well above the regulatory minimum. These funds account for about 70 per cent of contributions. This suggests that the reserve requirement imposes no costs on them.

- Six (very small) funds are operating with effectively permanent exemptions from the \$1 million requirement (and all have reserves considerably in excess of 2 calendar months of contributions). These funds have clearly been given an imprimatur to operate below the regulatory requirement, and are scarcely constrained by the regulation.
- This leaves a maximum of 13 funds. Eight of these had reserve levels just above the regulatory requirement and (at 30 June 1996) five funds were below it. These are the only funds which *might* to some extent be constrained by the reserve requirements.<sup>12</sup> Suppose that the absolute minimum commercially sensible reserve requirement is one calendar month of contributions. For this group of funds, the value of reserves above that minimum amounts to around \$44 million. On average, funds invested in reserves have earned rates of return of around 10 per cent (chapter 4). Say that an alternative investment by members could yield a (high) 10 percentage points higher rate. In this case, the *maximum* cost of the minimum reserve requirement would be around \$4.4 million.<sup>13</sup>

Quite apart from the question of appropriate reserve levels, there are other potential problems with the current regulatory arrangements:

- There are no general requirements that assets be held in liquid form. As pointed out by the Department: ‘In the event of a collapse, the value of such assets would not be easily realisable, which could affect the capacity of the fund to meet its obligations to its contributors’ (DHFS 1996b, p. 5).
- There are no clear policy guidelines on appropriate asset diversification. In theory, greater diversification reduces risk. On the other hand, if diversification is undertaken via a complex set of company structures it can be difficult for regulators to assess the risk status of investments.

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<sup>12</sup> Funds trading *above* but close to the reserve requirement are included because a rational manager will try to avoid breaching the requirement, even if their prudentially safe reserve level is half of the specified reserve requirement.

<sup>13</sup> There is a related question of whether a maximum reserve requirement should be imposed, in an environment where governance structures may mean that decisions are not always in the interests of members. Six funds were operating with reserves in excess of 6 contribution months, but these funds were small and contributed little to aggregate contributions or reserves.

There are, therefore, both arguments for and against a regulatory approach to reserves. There may be grounds for abandonment of government reserve regulation. A self-regulated approach may be more flexible and cheaper.

On the other hand, an adaptation of the current regulatory regime may remove most of the deficiencies of the current system without incurring the uncertainty of an entirely new regime. *The Commission notes that the overriding purpose of any regime should be protection of consumers, and not protection of inefficient funds.*

A useful adaptation of the current system would be to establish a two trigger regime:

- The first trigger — the regulator would signal to a fund when a warning reserve level (perhaps 2 months) had been breached. The fund would have to undertake measures to build up reserves.
- The second trigger — the regulator would signal to a fund that it was to compulsorily merge with another fund if the fund's reserves fell below a critical level (perhaps one month).

However, to add flexibility to this regime, individual funds could elect for tailor-made trigger points, so long as an independent actuary (appointed by the regulator and paid for by the fund) agreed these met the solvency *objectives* of the regulator. To some extent such a 'shift' would enshrine in legislation what appears to be happening in a defacto way now.

Such a trigger system could be supplemented by clarification of guidelines for the liquidity and diversification of reserve assets.

These suggestions met with general approval from participants responding to the Discussion Draft (for example, the DHFS, Sub. D277; SGIO, Sub. D237). There was some disagreement about the appropriate response to the second trigger. Medibank Private (Sub. D242) and MBF (Sub. D203) advocated enforced mergers/takeovers if the second trigger were breached, while the Government Employees Health Fund (Sub. D220) opposed such mandatory enforcement.

Beware the regulator who wants clear guidelines. AHIA's viewpoint on this matter is correct. The Department (Box 3.10) is wrong. NMHI are arguing from shareholder interest. Medibank Private is just plain jealous of the success of some health funds. (Government Employees Health Fund, Sub. D220, p. 7).

It is absolutely essential if there is to be a minimum reserve base below which funds are deemed to have become insolvent ... that whatever regulations are in place are enforced. The leniency with which regulations have been dealt with in

recent years has made a mockery of those regulations. Funds must have the right to fail. (MBF, Sub. D203, p. 9)

The Commission considers that tailor-made triggers avoid arbitrariness. But any triggers have to be enforced to be effective: otherwise the incentives for prudential fund management are undermined. Therefore, the Commission favours flexible determination of the appropriate trigger points for different types of funds, but with enforcement of those pre-determined triggers.

**Recommendation 15**

The Commission recommends that:

- a clear protocol for breach of reserves be developed;
- flexibility be introduced into reserve requirements for funds facing different levels of risk; and
- clearer guidelines of what constitutes acceptable liquidity and diversification of reserves assets be produced.

**Who should the regulator be and on what basis?**

Another question relates to the appropriate regulator. Some submissions argued that if some of the regulations permeating the industry were relaxed then the onus of regulatory responsibility should shift from PHIAC to a body with greater skill in overseeing risks, such as the ISC (see chapter 3).

The Commission considers that the institutional location of the regulator is of secondary importance to the function, governance and conduct of a regulator. Arguably, any regulator should:

- be clearly separated from the policy-making bureaucracy;
- exclude representation by stakeholders in the management of the regulator. It is desirable for the regulator to consult with stakeholders, but at arm's length; and
- hire or acquire any required specialist skills needed to oversee regulatory compliance.

To some extent, PHIAC already complies with these criteria. It has no policy role itself, and it is separate from the Department. Further, it obtains regular outside actuarial advice. However, the nature of its relationship with industry stakeholders is unclear. On the one hand, the powers of PHIAC are expressed in

the National Health Act as powers of the Council. This consists of a Commissioner, three health fund representatives, and one other person. On the other hand, the Act specifies that questions arising at Council meetings 'shall be determined by the Commissioner, having regard to the advice of the members present' (NHA, section 82N(6)).

The Commission considers that, under current arrangements, there is some doubt as to whether PHIAC is sufficiently separate from industry stakeholders. It considers that this needs to be clarified, as the decisions and recommendations of PHIAC can have an important influence on the operations of individual health funds, and ultimately on the private health insurance sector as a whole. The Commission considers that the Council as presently constituted should be replaced by an independent board, with the board as a whole responsible for decision making.

**Recommendation 16**

The Commission recommends that the existing council be disbanded and the powers of PHIAC be vested in an independent Board, including a Commissioner and two to four other individuals independent of both the Department and the industry.

There is value in PHIAC consulting with relevant stakeholders about issues relating to private health insurance. However, the Commission considers that this should be done on an informal basis, rather than through the present Council mechanism. Further, in overseeing fund solvency, and providing information about private health insurance to the community, the role of PHIAC extends beyond an industry focus to protecting the interests of consumers. Thus, it is appropriate for PHIAC to include consumer representatives in its consultations.

**10.9 Changes to deal with consumer concerns**

The Commission received over 75 submissions from individual consumers, expressing a wide range of concerns as users of private health insurance (chapter 6). Their problems included:

- unpredictable and sometimes very large out-of-pocket costs associated with using health insurance;
- a perception that private health insurance was not value for money and that members were paying several times over for health care (Medicare levy,

other tax transfers, an insurance premium, any excess, the above-MBS schedule medical ‘out-of-pockets’ and a PBS copayment);

- time-consuming and frustrating payment systems, which could result in an individual consumer tracking dozens of bills;
- long-standing contributors sometimes being forced to relinquish their insurance because of cost; and
- a confusing system, with complex products which are hard to compare across funds.

Many of the problems facing consumers stem from flaws in private health insurance, and in the health system as a whole. These include:

- Lack of clarity over the role of private health insurance within the health system as a whole leads to confusion and inconsistencies in the financing and provision of health care in Australia.
- The current form of community rating (and its financial counterpart — reinsurance) contribute to excessive diversity in some product lines and consumer confusion, while limiting consumer access to other useful products (such as elective surgery products and reasonably priced catastrophe insurance policies).
- Community rating has also led to a downward spiral of adverse selection. The ‘community’ on which rating is based is becoming increasingly unrepresentative.
- Contracting arrangements between providers and funders, and the blunted incentives generated by reinsurance, have tended to weaken cost containment measures — with consumers footing the bill. The contracting arrangements have also failed to address a major concern of consumers: the *unpredictable* nature of out-of-pockets.

Many of the recommendations made by the Commission so far are aimed at ameliorating these problems, but their full resolution would require treatment of the fundamental problems affecting the whole system.

The Commission also considered a range of options to deal with some of the more specific consumer concerns.



## Payment system reforms

One of the major functions of health insurers is to act as a payments intermediary. For a variety of reasons, that function is exercised in a flawed and inefficient fashion (box 10.7).

### **Box 10.7: The payments experience**

Emma Smith has a standard front end deductible policy. She has been in health insurance for several years without needing to claim. But one day she has to go to hospital for an operation. The operation involves four doctors (of whom she only meets two), who all charge above the Medical Benefits Schedule. Some pharmaceuticals are also prescribed. Quite apart from any transactions relating to associated pre-admission and post-discharge doctor visits, Emma can expect something like the following sequence of transactions.

- She will have to pay the excess associated with the hospital costs (transaction 1) and the standard copayment for PBS pharmaceuticals (transaction 2).
- She will receive four separate bills from the doctors, which will arrive at different times. These she will send to Medicare (transactions 3, 4, 5, and 6), who will send back cheques (made out to the doctor) for 75 per cent of the MBS.
- She will then send these cheques to the four separate doctors, plus the additional payments which meet the outstanding bill amounts (transactions 7, 8, 9 and 10).
- She will then send a claim — or claims (if the sequence of bills is very spread out) — to the insurer, for the gap between the Medicare payment and the MBS (transactions 11 or more).
- Finally, she will get a cheque (or cheques) back from the insurer covering the gap.

If she is chronically ill, this paper cycle will begin afresh with each new hospital admission. If she is not, she may decide to drop private health insurance.

The Senate Community Affairs Legislation Committee (1996, pp. 51–5) found that there were a variety of options for pursuing billing reforms, and that such reforms ‘had general, but not as yet universal, agreement within the industry’.

The 1995 Amendment Act provided for the establishment of a committee (the Aggregate Billing Advisory Committee) to advise on a unified billing system. This Committee was not formed — neither the AMA nor the Council of Procedural Specialists nominated positions for the committee because of their other concerns about the Act.

On the other hand, in its submission to this inquiry, the AMA indicated its readiness to pursue billing reforms:

The AMA has proposed minor amendments to the Health Insurance Act to enable doctors to establish billing agents who could either themselves or through contracts with private hospitals or health funds, dramatically improve the billing arrangements for patients. (Sub. 130, p. 41)

Indeed, an informal Ministerial taskforce has been studying relevant issues. The Minister announced on 13 February that voluntary trials of simplified billing procedures would begin shortly, and would include supporting payment mechanisms together with procedures for informed financial consent for patients (Wooldridge 1997).

Most parties recognise the gains that consumers could obtain from reform of the currently uncoordinated system into one in which, *however organised*, consumers pay a single ‘insurance gap’ bill for an episode of treatment, rather than a score of practitioners and institutions.

There are two general routes down which billing reforms can go:

- Contracting arrangements between doctors and hospitals or funds which can coordinate bills (see chapter 8 and section 10.10).
- Other billing arrangements completely separated from issues such as contracting, the setting of MBS fees, and provision, or not, for insurance cover above the MBS fee.

### **Recommendation 17**

The Commission recommends that work towards achieving billing reforms, and facilitating informed financial consent, be completed as quickly as possible.

## **Systematic information on products**

Health insurance products are complicated. From fund to fund, and policy to policy they include variations in:

- premiums;
- rebates for different procedures (in ancillaries);
- varying product exemptions (hip replacements, cardiac by-pass surgeries etc);
- excesses;

- excess bonus schemes;
- waiting times for some forms of treatment in private hospitals;
- the extent to which they offer year round cover;
- who can be included as a member in a family policy;
- loyalty bonuses;
- coverage of participating private hospitals; and
- provision of consumer health information.

Product complexity means that some consumers will make bad choices — for example, selecting a private hospital policy from a fund which does not have an agreement with the major local private hospital, or selecting an exemption product when use of the exempted treatment is probable.

The industry regulator, PHIAC, has assumed responsibility for informing consumers about insurance and has produced a booklet titled *Insure? Not Sure?*, to assist consumers making choices. PHIAC makes no direct comparisons across funds, but provides consumers with the sort of questions they need to ask in judging whether a particular product meets their needs.

A number of participants argued that PHIAC should be required to conduct more detailed comparisons across funds. The ACA considered that:

Initially this could be achieved by having all current brochures available ... Consumers could then be provided with all the brochures for their state or territory by making one phone call. A phone line, either provided by the ... Complaints Commissioner or ... PHIAC to assist consumers to compare policies, to point out possible differences to follow up with health funds, could also be considered. (Sub. D266, p. 8)

The Commission doubts, however, whether government involvement in direct product and price comparisons can be justified:

- The cost of providing regular price and product comparisons could be very high, given the problems of (a) updating information on a market which is constantly in flux and (b) disseminating the information to those who really want it.
- Health insurance is not unique in its complexity. Governments do not undertake detailed price and product comparisons for other complex and expensive goods and services (such as motor vehicles, housing and investment funds). Detailed product comparisons may also lead to a view that government was endorsing particular products.

- It would also have to be demonstrated that private markets could not adequately provide the sort of information that consumers would find useful.

In this regard, perusal of any newsagent will demonstrate that consumers can obtain advice for purchases they see as complex, such as computers, cars, and holidays. CHOICE magazine undertook a detailed review of all health insurance products in mid 1996, and made detailed comparisons across products, as well as undertaking a survey of 3000 consumers. In many countries, brokers act as informed intermediaries for consumers purchasing motor vehicle insurance and other products (and obtain their fees from the service providers).

Another example of the private provision of information to consumers is the ACA's telephone information service to advise consumers about selection of credit cards. This service is operated on a user pays basis, with the charge being met in the form of a per minute call charge. The high *total* costs of obtaining up to date information on the roughly 600 credit cards on offer can be spread over many consumers so that individually the cost of information is low. The ACA also noted that a sister organisation in the United States operated five telephone information services on a user pays basis, on topics such as car insurance, home buying and bank accounts.

To the extent that such private market responses are inadequate in the case of health insurance, it may well be that consumers value the information at less than its cost.<sup>14</sup>

PHIAC's information role is complemented by the Private Health Insurance Complaints Commissioner (chapter 3). The Complaints Commissioner provides a valuable role in encouraging proper disclosure of information by funds, as well as highlighting in the public arena the risks that consumers face if they make ill-informed decisions. This should facilitate consumers' awareness.

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<sup>14</sup> Standard public good arguments do not have much application to this area. The usual argument is that knowledge can be costly to accumulate, but cheap to copy and disseminate. The consumption of knowledge is non-rival (one person's use does not deplete it for someone else) and non-excludable (it can be hard to confine knowledge to just one customer — talk is cheap). The consequence of these attributes of knowledge is that some activities which are socially beneficial fail to be undertaken in free markets because the gains cannot be appropriated by the inventor. But this argument is unlikely to apply to the sort of knowledge that consumers may wish to have about health insurance. The costs of duplication of market produced information (for example, in a magazine) are relatively high compared to the cost of the magazine, and in any case, copyright provisions provide some commercial protection.

The Commission does not consider that additional government measures are necessary to provide information to consumers about particular health insurance products.

### **10.10 Cost containment and efficiency strategies**

This inquiry was prompted by concerns over rising premiums. Those premiums reflect cost and usage in the public and, particularly, the private health systems (chapters 7 and 8). *To some extent*, concern over cost pressures is misplaced. The word ‘cost’ is often given a special and curious meaning in a health context, a use which confuses policy debate. In common parlance, costs usually refer to the price *per unit* of service. In a health context, costs often refer to the aggregate expenditure. The two concepts are radically different. Expenditure is a combination of prices and usage. A rise in a given expenditure level may reflect either increases in prices, usage, or a combination of both. Prices in turn reflect unit costs, as well as the market power of the provider (or buyer).

In most markets, pricing practices, unit costs and usage are not regarded as matters for policy concern. For example, per capita consumption of household appliances increased by about 40 per cent in real terms from 1987–88 to 1994–95 — no one complains of a cost spiral in the \$9 billion household appliances industry. Why is health special?

As noted in chapter 8, restricted entry by professionals, information asymmetries, a morass of regulations, institutional interventions and moral hazard problems are likely to lead to over-usage, cost inefficiencies and over-pricing of health services.

But an increase in aggregate expenditure is not *in itself* proof that a problem exists. The evidence in chapter 7 suggests that much of the increase in health insurance benefits is due to a shift in the product mix (from notionally cheaper public hospitals to more expensive private ones) and to increases in usage due to demographic factors (ageing and adverse selection). Demographic changes, increasing demand for new and better quality services, revised judgments about the value of health services relative to their costs, and rising incomes all imply that health care expenditure will inevitably and *appropriately* rise. Policy concern should only be focused on those components of expenditure changes which may be sub-optimal, due to:

- cost inefficiencies;
- adverse selection;

- inappropriate practice variations;
- market power exercised by players in the industry;
- moral hazard and over-servicing; and
- pricing practices of public hospitals.

Many of the cost efficiency issues have arisen in the previous section, or in other sections of this chapter. The Commission points out that the current system of reinsurance provides limited incentives for funds to seek to control the costs of the elderly (the highest users of health services) or to seek ambulatory alternatives to hospital therapies. We also note that existing governance and rules of conduct within the private health insurance industry (and especially those relating to hostile takeovers) may blunt incentives to cost minimise and restrict entry by efficient funds.

As well, the Commission has already reviewed the problems of adverse selection, and the impact that ‘diminishing pool’ rating has on insurance costs.

The issue of practice variations (chapter 8) is a complex and contentious one, which the Commission has not examined in detail.

We now turn to the remaining issues.

### **Market power issues**

The extent to which the different players exert market power in their dealings with each other and consumers is controversial and hard to determine (chapter 8). A single insurer often has a large market share in any given state or sub-region. There are often only one or two major private hospitals serving a geographical area, and the aggregate number of private sector beds is often controlled. But the hospitals can only get sufficient custom if specialists undertake their work there. The specialists also determine, through their various colleges, the number of new trainees. The government places various controls on prices and contracting by each of the parties.

Ultimately, rather than deciding who is ‘king of the castle’ in terms of market power, the relevant question is what policy changes could be implemented which help produce the best bargain between all these powerful parties. The best bargain would be an outcome closest to cost minimisation (technical efficiency) and the optimal allocation of resources (allocative efficiency).

In this context, the Commission notes:

- There are a number of potentially important supply side constraints which may raise prices. A review of rationing of medical services is, however, outside the scope of this inquiry.
- The current contracting regime weakens funds' capacity to negotiate with hospitals and doctors. The principal arguments of participants and the Commission's analysis of this issue is in chapter 8. Funds are required to pay a default benefit for a member in a non-participating hospital. They are also required to pay full hospital benefits for nursing home type patients for the first 35 days of care. The Commission finds that neither of these restrictions have a compelling rationale.
- Doctors and hospitals can only negotiate contracts under practitioner agreements at the MBS, which reduces the incentive for doctors to contract with hospitals. Doctors, however, have shown little interest in negotiating with funds directly. One possible option is to allow doctors to contract with hospitals at above MBS prices so long as the hospital has genuine case payment contracts in place with health funds. This provides hospitals with incentives for cost restraint. Under such a change, out-of-pocket in-hospital medical expenses could be insurable or predictable for consumers (although it would still be desirable to have some cost sharing).
- Contracts based on case payments are a voluntary feature of the current private health system, despite their apparent advantages in generating efficiencies (chapter 8). The 1995 Amendment Act requires contracts between health funds and hospitals to be *described* on the basis of AN-DRGs by July 1997. However, it does not stipulate the exact structure of the payment. The definition of case payment applied in the legislation is elastic, so that per diem casemix-based payment would be permitted. Per diem payment (or payment per day) is the softest form of arrangement — a point made by George Palmer (Sub. 132, pp. 1–2). The objective of case payment is to provide incentives for cost effective treatment associated with any particular episode of illness. Such incentives are not provided by daily benefit payments.
- It is not clear that the interplay of the different market participants, each with their varying bargaining power, will lead to the widespread adoption of contracting on a proper case payment basis. One policy option, noted above, is to provide incentives for such contracting by allowing practitioner agreements at prices above the MBS so long as hospitals and funds write genuine case payment contracts. As well, the Commission has already suggested that changes to reinsurance may increase the incentives for funds

to cost minimise, and should provide an additional impetus for genuine case payment contracting.

### **Recommendation 18**

The Commission recommends that funds no longer be required to:

- pay benefits for NHTPs at the acute rate for the first 35 days; and
- pay a non-contracted private hospital at any specified minimum default bed rate (including emergency admissions and psychiatric care).

The Commission recommends that where doctors and hospitals contract under practitioner agreements, the funds be able to offer full coverage for medical fees above the MBS, as long as proper case payment contracts between funds and hospitals exist.

The Commission recommends that the proposed wider review into the health system examine supply constraints in the medical market.

### **Moral hazard and over-servicing problems**

Under full cover insurance, consumers face no price incentives to constrain demand, and doctors making clinical judgements do not have to worry about the impact on the patient's budget. As a result, some of the health services consumed by patients may cost more than the benefit to the patient.

This problem may be compounded by incentive problems for providers too. Fee-for-service remains the main form of payment for doctors in Australia. As noted by Cutler (1994, p. 15):

Health care providers have traditionally been reimbursed for each test or procedure they perform, leading to incentives to increase the amount of care provided if the price paid is greater than the marginal cost of the services provided. ... [M]any patients have little financial incentive to monitor the amount of this care ... [and] information problems make it difficult for people to choose appropriately.

Regulatory constraints aside, health insurers with adequate incentives to reduce costs could be expected to try to overcome these usage problems via a number of routes. They will:

- customarily use front end deductible and other cost sharing mechanisms, rather than 100 per cent cover products;



- provide information to consumers about what constitutes effective treatments;
- conduct utilisation reviews;
- provide discounts for second opinions;
- reduce or eliminate excesses for cheaper treatments<sup>15</sup>;
- negotiate contracts with doctors or hospitals incorporating proper episodic case payments and encouraging best practice and clinically approved protocols for more effective, lower cost treatments; and
- write incentive compatible contracts with hospitals and doctors. For example, these may involve capitation payments and step-downs.

It may seem remarkable that so few of these mechanisms feature in the armoury of Australian health insurers. They do offer front end deductibles and, to a very limited extent, a version of no-claim bonuses, but that is the extent of it. However, against the background of the system in which they operate, this is explicable:

- The public system offers free access to hospital care. If insurers use copayments as a deterrent to usage, then the free substitute system will take 'market share'.
- The current system of reinsurance may also make individual funds less concerned about the moral hazard effects of offering a 100 per cent cover product to those aged over 65 years — the key users.
- Funds appear to have little capacity to bargain for capitation or other incentive compatible contracts with providers hostile to the concepts of managed care.

The Commission has suggested a number of changes to reinsurance, hospital contracting and default payments which should partly ameliorate these problems.

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<sup>15</sup> For example a person may have an excess of \$1000 and face an option of treatment A (costing \$3000) or treatment B (costing \$20 000). The existence of a front end deductible will not discourage the consumer from choosing B. But if the fund reduced the excess to zero for treatment A, the consumer would have strong incentives to adopt the cheaper alternative.

### **The pricing practices of public hospitals**

Prices for private patients in public hospitals are around half of those in private hospitals. This price variation does not reflect a real underlying cost advantage to public hospitals. A significant share of the average premium increase apparent in the last few years reflects a hidden form of cost shifting:

- the number of (subsidised) bed days in public hospitals used by privately insured patients has declined, being offset by an increase in bed days in private hospitals — with overall utilisation growing modestly. If public bed days had been priced at cost in the first place, the overall premium rise would have been much less.

A number of submissions (for example, Sub. 140) advocated removal of the implicit bed day subsidy for private patients in public hospitals. There are grounds for considering such a change. It:

- would place public and private hospitals on a competitively neutral level, and could lead to gains in efficiency in the health system, with lower costs;
- would be a first step in breaking the artificial nexus that exists between funding and provision in Australia; and
- could lead to a more innovative role of the public hospital sector in the treatment of private patients (Box 10.8).

However, the implementation of such an arrangement would:

- need to avoid a situation in which treatment of private patients is substituted for public patients;
- require that public hospitals have appropriate incentives to take on private patients. This may require changes to the Medicare Agreement; and either
- involve a reasonable transition period (for example five years) so that the impact of the change in pricing has only a modest effect on premiums; or
- a rebate from the government to the private health insurance industry to ensure that average premiums do not rise. At the moment there is already a hidden rebate via the public bed day subsidy. The introduction of a substitute rebate need not affect total government budgetary outlays. The government could offset the cost of the rebate by reducing the size of grants made to hospitals (who themselves would be making more income from their private patients). The advantage of a generalised rebate (say put into the reinsurance pool) would be that average premiums would not be affected, the subsidy would be transparent, and it would not influence choice of provider.

**Box 10.8: A bigger role for public hospitals in providing elective surgery to private patients?**

Under the new ‘equivalence’ arrangements, public hospitals could compete with private hospitals by contracting with funds on an episodic basis for elective surgery. It is likely that patients treated under this arrangement will be different from the current group of private patients treated in public hospitals. This is because such patients typically do not now access public hospitals for these purposes due to the Medicare provisions relating to elective surgery. Such contracts for elective surgery would need to be *over and above the Medicare commitments for public patients*. The possible advantages of this new role for public hospitals in the treatment of private patients include greater competition between providers in the system as a whole, with cost savings as patients move to the institutions most able to offer cost effective treatments (regardless of their ownership).

This third point, of course, presumes that continued subsidisation of private patient care is considered justified by government. Whether there are better uses for the relevant monies — for example in support of public health care, or even in non-health areas — should be considered by government before a decision was made. In this context, it should be noted that the substantial drift of privately insured patients from public to private hospitals (chapter 7) has represented a tacit removal of an indirect subsidy to the private health insurance industry and has not been offset by any compensation.

Implementation of full economic charging would require consultation and negotiation with the states and territories, and other interested parties.

**Recommendation 19**

The Commission recommends that, in the context of the next Medicare Agreement, the Commonwealth negotiate with the states and territories about introducing full economic charging for public hospital services for private patients.

**10.11 Tax and rebate regime**

In 1996, the government announced a package of rebates and levies to encourage membership of private health insurance, to apply from next fiscal year. The rebate varies with family size and is not available for people whose income exceeds a threshold (chapter 3).

These financial incentives can be analysed with respect to several implicit and explicit objectives (table 10.4).

Table 10.4: Rating the rebate/levy surcharge against some objectives

	<i>Does it encourage people to keep private insurance?</i>	<i>Does it assist private hospital provision?</i>	<i>Does it promote choice of public and private service provider?</i>	<i>Does it cost effectively relieve pressure on the public system?</i>	<i>Does it reduce the 'double payments' problem?</i>
<i>Rebate</i>	✓	✓ ?	✓ ?	✗	✓ ?
<i>Levy</i>	✓	✓ ?	✗	✓	✗

**Effects on membership**

The *rebate* provides a significant subsidy to private health insurance (chapter 3). Affordability is seen as one of the major problems of maintaining insurance. To that extent, the measure will be successful in helping to maintain membership of private health insurance.

The view that premium increases will 'wipe out' the effect of the rebate is misleading. The rebate still represents a substantial rate of assistance. Any price

increases would still have occurred — the rebate simply reduces their impact, helping to retain membership of insurance.

However, the rebate is not indexed, so that its *real* value will fall in time. Moreover, with inflation, the real income levels associated with eligibility for the rebate will also fall. Therefore, the impact of the rebate will diminish over time, unless it, and the income threshold, are subject to periodic revision.

The *levy* provides a substantial incentive for people above the relevant income to maintain their insurance in order to avoid paying it, and so also achieves the objective of encouraging membership. Unlike the rebate, however, the impact of the levy will increase over time, as inflation erodes the real value of the income threshold.

### **Effects on private provision**

Given the constraints imposed by the current system, the rebate and the levy both support private provision of health services. Under the current system, private hospitals largely rely on demand from people who are privately insured (around 80 per cent of their income), so that retention or expansion of private health insurance membership maintains the viability of that private system.

However, arguably the current linking of financing and provision is artificial — modifications to the current system could be made in which private and public providers competed with each other for public and private patients. The most effective method for encouraging private provision would be to cut the nexus between funding and provision, subject to the proviso that all players met competitive neutrality principles.

### **Effects on choice**

The choice of public or private provider existed before the rebate. However, a person cannot choose what is not affordable. The *rebate* clearly increases affordability, and thus for many people will facilitate a choice of private provider that could not otherwise have been exercised.

In contrast, the *levy*, being a tax on those who choose not to insure, does not increase affordability of private health insurance for that group.

## Effects on the public system

### *The rebate*

The rebate is unlikely to cost effectively relieve pressure on the public system:

- Most of the people receiving the rebate are already insured and will thus not reduce their demand on the public system. (Roughly nine in every ten dollars of the rebate will be directed to these people.)
- People who take up private health insurance as a result of the incentives are more likely to be lesser users of the public system in any case. Older and lower income people are the most intensive users of the public system — and the rebate is unlikely to make private insurance attractive to many of them.
  - It should also be noted that the rebate is likely to increase the uptake of (a) front end deductible policies the most and (b) insurance in states with younger population structures (such as Western Australia). This is because premiums are lower in these policies/states, so that the percentage price discount from the rebate is greater. In both cases, such new members are likely to be better health risks than the Australian population as a whole and, therefore, the gains from reduced public hospital use will be fairly modest (chapter 3).
- Privately insured people may still make use of the public system *as public patients* when having emergency care, or when having elaborate operations which may involve high copayments.
- The measures include rebates for private health insurance of ancillaries. Any increased demand for ancillary insurance will involve minimal offsetting reductions in public health expenditure, as most of the services funded by ancillaries are not universally and freely available under Medicare. Thus, the money set aside for the ancillary rebates may be better spent by giving additional encouragement to hospital cover.

The overall budgetary impact of the rebate will inevitably be negative: savings to Medicare will fall considerably short of the costs of the rebate (see chapter 3). If the main purpose of the rebate had been to reduce waiting lists, there would have been more effective routes. (For example, the revenue represented by the rebate could be allocated to the public system.)

To effectively relieve pressure on the public system a rebate would have to target only those people who were new to health insurance. However, that would appear very unfair to people who had been insured already, and might

produce all sorts of perverse incentives (like dropping out of, and then back into health insurance).

### *The levy*

The contingent levy is likely to add significantly to resources flowing to health care in Australia:

- For people who opt to pay the levy and still use the public system, there is no change in usage, but an increase in revenue.
- For people who elect to insure privately in response to the levy, there are savings in resources freed up from the public system, plus the addition of premium income to the private system.

### **Effects on double payment ‘inequity’**

As noted in chapter 2, people with private health insurance pay twice for health care insurance. They pay through tax transfers (income tax and the Medicare levy) for the right to use the public system as a public patient, and via an insurance premium for an entitlement to use the public and private system as a private patient. Some see this as inequitable, and seek at least partial recompense.

The *rebate* provides a partial solution. It provides substantial savings to people whose income meets the eligibility criteria. However, the rebate does not compensate people who self-insure (and who also have paid twice) nor does it apply to higher income earners (whose tax transfers to the public system are much greater than other groups). Moreover, there is no significant ‘double payments’ problem in relation to ancillaries which would justify a rebate for ancillaries. Most ancillary expenditure is met by self-insurance.

In contrast, the *levy* is effectively a tax on enrolment in the public system by people who have already contributed to that system far more than the average taxpayer.

### **Other issues**

The Commission also makes the following comments about the rebate measure (chapter 3):

- There are no phasing provisions, so that effective marginal tax rates at \$70 000 and \$100 000 are extreme, with adverse work and promotion incentive impacts for some people.

- It is important that the working party set up to consider detailed administrative issues clarifies exactly how the rebates will work in practice. Attention should be given by the working group and the Department to minimising administrative and compliance costs as far as possible.
- The rebate offers any particular person or family a *fixed* sum unrelated to their current expenditure on health insurance. This means that its price effects vary for differently priced policies. Is this a problem? In industry assistance regimes, for example, specific tariffs are regarded as inferior instruments because they tend to assist lower valued commodities more than higher valued ones. Ad valorem, or percentage based tariffs avoid this problem. However, the case of private health insurance is not analogous to this situation, because consumers can choose how to allocate their rebate (cum voucher) on any insurance product. Moreover, to the extent that the rebate represents an attempt to alleviate double paying, a fixed rather than ad valorem rebate is appropriate. Finally, in the context of the current system, a fixed rebate can have some inadvertently desirable outcomes, in that it counters the impact of the reinsurance liability on cheaper products (see section 10.6).
- The rebate is not available for the self-insured, that is those who pay for private treatment themselves. There are two possible rationales for exclusion of the self-insured. First, they can more readily access the 20 per cent medical expenses tax rebate than the insured — in this sense there is already an incentive for self-insurance. By definition, those who self-insure would have (on average) much larger out-of-pocket hospital charges to meet than those with private health insurance, and so are likely to take greater advantage of the medical expenses income tax rebate. Set against this, however, the insurance rebates will be available each year whereas, for most people, hospital treatment is infrequent. It is difficult to know where the net advantage lies. A second argument against extending the rebate to the self-insured is that, without adequate safeguards (which could be difficult to devise and enforce), they could be more likely than those with adequate private health insurance to seek treatment in the public system, when hospital treatment of significant expense is required. On balance, the Commission considers that there is no compelling case to change the current arrangement.
- A number of submissions considered whether alternative ways of using the rebate funds would be better — in particular, the possibility of contributing the subsidy to the reinsurance pool. This would have the effect of reducing premiums for everyone who was insured, rather than just those with lower incomes. Such a proposal is consistent with a general desire to cut the burden



of double payments. On the other hand, it would reduce the incentive effect of either retaining or attracting lower income people to health insurance.

**Recommendation 20**

The Commission recommends that the rebates for ancillary insurance be abandoned. If there was a concern to maintain the overall size of the package of subsidies to private health insurance, the relevant amount could be added to the rebates for hospital cover.

**Recommendation 21**

The Commission recommends that smoother phasing provisions be introduced in both the rebate and levy surcharge arrangements.

## 10.12 A wider inquiry?

The Commission has discussed a range of possible policy measures which could be introduced. These measures:

- deal with many of the problems of adverse selection which are affecting the industry's viability;
- are in many respects fairer;
- allow greater innovation; and
- should help to remedy some of the problems that affect pricing, utilisation and efficiency in the health system.

A more detailed outline of impacts and implementation strategies is provided in the next chapter.

However, the measures are essentially incremental in nature and designed to alleviate the problems of the health insurance industry in the short term. A long-term solution will require more. Private health insurance is 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. There are grounds, therefore, for looking at other aspects of the health system. It is important, however, not to simply undertake a series of 'atomistic' reviews of different parts of the health system, because that takes as given the functioning of the other parts.

A proper review should:

- encompass the whole system and examine the interactions between the parts,
- set out principles and objectives that motivate the design of the bigger system, and
- question arrangements (such as the artificial division between the public and private hospital sector) that do not accord with those principles and objectives.

It has become apparent from this inquiry that it is impossible to define the most appropriate role of private health insurance without determining how that bigger system is intended to function. That is true for any other part of the health system by itself.

### **Recommendation 22**

The Commission recommends a broad public inquiry into Australia's health system. Such an inquiry should encompass:

- health financing, including state/federal cost shifting incentives;
- integrated health systems and coordinated care (including assessment of the role of private insurers);
- the role of copayments;
- competitive neutrality between players in the system (for example between public and private providers, between untaxed not-for-profit private hospitals and taxed private hospitals, and taxed and untaxed health insurance funds);
- market power exerted by players in the system, including supply constraints in the medical market;
- community rating, including assessment of pre-existing ailment rules;
- information management in health care (such as transferable patient records and use of information in quality assurance); and
- progress of protocol development.

In the event that such a broad strategic inquiry is considered unmanageable, a number of specific inquiries could be undertaken, focusing on themes such as financing issues, quality of health care, and competitive neutrality.

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## 11 IMPLEMENTATION AND EFFECTS

The previous chapter explained *what* needed to be done, at least in the short term, to increase stability, efficiency and equity in private health insurance. This chapter provides guidelines on *how* to implement these reforms and the likely *impacts* on premiums and on different stakeholders.

### 11.1 Implementation strategies

#### Interdependencies

Throughout this report the Commission has consistently emphasised that private health insurance is just one part of a highly complex and interrelated health system. That bigger system largely shapes the incentives and institutional arrangements of its small partner. It *is* possible to achieve some improvements in private health insurance by introducing an isolated set of reforms, but it is likely that more beneficial and durable reforms require changes in the system as a whole (applying some of the principles discussed in chapter 9).

The danger posed by piecemeal reform of a big system is that it ignores how each part relates to the others, and worst of all may actually frustrate systemic improvements. For this reason the Commission has been careful to advocate changes which:

- are worthwhile in their own right; but
- do not cut off potentially more beneficial longer term options for the Australian health care system.

The Commission's recommendations to bolster the stability and efficiency of community rated private health insurance through unfunded lifetime community rating and a range of other measures represent an *interim* solution only. Their implementation would not resolve the inherent tension between universal access under Medicare and voluntary, community rated, private health insurance. However, it would result in improved stability of the private health insurance system, and little would be lost if more fundamental changes were subsequently made as an outcome of the proposed broader inquiry. This is because, with unfunded lifetime community rating and other proposed changes, private health insurance would still continue to operate on a year-by-year unfunded basis.

Further, while the whole package of reforms is greater than the sum of its parts, the Government could nevertheless implement each of the recommendations individually with the prospect of benefit. The exceptions to this are the recommendations relating to unfunded lifetime rating and reinsurance, which are intimately linked.

## Timing

There are few barriers to immediate implementation of the Commission's recommendations. However, the Commission is of the view that introduction of unfunded lifetime community rating, amendments to reinsurance, and increased maximum waiting periods for pre-existing ailments will require short transition periods:

- With unfunded lifetime community rating, the rules of the game for late entry change. Those joining 'late' will pay a penalty. People may think that immediate introduction of such a system is unfair because just prior to the change someone could join late with no penalty, whereas just after the change they may face a large penalty. One way of accommodating these concerns is to allow a transition period — of say three to six months — in which anyone can join without penalty regardless of age. This is unlikely to have an adverse impact on the risk profile of funds so long as the entry age penalty commences at a relatively young age. Such a transitional provision may also substantially increase fund membership, especially if its timing coincides with introduction of the rebate.
- Changes to the reinsurance arrangements can have significant financial implications for individual health funds — with switches of many millions of dollars (chapter 3). For this reason, the Commission considers that any large changes to reinsurance should be phased in. How this should best be done is partly a technical problem, depending on the nature of desirable changes. The Commission considers that the new reinsurance arrangements should include appropriate transitional arrangements.
- The recommended increases to pre-existing ailment waiting periods protect existing fund members by minimising the impact of 'hit and runs'. However, if changes were implemented without notice, or too quickly, they could also prevent entry by some people who intend to become long-term members. This would actually weaken the risk profile of funds, to the detriment of existing members. Take the case of obstetrics, for example:
  - Under the present arrangements, women could join a hospital fund and receive coverage for obstetrics after nine months. Some of these

women would be ‘hit and runs’, but many of them would stay in insurance, and in doing so eventually cross subsidise the old and sick.

- A pre-existing ailment period of say two years for obstetrics would mean that to obtain obstetric coverage women must join at least 15 months before becoming pregnant. Thus, any non-member becoming pregnant in the first 15 months after the change is made could not benefit from obstetric cover under a private health insurance policy with a two year waiting period. In that case, the health funds might fail to recruit such people at all.

The Commission suggests that a period of notice of, say, three months be given to allow notification of any changes to the pre-existing ailment rules. After that, each fund could implement changes when it considered it most appropriate to do so. As the rules relate to *maximum* waiting periods, funds could then exercise their own discretion if they wished to implement shorter waiting periods to boost recruitment.

## 11.2 Broad impacts

The Commission’s recommendations aim to restore stability to private health insurance by removing the weight of regulations and tempering, if not eliminating, the perverse incentives that drive adverse selection.

Regardless of the individual impact on particular groups, the overall effect of the Commission’s recommendations is to enhance the stability, efficiency and equity of private health insurance by:

- encouraging membership through changes to premium structures;
- removing unnecessary regulatory controls;
- improving the attractiveness of the product to consumers;
- facilitating alternative care, such as out-of-hospital care, where possible;
- removing perverse incentives facing the health funds in regard to cost containment;
- encouraging efficiency of health fund management;
- improving competitive neutrality between funds;
- protecting consumers from fund collapses;

- improving mechanisms for contracting between funds, hospitals and doctors; and
- improving the effectiveness of the Government's financial incentives.

By encouraging private health insurance, the recommendations will also relieve pressure on the public hospital system, increase the viability of private provision of health care<sup>1</sup>, and augment consumer choice.

### 11.3 Impact on cost drivers

This inquiry was largely prompted by concerns about increasing health insurance premiums. While the Commission's recommendations go beyond relieving pressures on premiums, it has advocated changes which should moderate premium inflation stemming from nearly all of its sources (figure 11.1).

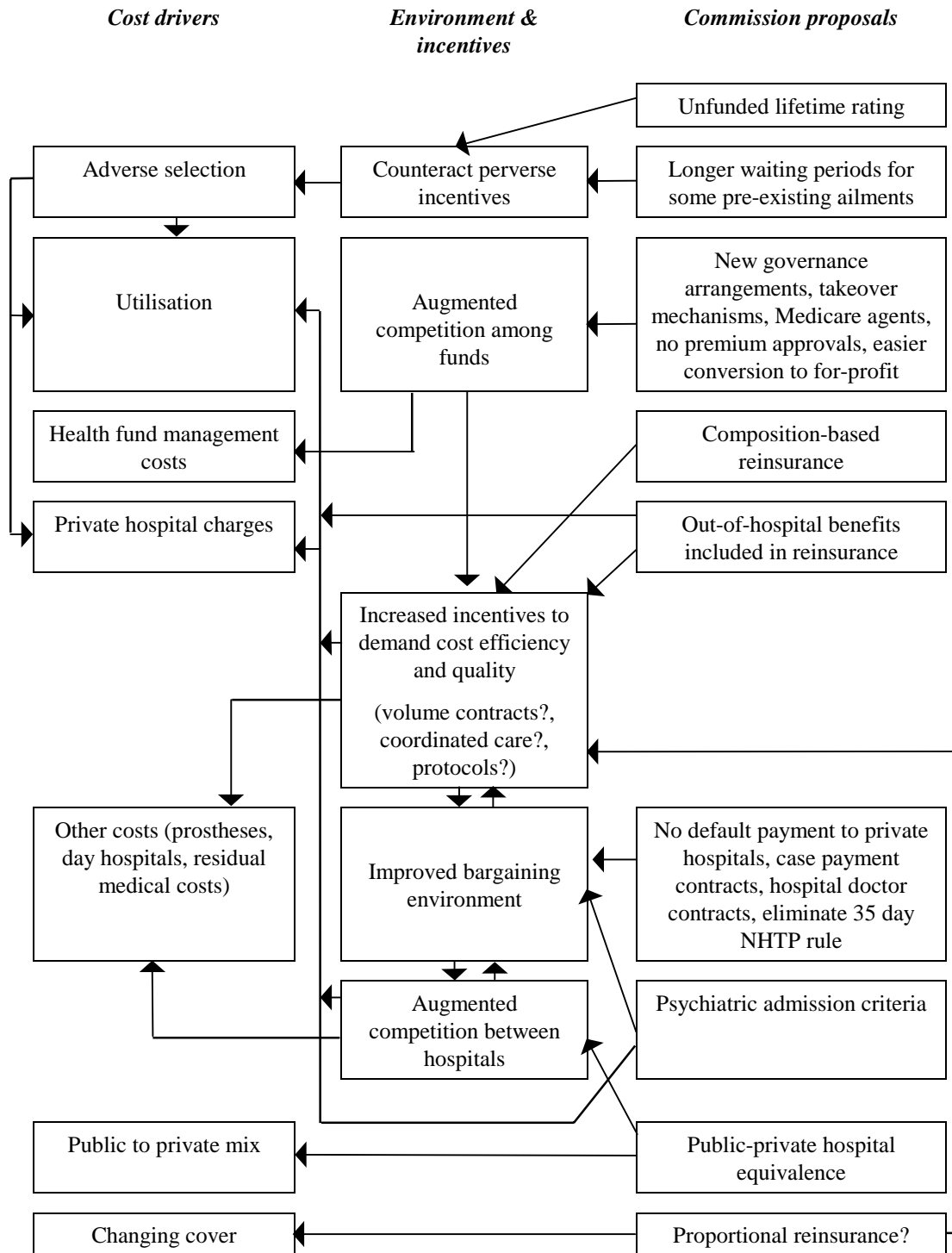
However, the Commission's recommendations aim to do more than simply address each cost driver as a separate problem. Rather, they seek to create an *environment* in which all players have incentives to minimise costs, subject to achieving quality clinical outcomes. Accordingly, the Commission's proposals aim to achieve a set of interdependent changes in the environment facing funds:

- they augment competition between funds through the introduction of takeover mechanisms, easier conversion to for-profit status, more disciplined governance arrangements, and improvements to competitive neutrality (access to Medicare retailing);
- they increase incentives for funds to demand increased efficiency of providers through the changes in reinsurance (a composition-based reinsurance scheme, the inclusion of out-of-hospital costs in reinsurance, and possible introduction of proportional reinsurance), and an improved bargaining environment in which funders and providers participate;
- they enhance competition among hospitals by improving the bargaining environment (through, for example, no default benefits for private hospitals, introduction of psychiatric admission criteria, elimination of the 35 day NHTP rule, and encouragement of case payment contracts) and by introducing full economic charging policies for public hospitals; and

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<sup>1</sup> Because the current system, quite arbitrarily, links financing mechanisms and provision.

Figure 11.1: Taking the pressure off premium growth



- they counteract the perverse incentives in the system by introducing unfunded lifetime rating and longer waiting periods for selective pre-existing ailments, such as obstetrics.

There are a number of instances where the Commission's recommendations could increase costs in one area to save them elsewhere, or to achieve other objectives. For example, the Commission recommends that where hospitals and doctors contract with each other, the full medical gap should be coverable by a fund, so long as the fund and the hospital contract on a case payment basis. Medical gap costs per service might rise, but overall costs per episode of care should fall — and insured people could elect to take out policies which either fix or fully insure out-of-pocket expenses, a major source of current frustration.

As well, regardless of the impact on premiums, there are strong grounds for introducing full economic charging in public hospitals for private patients (chapter 10). The adverse impact on premiums could be reduced by:

- a government transfer to the reinsurance pool; or
- phasing the change in over a number of years; and
- gains made from competition between private and public providers — for example, in elective surgery.

## **11.4 Impact on stakeholders**

While exact quantification of the impacts of the Commission's recommendations would be impossible, it is useful to have some understanding of the likely consequences for particular community groups. For some policy reforms, there are clear winners and losers, because the impact of reform is to redistribute resources between different parties — to cut the cake in a different way. But taken as a whole, the reforms to private health insurance advocated by the Commission, by increasing static or dynamic efficiency, would make the cake big enough that nearly every stakeholder gains.

### **Aged and sick**

#### *Stability*

Some participants expressed concern that attempts to stabilise community rating would hurt the aged and the sick. In particular, they expressed apprehension about penalising late entrants — through either longer waiting periods or higher premiums. However, if penalties for late entry are *not* introduced, the costs for



all elderly subscribers to health insurance may become insupportable as the process of adverse selection continues. The currently flawed system of community rating is like a pyramid selling scheme, in which each successive young generation takes a bet that the next will pick up their costs when old. Ultimately, when such an unstable system collapses, it is the old and the sick who bear the burden of its failure.

If a set of *incentives* (late entry penalties) encourage young people to join and stay in health insurance, this increases the stability of the system, and means that the bet they make with the unborn generation is at least a more secure one. As the risk profile of fund members improves, health insurance affordability increases, resulting in fewer longstanding members dropping out (see box 6.2 in chapter 6).

But how equitable are the late entry penalties imposed by *any* more stable version of community rating? Late entry is a rational response to the incentives posed by the current system — *but it can scarcely be regarded as equitable*. A person who joins later in life will on average pay premiums much less than the benefits they consume. Someone must pay the deficit — and it is borne by longstanding members. *Reversing this inequity is one of the advantages, not handicaps, of a shift to lifetime rating schemes.*

Further, the three to six months' period of notice suggested by the Commission should give everyone the opportunity to join a health fund under the existing arrangements:

- inevitably some people will choose to join later, and may conclude when they do that the entry penalties are too high. At worst, however, such people will still be able to use services provided by the public system (although they may have to wait for elective surgery).

By increasing the stability of private health insurance, the strains on the public system will be reduced — with benefits for those old and sick who, through income or choice, prefer to use it.

'Hit and runs' represent another form, on a much smaller scale, of adverse selection. Some sicker people could be disadvantaged by changes to the maximum waiting periods for treatment for people with pre-existing ailments. However, the changes would reduce the scope for 'hit and runs' — which are unfair to existing members, including the sick. The public system would of course also be available to treat those people, with priority accorded on the basis of clinical need.

*Cost efficiency and effectiveness of care*

The basic thrust of the Commission's recommendations is to remove some of the thick mantle of regulation inhibiting Australia's major funders of private health care. Funders play a complementary role in the system with providers and their patients. It is not in the interests of insurers to penalise the sick or to destabilise providers of care. Removing some of the constraints faced by funders should enable them to better meet the needs of their members.

Development and implementation of protocols for admission to hospital of people with psychiatric conditions, together with the development of mechanisms to facilitate the extension of hospital cover to out-of-hospital substitute care, should lead to better treatment for people with those conditions.

Similarly, the elimination of the requirement to pay nursing home type patients in private hospitals for the first 35 days at the acute rate should lead to the provision of more appropriate care in non-hospital settings. Funds will negotiate with hospitals to pay according to the type and standard of care provided.

The reinsurance mechanism has a fundamental impact on efficiency and equity within an unfunded community rating system — and effectively ensures that cross subsidies flow to the sick. The current system reallocates the hospital costs of people aged 65 or more (and of those with more than 35 days of hospitalisation a year) between health funds. Changes to reinsurance, such as an alteration of the higher risk categories included, or subdivision of the present single old age category, could result in changes to the allocation of costs between health funds — and thereby premiums. Sick or old people in one fund could benefit at the expense of those in another. However, any person can move from one fund to another given the guaranteed portability provisions. In any case, the Commission has proposed a system of reinsurance which has more 'age brackets'. This accounts better for variations in the age distributions of different funds, while simultaneously providing stronger incentives for better management of hospital costs. The overall impact should be lower average premiums, and improved care.

A more fundamental change, such as proportional reinsurance, could increase the premiums of the aged as a group relative to younger health fund members, as the aged tend to have higher cover than younger members. If implemented, it would need to involve design features which limited the potential for this to occur. However, it could have the virtue of providing other efficiency benefits and may provide an additional route for stabilising membership.

Currently, funds are not required to cover all conditions, except for psychiatric, palliative and rehabilitative care. While the Commission has recommended

provisional continuation of mandatory cover for psychiatric care, it found no grounds for mandatory cover of palliative and rehabilitative care. People will be able to elect particular insurance options they find attractive. Many funds could continue to offer palliative and rehabilitative care, in response to their members wishes, in institutional settings and with better admission criteria and treatment protocols.

The Commission has recommended the removal of the minimum default payment to private hospitals. Is this likely to have adverse impacts on:

- choice for sick people?
- access to appropriate care?
- prices paid for services?

Ultimately there is a tradeoff between achieving complete choice and the price of the service — in this case represented by the premium. The current system does not freely allow people and funds to determine commercially the optimum tradeoff, but prescribes it by requiring that all funds must deal with every hospital, at least at the default rate. The overall outcome from removal of the default is that funds are likely to contract only with some hospitals in urban areas where there are many private hospitals. Offsetting this compression in choice are likely to be reductions in costs, as funds will have incentives to contract with the most efficient hospitals or to contract for the services in which particular hospitals have a comparative advantage.

If the default were removed, cases could arise where a person is admitted to a particular private hospital with which the relevant health fund does not have a contract. For example, there may be an error made by that person, or a genuine emergency, or a particular specialist who only operates at a non-contracted hospital may be needed. In such cases, in the absence of the default benefit, that person might be liable for higher out-of-pocket expenses than otherwise.<sup>2</sup>

However, the absence of a legislated minimum default does not prevent a health fund from declaring its own minimum levels of payment to private hospitals with which formal contracts are not held. These payments, which might vary according to the circumstances of admission, the relevant condition, and the standard of treatment, could well be considerably in excess of the present legislated minimum. At present, most health funds already pay non-contract hospitals at rates substantially above the minimum default. A health fund which did not meet reasonable hospital costs would alienate its members for little

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<sup>2</sup> Even with the default, the patient would be liable for any proportion of the charges not covered by the health fund policy.

financial gain. Further, funds do appear to be meeting their members' needs for choice by contracting with a wide range of hospitals.

### *Other impacts*

Sick and old people, as a group, would benefit from several of the other recommendations:

- Removing community rating from ancillary insurance could, if anything, be beneficial for older people. There is some evidence that they draw on ancillary cover to a lesser extent than younger people. Thus, if health funds decided to differentiate ancillary premiums on the basis of age or claims experience, there could be some small decline in premiums for older people.
- Improvements in procedures to enable single billing and 'informed financial consent'.
- Better coverage of medical gaps.

### **Providers and funders**

Funders (health insurers) and providers (doctors, and private and public hospitals) exist in a symbiotic relationship. The Commission's recommendations aim to increase competition between parties (figure 11.1) but do not weaken the mutual interests of these bargaining parties to:

- sustain strong membership of health insurance, underwritten by appropriate incentives (counteracting adverse selection) and improved cost efficiency.

Competition among funds is intensified by a range of governance, takeover and competitive neutrality initiatives. Competition among hospitals would also be intensified by the introduction of full economic charging of private patients in public hospitals, removal of the default benefit, strong incentives by funds to seek cost efficiencies from providers and a range of other initiatives. The Commission sees few long-run costs to any of the players — the gains realised from increased competition are efficiency dividends, not merely re-directed revenue.

### *Doctors*

Overall, the Commission's recommendations add to the total funding available for health care in Australia by improving the stability of private health insurance. Other things being equal, this should advantage the medical profession as a group. None of the Commission's recommendations impose any constraints on doctors in matters such as: the doctor–patient relationship,

freedom to set fees, and the freedom of doctors to associate with particular hospitals.

### *Private hospitals*

Private hospitals rely on health fund members for about 80 per cent of their revenue. Thus, the recommendations aimed at improving the stability of the private health insurance industry should advantage the private hospital industry, at least in the longer run.

Nevertheless, there were objections to some of the proposals raised in the Discussion Draft from some private hospitals and their associations. Some of these proposals have been modified in this final report — in relation to psychiatric care, for example — and the objections may not still apply in those cases. However, it can be presumed that private hospitals would still object to the recommendations about:

- rehabilitative and palliative care;
- the removal of legislated minimum default benefits;
- the extension of maximum waiting periods for pre-existing ailments (a longer waiting period for obstetrics was supported); and
- the removal of the 35 day rule for NHTPs.

It may well be that adoption of these recommendations could, in the shorter term, result in some loss of revenue for individual private hospitals (for example one reliant on NHTPs).

However, these recommendations (together with the others) are necessary to reduce the destabilising adverse selection in the health funds, and remove unnecessary or unjustified costs imposed on them by existing requirements. In the medium term, this should result in stabilisation of health fund membership and thus, indirectly, improve the prospects of the private hospital sector generally.

Indeed, unless the Commission's recommendations are adopted, or other similar action is taken, private health insurance could continue to decline with consequent adverse longer term effects on the private hospital sector.

In regard to the default benefit, it is clear that for non-emergency admissions this is not at present generally a binding constraint — the APHA indicated that the default rates are well below the levels of profitable operation for most hospitals. Thus, it is already possible for the health funds to pick and choose among hospitals if they wish — they can advise members to avoid particular

(non-contracted) hospitals because they would not be adequately covered. However if, as advocated by the APHA, the default were to be lifted to 85 per cent of average benefits from the present level of less than one-half, the funds would, in effect, be compelled to deal with *all* private hospitals. This is effectively the situation which currently prevails with the higher emergency default.

In the Commission's view, it would be anti-competitive and inimical to encouraging greater efficiency in health funds and private hospitals to require all health funds to deal with all private hospitals. As discussed above, there is likely to be little adverse effect on patients from removal of the legislated minimum default.

As previously noted, the measures recommended by the Commission should augment competition among private hospitals. This also should increase the incentives for private hospitals to improve efficiency, and to improve the quality of care provided to their patients.

### *Public hospitals*

Full economic charging of private patients in public hospitals would achieve competitive neutrality between the public and private sectors — and begin to transform the currently arbitrary funder-provider links. In an environment of competitive neutrality, it seems increasingly artificial that most private patients should be referred to private hospitals, and public patients to public hospitals. Thus, for example, full economic charging may lead to a stronger role by public hospitals in the treatment of private patients seeking elective surgery.

Several participants expressed concern about proposals which might shift health expenditure back to the public hospital system. For example, some individuals may respond to deterrents to late entry and hitting and running by never joining private health insurance.

It is likely, however, that the main effect will be to encourage existing members to stay and non-members to join earlier than they otherwise might.

In other words, the net effect of these measures is to stabilise insurance membership and reduce pressure on the public system.

### *Health funds*

As noted above, the Commission's recommendations should enhance the stability, efficiency and equity of private health insurance in a number of ways. This of course would bring benefits to the private health funds themselves.

However, the recommendations also affect the funds in a number of specific ways. For example, the initiatives relating to governance and the conduct of health funds aim to enhance competitive disciplines on the funds — they will need to reduce operating costs, improve their management skills, and become more accountable to members.

Most of the recommendations do not discriminate between *categories* of fund: big and small, restricted and open, for-profit and not-for-profit. But to take full advantage of the measures which enhance the environment in which they compete, all funds will need to seek ways of adding value to the services they provide for their members, and to become more skilled in negotiation with health care service providers. Some will be more successful in adapting than others.

### **11.5 Summing up**

Overall, the Commission's recommendations are designed to enhance community welfare by increasing the efficiency and equity of the private health care system. The recommendations should also take some pressure off the public system. Premiums should be lower, and health insurance *less* prone to instability. No community group would be unfairly disadvantaged, especially with the transitional arrangements proposed.

Nevertheless, the policy proposals cannot resolve some of the wider tensions that exist between a voluntary, community rated, private health insurance system, and universal 'free' access under Medicare. For this reason, the Commission has recommended a broad public inquiry into the Australian health care system.

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## APPENDIX A: TERMS OF REFERENCE

I, PETER COSTELLO, Treasurer, under Part 2 of the Industry Commission Act 1989, hereby:

1. refer the private health insurance industry in Australia to the Industry Commission for inquiry and report by 28 February 1997;
2. specify that the inquiry will be conducted against the background of the Government's policy to retain Medicare, bulk billing and community rating, and to provide financial incentives for families and individuals with health insurance;
3. specify that in making its recommendations, the Commission aim to improve the overall economic performance of the Australian economy;
4. specify that a draft report need not be made available;
5. request that the Commission report on:
  - (a) the current state of the private health insurance industry including its structure and efficiency;
  - (b) the cost pressures upon the industry, particularly:
    - (i) the impact of declining membership levels;
    - (ii) increasing health care costs, including the relationship between private health funds and hospitals;
    - (iii) usage of private hospitals;
    - (iv) the impact of reforms allowing the setting of premiums for 100 per cent private cover; and
    - (v) the different costs to the industry of hospital beds in private and public hospitals;
  - (c) the most effective means of ensuring that contributors receive the maximum benefit from the Government's private health insurance financial incentives;
  - (d) options to encourage the emergence of innovative and price competitive products which cater for the varying needs of consumers;



- (e) an appropriate regulatory framework within which funds should set reserves and premiums;
  - (f) any other measures which could be undertaken to remove impediments or otherwise contribute to the efficiency and development of a competitive industry; and
  - (g) the identification of groups which would benefit from, or be disadvantaged by, any measures which would flow from 5(d), (e) and (f) above, and implementation strategies for the proposed measures;
6. specify that the Commission have regard to:
- (a) any recent substantive studies undertaken elsewhere;
  - (b) the economic and social objectives of government;
  - (c) the Health Insurance Act 1973 (Part III) and the National Health Act 1953 (Part VI, VIAA, VIA, VIB, VIC and Schedule 1);
  - (d) the Legislative Review provisions of the Competition Principles Agreement;
  - (e) the report of the Senate Community Affairs Legislation Committee on the private health insurance reforms; and
  - (f) reforms being developed in the COAG process; and
7. note the intention that the Commission's recommendations will be considered by the Government and its response announced as soon as possible.

PETER COSTELLO

17 September 1996

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## APPENDIX B: PARTICIPATION IN THE INQUIRY

### B.1 Research team

The following staff assisted in the preparation of this report:

Ralph Lattimore	Assistant Commissioner
Jim Roberts	Inquiry Director
Ian Bickerdyke	Director
Paul Emery	Director
William Kerley	Assistant Director
Robert Phillips	Assistant Director
Claudia Leslie	Senior Research Officer
Abdul Waris	Senior Research Officer
Geraldine Martisius	Administrative Support Officer
Jill Irvine	Administrative Support Officer

### B.2 Submissions

The following table lists submissions received during the inquiry. Those with the prefix 'D' were received following the release of the Discussion Draft. All submissions containing personal medical information have been treated as 'Confidential' unless the Commission was otherwise advised.

Participant	Submission No.
Acute Care Advisory Committee	104
Adams, Leonora	155
Allen, J and A	2
Allen, J R	100
Allen, Ailsa E	101
AMP Financial Services	159
AMR Pty Limited	160, D198
Association for the Advancement of Private Health	109
Australian Association of Private Radiation Oncology Practices	177
Australian Association of Surgeons	124, D209, D261, D283
Australian Association of Surgeons — SA	7

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Participant	Submission No.
Australian Cancer Society	42
Australian Catholic Health Care Association	150, D215
Australian Consumers' Association	77, D238, D266
Australian Dental Association Inc.	50
Australian Dental Association South Australian Branch Inc	75
Australian Dental Association Victorian Branch Inc.	59
Australian Doctors' Fund Limited	184, D224
Australian Health Insurance Association Ltd	108, D221, D279, D280, D282, D284, D286
Australian Health Management Group	81
Australian Health Service Alliance Ltd	44, D274
Australian Hospital Care Ltd	82
Australian Institute of Health & Welfare	169, 178, D202, D207
Australian Medical Association Limited	130, D223
Australian Nursing Federation	22
Australian Pensioners' & Superannuants' Federation	D258
Australian Physiotherapy Association	105
Australian Private Hospitals Association	51, D217
Australian Private Hospitals Association Psychiatric Committee	63
Australian Services Union New South Wales Clerical and Administrative Branch	46
Australian Society of Anaesthetists	65, D247
Australian Unity Friendly Society	163
Bailey, J S	188
Baker, W L	111, D268
Ban, Elizabeth	148
Beacham, Dr Bronwen	76, D222
Belcher, Ms Helen	D244
Bendall, Grace	135
Bensley, Douglas	3
Blackwood & District Community Hospital Inc	D212
Boyce, Jillian	173
Brown, Alan	34, D231
Burt, K	134
Busuttil, Paul	89
Caldecott, John E	D263
Campbell, Clem	86
Caritas Christi and Order of Malta Hospice Home Care Service	43
Caritas Christi Hospice	138
Carroll, Peter	9, D213
Chappell Dean Pty Limited	18
Chesterfield-Evans, Dr Arthur	67
Church & Charitable Private Hospitals Association Inc.	126
Clark, Roger	1
Clarke, Allistair R	96
Coghlan, Rebecca	93
Collopy, Brian T	185
Concerned Citizens Association of WA	16
Consumers' Health Forum of Australia Inc.	64, D254
Coopers & Lybrand	58
Council of Procedural Specialists	D256
Council on the Ageing (Australia)	D246

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<b>Participant</b>	<b>Submission No.</b>
Croydon, Kerry	103
Department of Health and Family Services	175, D277
Diabetes Australia	D267
Dillon, Patrick C	118
Doctors Reform Society (Australia)	52, D233
Douglas, Graham	97
Dowling, Gillian	172
Dowling, Marie	87
Drummond, Philip	115
Dunhill Madden Butler	69
Dye, Esmee	114
Eastern Metropolitan Palliative Care Providers Group	62
EB Consultants Pty Ltd	D281
Edwards, E	147
Employers Health Group	91, D219
FAI Health Benefits Ltd	30, 166
Federation of Natural & Traditional Therapists	17
Ferguson, J R	149
Fit For Work	131
Fitzgibbon MP, Mr Joel	D269
Florance, Marjorie S	146
Fowler, M R	171, D240
Frank, Oliver	10
Franz, Mrs Moray MacDonald	47
Fremantle Kaleeya Hospital	154, D199
Fuller, Ronald J	119
Gay, Cheryl	156
Geary, Faye	85
Gentleman, Stephen	137
Gilchrist, Patricia	167
Good, Mary H	145
Goodfellow	98
Government Employees Health Fund	D220
Graham, Lindsay	31
Grampe, Maryellen Adelaide	121
Gray, A S	116
Green, Robert C	143
Hardwick, Nancy	174
Harrington Associates Limited	56, D201
Harwood, Karen	8,
HCF of Australia Limited	158, 179, D225, D276, D278
Head, Mr Richard J	D226
Health Benefits Council of Victoria	D265
Health Care of Australia	128, D248
Health Consumers' Council WA (Inc)	24
Health Insurance Restricted Membership Association of Australia	71, 144, D204, D273
Health Issues Centre	125
Healthscope Limited	190
Hindle, Professor Don	D205
Hospital Benefit Fund of Western Australia (Inc)	33, D228, D270

<b>Participant</b>	<b>Submission No.</b>
Hospitals and Health Services Association of South Australia Inc.	55
Hutchinson, Dr Leone	60
Institute of Actuaries of Australia	141, D218, D288
Insurance Council of Australia Limited and the Life, Investment and Superannuation Association of Australia	161, 189
Jones, Dr David Neil	120, D235
Lapsley, Helen	181
Latham, Mark	4
Lott, Mark	79
Lysaght Hospital and Medical Club	107
Mackenzie, Leanne	95
Macquarie Health Corporation	129, D271
Manchester Unity Friendly Society (NSW)	D245
Mannix, Gary	170
Manson, David	11
Marland Consulting Pty Ltd	D196
McAuley, Ian A	13, D194
McCuaig, John	152
McRae, Murray	D200
Medibank Private	168, D192, D242
Medical Benefits Fund of Australia Limited	29, D203, D275, D285
Medical Industry Association of Australia	70
Menzies, Commander Fred	5
Mercantile Mutual Health Limited	142
Minister for Community and Health Services — Tasmania	182, D272
MIRA Consultants Limited	53
MIRA Consultants Limited and Dr Walther Neuhaus	D239
Morey, Burnard S	113
Morrison, Robert L	20, D195
Motor Neurone Disease Association of Australia Inc.	36, D241
Murphy, J	151
Nagy, Joe	112
National Association of Nursing Homes and Private Hospitals Inc.	32, D227
National Association of Practising Psychiatrists	D243
National Association of Specialist Obstetricians and Gynaecologists	187
National Community Advisory Group on Mental Health	49, D229
National Herbalists Association of Australia	39
National Mutual Health Insurance Pty Ltd	140, D210, D287
Naval Health Benefits Society	72
New South Wales Government	180
Newton, Peter	183
NIB Health Funds Limited	D236
Niola Private Hospital	54, D255
NSW Health Funds Association	57
O'Donnell, Carol	132
O'Dwyer, Lawrie	88
Ohlrich, John	6
Oulianoff, Peter	122
Over Fifties Focus	D251
Owen, Professor Harry	D208

<b>Participant</b>	<b>Submission No.</b>
Palmer, Professor George	61
Passier, Robert	78
Peerson, Ms Anita	D211
Phillips Fox	25, D230
Prior, M S	99
Private Health Insurance Administration Council	90, D262
Private Health Insurance Complaints Commissioner	80, D259
Private Hospitals Association of Queensland	D232
Private Hospitals Association of Victoria	74
Public Health Association of Australia's Political Economy of Health Special Interest Group	84
Qual-med Pty Ltd	14
Queensland Health	176, D252
Queensland Mental Health Consumer Advisory Group	D257
Ramsay Health Care Group	127, D216
Randerson, J R	191
Richard Glenn and Associates	68
Rousell, Mrs Lyn	D206
Rowles, John	117
Royal Australasian College of Radiologists	35, D253
Royal Australasian College of Surgeons	27
Royal Australian and New Zealand College of Psychiatrists	102, D260
Ryall, Lesley	153
Savins, G	40
Scotton, Professor R B	D234
Secal Monitored Security Alarms	21
SGIO Health Pty Ltd (previously SGIC Health Pty Ltd)	26, D237
Sharry, Leo	186
Simmonds, David and Margaret	110
Sims, Angela	165
Sinclair Wornell & Associates Pty Ltd	D264
Smith M.H.R., Tony	83
Smith, Lindsay M	23
South Australian Government	D193
Speech Pathology Association of Australia	41
Spielman, Dr Ron	19
Sprinkmeier, Thomas	94
St John of God Health Care System Inc.	66
St John of God Hospital - Richmond	D214
Stace, Trevor	48
Stephenson, N J H	45
Strehlow, Rotraud	157
Stuart, W D	15
Tattam, Amanda	92
Tonnet, Joyce	139
Tony Wade & Associates	37
Torre, Andrew	28
Tuckey MP, Wilson	12
Urological Society of Australasia	164
Vercoe, Bill	123, D250
Victorian Association for Hospice and Palliative Care Inc.	38

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Participant	Submission No.
Victorian Community Advisory Group on Mental Health	D249
Walker, Brent	73, D197
Westfund — Western District Health Fund Ltd	133
Winsen, J K	136
Woodroof, A A	106
Yeates, Nan	162

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### B.3 Roundtable

The following people participated at Roundtable discussions held by the Commission on 1 October 1996.

Mr Garry Richardson  
National Mutual Health Insurance/  
Hospital Benefits Association

Ms Colleen Krestensen  
Deputy Director  
Consumer Health Forum

Mr Dudley Wrigley  
General Manager  
NSW Teachers' Federation Health Society  
(NSW Teachers' Fund)

Dr Bill Coote  
Secretary-General  
Australian Medical Association

Mr Peter Baulderstone  
National Director  
Australian Hospital Association

Mr Russell Schneider  
Chief Executive  
Australian Health Insurance Association

Dr Maura McGill  
General Manager, Legal and Policy  
Health Care of Australia

Mr Francis Sullivan  
Executive Director  
Australian Catholic Health Care Association

Mr Ian Chalmers  
Executive Director  
Australian Private Hospitals Association

Mr Clive Ashenden  
Managing Director  
Medical Benefits Fund of Australia Ltd

Dr John Deeble  
National Centre for Epidemiology and  
Population Health  
Australian National University

Mr Andrew Podger  
Secretary  
Department of Health and Family Services

Mr Brent Walker  
Brent Walker Actuarial Services

Professor Jeff Richardson  
Monash University

Mr John Evered  
Managing Director  
Health Insurance Commission

## **B.4 Discussion draft**

The Commission released a Discussion Draft for public comment on 18 December 1996. Prior to the public release, the Commission held two briefings:

- on 17 December for ministerial and departmental advisers; and
- on 18 December for some key stakeholders.

## **B.5 Public hearings**

To receive comment on the Discussion Draft, public hearings were held in Melbourne on 28 January 1997 and in Canberra on 30–31 January. The following participated:

Australian Association of Surgeons  
Australian Catholic Health Care Association  
Australian Consumers' Association  
Australian Doctors' Fund  
Australian Health Insurance Association  
Australian Medical Association  
Australian Private Hospitals Association  
Carroll, Peter  
Doctors Reform Society (Australia)  
Employers Health Group  
Government Employees Health Fund  
HCF of Australia  
Health Insurance Restricted Membership Association of Australia  
Hospital Benefit Fund of Western Australia  
Institute of Actuaries of Australia  
National Community Advisory Group on Mental Health  
National Mutual Health Insurance  
NIB Health Fund  
Phillips Fox

## **B.6 CEDA forum**

A CEDA (Committee for Economic Development of Australia) Forum was held in Sydney on Thursday 23 January 1997 to receive comment on the Commission's Discussion Draft. The Presiding Commissioner, Gary Banks, made a presentation at the forum. It was also attended by Dr Brendon Kearney, the inquiry's Associate Commissioner.



## B.7 Informal discussions and visits

Allsop, Dr John  
AMP General Insurance  
Association for the Advancement of Private Health  
Australian Health Insurance Association  
Australian Hospital Care (AHC) Group  
Australian Hospitals Association  
Australian Institute of Health and Welfare  
Australian Medical Association  
Australian Private Hospitals Association  
Baume, Professor Peter — School of Community Medicine, University of NSW  
Bluhm, Mr Bill  
Brent Walker Actuarial Services  
Chappell Dean Pty Ltd  
Consumers' Health Forum  
Deeble, Dr John — National Centre for Epidemiology and Population Health, ANU  
Duckett, Professor Stephen — Dean of Health Sciences, LaTrobe University  
Department of Health and Family Services  
Department of Health — WA  
Department of Human Services  
Department of Prime Minister and Cabinet  
Eastern Metropolitan Palliative Care Group  
HCF  
Health Care of Australia (HCoA)  
Medibank Private (Health Insurance Commission)  
Health Issues Centre  
Institute of Actuaries  
Insurance and Superannuation Commission  
Lapsley, Ms Helen — University of NSW  
LISA/ICA  
Logan, Mr John  
McAuley, Mr Ian  
Medical Benefits Fund (MBF) of Australia  
National Mutual Health Insurance  
NSW Department of Health  
NSW Teachers Fund  
Palmer, Professor George — University of NSW  
Private Health Insurance Administration Council  
Private Health Insurance Complaints Commissioner  
Richardson, Professor Jeff and Ms Leonie Segal — Centre for Health Program Evaluation,  
Monash University  
Royal Australasian College of Surgeons  
Scotton, Professor Richard — Centre for Health Program Evaluation, Monash University

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## APPENDIX C: RATING SCHEMES

### C.1 Introduction

As discussed in the main report, the existing version of community rating has a number of major flaws, particularly a susceptibility to adverse selection. As chapter 7 indicates, adverse selection is one of the key drivers of premium increases and instability in the system.

The Commission examined a number of alternative rating schemes, still within the orbit of community rating, to see whether they were practicable. This was done against a backdrop of some structural and administrative principles that would seem desirable.

#### Structural principles

- *Deter 'hit and runs'.* Opportunistic use of health funds (taking out cover with the intent of claiming, and then leaving after the claim) is a perfectly rational response by consumers within the existing regulatory framework. However, hit and runs put pressure on premiums, further undermine the stability of the system and are inequitable to long term members.
- *Deter late entry ('hit and stays').* From an actuarial perspective the optimal time to enter a health fund for a risk neutral consumer is around age 65 years. Yet the more people who enter later, the less cross subsidy is available to the old and the sick, and the higher their premiums have to be. Some may see barriers to late entry by the old and the sick as inequitable. But in fact, it is the old and sick who are most adversely affected by a policy which allows unpenalised late entry.
- *An ability to attract new, younger, and more healthy people to health insurance,* so as to 're-balance' the skewed demographics of the existing pool of contributors. Unless funds can stem the flow out of, and/or promote the entry into, insurance by the young and healthy, then premiums will continue to rise rapidly.
- *Not adversely affect existing members.*
- *Not discourage use of health insurance by the old or the sick.* Health insurance offers consumers two valuable features: genuine insurance, at any age, for unanticipated health care costs; and a funding mechanism for

meeting the fairly predictable costs of the aged. If health insurance only met the needs of the young and healthy, it would fail to meet these key objectives adequately. It would intensify pressures on the public system as the sick and the old made increased demand on public hospitals, and threaten the viability of private supply of health care services.

### **Administrative principles**

- *Involve no lengthy or costly transitions.* There is a tradeoff between the cost of change and the benefits that would be created by developing a better system.
- *Be administratively feasible,* involving simple and transparent arrangements.
- *Be robust to sovereign and other regulatory risks.* Changes in Australia's health system — engendered by policy in response to changing technology, financing demands, demography, preferences or other pressures — are inevitable. This raises questions about how different rating schemes would fare in a changed environment. Would there be big costs associated with moving away from the rating scheme at some future date? Would particular rating schemes be likely to prejudice broader reforms because they lock people into a system which is too costly to alter? Would the very possibility of vulnerability to change weaken the uptake of health insurance under the new rating scheme?
- *Allow portability between funds.* Portability between funds by members encourages competition among funds. If people were locked into long-term arrangements with particular funds, these competitive forces could be diluted to the detriment of consumers and economic efficiency.
- *Meet the needs of people who may be unable to contribute all their lives.* Arguably, people who periodically left insurance (for example, because of employment overseas or a low income period) would need to have provision for preservation of past benefits, rather than starting afresh on return at a new entrant's premium contribution rate.
- *Not hinder product innovation.* For example, some rating schemes may make it hard for people to shift from a lower benefit product to a higher benefit product over their lifecycle.
- *Not create barriers to entry by new funds.*
- *Be feasible given the new membership categories.*

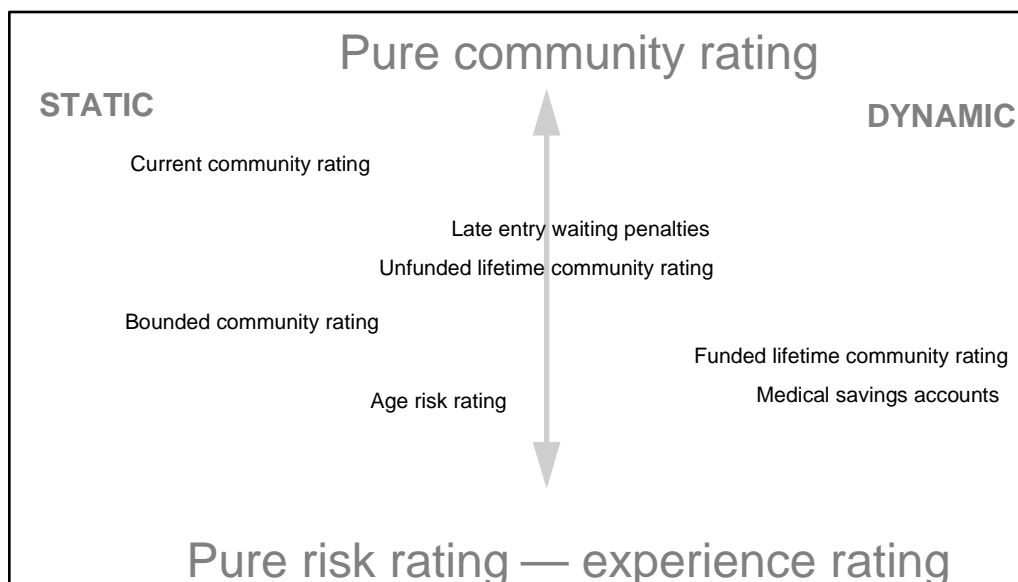
No single scheme can meet all these principles. But some would do better than others. The Commission examined five types of schemes:

- funded lifetime community rating;

- unfunded lifetime community rating;
- a non-price version of unfunded community rating — late entry waiting periods;
- bounded community rating; and
- medical savings accounts.

It should be emphasised that **none** of these schemes are ‘pure’ community rating schemes (figure C.1). A pure community rating scheme would require an equal payment from each member for private health insurance. The current system is a hybrid in which payments can vary significantly by member, because family size is ignored, and where premium relativities exist between certain prescribed classes of membership. With exclusions and front end deductibles, the current system embodies an implicit acceptance of partial age rating.

Figure C.1: The rating scheme continuum



Medical savings accounts (MSAs) and funded lifetime rating are *dynamic* versions of age rating. In theory, if age rating were allowed, some funds might offer MSAs and funded lifetime rating policies as options. Because they smooth premiums *over time*, these policies allow a person to pay the same relative premium over a lifetime — and in this sense meet the principal objective of ‘community’ rating to redistribute the burden between the sick and the healthy. However, they achieve this end by spreading the burden across a narrow group of people over time (or in the case of MSAs just one person), instead of across a wide cross-section of people at a given time.

Bounded rating is overtly a compromise between full age rating and pure community rating — representing an elaboration of the current scheme.

Unfunded lifetime rating and late entry waiting periods incorporate dynamic features, in that they provide incentives for early entry (disincentives for late entry) but are static in that they are unfunded schemes which spread the burden of the sick across the community at a given time.

## **C.2 Funded lifetime community rating**

### **Description**

The current system of community rating is an unfunded scheme in the sense that it is a ‘pay as you go’ scheme. The costs of the claimers in any one year are met principally by contribution income in that year. Reserves ‘smooth’ year to year fluctuations in drawing rates, but have no long term financing function. The current group of people aged 20–40 years finance the health care needs of the currently sick and elderly, and rely on a yet to be born generation to fund their health care needs when they have aged — a bad bet if there are not enough young people interested in health insurance in thirty years time. In this sense, an unfunded voluntary community rating scheme is subject to the same risks as pyramid selling schemes.

An alternative rating scheme achieves parity between the premium *rates over the lifecycle* by accumulating reserves when people are young, and drawing them down when they are old. Under funded lifetime rating, a group of people born in a particular year fund the lifetime costs of that cohort. The next year’s cohort funds themselves and so on. There are no intergenerational transfers unlike in unfunded schemes. However, there *are* intragenerational transfers.

For example, say that 50 000 people are enrolled in a lifetime scheme at birth in 1997. Each person pays the same premium, and apart from inflation in hospital costs will pay the same premium until they die. Some may never claim, finally dying of a heart attack while jogging at 80 years of age — others may be chronically ill over a long period and make substantial claims on reserves. But claims on these reserves are restricted to the class of ‘97.

What happens to late starters? That is, say you were born in 1997 but did not join a lifetime scheme until 2060? Such a late entrant has to pay a lot more under a fully funded scheme compared to the early starters because they have to start accumulating reserves for a now not too distant old age, whereas the early

starters have 60 years of accumulated reserves established. Thus lifetime rating removes any incentive for late entry.

## Impact

What sort of pricing structure could be expected under a funded lifetime rating scheme? The Commission undertook some simple analysis (box C.1) to indicate the possible magnitude of lifetime premiums drawing on the analysis and data provided by Alan Brown (Sub. 34).

### Box C.1: Modelling lifetime rating

We used the following assumptions:

- People cannot live beyond 100 years old, though may well die before reaching 100.
- Rating is done on a per member basis, not on an SEU basis. This makes it easier to undertake the calculations and will provide an indication of the relative magnitudes of premiums under the existing unfunded community rating scheme compared to a funded lifetime rating scheme.
- A person leaving a lifetime rating scheme receives full redemption of their share of the accumulated reserves of their cohort at the time of departure. This assumption means that we do not have to model the age specific likelihoods of people leaving the scheme, other than through death.
- We assume that real drawing rates are fixed over time. In fact, they have been changing quite rapidly. However, any practical implementation of lifetime rating would probably not try to build in anticipated real lifetime premium increases to keep premiums literally fixed through life. Instead, from year to year, there would be premium adjustments to meet above inflation increases in hospital costs.

The present value of total benefits consumed by a cohort, born at time  $t$ , who enter a lifetime rating scheme at birth is:

$$PVB_t = \sum_{a=0}^{100} \frac{d_a N_a}{(1+r)^a} \quad \{1\}$$

where  $d_a$  is the inflation adjusted drawing rate of people of age  $a$ ,  $r$  is the real discount rate and  $N_a$  is the number of survivors of age  $a$ . The number of survivors (averaged over the year) is calculated as:

$$N_a = (h_a + h_{a-1}) / 2 \quad \{2\}$$

/cont'd

**Box C.1: cont'd**

where  $h_a$  is the number of people of age  $a$  at the beginning of the period  $a$ . In turn  $h$  is determined as:

$$h_a = h_{a-1} \times (1 - s_{a-1}) \quad \text{and} \quad h_0 = H \quad \{3\}$$

where  $s_{a-1}$  is the probability of survival over the next year of a person aged  $a-1$  and  $H$  is the number of people born in the starting year.

Under lifetime rating, the present value of total contributions made by a cohort who start contributing at birth is:

$$PVC_t = C \sum_{a=0}^{100} N_a / (1+r)^a \quad \{4\}$$

where  $C$  is the inflation adjusted lifetime premium,  $r$  is the real discount rate and  $N_a$  is the number of survivors of age  $a$ .

Ignoring the loading fee associated with insurance, the premium  $C$  must be set to cover lifetime expenses. Accordingly the lifetime premium of a person born at  $t$  and contributing from time  $t$  is:

$$C_t = \frac{\sum_{a=0}^{100} d_a N_a / (1+r)^a}{\sum_{a=0}^{100} N_a / (1+r)^a} \quad \{5\}$$

If someone enters at a time later than  $t$ , the appropriate premium must be re-calculated as:

$$C_j = \frac{\sum_{a=j}^{100} d_a N_a / (1+r)^{a-j}}{\sum_{a=j}^{100} N_a / (1+r)^{a-j}} \quad \{6\}$$

where  $j$  is some time between  $t$  and 100.

The Commission compared the value of  $C$  derived using this method with the rate that would apply under a pure 'pay as you go' community rate. The pure unfunded community rate across the *cross-section* of the population at time  $t$  is calculated as:

$$CR_t = \sum_{a=0}^{100} d_a \beta_{a,t} \quad \text{where} \quad \beta_{a,t} = \frac{I_{a,t}}{\sum_{a=0}^{100} I_{a,t}} \quad \{7\}$$

where  $I_{a,t}$  is the number of insured persons aged  $a$  at time  $t$ .

The analysis suggests that the one crucially important distinction between unfunded community rating and lifetime rating is that the community rate

changes as the age distribution of each year's cross-section alters, while the lifetime rate is invariant to shifts in the age distribution. For example, over time, ageing and adverse selection can have profound effects on the share of insured who are in high risk, high drawing groups. Thus, the community rate in 65 years time for a person now aged 0 will reflect the age distribution of the insured population 65 years from now. In contrast, the lifetime premium rate in 65 years of a person now aged 0 is quite independent of the age distribution prevailing in 65 years time — any cohort is self-funding throughout their lives.

Figure C.2 shows the relative price of a lifetime versus an unfunded community rated premium. The lifetime premium is 30 per cent lower than the community rate, reflecting the fact that:

- *reserves* earn interest; and
- *excess* reserves are not bequested.

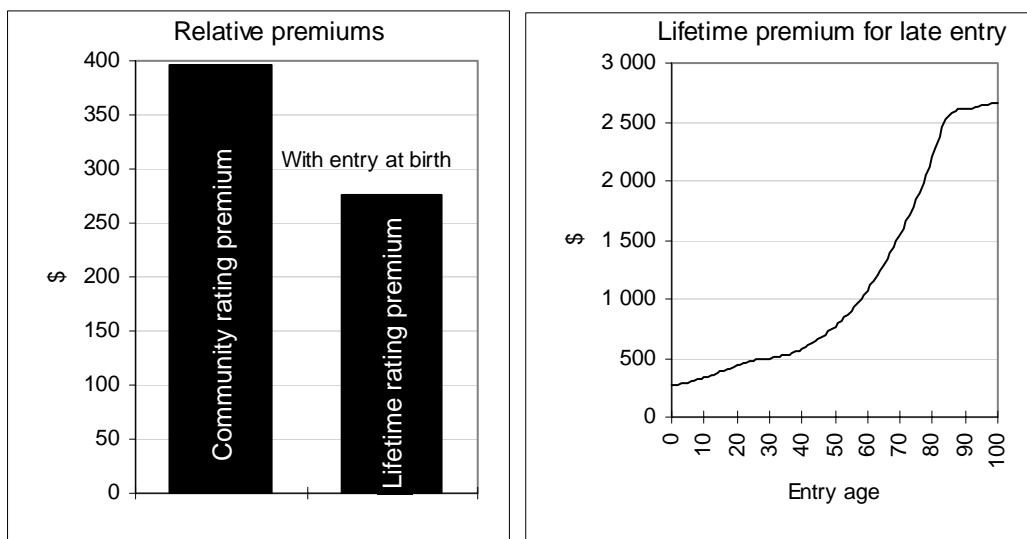
Moreover, funded lifetime rating premiums are not subject to age adverse selection whereas pay-as-you-go community rated premiums are. The relative advantage of the lifetime rated premium over the community rated premium could be well in excess of 30 per cent in a number of years.

In the long run, a shift to funded lifetime rating would be likely to attract many more young people to health insurance because of the lower premium and large penalties for joining late (figure C.2). For example, a person joining at birth pays nearly half the premium of someone who joins at age 40. Funded lifetime rating therefore eliminates the incentives for adverse selection by age. Over time, this is likely to 're-balance' the demography of health insurance, *reversing* the vicious circle.

Funded lifetime rating reduces but does not significantly eliminate incentives to 'hit and run'. Compared to the current scheme, funded lifetime rating somewhat penalises a person who periodically 'raids' a fund for benefits because they face a higher premium on second and subsequent raids. Even so, incentives for hit and run for expensive operations, such as hip replacements, still remain.

Funded lifetime rating would also eliminate most incentives for cream skinning — arguably leading to less proliferation of product types.



Figure C.2: Funded lifetime versus community rating premiums<sup>a</sup>

a These results are based on estimates of the key parameters. The estimates are based on data applying to the calendar year 1995. The drawing rate ( $d_a$ ) was estimated as  $d_{a,1995} = (1+\gamma) d_{a,1992}$  where  $d_{a,1992}$  is the MIRA estimate of drawing rates for 1992 and  $\gamma$  is the growth rate in drawing rates consistent with the observed aggregate benefits paid during 1995. That is:

$$\gamma = \text{benefits}_{1995} / \sum_{a=1}^{100} d_{a,1992} I_a - 1$$

where  $\text{benefits}_{1995}$  is the aggregate benefits paid in 1995 (from PHIAC data). The real discount rate is set at 3 per cent. A higher discount rate significantly lowers the lifetime community rate. For example, if  $r = 5$  per cent, the lifetime rate is \$211 instead of \$276. The community rate is determined using equation {7} in box C.1. The values of  $I_a$  were estimated as:

$$I_a = \psi_a N_a$$

where  $\psi_a$  is the propensity to insure (derived by applying a natural cubic spline to unpublished data from the ABS Health Survey, 1995) and  $N_a$  is population by age data for 1994–95 from the ABS.

Where funds effectively manage the lifetime risks of sets of cohorts of a certain age, rather than simply pooling risks across cohorts of different ages at any particular time (as now), there are portability and prudential supervision challenges akin to those prevailing in the superannuation industry.

Any funded lifetime rating scheme would have to develop fairly straightforward redemption options for consumers wishing to move from one fund to another or to leave insurance altogether (for example overseas or when unable to afford premiums). Superannuation policies have developed such redemption options, and it seems highly likely that effective exit and portability mechanisms could be conceived.

An experimental exit mechanism is described in box C.2. Under the current community rating system, insured people with reduced income or with episodes of sickness may not be able to afford to maintain their insurance. They forfeit

their accumulated premiums, a situation they see as very unfair. Contrary to the concerns expressed in the Discussion Draft, the existence of redemption options under a funded lifetime rating system is likely to solve this problem.

### **Box C.2: Exit mechanisms for funded lifetime rating**

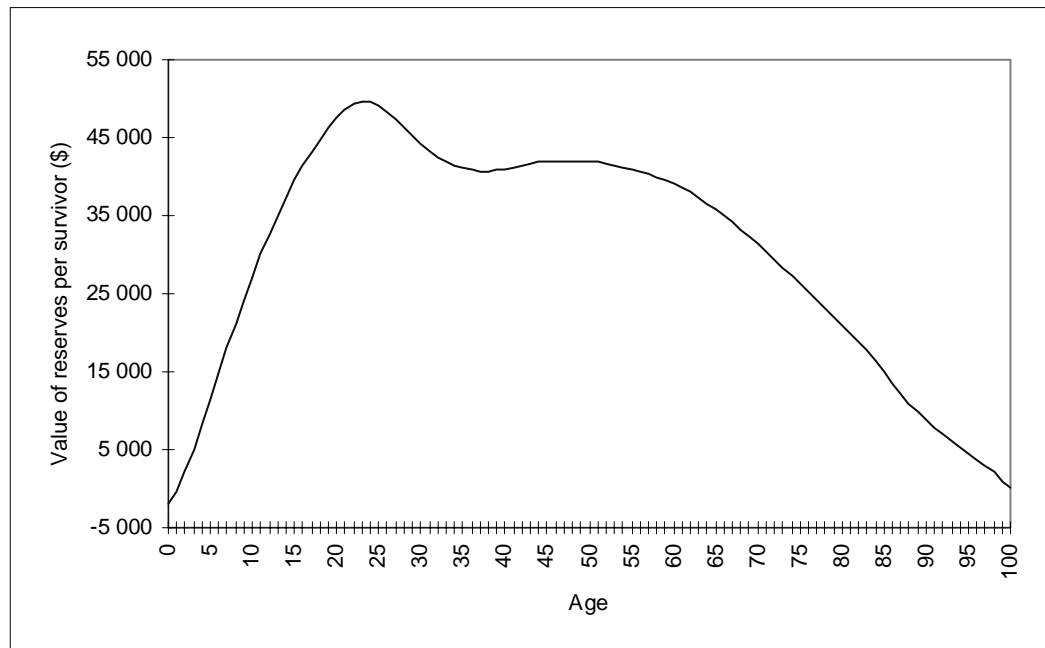
A 50 year old (born in the year 2000) who had been contributing since birth wants to leave health insurance, because their income has dropped so much that they cannot afford to pay their premiums. The fund has kept a record of the year 2000 cohort — represented simply by the accumulated reserves of that age cohort (see figure C.3). Each survivor of that cohort has a share of the reserves equal to around \$42 000 per person in 2050 (based on the parameters used in figure C.2). The 50 year old is given their share, less the administrative expenses in dealing with their exit.

It may also be necessary to guard against opportunistic behaviour by some people. The reserve income of the funds is tax favoured — bearing no tax at all. If people could extract their equity in the fund when they wanted with no penalty except a small administrative fee, they might use insurance as a de-facto tax favoured savings plan, redeem the policy before retirement, and resort to the public health system. This problem could be alleviated by appropriate penalties for early exit, or by giving health insurance reserves no more favourable tax treatment than other long term savings, such as superannuation.

A person transferring to another fund would presumably bear either no cost, or only the administrative cost (with possible oversighting of reserve transfers by a body such as PHIAC).

A number of other possible flexible arrangements could also be used. For example, people with interrupted earnings could maintain their insurance without contributions for a period, subject to making up their contributions to reserves later. Or they could preserve their benefit until they started making contributions at a later date.

Figure C.3: Reserve equity (real 1995 prices) of a person in a lifetime community rated policy



Many participants in the inquiry saw virtues in the adoption of a funded lifetime rating scheme or its more simple unfunded version (box C.3). On the other hand, a number of participants were concerned about the impact of lifetime rating schemes on the aged. In response, the Commission notes that the impact on the aged could well be positive if the scheme stabilises private health insurance, and in no way discriminates against old people who are early entrants.

Despite its attractions, funded lifetime community rating also has some drawbacks:

- It could be vulnerable to sovereign risk problems. Government policy towards private health insurance has historically been in flux. A funded lifetime community rating system requires substantial re-organisation of reserves management by funds and a different level and type of prudential regulation. These involve significant up-front fixed costs, whose expenditure would be wasted if changes in government health policy were to require a future shift away from lifetime rating. As well, the lifetime premiums calculated for consumers presume a certain path for taxation (or non-taxation) of reserve income. Future changes in the tax treatment of reserve income could require large increases in premiums to fund rest of life health expenditures. Uncertainty over the taxation treatment and longevity of the arrangements may prejudice uptake of lifetime policies. On the other hand,

so long as consumers can extract their equity in the accumulated reserves if lifetime rating is wound up, then the costs posed by sovereign risks are reduced.

### **Box C.3: Participants' views on lifetime community rating systems**

#### **Those in favour ...**

'The free rider incentives in the present community-rating formula are so gross that, on both equity and efficiency grounds, a high priority must be attached to changing it. The transitional difficulties in moving to the lifetime formula are substantial ... but I do not think they are insurmountable.' (R. B. Scotton, Sub. D234, p. 1)

'I support the concept of lifetime community rating. ... It will not be the product of choice for a large section of the public, but it should be allowed to flourish as a means of developing and strengthening the private health insurance market. Funds would need to be adequately supervised to ensure that they maintain a proper level of policy reserves for this product, and that such reserves as were held were not dissipated in the support of other products marketed by the fund.' (Alan Brown, Sub. D231, p. 17)

'MBF believes that the only viable alternative that satisfactorily maintains the concept of community rating is what has come to be known as "lifetime community rating", ie one where an individual subsidises him or herself over time as opposed to subsidising others.' (MBF, Sub. D203, p. 5)

'Lifetime community rating on a funded or unfunded basis is an equitable response to the problems with the current community rating arrangement. By making late entry to private insurance a poor strategy, it reduces adverse selection, thereby producing a more balanced pool of risks.' (NMHI, Sub. D210, p. 3)

'To recognise that age-related risk is a contingency which must be catered for in the context of affordability, equity and access is not to discriminate against the aged but to recognise that this is an issue for resolution and to make provision for it. ... We believe lifetime community rating (or age at entry rating) can positively contribute to both alleviating the current crisis in health insurance and also the development of a more stable system for the long term.' (Institute of Actuaries of Australia, Sub. D218, pp. 2–3)

'Entry age rating provides the most appropriate modification to community rated health insurance. It offers the potential to stabilise premiums and provides a window of opportunity for a full health financing review.' (Australian Private Hospitals Association, Sub. D217, p. 12)

/cont'd

**Box C.3: cont'd**

'It would permit product innovation in directions beneficial to the industry by encouraging membership at an early age and militating against "hit and run" insurance.' (DHFS, Sub. 175, p. 35)

'in a consumable which is as highly age-related as health services, the capacity to "community rate" by age at entry to membership would enormously improve the stability of the product from a theoretical perspective.' (Institute of Actuaries of Australia, Sub. 141, p. 2).

'The Government should allow funds to apply higher premiums to people who defer joining ... until later in life. Again, this would not affect existing members. Rather, it would protect them from those people who take advantage of loopholes in the law.' (J. S. Bailey, Sub. 188, p. 1)

**Those against ...**

'This [lifetime community rating] proposal would be unacceptable ... [because it] does not address any of the problems of affordability of private health insurance for older people in the short to medium term; ... it would always be a highly discriminatory system; [and] ... it is a system that is incongruent with current and emerging patterns of Australian life.' (Council on the Ageing, Sub. D246, pp. 2–3)

'A system of "lifetime" community rating in which premiums were less if you joined at an early age, suffers from some of the same disadvantages as superannuation in that it would not allow for the fact that most people do not have an unbroken work pattern throughout their lives and significant sections of the population go through a period or periods of unemployment. Labour force participation among people 55 plus is lower than any other age group. Thus people's ability to keep an unbroken record of contributions to a health fund over long periods might be difficult.' (Australian Pensioners' and Superannuants' Federation, Sub. D258, p. 4)

'Lifetime community rating is a sound concept but does pose problems for people who experience financial difficulties and need to withdraw from private health insurance. The complaint most often voiced by the elderly is that insurance becomes too expensive once they have to pay for it from their pensions.' (Diabetes Australia, Sub. D267, p. 2)

- While there is a route for 'cashing-out' lifetime policies, lifetime rating may still inhibit broader systemic reforms, because it sets up expectations in funds and consumers for a durable system of private sector funding. If the rules change in that bigger system, funded lifetime rating may not still be the best arrangement. And if the costs of shifting from lifetime rating were considered high, this might prejudice broader reforms.

- A move to funded lifetime rating would require more sophisticated reserves management by both funds and regulators than under the current system<sup>1</sup> — to avoid any likelihood of reserves (people's lifetime health savings) being dissipated through insolvency of a fund, or through investment in highly risky assets.
- To the extent that consumers do not have long planning horizons, people may not take out insurance when young, and then be deterred by high premiums later in life.
- It may set up some barriers to entry to smaller players since there are considerable reputational advantages for large fund managers, as well as potentially quite high entry costs associated with the sophisticated management of reserves. On the other hand, since some rules and regulations which may currently deter entry (for example, relating to membership categories) would become redundant, and with the problem of industry instability largely addressed, a new breed of bigger, more sophisticated players may enter and compete with each other.
- While funded lifetime rating might eliminate product diversity aimed at cream skimming, the complex reserving requirements of lifetime rating may also partly frustrate appropriate product innovation. It may be difficult to track the reserve equity of any individual in a cohort whose members have policies offering different benefits.
- It raises transition problems.

Of these, the last is the most problematic. The transition could be complex and protracted, because the reserves to meet the lifetime health costs of current older contributors do not currently exist:

The greatest weakness ... is that reserves of the required size do not exist for the existing contributors ... inequity would persist until the generation of existing members pass out of the system. (Alan Brown, Sub. 34, p. 5.5)

Existing members who are currently old or approaching retirement would have to pay significantly higher rates, which would not be regarded as fair. Even people in middle age would have to pay a significant additional premium. This could be eased by utilising the proposed rebate to compensate people

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<sup>1</sup> One commonly raised problem is that of having to accurately foretell future costs. As noted by Alan Brown, this is probably not a genuine problem (Sub. 34, p. 5.1). Under lifetime rating the funds set premium rates as a multiple of a 'community rate', say the premium for an adult aged 50 years. The 'community rate' would vary with inflation from year to year, with the lifetime relativities left intact (figure 10.1).

disadvantaged by the transition. However, even the full utilisation of the rebate for people affected by the transition would not be sufficient to insulate them from substantial premium increases from immediate implementation of lifetime rating. A rapid shift to lifetime community rating necessitates costs being borne by someone over some time period, namely:

- existing incumbents;
- taxpayers; and/or
- new entrants to funded lifetime rating.

It is likely that any transition will involve some equity problems for existing incumbents and budgetary implications for government, although the burden on any one group can be reduced by spreading it across all parties.

The Commission produced some ‘back of the envelope’ estimates of the unfunded liability represented by the current community rating scheme. This was done by *imagining* that a new lifetime rating system was introduced gradually as follows. In year 1, only those born in that year pay the lifetime rate, and everyone else pays a premium which meets the costs of the remaining age groups. In year 2, those aged 0 and 1 pay the lifetime rate and everyone else meets the costs of the remaining insured. As the years roll by, the community rated group dwindles, the age distribution tilts increasingly towards the aged, and the average premium rises steeply. In the last year, year 100, a few people aged 100 would bear the full costs of their care.

What is the subsidy that government would have to provide in order that the community rated group paid no more than the initial community rate during this transition (ignoring inflation and any real increases in drawing rates)? Figure C.4 shows the magnitude of the yearly subsidy required and the number of people needing to be supported to achieve this objective. Using a 3 per cent real discount rate, the present value of the subsidy is equal to around \$28 billion in 1995 prices. An annual subsidy of around \$800 million (real 1995 prices), paid every year for a century, would be needed to meet the unfunded liability.

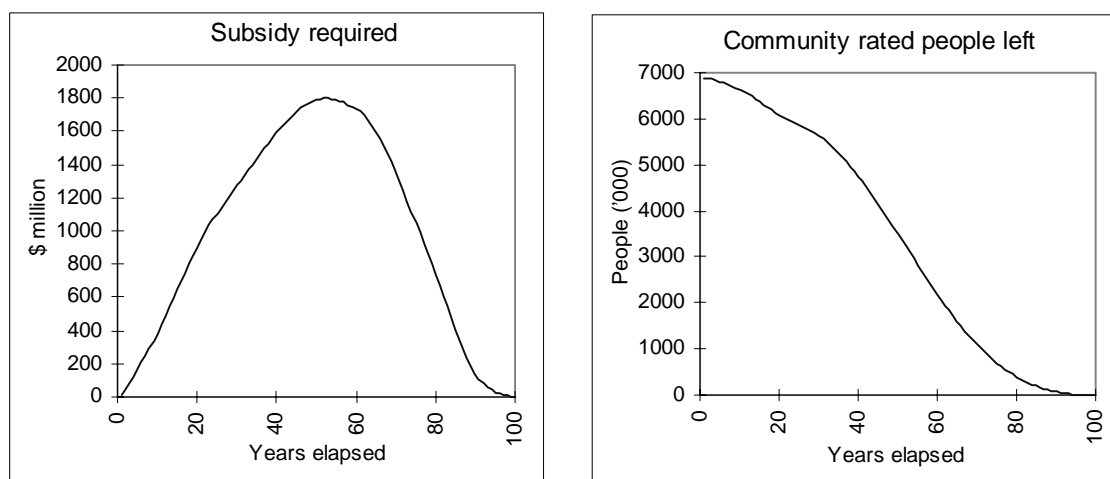
There are other ways of achieving the transition. For example:

- Younger people might actually bear the full cost of their transition to lifetime community rating — spread over their lives the cost would be relatively modest. This would reduce the outstanding burden to be met by taxpayers.
- New entrants to lifetime rating could pay a surcharge to meet the costs of the remaining pool of community rated people. The major problem with this financing method is that it sacrifices one key advantage of lifetime rating, at

least over the medium term — its ability to offer premiums to new entrants at much discounted rates.

However, no lifetime rating option is feasible without either substantial expense, reduction in the attractiveness of the product to new entrants, or a long transition period — there is ‘no free lunch’.

Figure C.4: Subsidy required for transition to lifetime rating



### C.3 An unfunded lifetime community rating scheme

#### Description

A funded lifetime community rating scheme is based on premiums which fund a particular age group's consumption of insured health care services over a lifetime. People entering late pay higher premiums because they must compress the savings for the high usage part of their life into a smaller period. There is an alternative *unfunded* arrangement, often also called lifetime rating, which similarly rewards early entry (penalises late entry), but without the costly transition arrangements posed by true lifetime rating. No reserves are built up to cover future health costs.

Under an unfunded lifetime community rating scheme (ULCR) premiums for people entering insurance early in their lives are set at a discounted rate while people who enter after a certain date have to pay a loading (box C.4).

Thus an unfunded lifetime rating scheme implies that:



- A 65 year old who had entered insurance as a 30 year old would pay a much lower premium than a 65 year old who had entered health insurance as a 60 year old.
- A 30 year old and a 65 year old who had both entered at age 25 would pay the same premium — preserving equal premiums for differently aged people, so long as their entry age was identical.

#### Box C.4: Calculation of premiums under an unfunded lifetime rating scheme

Under ULCR the premium varies depending on age. Accordingly:

$P = R_{DISCOUNT}$  if aged below a threshold age ( $\hat{A}$ ) at entry; and

$P = \frac{A_E}{\hat{A}} R_{DISCOUNT}$  if the entry age ( $A_E$ ) exceeds a threshold ( $\hat{A}$ )

where  $P$  is the premium and  $R_{DISCOUNT}$  is the discounted premium available to early entrants.

How is the discounted premium calculated? For any fund, the total costs ( $C$  or benefits plus loading) must on average be met by premiums so that:

$C = R_{DISCOUNT} N_E + \sum_{j=1}^{N_L} \frac{A_j}{\hat{A}} R_{DISCOUNT}$  so that

$$R_{DISCOUNT} = \frac{C}{\left( N_E + \sum_{j=1}^{N_L} \frac{A_j}{\hat{A}} \right)}$$

where  $N_E$  is the number of early entering SEUs,  $N_L$  is the number of late entering SEUs and  $A_j$  is the late entry age of the  $j$ th late entrant. For example, suppose that  $\hat{A}=30^2$  and that the costs of private health insurance are \$4 billion with 4.5 million SEUs. The premium which equalises these costs across all SEUs is therefore \$888. Say that 500 000 SEUs ( $N_L$ ) entered at age 60 while the rest all entered at or below age 30 years. In this case, the discounted premium for early entrants is \$800 and the premium for those who waited until 60 to join is \$1600.

The exact nature of the penalty function is a matter for future design, but it should be designed to:

<sup>2</sup> Alan Brown (Sub. D231, p.17) poses the case where  $\hat{A}=50$ . However, such an older age may not have as great an incentive on early entry as a younger age, say 30 years.

- Attract young people to health insurance, as this will lower average premiums for everyone. For example, if the late entry penalty only commenced at age 50 or 60 years then young people would have no incentive to join until that age.
- Deter late entry. The penalty needs to be high enough that strategic late entry is largely avoided — the intention of the penalty is not to collect late entry surcharges, but to prevent late entry.
- Avoid a situation in which the penalty for late entry is so great that it exceeds the costs imposed on the system by late entrants. The optimal penalty function will probably be a non-linear function of age, based on actuarial data on health costs by age.

One possible variant of ULCR would stipulate that people entering at or below the threshold age must all be charged the same premium rate, but leave up to individual funds the appropriate penalty for entry at a later age. This has the advantage that funds would have strong incentives to price the penalty appropriately and flexibly, avoiding potentially complex regulation. As the actuarial costs of late entry changed they would vary the penalties. Competitive forces would stop them from setting excessively high penalties.

ULCR requires no reserves. Any excess from late entrants is used to lower premiums. As well, it can be introduced without a long transition. People of any age could be given an opportunity to join the scheme during a grace period of some months. All current incumbents of health insurance and all those considering joining would be able to do so without penalty in this period. Only those who join late after the start of the scheme would pay any penalty.

## Impact

The scheme has a number of advantages over the existing system:

- It removes some incentives for adverse selection. Unfunded lifetime rating makes late entry to private insurance a poor strategy, and therefore produces a more balanced pool of risks.<sup>3</sup> It encourages earlier entry by those who plan at some point to join health insurance.

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<sup>3</sup> Interestingly, the private health insurance market has developed innovative ways of emulating some features of lifetime rating within the current regulatory framework. Funds *are* able to offer a rebate on the excess in front end deductible products. For example, HBA Health Insurance marketed a product in 1996 with a membership bonus. Each customer is provided with a credit to the value of one excess on joining HBA. HBA then provides each customer a credit equal to half an excess for each year of membership.

- It removes some but not all incentives for product complexity and cream skimming that are prevalent under a community rating system.
- It will, over time, make insurance for the old and sick cheaper than it would have been under the existing scheme, so long as they either entered earlier than the threshold age, were in insurance prior to implementation of the policy, or took advantage of the proposed amnesty. But old and sick people who defer entry until they become high expected claimants will pay more under this scheme than the current scheme — an outcome with arguably appropriate equity and incentive impacts.
- The scheme is robust to risk, and is easy to adapt, with little sovereign risk.
- Portability between funds is unaffected.

This form of rating was supported by a variety of participants as a viable way of stabilising the private health insurance industry.

However, unfunded lifetime rating still falls short of an ideal rating system:

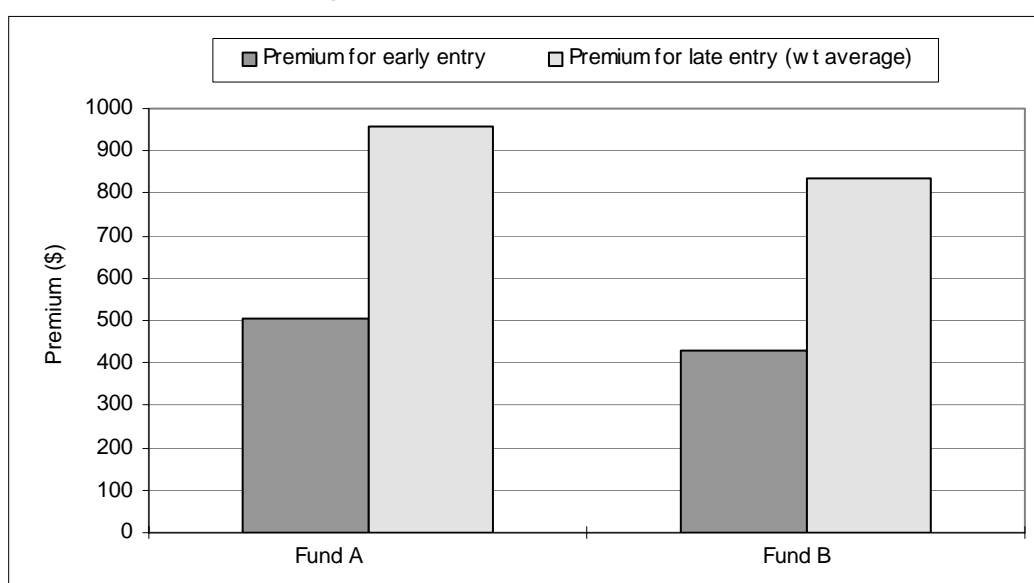
- Because it is an unfunded scheme, it may be exposed to some degree of variation in the age distribution of the insured population over time. This in turn exposes the current generation of young contributors to the risk that premiums will still have to rise significantly in their old age if there is not a sufficiently large group of new young contributors to fund them.
- If young people are not initially attracted to private health insurance, the later penalties may deter them from joining at all — imposing cost pressures on the public system.
- It has limited capacity to deter one-off hit and runs, though it does discourage people from periodically hitting and running.
- Administrative arrangements may involve some complexities associated with reinsurance. The current system of reinsurance cannot be used with unfunded lifetime rating. The Commission undertook modelling which demonstrated that while reinsurance would (all things other than the age distribution being equal) still equalise the average weighted premiums between funds, the existence of the penalty premium for late entrants would result in potentially large disparities between funds' premiums for the different classes of member (figure C.5). Reinsurance would have to be adapted in order to ensure appropriate equalisation. This is not an insurmountable obstacle to implementation.

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These can be redeemable against hospitalisation claim excesses, but not for money. This sort of policy encourages early and continuing membership.

- Mechanisms would have to be developed to allow sporadic membership. People who periodically left insurance would need to have a provision for credit for past membership. APHA (Sub. 51, p. 43) recommended a credit system for people who have been periodically insured. Such a credit system may need to be carefully designed. For example, a period of leave from insurance from age 35 to 40 should be penalised more than a period of absence from age 75 to 80.

Figure C.5: Reinsurance and relative premiums with late entry penalties: an example



## C.4 Late entry waiting periods

### Description

As suggested by the AHIA (Sub. 108), one form of lifetime community rating, without the administrative and sovereign risks of true lifetime rating, might be based on applying longer waiting periods for late entrants. This is a *non-price variant* of an unfunded lifetime rating scheme, and shares many of its features.

Under one approach, the period before a pre-existing ailment could be treated might vary from one year (for an entrant at say age 35 or before) to 3 years (for someone aged 65 and over). This would provide incentives for early insurance. It would disadvantage no person currently insured. And it would be much more robust to future changes in government policy affecting health insurance. It does generate some different incentives to the price version of an unfunded lifetime scheme:

- A healthy person (ie with no pre-existing ailments) can join and enjoy full cover after 2 months.
- The penalty imposed by waiting is equal to the premium income forgone during the waiting period plus the perceived cost to the waiting patient of delayed treatment. Some people would far prefer to pay a higher monetary penalty to waive the waiting period — a point noted by the APHA (box C.5).

Claims that waiting periods have equity or ethical repercussions for sick people who elect to insure late are not well based (box C.5 and chapter 10 for more discussion). There is, after all, the public hospital system alternative. And it may be considered even more unfair for people who have contributed all their lives to pay for the treatment of people who enter only when they have become sick.

However, these forms of lifetime community rating have difficulties. A healthy person aged 65 without a pre-existing ailment would still face an actuarially attractive product, and that person's costs would have to be borne by lower risk cohorts. The problem of adverse selection would be reduced, but would remain a continuing flaw in the system.

As well, an increase in the pre-existing ailment qualification period may increase disputes about whether ailments were genuinely pre-existent or not. This might be overcome by medical examination at the start of an insurance contract for a late entrant.

Another version of the AHIA plan without the risks of these disputes could involve increased waiting periods for later entrants before access to any form of insurable treatment under health insurance — regardless of whether the conditions were pre-existing.

A number of other countries use waiting periods as deterrents to late entry. In Ireland, for example, qualifying periods for insurance can be varied by the age of the applicant. Both Ireland and the UK *exclude* admission to private insurance for people aged over 65 (AHIA, Sub. 108, p. 12).

### Box C.5: Participants' comments on differential waiting periods

#### In favour ...

'AHIA strongly supports ... reduc[ing] adverse selection by allowing funds to introduce longer waiting periods for late entrants.' (Australian Health Insurance Association, Sub. D221, p. 3)

'After a suitable moratorium period (this should be relatively short) application of more appropriate waiting periods would be supported by SGIO Health. Such waiting periods should reflect not only the age of entry but also various conditions (eg obstetrics, plastic and cosmetic surgery, etc).' (SGIO Health Pty Ltd, Sub. D237, p. 3)

#### Against ...

'The Council ... is opposed to this option on the basis that it discriminates against people on the basis of their age and destroys the basis for community rating. There are already pre-existing ailment rules which mean that people must wait a period of 12 months before they can make a claim on a fund. ... The proposal does not address existing problems of high insurance premiums which stretch the budgets of older people on low incomes.' (Council on the Ageing, Sub. D246, p. 3)

'To introduce waiting periods for access ... will undermine the value of the product. ... It also presupposes a robust and practically accessible public system as a viable alternative. If this presumption is correct, then introducing waiting periods in private care will be counter-productive. Those who consider waiting to be less onerous could settle for public cover seemingly for the same advantage and far less outlay.' (Australian Catholic Health Care Association, Sub. D215, p. 3)

'the introduction of extended waiting periods for older fund entrants ... unfairly discriminates against older Australians. ... [T]he imposition of mandatory age based waiting periods requires late entrant members to pay premiums for up to 5 years, while being denied access to insurable treatment — and without the opportunity to pay a penalty in order to gain such access — for the whole period. This proposal is unconscionable and must not proceed.' (Australian Private Hospitals Association, Sub. D217, p. 2)

'CHF cannot support the proposal to increase waiting periods for older consumers because it offers little to most health consumers. It may reduce premiums for younger consumers, and it may increase the viability of the industry. However, it will do little to relieve pressure on the public system, as it relies on reducing the risk pool of private health insurance to reduce costs to contributors.' (Consumers' Health Forum of Australia, Sub. D254, p. 3)

## C.5 Bounded community rating

### Description

Peter Carroll advocated that the government introduce a system of *bounded* community rating:

Relax community rating for hospital insurance products, commencing with a tolerance of say 15 per cent above and below the central community rate. This would invigorate price competition and encourage greater participation in the market by good insurance risks, while preserving reasonable affordability for all participants. (Sub. 9, pp. 34–5)

Bounded community rating could allow premiums to vary across some risk categories but not others. If necessary, certain risks could be exempt from this variation — for example, people who acquire a chronic illness or have a genetic disposition to a costly ailment. Other risk categories, such as people of different ages or those accepting self-inflicted risks, could face premium variations within the band.

Introduction of bounded community rating is a further step from the current hybrid version of community rating towards full risk rating (figure C.1).

### Impact

Bounded rating reduces some of the perverse incentives of community rating. Even with a narrow 15 per cent band around a central community rate, such an amendment reduces adverse selection because the young would face premiums set at roughly 26 per cent less than the maximum rate.

This version of community rating:

- does not suffer from substantial sovereign or other risks;
- meets the needs of sporadic users;
- does not hinder product innovation, while at the same time rendering many ‘cream skimming’ products superfluous;
- allows easy portability between funds;
- presents no barriers to entry by new players in health insurance; and
- is feasible given the new membership categories.

On the other hand, it suffers some clear limitations:

- It would probably require changes to reinsurance.

- It may generate pressures on the strained public system. While, theoretically, forward looking people could eliminate the financial burden represented by the premium surcharge when old by saving when young, many may not do this. They may then leave private health insurance and resort to the free public system at substantial cost to taxpayers. Similarly, if those accepting self-inflicted risks are charged higher premiums they too may resort to the public system. These problems constitute the distinctive signature of an ill-designed health *system* — rather than a problem unique to private health insurance.
- It does not deter hit and runs.
- It would adversely affect existing high risk members, unless the government were to subsidise the transition. The transition under bounded rating would be less long and the costs much less marked than that required by a funded lifetime rating scheme.

## C.6 Medical savings accounts

### Description

MSAs are not really a form of insurance, although they do recognise that many people can smooth their health expenditures over time by building up savings. This is possible because, while hospital health costs are unpredictable for any individual from month to month and year to year, they are less variable over a lifetime. For example, say that 80 per cent of the cohort of people born in 1958 could expect the present value of their lifetime privately met health costs to lie in the range \$20 000 to \$80 000, with an average expenditure of \$40 000. In the context of a lifetime, these are not extraordinary sums and many people would be able to amass such savings if they put aside the current amounts that they pay for private health insurance.

Currently, effective tax rates on interest on deposits are relatively high compared to those on other assets like housing, shares and superannuation. Thus a shift to medical savings accounts would require some form of concessional tax treatment along the lines of other long-term savings, such as superannuation.

Medical savings accounts are close to funded lifetime rating except that:

- There is no risk pooling between individuals. The savings built up in an account are used for that individual alone. Funded lifetime rating, by contrast, pools risks within the age cohort.



- At death people can pass on any unused savings to others, whereas all reserves accumulated under a funded lifetime rating scheme are used to fund health care. This implies that the yearly rate of savings required to meet a fixed set of health care costs would be higher under MSAs than under lifetime rating.

## Impact

Medical savings accounts present a number of advantages:

- They solve the adverse selection problems of community rating, because people contribute to their *own* expected lifetime health care needs.
- They may reduce moral hazard, since a person does not want to dissipate savings on ineffective health care.
- They generate better equity outcomes for retirees on low incomes because they could still access their stocks of savings, even if they could not afford to add to them.
- This redemption feature also makes medical savings accounts less vulnerable to future government interventions. People would be able to extract a portion of their contributions if they left the country or if government policy changed.
- They could be combined with superannuation accounts, lessening the transactions costs of building up a separate saving system.
- It eliminates the incentives for cream skinning entirely, thus eliminating some product types whose intention is to cream skim. On the other hand, it leaves consumers with full flexibility to choose the type of health care product or subsidiary insurance product they want at different times of their lives.
- Ultimately, many of the long term financing problems of health care in its broader sense (encompassing hospital, ambulatory and nursing home care) are fundamentally national savings problems. The danger of leaving the funding of the health care needs of the currently middle aged until 2020 is that the pool of funders at the time may be too small or reluctant to finance the needs of the sick. As noted by the Institute of Actuaries of Australia, 'The population hump is not being replaced by new births or immigration, and will place a strain on funding arrangements in the next century unless steps are taken to prepare for this effect' (Sub. 141, p. 5).

- It is a workable method for financing the bulk of a country's health expenditure. For example, Singapore introduced a tax favoured medical savings scheme as the main component of its health financing system 12 years ago (box C.6).

On the other hand, there are also some deficiencies. The most problematic is determining an appropriate target for savings accounts. Medical savings accounts are based on the premise that *much* 'insurance' is really intertemporal smoothing. But how much is 'much'? The Commission sought, but was unable to obtain, information on the likely target for savings needed to meet 90 per cent of people's lifetime health costs.<sup>4</sup>

### Box C.6: The Singapore system of medical savings

In 1984, Singapore introduced a *compulsory* hospital costs saving scheme called **Medisave**. Those under 35 years of age contribute 6 per cent of their wages to an employee's Medisave account. Those between 35 and 44 contribute 7 per cent, while those over 45 contribute 8 per cent. Interest earned is tax free. On reaching 55 years, contributors are allowed to withdraw some of their funds, but must leave a mandatory minimum balance. The balance is paid, at death, to a person's nominee. Medisave funds may be used by a contributor or his family to meet a certain level of hospital costs.

Medisave is complemented by **Medishield** (developed in 1990), which provides *voluntary* low cost catastrophe co-insurance. Medisave does not include insurance, so that a person with high health costs or a low current Medisave balance is inadequately covered. Medishield assists with the costs of hospitalisation in the subsidised wards of public hospitals. Pre-existing ailments are not covered and, as in the case of Medisave, various diseases regarded as self-inflicted are also excluded. Medishield premiums vary with age, increasing by a factor of ten from age 30 to age 70.

**Medifund**, an endowment fund, was created in 1993. The interest from the fund meets the hospital costs of the very poor.

*Sources:* Hsiao 1995, Barraclough and Morrow 1995, and Massaro and Yu-Ning Wong 1995.

- Some individuals' lifetime health costs will be low and others high. The latter's savings may be insufficient to meet their health costs. Moreover, a person might get chronically ill when young, before sufficient savings had been amassed.

As the AHIA noted:

<sup>4</sup> Note this figure is very different to the average lifetime expenditure. We need to know the 90 per cent decile of the distribution of the present value of lifetime health care costs.

MSAs do NOT take into account the fact that persons needing more than average care would be grossly under funded. ... Savings schemes are no substitutes for the creation of risk pools which allow individuals to share their risk exposure (although they may assist in creating sufficient savings to buy insurance in retirement). (Sub. 108, p. 42)

One possible response to this is to arrange a separate ‘top up’ catastrophe insurance product which would meet costs in excess of the savings balance (the Singaporean solution, see box C.6).

There are a range of other potential deficiencies in medical savings accounts:

- Medical savings accounts raise issues about transitional arrangements, portability, prudential requirements and sovereign risk<sup>5</sup>, similar to those posed by lifetime rating.
- Low income people are able to save less, and so could meet fewer exigencies than others. This is also true for people who opt in and out of the workforce (say because of child rearing). On the other hand, medical savings accounts may, in some cases, meet the needs of lower income consumers better than current insurance products. The current private insurance policies set a floor level to benefits and to premiums. If a person cannot afford the floor price, they cannot buy the policy at all (a situation which explains why higher income people are so much more dominant users of insurance — chapter 6). There are only a few options to elect for less cover at a lower price — and reinsurance makes these products actuarially very unfair. In contrast, in a savings plan, people would be able to amass any level of savings, low or high, and opt to use them to buy a highly selective group of services.
- Medical savings accounts would appear to require a completely different set of skills than those possessed by the current insurers. What would happen to current incumbents in the private health insurance industry? In some respects, such a development might be a positive challenge to them, forcing them to add value by being discriminating and informed purchasers on behalf of consumers. Consumers would pay them a fee for negotiating access to the system which would increase cost effectiveness and quality outcomes for consumers. They would also provide the ‘top up’ insurance cover for expenses beyond accumulated savings.

The transition problems appear to be the most conspicuous barrier to implementation of MSAs as an alternative to the existing rating system.

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<sup>5</sup> Sovereign risks are reduced to the extent that consumers can redeem their accumulated savings, but risks relating to tax changes could still be important.

However, MSAs may play a complementary role to other primary insurance systems — for example, by allowing people to accumulate savings which could meet their post-retirement premiums.

### **Box C.7: Participants' views on medical savings accounts**

#### **In favour ...**

'The ADF is pleased to see the inclusion of Medical Savings Accounts as a policy option. ... The ADF however takes issue with the number of statements in the [Draft] report concerning the downside risk of MSAs.' (Australian Doctors' Fund, Sub. D224, p. 3)

'The two key disadvantages of MSAs identified by the Commission are the need to provide a safety net for high drawers and excess savings for low drawers. These could both be addressed within one catastrophe insurance scheme. All medical savings accounts users could be required to purchase at least (risk rated) catastrophe insurance with higher benefit insurance available if desired.' (Australian Private Hospitals Association, Sub. D217, p. 37)

'The Society would support [MSAs] [as an] excellent adjunct to citizens' health care financing and would encourage people to take a greater interest in their health care costs.' (Australian Society of Anaesthetists, Sub. D247, p. 2)

#### **Against ...**

'Effectively, this option requires people to save up for their own health costs, rather like superannuation as a form of savings for retirement. As such, it offers nothing to present health consumers. MSAs are not an option that make sense in the context of the model of the present Australian health system in which Medicare is at the centre and private health insurance is at the periphery.' (Council on the Ageing, Sub. D246, p. 3)

'MSAs should not be viewed as a replacement for community rating, nor as a substitute for private health insurance. However, Queensland Health is supportive of creating an environment ... in which people are encouraged to save for their long term health care needs. ... It can be argued that the system of MSAs as outlined in the [Draft] Report, could disadvantage those from lower socio-economic groups who are likely to be able to save less. In addition, people would need a considerable period of time to accumulate savings.' (Queensland Health, Sub. D252, p. 2)

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## **APPENDIX D: REINSURANCE**

### **D.1 Introduction**

This appendix defines and analyses reinsurance schemes. In chapter 10, policy options for reinsurance are examined. In the Australian context, ‘reinsurance’ is a misnomer. Reinsurance is usually a service which allows an insurer to pass on certain risks to another intermediary for a premium. But in the Australian system, reinsurance is a system for sharing the hospital costs of high risk members between registered health funds. Funds with a greater proportion of low risk groups (the young) pay contributions to a pool which then distributes the income to funds with a greater proportion of high risk groups (the chronically ill and the aged). PHIAC characterises the reinsurance arrangements as support for community rating and a system for ensuring equitable treatment of funds with different coverage of risky groups.

Reinsurance has fundamental impacts on private health insurance. It:

- is playing a greater role as the proportion of insured aged over 65 years grows ever larger;
- increases the industry’s stability in the context of community rating;
- provides sometimes perverse incentives against full cost minimisation;
- is designed in a way that constrains the sorts of products that insurers can offer; and
- is an imperfect mechanism, in its current state, for equitable treatment of funds with different coverage of risk groups.

### **D.2 Importance of reinsurance**

Reinsurance has assumed a greater role as a cost sharing mechanism reflecting the impact of an ageing membership on hospital costs:

- Persons with private health insurance aged 65 or more have 5.8 times the hospital utilisation rate and 4.8 times the drawing rate of those aged under 65 years.

- Adverse selection and general demographic trends have skewed the age distribution of the insured towards the old. The proportion of the population covered over 65 was 10.2 per cent in June 1990 and 13.7 per cent in June 1996 — a 34 per cent increase. In 1995–96, 89 per cent of reinsurance benefits were paid for persons aged 65 years and over, with the small residual being payments for the chronically ill under age 65.

Reinsurance payments have grown by a trend rate of over 9 per cent per annum from 1989–90 to 1995–96 compared to a more modest 3.2 per cent per annum for other benefits (table D.1). By 1995–96, reinsurance benefits amounted to just under half of the total benefits paid by funds, compared to under 40 per cent in 1989–90.

Any design problems in reinsurance are magnified the greater the role of reinsurance payments as a share of total benefits paid.

Table D.1: Size of the reinsurance pool, 1989–90 to 1995–96

	<i>Hospital benefits</i>	<i>Ordinary account benefits</i>	<i>Reinsurance benefits</i>	<i>Reinsurance share of benefits</i>
	\$m	\$m	\$m	%
1989–90	1 905.0	1 161.2	743.9	39.0
1990–91	2 184.8	1 288.4	896.4	41.0
1991–92	2 388.3	1 373.5	1 014.8	42.5
1992–93	2 521.6	1 405.0	1 116.6	44.3
1993–94	2 572.5	1 398.3	1 174.3	45.6
1994–95	2 655.6	1 408.6	1 247.0	47.0
1995–96	2 834.1	1 463.1	1 371.1	48.4
Trend growth rate (%) <sup>a</sup>	5.9	3.2	9.4	3.5

a These are calculated by regressing the logged values of the relevant variable from 1989–90 to 1995–96 against a time trend using OLS.

Source: PHIAC.

### D.3 The importance of reinsurance as a stabiliser

To see why reinsurance is regarded as an important stabilising element in an industry constrained by community rating, consider a community rated system *without* such cost sharing.

Community rating requires that premiums are the same for people with different levels of health risk, but the benefits paid per person (drawing rates) are much higher for some risk groups than others. Accordingly, funds with a bigger proportion of high risks would have to levy higher premiums to cover their costs. Consumers would then switch from funds with a greater representation of higher risk groups (and consequently higher premiums) to lower risk funds. Working out the pace of change and the ultimate form of industry structure if there was nothing to stem these flows is hard to determine. It would depend on:

- which consumers are most mobile between funds<sup>1</sup>;
- the speed of movements between funds;
- the reserve positions of the funds;
- the cost of entry and exit; and
- the ability of funds to develop products with exclusions which deter high risk groups.

For example:

- If lower risk consumers were more mobile between funds, then this would initiate a vicious cycle of rising premiums and attrition of members in the high risk funds. A chain reaction of fund closures, displacement of high risk groups to other funds, and further fund closures would then occur, until the surviving funds had roughly similar mixes of risk groups. If entry costs were sufficiently low, the survivors might then be prone to predatory behaviour by new funds, which sought to attract members (who will typically be the mobile healthy) through lower premiums.
- If funds could develop sufficient exclusion products (such as those stipulating no coronary by-passes or hip replacements) to discriminate between risk groups, they could offer a two tier premium structure: a cheap one for the young and healthy and high one for the old and sick. The highest risk groups would tend to drop out of private health insurance altogether under this scenario — effectively negating the principle of community rating.<sup>2</sup>

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<sup>1</sup> For example, it will depend on whether the high or low risk consumers are the more mobile, or indeed whether mobility is random across risk categories. MIRA (1993 p.9) suggested that older, higher risk people were less mobile than young, low risk people.

<sup>2</sup> In the absence of the requirement for fixed prices between age groups, insurers would probably develop new products to maintain the membership of their young healthy members as they aged — for example, by spreading the load of high health costs after age

- Closed funds would typically be advantaged in the absence of reinsurance because they tend to have a lower proportion of high risk groups and can arrest entry by high risk groups from other funds.

How much of a long run threat the removal of reinsurance would pose to community rating depends on the assumptions about behaviours of consumers and funds. It *might*, as noted above, completely undermine community rating. In any case, in any transition, it:

- would disadvantage funds with bigger shares of high risk groups;
- would generate substantial transitional impacts on employment in the industry;
- would produce substantial short run variations in the premiums faced by consumers in the same risk category but in different funds; and
- could produce potentially large and fluctuating premiums for consumers as a group.

The system of reinsurance (or risk equalisation) between funds is intended to remove penalties which would otherwise apply to funds with higher representation of higher risk groups — and this achieves some measure of stability in the system. We turn to the exact workings of the current system of reinsurance next.

#### **D.4 How does reinsurance work?**

Reinsurance applies to the benefits paid out for insured people aged 65 and over and to the chronically ill (those with greater than 35 days of hospitalisation). In many cases, the old and the chronically ill coincide as risk groups. For the purposes of exposition we will ignore the chronically ill and look only at the age based risk group.

For the  $i$ th fund the gross benefits paid out (B) are:

$$B_i = S_{iy}d_{iy} + S_{ia}d_{ia} \quad \{1\}$$

where  $S_{iy}$  are the number of single equivalent units (SEUs) aged below 65 years in the  $i$ th fund and  $S_{ia}$  are the number of SEUs aged 65 years and over in the  $i$ th

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65 years over a lifetime. Thus in the absence of reinsurance, it is the existence of the community rating regulation which would most negate the principle of community rating.



fund.<sup>3</sup> The ‘d’ terms are the corresponding drawing rates (or average benefits paid out per SEU) for each of these risk groups. Under reinsurance, each fund identifies a fixed proportion of its costs (D) associated with the high risk group, or what PHIAC refers to as the ‘gross deficit’:

$$D_i = \theta S_{ia} d_{ia} \quad \{2\}$$

where  $\theta$  is the proportion allocated. As we explain later, the level of  $\theta$  is set to achieve equity between the funds. Across all funds in a state the total funds (TD) allocated to the old in this way are:

$$TD = \theta \sum_{i=1}^k S_{ia} d_{ia} \quad \{3\}$$

This is referred to as the ‘state reinsurance pool’ or the ‘reinsurance account deficit’. The total number of SEUs in the industry is:

$$N = \sum_{i=1}^k (S_{ia} + S_{iy}) \quad \{4\}$$

so that the average contribution to the reinsurance pool per SEU in the industry is:

$$AD = \frac{TD}{N} \quad \{5\}$$

Given their membership, each fund now calculates what its contribution (C) should be to this pool (or what PHIAC calls the ‘calculated deficit’):

$$C_i = (S_{ia} + S_{iy}) \times AD = N_i \times AD \quad \{6\}$$

where  $N_i$  is the total number of SEUs in the  $i$ th fund. The net reinsurance receipts (RI) of a fund — referred to in the industry as the net payment from the Health Benefits Reinsurance Trust Fund (HBRTF) — is the difference between the amount allocated to the elderly in their own fund (D) and its overall obligations to meet the needs of the elderly across all funds (C):

$$RI_i = D_i - C_i \quad \{7\}$$

If a fund has many elderly people, then it will tend to have a positive value for RI. The net benefits paid out by funds is equal to the gross benefits paid out (B) less any reinsurance receipts:

$$NBP_i = B_i - RI_i = S_{iy} d_{iy} + S_{ia} d_{ia} (1 - \theta) + N_i \times AD \quad \{8\}$$

Therefore, net benefits paid out per SEU (NB) are:

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<sup>3</sup> For the purposes of reinsurance, PHIAC calculates the numbers of SEUs as the average of the starting and ending numbers of SEUs in a given fiscal year.

$$NB_i = \frac{S_{iy}d_{iy} + S_{ia}d_{ia}(1-\theta)}{N_i} + AD \quad \{9\}$$

We can now ask how  $\theta$  is determined. The aspiration of the current system of reinsurance is to equalise benefit pay outs per SEU for funds with different shares of high risk groups, *holding drawing rates fixed*. We can calculate the value of  $\theta$  which achieves equalisation between pay outs for any two funds,  $i$  and  $j$ :

$$\frac{S_{iy}d_y + S_{ia}d_a(1-\theta)}{N_i} + AD = \frac{S_{jy}d_y + S_{ja}d_a(1-\theta)}{N_j} + AD \quad \{10\}$$

Define a share of the young in the SEU membership as:

$$\beta_i = \frac{S_{iy}}{N_i}, \text{ and } (1-\beta_i) = \frac{S_{ia}}{N_i} \quad \{11\}$$

This implies that:

$$\beta_i d_y + (1-\beta_i)(1-\theta)d_a = \beta_j d_y + (1-\beta_j)(1-\theta)d_a \quad \text{so that} \quad \{12\}$$

$$\theta = 1 - \frac{d_y}{d_a} = \frac{d_a - d_y}{d_a} \quad \{13\}$$

Thus  $\theta$  is a measure of the relative difference in the average industry drawing rates between the young and the old. The higher the drawing rate of the old relative to the young, the closer  $\theta$  is to unity.

Another way of looking at the significance of  $\theta$  is to consider the cost of adding another old person to a fund's membership relative to the cost of adding another young person. The expected cost of an old person is:

$$V_{ia} = d_a(1-\theta) + AD \quad \{14\}$$

while that of a 'young' person is:

$$V_{iy} = d_y + AD \quad \{15\}$$

Therefore, the difference in cost of recruiting one more young person compared to one more old person is:

$$DV_i = d_y - d_a(1-\theta) \quad \{16\}$$

The value of  $\theta$ , therefore, plays a major role in determining both the re-allocation of risks between funds, and the relative attractiveness of different risk groups to insurers. For example, prior to January 1995 (and from 1989)  $\theta$  was

set at unity. In the above equation this implies that the cost of a young person exceeds that of an old person. Thus during this time there was an incentive for an individual fund to encourage entry by an old person, notwithstanding the fact that from an industry-wide perspective, entry by such people increased overall premiums and discouraged entry by the young or healthy. Reinsurance actually exacerbated adverse selection. *It would be hard to find a more glaring example of a regulatory regime which produced perverse incentives.* This fault was not widely recognised in 1989 when these reinsurance arrangements were conceived because there was far greater representation by the young. But drop out rates by the healthy were marked in the intervening years and MIRA(1993) advocated sweeping changes. These were partly realised in the shift to the current system in 1995 when the value of  $\theta$  was set to remove this bizarre incentive.<sup>4</sup>

### An example

We illustrate the workings of reinsurance with a simple example (table D.2). Imagine that a state has just two funds, A and B. Altogether there are 860,000 single equivalent units (SEUs) of the insured covered by the two funds. Fund A has a weaker representation of people aged 65 and over (5 per cent of its members) compared to fund B (15 per cent of its members). In the absence of any reinsurance, fund A will pay out \$594 per member or 24 per cent less than fund B simply because of the age structure of its membership. Fund B would have to raise premiums relative to A — with resultant equity effects.

Under reinsurance, each fund calculates the amount it has to pay to those aged 65 years and over that belong to their fund, times the equalisation factor. This is called the ‘gross deficit’. We see from table D.2 that the gross deficit per SEU of B is three times that of fund A.

Each fund now calculates what their gross deficit would be if they had to pay the industry average of the gross deficit per SEU (equal to \$269 in this example). To work out their reinsurance receipts they take this calculated deficit away from the gross deficit. Thus Fund A has a gross deficit of \$5.6 million and a calculated deficit of \$16.1 million. They contribute around \$10.5 million in net reinsurance. This ensures that each fund is paying the same amount of benefits for each member (for given drawing rates).

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<sup>4</sup> It can be seen that setting equation {16} to zero and solving for  $\theta$  generates the same condition as {13}.

Table D.2: A simple example of reinsurance

	<i>Fund A</i>	<i>Fund B</i>	<i>Total funds</i>
Number of SEUs			
Aged<65 years	57 000	680 000	737 000
Aged 65+ years	3 000	120 000	123 000
Total SEUs	60 000	800 000	860 000
Drawing rates per SEU \$			
Aged<65 years	500	500	500
Aged 65+ years	2,381.0	2,381.0	2,381.0
Pay outs \$	35,642,857	625,714,286	661,357,143
Pay out per SEU \$	594.0	782.1	769.0
Gross deficit \$	5,642,857	225,714,286	231,357,143
Average deficit per SEU \$	94.0	282.1	269.0
Calculated deficit \$	16,141,196	215,215,947	231,357,143
Reinsurance claim \$	(10,498,339)	10,498,339	0
Net pay outs \$	46,141,196	615,215,947	661,357,143
Net pay outs per SEU \$	769.0	769.0	769.0
Equalisation factor	0.79	0.79	0.79

## D.5 Types of reinsurance

A plethora of alternative reinsurance arrangements have been mooted (MIRA 1993, 1994 and Sub. D239; Walker, Sub. 73 and Sub. D197; Brown, Sub. 34 and Sub. D231; Mercantile Mutual, Sub. 142; HCF, Sub. 225 and Gross, 1997). Every fund has different costs and contribution rates caused by differences in six factors (table D.3). Any reinsurance scheme aims to compensate for one or more of these variations. MIRA draws the distinction between *composition*-based, *usage*-based and *mixed* schemes of reinsurance.

*Composition* based schemes adjust (at least partially) for differences between funds' risk profiles and (sometimes) coverage. Composition based schemes do not compensate funds for poor cost and utilisation control. On the other hand, they will not compensate funds for any risk factors not explicitly identified. They may create incentives for cream skinning of risk categories not covered by the reinsurance.

*Usage* based schemes adjust partially for differences between funds' ex post utilisation and benefit levels. They therefore cover not only variations in risk and coverage, but also variations in utilisation and benefits — thus weakening incentives for cost minimisation (such as out-of-hospital care alternatives, utilisation reviews, hard bargaining with hospitals).

*Mixed* schemes combine elements of both usage and composition based schemes. They compensate for compositional differences and partly compensate for usage differences.

All of the above schemes typically include an additional element — arrangements for spreading at least part of the costs of 'extreme' events (hospital benefits for days in excess of 35 days for a contributor). These provide funds with an element of cover for insurance risk.

The systems which have been used or seriously proposed are:

- The *current system* compensates for variations in risk (but only that relating to two age groups). It partially equalises different levels of utilisation and benefit levels, but only for those aged 65 years and above. The current system is a slight variation on MIRA's *MIXED-2* proposal.
- *MIXED-1*, MIRA's preferred system in 1993, compensates partly for differences in utilisation, but not benefit levels. It also compensates for age variation relating to those aged under and over 65 years, and for differences in funds' coverage/SEU ratio.
- *MIXED-3*, MIRA's preferred system in the 1994 review, is the equivalent of *MIXED-1* except that it takes DRG-based payment arrangements into account. Thus under *MIXED-3* funds are partly compensated for differences between the fund's DRG-specific cost and the state average DRG-specific cost, weighted by the fund's own pattern of per-SEU utilisation.
- *Brent Walker's* scheme. This is an easy-to-administer composition based scheme. Under Walker's proposal, the reinsurance liability per member is 0.4 *times* (the average cost weight for a state *minus* the average cost weight for the fund) *times* the average state contribution rate. The average cost weight of a fund is a weighted average of the Medicare cost weights. The state average is the weighted average of the funds' cost weights. Walker's proposal is effectively like paying a risk based capitation fee per person into reinsurance.
- The *PROFILE* scheme (described in MIRA, 1994). This composition scheme applies the aggregate membership composition of a state to the drawing rates of any particular fund.

- *Gross's* (1997) scheme is a sophisticated composition based scheme in which reinsurance liabilities are based on the age, gender, location and health status of members.

None of these schemes take into account that some funds limit benefits to members by having front end deductibles or exclusions. *Proportional* reinsurance (section D.7) alters the reinsurance liability of a member in proportion to the benefit rate of their policy.

**Table D.3: Factors underlying variation in funds' drawing rates**

1	Utilisation measured as separations per insured person.	
2	Benefit levels measured as the average cost per separation	Overall usage is measured as benefits paid per person, which equals utilisation x benefit levels. Giving a high weight to usage in reinsurance means that funds paying large benefits are compensated by those paying low benefits per member.
3	Risk profile	For example, age, gender, occupation, location.
4	Coverage measured as persons per SEU	For example, some families have no children, others many.
5	Contribution rates	This introduces the concept of proportional reinsurance.
6	Insurance risk	'Extreme' events eg over 35 days hospitalisation.

## D.6 Incentive effects of reinsurance

All regulatory regimes generate, distort or remove economic incentives. What are the impacts of reinsurance on economic incentives of the funds or of consumers? The current system of reinsurance appears to have some unusual outcomes by:

- weakening incentives to control costs of the elderly because most of these costs are pooled;
- discouraging out-of-hospital care;
- discouraging funds from seeking care options that keep people from spending more than 35 days in acute hospitals;
- weakening the attractiveness to consumers of policies incorporating front end deductibles or copayments (although note that funds have incentives to sell some forms of cost sharing insurance policies so as to cream skim). This arises because every insurance policy bears a fixed reinsurance liability,

whose impact on prices is much greater for cheaper products. This also reduces the ability of funds to develop mechanisms to avoid moral hazard in the health system;

- weakening the attractiveness to consumers of policies which offer limited benefits (although note again the partly offsetting incentive to cream skim by insurers); and
- weakening the attractiveness to consumers of assembling an insurance *package* comprising a collection of policies from different insurers.

### *Reduced incentives to reduce costs for the old*

Under reinsurance, incentives to contain costs for the old are weakened (but not entirely extinguished). Looking at equation {9} the change in net benefits per SEU from a change in drawing rates are:

$$\frac{\partial \text{NB}_i}{\partial d_{ia}} = (1 - \theta)(1 - \beta_i) + \frac{S_{ia}\theta}{\sum_{i=1}^k N_i} \quad \{17\}$$

$$\frac{\partial \text{NB}_i}{\partial d_{iy}} = \beta_i \quad \{18\}$$

These equations suggest that:

- if a fund has a small market share in a state, then the bigger the value of  $\theta$  the less the increase in net benefits per SEU from an increase in drawing rates for the old;
- that the greater the proportion of over 65s in a fund's 'portfolio' of members, the bigger is the impact of an increasing drawing rate for the old; and
- that the market share of a fund affects incentives to cost contain.

Table D.4 illustrates the impact on net benefits paid per SEU of poor cost containment by funds:

- If a small fund (in this example, accounting for 7 per cent of a state's SEUs) fails to contain the costs of medical care for the elderly then there are small impacts on overall benefits paid out by the fund. So a 50 per cent increase in drawing rates for the old, increases a small fund's net benefits paid out per SEU by only about 5 per cent. This is because they can pass costs onto the rest of the industry, and also spread the burden of these costs across all of the insured, not just the old.

- If a large fund (in this case, one accounting for over 90 per cent of the SEUs of a state) fails to contain medical costs for the elderly, it faces considerable penalties on its overall pay outs. This is simply because such a fund dominates the market share of its state and therefore cannot spread its costs over other funds effectively. Curiously, then, market domination may provide some incentives for cost containment.

Table D.4: Impact of poor cost containment on net benefits paid per SEU

<i>Increases in aged drawing rates (%)</i>	<i>Poor cost containment by small fund</i>		<i>Poor cost containment by large fund</i>	
	<i>Impact on net payouts per SEU by:</i>		<i>Impact on net payouts per SEU by:</i>	
	<i>Small fund</i>	<i>Big fund</i>	<i>Small fund</i>	<i>Big fund</i>
	%	%	%	%
25	2.7	0.6	8.0	10.3
50	5.4	1.1	16.1	20.7
100	10.8	2.2	32.1	41.3
200	21.5	4.5	64.3	82.7

Source: Commission calculations.

### *Perverse incentives relating to the location of care*

The above discussion focuses on weakened incentives to control the cost of the elderly when they go hospital. Another potential source of inefficiency is the requirement that only hospital benefits count as part of the reinsurance pool. Perversely, a fund would prefer an aged consumer to have an expensive hospital operation than an inexpensive on-going ambulatory care alternative because (for a small fund) only 21 per cent of the costs of the former are billed to the fund, compared to 100 per cent of the latter (Brent Walker, Sub. 73). This would tend to encourage insurers to tilt benefit incentives away from ambulatory care options.

There are a number of alternative systems of reinsurance which generate better, though not perfect, incentives for cost minimisation, and these are discussed in section D5. In this context, it should be noted that MIRA developed the current (so-called ‘mixed 2’) arrangement as an interim arrangement only.

These, more complicated, schemes provide funds with greater incentives to control unit costs of all members and utilisation. Casemix data would be used to calculate the value of hospital benefits to be included in the reinsurance pool.



APHA (Sub. 51) also advocated the use of casemix average benefits rather than actual benefits paid.

*Perverse incentives relating to bed day duration*

The current reinsurance pool includes benefits paid for days in excess of 35 days of hospital care for an insured person.<sup>5</sup> Brent Walker (submission 73) indicated that this could create incentives for funds to market policies with better terms for consumers electing to undertake more expensive long duration hospital treatments rather than shorter duration, less expensive treatments. This is possible, but the impacts on incentives and inefficiency are weak unless very long hospitalisation periods are involved.

For example, say that the total cost of hospital treatment (CH) are:

$$CH = (35 + d)C + ETC \quad \{19\}$$

where d is the number of days in hospital over 35, C is the average daily bed day cost and ETC are early treatment costs (such as theatre fees and MBS fees). The fund liability (FL) associated with these costs is:

$$FL = (0.21 \times d + 35)C + F \quad \{20\}$$

Say that there is an alternative hospital treatment requiring less than 35 days of hospital treatment and costing V. If  $FL < V < CH$  then the current reinsurance arrangements produce a perverse effect. The maximum level of inefficiency in this case is (IE):

$$IE = \frac{(CH - FL)}{FL} = \frac{0.79 \times c \times d}{(0.21 \times d + 35)c + F} \quad \{21\}$$

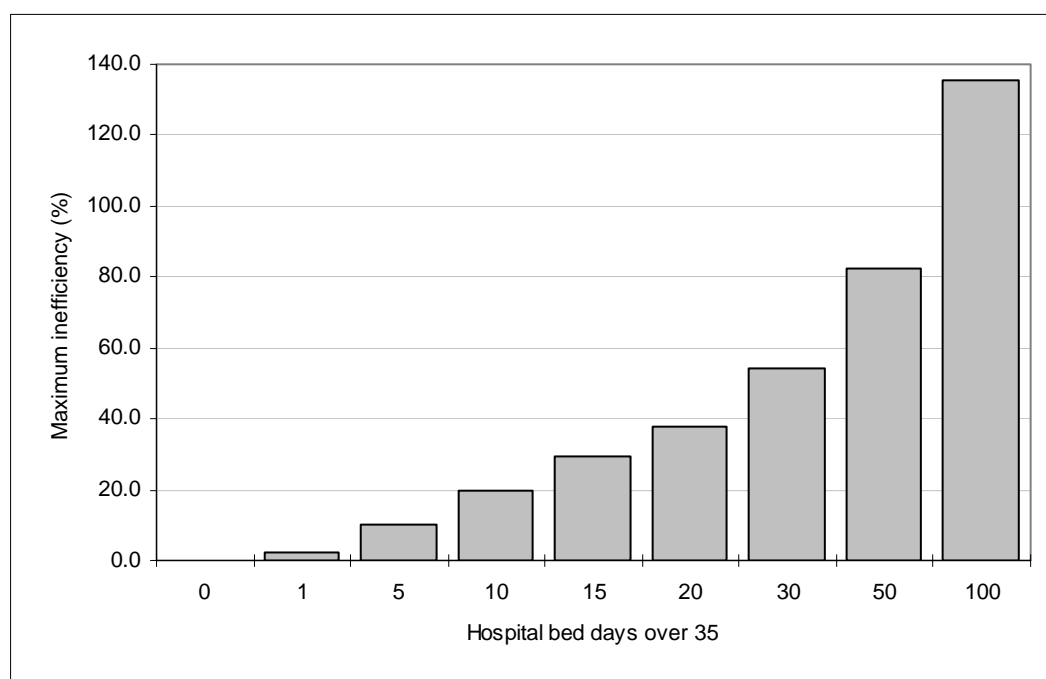
Figure D.1 indicates the maximum level of inefficiency as the length of hospital treatment rises (for  $c = \$500$  and  $ETC = \$1,200$ ). The maximum inefficiency would be around 20 per cent for a treatment with a duration of 45 days and over 100 per cent for hospitalisation of six months. However, the circumstances in which:

- (a) there is a viable short term substitute for long duration hospitalisation; and
- (b) long term hospitalisation is considered;

<sup>5</sup> It should be noted that unlike the arrangements for the elderly, the 35 day rule may also partly insulate funds from 'severity risk'—the risk of an extraordinarily large payment to one contributor during a year (for example, serious burns to a whole family). See MIRA (1993, pp. 14–15).

are relatively rare. We found no evidence that any insurers' policies were tilted in favour of longer term hospitalisation. Thus while the 35 day rule does have *scope* to distort incentives, there was no evidence that it had actually done so.

Figure D.1: Impact on inefficiency as bed days rise



### *Reduced attractiveness of front end deductibles and other cost sharing policies*

While health expenditures as a whole are less price responsive than many other goods, copayments and deductibles still affect the demand for health care (especially for elective care). Prices may also affect choice of a procedure by patient and doctor, and they may influence duration of stay in a hospital. Prices can also crudely filter opportunistic users from others and thereby be used to partly deter certain opportunistic behaviours by consumers – such as ‘hit and runs’.<sup>6</sup> Accordingly, the discretion by insurers to use price signals where they are effective is a potentially powerful part of an efficient market for health. Cost sharing can also help consumers. They may prefer a policy which is cheaper

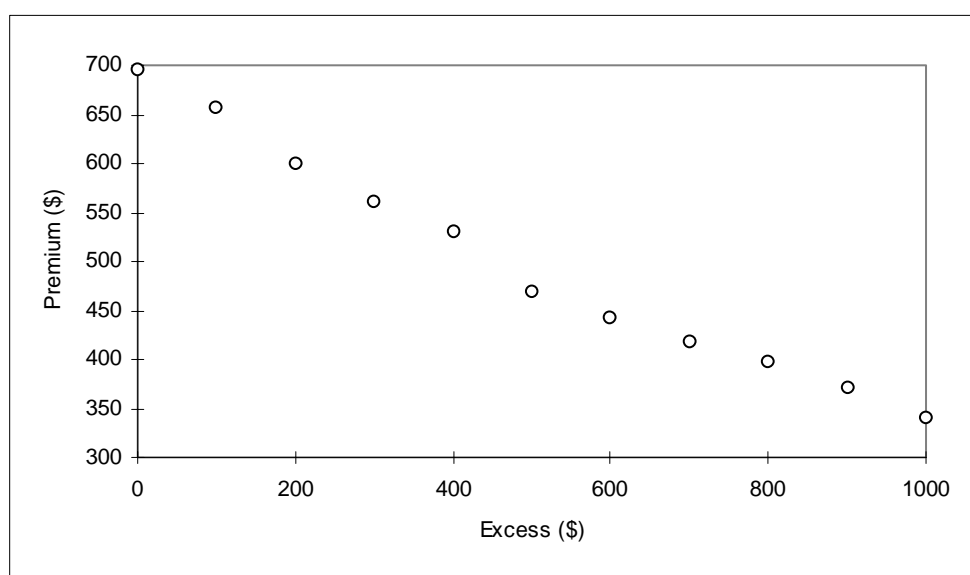
<sup>6</sup> This is because consumers who do not intend to hit and run will be far more likely to elect a front end deductible product than someone who intends to use the system and then leave. The insurer can then raise prices for top cover products for the group which intends to claim.

(but in which they consume less health services<sup>7</sup>) to one which is expensive (and where more services are purchased).

Reinsurance reduces the attractiveness of cost sharing products because the same reinsurance liability is levied on all products regardless of the level of benefit they offer consumers.<sup>8</sup> The bigger the deductible or copayment the more the burden of the reinsurance on the price of a policy.

Thus, the major reason for the relatively flat profile of premium declines associated with increasing excesses (Figure D.2) is the burden of reinsurance.

Figure D.2: Premiums associated with different excesses



Source: MBF Single top cover product, 1996.

The Commission simulated an insurance population to examine the impact of reinsurance on the attractiveness of front end deductibles (box D.1 and table D.5). The loading on FED policies becomes very high for large excesses — at around 85 per cent for policies with a \$1000 excess compared to around 34 per

<sup>7</sup> Abstracting from any gains from signalling their health status, it can be easily demonstrated for any standard utility function that consumers will not find front end deductible policies attractive *unless* such policies reduce their demand for medical services (eg Jacobs 1991, pp. 108–109).

<sup>8</sup> It is important to note that reinsurance imposes this tax burden relative to the counterfactual of no reinsurance. However, relative to a reinsurance system with more profound equalisation of risks, the current system actually encourages the use of front end deductibles, because they are a way of identifying lower risk groups in the population (as described in the section below on ‘Swiss cheese’ policies).

cent for a policy with no excess. *Catastrophe insurance — with even higher excesses — is effectively priced out of the market by the form of reinsurance, a point noted by Mercantile Mutual in their submission (Sub. 142).*

### Box D.1: FED simulation model

The simulation model is based on a population of 100,000 members, comprising 87,000 people aged under 65 and 13,000 aged 65 and over. The inverse of the lognormal distribution was used to approximate the consumption of hospital services by consumers. A first distribution, with a mean of 7.3 and variance of 0.3 was used to generate a random sample of the hospital services usage of 1000 claimants aged under 65. A second, with a mean of 7.7 and variance of 1 was used to generate a random sample of the hospital services usage of 1000 claimants aged over 65. We assumed that this pattern of usage was replicated in any other claimants in these two distinct risk groups. We assumed that 20 per cent of the under 65s made claims, and that 50 per cent of those aged 65 years or more made claims. We also assumed that claim rates were identical in groups with and without FEDs (this will tend to *underestimate* the adverse effect of reinsurance on FEDs). In order to abstract from cream skinning, we also assumed that uptake of FEDs was identical, at 15 per cent, in both risk groups. We assumed that management costs per SEU were equivalent to:

$$\text{MANCOST} = \$85 \times \left( \frac{1}{2} + \frac{1}{2} \left\{ \frac{1000 - \psi}{1000} \right\} \right) \text{ where } \psi \text{ is the sum of people in the}$$

sample of 2000 whose excess is greater or equal to the value of their claim. Thus if excesses are very high in a FED then  $\psi$  tends to 1000 and management costs tend to \$42.50 (because some fixed costs of management remain, even if no claims are made). We assumed as well that the equalisation ratio was set at 0.79 and that the value of the reinsurance average deficit per SEU (AD in the nomenclature of this appendix) was \$241. We ignored the small interaction between the uptake of FEDs and its impact on the state wide average deficit. This simple and illustrative model can then be used to examine the impact of different FED excesses on the average benefits claimed by FED policy-holders and on premium levels.

Table D.5: Premiums, benefits and loadings in front end deductible policies compared to standard policies

<i>Excess</i>	<i>Premiums</i>		<i>Benefits<sup>a</sup></i>		<i>Loading<sup>b</sup></i>	
	<i>No FED</i>	<i>FED</i>	<i>No FED</i>	<i>FED</i>	<i>No FED</i>	<i>FED</i>
	\$	\$	\$	\$	%	%
0	641	641	480	480	33.5	33.5
100	641	622	480	456	33.5	36.4
200	641	603	480	432	33.5	39.6
400	641	566	480	385	33.5	47.0
600	641	528	480	338	33.5	56.1
800	641	490	480	293	33.5	67.3
1000	641	452	480	250	33.5	81.0

a These are average benefits paid by the insurer for a FED policy holder for different levels of excess. Note the major reason that a \$100 excess reduces average benefits paid by only \$24 is because it is still the case that many members are not claimants in any given year.

b The loading is equal to the percentage difference between the premium income and the average benefits paid out per SEU for a given policy.

Source: Commission estimates.

Mercantile Mutual proposed that the reinsurance payments be proportional to the benefits paid rather than a flat surcharge per policy as applies currently. This implies that:

$$\frac{AD_f}{\left(\frac{B_f}{N_f}\right)} = \frac{AD_{nf}}{\left(\frac{B_{nf}}{N_{nf}}\right)} \quad \{22\}$$

where  $AD_f$  is the reinsurance contribution per SEU from a FED policy holder,  $AD_{nf}$  is the reinsurance contribution per SEU from a policy holder with no FED, and the  $N$  and  $B$  variables denote the number of SEUs and gross benefits of SEUs.

The total contribution to the reinsurance pool per SEU stays fixed:

$$\frac{AD_f \times N_f + AD_{nf} \times N_{nf}}{N_f + N_{nf}} = AD \quad \{23\}$$

This implies that the appropriate rule for allocating reinsurance liabilities is:

$$AD_f = \frac{AD}{\beta \left(1 + \frac{B_{nf}}{B_f}\right)} \quad \text{and} \quad AD_{nf} = \frac{AD}{(1 - \beta) \left(1 + \frac{B_f}{B_{nf}}\right)} \quad \{24\}$$

where:

$$\beta = \frac{N_f}{N_{nf} + N_f} \quad \{25\}$$

Proportional reinsurance considerably lowers premiums for FEDs and catastrophe products. For example, using the Commission's simulated model it lowers the premium of the \$1000 excess product by about 25 per cent. It produces a modest 3 per cent increase in the price of the policies with no FEDs. These results, while indicative only, suggest that substantial incentive effects in favour of FEDs can be produced by changing the system to proportional reinsurance.

### *Reduced attractiveness of exclusion policies*

Not every consumer wants the full package of insurance. For example, people might just want to be covered in a private hospital for those elective surgery procedures (ESPs) where public hospitals face the biggest waiting lists, while using the public system for the urgent and sophisticated treatments at which it excels. Exclusion policies can be cheaper for two reasons:

- they skim the cream of the insured — identifying the lower risk groups. This is inimical to community rating; and
- they don't cover some operations, so that expected benefits paid can be significantly less.

*Relative to no reinsurance*, the current reinsurance scheme penalises all exclusion products, because (as noted in the previous section) it levies a fixed reinsurance liability on any policy regardless of the average benefits paid out. But it imposes bigger penalties on exclusion products which the aged might want (such as ESPs). This is because, while all exclusion products (regardless of the age group targeted) bear the full liability associated with the reinsurance pool, individual funds have:

- weak incentives to reduce the drawing rates of the old because 79 per cent of the costs are pooled; and
- strong incentives to lower drawing rates in the under 65s by identifying lower risk age groups within this broad age category.

### *Reduced attractiveness of insurance packages*

For many goods and services, consumers like to shop from a variety of sources, rather than buying all the goods and services from just one provider. This

enables consumers to buy particular goods or services from the providers which have some advantages in their production. Reinsurance effectively precludes shopping around in private health insurance, because each time the consumer buys an insurance product they face the full liability of the reinsurance levy. This would be like paying a \$100 entry fee to a patisserie, another \$100 entry fee to the butcher, and so on. The implication is that health insurers cannot specialise in particular policies, because consumers will require them to be insurance ‘supermarkets’ given the high fixed entry fee.

If reinsurance was altered to remove the disincentive for specialisation, how important could such speciality products be?

It is likely that most funds would probably want to cater for most health insurance needs. But some specialised entrants, with a good capacity to price and negotiate arrangements for particular classes of DRG, might develop boutique products. These could then be combined with others from the non-specialised insurers. This would be somewhat like going to the supermarket for most of your shopping but buying a delicacy from a speciality shop. Increasingly, computer technology could allow insurance broker services to package insurance components together in this way.

Moreover, the threat of shopping around would force insurers to price all the sub-components of insurance policies at competitive prices.

A shift to proportional insurance would allow the development of such specialised insurance products.

On the other hand, many participants considered that there were risks from the application of proportional reinsurance (such as excessive cream skimming and administrative difficulties) — these are examined in chapter 10.

## **D.7 Some ‘equity’ issues**

The current reinsurance system is premised on equalisation of treatment of funds with differing age and chronic illness membership profiles. But how well does it deal with other variations in risk profiles? In fact, reinsurance is a relatively blunt instrument for risk equalisation. Funds will be disadvantaged if they have greater representation of:

- females cf males;
- females of child bearing age cf other females;
- families with children cf families with no children;

- people aged in the early 60s of younger aged people;
- very old people of people aged just over 65;
- high claimants within any risk group; and/or
- the elderly or other high risk groups than funds in other states.

These raise two broad issues. Compared to a reinsurance system where there were more diverse risk categories the current reinsurance arrangement creates incentives for ‘Swiss cheese’ or exclusionary products — which in turn compromises the objective of community rating. Second, it raises the question of whether reinsurance should recognise state boundaries or not. We turn to these two issues next.

### **Swiss cheese policies**

The fact that reinsurance equalises only some risks creates incentives for insurers to offer products that identify lower costs users, of which ‘Swiss cheese’ policies represent the most exotic variant. Front end deductibles and copayment products represent another class of such products.

A fund is able to reduce the drawing rate for the under 65s by targeting policies at the younger or less risky groups in this category, without formally excluding other groups. For example, a policy may exclude hip replacements or heart by-pass operations — conditions which most affect the elderly. This flows onto lower premiums for that fund, but leads to higher premiums for funds from whom these lower risks have been ‘cannibalised’.<sup>9</sup> Moreover, it creates premium differences between different risk categories, so weakening community rating. Whether this is a defect depends on judgments about the desirability of community rating.

An extended example is provided in table D.6 indicating the premium and benefit outcomes of the introduction of a ‘Swiss cheese’ policy. The table is based on a simple model incorporating the following assumptions:

- the over 65s initially account for 13 per cent of a fund’s members and have a drawing rate five times as high as the under 65s;
- the drawing rate of the under 65s is initially \$650 per SEU;

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<sup>9</sup> Note, however, that to the extent that exclusionary policies attract new members altogether to private health insurance this externality between funds may be avoided.



- there are just two risk sub-categories within the under 65s (who collectively account for 87 per cent of the fund's members). One fifth of the group comprises SEUs with an average drawing rate equal to \$250 and the remaining 80 percent are people with an average drawing rate of \$750;
- each fund has a management cost per SEU of \$90;
- each fund operates to break even; and
- 50 per cent of the new members attracted to Fund A following the introduction of the 'Swiss cheese' policy are new to health insurance altogether, but all of the people repelled from Fund A go to other funds.

Before the introduction of the exclusionary products, the premiums are set at \$980.50 per year per SEU. When Fund A decides to market an exclusionary product which targets the low risk sub-group of the under 65s a sequence of events follows:

- they can charge a lower price for this risk class (ultimately \$582 or a discount of around 40 per cent);
- they get slightly lower drawing rates for this risk class because they avoid some of the costs associated with the medical exclusions;
- they attract people from the low risk group from other funds;
- they have to put up premiums for both the old and for the higher risk groups under 65 (these go to \$1060);
- overall weighted premiums for Fund A fall by around 4 per cent, while those of the 'other funds' rise by only a modest amount (reflecting the loss of the lower risk sub-group of under 65s); and
- some of the old and the higher risk members of the under 65s move to other funds (though the impact of this on other funds is compensated by reinsurance).

The unrealistic feature of the model underpinning these results is the lack of responsiveness by other funds. As a competitive response, they too are likely to shift to similar exclusionary policies. If they do, then premiums for the old rise relative to lower risk groups across all funds — and some of the old would leave private health insurance. This would lower average premiums somewhat across the industry, but would shift some high cost cases to the public sector.

It should be emphasised that compared to the counterfactual of no reinsurance, the reinsurance system does *not* encourage 'Swiss cheese' policies. If there were no reinsurance, then firms would be able to price 'Swiss cheese' policies at a

much lower price and they would have far more impact on the market. We develop this argument later. However, the current reinsurance arrangements do create incentives for exclusion products compared to a reinsurance arrangement based on a broader group of risk categories (as say advocated by Brent Walker in his submission).

Table D.6: Impact of 'Swiss cheese' policies

	<i>Status quo</i>			<i>Exclusionary products</i>		
	<i>Fund A</i>	<i>Other funds</i>	<i>All funds</i>	<i>Fund A</i>	<i>Other funds</i>	<i>All funds</i>
<b>SEU membership:</b>						
Sub-group 1 of under 65s	52 200	226 200	278 400	75 690	214 455	290 145
Sub-group 2 of under 65s	208 800	904 800	1 113 600	198 360	915 240	1 113 600
Total under 65s	261 000	1 131 000	1 392 000	274 050	1 129 695	1 403 745
Over 65s	39 000	169 000	208 000	37 050	170 950	208 000
Total membership (SEUs)	300 000	1 300 000	1 600 000	311 100	1 300 645	1 611 745
<b>Benefits paid (\$m):</b>						
Sub-group 1 of under 65s	13.1	56.6	69.6	18.0	53.6	71.6
Sub-group 2 of under 65s	156.6	678.6	835.2	148.8	686.4	835.2
Total under 65s	169.7	735.2	904.8	166.7	740.0	906.8
Over 65s	97.5	422.5	520	92.6	427.4	520.0
Total gross benefits paid	267.2	1 157.70	1 424.80	259.0	1 167.0	1 427.0
<b>Drawing rates (\$):</b>						
Sub-group 1 of under 65s	250.0	250.0	250.0	237.5	250	246.7
Sub-group 2 of under 65s	750.0	750.0	750.0	750.0	750.0	750.0
Total under 65s	650.0	650.0	650.0	608.5	655.1	646
Over 65s	2 500.0	2 500.0	2 500.0	2 500.0	2 500.0	2 500.0
Total drawing rate	890.5	890.5	890.5	833.7	897.6	885.2
<b>Reinsurance calcs (\$):</b>						
Average deficit per SEU	256.8	256.8	256.8	235.2	259.6	254.9
Average net benefits paid out per SEU	890.5	890.5	890.5	853.4	892.9	885.2
<b>Net costs (\$m):</b>						
Total net benefits paid	267.2	1 157.70	1 424.8	265.5	1 161.3	1 426.8
Management costs	27.0	117.0	144.0	28.0	117.1	145.1
Total costs = total premium income	294.2	1 274.7	1 568.8	293.5	1 278.4	1 571.8
<b>Premiums given zero profits (\$):</b>						
Total premiums	980.5	980.5	980.5	943.4	982.9	975.2
Sub-group 1				582.4		
Others				1 059.5		

### National versus state reinsurance

A more controversial equity issue relates to state versus national reinsurance. At the moment, each state has its own reinsurance pool, which takes account of demographic variations between funds in that state, but entirely ignores variations in demography between states. Community rating as practised does not, therefore, relate to the Australian community as a whole, but to seven sets of communities, each with different risk characteristics. To the extent that demographics vary, then state reinsurance negates the principle of genuine community rating.

An extreme example illustrates this point. Say that each state attracts a very narrow age group — with the very young in the Northern Territory, the next age group in WA and so on, with Victoria having all people aged over 65. In this case, premiums will be very high in Victoria and very low in the Northern Territory — with little cross subsidisation of the sick between the states.

Of course, the situation is far from this stark. Even so, there are marked variations in the age structure of the different states. For example, in 1995–96 under 5 per cent of the insured are aged over 65 in the Northern Territory, about 10 per cent in Western Australia and about 16 per cent in Victoria. These differences can produce quite pronounced effects on average premiums. The impact of just the variation in the distribution of these two age categories (those aged under 65 and those aged 65 and over) can be modelled by imagining that each state had the same demographic structure as Australia as a whole (this is a simplified national application of the PROFILE reinsurance scheme). Thus for any state (s) the existing benefits paid ( $B_s$ ) are:

$$B_s = B_{s,a} + B_{s,y} \quad \{26\}$$

while the benefits paid if they have the same demographics as Australia are:

$$\hat{B}_s = \frac{\psi N_s B_{s,y}}{S_{s,y}} + \frac{(1 - \psi) N_s B_{s,a}}{S_{s,a}} \quad \{27\}$$

where  $B_{s,a}$  is benefits paid to those aged 65 and over,  $B_{s,y}$  is benefits paid to those aged under 65,  $\psi$  is the proportion of people aged under 65 in the Australian insured population as a whole,  $N_s$  is the number of insured in state s,  $S_{s,y}$  is the number of ‘young’ insured people in state s,  $S_{s,a}$  is the number of insured ‘aged’ people in state s, and  $\hat{B}_s$  is the demographically adjusted benefits paid of state s.

If this method of reinsurance is applied then benefits paid out (and presumably premiums) in the Northern Territory would be one third greater. They would be

8 per cent more in Western Australia and nearly 6 per cent less in Victoria compared to the current state-based reinsurance system (see table D.7, rows marked 'DEMOG benefits' and "Change compared to SREI").<sup>10</sup>

Table D.7: Estimates of impact of national reinsurance, 1995–96

	NSW	Victoria	QLD	SA	WA	TAS	NT	Australia
<b>State based reinsurance (SREI)</b>								
Average coverage <65 (000)	2002	1280.3	890.7	422.6	578.5	153.9	33.8	5361.8
Average coverage >65 (000)	287.3	242.2	141.4	79.2	67.2	20.1	0.9	838.3
Total members (000)	2289.3	1522.5	1032.1	501.8	645.7	174	34.7	6200.1
Proportion 65 and over (%)	12.5	15.9	13.7	15.8	10.4	11.6	2.7	13.5
Benefits paid <65 (\$m)	532.1	413.6	290.2	145	171	52.2	10.7	1614.8
Benefits paid 65+ (\$m)	370.7	384.1	217	124.8	88.5	33	1.3	1219.3
Benefits paid per member <65 (\$)	265.8	323	325.8	343.1	295.6	339.2	315.5	301.2
Benefits paid per member 65+ (\$)	1290.3	1585.9	1534.7	1575.8	1317	1639.3	1363.4	1454.5
Benefits paid per member (\$)	394.4	523.9	491.4	537.7	401.9	489.4	343.3	457.1
SREI benefits paid (\$m)	902.8	797.7	507.2	269.8	259.5	85.2	11.9	2834.1
<b>National reinsurance (NREI)</b>								
NREI benefits paid (\$m)	965.6	730.8	496.1	249.2	289.9	86.2	16.3	2834.1
Change compared to SREI (%)	7.0	-8.4	-2.2	-7.6	11.7	1.2	36.9	0.0
DEMOG benefits paid (\$m)	925.6	751.8	505	255.8	280	89.6	15.9	2834.1
Change compared to SREI (%)	2.5	-5.8	-0.4	-5.2	7.9	5.2	33.2	0.0

Several submissions (for example, National Mutual and the South Australian Government) argued that a more appropriate arrangement would be national reinsurance. If the current system of reinsurance was applied nationally, rather than by state, this would produce gross flows between states of around \$200 million. For example, Victoria would pick up nearly \$70 million and Western Australia would lose around \$30 million (see table D.7, row marked 'NREI benefits paid').

There are problems with shifting to a system of national reinsurance:

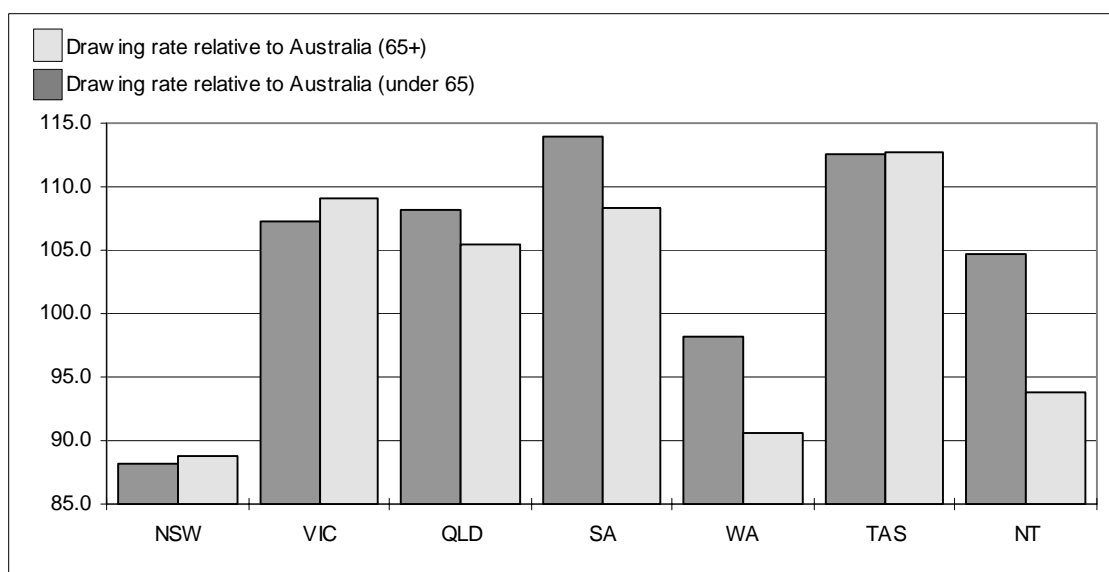
- The major apparent obstacle is presented by variations in costs by state which do not relate to demography (figure D.3). National reinsurance penalises states which have developed systems for combating hospital costs, or which just happen to face lower costs (unrelated to the risk profile of their population). But this problem is not isolated to states. Individual funds *within*

<sup>10</sup> However, there is a funding shortage of around \$10 million when this demographic correction is applied. This could be made up by levying a separate tax proportional to benefits.

a state reinsurance system are similarly penalised under current arrangements if they have lower costs (say a regional fund compared to a big city fund). In this sense, the problem is inherent to the current system of reinsurance, and not one unique to a national reinsurance regime.

- Funds can to some extent affect the demographics of their membership (through marketing and product innovations). Some states appear to have a much greater representation of old people in health insurance than the demography of the state would suggest (for example, Victoria — see table D.8). A move to national reinsurance would penalise funds which had sought to re-balance the demography of their membership.
- As noted in the previous section, a fund with a dominant share of a state internalises most of the costs of reinsurance — and faces relatively strong incentives for efficiency. In contrast, if reinsurance was changed to a national basis and the current version of mixed 2 retained, then the incentive to shift the costs of the elderly to other funds would increase because no fund would have such a large market share.

Figure D.3: Differences in state drawing rates relative to the Australian average (Australia = 100.0), 1995–96



Source: PHIAC 1996a.

Table D.8: Deviation in insurance demographic profile and state demographic profile, 1994–95

	<i>Deviation in demographic profile</i>	<i>Proportion of people aged 65 and over in the overall population</i>	<i>Proportion of people aged 65 and over in the insured population</i>
NSW	0.56	11.68	12.24
VIC	4.48	11.48	15.96
QLD	3.04	10.53	13.56
SA	1.98	13.64	15.61
WA	0.55	9.66	10.22
TAS	-0.47	11.77	11.30
NT	1.30	2.87	4.17
Australia	2.23	11.16	13.39

Sources: PHIAC 1995. ABS demographic data.

## D.8 Summary of issues relating to reinsurance

Reinsurance is a key influence on incentives in the private health insurance industry. Although it is a flawed prop to community rating and generates sizeable perverse incentives, its impact on the industry has been growing as the age distribution of the insured tilts more and more to the old. Its major problems are:

- it does not equalise across all relevant risk categories, which encourages funds to cream skim;
- it does not compensate states with older population distributions;
- it reduces incentives to reduce costs for the old;
- it reduces incentives to use ambulatory care rather than hospital care;
- it creates some incentives for longer term hospitalisation — although in practise these are likely to be weak;
- it increases the insurance loading on any products offering lower benefits to consumers such as front end deductibles, catastrophe insurance products and exclusion products, thus making these less attractive to consumers; and
- it effectively eliminates the possibility of specialisation in insurance products.

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## APPENDIX E: TAXATION ISSUES

### E.1 Introduction

Most registered health benefits organisations are exempt from income tax.<sup>1</sup> Section 23(eb) of the Income Tax Assessment Act (ITAA) specifies that exemption from tax will be provided to:

(eb) income of an organisation which:

(i) is a registered health benefit organisation, a registered medical benefits organisation or a registered hospital benefits organisation for the purposes of the National Health Act 1953 or of that Act as amended; and

(ii) is an organisation carried on otherwise than for the purposes of profit or gain to the individual members of the organisation. (ITAA, 1936)

The Commission sought to examine the impact that exemption from tax for not-for-profit health insurers has in an industry in which tax paying and exempt organisations compete.

National Mutual argued that:

The taxation regime favours some funds (including the government owned insurer, Medibank Private). This distortion to competition and to usage of scarce resources is not justified by the fact that most insurers are mutuals, any more than it would justify making life insurers or credit unions tax exempt. The distortion should be removed ... (Sub. 140, p. vi)

On the other hand, non-taxable funds argued that their tax exempt status was appropriate given the social purpose of their activities (for example, Health Benefits Council of Victoria, Sub. D265, p. 10).

There are three questions which need to be resolved in order to assess any claim for exemption:

- is the exemption consistent with other exemptions granted under section 23 of the ITAA or does it appear anomalous?
- does tax exemption have any economic effects (on premium prices or on the number of policies sold)?

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<sup>1</sup> Section 23(eb) of the Income Tax Assessment Act (ITAA). Note that the mutual funds are *not* exempt from input taxes, such as payroll taxes, wholesale sales tax and fringe benefits tax, and state taxes, such as land taxes.

- are there any other gains from the introduction of taxation, such as instilling an improved corporate culture in mutual funds, or easing the transition to for-profits?

Section 23 stipulates many ‘special’ cases for tax exemption of different sorts of organisations and people. But, arguably, the main thrust of section 23 relates to the tax treatment of two sorts of organisations. First, one set, exemplified by clubs, engages in activities for the benefit of members, but does not have to aim to secure any surplus. It is correct that such clubs may have a competitive advantage vis-a-vis tax paying businesses providing the same services. However, the logic of exempting these entities from tax is that the imposition of a tax would make no economic difference, since a tax can only relate to a surplus, and a club can always choose to eliminate a surplus.

Second, another set of entities, exemplified by charities, collects donations from one group to distribute to another group (typically of very low income people, who themselves would be tax exempt). These entities aim to maximise their surplus, in the same way as any taxable entity. It can be argued, therefore, that they have no incentive to undercut the prices of tax paying competitors, and neutrality is preserved (IC 1995).

Health insurers most resemble the first type of entity — clubs. However, there is one potentially important difference: the existence of substantial financial reserves. These reserves serve a number of functions which are not readily avoided:

- there is a regulatory requirement that each fund must have a minimum of two calendar contribution months of reserves;
- normal prudential motives mean that funds will often wish to exceed the statutory floor; and
- such reserves constitute the capital of a fund — used for achieving business expansion or change.

A tax exempt fund does not pay taxes on the accumulation of reserves (including the income earned on reserves). But unlike clubs, such a fund cannot typically elect to eliminate its whole surplus in the event that it faces taxation. For example:

- from time to time a fund will find that its level of reserves falls below its optimal level, and will need to re-build them; and
- if the number of members in a fund grows then that fund will need to build up reserves.



In either case, a tax paying fund must raise premiums by a greater amount than a tax exempt fund in order to reach the optimal level of reserves.

Of course, a taxable entity can carry forward any tax losses that it acquires when reserves are falling. It can set these against the taxes imposed when reserves are rising. In contrast, non-taxable entities face the full cost of losses when they occur. We turn to a number of heuristic models to see what the scale of any distortion may be.

## **E.2 A simple model of tax distortions: stable membership with shocks to payouts**

The Commission modelled the premium outcomes from a situation in which a tax exempt and a taxable fund face identical shocks to their payouts and must aim to restore their reserves to prudentially safe levels (Tables E.1 and E.2).

In period (T-1) both of the funds have premiums set at a level which provides them with zero profits<sup>2</sup> and a target reserve level equal to one third of their annual total costs (comprising management costs and benefits paid out).

In period (T) the funds are faced by a benefit payout blow-out (from \$65 million to \$70 million). Their premium levels are still at their old level, and both funds make a loss of around \$5 million, so that their reserves fall. They are now well below their desired reserve target — both because current reserves have fallen, and because the required reserve levels have risen with the increase in benefits paid out. Both funds must now contemplate an increase in premiums to achieve the desired level of reserves.<sup>3</sup> To do this, they must make a profit in the period (T+1) of around \$7 million.

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<sup>2</sup> A zero profit is the appropriate equilibrium point in these experiments because any distorting impact of the tax status of a not-for-profit mutual fund stems from its ability to avoid taxes on reserve accumulation. Its ability to realise no profits may confer it a competitive advantage, but it is not an advantage affected by the imposition of taxes. If the experiment required the taxable entity to earn positive profits and the not-for-profit a zero profit, the premium disadvantage would be much greater — but the experiment would confound two quite separate issues.

<sup>3</sup> In this particular example, that decision is discretionary because the regulated reserve requirement has not been violated. But if the shock had been of sufficient magnitude then the funds would have been obliged to increase premiums to meet the reserve hurdle.

Table E.1: Premium setting in a tax-exempt fund

<i>Non-taxable fund</i>	<i>T-1</i>	<i>T</i>	<i>T+1</i>	<i>T+2</i>
Members	100 000	100 000	100 000	100 000
Premium \$	698	698	821	745
Contribution income \$'000	69 779	69 779	82 070	74 541
Investment income \$'000	3 416	3 040	3 156	3 649
Benefits paid out \$'000	65 005	70 000	70 000	70 000
Management and other costs \$'000	8 190	8 190	8 190	8 190
Profit \$'000	0	(5 371)	7 036	0
Reserves (this period) \$'000	24 398	19 027	26 063	26 063
Reserves (last period) \$'000	24 398	24 398	19 027	26 063
Target reserves \$'000	24 398	26 063	26 063	26 063

Table E.2: Premium setting in a taxable fund

<i>Taxable fund</i>	<i>T-1</i>	<i>T</i>	<i>T+1</i>	<i>T+2</i>
Members	100 000	100 000	100 000	100 000
Premium \$	698	698	830	745
Contribution income \$'000	69 779	69 779	83 006	74 541
Investment income \$'000	3 416	3 040	3 156	3 649
Benefits paid out \$'000	65 005	70 000	70 000	70 000
Management and other costs \$'000	8 190	8 190	8 190	8 190
After tax profit \$'000	0	(5 371)	7 036	0
Reserves (this period) \$'000	24 398	19 027	26 063	26 063
Reserves (last period) \$'000	24 398	24 398	19 027	26 063
Target reserves \$'000	24 398	26 063	26 063	26 063
Carry forward value of tax losses	0	1 934	0	0

This is where the difference in tax treatments comes into play. The non-taxable fund simply puts up premiums by an amount which will just reach the required reserve target, knowing that none of the profit will be taxed. They increase premiums to \$821 (table E.1). The taxable fund must raise the same level of *after-tax* profits, and therefore must, on the face of it, raise premiums by much more than the non-taxable fund. However, unlike the non-taxable fund, the taxable entity can cast back to the last period, and offset the tax value of its

losses against this period's profits. That reduces the pre-tax profit hurdle it has to reach. Ultimately, the taxable entity can achieve the target reserve level with a premium increase to \$830 (table E.2), or \$9 more than the non-taxable fund. In this simple model, the taxable fund puts up premiums by 19 per cent and the tax exempt fund by 17.6 per cent.<sup>4</sup>

The Health Benefits Council of Victoria (HBCV, Sub. D265) undertook similar analysis to the Commission, but added a prior year in which both funds recorded another identical loss. Inevitably, this will tilt the situation in favour of the taxed entity because of the more favourable treatment of losses for a taxed entity. But it is not an appropriate assumption in an experiment intended to show the impact of a shock which pushes funds from an equilibrium position (a steady state with zero profits and achievement of the reserves target) out of equilibrium (insufficient reserves) and back to equilibrium. The HBCV method could provide an arbitrarily large advantage to any for-profit entity by simply cranking up the loss in year T-2 to a sufficiently large level. The impact of the HBCV modeling is that insurers are on average making a loss — an assumption not consistent with their continued existence.

### E.3 A simple model of tax distortions: growing membership and stable benefits per member

The Commission also modelled the premium outcomes from a situation in which a tax exempt and a taxable fund are new to health insurance and are trying to rapidly increase their market share. This is suggestive of the extent to which the varying tax status of different funds may affect incentives for taxable entities to enter private health insurance. The model is based on the following relationships:

$$N_t = \frac{75000}{1 + 149 \exp(-0.6t)} \quad \{1\}$$

$$B_t = 650N_t \quad \{2\}$$

$$M_t = 0.126B_t \quad \{3\}$$

$$\pi_t = (C_t + I_t - B_t - M_t).(1 - \phi\tau) \quad \{4\}$$

<sup>4</sup> In the next period, T+2, equilibrium is restored and both funds charge the same premiums. It should be emphasised that this is a *stylistic* model. It is not intended to capture the genuine dynamics of adjusting premiums, but to illustrate how distortions from taxation can arise.

$$I_t = 0.14 \frac{R_t + R_{t-1}}{2} \quad \{5\}$$

$$R_t = \hat{R} = \frac{M + B}{3} \quad \{6\}$$

$$R_t = R_{t-1} + \pi_t \text{ so that} \quad \{7\}$$

$$C_t = \frac{\left\{ \frac{M + B}{3} - R_{t-1} \right\}}{(1 - \phi\tau)} - (I - B - M) \text{ therefore:} \quad \{8\}$$

$$P_t = \frac{C_t}{N_t} \quad \{9\}$$

where  $\pi$  is the profit,  $C$  is contribution income,  $I$  is investment,  $B$  is benefits paid,  $M$  is management costs,  $t$  is time,  $\phi$  is an indicator function taking the value of 1 if an entity is taxable and zero if not,  $\tau$  is the corporate tax rate,  $R$  is the reserve level at the end of the year,  $\hat{R}$  is the target reserve level,  $P$  is the premium and  $N$  is the number of SEUs. We have assumed a logistic function describes the recruitment of a new fund, with early rapid growth in members and then a gradual decline in growth to a final level of membership.

Figure E.1 shows the premium path for the untaxed and taxed entities as they expand membership. The premiums for the taxed fund have to be higher than the untaxed fund in order to achieve the reserve target. When membership growth is at its most rapid, the relative disadvantage for taxed funds is at its greatest.

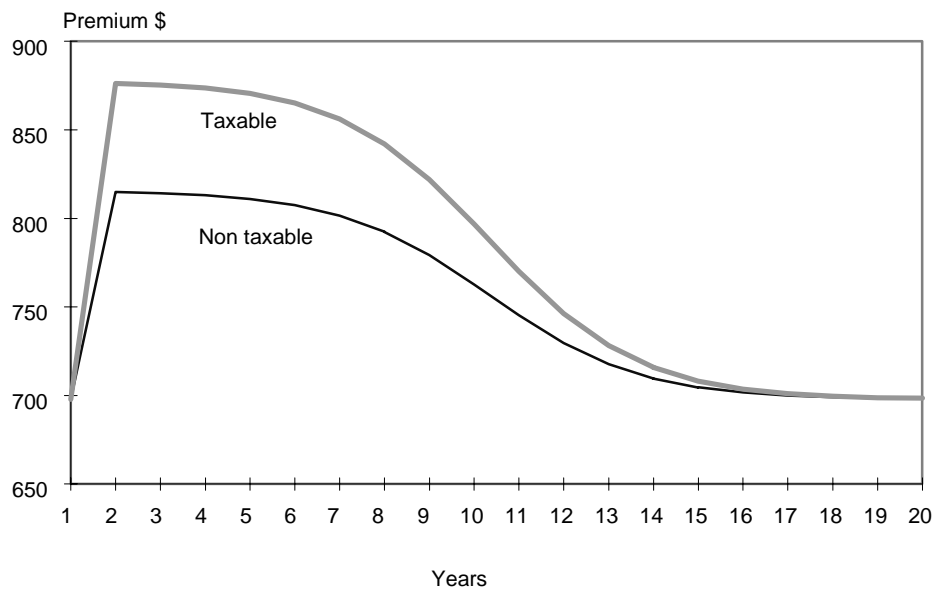
## E.4 Implications of tax distortions

To what extent do the above findings represent a theoretical case for removal of the tax exempt status of private health insurers? There are two possible grounds:

- A The prices in the industry appear to be too low, relative to other goods and services in the economy at large. A tax is effective at raising them somewhat towards their desired level, so a tax should be imposed. Premiums will rise slightly and fewer policies will be written.
- B A taxable (for-profit) fund is somewhat disadvantaged relative to a tax exempt fund. If for-profits had governance structures and incentives which were better directed towards cost minimisation and innovative products, then the existence of the price difference between taxable and tax exempt

insurers channels resources into firms which are less productive.<sup>5</sup> A tax will partly redress this balance and achieve productivity gains.

Figure E.1: Relative premiums of taxed and untaxed funds with growing membership



Argument A normally represents a cogent reason for taxation. However, in the context of a free and universally available health care system (Medicare) and a host of complex regulatory and institutional constraints, it is questionable whether there are too many health insurance policies from an economic perspective.

Another way of looking at this problem is to ask what should happen to the income generated by taxation of hitherto untaxed funds. If the original motivation for tax exempt status of the mutuals reflects a special social purpose for the activities they engage in (or corrects other distortions elsewhere), then there are grounds for the government to provide the tax revenue back to the privately insured as a rebate. As National Mutual pointed out (Sub. 140), under the current system this could be achieved with a subsidy to the reinsurance pool.

<sup>5</sup> There is another, more subtle, argument in favour of taxation. It is sometimes asserted that taxation of previously exempt bodies, for example, government trading enterprises, brings with it a better 'corporate culture'. There may be some element of truth in this, but fundamentally, there is a gulf between the objectives and governance structures of a body and its taxation status. Changing the taxation status of funds is not likely to have big impacts on their governance or incentives to any substantial degree.

In this case, the average insured consumer faces no increase in premium, and presumably no fewer policies are written. However, if that is the case, then why bother to tax the tax exempt funds in the first place? Accordingly, argument A appears to be an irrelevant ground for taxation, given no presumption of over-utilisation of insurance.

This then leaves Argument B. This is a stronger argument than A, and could potentially achieve some efficiencies at the margin. However, premiums would rise unless the government redistributed the revenue collected from the tax exemptions back to the industry — for example, by adding it to the reinsurance pool.

## **E.5 Dividend imputation**

The existence of dividend imputation raises additional complexity. Under Australia's company tax system, dividends are only taxed once, at the marginal rate of the relevant shareholder. Some shareholders will be taxed at rates which are ultimately higher than the company tax rate, and some (for example, if shareholders are super funds) at rates much lower than the company tax rate.

Since there are many avenues for avoiding the highest tax rates, it is likely that the average marginal rate at which dividends are ultimately taxed is below the company tax rate. If mutual funds were taxed at the corporate rate, they would not be able to distribute franked dividends to their members, as can National Mutual, SGIO and FAI (the three tax paying entities).

Accordingly, the corporate tax rate may be too high — justifying a tax rate at something less than 36 per cent. SGIO Health considered that the 'most appropriate rate' would be the average PAYE marginal rate — around 30 per cent (Sub. D237, p. 10).

## **E.6 Revenue impacts**

The amount of revenue collected by the imposition of such a tax is likely to be small *over the long run*, and will depend on whether the industry is building up or depleting reserves.

In the shorter run, the revenue raised, and the associated distortions could be bigger. In this context, the Commission notes that since 1990–91 the funds have been increasing their ratio of reserves to benefits paid (with the exception of 1995–96 when substantial losses occurred in the industry). It is during such

times of reserve accumulation, that taxable funds appear to be relatively disadvantaged compared to tax exempt funds.

As an overall indicator, the taxation at current tax rates of that aggregate surplus over those six years would have netted around \$190 million. Of course, it is likely that reserve policy would have been different had such taxes been in place, and not all of this revenue would have been collected. Moreover, reserve accumulation does not go on forever at this rate — the increase in reserves from 1990–91 can probably best be seen as an attempt to restore reserves to commercially sensible levels, after they fell dramatically in the late 1980s. Having achieved rough parity with historical reserve levels, it is unlikely that the next five years will witness similar surpluses.

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## APPENDIX F: MANDATORY COVER

### F.1 Introduction

Funds must cover psychiatric, palliative and rehabilitative care, at least at the default rate. These represent the last *explicit* product rules. In the Discussion Draft, the Commission asked for feedback on whether there was continued justification for such mandated cover.

A wide range of providers responding to this issue argued that psychiatric services possessed some special qualities which earmarked them for special consideration. Some submissions noted the *importance* of palliative care (for example, Diabetes Australia, Sub. D267) but few cogent arguments were provided that suggested that rehabilitation and palliative care possessed similarly *special* qualities demanding attention over a whole range of other conditions. Some participants observed that all three types of care could involve high costs over long periods, which might deter funds from covering them. However, there are many conditions — for example, renal dialysis and diabetes — also requiring long term, costly care which are not mandatory. Cost and duration of care are not genuinely special qualities of the currently compulsorily covered treatment classes.

Accordingly, we scrutinise the arguments relating to psychiatric care for the remainder of this appendix.

### F.2 Special problems with psychiatric cover?

A first step in analysing the significance of psychiatric cover is to assess to what extent such treatments have any special cost and efficiency problems compared to other services. The Commission found that:

- Major affective disorders (AN-DRG 843) were the second most important illness treated by private hospitals in terms of bed days and sixth in terms of absolute costs in 1994–95.<sup>1</sup> Other affective & somatoform disorders (AN-DRG 844) were 14th in terms of bed day ranking.

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<sup>1</sup> Based on the 1994–95 Department of Health and Family Services casemix data for private hospitals. Note that not all of these bed days will be occupied by insured patients.



- A number of service providers noted that existing admission criteria, patterns of in-hospital versus out-of-hospital care, and the classification system for psychiatric illnesses needed revision:

APHA recognises that guaranteed coverage could lead to the development of programs which do not provide appropriate psychiatric care, rehabilitation or palliative care. To address this problem, APHA would be willing to support, and assist with, the development of admission criteria for psychiatric care, rehabilitation and palliative care. (Sub. D217, p. 23)

Whatever the merits of the current DRG-based approach to casemix funding, there is abundant evidence that this classification system is a failure when it is applied to psychiatric services. ... The Commonwealth is funding a mental health casemix classification project (MH-CASC) which it is hoped will produce a superior classification based on episodes of care. (Royal Australian and New Zealand College of Psychiatrists, Sub. D260, p. 2)

The College acknowledges that there is a view that current psychiatric care in the private sector is too narrow in scope with an emphasis on in-patient treatment with missed opportunities for day hospital care and other outreach services. (Royal Australian and New Zealand College of Psychiatrists, Sub. D260, p. 2)

- Average length of stay in a private hospital for these conditions (AN-DRG 843 to 863) was in aggregate 29 per cent higher than for such conditions in the public hospital system in 1994–95<sup>2</sup>, notwithstanding agreement that the most serious psychiatric cases are treated in the public system. In contrast, for non-psychiatric AN-DRGs, the average length of stay in a private hospital is about 15 per cent *less* than in the public system.
- Treatments for psychiatric and dependence conditions (for example, alcohol abuse) accounted for 4.1 per cent of total private hospital costs in 1994–95 — and probably a somewhat smaller share of benefits paid by insurers.<sup>3</sup>

### F.3 Insurance fund concerns

Funds have expressed concern about these vestigial product rules, partly reflecting perceptions about their costs. The AHIA and some health funds considered that the requirements were illogical and unnecessary. The AHIA considered:

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<sup>2</sup> If drug dependency conditions are excluded the ratio of average length of stay falls to 16 per cent.

<sup>3</sup> These costs relate to the private hospital system — not to insured patients in private hospitals. The APHA (Sub. D.217, p. 23) estimated that psychiatric costs amounted to 2.4 per cent of total private insurance benefits paid in 1995–96.

Despite the claims of providers which are based on emotion rather than logic, there is nothing particularly unique about these treatments ... the existence of Medicare ensures treatment ... ' (Sub. D221, p. 5)

Similarly, SGIO Health stated that:

As long as exclusion type products are allowed, differential requirements pertaining to in-hospital psychiatric, rehabilitative and palliative care are a reflection of an illogical system highlighting the success of particular political lobby groups. (Sub. D237, p. 4)

## **F.4 Provider views**

However, in both initial submissions to this inquiry and in response to the Discussion Draft, some participants expressed concern that removal of mandated cover may mean that people do not get care when they need it, or that it would place pressure on the public health system. These participants put forward a series of linked arguments for preservation of the status quo for psychiatric care. They argued that:

- (a) People may not be well informed about the risks of acquiring certain psychiatric conditions. Because of consumer ignorance and stigma, it is claimed that funds would be able to exclude such products from *all* of their policies without fear of substantial consumer complaint.

No-one believes that they, or any member of their family, will ever develop a mental illness. (National Community Advisory Group on Mental Health, Sub. D229, p. 3)

consumers do not possess perfect information in relation to their demand for these services and therefore may not be able to accurately anticipate their need (Queensland Health, Sub. D252, p. 4).

- (b) There are no effective alternatives to mandated inclusion of psychiatric cover, such as public awareness programs.

No-one believes that he or she, or any member of their family, will ever develop a mental illness. The National Mental Health Strategy has recognised this problem by the allocation of eight million dollars to begin tackling the problem. All concerned believe that this will barely scratch the surface and any meaningful change will take years to achieve. (Victorian Community Advisory Group on Mental Health, Sub. D249, p. 3)

- (c) The public system is not an effective safety net for psychiatric illness.

The Commission argues that 'there is a public system available for care of patients with all illnesses'. For psychiatric patients ... this is clearly inaccurate. In reality, to access the public system, a patient must be either psychotic (for

voluntary admissions) or detainable under the Mental Health Act. (APHA, Sub. D217, p. 22)

people with serious mental health care problems have, in many cases, been forced to seek treatment privately due to lack of access to the public sector. (National Community Advisory Group on Mental Health, Sub. D229, pp. 1–2)

- (d) The requirement that all funds must cover all conditions in at least one table would not be sufficient to safeguard the needs of the psychiatrically ill. It was argued that top table cover would be too expensive for many people with mental illnesses (Sub. D229, p. 4). As well, it was maintained that it would be the young who would be targeted for products excluding psychiatric cover, notwithstanding the fact that they are a relatively high-risk group.

Stereo-typical misconceptions of psychiatric illness, and of psychiatric patients, appear to be influencing decisions by the industry to exclude episodes of psychiatric illness from insurance coverage. For instance, the advertising material for a product aimed at the younger sector of the market claims to exclude ‘those things that young singles are hardly likely to need, such as ... psychiatric services in private hospitals ... Such a claim is misleading and displays a marked lack of understanding about the onset of mental illness. There is clear evidence pointing to the onset of mental illness in late adolescent and young adult years. (Royal Australian and New Zealand College of Psychiatrists, Sub. 102, p. 2)

## **F.5 Evaluation of the arguments**

The case for mandatory inclusion of psychiatry in all tables rests on *all* of the above arguments being defensible. We look at each proposition in turn.

*Consumers are ignorant?* The Commission is not in a position to evaluate to what extent consumers are poor at gauging the risk of contracting a mental illness which would require hospitalisation. We note, however, that the issue of consumer ignorance, if present, is likely to extend to conditions other than psychiatric illnesses — for example, the risk of hernias, lens procedures and cholecystectomies — where no one is arguing for mandatory cover. The premise of the argument relies on health funds having little regard to their members well being, despite the fact that commercial success as a health fund relies not only on containing premiums, but on facilitating access to a wide range of services to their customers. Indeed, private health insurance has greatest leverage with consumers when it can demonstrate access to services which are rationed or unavailable elsewhere, as apparently claimed. On the other hand, the special stigma attached to mental illness, rather than ignorance per se about risk, may discourage funds from marketing this advantage to members.

*No effective alternatives?* In the Discussion Draft the Commission noted that if ignorance of risk — the ‘it can’t happen to me’ syndrome — were the major market failure, there may be measures which could be directly aimed at this problem. The regulatory solution will advantage short sighted or ignorant consumers, but it also penalises consumers with an accurate perception of the risks, who would elect not to undertake insurance for all possible illnesses. On the other hand, the extent to which direct measures (for example, public awareness programs as part of the National Mental Health Strategy) would be successful in overcoming consumer ignorance is unknown. Health awareness programs have been used in a number of cases in Australia (for example, in respect of AIDS). If consumer ignorance about mental health risks was substantiated, the Commission considers it premature to jettison this solution.

*No safety net?* The costs of a consumer making a mistake in choosing health care cover may be more appreciable if they cannot access substitute forms of treatment in the public system. Objective evidence on the extent to which the public system offers adequate care for psychiatric disorders is hard to obtain and interpret. Casemix data on psychiatric disorders reveal that in all but one DRG (eating disorders) most psychiatric care is still provided by public hospitals. The share of total hospital psychiatric separations accounted for by the private sector is 30.6 per cent — only slightly more than their share of total non-psychiatric separations.<sup>4</sup> The aggregate figures do not suggest that psychiatric care represents a special niche of comparative advantage for private hospitals. The figures certainly suggest that the public system’s capacities extend well beyond treatment of psychotic cases.

Unfortunately, while these data support the contention that the public system has a primary role in psychiatric care, and therefore might genuinely constitute a safety net, they do not illuminate two other important issues:

- the extent to which public sector services are rationed for clinically required care; and
- the extent to which there may be gaps in services, hidden within the broad DRG classifications.

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<sup>4</sup> The National Community Advisory Group on Mental Health pointed out that 70 per cent of psychiatrists currently practise in the private sector. How can this figure be reconciled with the finding that the private hospital sector accounts for only about 30 per cent of psychiatric admissions? The answer lies in the distinction between in-hospital and other services. However, out-of-hospital services are not covered by private hospital insurance anyway, and so the role of private provision here is not a relevant argument in respect of mandatory cover for in-hospital care.

*One table not enough?* There are two separate issues here. First, would a top cover product be too expensive for a person needing psychiatric care? In fact, a person suffering a psychiatric illness will very likely find the overall costs of using a top cover product markedly cheaper than any other table, once allowance is made for their level of service usage. This is because other tables principally have lower premiums because they have front end deductibles — which is why they are less attractive for anyone expecting to be ill.

Table F.1: The relative importance of the private sector in the treatment of psychiatric disorders

AN-DRG number	Description	Share of total hospital separations in private sector	Share of total hospital bed days in private sector
		%	%
841	Schizophrenia Disorders	20.2	15.9
842	Paranoia & Acute Psychotic Disorders	16.7	20.2
843	Major Affective Disorders	40.2	43.6
844	Other Affective & Somatoform Disorders	36.5	47.7
845	Anxiety Disorders	39.2	42.0
846	Eating & Obsessive-Compulsive Disorders	60.0	49.5
847	Personality Disorders & Acute Reactions	27.4	38.3
848	Childhood Mental Disorders	2.6	7.4
860	Alcohol Intoxication & Withdrawal	8.6	19.6
861	Drug Intoxication & Withdrawal	10.5	13.9
862	Alcohol Use Disorder & Dependence	36.3	52.7
863	Other Drug Use Disorder & Dependence	23.5	41.7
	<i>Total Psychiatric disorders</i>	<b>30.6</b>	<b>36.3</b>
	Non-psychiatric disorders	<b>30.2</b>	<b>26.8</b>

Source: DHFS 1996d.

Second, would young people, who tend to elect lower priced exclusion products, be particularly disadvantaged by the availability of psychiatric cover in just the top table? The answer depends on the extent to which such young consumers are ignorant of their risks (an issue examined above). However, any claim that private health insurance currently plays a special role in looking after the needs of the young at risk is not substantiated. In the public system nearly 50 per cent of patients treated for these conditions are aged under 35 years — in the private system it is nearly half that proportion.

Furthermore, private health insurance is, in its current form, scarcely a socially optimal route for ensuring coverage of the young post-adolescent:

- Insurance coverage of the young (aged 20–34) is lowest among all groups.

- Where they are covered, they tend to be relatively well off compared to their uninsured peers (chapter 6). Yet the incidence of poor mental health increases with poverty (AIHW 1996, p. 89).
- Those most at risk from suicide are in rural and remote areas (AIHW, Sub. D196, p. 84) where insurance rates are very low.

Table F.2: Treatment of psychiatric disorders by age of patient

<i>Age of admitted patient</i>	<i>Public</i>		<i>Private</i>	
	<i>Share of public psychiatric admissions</i>	<i>Cumulative share of public psychiatric admissions</i>	<i>Share of private psychiatric admissions</i>	<i>Cumulative share of private psychiatric admissions</i>
	%	%	%	%
0 years	1.8	1.8	0.3	0.3
1 to 9 years	2.3	4.1	0.2	0.5
10 year - 14 years	3.9	8.0	0.6	1.1
15 years - 34 years	37.8	45.8	24.6	25.7
35 years - 49 years	26.5	72.2	39.6	65.3
50 years - 69 years	15.9	88.1	25.1	90.5
70 years plus	11.9	100.0	9.5	100.0

Source: DHFS 1996d.

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## APPENDIX G: SCALE ECONOMIES IN HEALTH INSURANCE

### G.1 Introduction

As suggested by figure 4.11 in chapter 4 and observed by Ian McAuley (Sub. 13), there seems to be no relationship between management cost shares and the size of funds. This implies constant returns to scale, which in turn suggests that there are no cost advantages for large funds. It also implies that there are no losses in efficiency stemming from the reduction in the average size of funds witnessed over the past few years. However, partial correlations can be misleading, prompting the Commission to undertake a more sophisticated analysis of the data.

Using records of individual funds published by PHIAC for 1995–96, the Commission examined a number of possible sources of differences between funds in management costs per member:

- Scale effects driven by membership numbers (are there economies of scale, diseconomies or constant returns to scale?).
- The role of claims per member, proxied by a weighted average of ancillary and hospital benefits paid per member (do funds with higher apparent claims per member have higher management costs?).
- The impact of duration of the fund in each state.<sup>1</sup> Funds which are attempting to ‘break’ into a new market bear additional fixed costs per member as they open new (at first inadequately used) branches and advertise heavily.
- The impact of past profits — highly profitable funds might try less hard to minimise management costs (especially in an industry where profits typically cannot be distributed to shareholders).
- The state market share of a fund. This could have different impacts. On the one hand, a complacent fund with a large market share may be less strenuous in eliminating wasteful practices, or it may use older rather than new technology. On the other hand, a large fund may not need to spend as much

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<sup>1</sup> Funds were classified as ‘new’ if they had a presence in a state for less than five years and ‘old’ otherwise.

on overheads, such as advertising or new branches, compared to funds seeking to significantly raise market share.

- Differences in cost structures between major players, smaller open funds, and closed funds. Most of the smaller open funds and the closed funds do not have branch overheads or very large advertising costs. As well, there is compelling evidence that some of the closed funds report management costs which reflect implicit subsidies from their host agency. For example, both the Commonwealth Bank and the Reserve Bank of Australia funds report management costs per member of under \$10 per year, despite having some of the highest payouts in ancillary and hospital benefits per member in Australia. Aggregate analysis mixes these three very different groups together, hiding possible scale and other effects.
- Variations in state costs, due to variations in rentals and other factors.

## G.2 Results

At the very aggregate level, the Commission found only a few systematic patterns in the data. The management costs per member of the major players were significantly higher than those for open funds as a whole, which in turn were higher than those for closed funds (table G.1).

Table G.1: Management costs per member by nature of fund operation, 1995–96

	Open <sup>a</sup>	Closed	Major <sup>b</sup>	All
	\$	\$	\$	\$
Unweighted average	169.4	93.9	195.0	158.0
Weighted average	148.5	115.0	145.7	145.7
Number of operations	63	18	27	81

a Open funds includes the major funds.

b Major funds were the open funds with either very substantial membership or a national presence. They were HCF, MBF, Medibank Private, National Mutual, NIB, and HBF of WA. These funds account for 78 per cent of total benefits paid in 1995–96.

Source: PHIAC, Annual Report, 1995–96.



This is not surprising, reflecting the very different factors at work:

- open funds must actively recruit new members through marketing campaigns, and to some extent high visibility through a branch network;
- open funds tend to establish a branch network to service decentralised customers, whereas closed funds tend to service members at the place of work; and
- there are likely to be some cross subsidies between employers and some closed funds which distort the cost data.

Given these significant differences, the Commission examined the determination of management costs in the major Australian funds alone, because these are more likely to share a similar technology. Altogether data for 27 operations of six funds spanning all the states of Australia were used in the model.

Starting with a highly general specification, the model was reduced to:

$$\log C = 2.06 - 0.320 \log M + 1.52 \log (CLAIMS) + 0.886 ESTAB$$

(4.7)      (6.5)      (14.1)      (3.3)

$$R^2 = 0.73, \quad \bar{R}^2 = 0.69, \quad se = 0.332, \quad Excess\ kurtosis = -0.51, \quad skewness = 0.63$$

Figures in parentheses are White's heteroscedastic corrected t statistics.

where  $C$  is management costs per member,  $M$  is total members of the fund (both ancillary and hospital),  $ESTAB$  is a zero-one dummy variable equal to one if a fund has been established for five years or more, and  $CLAIMS$  is a variable which picks up the differential costs of processing ancillary and hospital benefits:

$$CLAIMS = \frac{(\alpha HOSP BEN + ANCBEN)}{MEMBER}$$

where  $\alpha$  was set at 0.263 following non-linear estimation of the model in which  $\alpha$  was a free parameter. The lower weight on hospital benefits reflects the fact that there are fewer hospital claims than ancillary claims.

The model explains nearly three quarters of the variation in management costs per member between the major funds. The model does not fail any of the standard specification tests<sup>2</sup> — except for some evidence of heteroscedasticity.

<sup>2</sup> A range of statistical tests to gauge the presence of heteroscedasticity, functional form misspecification, and normality of the residuals was conducted.

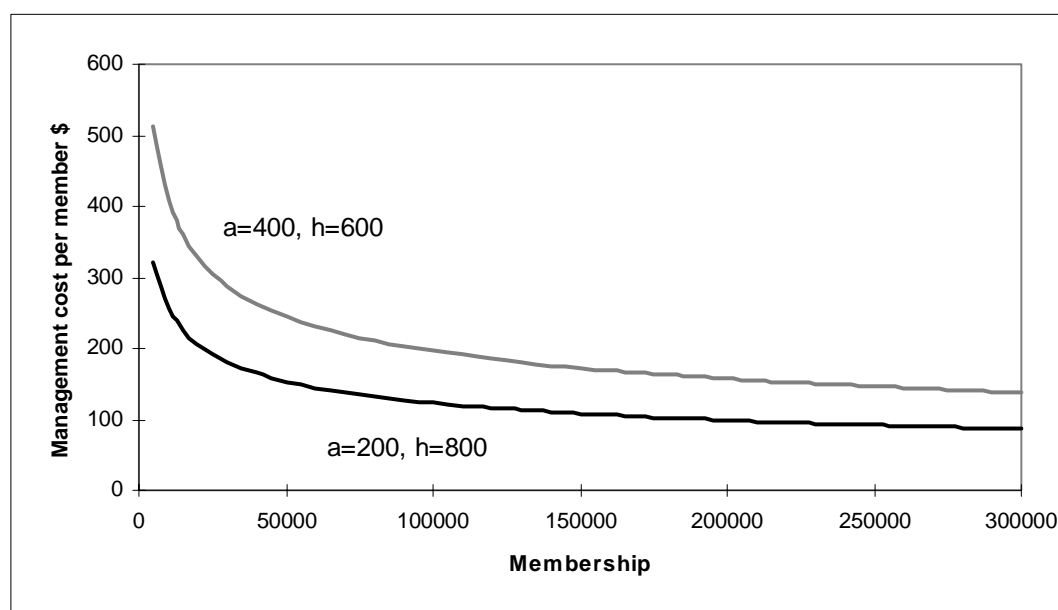
White's *t* statistics, which take account of possible heteroscedasticity, should still allow reliable statistical inference.

No statistically significant state differences were found, nor impacts on cost efficiency from past profits. A dummy variable was used in the modelling to test whether Medibank Private had lower costs than other major players, *after allowing* for scale, age of operation, and product mix effects. Taking account of these other effects, Medibank Private was found to have lower costs than the average, but the effect was not statistically significant.

The model implies that variations in management costs are primarily due to differences between funds in:

- *Ancillary benefit payouts per member.* Ancillaries are costly to process. Figure G.1 shows how management costs vary as the share of ancillary benefits paid rises. Regardless of membership numbers, a fund paying out a greater share of total benefits per member as ancillaries faces significantly higher management costs per member.

Figure G.1: Simulated effects of scale and product mix on management costs per member



Note: *a* denotes ancillary benefits per member and *h* denotes hospital benefits per member. *ESTAB* was set at unity for all simulations.

- *Membership numbers.* There are economies of scale operating in the major funds — every doubling in membership provides a 20 per cent reduction in management costs per member. This implies that large absolute changes in

membership are required to generate cost reductions after a fund reaches substantial size (100 000 to 200 000). Thus a fund with 5000 members can reduce management expenses by around 20 per cent by recruiting 5000 more members, while a fund with 200 000 members must recruit 200 000 new members, or 40 times this amount, in order to achieve the same cost saving.

- *Age of operation.* Funds with a longer period of incumbency have higher management costs per member, *all other things being equal*, than newer entrants to a market. This may reflect the technological lead that a new entrant has, or greater incentives to cost minimise.

The existence of economies of scale has the implication that:

- a new player entering the market with the aspiration of being a major player will face a cost disadvantage relative to larger established incumbents, unless it can take over an existing player; and
- there are possible scale gains from rationalisation of the major funds, but (surprisingly) no obvious gains from rationalisation of the ‘niche’ players.

This analysis of scale is against a background of existing technology and approaches to retailing:

- Kierzkowski et al (1996) suggest that insurance is receptive to trading on the internet — in effect ready access to cheap ‘virtual’ branches instead of costly real ones. This could lower transactions costs considerably, as well as allowing consumers to compare products and services more readily. This may reduce the impact of scale economies.
- Contracting and case payments will require more sophisticated players, with elaborate software and technical expertise — which may increase scale economies.

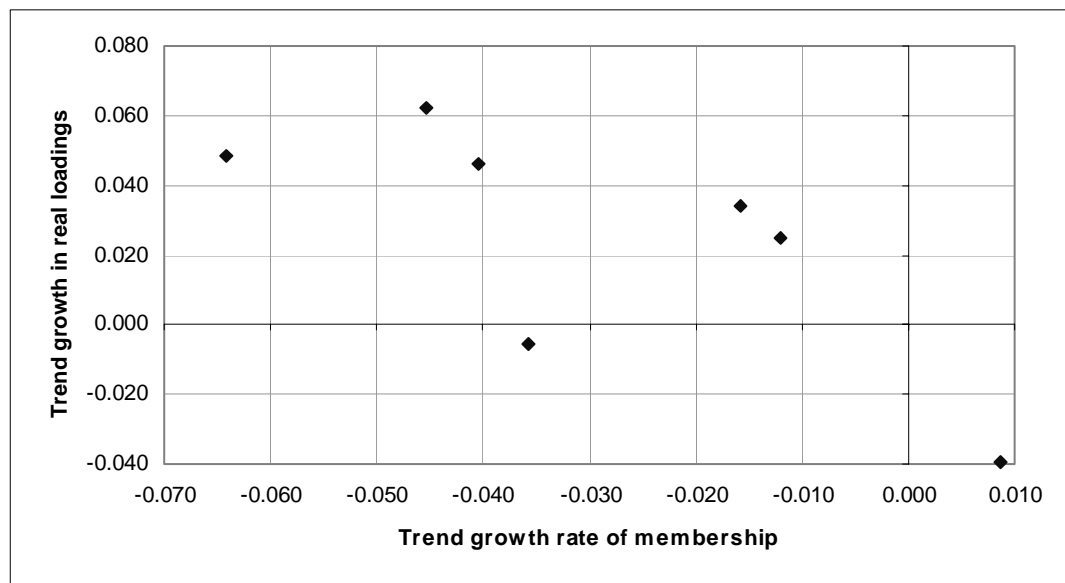
### **G.3 Dynamic implications**

The modelling results imply that there is a further twist in the tail of adverse selection. As adverse selection forces up premiums, it drives down membership numbers. This contraction in the membership of health insurance funds will:

- increase average management costs via a scale effect and thereby a further premium impact; and/or
- result in adjustment costs as funds are rationalised in order to achieve economies.

To partly assess these dynamic effects, the Commission examined time series data on management costs per member and membership declines for a number of funds across three states (figure G.2). There is a strong negative correlation between trend growth rates in membership and trend growth rates in real loadings (management costs). This can reflect two factors. First, membership reductions elicit scale effects, which force up real management costs per member. Second, and in the opposite direction of causality, increased management costs (whatever their source) force up premiums and in turn elicit reductions in membership. It is hard to determine which direction of causality dominates with so small a set of data — but it seems likely that both are in operation.

Figure G.2: Association between membership decline and real management costs per member, 1989–90 to 1995–96



#### G.4 Implications for technical inefficiency

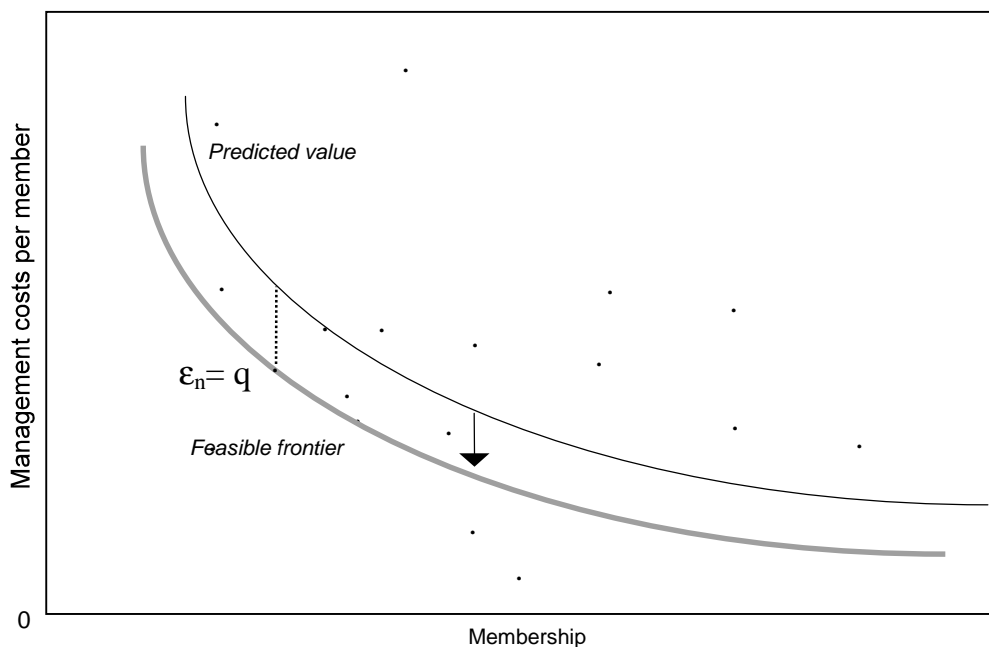
There are still marked differences in management costs per member not explained by the factors considered. These residual effects will partly reflect variations in the efficiency of the funds. The Commission undertook some guesstimates of the degree of technical efficiency in the major funds.

- First, the residuals of the equation were ordered and the 1st quartile determined ( $q$ ).
- Second, the intercept of the estimated cost function was moved by adding  $q$  to the predicted values for each fund to form a *feasible minimum cost frontier*.

(figure G.3). This implies that 75 per cent of all funds were operating above that minimum cost function. The reason for selecting the first quartile rather than the minimum residual as the basis for defining the frontier is that the data is stochastic — it is unlikely that all funds could genuinely operate at the level of efficiency implied by the notionally best performing fund. This technique is more arbitrary than either data envelopment analysis or stochastic functions, but is still illustrative.

- Third, the adjusted ordinary least squares equation was used to predict the costs of each fund — these being the minimum attainable costs for each fund. A measure of technical efficiency is obtained by calculating the ratio of the minimum attainable costs to the observed costs.
- Fourth, the savings which would be realised if each of the major funds were on the estimated frontier was calculated. This amounted in 1995–96 to about \$65 million, or about a 17 per cent reduction in management costs. This represents savings equivalent to about 2.0 per cent of the contribution income received by the major funds. This is a broadly illustrative estimate of the cost savings that could be achieved. However, it is important to note that these savings, if realised, need not reduce *hospital* premiums by that percentage, as management costs relate to both ancillaries and to hospital insurance.

Figure G.3: Defining the minimum cost frontier



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## APPENDIX H: HIT AND RUNS

In the health insurance industry, ‘hit and run’ refers to the phenomenon whereby people join a health fund for the specific purpose of obtaining benefits for *known* future hospitalisation (the ‘hit’) — and then exit the fund following their hospital episode (the ‘run’). The issue was discussed briefly in chapter 6 as one of the perverse features of the demand for health insurance.

It is an opportunistic and focused form of adverse selection. This group of users are poor insurance risks, not necessarily because of their age or their general state of health, the more common risk factors, but because they respond (quite rationally) to the incentives posed by the regulatory system and community-rated premiums. The outcome is that they gain a cross subsidy from longer-term fund members. While the usual example of a hit and run is obstetrics, other procedures known to be frequently subject to the phenomenon are cataracts, and hip and knee replacements.

‘Hit and runs’ are a perverse outcome of a system with added incentives. However, their measurement is confounded by other factors. For example, a person who joins health insurance, makes a claim, and then experiences unanticipated costly ‘out-of-pockets’ which leads to a decision to drop insurance, is in no way behaving opportunistically. To that extent, it is likely that some of the reported cases of ‘hit and run’ are really ‘join, disenchantment and leave’.

Several submissions to the inquiry provided limited statistics on estimated hit and runs. In addition, the Commission obtained some data on a confidential basis from two of the major health funds.

While much of the evidence relates specifically to obstetrics, the Commission also obtained data on the overall impact of hit and runs. Turning first to obstetrics, the Government Employees Health Fund briefly commented that:

Nearly 20 per cent of the GEHF obstetric cases in Queensland left within 12 months and 30 per cent of these people joined in the year prior to having the baby. (Sub. D220, p. 5)

HCF (Sub. D225) examined 6000 obstetric cases occurring in one year (1994–95) and compared data on the length of membership both prior to and after the confinement. They found that around 18 per cent of members lapsed their membership within 12 months of confinement (average 4.5 months) and consumed about \$2.6m (1.7 per cent) of total hospital benefits.

Commenting on these results, HCF said:

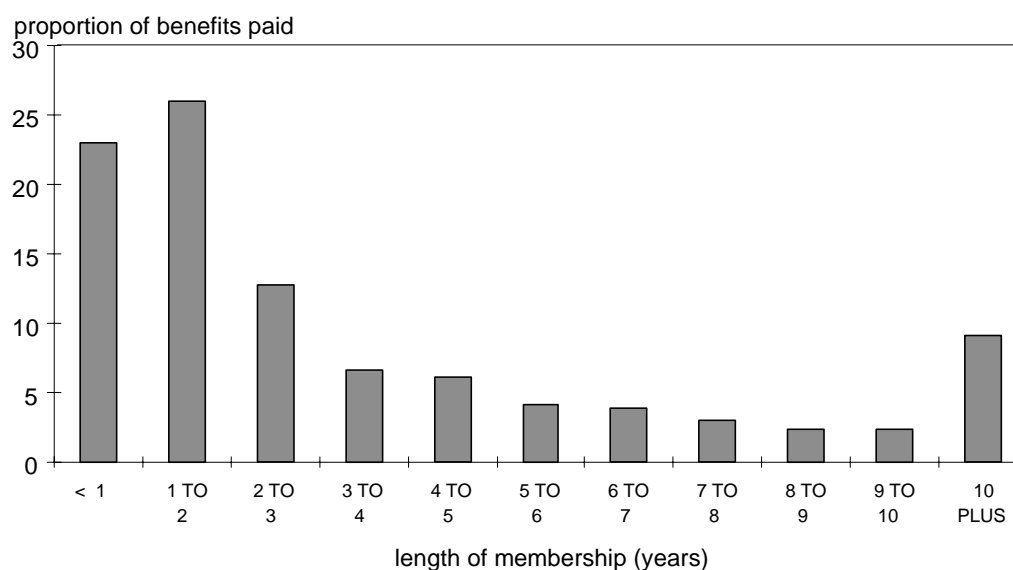
This might suggest that the syndrome is not excessive. However there are a number of other conditions subject to hit-run action, not all of which are as obvious as obstetrics. (Sub. D225, p. 8)

Another major fund examined obstetric hit and runs by:

- First, examining cancelled memberships over a two year period and isolated persons who *at some stage of their membership* had claimed for obstetrics episodes.
- Second, comparing the benefits paid for obstetrics with the length of membership prior to cancellation.

The results of this exercise (figure H.1) provide strong evidence of possible hit and run behaviour. The data reveal that approximately half of the obstetrics benefits paid to members who had exited the fund in 1995 and 1996 were paid to those who had been in the health fund for less than two years. The proportions fall away rapidly for longer terms of membership.

Figure H.1: Obstetric benefits, by length of fund membership, for members who exited the fund in 1995 and 1996 (per cent)



Note: The chart refers only to those members who have cancelled their membership and have claimed hospital benefits for obstetric admissions during the course of their health fund membership. Data are for members cancelling their memberships during the period January 1995 to December 1996.

Source: Confidential data supplied by a major health fund.

Another major health fund supplied the Commission with an in-house 1993 report on hit and runs — in which it classified members as hit and runs when

they claimed within one year of joining and left the fund within one year of the procedure. The report showed that claimants in this classification who had an obstetric procedure had a net negative average margin of \$1.89 benefits for each \$1 of contributions paid. The fund observed that there was sufficient evidence to suggest that obstetric claimants generate a significant burden on all fund members. It also said that since the number of identified claimants is high, any action taken to reduce the incidence of hit and runs could have a significant effect on membership — but would potentially save the fund a considerable amount in each financial year.

The above data suggest that hit and run for obstetrics may pose particular problems for the health funds. But how significant are *overall* hit and runs to the funds?

Data provided on a confidential basis by a major health fund shows that the probability of leaving a fund tends to decrease with each year of tenure. Members cancelling with less than 12 months membership account for one-fifth of all cancelled members' claims. Those persons cancelling with less than 12 months membership were dominated by the 60+ age group (almost 40 per cent), and 30-39 year olds (25 per cent). Possible hit and run activity is indicated by data showing the 60+ group of the cancelled members to be the largest claimers for any membership length — except for cancellations with 1–2 years membership where they are behind both the 20–29 and 30–39 age groups.

Another major fund analysed hit and runs in 1993 and estimated they were responsible for 1.6 per cent of total benefits (with obstetrics being by far the most prevalent of identifiable hit and run procedures). Taking into account the contribution income received from the hit and runs, the net loss was equivalent to around 0.8 per cent of benefits. The hit and run members represented 1.9 per cent of all claimants and only 0.3 per cent of persons covered. The fund found a higher incidence of hospital only cover amongst hit and run claimants, which it believed was evidence of 'intentional' hit and run activity.

HCF (Sub. D225) examined the three year period to June 1996 and identified clear hit and runs as those persons who joined and left within the period. It found that these persons accounted for only 1 per cent of benefits paid over the period.



Adding a residual group<sup>1</sup> to these ‘joiners and leavers’ brought the proportion up to around 8 per cent of benefits. However, it is unlikely these people would all be hit and runs.

Accordingly, HCF concluded:

On balance, we believe a reasonably conservative estimate for ‘hit and run’ memberships would be approximately 5 per cent of benefit outlays. (Sub. D225, p. 9)

However, the HCF estimates do not appear to include an offset for the contribution income received from the hit and runs.

Overall, the data examined by the Commission suggest that the most probable hit and run cases have a net cost to the health funds of between 1–2 per cent of annual benefits payable (around \$40m–\$80m in 1995–96). However, this proportion could be significantly higher if other (and wider) definitions of hit and runs are adopted.

Unfortunately, the Commission was unable to assess the extent to which hit and runs were a growing phenomenon. However, since they represent a rational response to the current set of pre-existing ailment rules, they are likely to grow in significance over time.

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<sup>1</sup> The residual group consisted of persons left over after accounting for those with continuous membership in the period, the joiners, the leavers and the joiners/leavers. It included people with at least two membership movements during the three year period. HCF noted that the simplest example would be a person who was with HCF at the beginning and the end of the period, but had a period of non-membership in the middle.

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## APPENDIX I: HEALTH INSURANCE COSTS

This inquiry was prompted by concerns about increases in health insurance premiums and costs. The purpose of this appendix is fivefold:

- to explain the cost methodology for determining the components of the premium increases used in chapter 7;
- to provide aggregated nominal results for cost contributors to hospital insurance benefits;
- to summarise the key cost drivers as identified in submissions to the inquiry;
- to provide additional results for the cost drivers in individual states; and
- to provide the industry data on which the Commission's national cost calculations are based.

### I.1 Cost methodology

The cost methodology has been elaborated since the Discussion Draft:

- Real rather than nominal premium increases have been assessed. Data are in 1989–90 prices (using the CPI as the deflator). Arguably, only increases in premiums above the general inflation rate are of interest to policy makers.
- The SEUs and persons covered are centred on December of the fiscal year by taking their moving average — rather than by using end of year data.
- A numerical integration technique has been used so that impacts add to 100 per cent.
- More detailed demographic and actuarial data have been combined with a different approach to estimate the impact of demographics (changes in the age distribution of the Australian population as a whole) and adverse selection (changes in the age distribution of the insured population relative to the population as a whole).

### Measurement theory

There are a variety of different feasible methods for summarising the impact of the multifarious factors on insurance pricing. Initially, let us define the problem

in a simple way to outline the key possible approaches. Suppose that for the moment we consider only direct hospital costs per SEU (ie ignoring prostheses, medical gap, day hospital and non-hospital costs contributing to total benefits):

$$H_t = u_t \times c_t$$

where  $H$  is direct hospital costs per SEU in constant 1989–90 prices,  $u$  is utilisation measured as public and private hospital bed days per SEU, and  $c$  is real hospital benefits per bed day. The change in  $H$  can be broken down into its sub-components by asking the following questions: what is the change in  $H$  given constant utilisation, and what is the change in  $H$  given constant benefits per bed day? That is:

$$\Delta H_t \Big|_{\Delta u_t = 0} = \Delta c_t u_{t-1} \text{ as the impact of cost changes; and}$$

$$\Delta H_t \Big|_{\Delta c_t = 0} = \Delta u_t c_{t-1} \text{ as the impact of utilisation changes.}$$

This method (*the discrete derivative approach*) for determining the impacts of various factors on  $H$  has the virtue of simplicity and analytical plausibility. But it has one drawback — the sum of the two partial impacts does not sum to the total change in  $H$  except in the limit:

$$\Delta H_t = \Delta u_t c_{t-1} + \Delta c_t u_{t-1} + \Delta u_t \Delta c_t$$

This occurs because as  $c$  changes, so does  $u$  — the two terms interact. The implication of the existence of this interaction term is that a percentage decomposition of the change in  $H$  does not add to 100 per cent. In a technical sense this is NOT a problem — but it can be confusing for people trying to understand the sources of cost increases.

A second method (*the logarithmic approach*) has no interaction term when analysing the above problem:

$$\Delta \log H_t \Big|_{\Delta \log u_t = 0} = \Delta \log c_t \text{ as the impact of cost changes; and}$$

$$\Delta \log H_t \Big|_{\Delta \log c_t = 0} = \Delta \log u_t \text{ as the impact of utilisation changes.}$$

$$\Delta \log H_t = \Delta \log u_t + \Delta \log c_t \text{ as the total change.}$$

Unfortunately the log method does not achieve a neat decomposition where  $H$  is an additive function (for example, a function like  $H = x + y$ ).

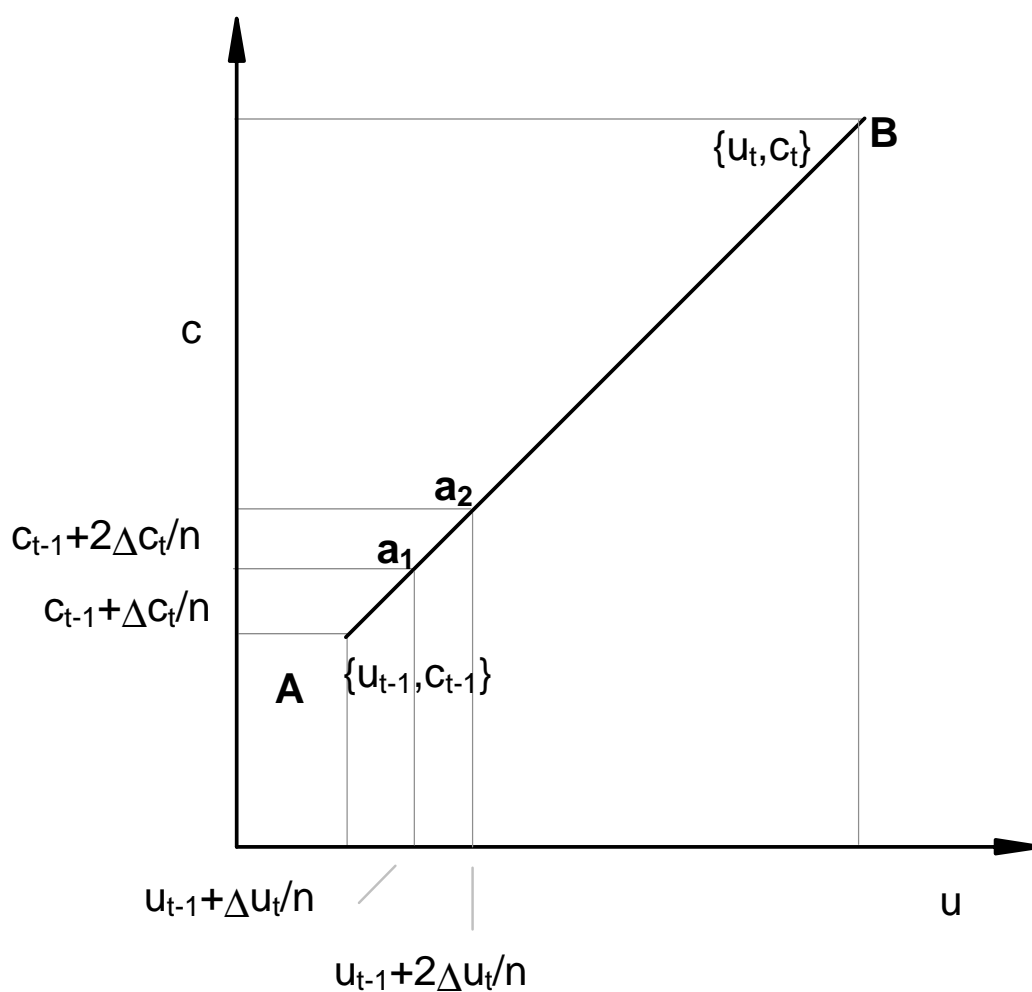
A third method (*the linear interpolation method*) eliminates the interaction term for any function, but is less straightforward to interpret. Say that we observe just two points  $A(u_{t-1}, c_{t-1})$  and  $B(u_t, c_t)$ , but that we imagine a straight line joining

these two points across the time interval from  $t-1$  to  $t$ . This line can be broken into  $n$  arbitrarily small segments (figure I.1).

If we applied the discrete derivative method to the first segment (move from  $A$  to  $a_1$ ) we find that the impact of a change in utilisation, given fixed costs, is:

$$\Delta H_1|_{\text{fixed } c} = \frac{\Delta u_t}{n} \times c_{t-1}$$

Figure I.1: The linear interpolation method



In the next few periods it is:

$$\Delta H_2|_{fixed\ c} = \frac{\Delta u_t}{n} \times \left\{ c_{t-1} + \frac{\Delta c_t}{n} \right\} \quad \text{and} \quad \Delta H_3|_{fixed\ c} = \frac{\Delta u_t}{n} \times \left\{ c_{t-1} + \frac{2\Delta c_t}{n} \right\} \quad \text{and}$$

$$\Delta H_4|_{fixed\ c} = \frac{\Delta u_t}{n} \times \left\{ c_{t-1} + \frac{3\Delta c_t}{n} \right\} \quad \text{and so on until } \Delta H_n|_{fixed\ c} = \frac{\Delta u_t}{n} \times \left\{ c_{t-1} + \frac{(n-1)\Delta c_t}{n} \right\}.$$

If we sum each of the small changes in H across all n intervals we get an estimate of  $\Delta H_t$ . It can be shown that:

$$\lim_{n \rightarrow \infty} \sum_{i=1}^n \Delta H_i|_{fixed\ c} = \Delta u_t c_{t-1} + \frac{\Delta u_t \Delta c_t}{2} = \Delta u_t \left\{ \frac{c_{t-1} + c_t}{2} \right\}$$

By symmetry, we find that:

$$\lim_{n \rightarrow \infty} \sum_{i=1}^n \Delta H_i|_{fixed\ u} = \Delta c_t u_{t-1} + \frac{\Delta u_t \Delta c_t}{2} = \Delta c_t \left\{ \frac{u_{t-1} + u_t}{2} \right\}$$

Under this method, there is no residual interaction term. To produce an estimate of the impact of costs or utilisation across more than one year, the results from these linear interpolation method are simply added — representing a piecewise linear interpolation through all successive points.

For example,  $H_{t+1} - H_{t-1} = \Delta H_{t+1} + \Delta H_t$ . The difference between this method and the more customarily applied discrete derivative method is that the latter holds the value of one variable fixed at its initial value, while the former updates the value of the fixed variable along the adjustment path.

Unfortunately one of the limitations of the linear interpolation method is that it is not always easy to derive a closed form solution to the infinite sums when there are more than two variables.

It is NOT the case that a three, four or n variable problem can be legitimately broken down into a number of two variable problems. For example, say that  $H = q.c$  (that is where  $q = u.s$ ). One *might* imagine that the solution to the decomposition is:

$$\Delta H_t|_{due\ to\ c} = \Delta c_t \frac{(q_{t-1} + q_{t-1})}{2} = \Delta c_t \frac{(u_{t-1}s_{t-1} + u_{t-1}s_{t-1})}{2}$$

$$\Delta H_t|_{due\ to\ s} = \Delta s_t \frac{(u_{t-1} + u_{t-1})}{2} \frac{(c_{t-1} + c_{t-1})}{2} \quad \text{and}$$

$$\Delta H_t|_{due\ to\ u} = \Delta u_t \frac{(s_{t-1} + s_{t-1})}{2} \frac{(c_{t-1} + c_{t-1})}{2} \quad \text{noting:}$$

$$\Delta q_t|_{due\ to\ u} = \Delta u \frac{(s_{t-1} + s_{t-1})}{2} \quad \text{and} \quad \Delta q_t|_{due\ to\ s} = \Delta s \frac{(u_{t-1} + u_{t-1})}{2}$$

But, while these components *do* add up to  $\Delta H$ , they do not represent a *unique* solution. If the problem had been re-parameterised as  $H = u.l = u.s.c$  (that is, where  $l = s.c$ ) then (*slightly*) different values for each of the three impacts are found.

Solutions to the linear interpolation method without this flaw can be readily found by using computer intensive techniques (Box I.1).

In this report we have used the linear interpolation method (solved numerically) to summarise the impact of the various factors on premiums. This linear interpolation method is *not* superior to the other two — it simply answers a different but useful question.

## Detailed methodology

### *Hospital benefits*

Let us define total real hospital benefits per SEU as:

$$H_t = u_t^{hosp} c_t^{hosp} + u_t^{day} c_t^{day} + u_t^{pros} c_t^{pros} + u_t^{gap} c_t^{gap} \text{ where}$$

$$c_t^{hosp} = (v_t^{pu} s_t^{pu}) \psi_t^{pu} + (v_t^{pr} r_t^{pr} s_t^{pr}) (1 - \psi_t^{pu}) \text{ and}$$

$$u_t^{hosp} = b_t a_t m_t$$

where the variables are defined in Table I.1. Using the numerical integration techniques described in the previous section, we can determine how each of the variables above affects the change in real hospital costs.<sup>1</sup>

<sup>1</sup> The way in which hospital benefits per SEU ( $H$ ) are represented here may strike some as unusual, in that it includes two terms which cancel out. We include a term “ $b$ ” in utilisation which captures average length of stay, and two offsetting terms,  $s^{pu}$  and  $s^{pr}$ , which capture the reciprocal of the average length of stay. The reason for doing this is that it usefully sheds light on why overall bed days per SEU did not rise rapidly (ie admissions per SEU were offset by reduced length of stay), and why charges per bed day did rise (rising charges per admission and reduced length of stay elevated charges per bed day). Note that there is an utterly different way in which  $H$  could be parameterised, which some may find useful. Instead of measuring utilisation as bed days per SEU and costs as benefits per bed day, an alternative measure of utilisation is admissions per SEU and an alternative measure of costs is benefits per admission. The two, when multiplied, still give benefits per SEU. How can the two approaches be reconciled and how do they alter the results? Using the row numbers in Table I.2, the impact of the alternative hospital utilisation measure is equal to (2) + (3). The value of the alternative private hospital charge measure is (8) +(9) and for public hospitals (12). In other words, the new measures are simply derived by removing the influence of the average length of stay, with all other impacts left at their previous values with one exception — the public/private mix effect. The mix

Most data for the calculations was derived from PHIAC. Data for the adverse selection and demographic calculations used actuarial data provided by Alan Brown (Sub. 34), and ABS Health Survey and population census data. A *consistent* set of data on admissions in private and public hospitals by insured patients is not readily available — but had to be derived from a variety of sources including ABS Private Hospital surveys and information provided by the Department of Health and Family Services. The Commission has concerns over the reliability of the admissions data. This will mean that while estimates of hospital benefits per bed day will be accurate, estimates of costs per admission may be somewhat imprecise.

### *Management and other fund costs*

Total hospital benefits are the major, but not exclusive, factors shaping insurance premium increases. The first step in calculating the impact of these factors is measurement of hospital insurance premiums. Unfortunately PHIAC does not have data which separate hospital from ancillary insurance contributions.

The Commission assumed hospital insurance contributions (HOSPINC) were:

$$HOSPINC_t = \frac{HOSPBEN_t}{TOTBEN_t} TOTINC_t$$

where HOSPBEN is hospital benefits, TOTBEN is total benefits and TOTINC is total contributions. Hospital contribution income divided by SEUs represents the weighted average premium for health insurance.

The accounting identity for the funds can be used to indicate what other factors might be at work in determining premiums:

$$HOSPINC_t \equiv \gamma MANCOST_t + HOSPBEN_t + RESIDUAL_t \text{ where}$$

$$RESIDUAL_t = \Delta RESERVES_t - INVEST_t + PROVISIONS_t$$

$$+ LEVY_t - MOVEMENT_t - ANCSURPLUS_t \text{ and}$$

$$ANCSURPLUS_t = \{ANCINC_t - (1 - \gamma)MANCOST_t - ANCBEN_t\}$$

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effect in the alternative parameterisation has to be recalculated because it no longer uses the bed day share as the measure of relative use of public and private hospitals, but admissions instead. The value of the alternative mix effect is equal to (7) + (1) + (10) + (13) or the old mix effect and the sum of the average length of stay effects, which is intuitively plausible.

### Box I.1 A computer algorithm for solving the linear interpolation method

Suppose that there are  $m$  variables denoted  $\{x_1, x_2, \dots, x_m\}$  such that:

$$H = \prod_{j=1}^m x_j$$

In this case the impact of the  $k$ th variable on  $\Delta H$  is:

$$\Delta H|_{\text{due to } x_k} = \sum_{i=1}^n \frac{\Delta x_k}{n} \prod_{j=1, j \neq k}^m \left\{ x_{j,t-1} + \frac{(1-i)\Delta x_{j,t}}{n} \right\}$$

For example, in a three variable case where  $H = \text{u.s.c}$  a computer algorithm would be:

Step	Code example	Comment
1	sum <sub>1</sub> =0: sum <sub>2</sub> =0: sum <sub>3</sub> =0	Initialise count variables to zero
2	For i= 1 to n	Set up a loop
3	$\text{sum}_1 = \frac{\Delta u_t}{n} (c_{t-1} + (1-i) \times \frac{\Delta c_t}{n}) (s_{t-1} + (1-i) \times \frac{\Delta s_t}{n}) + \text{sum}_1$ $\text{sum}_2 = \frac{\Delta c_t}{n} (u_{t-1} + (1-i) \times \frac{\Delta u_t}{n}) (s_{t-1} + (1-i) \times \frac{\Delta s_t}{n}) + \text{sum}_2$ $\text{sum}_3 = \frac{\Delta s_t}{n} (u_{t-1} + (1-i) \times \frac{\Delta u_t}{n}) (c_{t-1} + (1-i) \times \frac{\Delta c_t}{n}) + \text{sum}_3$	Calculate the impact of the three variables
4	Next i	Iterate loop
5	solution <sub>1</sub> = sum <sub>1</sub> solution <sub>2</sub> = sum <sub>2</sub> solution <sub>3</sub> = sum <sub>3</sub>	Solutions are the sums over the loop

So long as a sufficiently large number of iterations ( $n$ ) are performed, extremely accurate results are found. The Commission used values of  $n$  from 1,000 to 10,000 — results are accurate to the nearest cent.



Table I.1: Definition of variables<sup>a</sup>

$H_t$	Total hospital benefits per SEU in 1989–90 prices (including prostheses, medical gap, day and other hospital costs)
$u_t^{hosp}$	Measure of public and private hospital utilisation (bed days per SEU) at time t
$c_t^{hosp}$	Measure of public and private hospital costs (benefits per bed day) at time t
$c_t^{day}$	Measure of day hospital costs (benefits per bed day) at time t
$b_t$	bed days per admission in public and private hospitals (or average length of stay) at time t
$a_t$	admissions per person covered at time t
$m_t$	persons covered per SEU (or coverage) at time t
$u_t^{gap}$	medical gap services per SEU at time t
$c_t^{gap}$	medical gap benefits per service at time t
$u_t^{pros}$	prostheses per SEU at time t
$c_t^{pros}$	benefits per prosthetic device at time t
$u_t^{day}$	private day hospital bed days per SEU at time t
$v_t^{pu}$	public hospital benefits per admission at time t
$s_t^{pu}$	public hospital admissions per bed day (ie reciprocal of average length of stay) at time t
$v_t^{pr}$	private hospital charges per admission at time t
$s_t^{pr}$	private hospital admissions per bed day (ie reciprocal of average length of stay) at time t
$r_t^{pr}$	private hospital benefits to charges ratio at time t (ie picks up the extent to which insurance covers private hospital costs)
$\psi_t^{pu}$	The ratio of public bed days to total public and private bed days.

a PHIAC records the value of SEUs and persons covered for the end of any fiscal year. In order to centre these data, they were averaged over the current and past year.

MANCOST are the funds' management costs,  $\Delta$ RESERVES are the change in reserves, INVEST is investment income, MOVEMENT is movement in capital and reserves (typically due to revaluation), PROVISIONS are provisions for claims, LEVY is the ambulance levy, ANCSURPLUS is the surplus from ancillary policies, ANCINC is ancillary contributions income, ANCBEN is ancillary benefits and  $\gamma$  is the share of management costs which are allocated to hospital insurance costs. We estimated that 50 per cent of management costs relate to managing hospital insurance — based on survey data from funds.

Accordingly, health fund premiums are based on hospital costs, management costs and a complex (but small in the long run) residual comprising a group of offsetting variables such as investment income and provisions.

The change in real premiums can be expressed as<sup>2</sup>:

$$\Delta\left(\frac{HOSPINC_t}{SEU_t}\right) = \Delta PREM_t = \gamma \Delta\left(\frac{MANCOST_t}{SEU_t}\right) + \Delta\left(\frac{HOSPBEN_t}{SEU_t}\right) + \Delta\left(\frac{RESIDUAL_t}{SEU_t}\right)$$

### *Adverse selection and demography*

Adverse selection and demographic effects are key drivers of insurance costs and therefore premiums. However, it is important to emphasise that they are not *additional* sources of cost increase to the factors already noted — but rather they are effects which lie *behind* some of the increases in utilisation that are apparent. Much of the impact of these variables is felt in admissions per SEU, but also in the use of prostheses and medical gap benefits.

The impact of adverse selection and ageing was determined by noting that the hospital benefits per person covered (not SEU) are:

$$\frac{HOSP_t}{M_t} = \frac{\sum_{j=1}^k \phi_{j,t} POP_{j,t} DRAW_{j,t}}{\sum_{j=1}^k \phi_{j,t} POP_{j,t}}$$

where HOSP are total hospital benefits, M are insured persons covered,  $POP_{i,t}$  is the number of people in the population of age j at time t,  $\phi_{i,t}$  is the insurance propensity of age group j at time t, and  $DRAW_{i,t}$  is the drawing rate of insured people aged j at time t.

The impact on the change in hospitals benefits per person covered due to:

- changing POP is the *demographic* (largely ageing) effect;
- changing  $\phi$  is *adverse age selection*; and
- changing DRAW is the *cost* effect. This comprises two parts. The first part, another manifestation of adverse selection, represents increases in drawing rates reflecting deterioration in the risk profile of the insured of a given age (for example a sick 25 year old stays, but a healthy 25 year old leaves). The second, part is the increasing drawing rates applying to people of the same risk profile of a given age. The Commission did not have information available to break the cost effect into its two parts.

<sup>2</sup> Noting that all the variables are expressed in 1989–90 constant prices.

## **I.2 Aggregate nominal results**

In the main text in chapter 7 we report results for real hospital insurance benefits (at 1989–90 prices). However, most other studies of health insurance costs present the results on a nominal basis. For the sake of comparison with those results we present a nominal set of summary figures on the proximate sources of hospital benefit increases from 1989–90 to 1995–96 (table I.2).<sup>3</sup>

It is apparent that nominal reporting of results tend to understate the importance of real variables relative to nominal ones. For example, utilisation variables (comprising hospital bed days per SEU, prostheses services and medical services) contributed to 22.4 per cent of the real increase in benefits paid per SEU, and 19.5 per cent of the nominal increase in benefits paid per SEU. Similarly, the shift in usage by the insured from public to private hospitals contributed 29 per cent of the real increase in benefits but only 20.5 per cent of the nominal change. In contrast, the importance of private hospital admission charges is overdramatised using the nominal data. Using real data, such charges contribute 13.5 per cent of the increase in benefits per SEU, but 30.5 per cent using the nominal data.

The impact of inflation on changes in overall hospital insurance benefits is demonstrated in table I.3. The table details the real effect and the inflation effect on annual increases in hospital benefits per SEU (a close proxy for premiums). Over the 1989–90 to 1995–96 period it is estimated that inflation accounted for 30.7 per cent (and real factors, 69.3 per cent) of the rise in nominal hospital benefits per SEU.

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<sup>3</sup> A comparison of the key cost drivers identified in submissions to the inquiry is shown in table I.4 (section I.3) below.

Table I.2: Summary of sources of increases in hospital benefits per SEU, 1989–90 to 1995–96 (current prices)

Row	Description	Impact on benefits per SEU (1989–90 to 1995–96)	
		\$	%
	<b>Utilisation (bed days per SEU)</b>		
	<i>Public and private hospitals</i>		
1	Average length of stay (bed days per admission)	-60.1	-22.3
2	Service usage (admissions per person covered)	79.3	29.4
3	Membership coverage (persons covered per SEU)	-15.4	-5.7
4	Sub-total	3.8	1.4
	<i>Day hospitals</i>		
5	Bed days per SEU	3.6	1.3
6	<b>Total</b>	7.4	2.7
	<b>Bed day costs (benefits per bed day)</b>		
7	<i>Shift from public to private hospitals</i>	55.3	20.5
	<i>Private hospital bed day costs</i>		
8	Costs per admission ( technology, clinical practice, real factor prices)	82.4	30.5
9	Benefits relative to costs (reflecting changing cover)	14.0	5.2
10	Impact of average length of stay	38.5	14.2
11	Sub-total	134.9	50.0
	<i>Public hospitals</i>		
12	Benefits per admission	15.0	5.6
13	Impact of average length of stay	9.3	3.4
14	Sub-total	24.3	9.0
	<i>Day hospitals</i>		
15	Benefits per bed day	4.0	1.5
16	<b>Total</b>	218.5	80.9
	<b>Other factors</b>		
	<i>Prostheses</i>		
17	Service use	30.2	11.2
18	Service cost	-6.9	-2.6
19	Sub-total	23.2	8.6
	<i>Medical gap benefits</i>		
20	Service use	12.4	4.6
21	Service cost	8.6	3.2
22	Sub-total	21.0	7.8
23	<b>Total (benefits per SEU)</b>	<b>270.0</b>	<b>100.0</b>
	<b>Other underlying factors</b>		
24	Impact of ageing (1990–95)	9.5	6.1
25	Impact of adverse selection (1990–95)	21.8	14.0

Table I.3: Impact of inflation on changes in hospital insurance benefits per SEU, 1989–90 to 1995–96 (per cent contribution)

<i>Year</i>	<i>Impact on dollar change in benefits per SEU (\$)</i>			<i>Contribution to rise in nominal benefits per SEU (%)</i>		
	<i>Inflation effect</i>	<i>Real effect</i>	<i>Total nominal change</i>	<i>Inflation effect</i>	<i>Real effect</i>	<i>Total nominal change</i>
1990–91	19.8	32.9	52.7	37.6	62.4	100.0
1991–92	9.2	38.8	47.9	19.1	80.9	100.0
1992–93	6.1	35.1	41.2	14.8	85.2	100.0
1993–94	10.0	16.8	26.9	37.4	62.6	100.0
1994–95	18.2	23.1	41.3	44.0	56.0	100.0
1995–96	26.8	33.2	60.0	44.6	55.4	100.0
1989–90 to 1995–96	82.9	187.2	270.0	30.7	69.3	100.0

*Source:* Commission estimates.

### I.3 Cost drivers identified in submissions to the inquiry

A number of submissions to the inquiry included discussions of the cost pressures in the health insurance industry and several provided their own estimates of the important cost drivers.

In principle, all these estimates should be very similar as they are dealing with the same industry and often drawing on common data. But they differ substantially, in terms of both relative contributions to premium increases and in rankings. There are several key reasons — other than data quality and availability — why results differ.

A variety of time periods are in evidence: ranging from 1989–90 to 1994–95 for the AMA and the ‘current situation’ for Medibank Private. This makes comparisons problematical as the significance of individual cost drivers can change dramatically, depending on whether a short or long-term view is taken. (as demonstrated in chapter 7).

Another hindrance to drawing comparisons is the differing treatment of inflation effects. Some submissions explicitly highlight a ‘CPI effect’ while others ignore the issue and simply report the nominal findings. None appear to analyse cost drivers in constant price terms.

The rankings of cost drivers by the relevant submissions are detailed in table I.4. The comparable rankings by the Commission (in nominal terms) can be derived from table I.2 (section I.2).

Table I.4: Comparison of cost drivers identified in submissions

<i>Cost driver s (rank)</i>	<i>AHIA 1994–95 to 1995–96</i>	<i>AMA 1989–90 to 1994–95</i>	<i>APHA 1995–96</i>	<i>HCF 1992–93 to 1995–96</i>	<i>Medibank Private 'current situation'</i>
1	Private hospital use - under 65s (31%)	Prices, usage and complexity (67%)	Private hospital bed day costs (23%)	CPI (40 per cent)	Private hospital bed day costs (38%)
2	Private hospital use - over 65s (27%)	Ageing and adverse selection (33%)	Public-private shift (22%)	Public-private shift (36%)	Decline in persons covered - incl. age effects (32%)
3	Private hospital bed day costs (33%)		General health care costs - pop, technol (17%)	Change in age profile (19%)	Public-private shift (28%)
4	Prostheses (10%)		Adverse selection (16%)	Benefit inflation beyond CPI (16%)	Public hospital bed day costs (2%)
5	Change in age profile (7%)		Prostheses (9%)	Bed day utilisation rate (-11%)	Day hospital costs (1%)
6	Gap (6%)		Change in age profile (6%)		
7	Public hospital use and bed day costs (-16%)		Changes in insurance cover (4%)		
8	—		Public hospital bed day costs (2%)		
9	—		Gap (2%)		

Note: Percentages in brackets show estimated contribution to increase in health fund benefits payable. These proportions were calculated by the Commission on the basis of data presented in the submissions.

Sources: AHIA (Sub. 108), AMA (Sub. 130), APHA (Sub. 51), HCF (Sub. 158), Medibank Private (Sub. 168).

## I.4 State data

Table I.5: Hospital insurance benefits, 1995–96

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
Benefits (\$'000)	902 843	797 713	507 267	269 788	259 528	85 105	2 834 147
Share (%)	32	28	18	10	9	3	100

Source: PHIAC annual report.

Table I.6: Hospital insurance benefits, by major category, 1995–96 (per cent)

<i>Category</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>	<i>NT</i>	<i>Aus</i>
Public hospitals	18	10	8	9	11	9	6	12
Private hospitals	67	77	79	77	77	80	84	74
Day hospitals	2	1	1	2	0	0	0	1
Medical gap	8	8	8	8	7	7	8	8
Listed prostheses	5	5	4	4	5	4	2	5

Source: PHIAC annual report.

Table I.7: Patient revenue per bed day, private hospitals (\$)

<i>Year</i>	<i>NSW &amp; ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>SA &amp; NT</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
1991–92	449.89	448.08	361.42	380.46	463.44	458.93	424.16
1992–93	469.79	467.23	387.57	391.70	480.11	488.27	444.35
1993–94	483.63	474.36	409.46	408.95	493.75	509.44	457.93
1994–95	519.51	497.21	427.44	423.94	506.42	569.58	482.53

Source: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years.

Table I.8: Nominal change in patient revenue per bed day, private hospitals (per cent change on previous year)

<i>Year</i>	<i>NSW &amp; ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>SA &amp; NT</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
1992–93	4.4	4.3	7.2	3.0	3.6	6.4	4.8
1993–94	2.9	1.5	5.7	4.4	2.8	4.3	3.1
1994–95	7.4	4.8	4.4	3.7	2.6	11.8	5.4
1991–92 to 1994–95	15.5	11.0	18.3	11.4	9.3	24.1	13.8

Source: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years.

Table I.9: Real change in patient revenue per bed day, private hospitals (per cent)

<i>Year</i>	<i>NSW &amp; ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>SA &amp; NT</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
1992–93	3.5	3.5	5.8	0.8	3.3	5.0	3.7
1993–94	1.5	-0.5	3.6	2.4	0.7	1.3	1.2
1994–95	3.8	2.1	0.7	0.6	-0.9	8.4	2.1
1991–92 to 1994–95	9.0	5.1	10.3	3.8	3.1	15.4	7.2

Source: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years. ABS Ausstats CPI data.

Table I.10: Change in length of stay, 1989–90 to 1994–95 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>	<i>NT</i>	<i>ACT</i>	<i>Aus</i>
All private patients	-5	-12	-20	-9	-9	-8	12	-19	-10
Private hospitals — private patients	-4	-7	-19	-10	-7	-5	16	13	-9
Public hospitals — private patients	-2	-16	-20	-7	-8	-11	10	-17	-9
Public hospitals — public patients	-26	-33	-24	-27	-24	-28	-34	-30	-27
Total patients	-16	-23	-22	-20	-18	-19	-25	-24	-20

Source: Information supplied by the Department using data obtained from Medicare hospital statistics.



Table I.11: Proportion of insured bed days (per 1000 SEU), by hospital type

<i>Year and hospital type</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
1989–90							
Public	59	43	29	34	42	31	46
Private	41	57	71	66	58	69	54
1990–91							
Public	58	41	28	34	39	29	44
Private	42	59	72	66	61	71	56
1991–92							
Public	56	38	28	32	37	28	42
Private	44	62	72	68	63	72	58
1992–93							
Public	54	36	26	31	36	27	40
Private	46	64	74	69	64	73	60
1993–94							
Public	50	33	25	28	34	26	37
Private	50	67	75	72	66	74	63
1994–95							
Public	46	29	23	26	29	22	33
Private	54	71	77	74	71	78	67
1995–96							
Public	41	23	19	22	26	21	28
Private	59	77	81	78	74	79	72

Source: PHIAC annual reports.

Table I.12: Benefits paid per bed day, by hospital type (\$)

<i>Year and hospital type</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
1989–90							
Public	156	156	143	132	139	162	152
Private	305	322	269	300	337	343	307
1990–91							
Public	170	176	161	148	154	177	168
Private	350	364	298	341	382	383	347
1991–92							
Public	179	186	173	168	178	200	180
Private	397	397	333	378	410	431	384
1992–93							
Public	186	193	179	173	191	212	187
Private	427	416	359	393	435	465	408
1993–94							
Public	187	197	179	171	203	210	189
Private	453	431	384	410	456	488	429
1994–95							
Public	189	199	182	165	205	218	191
Private	479	446	408	405	493	504	449
1995–96							
Public	193	205	184	168	208	222	194
Private	510	461	431	421	501	522	471

Source: PHIAC annual reports.

Table I.13: Real change in benefits paid per day, by hospital type (per cent)

<i>Year and hospital type</i>	<i>NSW &amp; ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>SA &amp; NT</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
1990–91							
Public	3.4	6.6	7.1	5.7	5.9	4.5	4.9
Private	9.3	6.7	5.4	7.1	7.8	6.5	7.5
1991–92							
Public	3.7	3.4	5.5	10.7	14.5	10.7	4.9
Private	11.5	6.7	9.5	8.2	6.7	10.1	8.7
1992–93							
Public	3.0	3.2	2.0	0.6	6.9	4.2	3.0
Private	6.5	4.1	6.5	1.8	5.7	6.7	5.2
1993–94							
Public	-0.8	-0.1	-1.8	-2.6	4.1	-3.5	-0.8
Private	4.7	1.6	4.9	2.3	2.7	2.0	3.1
1994–95							
Public	-2.2	-1.5	-2.1	-6.7	-2.7	0.7	-2.0
Private	2.2	0.8	2.3	-4.2	4.4	0.0	1.6
1995–96							
Public	-3.0	-0.9	-2.9	-1.7	-2.4	-2.3	-2.2
Private	1.5	-0.4	1.7	0.3	-2.3	-0.2	0.6
1989–90 to 1995–96							
Public	4.0	10.9	7.8	5.2	28.3	14.6	7.8
Private	41.0	20.8	34.2	16.0	27.4	27.3	29.5

Source: PHIAC annual reports. ABS Ausstats CPI data.

Table I.14: Contributions of inputs and surplus to real patient revenue per bed day, private hospitals, 1991–92 and 1994–95 (per cent)

<i>Year and component</i>	<i>NSW &amp; ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>SA &amp; NT</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
1991–92 Labour	54	61	57	58	55	58	57
1994–95 Labour	54	58	57	59	56	58	57
1991–92 Non-labour	40	36	34	37	36	36	37
1994–95 Non-labour	42	38	37	37	41	36	39
1991–92 Surplus	6	3	9	5	9	7	6
1994–95 Surplus	4	5	6	3	3	5	4

Source: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years. ABS Ausstats CPI data.

Table I.15: Contributions of inputs and surplus to real patient revenue per bed day, private hospitals, 1991–92 to 1994–95 (per cent)

<i>Component</i>	<i>NSW &amp; ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>SA &amp; NT</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
Labour	54	60	56	59	55	58	57
Non-labour	41	36	34	37	38	33	37
Surplus	5	5	9	4	6	9	6

Source: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years. ABS Ausstats CPI data.

Table I.16: Contribution of inputs and surplus to real increases in patient revenue per bed day, private hospitals, 1991–92 to 1994–95 (per cent)

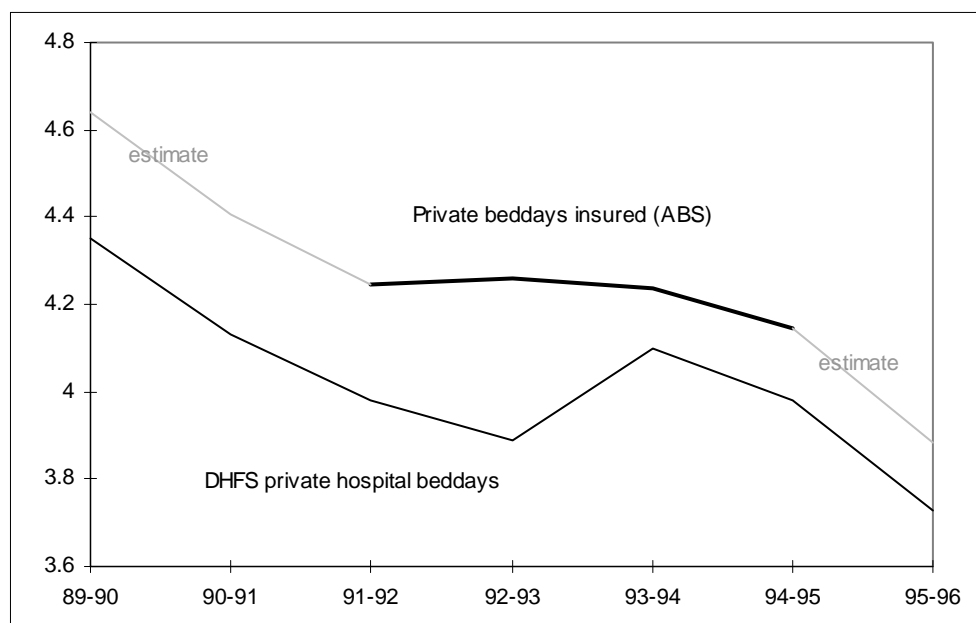
	<i>NSW &amp; ACT</i>	<i>Vic</i>	<i>Qld</i>	<i>SA &amp; NT</i>	<i>WA</i>	<i>Tas</i>	<i>Aus</i>
Real increase in patient revenue per bed day (%)	9.0	5.1	10.3	3.8	3.0	15.4	7.2
Labour	58	1	54	78	75	63	46
Non-labour	70	64	67	46	214	40	71
Surplus	-28	34	-22	-25	-189	-3	-16

Source: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years. ABS Ausstats CPI data.

## I.5 National industry data

This section reproduces the data underlying the cost calculations of chapter 7. All data are in current prices.

Figure I.2: Estimates of average length of stay (beds) by privately insured patients in private hospitals, 1989–90 to 1995–96



Sources: ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years. Information supplied by the Department of Health and Family Services using data obtained from Medicare hospital statistics. Commission estimates.

Table I.17: Industry data — SEUs, persons covered and hospital usage, 1988–89 to 1995–96 ('000)

<i>Year</i>	<i>Hospital insurance SEUs (June)</i>	<i>Hospital insurance, persons covered (June)</i>	<i>Hospital insurance, persons covered aged 65 or more</i>	<i>Private hospital bed day usage by the insured</i>	<i>Public hospital bed day usage by the insured</i>	<i>Free standing day hospital bed day usage by the insured</i>
1988–89	5 321	7 645	755	..	..	..
1989–90	5 330	7 588	773	3 948	3 318	40
1990–91	5 317	7 548	824	4 076	3 218	60
1991–92	5 105	7 164	832	4 125	2 999	70
1992–93	4 990	6 967	844	4 166	2 806	82
1993–94	4 783	6 632	844	4 178	2 462	89
1994–95	4 572	6 304	844	4 257	2 099	91
1995–96	4 458	6 149	843	4 452	1 757	113

Sources: PHIAC annual reports.

Table I.18: Industry data — SEUs, persons covered and population estimates, 1989–90 to 1995–96 ('000)

<i>Year</i>	<i>Hospital insurance SEUs (average)</i>	<i>Hospital insurance, persons covered (average)</i>	<i>Hospital insurance SEUs, aged 65 and over</i>	<i>Hospital insurance SEUs, aged 64 and under</i>	<i>Estimated Australian population, aged under 65</i>	<i>Estimated Australian population aged 65 and over</i>
1988–89	..	..	..	..	14 968	1 846
1989–90	5 325	7 617	764	4 561	15 172	1 893
1990–91	5 323	7 568	798	4 525	15 333	1 951
1991–92	5 211	7 356	828	4 383	15 485	2 004
1992–93	5 047	7 066	838	4 210	15 599	2 057
1993–94	4 886	6 799	844	4 042	15 731	2 108
1994–95	4 677	6 468	844	3 833	15 900	2 154
1995–96	4 515	6 227	843	3 671	16 070	2 202

Sources: PHIAC annual reports. ABS population census data.

Table I.19: Industry data — hospital insurance benefits, 1989–90 to 1995–96 (\$'000)

<i>Year</i>	<i>Private hospital insurance benefits</i>	<i>Public hospital insurance benefits</i>	<i>Free standing day hospital insurance benefits</i>	<i>Medical gap benefits</i>	<i>Prostheses benefits</i>	<i>Total hospital insurance benefits</i>
1989–90	1 210 255	504 453	5 936	151 378	33 010	1 905 031
1990–91	1 414 298	540 513	9 540	173 244	47 192	2 184 788
1991–92	1 586 016	538 673	12 121	189 460	61 990	2 388 260
1992–93	1 701 574	524 242	14 737	202 200	78 805	2 521 558
1993–94	1 791 308	464 729	16 748	207 669	92 091	2 572 545
1994–95	1 913 181	400 443	18 633	215 783	107 606	2 655 646
1995–96	2 097 100	341 700	39 400	223 051	132 900	2 834 151

*Source:* PHIAC annual reports.

Table I.20: Industry data — reserves, contribution income, management costs and investment income, 1988–89 to 1995–96 (\$'000)

<i>Year</i>	<i>Health fund reserves</i>	<i>Estimated hospital insurance contribution income</i>	<i>Management costs allocated to hospital insurance</i>	<i>Health fund investment income</i>	<i>Estimated ancillary insurance contribution income</i>
1988–89	900 504	..	..	..	..
1989–90	861 630	2 090 611	195 211	173 585	1 005 528
1990–91	850 976	2 393 844	205 713	177 161	1 099 793
1991–92	991 312	2 772 133	219 736	162 396	1 160 511
1992–93	1 205 391	2 946 819	230 348	147 914	1 197 798
1993–94	1 350 058	2 998 865	240 895	133 863	1 231 599
1994–95	1 408 982	2 984 465	247 501	161 418	1 273 156
1995–96	1 295 327	3 076 190	251 800	193 024	1 311 527

*Sources:* PHIAC annual reports. Commission estimates.

Table I.21: Industry data — various, 1989–90 to 1995–96

<i>YEAR</i>	<i>CPI</i>	<i>Private hospital patient revenue per bed day</i>	<i>Hospital insurance benefits paid to persons aged 64 or under</i>	<i>Hospital insurance benefits paid to persons aged 65 or over</i>	<i>Ratio of private hospital benefits per bed day to patient revenue per bed day</i>	<i>Prostheses units</i>	<i>Medical gap services</i>
	1989–90 = 1.0	\$	\$'000	\$'000		'000	'000
1989–90	1	348	1 333 831	571 200	0.882	71	8 946
1990–91	1.053	392	1 479 888	704 900	0.884	113	8 712
1991–92	1.073	424	1 589 660	798 600	0.906	152	9 371
1992–93	1.084	444	1 644 158	877 400	0.919	212	10 323
1993–94	1.104	458	1 653 545	919 000	0.936	303	10 136
1994–95	1.139	483	1 695 146	960 500	0.931	318	10 227
1995–96	1.187	509	1 777 251	1 056 900	0.926	445	10 318

*Sources:* PHIAC annual reports. ABS *Private Hospitals, Australia* (Cat No. 4390.0), various years.  
ABS Ausstats CPI data.



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