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Private health insurance in Australia: policy reform approaches towards greater competition and efficiency to improve health system performance

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EXECUTIVE SUMMARY

All countries are facing increasing pressure on their health care budgets stemming from an ageing population, changing illness and disease conditions, and cost enhancing technologies. Moreover, the rise in chronic diseases, which is now the leading cause of ill health and deaths in Australia, results in a significant economic burden and poses particular challenges. Many countries are re-orientating their health systems towards prevention and chronic disease management and introducing incentive structures to support dynamic efficiency. Private health insurance (PHI) is an important component of the Australian health system, as it reduces public contribution to hospital expenditure and provides Australians with choice. However, PHI in Australia is heavily regulated. The failure to redefine the role of PHI with the introduction of Medicare has resulted in a legacy of regulatory impediments which are anti-competitive and counter to system efficiency.

A key regulatory feature of PHI is community rating, where health funds are required to charge all consumers the same premium regardless of health status. The intention is to address affordability, through cross-subsidisation from low risk to high risk individuals. When Medicare was introduced in 1984, PHI coverage initially fell to 50% but continued to decline steadily to 30% by mid/late 1990s. This decline is recognised as an *adverse selection* spiral, where low health risk enrolees, who face premiums greater than their expected health costs, drop out and rely on the 'free' public system. This increases the average risk profile of the insured pool resulting in higher premiums and precipitating a further drop-out by lower risk cohorts. This decline was halted with a series of reform measures introduced over 1997-2000 which included: 30-40% rebates; tax penalties for high-income earners who do not take out PHI, and partial risk-rating for those over 30 who fail to take out PHI cover. Since 2000, PHI coverage has been around 45-47% of the population.

A major regulatory limitation of PHI is the risk equalisation fund used to underpin community rating. To maintain solvency for health funds with above-average risk profile, a mandatory risk equalisation mechanism transfers funds through a reinsurance pool from insurers with lower than average claim costs to those with higher than average claim costs. However, Australia operates a retrospective claims equalisation scheme which is based on actual costs incurred by health funds. Claims equalisation reduces the incentives to control costs for high cost claimants since these costs are shared through the equalisation fund. Moreover, it dampens the incentives to undertake investment in preventative care and in managing chronic disease conditions since the savings through lower claims made by one insurer are shared by all, including inefficient insurers. The optimum regulatory design to cross-subsidise from low to high risk cohorts and maximise incentives to minimise costs and risk selection behaviour is an

accurate ex ante risk equalisation scheme based on health risk, and therefore expected costs. A well-established research program has been underway internationally since the early 1990s – where state-of-the-art developments have incorporated sophisticated techniques based on prior utilisation data derived from patient encounter with the health system. Consistent with calls made by a number of researchers, this study advocates that a research program be established, similar to other countries, for the purpose of developing and transitioning to an ex ante risk equalisation system to enhance efficiency of PHI.

Another major impediment is that health funds are prevented from contracting medical services for which Medicare benefits are payable. GPs play a central role within primary care and the sector is considered key to re-orientating away from treatment in a hospital setting to providing patient centred care with a focus on prevention and chronic disease management. This is a significant limitation as it creates perverse incentives to default to more expensive curative care rather than engage in innovative patient-centred care models in accord with overseas developments centred on disease prevention and management in a primary care setting. The government needs to reassess the limitations of the contracting legislation to allow medical treatment in a primary care setting.

A related regulatory limitation is the requirement known as *Second Tier Default Benefit* – where private hospitals that do not have contracts are eligible for default benefits equivalent to 85 percent of the average benefits paid by health funds for comparable episodes of care. The default benefits weaken the capacity for health funds to engage in selective contracting, negotiate lower prices and apply performance measures. Instead there are perverse incentives for inefficient providers to rely on default benefits, charge out of pockets payments, and avoid the quality conditions attached to contracts. The removal of second tier arrangements would promote competition and efficiency.

Another restriction is that health funds must seek ministerial approval to adjust premium prices through an elaborate review process. This creates incentives for 'gaming' an upward movement in premiums as health funds maximise their price settings to the perceived likelihood of acceptance. Centralised price setting blunts incentives to minimise costs since any declared administrative savings are factored into the ministerial decision for premium approval. This study supports pricing deregulation that is overseen by an independent pricing authority, as it would remove political interference, increase transparency, and place greater competitive pressures on premium prices.

Whilst the above deregulatory reforms increase competition and efficiency incentives within the *existing* voluntary PHI system, they do not address the structural stability of voluntary PHI.

Over the past decade PHI premiums have risen by 6% per annum, more than twice the CPI rate; with the amount used to cross subsidise high risk rising at 7.5% per annum. For younger policy holders up to 70% of the basic premium is used to cross subsidise high risk individuals. PHI coverage has declined over the past two years, the first time since 2005; with the decline confined to 20-29 year olds. This has raised the spectre of a 'tipping point' and an adverse selection spiral as low risk cohorts opt for the 'free public' system rather than purchase actuarially unfair premiums. Moreover, the failure to integrate voluntary PHI into a coherent framework with Medicare has resulted in system-wide fragmentation and duplication between the public and private systems.

Managed competition is advocated as a longer-term reform framework that integrates PHI within the universal system and incorporates the requisite incentive structures to pursue dynamic efficiency. Here, the role of PHI is expanded and individuals are able to opt out of Medicare and transfer their universal entitlements to a competing health fund of their choice that receives ex ante risk-adjusted payments based on the expected health costs of the enrolee. Health funds contract with competing providers for health services that best meets the needs of their enrolee. In the Australian context, managed competition can vary in its extensiveness – ranging from a voluntary opt-out model where Medicare remains unchanged and reforms are confined to enabling health funds to contract for universal entitlements, to more comprehensive reforms that include the public system where funding sources are consolidated and a default public health plan is established.

Importantly, introducing reforms to improve efficiency of voluntary PHI also establishes a pathway for pursuing managed competition. Transitioning to an ex ante risk equalisation scheme not only improves the incentive structure of current reinsurance arrangements, but also provides the experience and technical skills for developing risk adjusted payments under an expanded model. By incrementally expanding the role of PHI, to eventually allow health funds to manage publicly-funded universal entitlements, increases the interaction between PHI and the publicly-funded universal system. This can act as a catalyst and promote reforms to the public system and facilitate progression towards unifying public funding of primary health care and enhance public fundholding capabilities. Consumers under these arrangements can choose to take their universal entitlements to a health fund of their choice or remain with the default regionally-based public insurer.

Australia has yet to adopt a coherent strategic approach to health policy reform. Instead, policy adjustments have vacillated between those supporting the universal system and those supporting the private sector, with limited attention given to integrating the two systems, which has led to ongoing structural tensions within the broader health system. The adoption of

managed competition as a long run strategic goal is consistent with the implementation of short run policies which improve efficiency. Adopting a strategic framework to guide incremental policy adjustment, where each successive step is carefully monitored and evaluated provides the greatest scope for effecting structural changes necessary to pursuit dynamic efficiency and enhance system-wide performance and thus best meet the challenge confronting the Australian health system over the coming decades.

CONTENTS

1. INTRODUCTION

The Australian health care system is a complex blend of public and private sectors in both the financing and provision of health care services reflecting both historical developments and the structural characteristics unique to its federal system of government (Biggs, 2017; Donato and Scotton, 1999). Broadly, the health system comprises the universal publicly-funded health system of *Medicare*, as well as a voluntary private health insurance (PHI) system. Under Medicare, all Australians are entitled to Commonwealth subsidised medical services provided by private medical practitioners, free access to public hospitals through jointly-funded Commonwealth-state arrangements, as well as Commonwealth subsidised prescribed medicines purchased through private pharmacies. In addition, the Commonwealth government through a series of subsidies and tax penalties actively supports voluntary PHI such that around 45% of the population hold some form of PHI in addition to their universal entitlements.

Essentially, there are two main types of PHI coverage: hospital treatment cover and general treatment ('extras') cover. For hospital treatment, PHI offers coverage against accommodation costs of private patients in both public and private hospitals, cost of prostheses, and gap insurance for medical services representing the differences between the 75% of scheduled fee paid to doctors by Medicare and the actual fees charged. General cover includes a range of non-medical ancillary services not covered by Medicare. The main reasons individuals choose PHI hospital cover despite automatic coverage under Medicare include: timely access to elective surgery and bypassing public waiting lists; perceived quality differences between public and private hospitals; choice of doctor, and additional 'frill's or amenities such as single room, cable-TV and meals up-grade. In addition, there is a wide range of ancillary benefits not included under Medicare arrangements such as dentistry, optical and physiotherapy which consumers can insure independently of hospital cover. In this regard, PHI in Australia plays both a duplicate and supplementary role for hospital treatment as well as complementary role for non-medical services with respect to the universal system (Industry Commission, 1997). By increasing PHI coverage, the government aims to relieve the cost pressures on the public system by shifting funding from public budget to private expenditure through health funds and their members as well as to provide greater choice, with the latter representing a historical feature of the Australian health care landscape (NCoA, 2014).

In Australia and in other developed countries an ageing population and more expensive medical technologies that have increased life expectancy and quality of life have put increasing pressure on health care budgets. Moreover the rise in chronic diseases which is

now the leading cause of illness and accounts for 90% of all deaths in Australia in 2011 has increased the economic burden and poses particular challenges to the Australian health system (AIHW, 2016). The federal government's 2015 intergenerational report projects per capita health expenditure to double over the next 40 years and aged care funding is expected to quadruple over the same period (Treasury, 2015). In order to meet these challenges it is crucial that health systems are be able to deliver coordinated healthcare services that are responsive to changing health conditions and consumer expectations in the most cost-effective way. Essentially health systems need to have appropriate design structures that support dynamic efficiency. To this end, many countries are re-orientating their health systems toward to patient centred care which focuses on prevention and management of chronic disease conditions in a primary care setting.

In this context, however, there are considerable concerns regarding the regulatory structures governing PHI in Australia which are anti-competitive and run counter to system efficiency. The need for government funding and support to maintain the stability of the PHI sector has been a source of ongoing political debate and tension over the role of PHI in the context of a universal system and the effectiveness of existing regulations (Shamashullah, 2011; Kay, 2007). These tensions have recently come to the surface in the wake of consumer concerns over rising premiums, affordability and 'value for money' of PHI, which prompted the federal government in October 2017 to announce a series of reform measures to enhance the structural stability of the sector.[1] The efficacy of current reforms is uncertain and deep-seated structural concerns for PHI remain.

The aim of this paper is to identify the main regulatory structures governing PHI which currently impede competition and efficiency incentives and to outline the reform options which can enhance system performance to the private sector. The paper discusses not only reform options aimed at improving efficiency under the *existing* structural arrangements but also canvass longer term structural reforms that reconcile the role of voluntary PHI with the universal system of Medicare to address structural stability concerns and support system-wide efficiency. The paper advocates the need to establish a research agenda to underpin the basic foundations of reforms and to develop a strategic framework for guiding incremental reforms along a path that is consistent with the longer term structural changes aimed at enhancing overall health system performance.

The rest of the paper is structured as follows. Section two outlines current regulations governing and supporting PHI, reviews industry statistics, and discusses concerns over

[1] See http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reform.

ongoing premium increases on the value and affordability to consumers and on the stability of the sector. Section three identifies the major regulatory barriers impeding competition and efficiency in PHI and outlines the reform options to address these concerns within existing structural features of voluntary PHI. Longer term structural reforms are discussed in section 4 where options to expand the role of PHI and to integrate the sector with the universal system under a managed competition approach are outlined. Section 5 presents a typology of reforms not as mutually exclusive options but as series of policy adjustments along a continuum and outlines the need to develop a strategic framework for guiding incremental reforms that is consistent with longer term structural changes. Section 6 concludes by advocating the need to review PHI in context of the entire health system and to establish a research agenda to inform ongoing policy reform and pursuing dynamic efficiency.

2. REGULATION OF PHI IN AUSTRALIA AND INDUSTRY STATISTICS

2.1 Regulation governing PHI

PHI in Australia is heavily regulated (Productivity Commission, 2015; NCoA, 2014). Prior to the introduction of Medicare in 1984, the Commonwealth government co-opted the PHI to effectuate its social welfare objectives which required substantial regulatory controls to mitigate the socially undesirable effects of competitive outcomes and market failures. With the introduction of Medicare, the need for anti-competitive regulations is greatly reduced as the government's welfare objectives are pursued through the universal system (Scotton and MacDonald, 1993). However, much of the regulatory features governing PHI are a legacy of when voluntary PHI was the basis of Australia's national health scheme. Consequently current regulatory arrangements impede competition and innovation and limits the capacity for the sector to achieve dynamic efficiency (Productivity Commission, 2017, 2015; Paolucci and Garcia-Goni, 2015; NCoA, 2014; Donato and Scotton, 1999).

Regulation of PHI is governed primarily by the *Private Health Insurance Act 2007* and the *Private Health Insurance (Prudential Supervision) Act 2015* administered respectively by the Department of Health (DoH) and the Australian Prudential Regulation Authority (APRA). Broadly, most of the regulation of PHI is aimed at:

- achieving social policy objectives of equity, enabling individuals the ability to afford to purchase PHI; and
- protecting the interests of consumers by maintaining solvency and prudential oversight of health funds, and address market failures such adverse selection or anti-competitive behaviour (Productivity Commission, 2017).

A key feature of the regulatory framework is the principle of community rating which is the requirement that a health fund charges all consumers the same premium and cannot discriminate based on health risk (i.e. expected health costs); and an insurer cannot refuse to insure an individual (i.e. open enrolment). The intention of community rating and open enrolment is designed to address affordability and equity considerations through implicit cross-subsidising from low risk individuals to high risk individuals.

In order to underpin community rating, a mandatory risk equalisation fund allows PHI funds to share risk by transferring funds through a reinsurance pool from insurers with lower than average claim costs to those with higher than average claim costs. The aim is to mitigate the incentives for insurers to risk select low expected cost enrolees and to maintain the solvency of those funds with higher than average risk profile and therefore average cost claims of their enrolees.

There are also a number of important regulatory requirements, which include:

- Health funds are not permitted to insure for services for which there are Medicare entitlements (e.g. medical services in a primary care setting) except gap insurance for medical services in private hospitals, nor are health funds permitted to cover prescription drugs listed on the Pharmaceutical Benefits Scheme;

- Health insurers seeking to increase premiums are required to seek regulatory approval by making an application to the Minister for Health who has the right to reject premium increases. The process for each premium round commences in October the previous year with approval and premium changes taking effect in the following April;

- From July 2015 the responsibility for the prudential supervision was transferred from the Private Health Insurance Advisory Council (PHIAC), a dedicated administrative body reporting directly to the Minister for Health, to the Australian Prudential Regulation Authority (APRA), the prudential regulator of the Australian financial services industry. Through APRA the general principles of solvency, capital adequacy, and governance are applied uniformly to the health insurance sector and with all other financial services;

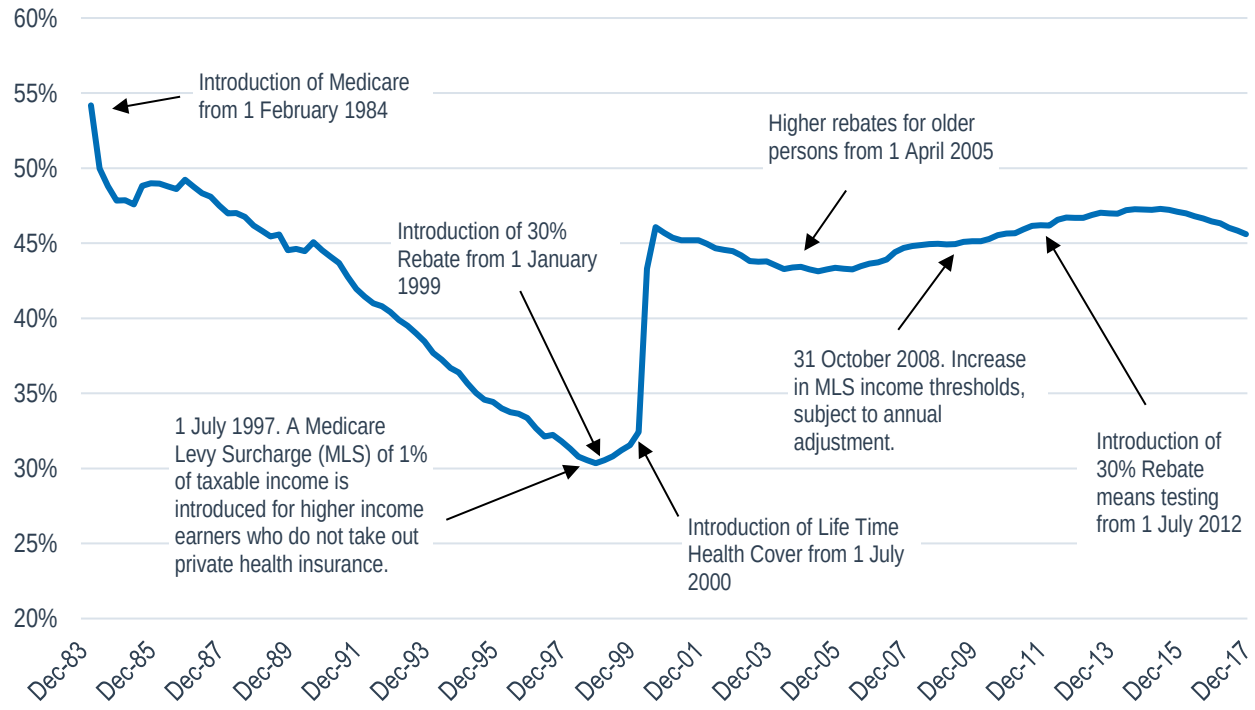
- Second tier default benefit, introduced in 1998, is a regulatory requirement whereby eligible hospitals that do not negotiate an agreement with health funds are eligible to default payments equivalent to 85% of the average contracted benefits paid by the health fund to comparable facilities for the same episode of care in that state/territory (PHA, 2017a);

- The benefit paid by health funds for implanted medical devices (i.e. prostheses) is fixed by regulation determined by a prescribed Prostheses List. However, this is now scheduled for change and reduced benefits will be phased in over the next four years from 2018.

2.2. PHI population coverage – recent trends and regulatory incentives

Prior to the introduction of its universal system, Australia experienced relatively high levels of PHI coverage with around 75-80% of the population covered by the subsidised voluntary scheme. This fell quickly to around 50% of the population with the introduction of Medicare in 1984. Figure 1 below shows PHI coverage (for hospital treatment) continued to fall in the years following the introduction of the universal scheme, from 50% in 1984 to 30% by the mid/late 1990s, during the Labor government's period in office. The dynamics of this decline from 1984 to 1997 is generally recognised as an *adverse selection* spiral, where low health risk enrolees who face premiums greater than their expected health costs under the community rating principle drop out and rely on the publicly funded universal system. This in turn increases the average risk profile of the remaining insured population causing an increase in overall premiums and thereby precipitating a further drop-out by lower risk insured population triggering further premium rises, and the decline in enrolees repeats itself (Barrett and Conlon, 2003; Connelly and Brown, 2010).

Figure 1. Hospital treatment coverage (insured persons as percentage of the population)



Source: APRA (2018a)

To address the problem of adverse selection and to bolster PHI coverage, the federal Liberal government introduced a series of regulatory measures over the 1997-2000 period. These were:

- In July 1997 a 30% rebate on premiums[2] for low income earners and a 1% income tax Medicare Levy Surcharge (MLS) on high income earners who do not take out PHI;
- In January 1999 a non-means test rebate subsidy of 30% was extended to all who take out PHI;
- In July 2000 a limited form of risk-rating was permitted. Known as Lifetime Health Cover (LHC) the amendment allowed health funds to charge a 2 per cent increment for each year above the base age of 30 to a maximum of 65 years for those who enrolled after July 15th 2000.

Together these incentives not only stabilised PHI membership but dramatically boosted coverage from 30.1% in 1999 to 45.7% of the population by September 2000; and coverage has since stabilised to around 44-46% of the population (APRA, 2018a). Although it is difficult to disentangle the impact of each of these policies, the general consensus is that the increase in coverage can be attributed mainly to LHC (Buchmueller, 2010; Ellis and Savage, 2008). According to Buchmueller (2010) the new enrolees who took up coverage in response to LHC were younger individuals than the average age of the existing pool, which caused the average age to decrease by two years. Since the introduction of PHI incentive schemes, a number of important changes have been introduced which primarily centre on limiting the extent of the rebate provisions and how it is calculated. Introduced initially by the Labor government and extended by the current Liberal government, the changes were ostensibly aimed at limiting the fiscal exposure and curbing the growth of the rebates which had risen to nearly $6 billion by 2011-12 and represented the fastest growing component of the federal government's health care budget. The changes introduced included:

- In July 2012 means testing to premium rebates were introduced - where rebate percentages were scaled back depending on income thresholds and age, from a maximum of 40% for those over 70 and on low income, down to 0% for those on high incomes at any age;
- In July 2012, the MLS on high income earners increased from 1% to 1.5%;

[2] In April 2005, the rebate was increased to 35% and 40% for those over 65 and 70 year olds respectively.

- In April 2014 a Rebate Adjustment Factor (RAF) was introduced, where rebates on premium increases were limited to general inflation and not to the more rapid increase in actual premiums – meaning that rebates, as a percentage of total premiums, would decline by a RAF each year;

- In 2016, income thresholds for PHI rebates and the MLS were frozen at the existing nominal levels and would not be indexed with inflation until June 2021.

A summary of current income thresholds and rebates to PHI (June 2018) in comparison to previous arrangements are outlined below in table 1.

Table 1: PHI rebates and means tested income thresholds – 2012-13 to 2017-18

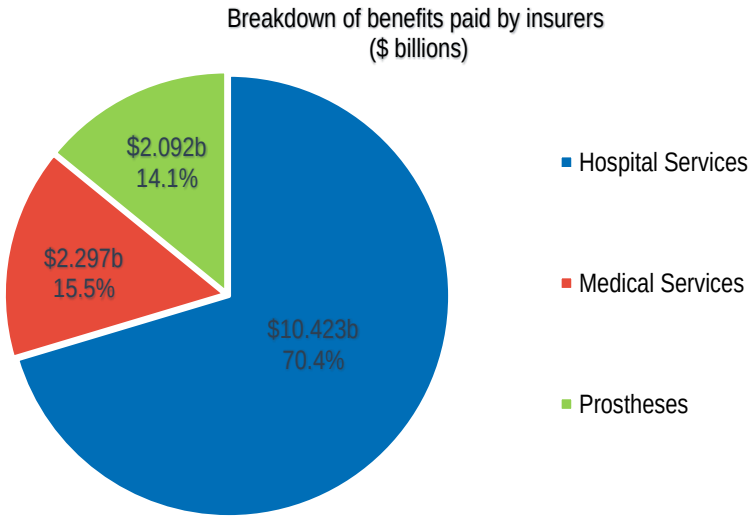
2012-13 REBATE ENTITLEMENTS – NO MEANS TEST				
< 65 years	30%			
65-69 years	35%			
≥ 70 years	40%			
2017-2018 – REBATE ENTITLEMENTS BY INCOME THRESHOLDS#				
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3***
Single/ family	≤less $90k/ ≤$180k	>$90k-$105k/ >180k-210k	>$105k-$140k/ >$210k-$290k	>$140k/ >$280k
< 65 years	25.93%	17.29%	8.64%	0%
65-69 years	30.26%	21.61%	12.97%	0%
≥ 70 years	34.58%	25.93%	17.29%	0%

 # The income thresholds are to remain fixed at current levels until 2021.
**The Medicare Levy Surcharge of 1.5% applies to those in the tier 3 income bracket who do not take out PHI.*

2.3. PHI industry statistics – expenditure, market share and products

Recent fiscal year data shows that PHI expenditure on health care for 2015-2016 was $14.9 billion representing around 8.8% of total health care expenditure. This percentage has increased from 7.6% of total health expenditure a decade earlier in 2005-2006 (AIHW, 2017). With regards to hospital treatment benefits, most recent data for the full 2017 calendar year shows the breakdown between the three major components of hospital services, medical services and prostheses with relative shares of 70%, 15.6% and 14.1% respectively (figure 2 below).

Figure 2: Hospital Treatment benefits by service type – 2017 calendar year

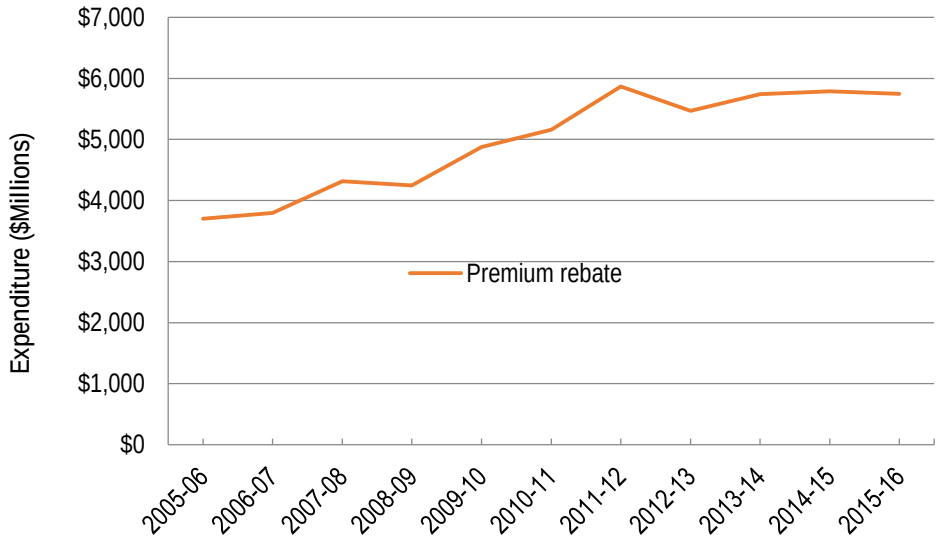


Source: APRA (2018a)

Over the past decade, the federal government rebate has increased steadily from $3.7 billion in 2005-06 to $5.8 billion in 2015-16 (constant 2015-16 prices) - see figure 3 below. This figure is projected to increase to $6.7 billion by 2019-2020 in the government's budget forward estimates.[3] The rebate in 2005-06 constituted around 8.1% of total government expenditure on health, which had increased to 8.9% by 2011-12, prior to the introduction of means testing. Since the means testing, the trajectory in government rebates has stabilised and currently sits at around 8.2% of federal government spending (AHW, 2017).

[3] See 2017-18 budget papers at: https://www.budget.gov.au/2017-18/content/bp1/download/bp1.pdf

Figure 3: Health insurance premium rebate – 2005-06 to 2015-16 (constant prices).



Source: AIHW (2017)

Currently there are 37 health funds registered under the *Private Health Insurance Act 2007*. However the industry is quite concentrated in that the two largest health funds, Medibank Private Limited (MPL) and BUPA, have 54% market share, whilst the top five health funds account for 80% (APRA, 2018a) – see table 2 below. There are also more than 20 funds who each comprise less than 1% market share and account for 7% of total policies in Australia. Most of these smaller funds act as an alliance for the purpose of hospital contracting, and negotiate collectively with hospital networks in order to lower transaction costs and to strengthen their bargaining power with major hospitals.

Table 2: Private health funds by market share - 2017

HEALTH FUND	MARKET SHARE
Medibank Private	27%
BUPA	27%
HCF	11%
NIB	7%
HBF	7%
Others	21%

Source: APRA 2018a

An interesting dynamic that has occurred over the past decade has been the shift in the relative market share from not-for-profit to for-profit status; which has increased from 15.9% in 2005 to nearly 70% of market share today (table 3). This change is mainly attributable to the conversion of NIB to for-profit status in 2007, the purchase of MBF by BUPA in 2008, and the privatisation of government-owned Medibank Private in 2009 (PHIAC, 2015). The not-for-profit health funds face a different tax environment including GST exemption but they have much stronger regulations over their investment activities. In contrast for-profit health funds are subject to company tax but have greater control over the use of their capital for investment purposes (PHIAC, 2015).

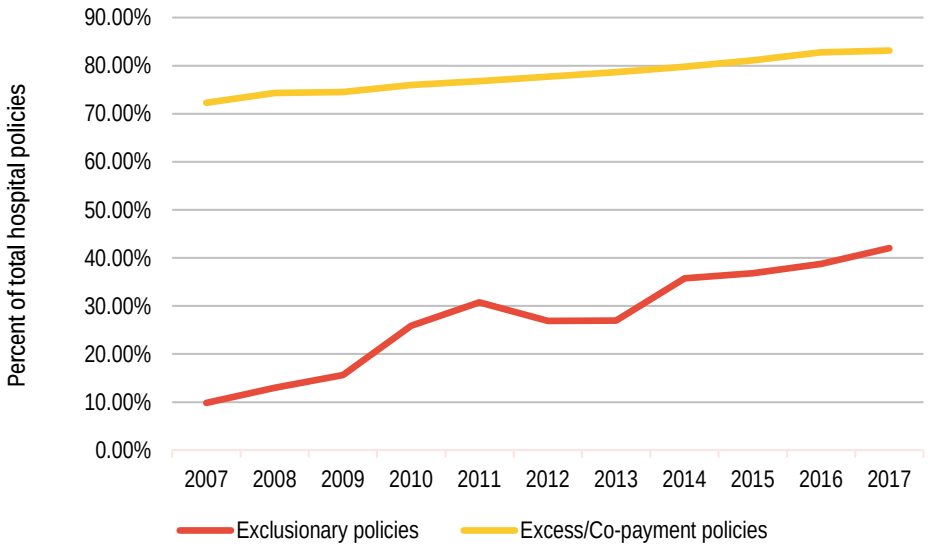
Table 3: Changes market share of not-for-profit and for-profit health funds - 1995 to 2018

YEAR	1995	2000	2005	2010	2015	2017
No. of Insurers	49	44	40	37	34	37
For-profit	2	4	5	10	10	12
Market share (for-profit)	4.0%	12.5%	15.9%	70.0%	68.5%	67.2%

Source: APRA (2018a); PHIO (2017)

The type of insurance products purchased have evolved over time such that in June 2015 the Australian Competition and Consumer Commission (ACCC) reports there were around 46,500 complying insurance products – noting that up to 86% of policies were practically identical but categorised differently across states (ACCC, 2015; PHIAC, 2015). In terms of the type of coverage, the number of policies with exclusions or co-payments has increased considerably in recent years. Figure 4 below reveals that the number of exclusionary policies increased from 7% in June 2007 to 40% in December 2017; and at present more than 80% of policies have some form of out-of-pocket expenses (APRA, 2018a). The most commonly excluded services include: heart-related investigations and surgery, eye and pregnancy related services, and hip and knee replacements.

Figure 4: Trends in policies with exclusions and excess/co-payments - 2007-2017



Source: APRA (2018a)

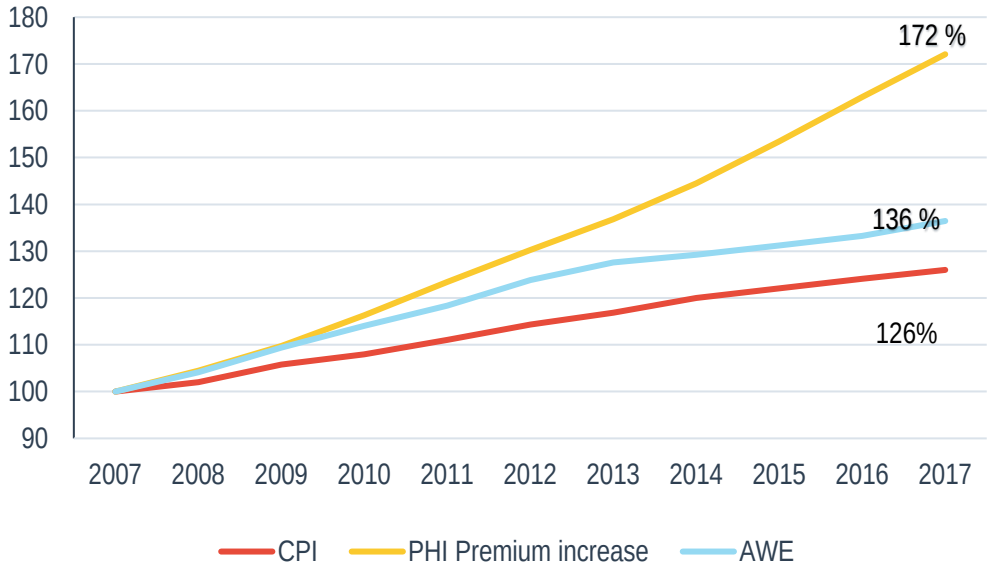
The plethora in the combinations and permutations of insurance products has added to the level of complexity, posing particular challenges for consumers to fully evaluate the value of a product. The following sub-section turns to consumer concerns regarding PHI.

2.4 Trends in PHI premiums, affordability, and recent coverage

The ongoing increase in PHI premiums over time, together with the growth of exclusionary products and co-payments, and greater product complexity, have led to growing consumer concerns over the value and affordability of PHI. These growing concerns have become a focus of inquiry by the government and the senate (Senate Committee, 2017).[4] Over the past decade, the rate of increase in premiums has far outpaced the increase in consumer price index (CPI) and average weekly earnings (AWE). Figure 5 below shows the cumulative increase in premiums over the 10 years to 2017 was 72%, double that of AWE which grew by 36% and 2.7 times that of CPI, which increased by 26% over the period – meaning that households have been outlaying an increasing proportion of their budget towards purchasing PHI cover.

4 The federal government in 2016 announced a review of PHI which culminated in a series of reform measures announced in October 2017 – which is discussed later. In addition a recent Senate Committee inquiry into PHI presented its report in December 2017 and concluded that increased product complexity, lack of information, and rising premiums and out-of-pocket payments has contributed to consumers' difficulty in understanding and assessing alternative insurance products and in the perceived poor value and affordability of PHI products (Senate Committee, 2017).

Figure 5: Cumulative increase in CPI, AWE and PHI premiums over 10 years to 2017.



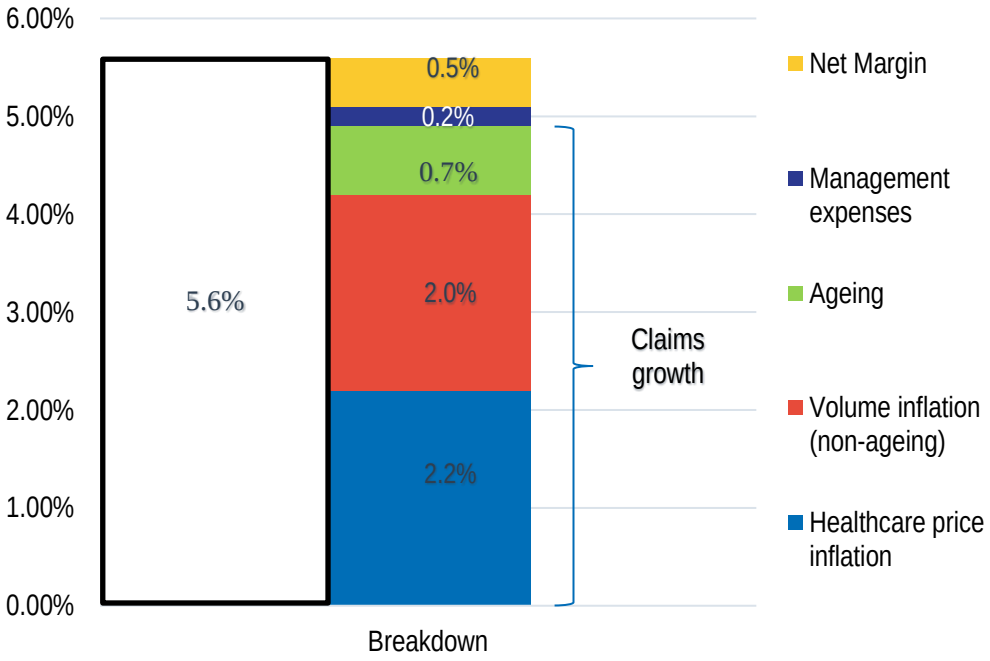
Source: Biggs (2009); ABS (2017)

Growth in benefits outlay

According to a recent analysis undertaken by Lim (2018), premiums have grown by around 5.6% per annum over the past 10 years. Most of the increase in premiums is attributable to health benefits outlay associated with claims expenditure which accounted for 4.9% of the 5.6% growth, whilst management expenses (0.5%) and net margins (0.2%) represent only a small proportion of the total increase (Lim 2018). According to the analysis, there are three factors driving claims expenditure growth (4.9%) over the past decade (see figure 6 below):

- Ageing population (0.7%) – with per capita consumption of health services increasing with an ageing population;
- (Non-ageing) volume utilisation per person (2.0%) – increase in per person utilisation of services from new technologies and greater provider and consumer expectations;
- Health care input prices (2.2%) – unit price inflation of health services (Lim, 2018)

Figure 6: Per annum premium growth rate - 2008 to 2017.



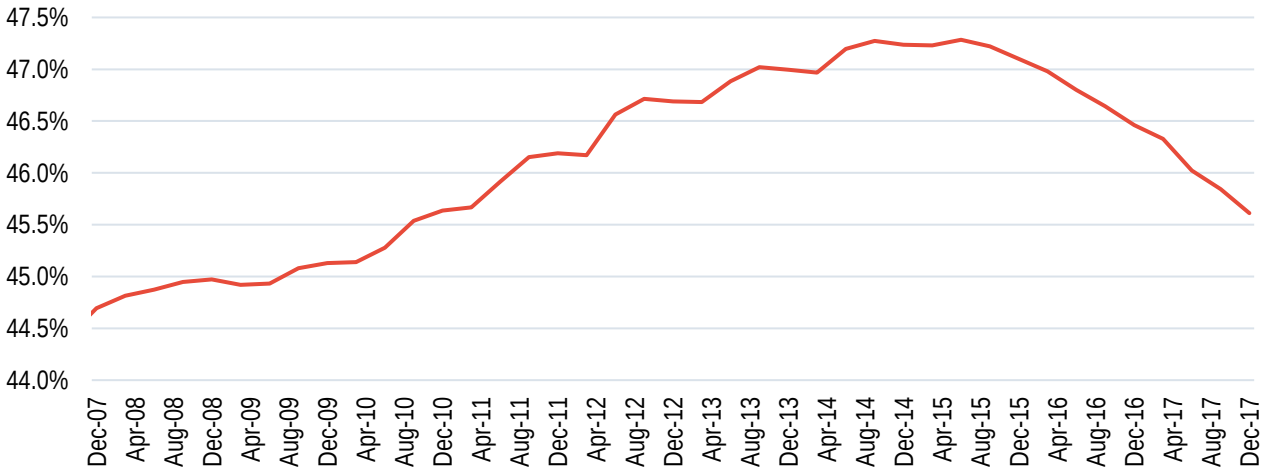
Source: Adaped from Lim (2018)

Adopting a different methodological approach, related work undertaken by Medibank Private using their own data over a 5 year period ending 2015 reveal that their total benefit outlays for hospital treatment increased by aound 6.6% per annum (Medibank Private, 2015). The drivers for this growth were a combination of: increasing number of particpants (1.6%), increasing episodes per participant (2.0%) and increasing benefits per episode (2.8%) (Medibank Private, 2015). Focussing on hospital utilisation rates, recent research by the Australian Private Hospitals Association (APHA), reported in their submission to the Senate Committee inquiry on PHI show that utilisation rates for hospital services increased from 321 episodes per 1000 insured persons in 2010 to 384.8 episodes per 1000 per from in 2016 - which represented forty percent of the growth in benefits paid out over the period (Senate Committee, 2017). The ongoing increases in PHI premiums, well above general inflation and average weekly earnings, can be expected to have some impact on insurance coverage given the presence of a 'free' universal system and the voluntary nature of PHI. Attention turns to this issue.

Recent trends in PHI coverage

Figure 7 (below) shows that over the past decade, PHI coverage increased steadily from 43.3% in June-September 2007 to a peak of 47.3% in June 2015; but has since declined to 45.6% of the population in December 2017 (APRA, 2018a).[5]

Figure 7: PHI hospital treatment coverage (%) – December 2007 to December 2017

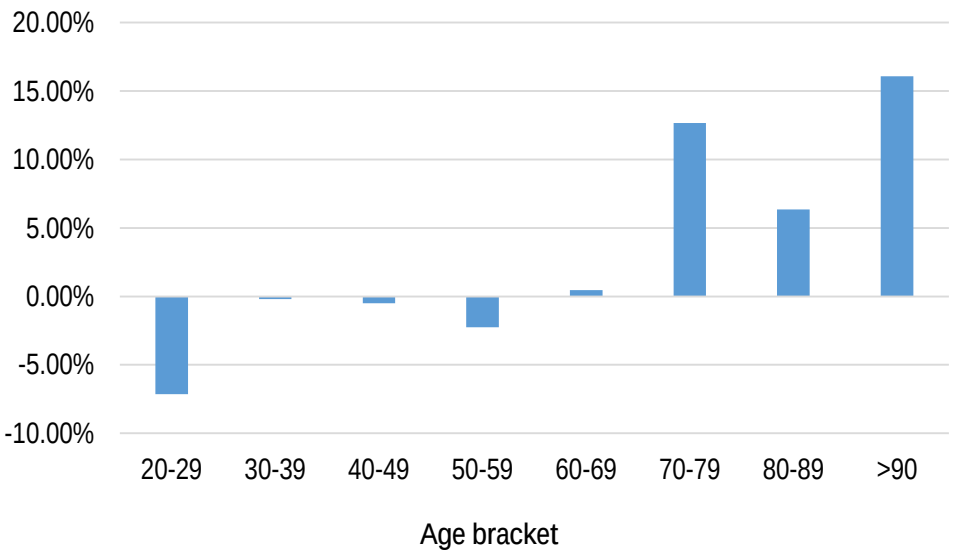


Source: (APRA, 2018a)

The decline in the percentage of the population covered is also represented in the decline in the absolute number of people enrolled in PHI notwithstanding the increase in the population over the period. The decline in absolute PHI membership over the past two years has been confined to the younger age cohorts whose average cost of treatment is much lower than the older age groups. Figure 8 below shows that PHI hospital coverage for 20-29 years olds over the last two years from December 2015 to December 2017 fell by more than 7% during the period and declined in general for all those under 60; but in contrast, there was an increase in membership for those over 60 and particularly so for those over 70 years old. (APRA, 2018a).

5 For general treatment, coverage was 54.6% in December 2017 down from 55.7% in June-September 2015 (APRA, 2018a).

Figure 8: Percentage changes in PHI membership in hospital treatment by age group - December 2015-December 2017



Source: APRA (2018a)

The decline in membership over the past two years and its concentration in the younger age groups increases the average health risk profile of the insured population and thus raises concerns over the longer term structural stability of the sector and the re-emergence of adverse selection problems which had characterised the system two decades earlier. The rising concerns expressed by consumer groups and industry peak bodies over the value and affordability of PHI, prompted the Federal government in September 2016 to establish a Private Health Ministerial Advisory Committee (PHMAC) - tasked with investigating and advising on reforms that would increase competition and provide value for money for consumers (Senate Committee, 2017).

The outcome of the PHMAC review led to an announcement in October 2017 of a series of reform measures. These main changes included:

- simplifying and standardising insurance products into gold/silver/bronze/basic policy categories;
- reducing benefits paid for implanted medical devices through the Prostheses Benefits list;
- allowing insurers to discount hospital insurance premiums for 18-29 year olds by up to 10% - to be phased out at 40 years of age;

- developing standard definitions on medical products across insurance products;
- Allowing travel and accommodation expenses to be included in hospital benefits for rural/regional policy holders;
- Making mental health care cover upgrades available to policy holders without waiting periods;
- Increasing the maximum excess on policies consumers can choose and exclude a range of natural therapies deemed to have little or no efficacy.[6]

The suite of reforms is scheduled to be introduced over the next two years to 2020 and addresses some of the concerns regarding PHI. However, regulatory impediments to PHI impacting on competition and efficiency as well as concerns over structural stability of the sector in the longer term remain. The following section turns to the major issues surrounding current regulatory structures impeding competition and efficiency to PHI.

3. REGULATORY RESTRICTIONS AND REFORM OPTIONS TO CURRENT PHI ARRANGEMENTS

3.1. Current risk equalisation mechanism – retrospective cost claims scheme

A major concern of current PHI regulatory arrangements is that the risk equalisation mechanism used to underpin community rating reduces the incentives to promote cost effective care (Fouda et al, 2017; Reid et al, 2017, 2013; Productivity Commission, 2015; NCoA, 2014; Ahluwalia et al, 2011; Paolucci and Shmueli, 2011). Australia adopts an ex post claims-based equalisation scheme based on the sharing of actual hospital and treatment costs incurred by health funds rather than an ex ante (prospective) risk equalisation based on actuarially determined expected health costs. The current scheme introduced in 2007 and administered by APRA since 2015 comprises: an Age Based Pool (APB) which shares the claim costs of older persons (who incur higher than average claims); and a High Cost Claim pool (HCCP) for the most expensive policy holders (above $50000). THE APB pool is the major component and makes up 97% of the equalised claims. HCCP are pooled after the operation of the APB and make up around 3% of equalised claims across the entire risk

[6] For an overview of proposed reforms see http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reform

equalisation pool. The percentage of claims included in the pool on age based scales is shown in Table 4 below.[7]

Table 4: Age bands and percentage of claims used in risk equalisation fund

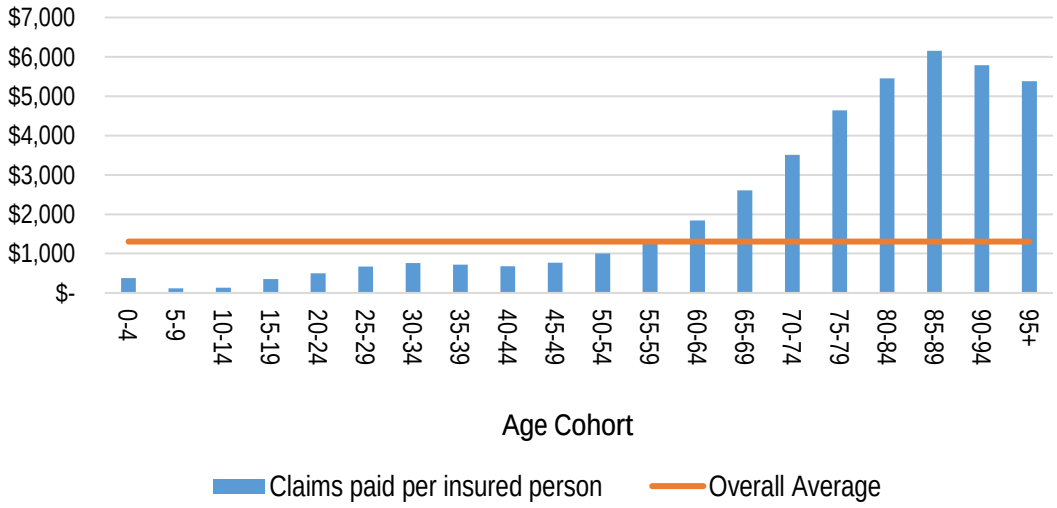
AGE BAND	PERCENT OF ELIGIBLE HOSPITAL BENEFITS INCLUDED IN THE ABP
0-54	0%
55-59	15%
60-64	42.5%
65-69	60%
70-74	70%
75-79	76%
80-84	78
85+	82%

Source: APRA (2018b)

The proportion of claims included in APB increases with each age band, ranging from 15% of claims for 55-59 rising up to 82% of claims for those over 85 included in the pool. The increasing proportion of claims included in the risk equalisation pools reflects the higher expected cost claims experienced by the older age cohorts as shown in figure 9 below. The risk equalisation system shares costs by age cohorts whose health care utilisation varies predictably with age; it does not allow for differences within age-bands or with other socio-demographic factors whose health utilisation may vary predictably such as, gender (i.e. females during maternity age), between small and large families, people living in urban or rural regions, or socio-economic status.

[7] Eligible benefits include hospital benefits, hospital substitute benefits and chronic disease management programs (APRA, 2018a).

Figure 9: Total hospital benefits per age cohort – calendar year ending 2017.



Source: APRA (2018a)

The Risk Equalisation Fund is a zero sum pool calculated on a quarterly basis within state/territory jurisdictions. Those PHI funds with lower than average claims based on APB and HCCP pay money into the Fund whilst those PHI funds with higher than average claims costs receive monies from Funds.8 In 2016-2017 $6.6 billion (or 80% of total benefits outlay) entered the Fund of which around $440 million was redistributed from health funds who had lower than average standardised cost claims to those health funds with a riskier demographic profile and who had higher than average SEU standardised cost claims (APRA, 2018b).

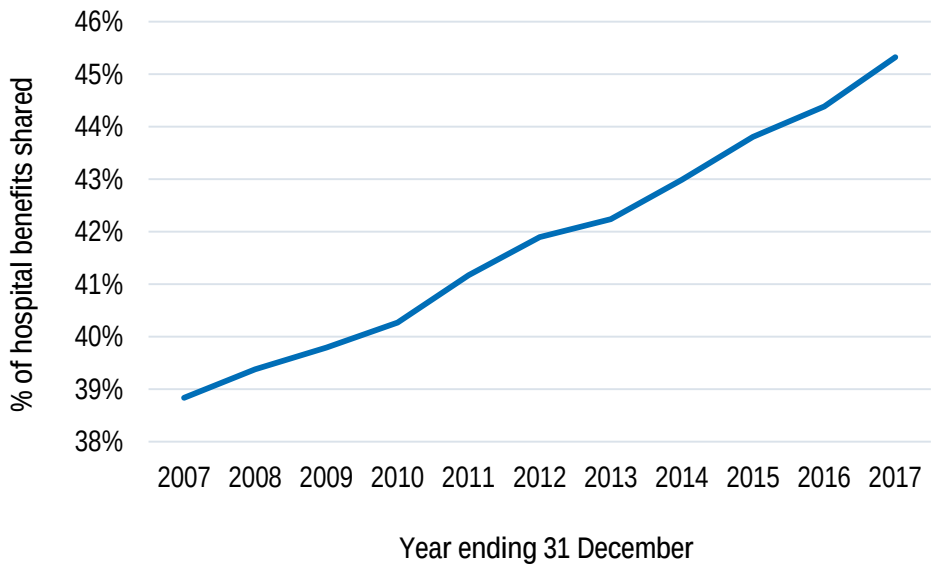
Australia essentially operates a retrospective claims equalisation scheme which is based on actual health cost outlays incurred by health funds rather than an ex ante prospective risk equalisation scheme based on risk profile and actuarially determined expected costs. It is well recognised that claims equalisation creates a lack of incentives for health funds to control costs for high cost claimants since these costs are shared through the risk equalisation fund. Moreover, the current scheme dampens the incentives to undertake innovative investment in preventative care and in managing chronic disease conditions (Productivity Commission, 2017; 2015; NCoA, 2014; Paolucci and Stoelwinder, 2011). Any gains made by one insurer by engaging in preventative care and managing chronic conditions are implicitly shared across all insurers – which reflects an implicit tax imposed by the risk equalisation scheme on investment activities undertaken by health funds (Productivity Commission, 2017, 2015). Essentially, any cost saving measures adopted by an individual insurer result in a lower individual calculated claims deficit which will result in that individual insurer paying more into

[8] Eligible benefits are standardised per 'Single Equivalent Unit' (SEU). Single policies count as one SEU; whilst couple and family policies count as 2 SEUs.

the risk equalisation pool to offset against the deficits (i.e. cost claims) incurred by those insurers who did not engage in cost-saving preventative activities (Reid, 2017). More poignantly, the savings through lower claims cost made by one insurer are shared by all including inefficient insurers (Reid et al, 2017). The Productivity Commission (2017), citing a case study experience of one particular health fund highlights that the implicit tax on cost-saving investment can readily be as high as 50%.

The greater the proportion of the costs that are shared through the risk equalisation pool the lower is the incentive to control costs and therefore the greater is the pressure on rising premiums and hence affordability (Reid et al, 2017; Ahluwalia et al 2011). Of particular concern here, is the proportion of hospital benefits that are shared in the risk equalisation pool has increased quite significantly over the past decade. Figure 10 below shows the proportionate share of hospital benefits in the equalisation pool increasing from around 38% in 2007 to over 45% at the end of 2017. This rising proportionate share increasingly reduces the incentive to engage in investment activities which aim to lower downstream costs through reduced hospitalisation and runs counter to the initiatives of patient centred care where the focus is on prevention, health promotion and chronic disease management (Productivity Commission, 2017).

Figure 10: Proportion of hospital benefits shared into the Risk Equalisation



Source: Calculated from APRA (2018a)

A related issue associated with the current risk equalisation scheme is that it also creates perverse incentives for health funds to engage in risk-selection behaviour. Risk selection occurs where health funds are able to exploit unpriced risk hetereogeneity by avoiding those individuals for whom expected costs exceeds the returns received for insuring that person and conversely selecting those enrolees for whom the returns of insuring the person exceeds

expected costs (van Kleef, 2013; Newhouse, 1996). In the presence of a crude risk equalisation mechanism (such as in Australia), efficiency can be undermined when health funds find it more profitable, in the short run, to engage in risk selection and devote resources to such activities rather than focussing on measures to lower costs and improve the value of their products to consumers (van de Ven et al, 2017; Van Keef, 2013).

Under the Australian risk equalisation scheme, the current APB pool does not include claims costs for those below 55 in the funds pool, notwithstanding that the average claims of 50-54 year olds are double the average claims costs of 20-24 year olds (see figure 9). Although it is illegal for health funds to refuse enrolees, various strategies can be employed to attract a preferred group and discourage others through the use of selective advertising and product differentiation, and developing an array of exclusionary products aimed at attracting good risks and avoiding bad risks. Similarly through their own claims data, health funds are in a position to discern non age-related factors influencing expected health costs not captured within the age-bands used in the claims equalisation scheme. Whilst the current risk equalisation in Australia is intended to minimise the incentives to risk select by spreading the cost of claims across the entire industry, it has been noted that the practise surreptitiously occurs (Shamashullah, 2011; Gale, 2005). For instance the government was forced to introduce regulation forbidding 'lifestyle' features such as gym memberships, camping equipment, bicycles and sports shoes, ostensibly designed to attract lower risk (younger) cohort (Shamashullah, 2011). Whilst the plethora of insurance products, replete with endless permutations of exclusions and co-payments which have developed in Australia over the past two decades may reflect the tailoring of policies to consumer preferences and a response to market conditions, strong incentives to risk select exists, and such intent cannot be discounted.[9] The current regulatory proposal scheduled for introduction in 2019 aims to standardise the multitude of insurance products into four distinct categories and to reduce the complexity of product types. This can be considered a regulatory response to countering the cumulative effects of possible risk selection type behaviour. However, under these proposed arrangements the *incentive* for risk selection remains.

Given that nearly half the Australian population have PHI, it becomes important that appropriate competitive and incentive structures are in place to enable the industry to engage innovative approaches in integrated health service delivery, which is focused on prevention and management of chronic disease conditions. The risk equalisation mechanism as it

[9] See Van de Ven et al (2017) for their empirical study of the Netherlands for an extensive discussion on the tools and activities health funds can deploy to risk select in in their health system setting where a competitive health insurance market operates with open enrolment and a risk equalisation mechanism. Although the Netherlands is generally recognised has having the most sophisticated risk equalisation scheme, the study found risk selection behaviour occurring in most health insurers.

currently operates in Australia, blunts the incentives for health funds to engage in dynamic efficiency. In this regard, moving to an ex ante prospective risk equalisation approach has been advocated in Australia as a policy reform option and a way forward to enhance PHI system performance (Fouda et al, 2017; Reid et al, 2017; Ahluwalia et al, 2011; Paolucci and Stoelwinder, 2011).

The current state-of-the art in risk equalisation arrangements to promote efficiency incentives, minimise risk selection, and support cross subsidisation from low risk to high risk is the establishment of prospective risk adjustment methods based on *expected* health costs. Establishing a prospective risk equalisation scheme in the Australian context is discussed below and also revisited in section 4.

A prospective risk equalisation scheme – a major stepping stone to PHI reform

Competitive markets in health insurance result in premiums being risk rated. For policymakers concerned with deleterious effects of such market outcomes there is the need to incorporate some risk equalisation arrangement which attempts to simultaneously meet equity objectives, contain efficiency incentives to control costs, and minimise the strategy for insurers to engage in risk selection. To this end, the optimum regulatory design which best meets these multiple objectives is an accurate ex ante risk equalisation scheme based on health risk (Fouda et al, 2017; Van Kleef et al 2013). The cross subsidisation from low risk to high risk is determined on *expected* costs based on health risk rather than actual claim costs incurred. Thus an insurer covering a policy holder with chronic conditions and higher claims history would attract a higher transfer than an insurer covering a 'healthy' policy holder with low morbidity conditions and claims history (Fouda et al, 2017; Van de Ven et al, 2013). The payment made to a health fund from the risk equalisation scheme creates a risk exposure for the fund, representing the difference between the actual costs incurred by the insurer and the risk adjusted payment received, and thus create incentives to control costs and maximise surpluses (and remain solvent). The more accurate the risk equalisation mechanism, the greater the scope there is to minimise risk selection, whilst maintaining incentives to control costs and pursue efficiency. To this end, a substantial and well-established research program in the development and implementation of health based risk equalisation mechanisms has been underway since the late 1980s/early 1990s in the United States and in a number of European countries (Van de Ven et al, 2013; Van de Ven et al, 2007).[10] The state of the art development in risk equalisation has moved beyond simple age and sex demographic factors known to influence health costs,

[10] Most notably, the countries which have introduced competitive health insurance markets within their universal systems are Netherlands, Germany, Belgium, Switzerland and Israel. The United States uses risk adjustment payment methods for some of its publicly funded programs under Medicare and Medicaid.

to incorporate more sophisticated techniques based upon prior utilisation data derived from clinical diagnostic information and prescription drug usage obtained from patient encounter with the health system (Van de Ven et al, 2007; Van de Ven and Ellis, 2000).[11]

In the Australian context, there have been strong calls from researchers and policy analysts to transition to and implement a prospective ex ante risk equalisation scheme as a policy reform approach to enhance efficiency of the PHI sector (Fouda et al, 2017; Paolucci and Stoelwinder, 2011; Paolucci and Shmueli, 2011; Donato and Richardson, 2006). In the first study using a large Australian hospital dataset, Donato and Richardson (2006) demonstrate the feasibility and potential efficiency gains of using diagnostic-based methods for risk equalisation purposes in Australia. Similarly Paolucci and Shmueli (2011) demonstrate options for converting the current ex post claims based equalisation scheme to an ex ante risk equalisation scheme using demographic scales derived from publicly available administrative data. Also Fouda et al (2017), updating the original work by Paolucci and Stoelwinder (2011) and drawing from recent internal experience extends the analysis and outlines a multi-year step wise approach to incorporating sophisticated ex ante risk equalisation scheme into the Australian PHI system. Essentially, shifting to a prospective risk equalisation enhances the incentives to promote efficiency and control costs and therefore limit health premium inflation whilst also minimising risk selection behaviour. In this regard a research agenda ought to be established similar to other countries, for the purpose of developing and implementing an ex ante risk equalisation system in order to underpin more substantive reform options and improve efficiency and PHI system performance (Fouda et al, 2017; Paolucci and Stoelwinder, 2011; Donato and Richardson, 2006).

3.2 Reforms to contracting in health care – expanding the range of primary care services

In 1995, following concerns over continually declining PHI membership and the need to control health costs, the federal Labor government introduced legislation aimed at facilitating contracting between health funds and hospital providers. The intention was aimed at promoting competition in the delivery of hospital services through specifying treatment costs and quality of care and putting downward pressures on prices by transforming health funds "*from passive takers to active purchasers of health services*" (ACCC, 2000:133). Notwithstanding the new legislation, membership continued to fall, as the drivers of adverse selection spiral dominated any potential positive effect that may have developed from contracting. The declining membership and adverse selection led the newly elected coalition

[11] The importance of a prospective risk adjustment system as part of more comprehensive reforms is discussed in section 4.

government to introduce its series of PHI incentive measures over 1997-2000, whilst the contracting legislation remained in place.

In 2007, a raft of PHI legislation provisions was consolidated under the Private Health Insurance ACT 2007 which included the introduction of a new product known as Broad Health Cover (BHC). Under BHC, health funds are allowed to cover services that do not require admission to hospital but which may be part of an episode of hospital care, substitute for hospital care or prevent hospitalisation (Biggs, 2013). The intention is to allow health funds to provide chronic disease management and preventative care and hospital substitute services (Buckmaster and Biggs, 2007). The services that are permitted are defined in the Act, but notably do not cover services where a Medicare Benefit is already payable such as GP and specialist services (Biggs, 2013).[12] As of December 2017, total benefits payable by health funds under BHC type arrangements amounted to around 3% of total benefits paid (APRA, 2018a). However, with the establishment of BHC, a number of health funds have undertaken a range of initiatives and investment in programs for managing selected disease conditions and engaging in preventative care aimed at decreasing hospitalisations. These programs have included employing dieticians, physiotherapists, exercise physiologists, psychologists, and registered nurses; and the activities have included phone-based support and outreach services, GP-administered health care plans, and members' engagement and involvement in promoting health (Biggs, 2013). [13]

Notwithstanding the number of program initiatives established under BHC, the scale of these activities in terms of the proportion of overall hospital benefits remains relatively small. Considerable regulatory restrictions continue to limit the ability for health funds to fully engage in disease management and preventative health, and has raised concerns over the capacity of the sector to control rising health costs and pursue system level efficiency (Productivity Commission, 2017, 2015; Senate Committee, 2017; PWC, 2017; Duckett et al, 2017; House of Representatives, 2016; PHA, 2017a, 2017b; NCoA, 2014). In addition to the poor incentives stemming from the cost claims equalisation scheme, a major restriction governing contracting arrangements is that legislation prevents health funds from covering medical services that are provided out-of-hospital for which Medicare benefits are payable – such as GP visits and specialist consultations. In addition, there are restrictions over the extent of allied health

[12] Chronic disease management programs include cardiovascular disease, diabetes, mental health, and smoke cessation programs; whilst hospital substitute treatment include wound care, IV therapy and early hospital discharge. See Biggs (2013) for a discussion on the services that are permitted in BHC under the 2007 ACT.

[13] For examples of the type of BHC type initiatives undertaken by some of the health funds see Productivity Commission, 2017 and 2015; House of Representatives, 2016.

services modalities that are allowed under BHC and the extent to which certain costs can be included in the risk equalisation scheme (House of Representatives, 2016).

GPs play a central role within primary healthcare and the sector is considered key to re-orientating health systems away from treating acute episodes of care in a hospital setting to providing patient-centred approach to health service delivery, involving prevention and ongoing management of people with chronic and complex disease conditions (Donato and Segal, 2010). The exclusion of medical services in a primary care setting is considered a significant limitation as it creates a perverse incentive to default to more expensive curative care in a hospital setting rather than deliver more comprehensive care which extends across service boundaries with a focus on continuity of care aimed at promoting health in the most cost-effective way (PHA, 2017a; Productivity Commission, 2015; NCoA, 2014).[14]

In many countries with advanced models of primary care, GPs are central to coordinating and enabling integrated health system delivery where the focus is on patient centred care (Donato and Segal, 2010).

The opportunity to identify health risks of patients whose first contact is through a GP and to be able to intervene early in managing their health condition is not available to health funds. Usually, a health funds' first awareness of their members' health condition(s) is only after they have been treated in hospital and are seeking reimbursement (NCoA, 2014). By allowing health funds to work closely with GPs when patients initially encounter the health system provides greater scope to provide coordinated services to better manage ill-health and pursue health promotion and preventative activities. Health funds argue that the current legislative restrictions are inhibiting the capacity to engage in funding innovative community based models of care in keeping with overseas development with clinical best practice centred on prevention and management of chronic conditions in a primary health care setting (PHA, 2017a, 2017b).15 The demonstrated capacity for PHI to engage in a number of preventative and disease management programs following the introduction of BHC, notwithstanding the regulatory restrictions and limited incentives, has led to strong support for health funds be given the opportunity to enhance their role in the primary care setting and to work closely with the public system to trial further pilot programs (Productivity Commission, 2017, 2015; PWC,

[14] Duckett et al (2017:25) make the observation of the 'puzzling differences' in patterns of care between public and private hospitals where admissions to private hospital for rehabilitation care have grown by 30% over the last three years (2013-14 to 2015-116) whereas admission the public hospital system have remained stable; with no published evidence supporting such growth.

[15] Private Healthcare Australia, the peak body group representing health funds, argue that the recent announcement by the Federal Government of a committee to review new and more appropriate models of care in mental health and rehabilitation should be extended to cover other areas in line with clinical best practice (PHA, 2017a).

2017; House of Representatives, 2016; NCoA, 2014). Health funds can play an advocacy role in promoting members well-being, engaging in prevention, and focus on managing chronic and complex disease conditions, with the aim of reducing costly hospital care.

The main concerns regarding expanding the role of PHI in primary health care centre around the possible development of a two tier system with PHI patients having access to primary care services (i.e. such as quicker access to GP services) and to particular chronic disease management and prevention programs not available to, or at the expense of, public patients. It has been argued that expanding insurance into primary care can bring added complexity to the overall health system of funding in Australia and may also create a moral hazard problem of increased utilisation as the level of insurance coverage is broadened to encompass other services (Senate Committee, 2017). The general conclusion from recent PHI industry reviews and inquiries is that, subject to assessment, the government needs to consider extending BHC provisions and to allow a rebate for out-of-hospital medical treatment in primary care to the extent it does not create a two tiered system or inflate costs by adding another payer (Productivity Commission, 2017 and 2015; Senate Committee, 2017; NCoA, 2014).

Second Tier Default Benefits – removal of regulatory restrictions

A further regulatory impediment impacting on the incentives and on the competitive pressures in contracting between health funds and hospital provider networks relates to the 'second tier' default benefit requirements. Introduced in 1998, private hospitals that do not have contracts are eligible for default payments equivalent to 85 percent of the average benefits paid by the health fund for the same episode of care in comparable facilities in that State. Notwithstanding the Industry Commission (1997) recommendations against its introduction, the legislation was designed to support those providers who had little negotiating power against large health funds such as small, rural and regional providers (House of Representatives, 2016). Although in 2003 it was announced that the second tier default benefits would be phased out, owing to considerable consolidation in the hospital sector, the decision was subsequently reversed July 2004.[16]

It is argued that default benefits weakens the capacity for health funds to engage in selective contracting and negotiate lower prices as providers may choose not to contract below a particular price and instead rely on default benefits (Industry Commission, 1997; Owens, 1999; Willcox, 2001 and 2005). Health funds argue that the default benefits establishes a fall-back position for providers and sets a regulated floor price, and therefore acts as an impediment to

[16] Interestingly, the private hospital sector has consolidated further since then, with the two largest providers (Ramsay and Healthscope) increasing their market share from 37% to 44% (PHA, 2017a).

competitive and efficient contracting (PHA, 2017a and 2017b). Hospitals on default benefits have the scope to increase out-of-pocket payments to consumers and thus maintain their revenue base, and avoid the obligations contained in contractual arrangements. From a health fund perspective, whilst value-based contracting represents an important feature to pursue by way of incentivising best practise and quality care (i.e. reward for reduced re-admission rates), such an approach also raises the average contracting price and in turn default benefits. This creates incentives for inefficient providers not to contract and instead rely on default benefits, and thus avoid the quality conditions attached to such contracting arrangements.

Given the consolidation that has occurred in the private health industry over the past two decades, it can be argued that the original intentions of default benefits are no longer germane. A number of reform options have been advocated which include: removing the default benefit legislation; reducing the default benefits available (say from 85% to 60%); or restricting the default benefits to small and regional hospitals who have a very low market share (say ≤ 3%) (PHA, 2017a; 2017b; Industry Commission, 1997). The regulatory arrangements governing contracting between health funds and hospital provider networks needs to support competition that promotes cost effective services, enhances quality, and encourages dynamic efficiency in the sector. To this end, the removal or substantial curtailing of 2nd tier default benefits would address this current limitation in the contracting environment.

3.3. Removing regulatory controls over premium price changes

Current legislation requires all private health insurers to seek ministerial approval to adjust premium prices. The highly regulated process requires each health fund to provide notification to seek approval for premium changes in November each year which is then scrutinised by APRA, the Department of Health and the Minister.[17] The review process can take multiple iterations before final approval is given; where the Minister then makes a public announcement of premium increases in early March with premium changes coming at the beginning of April the following year (DoH, 2017; Parliamentary Library, 2009). The stated objectives of controlling premium changes is that PHI remains attractive to consumers, that downward pressure is maintained on premiums and that ultimately the interests of consumers are protected whilst maintaining a viable industry (PHIAC, 2015).

The regulatory controls over premium changes has been a source of considerable concern as it is argued it inhibits the competitive process in the industry and impedes system efficiency

[17] Health funds must include in-depth details about the reasons for requested premium changes such as: the magnitude of increases, when the changes will take effect, data on membership levels, benefit outlays, management expenses, gross and net margins, capital management, investments, dividend payments, any rule changes and both historical and forecast financial data.

and performance.[18] A major concern is that the ability to compete on price is restricted by the synchronise nature of the price setting arrangements which ostensibly allows changes only once per year (Productivity Commission, 2015). Competitive pressures that would drive prices down are dampened as funds are not able to react to competitors or engage in advantageous pricing strategies (PHIAC, 2015). Synchronous pricing also lead to 'gaming' behaviour resulting in upward movement in premiums as health funds anticipate government responses and maximise their price settings to the perceived likelihood of its acceptance - regardless of underlying cost structures (Deloitte-Access Economics, 2012). In their review, Deloitte-Access Economics (2012) found that due to the repetitive nature of the 'game', health funds seeking increases based on what they think the average industry increase will be has led to reduced variation in premium increases over time with such increases across each insurer becoming clustered around the average increase.[19] Moreover, centralised price setting blunts competitive pressures to minimise costs, since any declared administrative savings would be factored into the ministerial decision for premium approval (NCoA, 2014). Thus, there are perverse incentives for health funds not to reduce costs since these are traded-offs against premiums being negotiated down by the Minister (Productivity Commission, 2015). Reduced incentives to invest in cost-reduction strategies maintains more costly structures and practises and may implicitly support smaller inefficient funds remaining in the industry, which ultimately undermines overall system performance (Productivity Commission, 2015; Deloitte-Access Economics, 2012). It is also argued the once-a-year premium change can result in a lag of up to 17 months between receiving market signals and the ability to react to them and thus premium changes may be mispriced and/or needs to include a risk factor to account for the uncertainty these lags represent to the insurer (PHA, 2017b). This mispricing can be detrimental to consumer decisions on whether to purchase insurance.

A number of alternative policy approaches have been canvased ranging from improving current guidelines of existing arrangements to complete deregulation. Among the major reports and reviews into premium pricing regulation, the policy reform that is supported is a price monitoring approach where health funds have the freedom to set prices which is monitored by an independent pricing authority (NCoA, 2014; ACHR, 2013; Deloitte Access Economics, 2012; Insight Economics, 2011). The independent agency would play a similar role to the agency already in operation and currently overseeing public hospital pricing – the Independent Hospital Pricing Authority. It is argued this policy approach enables the benefits of deregulation to operate through greater competitive pressures but with a regulatory hand

[18] See for example, PHIAC, 2015; Productivity Commission, 2015; NCoA, 2014; ACHR, 2013; Deloitte-Access Economics, 2012; Insight Economics, 2011, Industry Commission, 1997.
[19] Centralised price controls may also open up the opportunity for collusive behaviour (NCoA, 2014).

that applies a 'light touch' in overseeing that premiums are competitively priced. It lowers transaction costs, removes political influence and gaming behaviour, and promotes efficiency. The policy approach prevents inefficient firms being supported by price-setting approvals and, in comparison to the current system, is more objective and transparent and retains a level of control over the industry in possible circumstances where prices rose unusually (NCoA, 2014; ACHR, 2013; Deloitte Access Economics, 2012; Insight Economics, 2011). Essentially, deregulatory reforms to the way health funds can set their premiums would enhance competition and efficiency in the sector.

This paper has outlined several regulatory reforms to voluntary PHI system that are likely to increase competition and promote efficiency. These include: transitioning to an ex ante risk equalisation scheme, broadening the range of primary health care services to be included in contracting; removing 2nd tier arrangements and deregulating premium pricing. These reforms can be augmented by additional policy changes such as further deregulation to prosthesis pricing, and providing additional support to enhance IT system capabilities and data-linkage protocols in order to facilitate greater information exchange and transparency for consumers, health funds and providers, on matters relating to price, quality and performance (PWC, 2017; PHA, 2017).

Whilst these reform measures can improve system performance within the existing PHI framework, there are concerns regarding the longer term structural stability of the voluntary PHI system. In order for the PHI industry to secure deeper efficiency gains and enhanced *system-wide* performance there needs to be greater coherence in the structural features governing PHI *within* a universal system. These longer term structural issues are discussed below.

4. LONGER TERM STRUCTURAL REFORMS TO PHI: TOWARDS MANAGED COMPETITION

A growing concern is the structural stability of the voluntary PHI system supporting the principle of community rating in the presence of a 'free' universal system (Reid et al, 2017; Reid et al, 2013; Ahluwalia et al, 2011). Figure 10 (above) shows that proportion of total hospital benefits that are equalised has increased from 39% in 2007 to nearly 46% in 2017, and thus the amount entering the fund pool and used to cross subsidise from low risk to high risk has been rising continuously - and has now reached its highest point since the mid-1990s (Reid et al, 2017). Reid et al (2017) demonstrates that for younger age policy holders of basic cover, this cross-subsidisation can represent up to 70% of the total premium. Over the past decade, the proportion of the premium of low-risk policy holders that is used to cross subsidise

high risk policy holders has been increasing at 7.5% per annum – greater than premium increases which has been rising at 5-6% per annum (Reid et al, 2017). As shown in Figure 7 and Figure 8 (above), PHI coverage has been falling over the past two years to December 2017, the first time since June 2005, of which nearly all those exiting have come from 20-29 age category. Compounding this deteriorating risk profile, the membership of those over 70 has actually increased since December 2015 increasing the average risk profile of the overall insured population. Ongoing increases in benefit outlays through rising volume and unit prices and changing age profile, coupled with percentage declines in premium rebates have heightened the dilemma of value and affordability for the younger age cohorts whose premiums are increasingly subsidising older cohorts. The rapid rise in exclusionary products in exchange for a lower premium could be considered a de facto form of risk rating in attempting to attract lower age cohorts. The current dynamics exhibited over the past 2-3 years of exiting lower age cohorts raises the concern over whether a 'tipping point' will be reached triggering an adverse selection spiral undermining the stability of PHI membership. The recent policy announcement (see earlier) to offer a 2 per cent discount, per annum, for each year a member enters PHI, below the age of 30 to a maximum of 10% is a reflection and a response to this concern. However, it is unclear whether such a modest discount will be sufficient to reverse the current trend – given that premium inflation has continually been outstripping wages growth and the presence of a free public system. If such discounts are inadequate, then further regulatory measures will be required to increase participation rates of younger members.

With continually rising premiums and greater cross-subsidisation, inducing more low risk individuals to purchase actuarially unfair premiums requires either even greater subsidies, a further relaxation of community rating, or greater tax penalties – all of which are problematic in the longer term. The structural dilemma facing PHI is that for young low risk individuals, hospital treatment offers largely duplicate coverage to the universal system. As there are no opt out provision, individuals who take out hospital cover effectively pay twice since they are still covered by the universal scheme. Notwithstanding the welfare losses due to over-insurance and consumer and producer moral hazard,[20] low risk individuals are faced with the choice of purchasing actuarially unfair PHI product or simply rely on a 'free' public system. In contrast, high-risk individuals face a different choice calculus, in that they have the option of purchasing actuarially *above-fair* premiums vis-à-vis relying on the 'free' public health system. Since PHI system in Australia is dependent upon a proportion of low-risk individuals taking out health cover, and given continually rising premiums at well above the inflation rates, voluntary

[20] See Paolucci et al (2011) for a discussion on the welfare losses associated with duplicate insurance.

PHI system in the presence of a universal system is structurally unstable. The extent to which regulatory measures can be continuously ratcheted up challenges the principles of community rating and affordability, and the *voluntariness* of PHI and thus raises the vexing issue regarding the long term role of voluntary PHI sitting alongside a mandated universal system.

A related structural concern is that the role of voluntary PHI was never redefined with the introduction of the universal system and consequently there is lack of integration and coherence between the PHI and the broader health system. The shift in the disease burden to chronic diseases has seen many countries re-orientate the structural design of their health systems to providing integrated patient-centred and whole-of-health approach to health service delivery with a focus on prevention and disease management (Productivity Commission, 2017; House of Representatives, 2016; AIHW, 2014; Donato and Segal, 2010). Developing a coherent and well-functioning primary care is key to having high-performing integrated health care system (Ham, 2010). In Australia, the fragmented and duplicative nature of health funding and delivery across public and private sectors and the lack of integration between voluntary PHI and the universal system contributes to system-wide inefficiencies and to avoidable rising health costs (Productivity Commission, 2017; 2015 Paolucci and Garci-Goni, 2015; NCoA, 2014). In this regard, there have been calls for a strategic review of PHI in the context of the whole health system in order to develop a coherent approach to system wide integration across public and private sectors (Gath, 2017; Productivity, 2015; NCoA, 2014). The framework under which such integration can occur within a competitive and market-orientated system is commonly referred to as regulated or managed competition. The broader principles of this system design are discussed below.

4.1. Expanding the role of PHI in Australia: system integration within a universal framework

Structural instability in PHI and the lack of integration with the universal system had led to calls for expanding the role of PHI to allow individuals to 'opt-out' of Medicare and transfer their publicly-funded universal entitlements to a health fund of their choice.[21] This was most evident in the final report presented in 2009 by a national commission of inquiry established by the Labor federal government, which recommended longer-term structural redesign to the health system enabling competing health funds to manage the universal entitlements of individuals who seek coverage with them – under a system called *Medicare Select* (NHHRC, 2009; Foley et al, 2009). More recently, the Liberal government's own National Commission of Audit

[21] See for example Paolucci and Garcia-Goni, 2015; NCoA, 2014; Stoelwinder, 2013; Paolucci et al, 2011;; Foley et al, 2009; Scotton, 2002; 2000; 1999). Most recently, the Productivity Commission (2017) recommended 'managed competition' of competing insurers as a possible longer term pathway in pursuing integrated health system delivery.

established to review sector wide inefficiencies, advocated expanding the role of PHI and integrating it within the universal health system along the lines of Medicare Select (NCoA, 2014). Paolucci and Garcia-Goni (2015) provide a comprehensive analysis of reform options and design features of the Australian health system where private insurers have a central role in competing for and managing individuals' universal health entitlements with a focus on integrated health service delivery for managing chronic disease conditions (Paolucci and Garcia-Goni, 2015). These structural redesign proposals for the Australian health system have been inspired by and based on international developments where a number of countries have introduced market orientated reforms to their health systems.

International developments supporting competition among health funds

Since the early 1990s, a number of countries began introducing greater competition into their health systems by giving responsibility to health funds for purchasing health services on behalf of enrolees who receive a universally entitled standardised benefits package (i.e. the Netherlands, Belgium Israel, Switzerland, and Germany) (Van de Ven et al, 2017; 2007). Consumer choice and competition provides incentives for health funds to compete for enrolees by purchasing the appropriate mix of services that best meets the tailored preferences of consumers in the most cost-effective way (Van de Ven et al, 1996; Segal, 2002; Flood, 2000; Schut and Van Doorslaer, 1999). Competition on both sides of the health market is designed to create incentives for greater innovation and experimentation in alternative payment and service delivery arrangements and promote dynamic efficiency (Allen et al, 2002; Segal et al, 2002). To enable efficiency and affordability objectives to be pursued through competitive health care markets a number of preconditions needs to be fulfilled (Van de Ven et al, 2013). As discussed earlier, a key component in a regulated competition system is the establishment of appropriate risk equalisation scheme which provides incentives for controlling costs and minimise the incentives for health funds to engage in risk selection behaviour and promotes both efficiency related behaviour and equity/affordability objectives (Van de Ven, 2017; Van Kleef et al 2013). To effect cross-subsidisation from low risk to high risk individuals and for health funds not to risk rate premiums (and adopt a community rating), health funds need to be compensated from the risk equalisation scheme based on the *expected* health costs of the individual, determined by their actuarial health risk class. In theory, a perfect risk adjustment mechanism would eliminate incentives for health funds to risk select individuals since the payment received from the risk equalisation scheme would reflect the expected health care requirements of the individual.

Most recent developments in risk adjustment mechanisms for predicting individual expected health costs have extended beyond socio-demographic factors to incorporate prior utilisation information of patient encounters with the health system (Van de Ven et al, 2013; Van de Ven and Ellis, 2000). In this regard, Netherlands is considered to have incorporated the most sophisticated risk adjustment methods, by incorporating not only socio-demographic factors such as age, gender, region and source income into their model, it has also added: twenty Pharmacy-based Cost Groups (PCGs) which map prescribed medicines to chronic disease classifications and; thirteen Diagnosis Based Cost Groups (DCGs) which cluster similar clinically diagnosed disease conditions with comparable cost groups (Fouda et al, 2017; Van Kleef et al, 2013). In the Dutch risk equalisation scheme, health funds receive a prospective payment for each enrolee insured with them based on their risk characteristics as reflected in the risk adjustment mechanism used in the scheme. A number of other countries including Germany, Belgium, and Switzerland, as well as some publicly-funded programs in the United States have also incorporated disease conditions classification systems into their risk equalisation schemes. All countries have had an ongoing research agenda spanning two decades focussing on developing, implementing and improving the risk mechanism used in their respective risk equalisation scheme.

The basic principles and features of how health funds are regulated within a competitive market environment include:

- Establishing a universally-entitled core benefits package of services and a requirement that competing health plans accept any eligible citizen into their plan;
- Payments are risk adjusted through a risk equalisation agency to the competing health plan chosen by the individual;
- Establishing an appropriate regulatory framework for ‘managing’ and regulating competition among health plans and among health providers (Segal et al, 2002).

Income cross subsidisation is determined by individuals contributing via general taxation and social insurance and risk cross subsidisation occurs through the ex ante risk equalisation arrangement by way of risk adjusted payment to the health fund chosen. Consumers may be subject to some limited financial responsibility through either contribution to premiums for the basic benefits package or co-payments to providers. Given the complexities of a managed competition system the main challenges centre on the technical conditions which need to be resolved – particularly with regards to developing good risk adjustment mechanism and equipping the regulator with appropriate tools to oversee and regulate competition among

health funds and providers (Van de Ven, 2013; Van de ven et al, 2007). Van de Ven et al (2013:1-2) determine ten preconditions viewed as crucial for competitive health markets to achieve affordability and dynamic efficiency: 1. Free choice of insurer; 2. Consumer information and market transparency; 3. Risk-bearing buyers and sellers; 4. Contestable markets; 5. Freedom to contract and integrate; 6. Effective competition regulation; 7. Cross-subsidies without incentives for risk selection; 8. Cross-subsidies without opportunities for free-riding; 9. Effective quality supervision; 10. Guaranteed access to basic care.

Interestingly, expanding the role of PHI in Australia and integrating it within the universal system was initially proposed by Richard Scotton, the co-architect of the original Medibank/Medicare scheme (Scotton, 2002, 1999; 1990). Under Scotton's managed competition model approach individuals can opt-out from Medicare and transfer their publicly funded entitlements to a competing health fund of their choice who would receive ex ante risk-adjusted subsidies based on the expected health costs of the enrolee. Health funds acting as consumer advocates and third-party purchasers would contract with competing providers for health services covered under universal entitlements (Scotton, 2002). Supplementary insurance would not attract public subsidies and would be risk rated. The original Scotton proposals have inspired subsequent research and studies into the area of expanding PHI and integrating it within the universal system. These studies differ mainly in the extensiveness of the structural changes - ranging from a voluntary opt-out model where reforms are mostly confined to PHI to more comprehensive reforms to include reforming the public system where funding sources are consolidated and public fund-holders intermediaries are established and act as a default public health plan. These two broader structural features are discussed in the following subsections.

4.2 Managed competition in Australia: voluntary opt-out from Medicare

Paolucci et al (2011) details a voluntary opt-out option from Medicare where consumers can transfer their universal entitlements to a competing health funds that receives a risk adjusted payment based on expected health costs of the enrolees. The authors demonstrates how ex ante risk equalisation scheme based on existing administrative data using demographic information can be established to replace the cost equalisation scheme currently operating in Australia. Over time more sophisticated risk adjusters can be included into the equalisation model such as DCGs and PCGs in the Australian context as informational capabilities develop, and data linkage protocols are established, to enable more accurate predictors of individual health costs. For consumers, Medicare and the basic benefits package provided by health funds are fully substitutable (Paolucci et al, 2011). Voluntary private insurance would still be made available and provide coverage for services not funded under Medicare and would not

attract subsidies, and premiums would be risk rated under standard insurance arrangements. Supporting similar principles, the National Commission of Audit in 2014 recommended, as a potential area of reform, expanding private health insurance to encompass basic health services currently covered by Medicare (NCoA, 2014). PHI would play both a substitute and supplementary role to Medicare. Essentially, under the voluntary opt-out arrangements, the major reforms focus on expanding the role of PHI to encompass the basic benefits package currently available under the universal system, whilst the structural features of the Medicare public system remains mostly unchanged. However changes to health system funding and payment arrangements would be required to enable health funds to receive risk adjusted subsidies equivalent to Medicare entitlements and be able to purchase health services from both public and private providers covered by the universal entitlements.

Interestingly also, expanding the role of PHI and creating incentives for health funds to adopt new and innovative approaches to health care payment and delivery systems, can act as a catalyst to stimulate structural reforms in the public system. For instance, if PHI prove to be successful in purchasing integrated health services on behalf of their enrolees, this may foster an expanded role for Primary Health Networks (PHNs) as fundholding intermediaries and stimulate more comprehensive primary health care reforms such as that supported by NHHRC and others (NHHRC, 2009; Donato and Segal, 2010).

4.3 Managed competition in Australia: public and private health insurance plans

The progression beyond the voluntary opt-out model towards more extensive structural reforms encompassing both PHI and also the Medicare system itself represents a more comprehensive model of managed competition. The major recommendation by NHHRC of *Medicare Select* represents a long term comprehensive reform approach which consolidates government funded health services (i.e. medical, hospital and all primary care) into a single funding source managed by the Commonwealth government and the establishment of regionally-based public fundholding intermediaries or health plans (NHHRC, 2009). A standardised universal benefits package is explicitly defined, and all citizens are offered the choice to access their universal entitlements by opting to join a competing private health fund or remain with the default public insurance plan (Foley et al, 2009). Both private insurance plan and the default public insurance plan will receive ex ante risk-adjusted payments and essentially compete with each other. Adopting a similar approach, Paolucci and Garcia (2015) outline a detailed plan, which they call Mandatory Integrated (public and private) Health Insurance – which also adopts a comprehensive approach to structurally reforming health funding and service arrangements across both public and private systems. Funding across health services are consolidated into a single source. Consumers exercise choice in accessing

their basic entitlements package from competing (public and private) health funds who receive risk adjusted capitated payments. The approach advocated by Paolucci and Garcia-Goni (2015) is more extensive than the Medicare Select as they extend funding arrangements to include long term and aged care services related to managing chronic diseases into the universal benefits package, which is supported by additional public funding through a social insurance savings account. A detailed 10 year phased implementation time plan is outlined under this system wide reform (Paolucci and Garcia-Goni, 2015). In contrast to a voluntary opt-out model, the advantage of a more comprehensive framework of regulated competition is that the public system is also reformed into a single fundholding intermediary model aimed at providing integrated health system delivery. At a conceptual level a more comprehensive model provides the greatest capacity to enhance overall health system performance as it also aims to overcome the fragmentary nature of the existing public system structures and eliminates cost and blame-shifting between commonwealth and state governments and promotes integrated health system delivery.

A notable feature of a regulated competition framework (both voluntary opt-out and a more comprehensive model approach) is that PHI is strategically integrated into the universal system and its role is explicitly defined. PHI becomes substitutable to the universal system and health funds can also provide voluntary supplementary cover for 'top up' or complementary services not covered by the universal system. Thus, duplicate cover is removed. The framework also addresses the structural problem of adverse selection present under existing voluntary PHI arrangements, since the universal entitlement is mandated for all consumers whether they choose either the public system or private health plan; whilst voluntary insurance is risk rated and therefore low risk consumers are not faced with actuarially unfair premiums.

However, regulated competition does pose technical, regulatory and organisational challenges. The complexity of the system requires the development of informational base, data linkage protocols and skills capabilities necessary for health funds to act as consumer advocates and active purchasers of health services. Regulatory authorities face technical challenges to ensure that an appropriate risk equalisation scheme is implemented, competition is effectively managed, there are incentives to pursue dynamic efficiency, and that social welfare objectives are achieved (Van de Ven et al, 2013; Hall, 2010; Van de Ven, 2007; Segal, 2002). Evidence from overseas suggests after more than a decade of cautious implementation, many of these technical challenges and preconditions are now being met. For these countries the gradual implementation of competitive market orientated reforms

represents a long term investment. In the case of Australia there is the opportunity to leverage off these international developments and establish a longer term reform agenda.

5. A STRATEGIC APPROACH TO INCREMENTAL REFORMS TO PHI IN AUSTRALIA

Introducing regulatory reforms to voluntary PHI system in Australia not only enhances competition and promotes efficiency within the existing structural arrangements, but also forms the basis for establishing a pathway for more comprehensive longer term structural reforms to the sector. In particular, transitioning from a retrospective cost-based claims equalisation system to an ex ante prospective risk equalisation scheme improves the incentive structures of current re-insurance arrangements and also provides the experience and technical know-how for developing risk-adjusted payments under an expanded role for voluntary PHI. Other reforms to PHI, as already outlined, such as broadening the range of services included in contracting to improve chronic disease management, removal of second tier regulations, and deregulating premium pricing, are all consistent with longer term reforms. Moreover, introducing an ex ante risk equalisation scheme also provides a stepping for health funds to begin to manage the health services for consumers covered by the public system, by way of 'carve-out' of defined services or disease groups. Here, Richardson (2003) argues that this type of gradual progression towards expanding the role of health funds to manage services for public patients can be done on a trial basis and be systematically expanded over time subject to appropriate monitoring and evaluation. The awarding to Medibank Private in June 2012 of a four year contract on behalf of the Australian Defence Force to manage and purchase health services for defence personnel, represents an example of the greater collaboration between public (funding) and the private health system that can develop overtime. [22] As Stoelwinder (2013:25) highlights "*the presence of competing insurers in Australia provides the structural basis for managed competition in Australia*".

Incrementally expanding the role of PHI to eventually allow health funds to manage publicly-funded universal entitlements through consumers choosing to opt-out of Medicare, increases the interaction between PHI and the publicly-funded universal system. Establishing a fundholding role for health funds can therefore act as a catalyst and promote reforms to the public system and facilitate progression towards unifying public funding of primary health care and enhance public fundholding capabilities (such as expanding the purchasing role of PHNs), and the development towards a more comprehensive managed competition framework. Consumers under these arrangements can choose to take their universal entitlements to a

[22] Medibank Private recently had the contract to manage health services for health defence personnel renewed.

health fund of their choice or remain with the default regionally-based public insurer. Thus, reforms to PHI in Australia can be considered as a continuum ranging from regulatory changes to the existing voluntary system, to expanding the role of PHI and enable opt-out arrangements from Medicare, to more comprehensive system-wide changes establishing both private and default public health plans, as shown in Table 5 below. The table depicts how these policy reform approaches represent a progression in terms of their scale and scope; the relative capacity to promote efficiency and enhance system performance; and the degree of complexity and challenges that are faced. Essentially, the greater the extent of reforms introduced to PHI the greater are the efficiency gains that can *potentially* be achieved. But with greater efficiency gains come greater technical complexity, higher transaction costs of exchange and greater political challenges for effecting more comprehensive reforms. Ultimately, it is an empirical issue whether the potential benefits of greater competition, innovation and choice outweigh the additional costs of implementing and managing greater system complexities.

Table 5. Incremental reform to PHI in Australia – a strategic approach towards comprehensive reforms

REFORM ELEMENTS	VOLUNTARY PHI →	MANAGED COMPETITION →	
	(Existing structural features)	**Voluntary – Opt Out**	**Comprehensive: public and private plans**
Ex ante risk adjustment mechanism	Yes- (within voluntary system)	Yes	Yes
Contracting deregulation and broadening primary care services	Yes - (within voluntary system; but can expand to public system overtime)	Yes	Yes
PHI integrated with universal system – basic benefits package	No	Yes	Yes
Reforms to public system – unified funding and establishing public plan	No	No/limited	Yes
Potential for dynamic efficiency	Increased efficiency over current PHI arrangement – but not 'first best' • Reforms only to PHI sector; • problems of adverse selection and structural instability remain; • Duplication with universal system	Enhanced efficiency – but mainly confined to PHI: • Some reform to public system to include PHI; • PHI offers scope to foster change in public system.	Whole of health system increase in efficiency; • More comprehensive integration of primary care; • Reforms to private and public systems
Complexity of reform	Complex: • technical complexity of moving to ex ante RE scheme; • Phased implementation.	More complex: • Allowing opting out of universal system; • complex RE scheme; • technical preconditions.	Most complex: • reforming public system into default public insurance plan • Possible extension of services covered in benefits package
Studies/reviews	Fouda et al (2017); Paolucci and Stoelwinder (2011); Productivity Commission (2015); NCoA (2014).	Paolucci et al (2011); NCoA (2014).	NHHRC (2009); Foley et al (2009); Paolucci and Garcia-Goni (2015)

In the absence of a strategic approach to health policy development, policy adjustments can amount to adhocracy and to what Linbolm (1959) refers to as policy of 'muddling through'. Australia has yet to adopt a coherent strategic approach to health policy reform. Instead, policy adjustments have vacillated between those supporting the universal system and those supporting the private sector, with limited attention given to integrating the two systems, which has led to ongoing structural tensions within the broader health system.

Managed competition is consistent with the Australian institutional landscape as it offers universalism with choice and reconciles PHI within the universal system; and its adoption as a long run strategic goal is consistent with the implementation of short run policies which improve efficiency. The challenges of implementing a more complex system require policymakers to monitor and evaluate each successive step, to assess the skills, capabilities and technical knowledge that have developed and to accumulate the empirical evidence in order to proceed along each subsequent stage.[23] Thus reforms to PHI need to be pursued in the context of the entire Australian health system and in the adoption of a strategic framework to guide incremental policy adjustment.[24] This provides the greatest scope for effecting structural changes necessary to pursuit dynamic efficiency and enhances system-wide performance and thus best meet the challenge confronting the Australian health system over the coming decades.

5. CONCLUSION

All countries are facing increasing pressure on their health care budgets stemming from an ageing population, changing illness and disease conditions, and cost enhancing technologies. The rise in chronic diseases in contemporary societies, which is now the leading cause of ill health and deaths in Australia, results in a significant economic burden and poses particular challenges for the Australian health system. In order to best meet these challenges in a cost-effective and sustainable way, health systems need to be innovative, flexible and responsive and have incentive structures that support dynamic efficiency. To this end, countries are re-orientating their health systems towards patient-centred care with a focus on prevention and chronic disease management in a primary care setting.

[23] Such an approach is essentially advocated by the Productivity Commission (2017:77) in their review of public system reform aimed at promoting integrated care where it concludes "*...the system changes we recommend could be a step along a pathway to managed competition if evidence mounted in favour of this more radical overhaul*"

[24] See for example Productivity Commission (2017, 2015), Garth, (2017), and NCoA, (2014).

PHI is an important component of the Australian health system; it reduces the public contribution to hospital expenditure and provides Australians with choice and has long been a part of the institutional health care landscape. But the failure to redefine the role of PHI with the introduction of the universal system of Medicare has resulted in a legacy of regulatory structures and impediments which are anti-competitive and counter to system efficiency. Whilst internationally there is a well-established research agenda with many countries enhancing competition between health funds through the adoption of ex ante risk adjusted payment mechanism which simultaneously promotes cost control, mitigate risk selection and support cross-subsidisation, such developments are absent in Australia. The current claims-based equalisation scheme to support community rating principle in PHI blunts both the incentives to control costs and to invest in innovative practises which may prevent hospitalisations. Moreover, there are restrictions preventing health funds from purchasing or paying for primary health care and engaging in disease prevention and management of chronic diseases consistent with latest international developments in patient centred care. These major issues together with second tier default arrangements and ministerial control over premium pricing, represent considerable barriers to competition and thus limiting PHI system performance.

There is the need to establish a research agenda fostering the development of, and transition to, an ex ante risk adjustment scheme to underpin community rating, together with the removal of regulatory impediments which counter the incentives for PHI funds to engage in chronic disease prevention and management through alternative approaches to integrated health service delivery. Although these reforms provide the opportunity to promote competition and efficiency to the *existing* arrangements of voluntary PHI, they do not address more fundamental problems of fragmentation and lack of integration between PHI and the universal system. By the same token, such regulatory reforms do provide the foundation and basis for, and they are consistent with, supporting longer-term structural reforms.

The failure to integrate voluntary PHI into a coherent framework with Medicare has resulted in chronic system-wide inefficiencies of duplication in insurance and fragmentation between the public and private systems as well as structural instability to voluntary PHI. With an ever increasing proportion of premiums for low risk individuals used to cross-subsidise high risk cohorts, greater tax penalties, further relaxation of community rating and increased subsidies are required to counter the threat of an adverse selection spiral. Ultimately, long term structural reforms are required. Under a managed competition framework, the role of PHI is expanded

to enable consumers to take their universal entitlements to competing health funds; whilst voluntary insurance is confined to supplementary and complementary services and is risk rated, and duplicate insurance is removed. Such longer term reforms offer the prospects for securing system wide efficiency gains and provide a more stable health system structure. Importantly, introducing managed competition in the Australian context is consistent with incremental policy adjustment aimed at improving competition and efficiency to the existing voluntary PHI arrangements. Along with establishing a research agenda on ex ante risk adjustment methods, there also needs to be a review of PHI in the context of the entire health system to establish a strategic framework to guide and inform, and to progressively extend, incremental policy adjustments to encompass longer-term structural reforms that support dynamic efficiency.

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