The Interface Between Voluntary Private Health Insurance & Mandatory Public Health Insurance: Challenges, Opportunities and Options for National Policy Design

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Agenda

1. Background: policy goals & instruments;

2. Interactions between mandatory public health insurance and voluntary private health insurance;

3. Options for policy design;

Part I.

Background
Policy goals

Over the past decades, the main health policy goals in most OECD countries have been:

1. Achieving universal access to health care services (i.e. affordability);

2. Improving the efficiency in the organization and delivery of health care.

3. Cost containment and fiscal discipline.
Policy instruments

Most OECD countries have introduced:

1. **Universal** mandatory coverage for a *uniform* set of services, as policymakers see it as *tool* to achieve the *goal* of affordable access to (the coverage of) health care services to vulnerable groups (e.g. low-income or high-risks individuals);

2. **Consumer choice** of insurers and/or providers and incentives as *tool* to achieve the *goal* of efficiency in the production of health care and in terms of responsiveness to consumers’ needs and preferences;

3. **Rationing** as *tool* to achieve the *goal* of containing overall healthcare expenditures and increasing the share of *individual* financial responsibility to contain *collectively* financed health care.
Problem/Question (I)

• Shifting (parts of) the costs of health care away from collective to individual responsibility leads to an increase in the demand for voluntary private insurance, which causes concerns regarding both efficiency and affordability.

• How does expanding the role of voluntary private insurance affect:
  • Affordability and efficiency of voluntary private and mandatory public (spillover effects) insurance?
Problem/Question (II)

• Most OECD countries have universal mandatory coverage for a uniform and broad set of services. But, if health insurance for uniform set of services is not affordable for certain groups of individuals it does not make sense to mandate to buy it (inefficient).

• If subsidies guarantee affordable access to health care services/coverage for vulnerable groups, what are the rationales for universal/uniform mandatory coverage?
# Definitions

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Mandatory</th>
<th>Voluntary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>BI (MBI)</td>
<td>SI (VBI)</td>
</tr>
<tr>
<td>Supplementary</td>
<td>MI (MSI)</td>
<td>VI (VSI)</td>
</tr>
</tbody>
</table>

- **BI** (Basic Health Insurance)
- **SI** (Supplementary Health Insurance)
- **MI** (Mandatory Health Insurance)
- **VI** (Voluntary Health Insurance)
Features of BI and SI

Key features of BI:

• **Mandatory (cross-)subsidies:**
  - Taxes, levies;
  - Premium rate restrictions e.g. community rating;
  - Premium subsidies; risk-equalization, etc.

• Universal **mandatory coverage** for a uniform benefits package with open enrollment;
  - National Health System or Insurance (NHS – e.g. UK, Italy etc. - or NHI – e.g. Australia, Ireland etc.-);
  - Competitive Social Health Insurance markets (e.g. Belgium, Germany, Israel, The Netherlands, Switzerland etc.).

• **Voluntary coverage** (Australia, Ireland, etc.);

Main features of (most) SI:

• **Voluntary coverage** ;

• **No mandatory cross-subsidies**;

• No standardized benefits;

• No open enrollment;

• Often linked to provision of BI.
Part II.

Effects of expanding SI & VBI on efficiency and affordability
Trends of an increasing role of SI/VBI

• The share of population with SI has increased in Germany (8-12%), Israel (46-70%), The Netherlands (89-92%) and Switzerland (62-73%);

• In terms of share of public spending SI-expenditures increased in Belgium (2-4%), Germany (1.5-3%), Israel (2.5-5%), The Netherlands (4-8%) and Switzerland (21-24%);

• Trends in other countries towards an increasing role of VBI: Australia (30-50%), Ireland (35-50%).
## Expanding SI

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Mandatory</th>
<th>Voluntary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services/Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td><strong>Mandatory Basic Health Insurance (MBI)</strong></td>
<td><strong>Voluntary Basic Health Insurance (VBI)</strong></td>
</tr>
<tr>
<td>Supplementary</td>
<td><strong>Mandatory Supplementary Health Insurance (MSI)</strong></td>
<td><strong>Voluntary Supplementary Health Insurance (VSI)</strong></td>
</tr>
</tbody>
</table>
a. Effects in SI markets

The expansion of SI may imply that premiums become risk-rated instead of community-rated (as in BI) because:

- SI-premiums are not regulated (in most countries);
- Competition which may force insurers to risk rate.

Assuming risk rating in SI, the transfer of benefits from BI to SI implies:

- Substantial increase in the premium range for:
  - Drugs (40-2200 euros per year);
  - Medical devices (12-723).

- Limited premium variation for:
  - Paramedic care (13-314);
  - Dental care (27-143).

If Society considers the premium variation too high for some benefits, a solution is to keep these benefits in BI (but *moral hazard*).
b. Spillover effects in BI markets

- In competitive BI/SI markets, e.g. Belgium, Germany, Israel, the Netherlands, Switzerland, the expansion of SI may create incentives and opportunities for SI to be used as a tool for risk-selection in BI markets.

- The four most important factors determining whether SI may be used as a tool for risk-selection in the five countries’ BI markets are:
  1) The incentives for risk-selection in BI markets;
  2) The (formal/informal) linkages between BI and SI;
  3) The strategies available to insurers to use SI for risk-selection;
  4) The role of SI in total health care financing.
## Countries’ summary table

<table>
<thead>
<tr>
<th></th>
<th>BE</th>
<th>GER</th>
<th>ISR</th>
<th>NL</th>
<th>CH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role of SI</strong></td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td><strong>Links</strong></td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td><strong>Evidence of different strategies</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Low</td>
<td>Limited</td>
</tr>
</tbody>
</table>
# Expanding VBI

<table>
<thead>
<tr>
<th>Services/Benefits</th>
<th>Coverage</th>
<th>Mandatory</th>
<th>Voluntary</th>
</tr>
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<tr>
<td>Basic</td>
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<td>Voluntary Basic Health Insurance (VBI)</td>
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</tr>
<tr>
<td>Supplementary</td>
<td>Mandatory Supplementary Health Insurance (MSI)</td>
<td>Voluntary Supplementary Health Insurance (VSI)</td>
<td></td>
</tr>
</tbody>
</table>
VBI: common elements

In some countries with universal non-competitive BI (i.e. NHI) such as Australia, Ireland, etc.:

• Universal basic *public* system:
  - Tax funded universal mandatory coverage;
  - ‘Free’ treatment as a public patient in a public hospital;
  - Subsidies for private medical services and pharmaceuticals.

• Voluntary basic health insurance (*VBI*) market:
  - Consumer choice of ‘level’ of coverage (i.e. flexibility for benefit package design) between competing ‘risk-bearing’ insurers;
  - Regulation & *subsidies*:
    - Restrictions on the ability of insurers to charge risk-related premiums (i.e. community rating);
    - Other incentives and subsidies in place for particular policy objectives.
Public-Private Mix in Australia

Mix of public-private financing of health services:


2. Private Health Insurance (National Health Act, 1953) (11% of THE).

3. Out-of-pocket payments. (22% of THE).
Private Health Insurance

- Voluntary supplementary and (duplicate) basic coverage;

- 50% of the population has VI;

- VI (VHE) share of total health expenditures 11% (33%);

- Fairly competitive market: 38 funds (32 not-for-profit), 60% market share for the 4 largest insurers;

- Heavily regulated (e.g. *mandatory subsidies*):
  - 30-40% *ad valorem* premium subsidy to individuals who purchase PHI;
  - Claims-equalisation scheme;
  - A tax penalty of 1% of income (for incomes exceeding $70,000 p.a. for singles and $140,000 p.a. for couples) if individuals do not hold PHI (the Medicare levy surcharge).
  - Lifetime community-rating per product per insurer (with open enrolment).
Subsidising VBI: WHY?

- The main country-specific policy argument for subsidising VBI in Australia is to decrease the financial pressure on the public scheme by:

**Problem** – Pressure on public budgets due to:
- Ageing population, new technologies;
- Increasing (competition with) other merit/public goods
- ...

**Solution** – Increase reliance on private financing, e.g. VBI.
Trends in the percentage of population covered by VBI

Introduction of Medicare

Introduction of tax subsidies

Lifetime community rating
Table 1: Funding of hospitals, current prices, by broad source of funds, 1995–96 to 2010–11 (per cent)

<table>
<thead>
<tr>
<th>Year</th>
<th>Government</th>
<th></th>
<th>Non-government</th>
<th></th>
<th></th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Australian</td>
<td>State/local</td>
<td>Private health</td>
<td>Other non-govt</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Govt</td>
<td>govt</td>
<td>funds</td>
<td>non-govt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995–96</td>
<td>37.4</td>
<td>35.9</td>
<td>73.3</td>
<td>17.8</td>
<td>9.0</td>
<td>26.7</td>
<td>100.0</td>
</tr>
<tr>
<td>1996–97</td>
<td>35.6</td>
<td>38.1</td>
<td>73.7</td>
<td>17.5</td>
<td>8.8</td>
<td>26.3</td>
<td>100.0</td>
</tr>
<tr>
<td>1997–98</td>
<td>38.2</td>
<td>38.2</td>
<td>76.4</td>
<td>14.7</td>
<td>8.9</td>
<td>23.6</td>
<td>100.0</td>
</tr>
<tr>
<td>1998–99</td>
<td>41.9</td>
<td>36.0</td>
<td>77.9</td>
<td>12.3</td>
<td>9.8</td>
<td>22.1</td>
<td>100.0</td>
</tr>
<tr>
<td>1999–00</td>
<td>43.8</td>
<td>35.8</td>
<td>79.6</td>
<td>10.5</td>
<td>9.9</td>
<td>20.4</td>
<td>100.0</td>
</tr>
<tr>
<td>2000–01</td>
<td>45.0</td>
<td>34.9</td>
<td>79.8</td>
<td>10.9</td>
<td>9.3</td>
<td>20.2</td>
<td>100.0</td>
</tr>
<tr>
<td>2001–02</td>
<td>44.0</td>
<td>35.0</td>
<td>79.0</td>
<td>12.4</td>
<td>8.6</td>
<td>21.0</td>
<td>100.0</td>
</tr>
<tr>
<td>2002–03</td>
<td>43.5</td>
<td>37.5</td>
<td>81.1</td>
<td>12.0</td>
<td>6.9</td>
<td>18.9</td>
<td>100.0</td>
</tr>
<tr>
<td>2003–04</td>
<td>42.6</td>
<td>38.0</td>
<td>80.6</td>
<td>12.1</td>
<td>7.2</td>
<td>19.4</td>
<td>100.0</td>
</tr>
<tr>
<td>2004–05</td>
<td>42.3</td>
<td>38.4</td>
<td>80.7</td>
<td>11.7</td>
<td>7.5</td>
<td>19.3</td>
<td>100.0</td>
</tr>
<tr>
<td>2010–1</td>
<td>40.6</td>
<td>40.5</td>
<td>81.1</td>
<td>11.1</td>
<td>7.8</td>
<td>18.9</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Why has this happened?

• Large public *subsídies* to increase VBI take up
  - Increase in public expenditures.

• Retention of *compulsory* public coverage
  - Those with VBI have weaker incentives to use it and are not using it.

**Result**: 50% of pop’n covered by VBI hospital cover but only 11% of hospital funding sourced from VBI
Subsidizing VBI: not without problems

- **Duplicate coverage & system efficiency**: *moral hazard* (Butler & Connelly, 2007); *transaction costs* (Paolucci et al., 2011); *cost shifting* (Scotton, 1989).

- Perverse incentives to maintain a stable equilibrium with acceptable waiting times in the public sector.

- **Selection**: flexibility for benefit package design is an effective tool for market segmentation and thereby *undermines community rating*: indirect premium differentiation via product differentiation.

- **Two-tier system**: VBI provides *faster access, more choice* and better (perceived) *quality* of care (including “private” care actually delivered in public hospitals) and as VBI-holders are likely to be high-income (Doiron, Jones & Savage, 2008) the *fairness* of the current system is objectionable.

- And regulatory uncertainty....
Main lessons

1. A continuous increase of *unsubsidised*-SI results in:
   - Reduced moral hazard (*efficiency*), public and total expenditures (*fiscal discipline & cost containment*).
   - An increasing conflict with society’s goal of *affordability*;
   - A *welfare loss* to society, e.g. if individuals’ (altruistic) preferences cannot be met;
   - In countries with a competitive BI market, a potential spillover effect of SI on the *efficiency* and *affordability* of BI occurs if there are opportunities to use SI as a selection device in BI markets.

2. Relying on duplicate *subsidised*-VBI results in several problems which:
   - Create instability and *inefficiencies* in the VBI-market;
   - Do not appear to decrease the financial pressure on the public funded scheme;
   - Jeopardise potentially the *fairness* in the access to services for everyone.
Part III.

Options for Design
Design Question (II)

• Most OECD countries have universal mandatory coverage for a uniform and broad set of services.

• If subsidies guarantee affordable access to health care services/coverage for vulnerable groups, what are the (economic...) rationales for universal/uniform mandatory coverage?

➢ Proposition: the arguments that motivate a system of mandatory cross-subsidies differ substantially from those that motivate mandatory coverage.
Mandatory cross-subsidies or mandatory coverage: why?

• Mandatory cross-subsidies:
  - Externalities (CE, initial health status, expected cost of service, consumer responsibility for incidence);
  - The financial risk of becoming a bad risk;
  - Subsidies-induced moral hazard.

• Mandatory coverage:
  - Free riding;
  - Lack of foresight;
  - Transaction costs.
Universality and uniformity of insurance packages does not account for heterogeneity across individuals (especially across income groups) and across treatments:

- It does not reflect differences in preferences;

- By forcing a level of coverage above the one some groups would have chosen autonomously, it induces moral hazard above the social optimal.
Universal mandatory coverage for a uniform package of services is not per se a necessary and/or proportionate measure to achieve the goal of affordable access to (the coverage of) health care services.

A system of mandatory subsidies may be a sufficient measure to achieve affordability.
Fine-tuning Mandatory Coverage

- Take into account differences in *income levels* and *type of services*, by allowing consumers to make a choice among different sets of insurance entitlements based eg. on price and quality;

- This consumer choice does not affect the (desired) extent of cross subsidisation across risks *as long as* the premium differences across insurance products reflect the differences in predicted expenses among these products.
Two possible strategies

- **Two-option scheme:**
  - High-option package for low income people - broad and comprehensive coverage;
  - Low-option package for high income people – less comprehensive than the high-option scheme and benefit from a (risk rated) premium rebate.

- **Single-option scheme with voluntary income-related deductibles***:
  - The higher the income, the higher the deductible.
Part IV.

Concluding remarks
• Although *universal* mandatory coverage for a *uniform* set of services is not per se a *necessary* and/or *proportionate* tool to achieve affordability, it is present in most OECD countries.

• SI can play a useful role in containing collective financing.

**But** policymakers when expanding SI should consciously decide which benefits to transfer by considering:

- To what extent (in terms of “allowable” premium variation) cross-subsidisation is desired (*affordability* and *efficiency* of SI);
- The potential spillover effects of SI on the *efficiency* and *affordability* of BI.

• A less drastic tool to contain collective financing than SI might be to increasing the fine-tuning of mandatory coverage of basic services with some form of co-insurance (eg. *income*-related deductibles).
Part V.

Appendix
Incentives for risk-selection in BI market

In case RA is imperfect, PRR and OE provide incentives for risk-selection in BI markets.

Risk-selection has adverse effects on solidarity and efficiency.
**Links between BI & SI**

**Proposition:** SI can only be used as a tool for risk selection if it is somehow linked to BI

**Three main possible linkages:**

- **Regulatory (formal) links:**
  - Limitations on the provision of SI only to BI providers;
  - Joint product (same premium for both).

- **Insurer established links:**
  - BI and SI offered by same insurer;
  - Different legal entities operating in same holding company, using same brand name, jointly marketing SI and BI;
  - Tie-in sale provisions in supplementary insurance policies.

- **Consumer preferences for joint purchase (one-stop shopping):**
  - Lower search and transaction costs;
  - Integrated/coordinated benefits;
  - Habit and convenience.
Risk selection via SI

Strategies to select individuals with favorable risk profiles relative to the imperfect RA:

1. Selective underwriting (e.g. based on health history questionnaires to applicants)

2. Offering selected benefit packages

3. Selective advertising

4. Premium differentiation (charging SI premiums below actuarially fair levels for favorable risks in BI)
The role of SI

- Percentage of SI expenditures as a share of BI expenditures;
- Percentage of BI-insured covered.
## Countries’ table 1: role and importance of SHI

<table>
<thead>
<tr>
<th>Type(s) of SHI</th>
<th>BE</th>
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<th>ISR</th>
<th>NL</th>
<th>CH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• MSHI</td>
<td>• MSHI</td>
<td>VSHI</td>
<td>VSHI</td>
<td>VSHI</td>
</tr>
<tr>
<td></td>
<td>• VSHI</td>
<td>• VSHI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exp SHI/Exp BHI %</td>
<td>-</td>
<td>1996: 2.1%</td>
<td>-</td>
<td>1996: 5.4%</td>
<td>1996: 37%</td>
</tr>
<tr>
<td>2003: 2%</td>
<td>-</td>
<td>1999: 3.3%</td>
<td>1999: 3.3%</td>
<td>1999: 3.3%</td>
<td>1996: 37%</td>
</tr>
<tr>
<td>(VSHI)</td>
<td>-</td>
<td>2000: 4.1%</td>
<td>2000: 6.3%</td>
<td>1999: 3.3%</td>
<td>1996: 37%</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>2002: 5.3%</td>
<td>2000: 6.3%</td>
<td>1999: 3.3%</td>
<td>1996: 37%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2003: 2.2%</td>
<td>2003: 6.5%</td>
<td>1999: 3.3%</td>
<td>1996: 37%</td>
</tr>
<tr>
<td>Share of BHI-insured with SHI</td>
<td>-</td>
<td>1933: 8%</td>
<td>-</td>
<td>1997: 94.5%</td>
<td>1997: 62%</td>
</tr>
<tr>
<td>2003: 95% (MSHI)</td>
<td>1999: 45.8%</td>
<td>2000: 6.3%</td>
<td>1997: 94.5%</td>
<td>-</td>
<td>1997: 62%</td>
</tr>
<tr>
<td></td>
<td>2003: 11% (VSHI)</td>
<td>2003: 6.5%</td>
<td>1997: 94.5%</td>
<td>-</td>
<td>1997: 62%</td>
</tr>
<tr>
<td>Relevance of SHI in health care financing</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
</tr>
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</table>
## Countries’ table 2: incentives for risk-selection in BHI

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Quality of RA?</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Level of competition?</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Moderate (2005)</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(2006)</td>
<td></td>
</tr>
<tr>
<td>Financial risk?</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incentives for risk-selection</td>
<td>Low</td>
<td>Very High</td>
<td>High</td>
<td>Moderate but increasing</td>
<td>Very high</td>
</tr>
</tbody>
</table>
## Countries’ table 3: 
**links between BHI and SHI**

<table>
<thead>
<tr>
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<th>NL</th>
<th>CH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>MSHI</td>
<td>VSHI</td>
<td></td>
</tr>
<tr>
<td>BHI &amp; SHI providers legally linked?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>BHI and SHI offered by same insurer?</td>
<td>Yes</td>
<td>Yes</td>
<td>MHI as agents</td>
<td>Yes</td>
<td>Same holding</td>
</tr>
<tr>
<td>BHI and SHI sold as joint products?</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Links</strong></td>
<td>Strong</td>
<td>Strong</td>
<td>Weak</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
## Outline of VBI markets

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Ireland</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>% population covered by VHI</td>
<td>47%</td>
<td>52%</td>
<td>15%</td>
</tr>
<tr>
<td>People covered by VHI</td>
<td>10.9 million</td>
<td>2.2 million</td>
<td>7.8 million</td>
</tr>
<tr>
<td>VHI expenses as % of total national hc expenses</td>
<td>11%</td>
<td>12%</td>
<td>55%</td>
</tr>
<tr>
<td>Do consumers have free choice of insurer to enroll within?</td>
<td>Yes, 93% are in open schemes</td>
<td>Yes, 95% are in open schemes</td>
<td>Yes, 67% enrollees in open schemes</td>
</tr>
<tr>
<td>Financial responsibility of individual insurance entities</td>
<td><strong>Very low.</strong> Costs &gt; AU$50,000 are shared.</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
# Market structure for VBI

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Ireland</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of open undertakings</strong></td>
<td>25</td>
<td>3</td>
<td>41</td>
</tr>
<tr>
<td><strong>Market share largest insurer</strong></td>
<td>30%</td>
<td>66%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Market share largest 4 insurers</strong></td>
<td>70%</td>
<td>100%</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Premium subsidies and/or tax-credits for VHI purchase?</strong></td>
<td>Yes (Rebate and Medicare Levy Surcharge)</td>
<td>Yes</td>
<td>Yes (but no subsidies for people earning below tax-threshold)</td>
</tr>
<tr>
<td><strong>Premium restrictions?</strong></td>
<td>Community-rated premiums</td>
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<td>Community-rated premiums</td>
</tr>
<tr>
<td><strong>Flexibility for benefit package design</strong></td>
<td>Very high</td>
<td>Very high</td>
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</tr>
</tbody>
</table>
‘Risk Equalisation’

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>‘RE’: year of implementation</td>
<td>2007</td>
<td>No transfers (most recent regulations 2003)</td>
<td>planned for 2010, but legislation still not passed</td>
</tr>
</tbody>
</table>
| Policy rationale for ‘RE’  | §To support CRP (risk-solidarity)  
§To increase industry stability i.e. prevent selection | §To support CRP (risk-solidarity)  
§To increase industry stability | §To support CRP (risk-solidarity)  
§To facilitate the introduction of Social Health Insurance |
| Risk factors              | § age  
§ health status proxy, i.e. a cap on the maximum insurer’s costs per person over a rolling 12-month period. | § age, gender;  
§ reserve power for health status proxy, i.e. private bed nights. | § age;  
§ numbers with 25 defined chronic diseases, with HIV and with multiple chronic diseases;  
§ maternity events. |
## Risk selection: incentives & tools

<table>
<thead>
<tr>
<th>Tools for risk selection by insurers</th>
<th>Australia</th>
<th>Ireland</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Selective advertising;</td>
<td>High</td>
<td>High</td>
<td>Very High</td>
</tr>
<tr>
<td>- Premium differentiation via</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product differentiation;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Voluntary deductibles.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Selective marketing;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Restricted product enhancement;</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Voluntary deductibles.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Selective marketing;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Benefits above the prescribed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>minimum benefits.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
a. Duplicate coverage

1. All contribute to public pool and have access to public provision;

2. However, insured are not able to shift the *avoided cost* of their public use over to private use;

3. 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*”; 

4. This distorts relative price of using private v. public facilities and increases cost of private cover, as it duplicates public cover.

Efficiency?

This duplication of coverage and subsidies for the same services raises concerns about moral hazard (Butler & Connelly, 2007).

Duplicate coverage and subsidies involve higher transaction costs compared to a single universal health insurance scheme (e.g. Medicare) (Paolucci et al., 2010).

Dual coverage $\rightarrow$ cost shifting (Scotton, 1989).
b. Waiting times?

Stable and acceptable waiting times in the public sector?

Perverse incentives for the government:

- Not to reduce waiting times in the public sector because the lower the waiting times the lower the demand for PHI;
- To increase waiting times in the public sector because the higher the waiting times the higher the demand for PHI and potentially the lower the pressure on public finances.

Perverse incentives for physicians not to reduce the waiting times in the public sector because it implies a reduction of demand for their own services in the private sector.
### Market structure for VHI

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<tr>
<td></td>
<td>Australia</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>Level of incentives for adverse &amp; risk selection</strong></td>
<td>High</td>
</tr>
</tbody>
</table>
| **Tools for risk selection by insurers**            | - Selective advertising;  
|                                                    | - Premium differentiation via Product differentiation;  
|                                                    | - Voluntary deductibles. |
c. Adverse Selection

Medicare (1984) → % of PHI-enrolees declined from 50% (1983) to 30% (1997);

Regulation-induced adverse selection?

1997-2000, subsidies (PHIIS, 30% rebate, LHC etc.) → 43% PHI-enrolees;

Further changes (2005-2008), e.g. increased rebate for 65+; MLS changes;

Adverse selection: a constant threat to the stability of the PHI market.
Flexibility for benefit package design is an effective tool for market segmentation and thereby **undermines community rating**: indirect premium differentiation via product differentiation.

**Adverse and risk selection are significant problems!**
d. Two-tier system?

Duplicate PHI provides faster access, more choice and better (perceived) quality of care (including “private” care actually delivered in public hospitals);

PHI-holders are likely to be high-income (Doiron, Jones & Savage, 2008), then the fairness of the two-tier system is objectionable:

- The beneficiaries of the subsidies are more likely to be high-income groups;

- The better-off PHI-holders have quicker access to “private” care delivered in public hospitals.