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III. INVITED ARTICLE I

Health Care Financing and Private Health Insurance in Australia

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Introduction

Private health insurance markets in Australia have recently been subject to a range of government interventions designed to boost membership. Over the past seven years, the Australian (Commonwealth) government has attempted to halt or reverse the steady decline in the proportion of the population covered by private health insurance that ensued following the introduction of the Australian national health insurance scheme (Medicare) in 1984. Around the time of the introduction of Medicare, coverage fell from 63 per cent in December 1983 to 50 per cent in June 1984. This "one-off" drop in coverage in response to the introduction of Medicare was anticipated. What was not anticipated was the steady decline in coverage that ensued: by the late 1990s coverage had fallen to approximately 30 per cent of the population. The major driver of this steady decline in coverage appears to have been adverse selection: in Australia, private insurers are required to community rate health insurance premiums. Following a government inquiry in 1997, the Commonwealth Government initiated a series of policies that were designed to arrest the long-term decline in coverage. These policies comprised subsidies of private health insurance premiums, income tax surcharges on medium-to-high income earners who did not buy private health insurance and more recently an interesting initiative called the "Lifetime Cover" (LTC) scheme.

The LTC scheme introduced a fundamental change to the way that insurers set premiums: it removed the age-independence of the community rating approach. The LTC scheme involves penalties, in the form of insurance premium loadings, which are perpetual and related to the age at which a person joins. Thus, the LTC scheme is designed to reward those who take out private health insurance early in life and retain it, and to penalise those who join at older ages. It involves a surcharge on the community-rated premium for individuals who join at 31 years of age and older. The surcharge is calculated as the joining age, minus 30, times two per cent. Thus, a person who joins at 40 years of age and maintains membership pays a premium that is 1.20 times the "base" premium for the duration of his/her membership. The loading is capped at 70 per cent, applicable to all new joiners aged 65 and above.

In this paper, we provide an overview of the LTC scheme and some of its key characteristics. We present two key arguments, namely (i) that the LTC scheme was the most effective and the cheapest reform of Australian private health insurance markets and (ii) that, while successful in raising membership, the LTC does not address the fundamental adverse selection problem in Australian private health insurance markets.

Institutional environment and policy background

The Australian Medicare arrangements involve a tax-financed scheme that provides (i) zero-price care to individuals who are treated as public patients in public hospitals, (ii) subsidies for services

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provided by private, fee-for-service (FFS) medical practitioners, both in-hospital and out-of-hospital, as well as (iii) subsidies for pharmaceuticals, pathology, diagnostic imaging and other health care (e.g. optometry) services.

The public sector's role in health care financing was, prior to the introduction Medicare (or its predecessor program "Medibank) mostly indirect, via income tax concessions (Butler 1998). In the decades prior to Medicare, most Australians held private insurance: at its zenith in 1970, 80 per cent of the population was covered (Hall, De Abreu Lourenco and Viney 1999). Following the introduction of the Medicare scheme, however, private health insurance coverage fell from 50% June 1984 to its nadir of 30.1% in December 1998 (Butler 2002).

The reasons for a long-run decline in coverage are easily appreciated when one considers the confluence of factors at work in the Medicare era. Australia's private health insurers have long been required to community-rate their premiums.¹ This regulation, which was designed to achieve the usual (equity, renewability, etc.) ends may be regarded as a hangover from the pre-Medicare period when, for many individuals and families, self-insurance was the only substitute for private insurance. Predictably, given ubiquitous public coverage with the introduction of Medicare, the retention of the community rating provision led to an adverse selection process.²

By way of an empirical indication of the adverse selection problem, between 1986 and 1998, private health insurance coverage fell from 44.2 to 30.1 per cent of the population (AIHW 2000, Butler 2002); during the same period, coverage of the 70+ years-old population increased from 31.5 to 36.4 per cent, while coverage of the 25-34 years-old population fell from 46.5 to 22.1 per cent (AIHW 2000). The historical depth of the adverse selection problem is also apparent from a State-level analysis of the expected benefit of health insurance for various age groups by Butler (1999). He estimated that the ratio of the highest to the lowest benefits per capita for individuals aged 20+ years in 1995 was at least 6.8:1 for females and 14.6:1 for males.

Several other aspects of Australian private health insurance markets are salient : first, private health insurance is not generally employment-based as it is, for example, in the United States. Relatively few employers routinely provide private health insurance as part of a remuneration package. Although health insurers often have corporate plans for various (usually large) employers, employees typically take up such offers as individuals and incur payroll deductions for the cover. Second, privately insured individuals are not required to declare or invoke their private insurance status and are still entitled to treatment as a public patient, in a public hospital, at the zero-price. Third, treatment as a private patient typically provides one or more of the following kinds of incremental benefits: (i) lower time costs, especially for "elective" surgery; (ii) treatment by medical practitioners of the patient's choosing; (iii) private accommodation (or, in shared accommodation, smaller numbers sharing); and (iv) accommodation-related amenities (e.g., greater choice at mealtimes). Fourth, the costs associated with exercising one's private health insurance status for hospital treatment are not always trivial, even if the deductible on the policy is low. Fifth, private health insurance policies in Australia offer service benefits (with various co-payment provisions) to claimants, as opposed to lump sum transfers for insured events of illness. Historically, one important reason for this outcome was the unavailability of insurance to cover the net prices of medical practitioner services, i.e. the difference between the market price and the Medicare subsidy. This issue has been addressed recently via changes to the *Health Insurance Act*, which enable some so-called "gap cover" arrangements to be agreed between insurers and

¹ Insurers, in fact, provide "community-rated" policies for both "singles" and "families" where the premium for the latter is simply double that of the former.

² The community rating regulation requires the same premium be charged for the same policy regardless of the risk of the purchaser (with premiums for families being double those of premiums for singles). It might be argued that private health insurers could subvert this regulation to a greater or lesser degree by offering a range of policies which differ according to the breadth of services covered, with more restricted policies having lower premiums. Individuals/families then reveal their risk status through their choice of policy. However, all policies offered by private health insurers must be approved by the regulator so that the degree to which policy proliferation can ameliorate the adverse selection effects of the community rating regulation can be limited by the regulator (see Butler 2003).

medical practitioners. Such arrangements currently cover a relatively small minority of medical practitioners.

Finally, it is important to appreciate the nature of the tax subsidies and penalties that are presently associated with private health insurance in Australia.³ At present

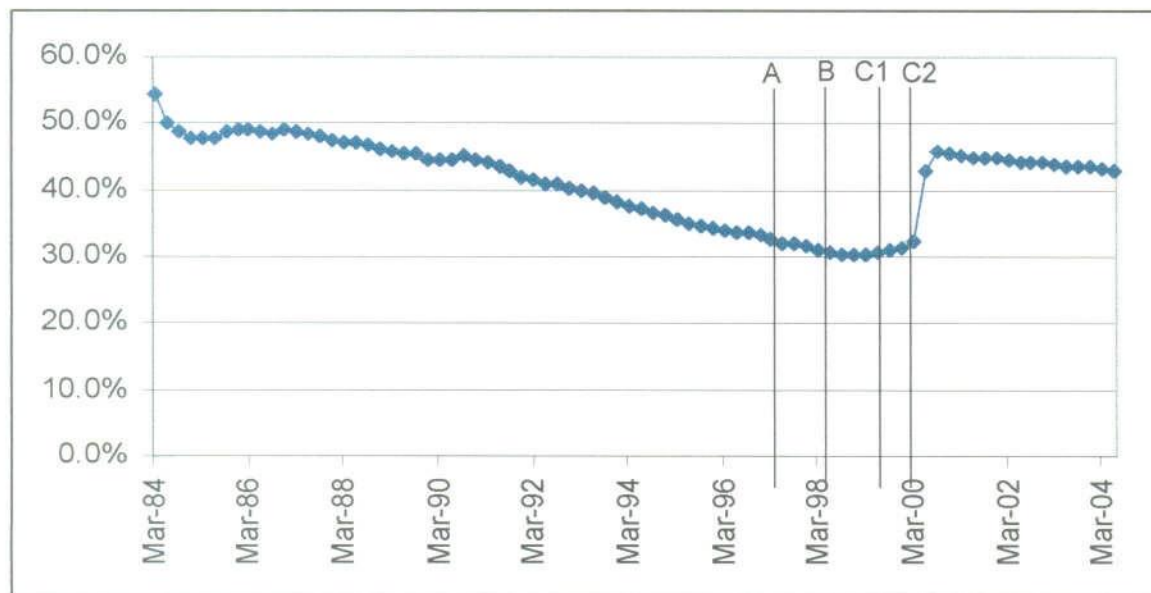
1. A 30 per cent private health insurance subsidy applies, regardless of income level, to all taxpayers who hold private health insurance with a registered fund. The subsidy can be claimed as
 - a. reduction in the price of the policy,
 - b. cash refund, or
 - c. tax deduction.
2. A 1.5 per cent levy (called the "Medicare Levy Surcharge") on the incomes of
 - a. individuals who earn a taxable income of more than \$50,000 per annum and do not have private health insurance with a maximum \$500 front-end deductible, and
 - b. families/couples who earn a taxable income of more than \$100,000 per annum and do not have private health insurance with a maximum \$1000 front-end deductible, with a registered private health insurer.

For a variety of reasons, Australia's health care financing arrangements present an interesting case study. Australia now finds itself somewhere on the continuum of health care financing problems both face "pure" welfare state arrangements as well as those that characterise competitive insurance markets (see, e.g. Neudeck and Podczech 1996).

Private health insurance policy and the lifetime cover scheme

Figure 1 provides quarterly data on the proportion of the Australian population insured for private hospital cover for the period March 1984 to March 2004.

Figure 1: Percentage of the Population Covered by a Private Insurance Table, March 1984 to March 2004



Source: Private Health Insurance Association Council (2004) and Butler (2002).

Notes: "A" indicates the introduction of the Private Health Insurance Incentives Act 1997; "B" indicates the introduction of the Private Health Insurance Incentives Act 1998; "C1" and "C2" are the announcement and implementation dates, respectively, of the Lifetime Cover initiative.

³ We present only a synopsis here. More detailed discussions of the policy background and the effects of each of these provisions are provided by (Hall, De Abreu Lourenco and Viney 1999) and Butler (2002).

The data in Figure 1 tell a reasonably straightforward story: as far as coverage is concerned, the LTC initiative clearly had the greatest impact. Moreover, it was the least costly of the three schemes although, as Butler (2002) argues, the extension of the 30 per cent subsidy to all purchasers of private health insurance prior to the introduction of the LTC scheme has proved an expensive "cart before the horse" policy for the Commonwealth government.

Will the lifetime cover scheme work?

There is no doubt that the LTC scheme has been successful in the sense that it increased membership dramatically: up to 14 per cent of the population that previously did not hold private hospital cover took out private cover when the scheme was announced/introduced. An important question is whether or not the initiative provides a long-term solution to the problem of adverse selection.

We, amongst others, have variously argued that the signs of an adverse selection spiral are either probably or definitely evident again (Butler 2002, Brown and Connelly 2004a, Brown and Connelly 2004b, Lewis 2002). Lewis has argued that the problem rests with the dissonance as between the linear LTC premium loading and an actuarially fair loading, for which Lewis has estimated an age-based spline relationship. Brown and Connelly (2004b) have gone further than this suggesting that, perversely, the LTC incentives might actually exacerbate adverse selection among older individuals. Specifically, they argue that amongst older individuals who do not hold private health insurance, low-risks will choose not to join because premiums will be actuarially unfair, while high-risks may still join and pay less-than-actuarially fair premiums. They also present empirical evidence that the adverse selection spiral has re-emerged following the introduction of the LTC scheme showing that, all (five-year) age groups over 50 comprise a growing proportion of the pool, while all but two age groups under 50 (i.e., individuals aged 15-19 and 20-24) comprise a shrinking proportion of the pool.

Discussion

The Australian LTC scheme is an interesting experiment designed to improve the efficiency of community-rated private health insurance markets. Unfortunately it does not address some of the fundamental problems that gave rise to the adverse selection spiral prior to its introduction. Arguably, the root of the problem is Australia's strong commitment to the principle of community rating in private health insurance markets *given* that a high-quality public alternative exists and that membership of that scheme is *compulsory*. Thus, we are critical of the LTC scheme's propensity to affect the long-term performance of Australia's private health insurance markets. Nevertheless, it should also be remarked that more efficient alternatives to LTC that both (i) preserve some degree of community rating and (ii) arrest adverse selection may well be inconceivable.

As Zeckhauser (1994) and others have noted, equity frequently dominates efficiency concerns in the health sector. Yet it seems that Australia is paying a high and increasing price for maintaining the principle of community rating in private health insurance markets, especially when one considers the universal, public alternative. Elsewhere (Brown and Connelly 2004a), we have proposed that experience-rated schemes of the "guaranteed renewable" kind proposed by Pauly, Kunreuther and Hirth (1995) may represent a viable alternative for Australia. Under such schemes, individuals are rewarded for joining as low risks (penalised for joining as high-risks) and are insulated from the problem of becoming high-risk and uninsurable.

References

Australian Institute of Health and Welfare (2000) *Australia's Health 2000: The Seventh Biennial Health Report of the Australian Institute of Health and Welfare*, AIHW, Canberra.

- Brown, H.S. III and Connelly, L.B. (2004a) "Market Failure in Long-Term Private Health Insurance Markets: A Proposed Solution", *Applied Economics Letters*, forthcoming.
- Brown, H.S. III and Connelly, L.B. (2004b) "Lifetime Cover in Private Insurance Markets, *mimeo*.
- Butler, J.R.G. (1998) "Health Expenditure", in Mooney, G. and Scotton, R.B. (eds) (1998) *Economics and Australian Health Policy*, Allen and Unwin, Sydney, pp.40-71.
- Butler, J.R.G. (1999) Estimating Elasticities of Demand for Private Health Insurance in Australia, Working Paper No.43, National Centre for Epidemiology and Population Health, Australian National University, Canberra.
- Butler, J.R.G. (2002) "Policy Change and Private Health Insurance: Did the Cheapest Policy Do the Trick?", *Australian Health Review*, Vol.25, No.6, pp.33-41.
- Hall, J., De Abreu Lourenco, R. and Viney (1999) "Carrots and Sticks – The Fall and Fall of Private Health Insurance in Australia", *Health Economics*, Vol.8, No.8, pp.653-660.
- Lewis, D. (2002) "An Evaluation of Recent Government Initiatives to Increase Participation in Private Health Insurance in Australia", Paper presented to the Thirty-First Australian Conference of Economists, Adelaide.
- Neudeck, W. and Podczeck, K. (1996), "Adverse Selection and Regulation in Health Insurance Markets", *Journal of Health Economics*, Vol.15, pp.387-408.
- Pauly, M.V., Kunreuther, H. and Hirth, R. (1995) "Guaranteed Renewability in Insurance", *Journal of Risk and Uncertainty*, Vol.10, pp.143-56.
- Private Health Insurance Administration Council (2004) *Statistical Trends: Memberships and Benefits*, PHIAC, Sydney, <http://www.phiac.gov.au/statistics>.
- Zeckhauser, R. (1994) "Public Finance Principles and National Health Care Reform", *The Journal of Economic Perspectives*, Vol.8, No.3, pp.55-60.

IV. INVITED ARTICLE II

The role of information in choosing a health insurer in the Netherlands

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Introduction

During the 1990s the Dutch social health insurance scheme has been reformed by the introduction of freedom of choice (open enrolment) of health insurer alongside a system of risk-adjustment to compensate health insurers for enrollees with predictable high medical expenses. The primary reason of the reform was to motivate sickness funds to improve the efficiency of health care. First, the legally protected regional monopolies were abolished and new sickness funds were permitted to enter the market. In addition sickness funds became in an increasing extent financial responsible for their policy, their financial risk increased gradually from three percent in 1995 to 54 percent in 2004. Halfway the nineties, each sickness fund charged the same out-of-pocket premium, but in the last five years the differences in out-of-pocket premiums increased rapidly. Now, the cheapest fund charges a premium of €215 and the most expensive one €385 per year. Although sickness funds are allowed to selectively contract with health care providers for outpatient

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