OECD Health Working Papers No. 8

Private Health Insurance in Australia: A Case Study

Francesca Colombo,

Nicole Tapay

https://dx.doi.org/10.1787/478608584171

OECD

DELSA/ELSA/WD/HEA(2003)8

OECD OCDE

Private Health Insurance in Australia
A Case Study

Francesca Colombo and Nicole Tapay

8

OECD HEALTH WORKING PAPERS

Unclassified **DELSA/ELSA/WD/HEA(2003)8**

Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development **30-Oct-2003**

English - Or. English

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

DELSA/ELSA/WD/HEA(2003)8
Unclassified

OECD HEALTH WORKING PAPERS NO. 8

PRIVATE HEALTH INSURANCE IN AUSTRALIA: A CASE STUDY

Francesca Colombo and Nicole Tapay

JEL Classification: I11, I18, I19

JT00152575

English - Or. English

DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS

OECD HEALTH WORKING PAPERS

This series is designed to make available to a wider readership health studies prepared for use within the OECD. Authorship is usually collective, but principal writers are named. The papers are generally available only in their original language – English or French – with a summary in the other.

Comment on the series is welcome, and should be sent to the Directorate for Employment, Labour and Social Affairs, 2, rue André-Pascal, 75775 PARIS CEDEX 16, France.

ACKNOWLEDGEMENTS

The authors wish to thank the Australian Department for Health and Ageing for helping to arrange their mission to Australia, during which much of the information contained in this report was collected, and for its generous assistance. Several experts in the Australian administration and in other institutions also provided useful information. The authors also wish to thank Elizabeth Docteur and Peter Scherer for their invaluable comments on this paper.

SUMMARY

1. Despite universal public insurance coverage, private health insurance (PHI) covers almost half of the Australian population – a high coverage rate in comparison with most other OECD countries. Reflecting the belief that a well-functioning health care system should be based on a mixed system of insurance and provision, Australia's policy makers have encouraged the development of private financing and delivery arrangements operating in parallel to the public system. PHI is seen as a vehicle for enhancing individuals' choice of provider and care options, and for reducing cost and demand pressures on public hospitals. Policy makers have intervened substantially in the private health insurance market. Regulation has promoted risk-pooling and incentive policies have stimulated the purchase of private cover.

2. This paper analyses the Australian private health insurance market. It describes how PHI interacts with the public system, and assesses its contribution to equity, efficiency and responsiveness of the health system. The analysis identifies some of the factors affecting performance, including insurance market characteristics, the regulatory and fiscal environment, the organisation of the health system, and any actors' incentives and behaviours.

3. The analysis presented in this paper suggests that PHI in the Australian context has been successful in addressing some policy objectives, although outstanding challenges – including important cost considerations – remain. Private health cover enhances choice over providers and access to timely elective care. It helps financing the development of private hospital facilities, thereby providing insurees with an alternative to public hospital care. Australia appears to be doing well in promoting access to private cover and safeguarding equity of access irrespective of insurance status in public hospitals, though some aspects may require monitoring.

4. Private health insurance poses nonetheless some challenges to cost. Private funds have not effectively engaged in cost controls. Subsidies to private health cover pose considerable pressures on public finances. The stringent Australian regulatory structure has promoted equity of both access to and financing of private coverage, however it has also revealed some tensions. Australia is engaged in on-going discussions about what should be the appropriate role for PHI and the appropriate scope of regulation for its PHI market aimed, among other things, at minimising some of these tensions.

RESUMÉ

5. En dépit de l'assurance publique universelle, l'assurance maladie privée couvre presque la moitié de la population australienne -- un taux élevé d'assurance en comparaison de la plupart des autres pays de l'OCDE. En reflétant (?) la croyance qu'un système de santé qui fonctionne bien devrait être basé sur un système mixte d'assurance public et privé, les décisionnaires australiens ont encouragé le développement des arrangements privés de financement et de provision des soins de santé qui fonctionnent en parallèle du système public. L'assurance maladie privée est considérée comme un moteur pour augmenter le choix des fournisseurs de soins et des options de soins ainsi que pour réduire les coûts et la forte demande envers les hôpitaux publics. L'Australie est intervenue largement sur le marché de l'assurance maladie privée. La régulation a favorisé la prise en charge de risque et les politiques d'incitation ont stimulé l'adhésion à la couverture privée.

6. Cet article analyse le marché de l'assurance maladie privée. Il décrit comment l'assurance maladie privée interagit avec le système public et évalue sa contribution à l'équité, l'efficacité et la réactivité du système de santé. Cette analyse identifie certains facteurs affectant la performance, y compris les caractéristiques du marché de l'assurance, la régulation et le cadre financier, l'organisation du système de santé, ainsi que les incitations et le comportement des différents acteurs.

7. L'analyse présentée dans cet article fait ressortir que l'assurance maladie privée dans le contexte australien a été un succès en suivant certains objectifs, mais plusieurs défis– comme l'importance des coûts – demeurent encore. La couverture médicale privée augmente le choix des fournisseurs des soins et l'accès ponctuel aux soins non urgents. Elle aide à financer le développement des hôpitaux privés, fournissant de ce fait aux assurés une alternative aux soins des hôpitaux publics. L'Australie semble bien favoriser l'accès à la couverture privée tout en sauvegardant l'équité d'accès aux soins indépendant du statut d'assurance dans les hôpitaux publics, bien que quelques aspects requièrent une surveillance.

8. L'assurance maladie privée pose néanmoins des problèmes de coût. Les fonds privés ne sont effectivement pas engagés dans la maîtrise des coûts. Subventionner la couverture médicale privée apporte des pressions considérables sur les finances publiques. La rigueur du système de régulation australien a encouragé l'équité d'accès a' et de financement de l'assurance privée, toutefois elle a également relevé quelques problèmes. L'Australie s'est engagée au cours des discussions sur le rôle approprié de l'assurance maladie privée et sur la portée de la régulation approprié pour le marché, visé, entre autres, à réduire au minimum certains problèmes.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS 3

SUMMARY 4

RESUMÉ 5

PRIVATE HEALTH INSURANCE IN AUSTRALIA: A CASE STUDY 8

Introduction 8
1. Policy relevance of private health insurance in Australia 8
2. Organisation of public and private health insurance in Australia 11
2.1 The Australia health care system 12
2.2 Private health insurance in Australia 15
3. Government interventions in PHI markets 18
3.1 Regulation of funds' offerings and activities 18
3.2 Government policies to support the take-up of PHI 23
3.3 Policies to deal with medical gaps 26
4. How well does the Australian health insurance mix meet health policy goals? 28
4.1 How has PHI influenced cost pressures in the health system? 28
4.2 Has PHI increased health system cost-efficiency? 31
4.3 What challenges does PHI pose to equity and access? 32
4.4 Hoes has PHI enhanced responsiveness of health systems? 36
5. Concluding remarks 37

REFERENCES 40

FIGURES AND TABLES

Figure 1. Proportion of insurees by age and gender, hospital insurance (2002) 17
Figure 2. Age profile of privately insured individuals 22
Figure 3. Evolution of population covered by PHI 25
Figure 4. Share of in-hospital medical services involving no medical gap 28

Table 1 Evolution of policies pertaining to public and private health insurance 11
Table 2 Coverage of health services and providers by public and private health insurance in Australia 13
Table 3 Sources of financing of health expenditure in Australia 14
Table 4 Percentage of public acute hospital beds and discharges from public acute hospitals in Australian States and Territories, 2000-01 14
Table 5 Contribution income of the major health funds as share of total market 18
Table 6 Main regulatory provisions on PHI 19
Table 7 Incentive policies to stimulate the take up of PHI ("carrots and sticks") 24
Table 8 Utilisation in public and private hospitals in Australia 29
Table 9 Areas of expenditure by funds and recent nominal growth 35
Table 10 Elective surgery waiting times in public hospitals, Australia 37

PRIVATE HEALTH INSURANCE IN AUSTRALIA: A CASE STUDY

Introduction

9. Among the countries with large private health coverage, Australia is a fascinating case. Large interactions exist between public and private coverage systems. These are the result of government approaches to financing health care, which have largely linked private health insurance (PHI) to the private hospital system, so that support to the former has been an important part of the funding for the latter. Private cover is considered one main vehicle for enhanced choice of provider and level of care. Views about PHI are nonetheless not homogeneous, prompting a lively debate over the role that it should have in the health system. Australia is also the ground of evolving interventions towards PHI. Regulation requires pooling across different risk groups for all private insurees, and a broad mix of regulatory tools and financial incentives has been implemented to achieve policy goals.

10. This study analyses the Australian PHI market, its interaction with public coverage systems, and its contribution to health policy goals such as equity, efficiency and responsiveness of the health system.[1] The analysis seeks to disentangle the factors behind performance, including those related to the insurance market, the regulatory and fiscal environment, and the organisation of the health system. The first part of the report explains why private health insurance plays a relevant role in the Australian health system by reviewing the evolution of government health financing policies (section 1). Public and private health insurance systems, and the regulatory and incentive environment applicable to PHI, are analysed in sections 2 and 3 respectively. All these factors influence actors' incentives and behaviours, affecting the performance of the system, as analysed in section 4. Section 5 concludes with a discussion of some main findings.

1. Policy relevance of private health insurance in Australia

11. Private health insurance plays a prominent role in the Australian health care system and health policy debates. Private hospital insurance covers 44% of the population,[2] one of the highest percentages of private coverage across OECD countries, following France (86%), the USA (70.3%), Canada (70%) and Ireland (48%). While PHI accounts for only 7.1% of total health expenditures, Australia can be grouped within the cluster of OECD countries where PHI has a relatively significant financing role, after the USA (34.8%), the Netherlands (14%), France (12.8%), Germany (12.5%), and Canada (11.2%).

1. The report is one of a series of case studies on private health insurance in selected OECD countries, which will feed into a wider analysis of the role that PHI plays in the health systems of OECD countries. The study uses data collected from two survey instruments (one on regulation and policy initiatives and one on statistics about PHI markets), a comprehensive review of academic and policy literature, and administrative data collected by government bodies. Several focussed group and individual interviews with a wide range of stakeholders were also carried out during a field visit to Australia in autumn 2002.

2. September 2002. Source: PHIAC: http://www.phiac.gov.au/statistics/membershipcoverage/hosquar.htm.

12. Historical reasons are partly behind this role. Until 1974, the Australian health system relied upon voluntary health insurance provided by private funds, subsidised by the government, and regulated under the 1953 National Health Act. Government support to PHI included fiscal advantages and financial incentives. Two main regulatory principles underpinned private cover. Community rating prohibited insurers from rating premiums on the basis of risk status, and open enrolment compelled funds to accept all applicants with no discrimination (Hurley *et al.*, 2002). After considerable debate over the government role in financing health care, and a short-lived introduction of universal public insurance in 1974 (Medibank), universal coverage was eventually re-established with Medicare in 1984 (Scotton, 2000). Medicare provides free hospitalisation in public hospitals and subsidised medical care.

13. Despite universal public health insurance, PHI continued to be a main pillar of the health system, providing cover to a large share of the population. Private hospital insurance covers hospitalisation either in private hospitals or in public hospitals for individuals choosing to be admitted as private patients.[3] It thereby represents a means for accessing different hospital provision channels than those afforded by public insurance. PHI also provides cover for ancillary services not insured by Medicare. However, funds have historically not been allowed to cover the medical costs already subsidised by Medicare, because such duplication was perceived to undermine universal insurance. This has resulted in a prohibition to offer PHI products for medical care received in outpatient settings (GPs and specialist consultations, and other ambulatory treatments), a ban that has been maintained until present.[4] It also resulted in Medicare reimbursing a share of the in-hospital medical costs for treatments received by private patients. Funds' responsibility for covering the remaining "medical gap"[5] has been gradually expanded over time (see section 3.3).

14. The broad population coverage and the perceived value of the choice afforded by private cover may explain why several public policy interventions continued to be applied to PHI even after the introduction of Medicare. Besides financial solvency requirements, Australia thus tightly regulates premium rating and insurers' offering for all private insurees, which reveals a desire to maintain broad participation in the PHI market across different risk cohorts. The core principles of community rating and open enrolment have been maintained in the system until present. Several provisions were also progressively introduced to build consumer confidence in private cover and create the conditions for a stable and viable industry, as analysed in section 4.1.

15. Private health insurance has also been encouraged by several government incentives, although policy changes have swung between supporting private *versus* public funding of the health system (table 1).[6] Over the years PHI has been increasingly viewed as a parallel financing system, or an alternative, to Medicare, and the main vehicle to channel finances towards private hospital care. Direct subsidies to private hospitals were discontinued in 1987, and support for private hospital care has been increasingly

3. *I.e.*, individuals that choose to pay for hospital care through their PHI policy or out-of-pocket, thereby enjoying choice of treating doctor and, where available, private or semi-private accommodation.

4. On 28 May 2003, the Australian Government introduced the Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 to Parliament. Amongst other initiatives, the Bill proposes two new safety nets for those whose medical condition involves them in substantial out-of-pocket expenses. One is the provision that private health insurance funds may offer cover to families for all out-of-pocket costs for out-of-hospital services exceeding USD1 000 in any year. (The other safety net is a Government-funded scheme to cover 80% of out-of-pocket expenses, in excess of USD500 in a calendar year, by pensioners and Commonwealth concession card-holders).

5. "Medical gaps" indicate, in Australia, the difference between doctors' in-hospital fees and the amount reimbursed by Medicare for that service.

6. Immediately after Medicare was introduced, PHI was viewed as a top-up to Medicare, a way for affluent people to opt for private treatment without opting out of Medicare (Deeble, 2003). The PHI system was regulated, but direct subsidies to PHI premiums, which existed prior to the introduction of Medicare, were removed. Government subsidies to private care were directly paid to private hospitals.

achieved by supporting private health insurance. This, together with the fact that Medicare reimburses a share of private in-hospital medical costs, indicates that Australia wishes to promote a mixed financing and provision system, as well as some degree of universal access to private hospital care. Private health insurance turned out to be considered necessary to sustaining a viable and dynamic private care sector, which Australian policy makers view as a vital component of a well-functioning health system.

16. The important role of PHI in financing private hospitals is a significant reason why policy makers became concerned with drops in the level of PHI membership after the introduction of Medicare. The concern was that if the population covered by PHI declined, then private hospitals would be negatively hit, with the consequence of limiting individual choice and increasing demand pressures on public hospitals to unsustainable levels. PHI membership started to drop in 1984 after the introduction of Medicare, and the decline continued in the 1990s, reaching 30% of the population in 1998 down from 50% in 1984. Population coverage decreased for several reasons. People had confidence in the universal coverage system. In the context of regulation mandating that PHI premiums be community-rated, the youngest and healthiest people dropped cover because the premiums they paid exceeded their true risk, creating a process of adverse selection.[7] This reduced risk pooling and increased the costs of coverage for the sicker insured population. Removal of subsidies on PHI premiums after the establishment of Medicare, the increase in the average cost of private hospital claims, and adverse selection, all contributed to premium increases. Private cover became increasingly less attractive and many ceased to consider it good value for money. In the mid-1990s, the private health insurance industry, with skyrocketing premiums and cost, widening operating losses and declining membership, was in crisis. The government became concerned about the load on Medicare as a result of this since the early 1990s.

17. Since 1996, Australian policy makers have implemented further policies to counteract the trend of declining membership and increase the saleability of PHI products. The package of initiatives, which was introduced in 1997 and 1998, included a stick (a tax penalty for high-income individuals without private cover) and a carrot (a 30% rebate on PHI premiums). A further regulatory 'stick', lifetime health cover, was implemented in 2000 to discourage people from delaying purchase of insurance by allowing funds to vary premiums of individuals above 30 according to the age of entry into the fund. Policies to reduce out-of-pocket expenditures associated with PHI have also been designed. These included allowing funds to contract with providers in 1995 and to offer insurance for medical gaps in 2000. Population coverage rose from 30% in 1999 to 45% in 2001.

18. Despite the increase in population coverage, many policy challenges confront the PHI system. The relative effectiveness of the carrot and stick policies is controversial, as well as uncertain is their longer-term impact on stability of PHI membership. Criticisms of the 30% rebate of PHI premiums focus on high opportunity cost of such a policy and its fiscal sustainability. A related issue concerns what should be the appropriate role for PHI in the Australian health system, and the mix of instruments through which the government should intervene to support such a role.

7. According to evidence from Hopkins and Kidd (1996) and Barrett and Conlon (2000), over the period 1989-1995 the probability of insurance coverage became more strongly correlated with health risk and status indicators, indicating an increase in the degree of adverse selection in the pool of insured individuals. Barrett and Conlon analysed data on families and single individuals from National Health Surveys carried out in 1989 and 1995. They utilised a number of explanatory variables to test the likelihood that individuals hold PHI coverage, including socio-economic variables (*e.g.*, sex, age, marital status, income), health status (*e.g.*, prevalence of certain conditions, self-assessed health status), and risk propensity (*e.g.*, smoking, consumption of alcohol). They found an increase in the importance of health status variables over time.

Table 1. Evolution of policies pertaining to public and private health insurance

Year and government	Policy towards public insurance	Policy towards private insurance
Before 1975	• No universal public health insurance	• Voluntary PHI regulated by the 1953 Health Act.
Fraser Government		
1975	• Universal, tax-financed public health insurance introduced: Medibank	
1976	• Health Insurance Levy to finance public insurance (Medibank Mark II)	• Medibank Private established (state-owned fund competing with other funds) • Opt-out option: individuals purchasing PHI would be exempted from the Levy
1978	• Health Insurance Levy removed	
1981		• Tax rebates on PHI introduced
Hawke Government		
1983		• Tax rebates on PHI removed
1984	• Universal public health insurance introduced • Medicare covers 85% of government-set medical fees (MBS) for private in-hospital medical services	• Private funds not permitted to offer PHI for any medical services, including private in-hospital medical services
1983-88		• Subsidies to the PHI reinsurance pool phased out
1985		• PHI funds required to cover 15% of the MBS for private in-hospital medical services
1986		• Bed-day subsidy for private hospital utilisation removed
1987	• Medicare covers 75% of MBS for private in-hospital medical services	• PHI funds required to cover 25% of the MBS for private in-hospital medical services
Keating government		
1993		
1995		• Lawrence Agreements allowing funds to establish contractual relationship with providers
Howard government		
July 1997		• Private Health Insurance Incentive Scheme • Medicare Levy Surcharge for high income earners failing to buy PHI
January 1999	o 1999-2003 Health care agreements indicate that funding to States would be reduced if PHI membership increased above a threshold. This claw-back clause was never applied	• 30% Rebate on PHI premiums
July 2000		• Lifetime health cover: funds allowed to charge regulated age-related premiums for purchasers of PHI after age 30
August 2000		• Funds allowed to offer full medical gap insurance for private inpatient treatments

Source: Adapted from Access Economics, 2002.

2. Organisation of public and private health insurance in Australia[8]

19. The Australian health care system is complex. Responsibilities are shared across different levels of government, involving several public and private payers and providers. Government health policies have been inspired by reliance on market mechanisms to a large extent (providers' competition, free choice of provider by individuals, partial deregulation of health prices, encouragement to private financing and delivery, reliance on financial and fiscal incentives) coupled with regulation to address markets' failure to

8. Factual information has been collected based on an OECD mission to Australia and interviews of stakeholders, and other published material such as Hilless, M. and Healy, J. (2001); Hurley, J., et al (2002). OECD (1995).

deliver equity goals in particular. This section briefly describes the Australia health system (see Annex 1 for more details) and its private health insurance market.

2.1 The Australia health care system

20. Responsibilities for the health system are split between the Commonwealth and States and Territory[9] governments. The Commonwealth funds and operates two *universal* benefit schemes: Medicare and the Pharmaceutical Benefit Scheme (PBS).[10] Public hospitals are jointly funded by the Commonwealth and the States, but the States are responsible for their administration. Funds are transferred from the Commonwealth to the States *via* prospective block grants, which are negotiated every 5 years in Health Care Agreements.[11]

Public and private coverage systems

21. Medicare is Australia's universal public health insurance scheme. All eligible Medicare patients receive free care in public hospitals where they have no choice of treating doctor. Patients can also elect to be treated privately in a public hospital, thereby enjoying freedom of choice of doctor, or in a private hospital, thereby also enjoying the possibility of quicker access to care. Medicare is financed by general taxation and by the Medicare Levy, set at 1.5% of taxable income. Since 1st July 1997, a Medicare Levy surcharge of 1% is applicable to high-income individuals failing to buy a PHI policy with front-end deductibles below an established amount. Medicare also subsidises the cost of medical treatments. While medical practitioners are free to set their fees, Medicare reimburses patients only for a portion of a government set fee schedule (Medicare Benefit Schedule, MBS), which establishes fees for all services and procedures. This subsidy is equal to 85% of the MBS for out-of-hospital treatments, and 75% of the MBS for in-hospital medical treatments delivered to private patients (public patients receive free hospital care).

22. There are two main types of private health cover. Private hospital insurance covers hospital inpatient charges for private patients (*e.g.*, theatre fees, accommodation). Funds are also obliged to pay 25% of the MBS rates for the medical in-hospital costs of private patients, and since 2000 can also cover part or the entire medical gap over the government set medical fees. Individuals are liable for paying any residual medical gap, and any cost sharing imposed by the PHI policy. Private ancillary insurance covers services not reimbursed by Medicare such as dental care, physiotherapy, and glasses,[12] subject to cost-

9. States include New South Wales, Queensland, Victoria, South Australia, Western Australia, and Tasmania. Territories include the Northern Territories and the Australian Capital Territory. In this paper, the text refers to "States" to indicate both States and Territories.

10. The Pharmaceutical Benefit Scheme subsidises the cost of listed pharmaceuticals, including most prescription drugs. Individuals are liable for co-payments, which are negligible for concession card holders. The Health Insurance Commission (HIC), Medicare's payment agency, administers enrolments and benefit payments under Medicare and PBS. HIC also administers the 30% rebate on PHI premiums.

11. The 1998-2003 Agreements included a "claw-back clause" according to which States would see a reduction in funds from the Commonwealth if PHI membership rose above certain levels. The clause was never applied. In the round of negotiation for the 2003-2008 Health care Agreements, the Commonwealth and States governments debated the appropriateness of the 30% rebate on PHI premiums. The State and Territory governments claim that increased subsidises to public hospitals would be a more efficient and equitable use of the money spent in the rebate, while the Commonwealth defend the rebate on the ground that it increased PHI membership, individual choice, and utilisation in private hospitals.

12. Ancillaries include, for example, non-physician professional services (*e.g.*, physiotherapy, dental), optometric services, dentistry, home care, prostheses, hearing aids, ambulance, acupuncture and other ancillaries. Similar types of supplementary health insurance cover a wide range of different services across OECD countries, depending on what the public insurance system does not cover, and the insurers' definition of 'health benefits'.

sharing imposed by the PHI product. Table 2 provides more detail about the Australian health coverage mix.

Table 2. Coverage of health services and providers by public and private health insurance in Australia

	PUBLIC HEALH INSURANCE (Medicare, PBS, other public funding)	**PRIVATE HEALTH INSURANCE (Private hospitals and private ancillary insurance)**
Hospital care		
Hospital charges	Public patients (in public hospitals) • Universal free care under Medicare • Medicare covers the full cost of public patients' in-patient stay (theatre, basic accommodation) • Upgraded accommodation not covered by Medicare	Private patients (in public or private hospitals) • Private hospital insurance covers hospital in-patient charges for private patients, subject to cost-sharing imposed by the PHI policy (*e.g.,* deductibles) • In public hospitals, the benefit paid by the funds is equal to the Medicare Benefit Schedule (MBS) daily rates • In private hospitals, the benefit paid by the fund is negotiated if funds enter into contractual agreement, or is otherwise a default payment set by the government
Drugs	Public and private patients • The Pharmaceutical Benefit Scheme (PBS) covers the cost of listed drugs	• Private hospital insurance covers part or all of the cost of drugs that are not reimbursed by the PBS
Medical charges	Public patients (public hospitals) • Medicare covers doctors' fee in public hospitals, with no co-payments • No choice of doctor Private patients (public & private hospitals) • Medicare subsidies private patients' fees for 75% of MBS rates	Public and private hospitals • Private hospital insurance must covers 25% of MBS rates • Private hospitals insurance may cover the remaining gap above the MBS rates, based on non-contractual agreements with doctors • Choice of doctor by patients • Medical fees are unregulated (but funds can reach agreements with doctors on fees)
Ambulatory physician services (GPs and specialists)	• Medicare offers a universal rebate on these medical costs equal to 85% of MBS rates. • Doctors' fees are unregulated: - Doctor can bill Medicare directly and accept the MBS rate as full payment (bulk-billing). - Doctors are allowed to charge above the MBS rate. In this case, individuals pay in advance and bear themselves out-of-pocket payments equal to 15% of MBS fee and any extra billing.	• Private health insurance coverage NOT allowed
Long-term care and home care	• Predominantly publicly financed (but not by Medicare).	• Private health insurance is allowed but is not common.
Drugs *Prescription drugs* *Other drugs*	• All Australians are covered through the Pharmaceutical Benefit Scheme (PBS) • Individuals are liable for co-payments • Not covered	• Private health insurance coverage of co-payments not allowed • Private health insurance (hospitals and/or ancillary PHI) can cover the cost of these drugs
Ancillary benefits	• Not covered by Medicare	• Private ancillary insurance covers services not insured by Medicare (*e.g.,* alternative medicine, optical, dental, physiotherapy, etc)

Source: OECD elaboration based on several sources.

23. The Australian composition of public and private sources of health care expenditures (Table 3) is not dissimilar from that of other OECD countries. Public health expenditures accounts for about 70% of total health expenditures (THE) in Australia and, on average, 72% in OECD member countries. Out-of-pocket expenditure represents, on average, about 18.1%[13] and about 17% in Australia. The contribution of PHI to THE in Australia (7.1%) is similar to the OECD average of 6.9% for 1998[14] (5.2% excluding the USA). It steadily declined from 1991-2000, with a slight increase in 2000-01. (See also Annex 1)

13. Data from OECD Health Data 2001 from 28 countries for public health expenditures and from 18 countries for out-of-pocket payments (OOP).

14. Data from OECD Health Data 2001 for 17 OECD countries

Table 3. Sources of financing of health expenditure in Australia

	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
Government	67.67	67.34	66.94	66.37	66.32	67.15	66.55	67.93	68.76	70.25	69.96
PHI funds	11.23	11.46	11.34	11.02	10.71	10.52	10.40	9.16	7.86	6.82	7.13
Out-of-pocket	16.12	16.73	16.80	16.96	17.09	16.04	16.73	16.79	17.46	17.42	17.35
Other private	4.98	4.47	4.93	5.66	5.87	6.29	6.32	6.12	5.92	5.52	5.56
Break-down of private sources (total private sources = 100% and includes: PHI + OOP + Other)											
PHI funds	34.7	35.1	34.3	32.8	31.8	32.0	31.1	28.6	25.2	22.9	23.8
Out-of-pocket	49.9	51.2	50.8	50.4	50.8	48.8	50.0	52.4	55.9	58.5	57.7

Source: AIHW (2002). Health expenditure Australia 2001-01. "Year" refers to the financial year 1 July to 30 June. Note: PHI: Private Health Insurance; OOP: Out-of-Pocket expenditure.

Provision of services

24. Health care delivery is undertaken by a mix of private and public providers. Patients enjoy free choice of private provider. Setting aside a few GPs directly employed by the Commonwealth and medical officers employed as permanent staff in public hospitals, all doctors are self-employed. Australia has a large and growing private hospital sector operating alongside public hospitals. The 726 acute public hospitals provide for about 66% of the total acute bed stock[15] and 63% of acute care discharges with some variation across States (Table 4). Public hospitals tend to provide the most advanced tertiary treatments, accident and emergency services, and teaching facilities. The 509 private hospitals include 207 free-standing day hospital facilities and 302 other private hospitals. The predominant services provided are simple non-emergency care, such as uncomplicated elective surgery, however over the recent years clinical capacity and complexity of care in the private sector has expanded[16] (See also Annex 1).

Table 4. Percentage of public acute hospital beds and discharges from public acute hospitals in Australian States and Territories, 2000-01

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public acute beds/total acute beds	68.46%	64.83%	61.26%	63.83%	67.21%	55.65%	na	na	65.71%
Discharges from public acute beds/total discharges from acute beds	66.27%	64.57%	57.49%	59.35%	67.16%	53.14%	71.59%	na	63.39%

Source: Calculated based on data from AIHW (2002c).

Provider payments

25. The predominant professional payment for doctors is fee-for-service. In ambulatory settings, doctors can accept to receive from Medicare 85% of the MBS rates as full payment, with no further payment by individuals (bulk-billing).[17] However they are free not to bulk-bill patients and set their fee

15. Source: AIHW (2002c). Australian hospital statistics 2001-2001. Canberra: AIHW.

16. 30 private hospitals also run emergency departments, but most deal with elective surgery (source: APHA).

17. In the case of bulk-billing, doctors are directly paid by the Health Insurance Commission. Otherwise, the patient is liable for paying the doctor and can claim from the HIC the 85% of the MBS rates for medical charges. Almost 70% of all services are bulk-billed as are the vast majority of GP services.

competitively, and indeed bulk-billing rates have been decreasing over time.[18] For in-hospital medical treatments, doctors in public hospital are salaried or paid on a sessional basis for caring for public patients. Fees for private patients are on the contrary established competitively by the doctor, although public hospitals and private heath funds may seek to influence the level of the fee charged.[19] (See also Annex 1).

26. States determine the levels of funding and conditions for funding of public hospitals. Public hospitals are mainly financed through global budgets, casemix payments, or a combination of both. Almost all private hospitals are involved in contractual relationships with private health funds. The content of the contract concerns the level of the benefit paid (usually a *per diem*, although some funds are shifting to bundling payments on an episodic basis).[20] There is virtually no selective contracting in the system, and hospitals with no contracts with funds are entitled to receive a default *per diem* benefit payment by funds.[21] For hospitalisation of private patients in public hospitals, funds reimburse hospitals based on MBS daily rates. Funds do not have contractual agreement with doctors; however they establish non-contractual arrangements with some doctors concerning PHI coverage of the medical gap above MBS rates.

2.2 Private health insurance in Australia

27. Hospital private health insurance duplicates public coverage systems (for hospital stays) and complements Medicare (for coverage of the in-hospital medical 'gaps' faced by private patients). Ancillary private health insurance, on the other hand, supplements Medicare for services that are not publicly financed. These include dental, optical, chiropractic, physiotherapy, psychological counselling, occupational therapy, speech therapy and podiatry. Both types of cover are offered by competing funds, the majority of which are non-profit. Demand for PHI generally does not have an employment link and is largely determined by income.

Regulation of PHI vis-à-vis public coverage systems

28. The Australian approach to duplicate private health insurance presents some unique elements. Besides providing cover for in-hospital accommodation (bed, nursing, meals) funds can also duplicate coverage offered by the public system for a range of in-hospital services provided to Medicare patients in public hospitals, including rehabilitation, psychiatric and palliative care. However, Australia currently prohibits private funds from covering out-of-hospital services, including procedures in doctors' rooms for which a Medicare benefit is payable.[22] Medicare also pays 75% of the Medical Benefits Schedule fee for

18. The Health Legislation Amendment (Medicare and Private Health Insurance) Bill 2003 proposes the introduction of a General Practice Access Scheme through which general practitioners, who guarantee to provide medical care at no cost to patients who are covered by concession cards, will receive financial and other incentives. This is intended to counter the declining trend in bulk-billing.

19. The public hospital may require that doctors treating private patients charge fees no higher than the MBS rates. Funds also suggest fee schedules as part of "no or known gap" arrangements (see section 3.3). There remain nonetheless significant medical gaps particularly on surgeon bills. The government has taken varying approaches to the challenge posed by in-hospital medical gaps, and these have affected the role played by private health funds.

20. Reimbursement structures are not uniform. Usually, if a provider has an agreement with the fund the hospital sends the invoice directly to the fund. Some hospitals also function as billing agencies that manage the medical bills on behalf of the patients (so called "simplified billing": in this case, the patient is only given one bill indicating any out-of-pocket expenditure s/he has to bear. Otherwise, the doctor directly bills the individual.

21. As described later in section 3.3, there are two levels of default payments, which are both regulated. The basic default payment indicates the per diem that funds must pay to hospitals with which they have no contract (USD242 in 2002). The second tier default payment requires funds to pay non-contracted hospitals that meet certain quality and billing criteria a benefit equal to 85% of the average benefit paid to contracted hospitals.

22. See footnote 4 on recent initiatives for the coverage of outpatient expenses.

in-hospital medical costs, while PHI must cover a complementary share equal to 25% of the MBS fee for such services. (Funds do not have to contribute to the costs of medical services not listed in the MBS, for which Medicare does not pay a benefit either). Additionally, funds may cover the "medical gap", the difference between the fee charged by doctors for private health services and the combined health insurance and Medicare benefits for those services.[23]

29. This approach produces three effects. First, there is a large subsidy from Medicare to the private health insurance system (and indirectly, to private hospitals) as Medicare pays a share of the cost of inpatient medical treatments for private patients. Second, private hospital insurance pays for medical fees in excess of the government-set fee schedule (the Medicare Benefits Schedule-MBS) for in-hospital treatments, thus complementing the share of cost already reimbursed by Medicare.[24] Third, the ban on coverage of out-of-hospital medical treatments may encourage some doctors to treat patients as inpatients. The impact that such health insurance mix has on health system performance is reviewed in section 4.

The PHI market: Demand and supply

30. Private hospital insurance covers 44% of the population, and about 35% have both ancillary and hospital cover (which can be sold as stand-alone policies or packaged together). Less than 6% of the population purchases ancillary products alone. According to existing estimates, demand for private cover is not very sensitive to price (Clarke, 1998; Hopkins and Frech, 2001; Butler, 1999). Income has on the other hand a dominant influence on insurance status (Hopkins and Kidd, 1996; Barrett and Conlon, 2002),[25] which is consistent with evidence from other OECD countries. The likelihood of having private coverage is lower for individuals with concession health cards,[26] of which only 22% had PHI in 1998 (ABS, 1998). Age seems to affect purchasing decisions: levels of PHI coverage increase with age to reach a peak in the age cohort 45-54, declining thereafter (Figure 1).[27] Population membership varies across States, particularly for ancillary insurance, for example 22% of the population had ancillary PHI coverage in Victoria compared to 44% in Western Australia (ABS, 1998). The main reason for buying PHI seems to be risk aversion (47% of insured bought PHI coverage in 1998 for "security"). Choice of doctor and shorter waiting times are also important reasons (respectively 25% and 22%), while people not purchasing PHI think they don't need cover, or that Medicare already provides adequate cover, or that PHI does not offer good value for money (ABS, 1998).

23. Other OECD countries either entirely allow or prohibit duplication of public coverage systems. For example Canada forbids private health insurers from covering any medically necessary hospital, in-hospital and outpatient physician services which are provided by the publicly financed system. On the other hand, Ireland, New Zealand, the UK, and several Mediterranean and Scandinavian countries have no prohibition on duplication, although hospital coverage seems to be the predominant market. In addition, in other OECD countries with duplicate PHI systems, insurers cover the out-of-hospital and the in-hospital medical cost as well as hospital private charges.

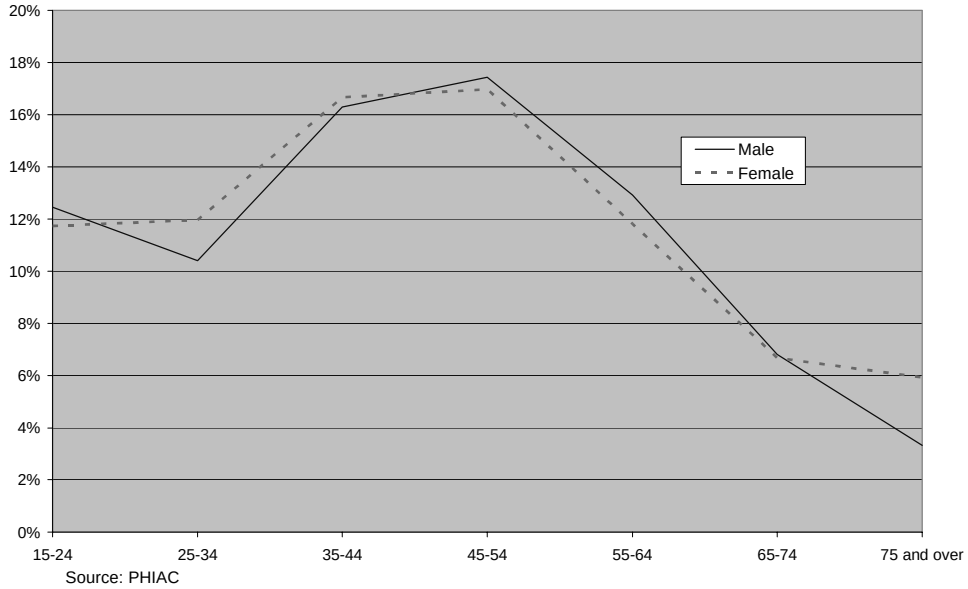
24. Conversely, private health insurance is not allowed to cover co-payments on drugs reimbursed by the Pharmaceutical Benefit Scheme, except where the patient has 100% health insurance cover for private hospital treatment and where the hospital has entered into a relevant contract with the patient's health fund

25. Barrett and Conlon (2002) provide a review of the Australian literature on factors affecting demand for PHI. All studies are consistent with the finding that demand for PHI is largely explained by income.

26. Low-income individuals who are entitled to reduction in the cost of prescribed medicines.

27. Levels of coverage are also high at birth, possibly because of large PHI coverage by couples with children.

Figure 1. Proportion of insurees by age and gender, hospital insurance (2002)



Source: PHIAC

31. Unlike many other OECD countries where PHI is largely purchased by employers, representing a work-related benefit, Australia has a predominantly individual market. This occurs in part because of historical and cultural reasons and in part because of the disincentives of the fringe benefit tax systems.[28]

32. Private health insurance is provided by health funds, most of which are incorporated mutual associations. Under the 1953 National Health Act, health funds are not permitted to conduct other business and must be registered with the government. Forty-three funds operate in Australia, of which 6 are for-profit. There is no visible difference in market behaviour between for-profit and not-for-profit funds, the only distinction being that the former can pay dividends[29] and have to pay taxes on profit. Health funds are either open to all members (28) or 'restricted membership' (15). These latter are union-based or employer-based, and provide insurance to certain professions such as teachers, defence forces, the medical profession, etc.[30] Restricted membership funds represent about 6% of the market. Given their employer-link, they tend to have a younger membership base and enjoy higher administrative flexibility than open funds. Both types of funds are subject to the same regulation and to the same capital adequacy and solvency requirements. With some limited exceptions, self-funding employers not licensed as health insurer cannot operate in the health insurance market nor bear the risk related to health insurance. Despite the large number of funds, the Australian PHI market is concentrated. As at 30 June 2002, Medibank Private Limited, the government-owned insurer, had a market share of 30%. The market share (by earned income) of the top 6 funds was 76.7%,[31] while the membership of the three major funds was 57% of the privately insured population.[32]

28. Nonetheless, some funds design and advertise policies specifically attractive to employers, which would then be purchased by individuals of the group. Employers may also provide corporate contributions to individual policies. The advantage of such products is a wider risk pool and therefore lower individual prices.

29. Dividends must be paid from monies in excess of the statutory minimum reserve levels.

30. Source: PHIAC: http://www.phiac.gov.au/healthfunds/list.html.

31. Source : http://www.actuaries.asn.au/PublicSite/pdf/hpchiorgs.PDF

32. Source: OECD Statistical questionnaire on PHI.

Table 5. Contribution income of the major health funds as share of total market

	Market share*	States where market leader and relative market share**
Medibank (MB)	27.8%	Victoria: 39.1%
Medical Benefits Fund (MBF)	18.0%	Queensland: 44.7% Tasmania: 46.1% New South Wales 24.0%
BUPA Australia (former AXA)	11.3%	South Australia: 51.9%
Hospital Contributors of Australia (HCA)	7.3%	
HBF Health Funds	6.9%	Western Australia: 69.5%

Source: * http://www.actuaries.asn.au/PublicSite/pdf/hpchiorgs.PDF, based on earned contributions in PHIAC's Annual Report for 2001/02. ** *ACHSE (2001).* Data based on hospital PHI contribution income for 1999/2000.

33. While insurers offer two main types of coverage (hospital and ancillary insurance) several different products can be found on the market that can be advertised and priced differently. Policies can differ in terms of out-of-pocket payments (particularly deductibles) and benefits covered (*e.g.,* exclusions or limitations from coverage of certain conditions). Individuals pay lower premiums if they buy policies excluding or limiting benefits for certain conditions, or if they agree to pay part of the cost of hospital treatments themselves. Since 2000, all funds are required to offer at least one policy that covers 100% of any in-hospital medical gaps, and the majority of the insurees buy this policy. They must also offer at least one policy which only covers the cost of being a private patient in a public hospital. Funds can also offer 'known gap' policies, where the extent of the medical gap is fixed and known by the insuree. Ancillary PHI can be acquired on its own or, more frequently, together with hospital insurance.

3. Government interventions in PHI markets

34. This section reviews the main government interventions towards the Australian PHI market and their impact on the structure of the health insurance system. It considers the key regulatory tools, the incentive schemes implemented to support PHI membership, and policies to reduce the gaps associated with private cover.

3.1 Regulation of funds' offerings and activities[33]

35. The scope of regulation on PHI in Australia is wide-ranging, as can be seen in Table 6. As in all other OECD countries, funds must adhere to financial solvency requirements, necessary to ensure insurers' financial stability. In addition, Australia tightly regulates funds' offerings and activities.

33. Responsibilities for regulating PHI are mainly split between the Private Health Insurance Administration Council (PHIAC) and the Commonwealth Department for Health and Ageing (DHA). PHIAC is an independent Statutory Authority responsible for financial regulation of PHI industry. The Australian Commonwealth Department of Health and Ageing sets policies on private health insurance and regulates the health insurance activity on its own. There is no overlap of powers between PHIAC and the DHA, the only partial duplication concerns the premium approval process.

Table 6. Main regulatory provisions on PHI

Main policy goal of regulation	Type of regulation	Description
REGULATION OF PHI IN ITS INTERACTION WITH PUBLIC COVERAGE SYSTEMS		
Ensure sustainable and fair public health insurance	Coverage of services allowed to PHI	• Funds cannot offer cover for out of hospital medical services for which Medicare already pays a benefit. • Funds are required to cover medical fees on private in-patient stays for 25% of MBS rates. Funds can also cover any remaining medical gap above the MBS rate. • Funds cannot cover co-payments on pharmaceuticals listed in the PBS.
	Provider coverage	• Funds can cover stays in public hospitals by private patients • Funds can cover services provided by private hospitals.
FINANCIAL REGULATION		
Promoting fund's financial stability	Solvency	• At any time, the value of the assets of the Fund must be of an amount considered sufficient to meet the obligations of the Fund at that date.
	Capital adequacy	• At any time, the value of the assets of the Fund must be of an amount considered sufficient to allow the Fund to continue to meet, into the future, its obligations.
REGULATION OF HEALTH FUNDS OFFERINGS AND ACTIVITIES		
Ensuring equity of PHI coverage	Open enrolment	• Insurers have to accept all applicants within certain membership categories. Risk selection/discrimination of the basis of sex, age, health status, etc is prohibited.
	Community rating	• Premiums are community-rated (Health Insurance Act, 1953) for each product. • Automatic renewal of membership.
	Product approval	• New products or changes in existing products must be filed with the Department for Health and Ageing, which may disapprove them.
	Minimum benefits	• All funds are required to provide Federal Government Defaults Benefits, although they may have policies covering those only as private patients in a public hospital.
Guaranteeing affordable coverage and financing equity	Premium approval	• Premiums must be filed with the Department for Health and Ageing, which may disapprove them.
	Gap cover scheme	• The Gap cover schemes – Act (2000) allows funds to cover part or the entire medical gap for private in-patient care above scheduled MBS fees. • Funds are obliged to offer at least one policy involving no gap.
Protecting consumers and building confidence	PHI Ombudsman	• Deals with consumer complaints. • Publishes aggregate data about complaints. • Makes available and publicises the Private Patients' Hospital Charter. • Does not have power to enforce a certain course of action following investigation of complaints, but usually funds adhere to recommendations.
	Informed financial consent	• Medical practitioners charging patient an amount above the benefit provided by the health fund must inform the patient of this cost, and obtain written financial consent. • Funds have an obligation to include in their agreements with hospitals a clause according to which providers apply informed financial consent requirements
	Information disclosure requirements	• Funds can change premiums or rules on PHI coverage but are required to inform members of any change adversely affecting the scope, level or nature of the benefit, including premium increases.
	Portability of cover	• Individuals transferring between funds do not need to serve additional waiting periods, if they transfer to a product with the same or lower level of benefits. • Benefits paid by the previous fund may be taken into consideration by the new fund when determining the annual benefit limit.
Protecting insurers against adverse selection	Waiting period	• Health funds may impose waiting period on hospital treatments where it is apparent that there was a pre-existing ailment. Waiting periods for pre-existing conditions consists of: i) 12 months for pre-existing ailments; ii) 12 months for obstetrics; iii) 2 months for all other circumstances.
	Pre-existing ailments	• A pre-existent ailment is an ailment, illness or condition, the signs of symptoms of which, in the opinion of the medical practitioner appointed by the fund, existed at any time during the 6 months prior to joining or upgrading a hospital PHI product.
	Exclusions and front-end deductibles	• Insurers are allowed to have exclusions in policies (for example a disease condition such as maternity, hip replacement, knee replacement, etc). • Since 1996, insurers can offer policies with front-end deductibles specifying the amount that an individual has to pay before health fund benefits are payable.
	Lifetime cover	• Introduced in 2000 as slight modification to the community rating regime by allowing funds to rate premiums on the basis of age of entry (see details in table 7)
Ensuring fair competition	Reinsurance	• A reinsurance pool exists, which equalised the cost of the elderly and chronically ill (*i.e.* hospitalised for over 35 days) across funds.

Sources: OECD questionnaire; PHIAC information booklet: "Insure or not sure?"; Walker (2002); Ombudsman (2002).

36. Historically, Australia has imposed stringent underwriting limits and rating requirements on all PHI products offered by health insurers in an effort to promote equitable access and pricing across age and risk cohorts, which is considered an important and ongoing government priority. The principles of community rating and open enrolment were maintained in the PHI market after universal public health insurance was established. Community rating, requiring premiums not to vary by risk,[34] is applied to the pool of individuals buying a given hospital or ancillary product in any given fund. This is linked to open enrolment, which guarantees access to PHI coverage by all applicants with no right of refusal for funds and include the continuous renewal of coverage over time.[35] Other regulatory provisions also seek to protect consumers and enhance opportunities for individuals to exercise choice of products and health fund. The PHI Ombudsman, a statutory corporation established in 1995 under the 1953 National Health Act, resolves complaints relating to PHI and acts as an umpire in dispute resolution (Ombudsman, 2002).

37. Funds are subject to premium[36] and product approval requirements. While they are allowed freedom and flexibility to design new products, they are required to notify the Department of Health and Ageing of any new product, or change in product. This allows the government to prevent changes that would breach the requirements of private health insurance legislation.[37] Funds can change the rules applicable to various PHI products unilaterally although they are obliged to communicate to insurees any change in policies or premiums adversely affecting their cover. The purpose of this regulation is to allow insurers to differentiate their products (which is desirable for individual choice) while preserving the principle of community rating by hindering insurers' ability to make PHI products selectively available to lower-risk individuals at lower prices.

38. A financial equalisation system operates across all funds for hospital cover. The Australian system of reinsurance pools 79% of the cost of over-65 members and insurees who were hospitalised for more than 35 days, and equalises such cost across funds with different risk structures. The rationale for reinsurance is to remove funds' incentives to select good risks that insurers may face in a voluntary PHI market with community-rated premiums, thus creating the conditions for fair competition across insurers with different risk structures.

39. These and other regulations have done well in promoting access to PHI across different risk groups, protect consumers and encourage fair competition across insurers. The achievement of such goals has however at times revealed some tensions. Regulatory tools to promote some policy objectives may induce certain strategic behaviours in insurers and individuals that may hamper other policy objectives. Among others, three challenges to the Australian PHI market have emerged in relation to its regulatory structure. The first concerns certain opportunities that exist under Australia's PHI regulatory structure that may undercut the goals of community rating. The second concerns the stabilisation of membership in the PHI market, particularly in relation to adverse selection. The third concerns experimentation with new approaches for monitoring insurers' activities.

---

34. Community rating refers to the method of premium calculation under which premiums are uniform and calculated according to the average risk of a group. In the case of Australia, some variation by age has been permitted since the introduction of lifetime cover.

35. Unlike other OECD countries where insurees enter into a contract to receive a package of benefits for a specified length of time, after which the contract needs to be renewed, PHI buyers in Australia do not receive a contract specifying the duration of the terms and conditions applicable to their cover.

36. PHIAC comments on the prudential effect of a fund's demand for premium increases, while the DHA is more concerned with its inflationary impact and affordability by consumers. The Minister makes final decision, taking into account both of these criteria, and may disallow premium increases.

37. The Health Legislation Amendment (Private Health Insurance Reform) Amendment Bill 2003, proposes removal of the current rule change assessment process and replacement of it by a system of monitoring and enforcement (see below under Innovation in regulatory approaches").

Challenges in relation to community rating

40. Community-rating is required within the pool of insured for each different product, but significant product differentiation according to benefits and cost-sharing provisions is allowed. Funds usually offer a very large variety of hospital and ancillary tables. While only about 20 plans are truly differentiated, there are up to 1 600 products on the market.[38] Insurers' have the ability to change the scope of products already purchased and the conditions applicable on any given product, subject to a small notice period, and subject to regulatory approval. This means that consumers are not assured that their contract will remain unchanged during any specified time period (such as an annual contract term). Insurers can decide to 'close' a product to new members and force migrations of individuals to a different product. People perceiving that their cover offers limited value for money can migrate to new products better suited to their risk profile, often at a lower cost. Meanwhile, higher risk persons may choose to stay in the existing product (due for example to its benefits), but its cost may rise according to the risk profile of enrolees.

41. The proliferation of products and funds' freedom to change conditions of cover gives insurers the opportunity to direct individuals according to risk by allowing lower-risk individuals to self-select into less comprehensive policies. Less generous policies that attract better risks can be priced more competitively, as premiums reflect differences in subscribers' risk rather than solely differences in benefits covered.[39] As funds have to accept new applicants and are unable to selectively lower their premiums to appeal to lower risk persons, they may seek to select risks indirectly, by designing different hospital and ancillary products. Certain avenues for insurer risk selection hence remain, tough they may be difficult to monitor.

Adverse selection

42. Regulatory refinements have been introduced to address certain adverse selection phenomena that the PHI sector faced during the 1990s. Adverse selection harms insurers both because it creates unfair competitive advantages for funds with better-than-average risk structures, and because, especially in the context of community rated premiums, it creates a premium death spiral hampering the long-term financial sustainability of the industry. Regulatory provisions to contain certain opportunistic behaviours by insurees include limitations on coverage of pre-existing conditions and waiting periods.[40] Since 1996, funds have also been granted the ability to introduce some exclusionary products (for example for a particular disease condition) and front-end deductibles.

43. Measures to give private funds greater allowance for risk pricing had also been advocated as a solution to the destabilising effects of adverse selection in the voluntary PHI market (Banks, 1998; Productivity Commission, 1999). This has been in part addressed with the introduction of lifetime health cover, which encourages the take up of insurance policies at early stages of life. Younger population groups indeed joined PHI after the introduction of lifetime health cover, which helped to improve overall risk profiles.[41] While the degree of risk adjustment allowed by lifetime cover may not eliminate entirely

38. According to commentators interviewed during case study tours. Vaithianathan, R. (2000), compared the number of plans options offered by the largest insurers in Australia and in New Zealand, finding that in New Zealand, where community rating is not mandated, plan diversity is less than in Australia.

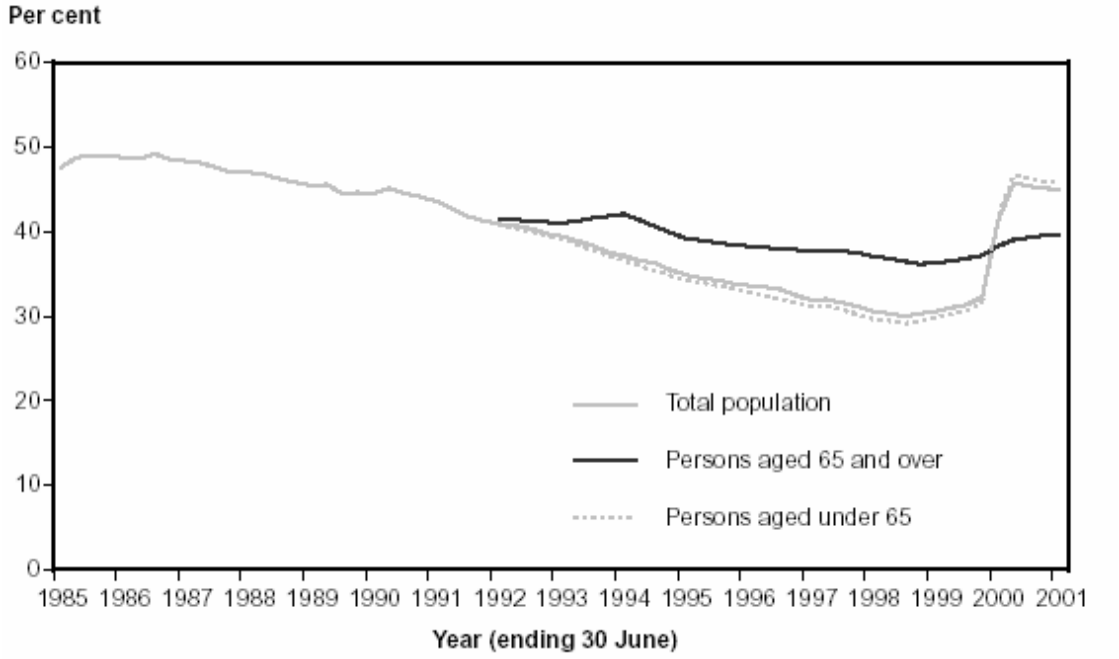
39. For example, certain products excluding services more frequently utilised by the elderly, such as hip replacement, or excluding certain gender-oriented services, such as gynaecological and obstetrics benefits, may be biased towards younger age cohorts and males.

40. The Government has introduced best practice guidelines for pre-existing ailments waiting periods.

41. In March 2000, 26.9% of people aged 30-34 had PHI. Lifetime health cover was introduced from 1 July 2000. In September 2000 this percentage had grown to 45.9. As at 31 March 2003 the figure was 40.3%. The percentage of the total population with private health insurance during the same timeframes was 32.6%, 46.8 % and 44.8% respectively.

adverse selection incentives,[42] lifetime health cover encourages relatively young people to consider taking out health insurance and maintaining their cover rather than waiting to buy PHI when they think they will use it. Further policies in this direction would reduce equity of coverage by weakening the principle of community rating.[43]

Figure 2. Age profile of privately insured individuals



Source: AIWH, 2002. Figure 5.6. Based on PHIAC data

Sources: AIHW, 2002. Based onPHIAC 2001, 2002 and PHIAC unpublished data.

Innovation in regulatory approaches

44. Australia is engaged in several innovative efforts with the scope and content of its PHI regulation. While regulation has traditionally followed a 'command and control' approach, specifying and approving contract provisions, regulators are currently experimenting with incentive-based, or "outcome-oriented", regulation, to come into effect in July 2003. This is meant to simplify the complex and hefty regulatory framework on private health insurance. Under this approach, regulators would monitor specified indicators, and would only impose more traditional and lengthy control and approval processes if funds failed to meet certain outcome targets.

45. As part of this effort, the government is concentrating on outcomes relating to premium inflation, community-rating requirements, and efficiency indicators based on management expenses. For example, the annual premium change procedure has been streamlined for funds proposing an increase equal to, or less than, the change in CPI, thus reducing reporting paperwork for these funds. However, the Minister

42. This is because the 2% loading on premiums (for each year over age 30 for individuals that did not buy cover) may not be a penalty large enough to maintain young and healthy people within the pool in the long-run.

43. Regulators face a trade-off between the need to protect insurers from being adversely selected against, which would improve by giving insurers more allowance for risk rating, and the need to guarantee equity of access to the pool for high-risk groups, which is promoted by community rating.

continues to retain discretion to disapprove increases, if the Minister considers disapproval to be in the public interest. Another example includes an attempt to closely examine the changing risk profiles of funds, by monitoring hospital utilisation by fund. Through this measure, regulators seek to detect funds engaged in risk selection activities. With respect to the premium approval measure, while funds appreciate this effort and foresee that it could provide some relief, some raise the question of whether the proposed limit is high enough to accommodate increases in medical costs. Some also question whether hospital utilisation measures are the best or most appropriate proxy for fund' risk profiles. Confirming the accuracy of such filings is also one of several challenges for these measures.

46. The success of the initiative will hinge upon the choice of the indicators and the ability of this new approach to truly reduce the regulatory burden of funds, while maintaining consumer protection. It will also be affected by any unintended, but related, consequences.[44] The process through which indicators are chosen, including the involvement and acceptance by the industry, may affect its implementation.

47. The Australian authorities have also sought to encourage insurers' self-regulation.[45] One example of self-regulation is the "Voluntary code of practice for hospital purchaser/provider agreement negotiations between private hospitals and private health insurers", which was agreed upon by the Australian Private Hospitals Association and the Australian Health Insurance Association. The Code encourages best practice in contracting, and is particularly concerned with the negotiation process and with contract renewal issues.[46] Open issues concern the adoption of the Code by all parties and certain areas of disagreement.

3.2 Government policies to support the take-up of PHI

48. Encouraging private health insurance has been an important goal of the Federal government since 1996. Table 7 summarises the main incentive policies to stimulate the take-up of PHI and improve the deteriorating risk profile of the insured pool (so-called "carrots and sticks" policies). Those evaluating the relative effectiveness of these policies – the subsidies, the tax penalty, lifetime cover, and the publicity campaign associated with lifetime cover – disagree on their influence.[47]

44. For example, there are concerns among insurers that a focus on the number of hospitalisations as a proxy for measuring risk-spreading within funds may not accurately measure actual mix of risk categories.

45. Voluntary codes of practice include: the establishment of a voluntary industry convention that premium increases will occur only once per year; a code of practice for ancillary benefits; a code on the development of information statements on PHI products (Key Features guides). The Government has also given the industry the opportunity to self-regulate in the area of standard disclosure of information on PHI products, but is prepared to regulate if a national code will not be implemented by the end of 2004.

46. If the Code is breached, a dispute resolution process takes place. Fist, the dispute is taken between the fund and the hospital; second, and if conflict persists, the dispute is taken to the Ombudsman for resolution. The code is currently under review. One debated issue is whether it should be made mandatory or not.

47. The effects of the policies have been analysed by a number of commentators including: Access Economics, 2002; Butler, 2002; Clarke, 1999; Deeble, 2003; Duckett and Jackson, 2000; Hall *et al.*, 1999; Hopkins and Frech, 2001; Palmer, 2000; Vaithianathan, 2000; Vaithianathan, 2002; Willcox 2001; Harper, 2003.

Table 7. Incentive policies to stimulate the take up of PHI ("carrots and sticks")

Type of incentive	Date of introduction	Main provisions of the Scheme	Applicability
Private Health Insurance Incentive Scheme (PHIIS)	1/07/1997	• Subsidy for lowest income band: means-tested partial premium refund • Tax penalty for highest income band: 1% Medicare Levy Surcharge for individuals failing to purchase an eligible hospital and/or ancillary PHI (eligible defined as minimum annual premium) • No incentives nor sticks for the middle income band	Hospital and Ancillary PHI
Amendment to PHIIS (Rebate)	31/12/1998	• 30% premium rebate for all individuals purchasing PHI, replacing the means-tested subsidy • Change in criteria for avoidance of tax penalty: eligibility defined as hospital PHI with front-end-deductibles lower than a set amount	Hospital and Ancillary PHI
Lifetime health cover	Announcement: 29/09/1999 Implementation: 15/07/2000	• Health funds are required to apply the same base premiums, calculated at age 30, as long as individuals take out insurance cover before 30 and remain insured thereafter • Insurers can apply premium increases to individuals buying health coverage after age 30 equal to 2% of the base premium per each year of age above 30, with a maximum increase of 70% • Above 30 individuals without hospital cover before 15 July 2000 would pay a uniform but higher premium over the rest of their lifetime. • People aged 65 years and over on 1st July 2000 are exempt from lifetime community rating. • Transfer of membership across funds does not affect the continuity of membership for lifetime community rating.	Hospital PHI

Source: Butler, 2002; PHIAC: *Insure? Not Sure?*

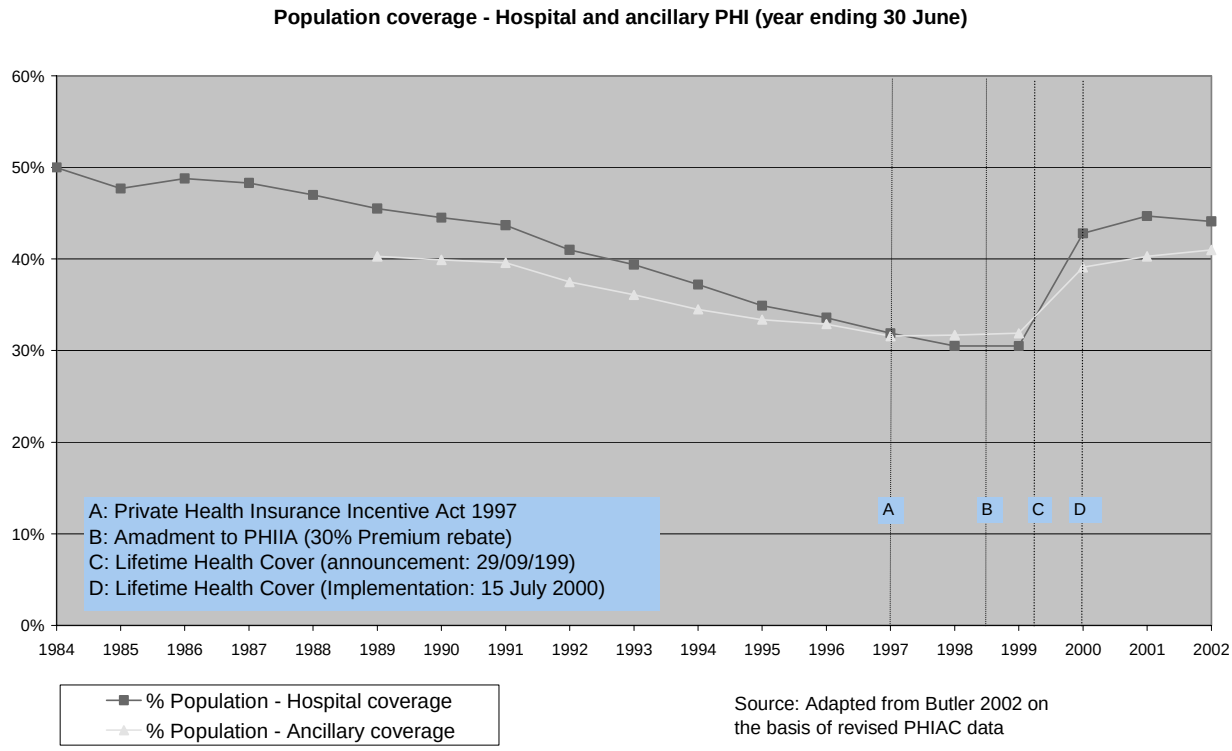
49. According to PHIAC data, the decline in membership of hospital insurance stabilised but did not increase much following the introduction of the Private Health Insurance Incentive Scheme (PHIIS) in 1997 and the 30% premium rebate in 1998.[48] Price advantages may have led people who already had PHI to upgrade their cover. Some high-earners seem to have bought insurance to avoid the tax penalty.[49] While only little time elapsed between the implementation of the rebate and the introduction of lifetime cover, dramatic effects on insurance membership followed the introduction of this latter policy, as it appears in Figure 3.[50] The proportion of Australians with private hospital cover rose from 31% in June 1999 to 45.3% in June 2001.

48. These data reflect empirical evidence of a low-price elasticity of demand for private health insurance (Clarke, 1999; Butler, 1999), although other research suggests that affordability of private cover might be an important determinant of insurance decisions (Access Economics, 2002). According to Butler (1999) price elasticity of demand is -0.5, which means that a 30% decrease in premiums would entail a 15% increase (over the base) in membership. Clarke (1999) used a national survey to estimate a price elasticity of -0.15%, predicting low impact on membership from the 30% rebate.

49. For wealthy individuals it was more financially advantageous to buy a policy with high front-end-deductibles, and therefore a reduced premium, rather than pay the Medicare Levy surcharge of 1% of taxable income. To prevent applicants from buying high deductible policies with the sole purpose of avoiding the tax surcharge, eligibility to the tax rebate was restricted to hospital policies with front-end deductibles lower than a set amount in May 2000. The new criterion was not retrospective.

50. This is corroborated by analysis by Butler, 2001. Butler estimates that the 1997 PHIIS had very little or no impact, and that the premium rebate increased membership from 30% to 32.2%. See also: Hall *et al.* (1999), Hopkins and Frech (2001), Willcox (2001) and Deeble (2003).

Figure 3. Evolution of population covered by PHI



50. Estimating the relative impact of each policy individually is complex. The impact of incentives on insurance take up depends not only on the price elasticity of demand, but also on the responsiveness to other factors such as the perceived quality of public and private insurance. Several regulatory changes and incentives have been implemented in a very short period of time, and price and non-price factors might have added up to a compounding effect. The reasons why lifetime cover was so effective in lifting levels of coverage are not entirely clear. Between the announcement and the implementation of the policy, coverage increased from 31.0% to 42.0%. The threat of a 2% loading on premiums for each additional year without PHI after age 30 is an inadequate explanation of such a large uptake if one considers the anticipated costs of premiums alone.[51] Other factors are likely to have contributed, including the influential media campaign that supported lifetime cover, a "fear effect" and the increased anxiety associated with the lack of PHI cover (Deeble 2003; Richardson, 2002), and the misunderstanding that premiums would never increase if people bought cover prior to age 30. Initiatives to remove gaps in 1995 and 2000 may also have improved the saleability of the PHI products. Population coverage reached 45.3% in June 2001. Overall, it is likely that both price factors (tax penalty, rebate, premium loadings after age 30) and non-price factors (fear that the cover by Medicare would be inadequate, belief that premiums would not increase for those buying PHI, increased saleability of products) contributed to the large increase in PHI membership.

51. The policy of incentives has posed challenges for policy makers. First, the tax subsidies have a large cost, and there is considerable public discussion about the efficiency and opportunity cost of the rebate.[52] Mixed views have also emerged on whether the lifetime policy would have been alone sufficient

51. Considering premium costs alone, it would be more advantageous to wait to buy cover until health care needs arise. The net present value (NTV) of paying base premiums continuously would be higher than the NPV of a higher future premium (base premium plus age loading) purchased in a future date.

52. Subsidising PHI may be desirable if it finances efficient hospital provision. Researchers have debated whether public hospitals are more or less efficient than private hospitals. Duckett and Jackson (2000) find that, for a similar case-mix, public

to stimulate the increase in PHI coverage. Second, the message conveyed by the campaign that accompanied lifetime health cover has been effective in encouraging the purchase of PHI. However, it might have brought adverse publicity to Medicare and undermined confidence in the public system. Third, the impact of incentive policies on long-term PHI membership is uncertain. Recent data show that coverage has slightly declined from 45.6% at the end of September 2000 to 43.8% at the end of March 2003. This could be a temporary phenomenon, but it might also indicate that a process of adverse selection is reappearing in the system or that people do not consider PHI good value for money.

3.3 Policies to deal with medical gaps

52. Unexpected out-of-pocket expenditures increase the financial risk associated with private health cover and thereby represent a major concern for consumers buying PHI. There used to be large uncertainty over the level of out-of-pocket expenditures individuals had to bear themselves if using private cover. Policy makers worried that these gaps would undermine people confidence in PHI products and deter them from buying private cover or make them drop PHI as during the 1990s. Individuals were exposed to unexpected expenditures both on hospital charges and on medical fees. The distribution of medical gaps was especially problematic. In a few cases, patients were left facing extremely large gaps.

53. Legislation to minimise gaps has included a mix of policies requiring or allowing funds to cover the medical gap and policies encouraging price agreements between providers and funds to eliminate the medical and hospital gaps. When Medicare was introduced in 1984, funds were prohibited from offering medical insurance on any service for which Medicare paid a benefit. The prohibition was gradually lifted for in-hospital medical services. Funds were first required to cover a quarter of the government-set medical fees in 1987.[53] Medical in-hospital gaps, however, continued to exist as many doctors charged their private patients well above the MBS schedule. Patients also faced gaps on hospital charges. In 1995, the government passed legislation to allow funds and providers to negotiate reimbursement levels involving no further gaps for insurees. The idea was to encourage funds to engage in contracts with selected providers that accepted the benefit level offered by the fund as full payment, forming preferred provider networks. The law had different outcomes for hospital and medical gaps.

54. For hospital accommodation, most privately insured patients now face only the co-payments or front-end deductibles. Australian private health insurees have displayed a strong preference for insurance products which provide for hospital gap payments. The reforms introduced by the Federal Government in 1995 made contracting with funds the predominant payment model for private hospitals. An increasing number of private facilities now have contracts with health funds which eliminate (or at least reduce) the quantum of hospital fee gaps, depending on the individual contract arrangements. Another result of the reforms was a number of collaborations between small private hospitals to increase their bargaining power.[54] A significant segment of the PHI sector, mainly small-sized health funds, responded by forming a common organisation[55] to manage contractual arrangements with service providers. Contracting between

---

hospitals are 10% less costly than private hospitals. Others have argued that a more efficient way of sustaining private care would be by subsidising private hospitals rather than private cover (Deeble, 2003; Vaithianathan, 2002).

53. The share was 15% of MBS rates in 1985, which has been increased to 25% since 1987.

54. According to the Australian Competition Act, sellers of a service/product (*e.g.,* hospitals) cannot as a rule negotiate jointly unless within the same corporate structure (unlike purchasers). Hospitals can apply for an exception to the rule.

55. The Australian Health Service Alliance (AHSA) has 27 member funds that are joining their efforts for the purposes of: a) Negotiating hospital contracts; b) Negotiating medical agreements; c) Managing Gap Cover initiatives. The Alliance is the second largest purchaser of hospital services. Source: http://www.ahsa.com.au/AboutAHSA/privacy.htm.

funds and hospitals did not however take off on a selective basis,[56] because funds perceived PHI products with restricted choice of provider to be less marketable (on the basis that individuals buy PHI for increased choice). In addition, reflecting the concerns of the private hospital industry that selective contracting would endanger the financial stability of the hospital industry[57] (Willcox, 2001), the government passed regulation allowing a 'second-tier default payment'. This requires funds to pay non-contracted hospitals that meet certain quality and billing criteria[58] a benefit equal to 85% of the average benefit paid to contracted hospitals.

55. As to medical specialists, the 1995 reforms did not solve the problem of medical gaps, and were followed by a new "Gap Cover Scheme" in 2000. Doctors resisted fiercely the idea of entering into contractual relationship with funds for fear of losing their clinical independence and control over prices and patterns of care. The government introduced new legislation in 2000 that allowed health funds to pay a medical in-hospital benefit in excess of the MBS fee, on the basis of non-contractual 'arrangements' between funds and doctors. The Gap Cover Scheme was more agreeable to doctors because it did not force them into contracts with the funds.[59] Each fund suggests a medical schedule (which offers prices higher than MBS rates). If a doctor accepts to charge the suggested fees, the fund reimburses all or a "known" part of the gap. The doctor maintains discretion concerning whether to charge the proposed fee or a different one. If the fee charged by the doctor is higher than the reimbursement by the fund, the patient must be informed about the extent of the gap, and the doctor is obliged to obtain the patient's 'informed financial consent' before delivering the treatment.[60] Health funds, in turns, advise patients about the doctors that are included under no/known gap agreements. This legislation represents a further softening of the historical prohibition for funds to cover medical costs. All funds are now required to offer at least one hospital insurance policy involving no medical gaps for patients.

56. The new Gap cover arrangements have resulted in a significant improvement in the number of in-hospital medical services that are provided with no gap payment to the consumer. In June 2000, before the Government's new gap cover arrangements were introduced into the market, only 50% of privately-insured in-hospital medical services were provided with no gap payable by the patient. The most recent figures (March 2003), show that 81% of in-hospital services were provided with no gap.

56. In the period immediately after the so-called "Lawrence law" was passed, only few funds entered into selective contracts with private hospitals. This was favoured by a greater bargaining power of funds against private hospitals.

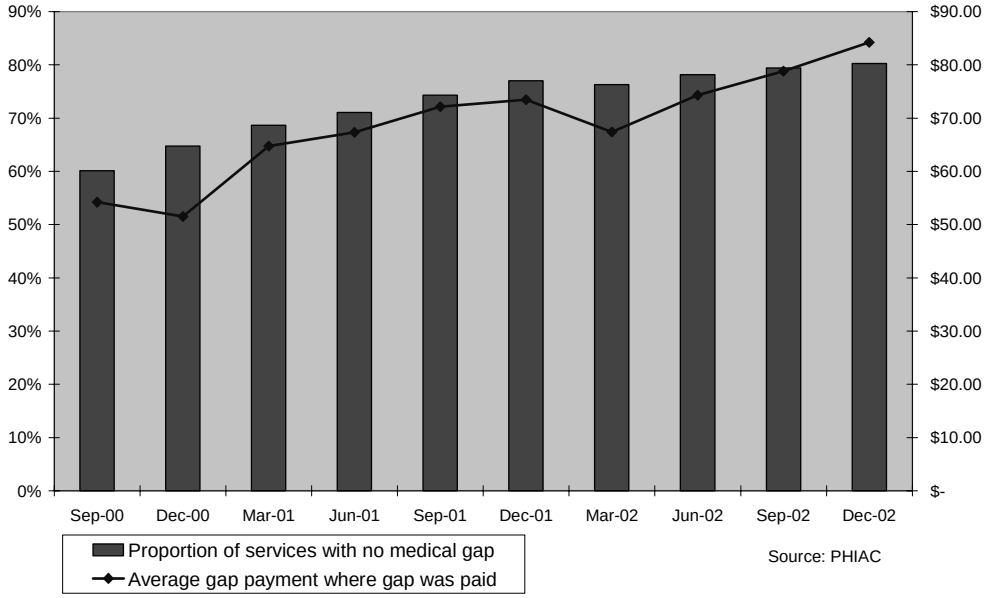
57. Many small hospitals lacking a contract with a fund were threatened with disappearance, as the funds would pay them only a 'default payment' equal to less than 50% of the hospital cost on average.

58. Hospitals must be accredited by an approved accreditation agency.

59. The Lawrence legislation allowed limited funds' offerings of in-hospital medical insurance above the scheduled (MBS) fees, but only in the context of contracts between funds and providers.

60. Informed financial consent occurs where a consumer consents in writing to receive certain medical treatment having first been clearly advised of any likely out-of-pocket expenses they will incur.

Figure 4. Share of in-hospital medical services involving no medical gap



4. How well does the Australian health insurance mix meet health policy goals?

4.1 How has PHI influenced cost pressures in the health system?

Impact of PHI on demand for hospital services and cost implications for the public system

57. One main reason why policy makers are interested in promoting PHI is that they hope it could reduce demand on the public system and thereby diminish cost pressures on public hospitals.

58. The impact that PHI has on demand for public and private hospital services in Australia is complex, and most likely involves a mix of increase in overall demand and demand shift across the two sectors. Data on the evolution in utilisation of public and private hospitals in Australia (Table 8) reveal that private hospitals, which are predominantly financed by PHI, are providing an increasing amount of health care services over time.[61] PHI has been the main financing vehicle for the development of private hospitals, and this role has also been supported by the Medicare subsidy to the medical costs of private in-hospital treatments. The level of additional admissions may have reduced the underlying demand for public hospital services. That said, the increase in private hospital utilisation has most likely not reduced demand in the public hospital sector by the same amount. This is because PHI members continue to utilise public hospitals, although they may not necessarily reveal their insurance status.[62] Private health insurance in the

61. For example the 12.1% increase in private hospital separations between 1999-2000 and 2000-2001 coincides with a 14% increase in PHI benefits paid to private hospitals. Some analysts have noted that private hospital activity has been increasing steadily over time even when PHI membership was declining, for example in the 1990s. This is consistent with observations that membership decline in the 1990s was due to adverse selection, hence people buying PHI were likely to be in need of care (Palmer, 2000). The increase in private hospital discharges was especially pronounced in the period between 1999-2000 and 2000-2001. This was due to the growth in claims at the end of a 12-month waiting period for people that took PHI during 2000. The growth of the private sector has been analysed by Access Economics (2002).

62. Deeble (2003) cites data according to which up to 55% of insured people using a public hospital do not declare that they have PHI coverage and choose to be treated as public patients. Patients may use public hospitals because they offer a different mix

Australian context also appears to have promoted an increase in overall utilisation.[63] This could be due to latent need, moral hazard, or a mix of both. More research is needed to quantify these effects.

Table 8. Utilisation in public and private hospitals in Australia

						% change	
	1996–97	1997–98	1998–99	1999–00	2000–01	Average since 96-97	1999-2001
Public acute hospitals							
Discharges per 1 000 population	193.1	197.0	198.7	196.5	193.0	0.0	–1.8
Patient-days per 1 000 population	789.4	774.1	751.6	741.0	721.8	–2.2	–2.6
ALOS	4.2	4.0	3.9	3.9	3.9	–1.8	–0.4
Private hospitals							
Discharges per 1 000 population	77.5	80.2	82.2	87.3	94.3	4.9	8.0
Patient-days per 1 000 population	290.2	290.9	286.1	294.0	301	0.8	2.4
ALOS	3.8	3.7	3.6	3.5	3.3	–3.7	–5.1
Private day hospital facilities							
Discharges per 1 000 population	11.8	13.0	13.4	14.1	16.9	10.7	19.4
Overall hospital discharges per 1 000 population	*282.7*	*290.6*	*294.6*	*298.0*	*304.5*	*1.9*	*2.2*

Source: AIHW (2002c).

59. The change in demand for public and private hospital treatments has cost implications for the public system. Public hospitals recorded a 2.7% cost increase (in constant prices) between 1999-2000 and 2000-01, compared to an average 3% for the period 1990-2000. However, the existence of public subsidies towards private cover has created cost challenges for the public system. The cost of the rebate on PHI premiums for the fiscal year 2000-01 was AUD2.2 billion (or about 6% of total government funding of health care). The Medicare subsidy for private in-hospital medical treatments and the subsidy for PBS-listed medicine also raise taxpayer cost.[64] Finally, tax exemptions from the Medicare Levy Surcharge have a cost estimated at around USD1.1 billion annually (Smith, 2000). Increases in PHI membership and utilisation hence impact on public cost because of the 30% rebate and other indirect subsidies toward private cover. Estimates of savings resulting from the shift of demand from the public to the private hospital sector range from USD700 million[65] (Deeble, 2002) to USD3 billion[66] (Harper, 2003). In the

of services than private hospitals, and may choose not to be admitted as private patients because by so doing they can avoid the deductibles and co-payments imposed by their PHI product.

63. For example, procedure rates after a heart attack have been shown to be 2 to 3 times higher for privately insured patients than for publicly insured patients (Robertson and Richardson, 2000). Savage and Wright (2003) indicate that moral hazard in the Australian PHI system leads to an increase in the expected length of a hospital stay. Other researchers from the Centre for Health Economics Research confirmed that PHI has led to an overall increase in utilisation in the Australian context (OECD mission to Australia, November 2002).

64. One estimate sets such cost at around USD410 million (Segal, unpublished paper).

65. Applying an average cost-per-discharge to the maximum shift that could have occurred between the two sectors. Deeble (2002) estimates the shift from public to private patient around 7.7%.

66. This estimate is based on trend rate of increase in public hospitals outlays prior to that time, which is then compared to actual outlays in public hospitals. It does however not take into account different factors affecting the evolution of outlays, nor estimates of actual demand shift.

absence of more elaborated and robust estimates, it appears difficult to verify to what extent savings by public hospitals offset the increased public cost.[67]

Impact of PHI on total health expenditure: has PHI contained cost?

60. Australia has implemented several mechanisms to contain cost that apply to the public sector.[68] Cost controls are conversely not well-developed in the Australian private coverage system. Insurers rely predominantly on demand-side mechanisms, such as front-end deductibles, exclusions, and reimbursement limits. Supply-side constraints, on the contrary, are still inadequate and include blunt instruments.

61. Funds do not seek to control hospital utilisation. Contracts with hospitals concern primarily prices, mostly per diem, but insurers do little to control volume of care or limit claims growth.[69] The level of the benefit paid by the fund depends on the relative contractual power of the two parties. This payment is higher than the basic default payment that funds must pay to hospitals with which they have no contract, including payments made to public hospitals.[70] There are disincentives for funds to negotiate prices below a certain level because hospitals may prefer not to enter in an agreement as they can rely on a default payment. Opportunities for health funds to control price by negotiating with hospitals selectively may be made more difficult by the fact that hospitals without contracts receive default payments (which discourages price and quality competition) as well as by fears of restricting individual choice of provider.

62. Funds exercise no or extremely limited control over medical utilisation in the private inpatient sector. Legislation to reduce medical gaps seems to have had some initial inflationary effect. The law increased the financial attraction of private cover by reducing the problem of unexpected out-of-pocket expenditures. However, by covering the gap, it risked the removal of price signals and increasing moral hazard incentives. The policy seems also to have led to some rise in the average medical prices.[71] At this stage, the evidence suggests that some specialists (particularly those who were charging below the market average for their specialty) initially responded to the introduction of gap cover arrangements by increasing the fees they charge patients. This in turn led to increases in the benefits funds pay for medical charges over the MBS. Although this appears to have been a one-off effect, the longer-term impact is still uncertain.[72]

---

67. Frech and Hopkins estimates that the price elasticity of demand for PHI would need to be as high as –1.43 for the rebate to be self-financing.

68. This is particularly the case of hospital spending. The Commonwealth government caps funding to public hospitals by negotiating 5-year resource Agreements. The States negotiate prospective budgets and case-mix funding to public hospitals. By establishing government-set medical fees, the Government also limits the amount of the subsidy paid on medical services.

69. Some funds started to bundle services into case-based payments, but the impact on cost is not yet clear.

70. This may be explained by the fact that the public sector tends to be a price setter, while funds in the private sector have less purchasing power and tend to be price taker to a larger degree. Input prices, especially manpower, are higher in the private sector.

71. Hopkins and Frech (2001), for example, report that since the introduction of no-gap insurance it is possible for some physicians to raise prices up to 50% without driving away customers. A continued increase in hospital utilisation associated with the growth of the private sector may also create pressures for private prices to rise.

72. Benefit growth in this area peaked sharply at the time agreements were introduced and again when schemes were introduced, but has not been as marked in other years. This can be explained by considering the operational controls funds have in place to manage gap cover expenditure. Gap cover arrangements do not lock funds into fully covering whatever fee a specialist may charge. All funds control expenditure by operating their own benefit schedules, and specialists who charge more than has been agreed with the fund will generally not be reimbursed for their gap which is a significant disincentive to patients' utilising the services of that specialist. This adds to the importance of a prospective patient having an accurate understanding of the costs he/she will be expected to meet for the medical services to be provided (so-called "informed financial consent": see section 3.3).

63. Medical devices have become an area of growing cost for insurers. The government formerly regulated benefits payable in respect of medical devises. After deregulation of prostheses benefits, insurers are finding it increasingly difficult to negotiate prices with medical suppliers. This seems to indicate that the monopsonic contracting power exercised by government in the past was more effective in containing the prices of medical devices.[73]

4.2 Has PHI increased health system cost-efficiency?

How large are administrative cost?

64. Private funds sustain underwriting costs and need to absorb advertising, marketing, billing, and product-innovation expenses, as well as the cost of atomised contracting with providers. Although comparisons are challenging due to measurement issues, the administrative cost of Medicare was 3.7% in the year 2001-02, compared to a PHI industry average of 11.1%.[74] The private industry average also hides significant variation across carriers, with administrative expenses ranging from 1% to over 20%. Restricted membership funds have lower average administrative costs, averaging 7.7% compared to 11.3% for funds with open membership, which reflect their lower underwriting cost. By international standards, Australia's PHI industry has on average relatively low administrative costs, and some funds' administrative costs are comparable to those of single-payer public programmes.

Has PHI enhanced efficiency and effectiveness in health care delivery?

65. Private insurers have engaged in efforts to manage care and risks to a limited extent.[75] Funds do not exercise control over the quantity, quality, and appropriateness of care provided,[76] and do not create selective provider networks based on these delivery conditions. Managed care tools, such as utilisation reviews, clinical guidelines, restrictions on treatments, incentives and information directed to consumers to promote the use of providers or services deemed to be particularly cost-effective, are not, or only very rarely, employed. Funds take decisions concerning insurance of certain innovative and costly technologies and drugs on a case-by-case basis. Some limited health prevention and promotion initiatives are being initiated by some funds, for example for the management of diabetes and other chronic conditions, but insurers have currently few incentives to implement these programmes. Current changes to reinsurance arrangements are intended to remove minor disincentives to programmes of this nature.

---

73. In April 2003, the Federal Government announced an intention to introduce new prostheses arrangements. The basic structure of the new arrangements requires health funds to provide at least one cost-effective clinically appropriate prosthesis in relation to each procedure that can be performed under the medical benefits schedule with no gap to be paid by the patient. The health funds will have the option of funding items that have not been assessed as being cost-effective with, or without a gap to be paid by the patient. The industry, including the health funds and the private hospitals will implement these new arrangements.

74. Sources: 1) Health Insurance Commission (2002). Annual report 2001-2002; 2) PHIAC (2002). Operations of The Registered Health Benefits Organisations Annual Report 2001-02.

75. Whether managed care has actually enhanced cost effectiveness of care where it has been implemented is highly disputed, and it is not something addressed here. In Australia the PHI industry has sought to enhance efficiency and effectiveness of care from funds' purchasing to a limited extent.

76. As PHI seems to result in larger utilisation and procedure rates, medical efficacy may become an issue because the marginal effectiveness of treatments may decrease.

66. The contribution of private ancillary insurance to enhanced cost-effectiveness of care is unclear, particularly for so-called lifestyle benefits[77] (and the appropriateness of the 30% rebate on premiums for these benefits is indeed questionable). However, the vast majority of ancillary benefits paid are for dental, optical, and other ancillary services,[78] while less than 1% of benefits is paid for 'lifestyle' items such as gym shoes, tents, CDs and golf clubs. The Australian government also intends to introduce regulations to prohibit payment of lifestyle benefits.

67. Several explanations for the limited influence by insurers in health care delivery are plausible. There are first of all fears of managed care by individuals, providers and insurers alike.[79] This prevented the implementation of mechanisms to contain cost and others tools intending to manage the demand and supply of care to ensure provision (and consumption) of appropriate services. Second, the reinsurance mechanism dampens some of the incentives for cost-effective management of high-risk cases because it pays funds retrospectively for differences in the actual costs of such risk categories.[80] Third, funds may face incentives to shift costs across different segments of the continuum of care rather than to manage health risk and cost.[81] Risk exposure is limited by the ban on coverage of out-of-hospital services and by the limited exposure to in-hospital medical costs, which reduces incentives to manage medical services or implement disease prevention programmes, and may actually prompt doctors to deliver more intensive care for private patients. Fourth, because of the strong link with private hospitals, which still offer a more limited range of services (predominantly elective surgery) than public hospitals, funds tend to pay for elective surgery, but the costs of high-risk patients or high-cost emergency and complex procedures are left with the public system.

4.3 What challenges does PHI pose to equity and access?

How does PHI affect coverage and access to health care across privately and publicly insured individuals?

68. Private health insurance is viewed in Australia as a vehicle for enhanced choice of provider, and therefore the system is designed to promote some differentiation in levels of choice and care between people with and without private cover. Such differences concern access to private hospitals, and free

77. In February 2003 the Australian Government and the private health insurance industry agreed that benefits for sport, recreation and entertainment would be phased out of ancillary products. This will be pursued by regulation.

78. Such as chiropractic, physiotherapy, midwifery services, psychological counselling, community and district nursing, occupational therapy, speech therapy and podiatry.

79. Individuals fear restricted choice, providers fear interferences with their clinical autonomy, and funds fear reduced saleability and marketability of their products.

80. This is despite its importance in mitigating insurers' incentives to select risks. Opinions about the effectiveness of the reinsurance system differ among funds depending on whether they are net payers to or receivers from the pool. The system could be reformed to enhance efficiency incentives, but this is a matter of considerable dispute. New reinsurance arrangements are being introduced, based on a risk-based capitation model. The new model will provide incentives for funds to service, more efficiently, insurees with high requirements for medical services-especially the chronically ill and the aged, while supporting community rating. Some argue, however, that changing incentives may be ineffective, and may actually produce risk selection, if funds employ only a limited range of tools and levers to manage risk.

81. For example, funds may have incentives to challenge decisions by the Acute Care Advisory Committee which advises on the needs for particular patients to receive prolonged acute care in hospitals. Insurers benefit if an insuree is treated as a long-term care patients rather than an acute care patients because their risk exposure is smaller and the public system finances a large share of cost. By law, insurers have to take a minimum risk exposure of 35 days of hospitalisation for acute care patients, after which their risk exposure is limited to 230 days at the cost of USD90 (the rest of the cost is paid by the government). In the past few years, insurers have been challenging decisions by the Committee as they sought to limit their risk exposure.

choice of doctor in hospital settings. On the other hand, the Australian system also intends to provide equity of access irrespective of insurance status by guaranteeing universal access to public hospitals.

69. There is no differentiation in access to care based on insurance status for outpatient care in Australia. This is because private funds are currently banned from covering out-of-hospital services already provided by Medicare or the gap over MBS rates for such services. While arguably inequities in access by income level exist because of the discretion given to doctors' over bulk-billing, lifting the prohibition for funds to duplicate Medicare for out-of-hospital services would not necessarily guarantee greater equity.[82] Coverage by PHI may lead doctors to raise fee levels, leaving people with no private cover, who are more likely to be lower income groups, with a higher financial burden. The current ban on PHI coverage of out-of-hospital services may also have a positive effect on equity of access to specialists. In other OECD countries, privately insured individuals seem to access specialist outpatient services more frequently than uninsured people, often bypassing the referral system.[83]

70. As to hospital treatments, access to public hospitals is governed by explicit rules that are set to guarantee equity of access across people with and without private cover. Admission to public hospitals is based on medical need and is irrespective of whether an individual elects to use private heath insurance. There is no *a priori* allocation of beds to public or private patients, and private patients often lie in the same wards together with public patients. The system is structured to assure that private patients do not have speedier access to public hospital care and insurees have limited incentives to be admitted as private patients. As to doctors, many of them have several public and private sector appointments. Because of the prestige and status associated with working in the public sector and because they can also treat private patients in public hospitals, in theory, doctors do not need to sacrifice time devoted to public hospital patients to treat patients in private hospitals.

71. Private cover may nonetheless create incentives for differentiated access and treatment according to insurance status because doctors and public hospitals treat both public and private insurees, and they are better paid when treating private patients. Unless explicitly forbidden by the hospital itself, Visiting Medical Officers can charge private patients higher fees than the MBS rates and this helps to keep doctors satisfied and retain them. While access to public hospitals is based on medical need, the way waiting lists are managed, whether they are centralised by the hospital or whether they are solely managed by the doctor, may affect discretion over who is ultimately admitted (the management of waiting lists varies by State). When admitting private patients, public hospitals receive payment by the fund and do not have to use resources from the State budget. Some public hospitals charge doctors for using hospital facilities for their private patients, representing a further revenue source. States may also set revenue targets for public hospitals as part of the hospital payment system.[84] Faced with such stimuli, some public hospitals have sought to encourage patients to elect to use their PHI policy, for example by offering to waive any out-of-pocket expenditure that private patients may face on their insurance product.[85] While Australian Health

82. A government proposed reform (announced at the end of April 2003) allows private funds to offer catastrophic private insurance to cover expenses for medical gaps on out-of-hospital services above AUD1000 in any year. It is unclear whether this would lead eventually to allowing full gap insurance in out-of-hospital treatments. See also footnote 4.

83. For example the work by Jones, AM., Koolman, X. and van Doorslaer E. (2002) (The impact of private health insurance on specialist visits: analysis of the European Community Household Panel. ECuity II Project, Working Paper n° 9) indicates that PHI has a positive effect on the probability of specialist visits in several EU countries. The work by Mossialos, E. and Thomson, S. (2001a) (Voluntary health insurance in the European Union. Discussion Paper No. 19, LSE Health and Social Care, London School of Economics and Political Science) indicates that PHI may weaken gatekeeping.

84. In the case of the State of Victoria and New South Wales, for example, the hospital can keep any revenue in excess of the target but will not receive any additional money from the States if the revenue target is not met. Most likely, hospitals will use such revenues to improve services, and working conditions for their staff, which obviously will benefit all patients.

85. The proportion of private patients separations in public hospitals was 12.8% in 2000/2001 (AIHW, 2002c).

Care Agreements require the States and Territories to meet agreed targets in relation to the admission of public patients, but there is some risk that incentives to admit private patients might result in preferences being given to them. The situation requires monitoring of compliance with rules that seek to assure access to care on the basis of medical need and irrespective of insurance status.

72. A final equity challenge concerns ancillary services. Equity and allocative efficiency of dental benefits have arguably worsened when a dental programme for the aged and the poor was discontinued in 1996. Private dental coverage, which is mostly purchased by higher income individuals and includes benefits such as cosmetic dentistry, is now subsidised at almost the same cost as the prior programme.

Equity of financing and affordability

73. The Australia health care system is predominantly tax-funded and therefore progressive, although arguably the decline in bulk-billing by doctors contributes to lessening financing equity. Financing equity is not an explicit objective pursued through private coverage, and generally private health insurance is less equitable than other collective ways of funding health care. However, several factors such as the way premiums are calculated, the degree of financial risk associated with the use of PHI, and the affordability of cover impact upon the subsidisation across income and risks groups within the insured pool. In the case of Australia, some of these factors worsen, others improve, equity of financing in the PHI system.

74. Regulation has an effect on equity of pricing. Community-rating regulation ensures greater financing equity than risk rating because it enables pricing irrespective of risk status. The variation in premia across different funds is attenuated by the reinsurance system, which pools the cost of the elderly and the chronically ill. However, the ability of insurers to differentiate products and their pricing reduces financing equity somehow, because premia can vary between higher-risk and lower-risk communities, within each fund.

75. Fiscal incentives also have an impact on financing equity. The 30% rebate is a more progressive type of tax incentive than other fiscal advantages, such as tax deductions, because it benefits all insurees equally irrespective of their taxable income and the subsidy is a greater proportion of income for less wealthy groups. Tax advantages for PHI have nonetheless redistributive implications for the overall health system. This is because they represent tax resources contributed by the entire community, which benefit only the purchasers of private coverage. The proportion of higher-income individuals buying PHI is higher than the proportion of lower-income groups with such coverage, hence the higher income brackets receive the highest proportion of tax rebates.[86] Unlike other government cash transfers that are taxable, the 30% rebate is paid equally to high and low incomes.

76. Insurers impose cost sharing arrangements in order to limit demand. Out-of-pocket expenditures represent the least equitable source of financing health care and can reduce the perceived value for money offered by PHI, thus discouraging people from taking out private cover. Currently, there is no specific regulation concerning limitation of cost sharing on private health insurance, although some insurance policies set maximum amount of co-payments that an insurees can pay in a given year. An increasing

86. According to Smith (2000 and 2001), 50% of the PHI rebate benefits the top 20% of tax-payers and only 25% of the rebate benefits the bottom 60%. The Government rationale for replacing the 1997 means-tested premium refund with a 30% premium rebate available to all PHI purchasers was that all individuals are universally eligible for Medicare. Since PHI buyers would not make use of the public hospital system (and, hence, would save the government money) they should be eligible for a tax rebate regardless of their income. While there is certainly validity to this reasoning, the argument is founded upon the assumptions that utilisation of public or private hospitals coincides with insurance status, and that the likelihood of buying PHI is homogeneous across income groups. These assumptions are not fully validated by evidence. Utilisation of public hospitals is not an indication of lack of insurance status, and vice versa. The probability of having PHI cover is higher for high-income individuals, which means that an untargeted rebate benefits wealthier people foremost.

proportion of PHI products include a front-end deductible (56% at the end of 2002). Following the introduction of the "Gap Cover Scheme" the percentage of services involving no gaps has steadily increased, from about 60% in September 2002 to 80.3% of all medical services at the end of December 2002. The average out-of-pocket payment for services still involving a gap has however increased, suggesting that the doctors not agreeing to charge the fees set by the funds are usually those charging the highest fees. While the government policy has eliminated many of the gaps, the variability of the gap is still high. At the end of 2002, about 7% of insured services involved a gap above 150% of the MBS fees.

77. Premium inflation limits affordability of PHI cover. Between 1989 and 1996, PHI premiums grew on average at rates three times higher than the consumer price index (Banks, 1998). However, between 1996 and 2003, a period of substantial industry reform, the average annual increase fell to less than 5%. Premiums did not increase in 2000 (most likely as funds' revenues rose due to the larger PHI membership), but they more recently appeared to resume growth at much higher rates than the 1.7% general price inflation.[87] The industry attributes this rise to health providers' costs of 2.5 times the CPI (Quinlivan, 2002), however health price inflation is estimated at 2.4%. Funds are experiencing large outlays not simply because of health price inflation, but because of a real growth in health cost due to the upsurge in members' use of private cover. Drivers of cost include larger coverage of medical gaps, increased utilisation of ancillary services, higher cost of medical devices,[88] and an overall volume increase as individuals perceive PHI to be a product from which to extract value. Policy and academic experts have debated the impact of the 30% premium rebate on affordability, and the ability of the rebate to mitigate premium increases (Deeble, 2003; Access Economics, 2002). While the rebate might improve premium affordability at one point in time, it does not prevent affordability from declining if premiums keep on rising over the years spurred by claim escalation, because consumers will be confronted with the same rate of growth in prices.

Table 9. Areas of expenditure by funds and recent nominal growth

	Nominal increase between 1998-1999 and 1999-2000	Nominal increase between 1999-2000 and 2000-01	% in total funds outlays (1999-2000)	% in total funds outlays (2000-01)
Public hospitals (H)	-0.69%	12.20%	5.42%	5.00%
Private hospitals (H)	3.49%	14.47%	49.34%	46.44%
Ambulance (A)	8.80%	33.09%	2.57%	2.81%
Medical services (H)	11.07%	51.96%	5.31%	6.63%
Other health professionals (A)	11.49%	27.10%	4.95%	5.17%
Pharmaceuticals	19.44%	23.26%	0.81%	0.82%
Aids and appliances (A)	12.90%	27.62%	3.97%	4.16%
Community/public health	0.00%	0.00%	0.02%	0.02%
Dental (A)	5.47%	21.70%	12.01%	12.02%
Total health	5.10%	19.67%	84.42%	83.07%
Health administration	21.32%	17.57%	13.54%	13.09%
Non-health ancillaries (A)	13.33%	58.82%	0.32%	0.42%
Total expenditure	8.77%	21.61%	100%	100%

Note: H = Hospital insurance; A = ancillary insurance. Source: AIHW (2002). *Health expenditure Australia 2001-02*.

78. Individuals that do not perceive PHI to represent good value for money may be discouraged from buying private cover. Certain services may lend themselves to self-funding more than others; for example, many ancillary services are much less costly, and possibly predictable, than the non-covered expenses of an operation in a private hospital for someone without PHI. The degree of out-of-pocket expenditures associated with stays in private hospitals seems to have fluctuated from 19% in 1990-91, to 12% in 1997-

87. The average increase in premiums, per member, of private health funds was 6.9% in 2002 and 7.4% in 2003. While it is unclear what will be the long-term prospect for premium inflation, as long as cost inflation in this sector is unrestrained, premiums are likely to continue to rise.

88. Several stakeholders pointed to significant and unregulated prostheses cost increases as a significant source of premium increases.

98, to rise again to 18% in 1999-2000. It is unclear what portion of this is accounted for by self-insurance as opposed to cost sharing on private health plans. Vaithianthan (2002) estimates the extent of self-insurance prior to the implementation of various policy initiatives to be around 9%.[89] This is expected to have dropped following the large up-take of PHI, but the longer run evolution of self-insurance phenomena will depend upon the perceived value of private cover, among others.

4.4 Hoes has PHI enhanced responsiveness of health systems?

Promoting choice and flexibility

79. Private health insurance improves individual choice compared to options available for people without private cover.[90] Choice can be exercised at several levels. People have, first of all, choice over different funds, and can tailor their individual preferences (relating to both benefits and cost-sharing) by selecting among several products. Private insurees can use a greater variety of providers (public or private hospitals, doctor of their choice) than publicly insured patients, with almost unrestricted choice. They also have better choice over the timing of care and timely care, particularly for elective surgery.

80. Despite the presence of 44 insurers and rules to ensure full portability of cover, limited switching occurs across funds as individuals prefer to stick with the fund they are insured with. This may be caused by important transaction and information costs borne by individuals deciding to change insurer. Insurees seem more prone to change their insurance product if they want to better tailor their risk preferences. After the introduction of policies to stimulate the take up of PHI, for example, several thousands people purchased upgraded hospital cover or ancillary insurance. Although choice is enhanced by availability of different and innovative products, the existence of a large number of products may be confusing to consumers, thus effectively restricting choice. Insurees seem also to experience confusions about benefit limitations and exclusions as they may not understand the rules related to different products. Another issue concerning insurees is the uncertainty about the financial risk associated with choosing private cover. These concerns have been, in part, addressed by regulation. Funds are required to inform insurees of any change in their insurance policies and premiums, and both providers and funds need to obtain the patient "informed consent" before performing a procedure that requires out-of-pocket payments. Some problems due to misleading publicity by funds have also been identified.[91]

Impact of private health insurance on waiting

81. One considerable advantage of private hospital cover is that it may allow flexibility over the timing of care, and access to more timely care. This is a significant advantage in Australia where public hospital patents can endure long waiting times for elective surgery. Indeed one of the main motives driving individuals to buy private cover is the uncertainty over whether they can access care at the time and condition of their choice. The public hospitals system guarantees access to care in case of catastrophic

89. It is also unclear how who the self-insured individuals are. Barrett and Conlon (2002) indicate that the highest income groups have a preference to self-insure, although Hopkins and Kidd (1996) do not support this view.

90. As argued by Harper (2003) it is mainly hospital PHI that improved choice, while the decision to take up insurance for ancillaries is mainly about reducing the risk of unforeseen expenditures.

91. Ombudsman (2002). The PHI Ombudsman has been successful in solving a large number of complaints, particularly after the introduction of lifetime cover, around the application of pre-existing ailments and portability. Problems remain around issues such as informed financial consent and the minimisation of unexpected out-of-pocket expenditure, premium rates increases and benefits limitations and exclusions. The Australian Competition and Consumer Commission has also taken consumer protection enforcement actions against eight health funds for false, misleading and deceptive advertising.

illness or life threatening conditions. However access for elective surgeries is rationed, with priority for admission assigned on the basis of need. Policy makers have placed emphasis on individual responsibility for buying private cover as a way to by-pass queues in the public system. Australia regulates and subsidises PHI as part of efforts to enhance the degree of choice and access to care available to individuals.

82. Despite a clear link between demand for PHI and waiting times in the public sector, the contribution of private cover to the length of waiting in the public sector is less certain. Hurst and Siciliani (2003) observe a reduction in Australian waiting times over the period 1999-2001 for selected procedures, which coincides with an increase in the proportion of population covered by PHI and in privately-funded hospital activity. On the other hand, a 2003 report by the Productivity Commission, which reports new indicators on times waited for admission for elective surgery, show some worsening in overall waiting (table 10). Other reports present conflicting results on both waiting lists and times (Deeble, 2003; Hopkins and Frech, 2001; Hanning, 2002; Hurley *et al.*, 2002). Analysis of the link between PHI and waiting is limited by several difficulties. Data on waiting times are difficult to measures and complex to interpret. Comparability across jurisdictions and over time is hampered, for example, by inconsistencies with classifying clinical urgency categories and may be affected by the way the waiting list is managed by State and Territory Governments. Several factors impact upon waiting and private sector activity, and despite correlation, it may be difficult to explain if a causal link exists between the two.

Table 10. Elective surgery waiting times in public hospitals, Australia

	Days waited at 50th%ile		Days waited at 90th%ile		% waited more than 365 days	
	1999-2000	2000-2001	1999-2000	2000-2001	1999-2000	2000-2001
Cardio-toracic	11	11	65	73	0.1	0.1
Ophthalmology	54	52	268	371	5.4	10.3
Orthopaedic	53	44	315	324	6.6	8.2
All speciality	27	27	175	202	3.1	4.4

Note: Number of days at which 50% or 90% of patients were admitted. Source: Productivity commission, 2003.

83. Private health insurance has represented in Australia a main source of financing of private hospital activity. It has contributed finances to the development of a large private hospital sector and has helped to fill its capacity. It may be reasonable to assume that, as PHI finances an increasing share of hospital procedures, the shift of demand between the public and the private sector will be higher for procedures for which long waits exist in the public system compared to other types of surgery.[92] There are nonetheless caveats. As long as PHI creates additional demand beyond to a shift in demand from the public hospitals, and considering the uncertainty over the sustainability of the current high PHI membership, it is unclear what the long-run impact of PHI on waiting times within the public sector might be.

5. Concluding remarks

84. Private health insurance is a main component of the Australian health care system. The health system is designed to offer comprehensive publicly funded health care services. Treatment in public hospitals is universally free of charge. A significant private hospital sector that is only partially funded by the public Medicare programme parallels public hospitals. Financing policies have encouraged private health insurance for hospital care as a means for supporting private delivery (and indeed had a direct impact on the size and structure of the private hospital sector), while they have forbidden health funds from duplicating Medicare coverage of out-of-hospital medical services. Private health insurance also offers ancillary benefits not insured by Medicare.

92. The recent reforms to private health insurance have seen the number of privately insured people increase to nearly nine million, and an increase of some 400, 000 private hospital separations during the two-year period 1999/2000-2001/02. Were it not for these episodes being undertaken in the private sector, there may have been a further increase in waiting times.

85. Policy makers believe that a well-functioning health care system should be based on mixed economies of insurance and provision, and for this reason they have promoted a private-sector financing and delivery system alternative to Medicare. Availability of a public and a private alternative, both in the financing and in the delivery of care, is seen as a vehicle for improving individuals' well-being by offering greater individual choice of provider and care options, and faster care for elective treatments plagued by long waiting lists in the public system. A mixed health system is also promoted in order to help maintaining a sustainable public health sector, by reducing cost pressures on public hospitals. In order to maintain a dynamic and fair mixed system, policy makers have intervened substantially in the PHI market. Regulation has protected consumers and promoted equitable access to private cover for all those wishing to take up PHI, irrespective of their risk status, while incentive policies have, since 1997, addressed certain signs of crisis in the private health insurance industry.

86. The analysis presented in this paper has revealed interesting insights about the way the mixed system of Australia works, and the impact that private cover has on it. Clearly, there are both costs and benefits to private health insurance coverage.[93]

87. The Australian's regulatory structure is stringent, as premium and access regulation apply to the whole private health insurance market. This has promoted equity of access to and equity of financing of private coverage, has built consumer confidence about PHI products, and improved their appeal. Nonetheless, the regulatory framework has revealed some tensions, for example the advantages of leaving insurers free to design different products may have the possible downside of creative insurers' incentives to select risk by product differentiation. During the 1990s, the viability of the PHI market has been troubled by adverse selection trends. These have been reversed by fiscal incentives and regulatory reforms, such as lifetime cover and allowance for insurers to offer exclusionary polices. While resulting in a large enrolment in private cover, these may not have entirely eliminated the risk of adverse selection. Coverage of the cost of high-risk cases also presents challenges. The reinsurance system decrease insurers' incentives to select risks by spreading the cost of high risks evenly across insurers. However, by compensating insurers with worse-risk profiles for their consequent higher costs, it also removes insurers' incentives to manage high-cost cases in the most cost-efficient manner. New reinsurance arrangements are being introduced to provide incentives for funds to service efficiently insurees with high requirements for medical services. Overall, Australia is engaged in on-going discussions about the appropriate scope of regulation for its PHI marke, aimed, among others, at minimising some of these tensions.

88. Private health cover in Australia promotes health system responsiveness. Insurees benefit from having greater choice over hospitals and the timeliness of hospital care. Private health insurance helps financing private hospital care, and, to the extent that demand shifts from public to private care, it helps relieve capacity and financial pressures from public hospitals, especially for elective surgery. There are nonetheless some opportunities for increasing responsiveness further. Choice of doctor may still have different financial implications for individuals, depending on the fees charged by different physicians. Some challenges also remain in building consumer confidence, including improved market transparency.

89. Australia appears to be doing well in promoting access to private cover and safeguarding equity of access irrespective of insurance status in public hospitals, though some aspects may require monitoring. Higher payments for professionals when treating private patients may affect the elasticity of the supply of doctor time between the public and private sector. In public hospitals, despite rules of access to care based on medical need, there may be incentives for providers to offer preferential treatment to private patients

93. These insights will constitute the basis for further analysis comparing Australia to the experience of PHI in other OECD health systems in order to address questions abut the advantages and risks of PHI, and about the most effective practices in this area. In addition to the other countries examined in the OECD PHI Health Project (the Netherlands, Ireland, France, one US State), the comparative analysis will draw from material on other OECD countries collected through a Statistical Questionnaire, a Regulatory Questionnaire, and a literature review.

because of the revenues and higher payment they bring. As to financing equity, the tax rebate is more progressive than other type of fiscal incentives, but it also creates unequal distributional effects as private cover is predominantly purchased by wealthy households. Regulation to reduce medical gaps has reduced the unexpected expenditure related to private cover. However there are remaining problems in containing premium inflation and maintaining affordability of private cover in the long run, which can be in part linked to insurers difficulties to contain medical costs.

90. Private funds have not effectively engaged in cost controls. They seem to have limited tools and few incentives to promote cost-efficient care, and there are margins for some funds to improve administrative efficiency, thereby reducing administrative costs. PHI appears to have led to an overall increase in health utilisation in Australia as there are limited constraints on expenditure growth. Insurers are not exposed to the risk of managing the entire continuum of care. The Medicare subsidy to private in-hospital medical treatments has also reduced funds' accountability for the real cost of private care. Policies to reduce medical gaps have led to some price increase and may have enhanced supply-side moral hazard incentives. Finally, the rebate on PHI premiums has posed pressures on public cost, as it represents tax resources that have alternative uses.

91. Australia has the advantage of having some rich, recent experience and evidence from which to assess the demonstrated advantages and disadvantages of PHI. There is indeed a large debate on the cost-effectiveness of single policies towards private cover and there are clearly ways to fine-tune the current system. Funds may need to be made more accountable for the cost and quality of the care they finance. Some changes to the design of the public-private mix and its regulation may also improve incentives to manage risks and minimise equity challenges.

REFERENCES

Access Economics (2002). *Is there a doctor in the house? Rate rise imminent*. April 2002.

Access Economics. *An Analysis of the widening gap between community need and availability of GP services*. Report prepared for the Australian Medical Association, Canberra, (date?).

Access Economics (2002). *Striking a balance: Choice, Access and Affordability in Australian Health care*. Report commissioned by Australian Private Hospital Association. Canberra, October 2002.

ACHSE (2001). *Towards a better understanding of private hospitals.* Australian College of Health Service Executives by Wright, G.

Australian Bureau of Statistics – ABS (1998). *Health Insurance Survey.*

Australian Competition and Consumer Commission (ACCC) Report to the Australian Senate 2000. *Chapter 5. The private health industry.*

ACCC (year?). *PHI complaints commissioner: Guide to the Trade Practices Act for the promotion of PHI.*

ACCC (2001). *Report to the Australian senate on anti-competitive and other practices by health funds & providers in relation to PHI*. July 2001-Dec.2001.

Australian Health Care Agreement (AHCA) Reference Group (2002). *Interaction between Hospital Funding and Private Health Insurance.* Report provided to Health Ministers by the AHCA Group, September 2002.

Australian Health Care Association (AHA) (2001). *Health care brief. Private Health Insurance. The Problem Child Faces Adulthood.* Newsletter of the Australian Health Care Association. July 2001.

Australia Health Insurance Association (2002). Inter-departmental Committee Review. Private Health Insurance. May 2002.

Australia Health Insurance Association. Australian health Financing: A Public-private Partnership.

AIHW (2002a). *Australia Health 2002.* Australian Institute for Health and Welfare.

AIHW (2002b). Health expendiuture statistics

AIHW (2002c). Hospital statistics

Australia Medical Association (2002). Submission by interdepartmental review of the regulatory framework for PHI.

Australian Private Hospitals Association (APHA) (2001). *Information Paper. Structure of the private hospital industry 2001.* Australian Private Hospital Association. October 2001.

APHA Information Paper. PHIAC Quarterly Report Analysis, September Quarter 2001. Australian Private Hospital Association Analysis.

APHA (2002). *Annual report 2001-2002*.

Banks, G. (1998). *The Industry Commission Report on Private Health Insurance in Australia*. Keynote address to the conference 'The White Paper on PMI – Looking to the Future', Centre for Insurance Studies, University College Dublin, Ireland, 28 May 1998.

Barrett, G. and Conlon, R. (2001). *Adverse selection ad the Decline in Private Health Insurance Coverage in Australia: 1989-1995.* The University of New South Wales. School of Economics. Discussion Paper.

Bloom, A (2000). *Health reform in Australia and New Zealand.* Oxford: Oxford University Press.

Brown, H.S. (2001). *Mixed private/public health insurance. An evolutionary game*. The School of Economics. The University of Queensland. March 2001.

Butler, J. (2002). *Policy change and private health insurance: did the cheapest policy do the trick?* Australian Health Review, Vol. 25, No. 6.

Butler, J. (1999). *Estimating Elasticities of Demand for PHI in Australia.* National Centre for Epidemiology and Population Health (NCEPH) Working paper no. 43. ANU, Canberra.

Carrol, P. (1996). *Microeconomic Reform of the Australian Private Health Insurance Industry (A Synopsis).* Paper presented for the Productivity Commission Inquiry.

Clarke, P.M. (1999). *The effect of the 30% private health insurance rebate on the purchasing behaviour and intentions of the Australia population*. Australian Health Review, Vol. 22, No. 3.

Commonwealth Department of Health and Aged Care (2001*). Annual Report 200-2001. Outcome 8: Choice through private health.*

Commonwealth Department of Health and Aged Care (1999*). Public and Private. In Partnership for Australia's Health.* Occasional Papers: Health Financing Series, Volume 4.

Commonwealth Department of Health and Aged Care (1999). *Private Health Insurance*. Occasional Papers, New Series No. 4.

Commonwealth Department of Health and Aged Care. *Circular. Health Industry and Investment Division. New arrangements for health fund regulation.* August 2002.

Commonwealth Department of Health and Aged Care and Treasury. *Informed financial consent. Discussion paper*. http://www.health.gov.au/privatehealth/gaps/consumers/ifc_paper.pdf.

Commonwealth Fund (2001). *Australian Adults' Health Care System Views and Experiences, 2001.* Findings from the Commonwealth Fund 2001 International Health Policy Survey, pub. No. 551.

Commonwealth of Australia, Senate Community Affairs Reference Committee (2000). *Healing our Hospitals.*

Cromwell, D. (2002). *The lore about private health insurance and pressures on public hospitals.* Australian Health Review, Vol. 25, No. p. 72-74.

Cunningham, F. (2000). *Medicare: diagnosis and prognosis.* Medical Journal of Australia, N. 173, pp. 52-55.

Davoren. P. (2001). Why private health insurance initiatives don't help hospitals. New Doctor, issue No. 75, Winter 2001.

Deeble, J. (2003). *The private health insurance rebate. Report to State and Territory Health Ministers.* National Centre for Epidemiology and Population Health. The Australian National University. January 2003.

Deeble, J.S. (2000). *Medicare's maturity: shaping the future from the past.* Medical Journal of Australia, N. 173, pp. 44-47.

Deeble, J. (2002). *Funding the essentials: the Australian Health Care Agreements 2003-2008.* Australian Health Review, Vol. 25, No. 6.

Duckett, S. (2002). *The 2003-2008 Health Care Agreements: an opportunity for reform.* Australian Health Review, Vol. 25, No. 6.

Duckett, S. and Jackson, T.J. (2000). *The new health insurance rebate: an inefficient way of assisting public hospitals.* Medical Journal of Australia, No. 172, pp. 439-442.

Frech, H.E. and Hopkins, S. (2002). *Why subsidise private health insurance?* Paper presented at the conference: Regulating private health insurance. Priorities for Australia and lessons from Abroad, 25-26 June 2002.

Hall, J. De Abreu Lourenco, R. and Viney, R. (1999), *Carrots and Sticks – The fall and fall of private health insurance in Australia*. Health Economics, No. 8, pp. 653-660.

Hall, J. (1999). *Incremental Change in the Australian health care system.* Health Affairs. Vol. 18, No. 3, pp. 95-110.

Hanning, B. (2002). *Has the increase in private health insurance uptake affected the Victorian public hospital surgical waiting list?* Australian Health Review, Vol. 25, No. 6, pp. 64-71.

Harper (2003). *Preserving Choice. A Defence of Public Support for Private Health Care Funding in Australia.* Harper Associates, Narch 2003.

Health Insurance Commission (2002). *Annual report 2001-2002*.

Hilless, M. and Healy, J. (2001). *Health Care Systems in Transition: Australia.* World Health Organization, The European Observatory on Health care systems.

Hopkins, S. and Frech, H.E. (2001). *The rise of private health insurance in Australia: early effects on insurance and hospital markets.* Economics and Lanour Relations Review, No. 12 (2), Dec 2001, pp. 225-238.

Hopkins, S. and Kidd, M.P. (1996). *The determinants of the demand for private health insurance under Medicare.* Applied Economics, Vol. 28, pp. 1623-1632.

Hurley, J., et al (2002). *Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada.*

Hurst, J. and Siciliani, L. (2003*). Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries.* OECD Health Working Papers No. 6. Paris: OECD.

Iglehart, J. (2001). *An Activist Health Minister in a Conservative Government.* Health Affairs, Vol. 20, No. 3.

Richardson, J. (2002). *Financing health care : Short term problems - long run options*.

Leeder, S.R. and McAuley, I.A. (2000). *The future of Medicare and health service financing.* Medical Journal of Australia, N. 173, pp. 48-51.

Medicare Fact Sheet 1. New Doctor, Issue 75, winter 2001.

Otlowski, M. (2001). *Is There Scope for Lawful Genetic Discrimination in Health Insurance in Australia?* Journal of Law and Medicine, Vol. 8, No. 4, pp. 427-432.

Palmer, G.R. (2000). Editorial, Government policymaking, private health insurance and hospital efficiency issues. Medical Journal of Australia, 2000, Vol. 172, pp. 413-414.

Palmer, G.R. (2000). *Evidence-based health policy-making, hospital funding and health insurance*. Medical Journal of Australia, Vol. 172, pp. 130-133.

PHIAC. *Insure or not Insure?* Private Health Insurance Administration Council.

PHIAC. Industry Statistics, 20 September 2002. Statistics on: Membership and coverage, Medical gap, information.

PHIAC. Annual reports: 2000-2001; 2001-2002.

PHIAC (2002). *Operations Of The Registered Health Benefits Organisations Annual Report 2001-0.*

PHIAC. (2002). Quarterly Gap Payment and Medical Benefit statistics. June 2002.

PHIAC (2002). Quarterly Statistics Hospital. Ancillary tables membership and coverage. June 2002.

Podger, A. (1998). *Reforming The Australian Health Care System: A Government Perspective*. Health Affairs, Vol. 18, No. 3, pp. 111-113.

Private Health Insurance Ombudsman (2001). *Annual Report 2001, 1 July 2000-30June 2001*.

Private Health Insurance Ombudsman (2002). *Annual Report 2002, 1 July 2001-30June 2002*.

Productivity Commission (2002a). *Managed Competition in Health Care. Workshop Proceedings.* Canberra, 23 August 2002.

Productivity Commission (2002b). *Report on government services 2003. Chapter 9: Public hospitals*. Canberra: Productivity Commission.

Productivity Commission (1999). *Private Hospital in Australia*. Canberra: Productivity Commission. December 1999.

Quinlivan, B. (2002). *Strategy: Health-fund relapse.* BRW Vol. 24, No. 35, 5 September 2002.

Robertson, I. and Richardson, J. (2000). *Coronary angiography and coronary artery revascularisation rates in public and private hospital patients after acute myocardial infarction*. Medical Journal of Australia, No. 173, pp. 291-295.

Ross, J. (1995). *The use of economic evaluation in health care: Australian decision makers' perceptions.* Health Policy, Vol. 31, pp. 103-110.

Savage, E. and Hall, J. (2001). *The changing face of private health insurance.* Health Economics Review. Issue 18, June 2001.

Savage, E. and Wright, D.J. (2003). *Moral hazard and adverse selection in Australian private hospitals: 1989-1990.* Journal of Health Economics, Vol. 22, pp. 331-359.

Schneider, R. (2002). *Health insurance: managing risk in the private sector.* Australian Health Review, Vol. 25, No. 6, pp.49-53.

Scotton, R.B. (2000). *Medibank: from conception to delivery and beyond.* Medical Journal of Australia, N. 173, pp. 9-11.

Scotton, R.B. (2001). *Medicare: options for the next 25 years.* Medical Journal of Australia, N. 173, pp. 41-43.

Senate Community Affairs References Committee report on hospital funding 2000. *Government Minority Report. Chapter 5: Impact of the Private Health Insurance Rebate. Chapter 6. The Interface between private and public hospitals.*

Smith, J. (2000). *Tax expenditure and public health funding in Australia.* Discussion Paper No. 33, Australia Institute. September 2000. Canberra.

Smith, J. (2001). *How fair is health spending? The distribution of tax subsidies for health in Australia*. Discussion Paper No. 41, Australia Institute. October 2001. Canberra.

Stoelwinder, J.U. (2002). *The price of choice: private health insurance in Australia.* Australian Health Review, Vol. 25, No. 6, pp. 42-48.

Vaithianathan, R. (2000). *An Economic Analysis of the Private Health Insurance Incentive Act (1998).* The Australian University. November 2000.

Vaithianathan, R. (2000). *Will Subsidising Private Health Insurance Help the Public Health System?* The Economic Record, September 2002, vol. 78, no. 242, pp. 277-283(07).

Walker, B. 2002). *The development of prudential requirements for private health insurers in Australia.* ICA Cancun 2002.

Willcox, S. (2001). *Promoting Private Health Insurance in Australia. Do Australia's latest health insurance reforms represent a policy in search of evidence?* Health Affairs, volume 20, N. 3, pp. 152-161.

Wilson, J. (1999). *An analysis of private health insurance membership in Australia, 1995.* Discussion Paper No. 46, November 1999. Camberra: National Centre for Social and Economic Modelling.

Wright, G.W. (2001). *The new health insurance rebate.* MJA, Vol. 174, pp. 257-258.

Young, A.F., Dobson, A.J. and Byles, J.E. (2001). *Determinants of general practitioner use among women in Australia*. Social Science and Medicine, Vol. 53, No. 12, pp. 1641-1651.

Websites:

Private Hospitals in Australia 1999. http://www.pc.gov.au/research/commres/privatehospitals/index.html

Private Health Insurance 1997. http://www.pc.gov.au/ic/inquiry/57privatehealth/finalreport/index.html

Australian Private Hospitals Association (APHA). http://www.apha.org.au

Australian Health Insurance Asosciation (AHIA). http://www.ahia.org.au

Australian Bureau of Statistics (ABS). http://www.abs.gov.au

Private Health Insurance Administration Council (PHIAC). http://www.phiac.gov.au

Australian Institute of Health and Welfare (AIHW). http://www.aihw.gov.au

Commonwealth Department of Health and Ageing. http://www.health.gov.au

Private Health Insurance Commission. http://www.hic.gov.au/corp

Power-point presentations:

Russel Schneider, *AHIA* 2002. PHI in Australia

AXA. Australian Health care System Dynamics

Dennis Swift. *CASEMIX* - the Quest for Cost Effectiveness - Health Services Resource Management

Health Care Financing. Markets or pooling

Health Economics Unit (*HEU).* The Private Sector and PHI.

Medibank private. *Building a sustainable private health insurance industry. UBS Warburg healthcare conference*. Sydney Oct 2002

PHI benefits paid by BUYING group Hospital and Ancillary tables

Booklets/brochures/leaflet

Media release. "30% cut - A healthier New Year?" (dec31st 1998).

Providers:

Bayside Health Annual report 2001/2002 (Provider). Public hospital group.

Funds:

I.O.O.F. www.ioof.com.au. IOOF Health Services. Fund.

MBF www.mbf.com.au. A singles story - from cover to cover.

Australia Health Insurance Association (AHIA). "If you have PHI you are helping Australia "

AUH (Australian Unity Health Ltd www.australianunity.com.au)
- harmony
- Health cover - Super Extras cover
- Health cover - member support progrwm
- Comp. Extras cover
- Smart combination cover
- Simpler, smarter health cover
- Harmony Natural therapies cover
- Non-Obstetrics cover
- Basic hospital cover
- Comprehensive hospital cover
- Premium rate chart

HBA health Insurance www.hba.com.au
- "More of what you want from PHI"

HIRMAA - employee based not for profit HBA explanatory leaflet

Government and other Statutory bodies.

Department of Health and ageing
- Lifetime health cover
- Will the pre-existing ailment condition waiting period affect you?
- Closing the gap

PHI Ombudsman:
- The ten golden rules of PHI
- "Making a complaint"
- "the right to change"

CD ROM

CD Medicare benefits schedule Nov 1st 2002-11-20

OECD HEALTH WORKING PAPERS

No. 7 *MOST RECENT RELEASES ARE: EXPLAINING WAITING-TIMES VARIATIONS FOR ELECTIVE SURGERY ACROSS OECD COUNTRIES* (2003) Luigi Siciliani and Jeremy Hurst

No. 6 *TACKLING EXCESSIVE WAITING TIMES FOR ELECTIVE SURGERY: A COMPARISON OF POLICIES IN 12 OECD COUNTRIES* (2003) Jeremy Hurst and Luigi Siciliani

No. 5 *STROKE CARE IN OECD COUNTRIES: A COMPARISON OF TREATMENT, COSTS AND OUTCOMES IN 17 COUNTRIES* (2003) Lynelle Moon, Pierre Moïse, Stéphane Jacobzone and the ARD-Stroke Experts Group

No. 4 *SURVEY OF PHARMACOECONOMIC ASSESSMENT ACTIVITY IN ELEVEN COUNTRIES* (2003) Michael Dickson, Jeremy Hurst and Stéphane Jacobzone

No. 3 *OECD STUDY OF CROSS-NATIONAL DIFFERENCES IN THE TREATMENT, COSTS AND OUTCOMES OF ISCHAEMIC HEART DISEASE* (2003) Pierre Moise, Stéphane Jacobzone and the ARD-IHD Experts Group

No. 2 *INVESTMENT IN POPULATION HEALTH IN FIVE OECD COUNTRIES* (2003) Jan Bennet

No. 1 *PHARMACEUTICAL USE AND EXPENDITURE FOR CARDIOVASCULAR DISEASE AND STROKE: A STUDY OF 12 OECD COUNTRIES* (2003) Michael Dickson and Stéphane Jacobzone

Other series of working papers available from the OECD include:

OECD SOCIAL, EMPLOYMENT AND MIGRATION WORKING PAPERS

Most recent releases are:

No. 15 *LOW FERTILITY RATES IN OECD COUNTRIES: FACTS AND POLICY RESPONSES* (2003) Joëlle Sleebos

No. 14 *NATIONAL VERSUS REGIONAL FINANCING AND MANAGEMENT OF UNEMPLOYMENT AND RELATED BENEFITS: THE CASE OF CANADA* (2003) David Gray

No. 13 *THE COMPETITIVE MARKET FOR EMPLOYMENT SERVICES IN THE NETHERLANDS* (2003) Ludo Struyven and Geert Steurs

No. 12 *TOWARDS SUSTAINABLE DEVELOPMENT: THE ROLE OF SOCIAL PROTECTION* (2003) Marco Mira d'Ercole and Andrea Salvini

No. 11 *INDIVIDUAL CHOICE IN SOCIAL PROTECTION: THE CASE OF SWISS PENSIONS* (2003) Monika Queisser and Edward Whitehouse

No. 10 *IMPROVING WORKERS' SKILLS: ANALYTICAL EVIDENCE AND THE ROLE OF THE SOCIAL PARTNERS* (2003) Wooseok Ok and Peter Tergeist

No. 9 *THE VALUE OF PENSION ENTITLEMENTS: A MODEL OF NINE OECD COUNTRIES* (2003) Edward Whitehouse

No. 8 *FINANCIAL RESOURCES AND RETIREMENT IN NINE OECD COUNTRIES: THE ROLE OF THE TAX SYSTEM* (2003) Edward Whitehouse and Gordon Keenay

No. 7 *THE IMPACT OF PARENTAL LEAVE ON MATERNAL RETURN TO WORK AFTER CHILDBIRTH IN THE UNITED STATES* (2003) Sandra L. Hofferth and Sally C. Curtin

No. 6 *SOCIAL POLICIES, FAMILY TYPES AND CHILD OUTCOMES IN SELECTED OECD COUNTRIES* (2003) Sheila B. Kamerman, Michelle Neuman, Jane Waldfogel and Jeanne Brooks-Gunn

No. 5 *CHILD LABOUR IN SOUTH ASIA* (2003) Eric V. Edmonds

No. 4 *CHILD LABOUR IN AFRICA* (2003) Sonia Bhalotra

No. 3 *LE TRAVAIL DES ENFANTS EN AMÉRIQUE LATINE* (2003) Pierre-Emmanuel Couralet

Recent available working papers can be found on the OECD website: www.oecd.org.

RECENT RELATED OECD PUBLICATIONS:

COMBATING CHILD LABOUR: A REVIEW OF POLICIES (2003)

AGEING AND EMPLOYMENT POLICIES – SWEDEN (2003)

AGEING AND EMPLOYMENT POLICIES – BELGIUM (2003) (French version only with Executive summary in English)

A DISEASE-BASED COMPARISON OF HEALTH SYSTEMS What is Best and at What Cost? (2003)

OECD REVIEWS OF HEALTH CARE SYSTEMS – KOREA (2003)

TRANSFORMING DISABILITY INTO ABILITY: Policies to Promote Work and Income Security for Disabled People (2003)

BABIES AND BOSSES:Reconciling Work and Family Life (2003)

OECD HEALTH DATA (2003)
available in English, French, Spanish and German on CD-ROM (Windows 95, 98, 2000, NT or Me)

SOCIETY AT A GLANCE: OECD Social Indicators (2002)

TOWARDS ASIA'S SUSTAINABLE DEVELOPMENT – The Role of Social Protection (2002)

MEASURING UP: IMPROVING HEALTH SYSTEMS PERFORMANCE IN OECD COUNTRIES (2002)

BENEFITS AND WAGES – OECD Indicators (2002)

KNOWLEDGE AND SKILLS FOR LIFE: First Results from PISA 2000 (2001)

AGEING AND INCOME: Financial Resources and Retirement in 9 OECD Countries (2001)

HEALTH AT A GLANCE (2001)

SOCIETY AT A GLANCE: OECD Social Indicators (2001)

INNOVATIONS IN LABOUR MARKET POLICIES: The Australian Way (2001)

OECD EMPLOYMENT OUTLOOK July 2002 (published annually)

LABOUR MARKET POLICIES AND THE PUBLIC EMPLOYMENT SERVICE (Prague Conference) (2001)

TRENDS IN INTERNATIONAL MIGRATION: SOPEMI 2000 Edition (2001)

REFORMS FOR AN AGEING SOCIETY (2000)

PUSHING AHEAD WITH REFORM IN KOREA: Labour Market And Social Safety-Net Policies (2000)

A SYSTEM OF HEALTH ACCOUNTS (2000)

OECD ECONOMIC STUDIES No. 31, 2000/2 (Special issue on "*Making Work Pay*") (2000)

For a full list, consult the OECD On-Line Bookstore at www.oecd.org, or write for a free written catalogue to the following address:

OECD Publications Service
2, rue André-Pascal, 75775 PARIS CEDEX 16
or to the OECD Distributor in your country