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AUSTRALIAN CENTRE
FOR
ECONOMIC RESEARCH
ON HEALTH

Healthcare reform: the future of private health insurance in Australia

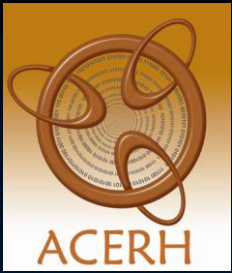
Jim Butler
ACERH, ANU

A presentation to the 8th Annual Health Insurance Summit
Sydney, 28-29 July 2009



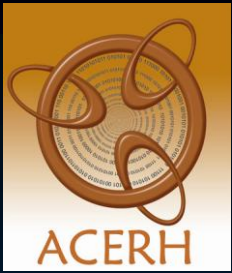
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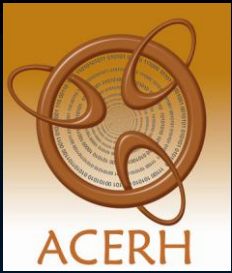
Overview

- Why reform health financing arrangements?
 1. Duplicate coverage
 2. Private financing share
- Policy options
 - Option 1: Reducing private health insurance coverage
 - a Medicare Hospital Benefits Scheme
 - Option 2: Medicare 'Opt Out' with Risk-Adjusted Subsidies
- Option 1 – HBS: comments
- Option 2 – Opt-out: comments
- Closing comments



Why reform health financing arrangements?

1. Duplicate health insurance coverage
2. Initiatives to increase private sector share in health care financing have failed



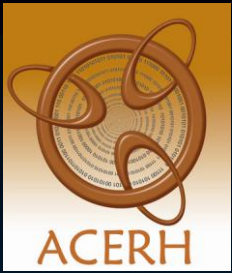
1. Duplicate coverage

Australia has universal, compulsory, tax-financed public health insurance

plus

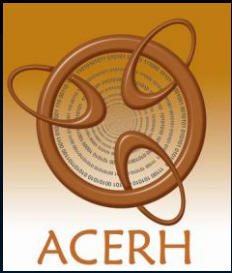
voluntary, subsidised private health insurance

→ duplicate coverage



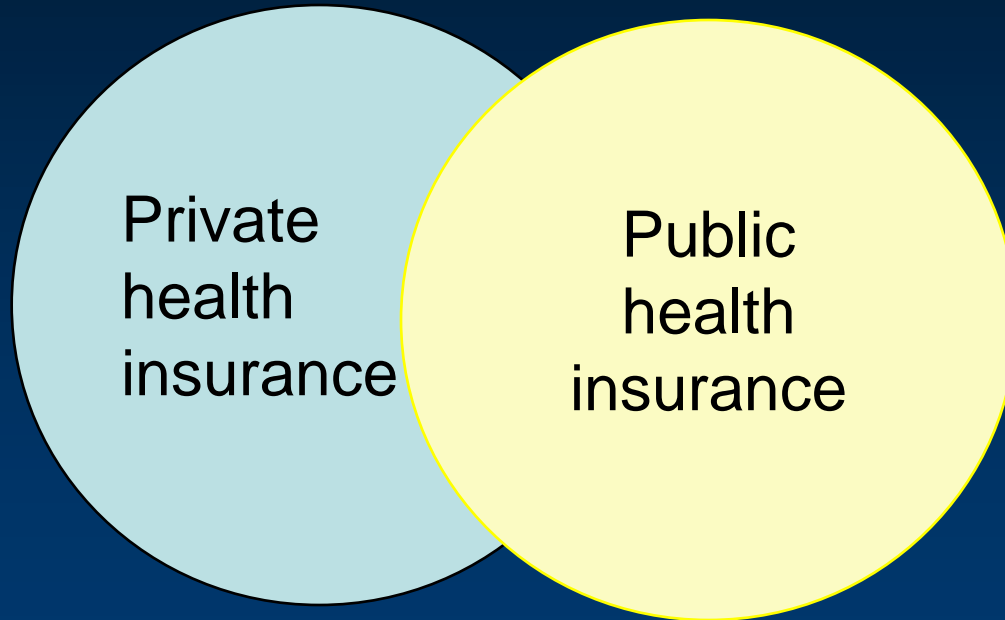
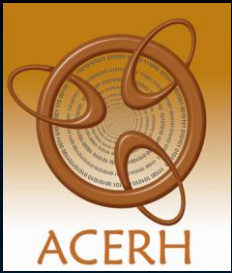
- Duplicate coverage:

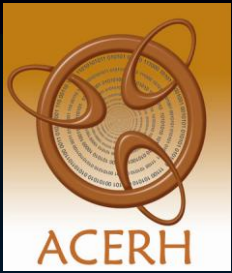
If insurance cover for private hospital treatment is purchased, insurance cover for public hospital treatment as a public patient is still compulsorily retained



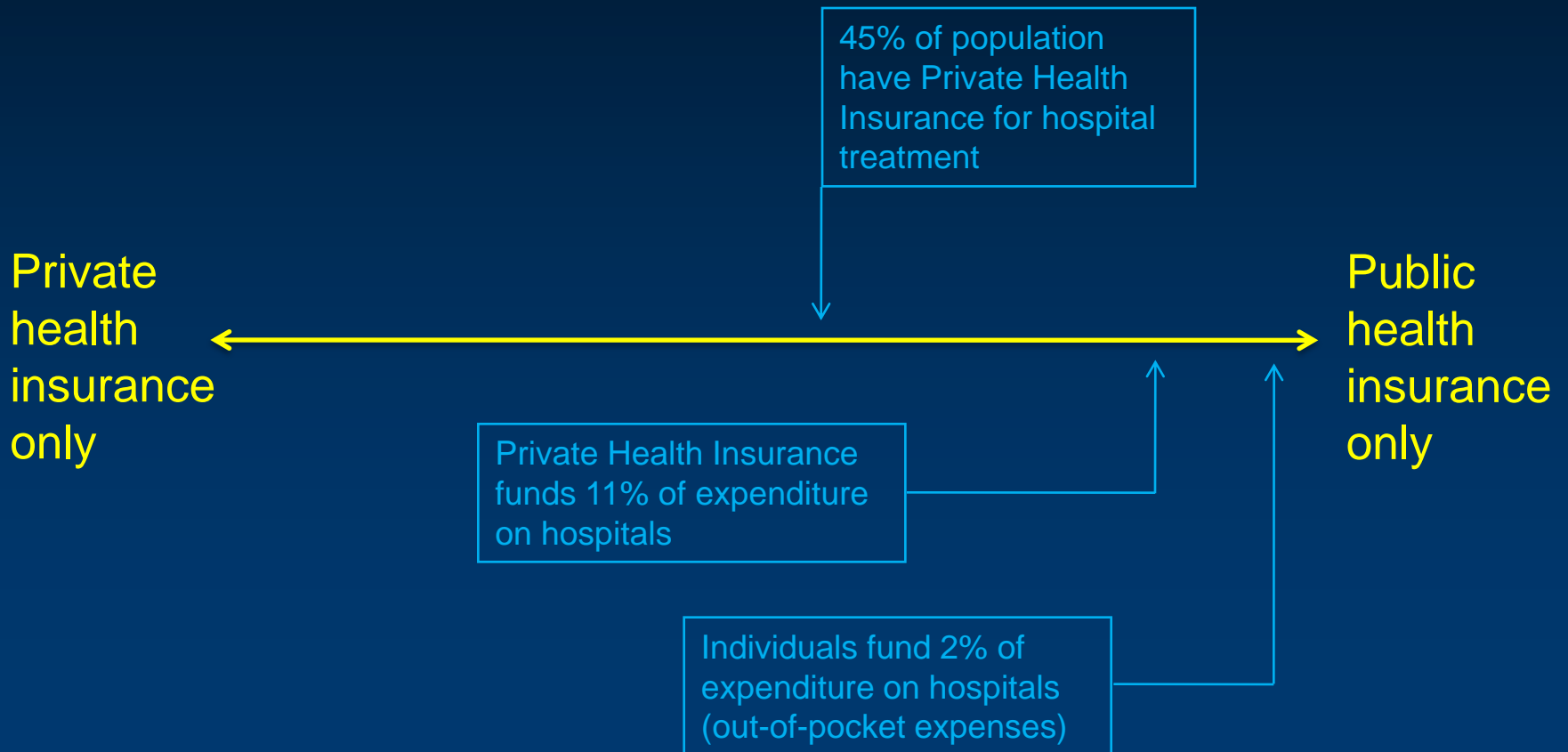
- all contribute to public pool and have access to public provision;
- however, insured are not able to shift the avoided cost of their public use over to private use;
- hence if they want to use private facilities, they face the full cost of these, rather than “full cost minus avoided cost to public sector of displaced use”

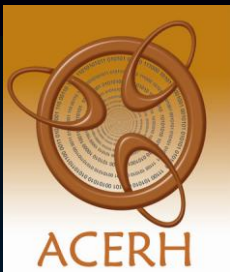
(Henry Ergas, 2008)





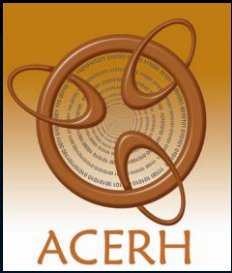
Which direction to move?





**Funding of hospitals, current prices, by broad source of funds,
1995–96 to 2006–07 (per cent)**

Year	Government			Non-government			Total
	Australian Govt	State/local govt	Total	Private health funds	Other non-govt	Total	
1995–96	37.4	35.9	73.3	17.8	9.0	26.7	100.0
1996–97	35.6	38.1	73.7	17.5	8.8	26.3	100.0
1997–98	38.2	38.2	76.4	14.7	8.9	23.6	100.0
1998–99	41.9	36.0	77.9	12.3	9.8	22.1	100.0
1999–00	43.8	35.8	79.6	10.5	9.9	20.4	100.0
2000–01	45.0	34.9	79.8	10.9	9.3	20.2	100.0
2001–02	44.0	35.0	79.0	12.4	8.6	21.0	100.0
2002–03	43.5	37.5	81.1	12.0	6.9	18.9	100.0
2003–04	42.6	38.0	80.6	12.1	7.2	19.4	100.0
2004–05	42.3	38.4	80.7	11.7	7.5	19.3	100.0
2005–06	40.6	40.5	81.1	11.1	7.8	18.9	100.0
2006-07	39.7	41.6	81.3	11.1	7.6	18.7	100.0



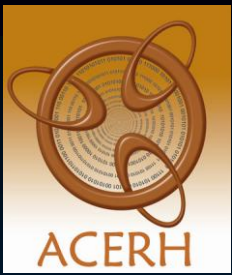
2. Private financing share

Problem - effect on public sector health budgets of:

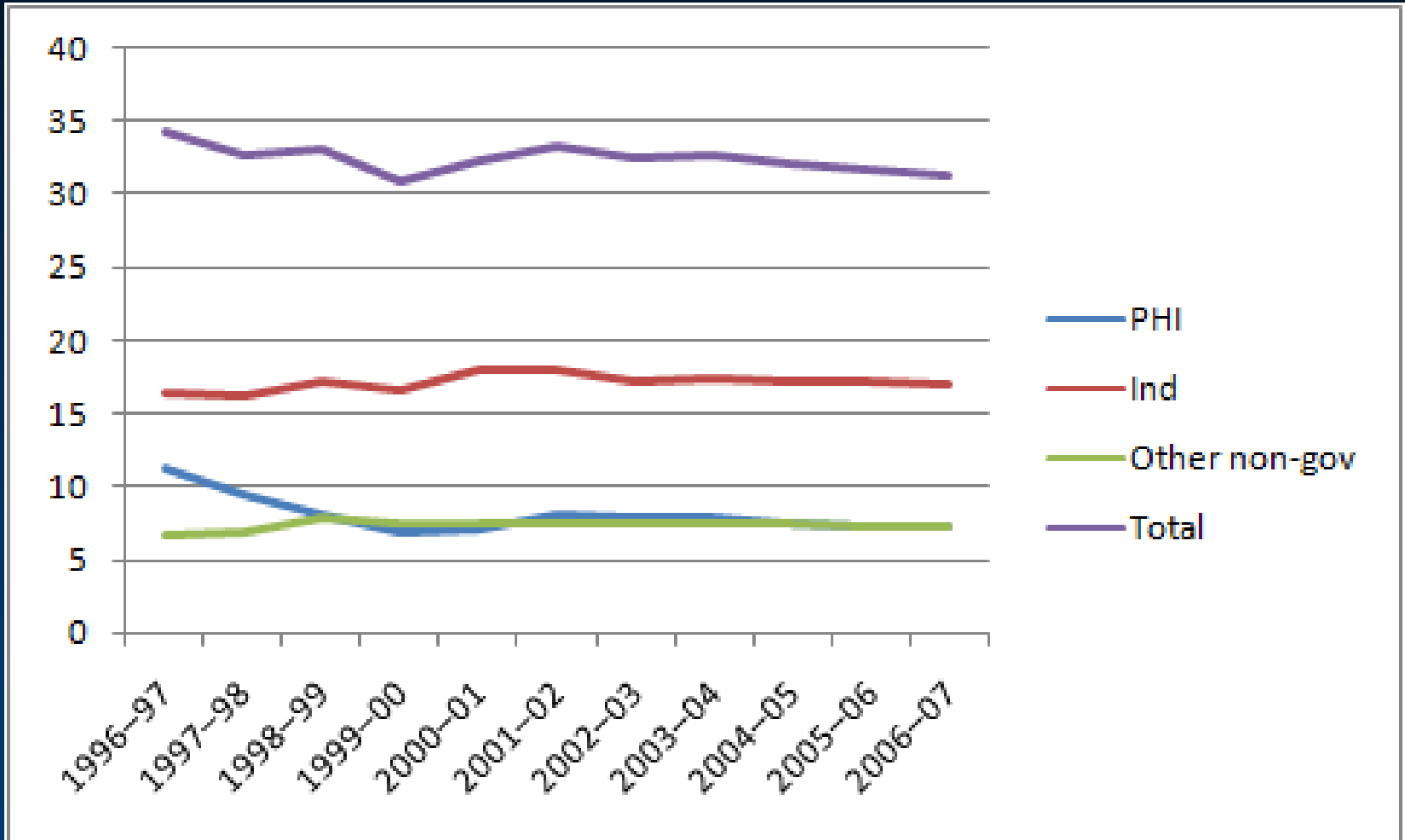
- Ageing of the population
- Technological change

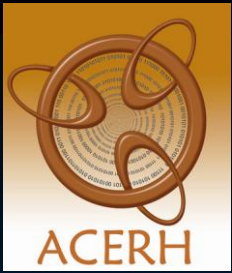
Solution – increase reliance on private financing

but the privately financed share of health expenditure has decreased over the last decade



Privately financed share of total health expenditure, Australia, 1996-97 to 2006-07

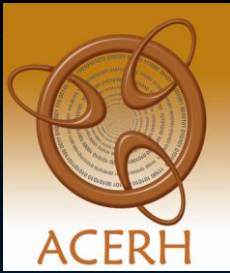




Policy options

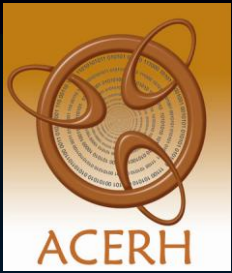
Two broad options to address duplicate coverage:

1. Reduce private health insurance coverage with public coverage taking up the 'gap'
2. Reduce public coverage with private coverage taking up the 'gap'

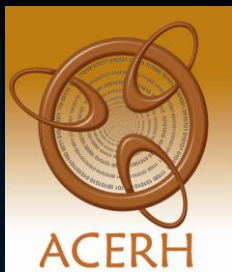


Option 1: Reducing private health insurance coverage – a Medicare Hospital Benefits Scheme

- Remove s.96 grants for hospitals
- Remove private health insurance rebate
- Replace with a hospital benefits scheme
- A hospital benefit of pre-determined value would be paid for each hospital admission
- Commonwealth role would be financing, not provision, so ownership of public hospitals remains with the States

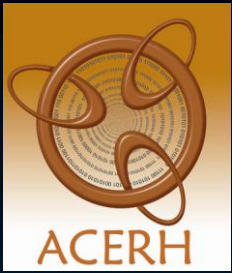


- Develop a Hospital Benefits Schedule (HBS)
- HBS items would be casemix-based
- Each item would have a defined rebate as in MBS
- Rebate can be set to ensure public hospital patients face no charge for an inpatient episode as at present
- Rebate would be paid for treatment in a public or private hospital

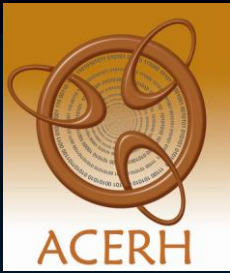


Option 2: Medicare 'Opt Out' with Risk-Adjusted Subsidies

- Terminate s.96 grants to states for hospitals and remove existing subsidies for private health insurance
- Allow individuals/households to 'opt out' of Medicare – 'take a subsidy and run' to private health insurance
- Subsidy would be the expected annual expenditure for a person/household with their risk characteristics (risk-adjusted) – so risk-adjusted subsidy would replace existing *ad valorem* subsidy



- Private health insurance would then cover the cost (fully/partially?) of their health care
- What health care services? All – or subset (e.g. excluding PBS drugs)



Important design issue:

Voluntary opt-out vs Compulsory opt-out
(i.e. would a public plan be retained?)

Yes (voluntary opt-out) – e.g. US Medicare

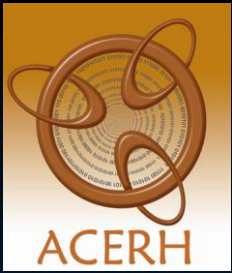
Paolucci, Butler & van de Ven (2008)

([ACERH Working Paper No.2](#)) - Working Paper No.2)

No (compulsory opt-out) – e.g. Dutch reforms

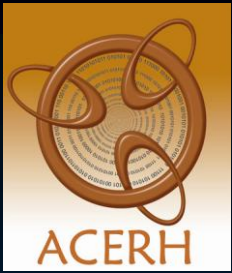
Stoelwinder & Paolucci (2009)

([MJA](#))



Option 1 – HBS: comments

- Would require increase in public funding (esp. if private hospitals to be included)
- Recent ninemsn.com.au poll indicated strong resistance to 'paying another \$1,000 per year for health care'
- Would be strongly resisted by private health insurance industry (leaves PHI with a 'gap' role only for private hospital coverage along with general treatment insurance)



Option 2 – Opt-out: comments

- If voluntary, would 'enough' opt out?
US 'Medicare Advantage' option since 1985, but opt-out proportion in 2007 was 20% (cf 45% of Australians with private health insurance)
(M Pauly, *Markets Without Magic*, 2008)
- If compulsory, would this be politically acceptable?
- What would risk-adjusted subsidies look like?

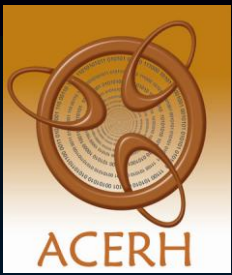
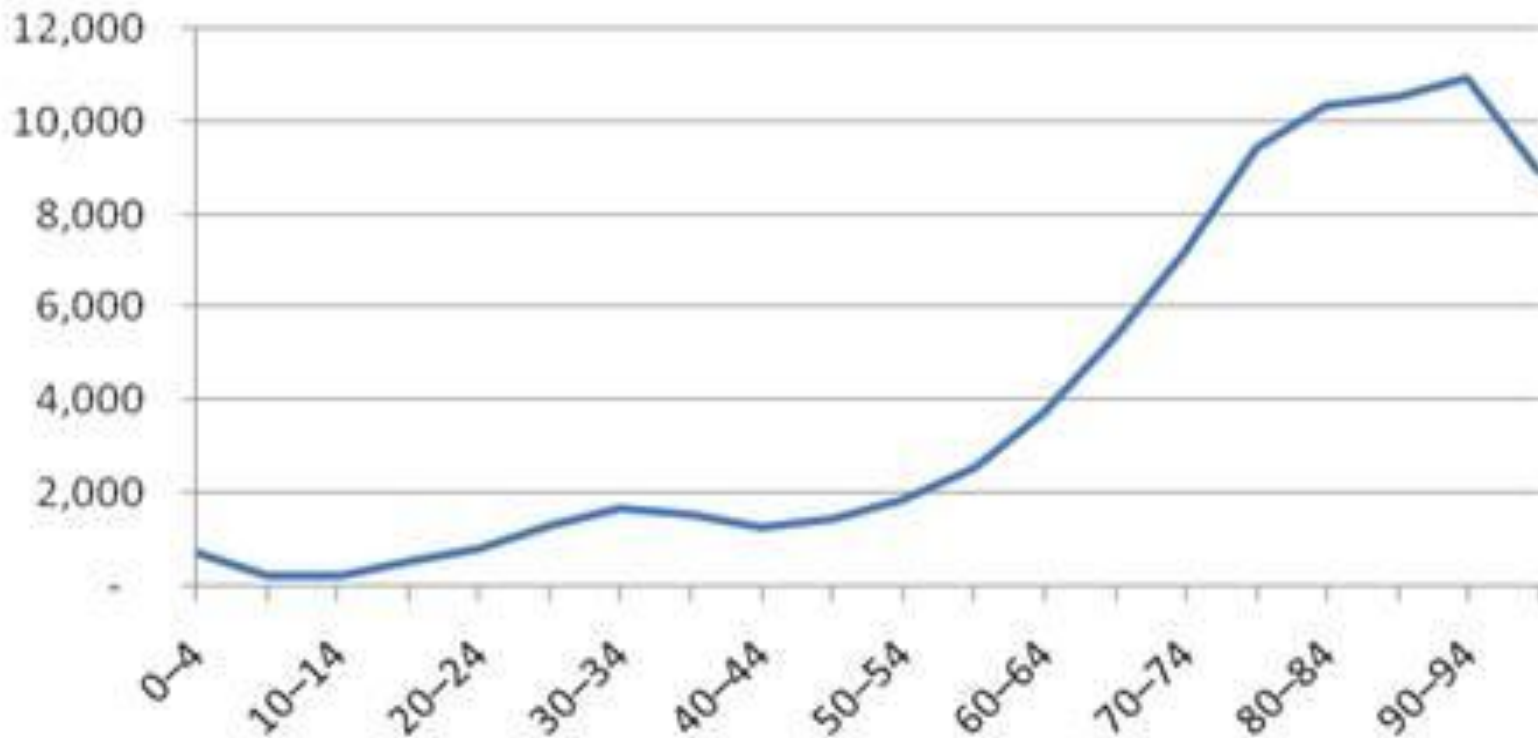
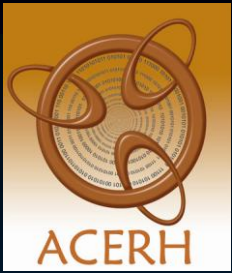


Figure 1: Illustrative per capita risk-adjusted annual subsidies for private health insurance



Source: Paolucci, Butler & van de Ven (2008)



Closing comments

- Whither private health insurance? May have the 'best of all worlds' at present
- Medicare HBS would reduce role of PHI
- Voluntary opt-out may also reduce role of PHI
- Compulsory opt-out would increase market size but industry would continue to heavily regulated to achieve social objectives