中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

Our Ref.: ( ) in FH/H/

Tel: 2973 8117
Fax: 2840 0467

7 January 2011

Ms Elyssa WONG
Clerk to Panel on Health Services
Legislative Council
Legislative Council Building
8 Jackson Road, Central

Dear Ms WONG,

Legislative Council Panel on Health Services
Healthcare Reform Second Stage Public Consultation
– Health Protection Scheme

At the meeting of the LegCo Panel on Health Services held on 13 December 2010, Members, in the context of discussing the Health Protection Scheme (HPS), requested the Administration to provide information on –

(a) Australia's experience in encouraging voluntary private health insurance as a means of reducing demand on public hospitals and thereby diminishing cost pressures on the public healthcare system, as well as the findings of a study on private health insurance by the Organisation for Economic Cooperation and Development in 2001-2004 (OECD study);

(b) the additional premium level if out-patient service was included as a core requirement under the HPS; and

(c) how existing group health insurance policies could migrate to HPS Plans.

Australia's experience and OECD study on private health insurance

The Administration had, among other things, taken into consideration relevant overseas experience on private health insurance when formulating the proposals for the HPS. This is set out in detail in the consultancy report "Local Market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views" for a consultancy study commissioned by the Food and Health Bureau for the purpose of devising the proposals for the HPS (available since October 2010 on the Healthcare Reform Second Stage Consultation website http://www.myhealthmychoice.gov.hk/en/studyReport.html), and summarised in Appendix D to the Healthcare Reform Second Stage Consultation Document "My Health My Choice").

As requested by Members of the Panel, I attach two bilingual information notes on Australia's experience on private health insurance and the findings of the OECD study on private health insurance respectively for Members' information.

Inclusion of out-patient service under the HPS

The main purpose of health insurance is to provide risk-pooling protection for financial risks arising from unforeseeable and costly healthcare needs, e.g. unforeseeable medical conditions requiring hospitalization or other costly surgical or clinical treatment procedures. Hence we propose to require Standard Plans under the HPS to cover, as a basic minimum coverage, private in-patient services and ambulatory procedures, which are relatively unpredictable and costly. Not everyone will require such services, but when someone does, the cost is likely to pose significant financial burden to the patient.

By contrast, private out-patient services (both specialist and general out-patient services) are relatively more affordable in Hong Kong, while in general most people would use out-patient services from time to time. Hence the risk-pooling value of health insurance to avert catastrophic financial risk arising from ill health in the case of out-patient services is relatively much more limited. In most cases health insurance for out-patient services is for all intents and purposes a form of pre-payment for future services rather than true risk-pooling to hedge against catastrophic expenses, where premium paid upfront is mostly and eventually reimbursed while smoothed out over the course of the insured period. The utilization of out-patient services can be much more elective and elastic thus more prone to moral hazard when financed by a third-party source such as insurance.

Generally speaking, the inclusion of out-patient services in a health insurance scheme would entail much higher premium due to (i) the premium will have to reflect the expected expenses due to the much higher certainty of claims by individuals; (ii) high administration costs for handling individual claims due to much

more frequent claims and the small amount of claims involved for each episode of out-patient service; and (iii) premium loading to offset the effect of likely higher utilization given the more elastic nature of out-patient services and associated moral hazard. The amount of additional premium incurred as a consequence of such inclusion will mainly depend on the actual coverage of out-patient services and other terms and conditions including cost-sharing and reimbursement amount or episode limits.

The Administration has not, as part of the consultancy study conducted for the purpose of devising the proposals for the HPS, assessed the additional premium required if out-patient services (both general and specialist out-patient services) were to be included as part of the basic coverage required for Standard Plans under the HPS. As a reference, we have sampled a number of medical insurance products available in the market with published premium rates. In general, the inclusion of out-patient services as an optional coverage where available often entails an additional premium that, depending on the actual terms of coverage, ranges from around 100% to 200% of the basic premium for the underlying base plan covering in-patient services. For instance, Members may wish to make reference to the voluntary medical insurance schemes made available for civil servants by a number of private insurance companies (http://www.csb.gov.hk/english/admin/benefits/1137.html).

Migration of existing group health insurance to HPS

The HPS is voluntary for individuals and employers with existing medical insurance, who are free to choose whether to migrate to HPS Plans. Based on previous discussions between the Administration and the insurance industry, insurance industry will be required under HPS to facilitate migration of existing holders of non-HPS policies to HPS Plans.

Regarding the migration of existing group health insurance policies to HPS, participating insurers will be required to offer existing group policy holders (mainly employers) upon renewal an option to switch to an appropriate tailored HPS Plan which meets or exceeds the requirements for Standard Plans, providing no less coverage and benefits and meeting the core requirements and specifications under the HPS. Employers could consider making use of HPS for the in-patient part of their employment medical benefits provided to their employees. This would allow them and the insured employees to enjoy the benefits and value-added proposition of the HPS. Further details of the migration arrangements will be developed in collaboration with the insurance industry if and when the HPS is to be finalized for implementation.

As a general rule to allow flexibility, the insurers may offer additional components to suit individual policy holders' needs. For the insured employees, portability of medical benefits upon changing jobs and after retirement (with guaranteed coverage of pre-existing conditions) under the HPS Standard Plans provides added protection to employees. For instance, if an employee currently

covered by an HPS plan retires or switches to a new job that does not offer medical benefits under the HPS, the employee may still subscribe to an HPS Plan on their own with no disruption to their pre-existing coverage). If that employee switches to a new job that offers medical benefits through an HPS Plan, his pre-existing coverage would also continue under the new plan.

Yours sincerely,

(Chris SUN)
for Secretary for Food and Health

For information

Legislative Council Panel on Health Services

Synopsis on Private Health Insurance in Australia

Purpose

Take-out of private health insurance (PHI) on a voluntary basis is actively encouraged by the government in Australia. This is achieved mainly through financial incentives and disincentives, together with a legislative framework to regulate activities in the PHI market. In response to the request of Members of the Panel, this note provides a synopsis on the policy framework and observed situation of PHI in Australia.[1]

Overview

2. The policy direction to actively promote PHI take-out dates back to the mid-1990s when the Australian government saw the declining population coverage of PHI an undesirable sign of health system development. The population coverage of PHI plummeted from more than 60% in 1984 when Medicare the social health insurance system was introduced to only 34% in 1996. This situation did not align with Australian government's policy desire to encourage the development of a mixed healthcare financing and delivery system whereby the private segment can operate and advance in parallel with the public sector.

3. The Australian government started to actively intervene in the PHI market in the latter part of 1990s. It has since introduced a lot of financial and regulatory measures to ensure affordability and value of PHI as a product, and enhance access of the insured population to private healthcare. In particular, all PHI products are required to meet the requirements under the regulatory framework (e.g. coverage scope and community-rating), and they cannot cover primary or specialist out-patient care or other healthcare services or pharmaceutical products funded by Medicare or Pharmaceutical Benefits Scheme. The population coverage of PHI coverage rises back to about 50% nowadays.

Incentives and Disincentives

4. The Australian government adopts a "carrot-and-stick" approach to encourage PHI take-out. In July 1997, it implemented the Private Health Insurance Incentives Scheme by which the government started to partially rebate premium paid by individuals

[1] This synopsis has made reference to the consultancy report "Local market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views" submitted by the Milliman Limited to the Food and Health Bureau in October 2010 for the purpose of devising the proposed Health Protection Scheme, as well as other sources of data and information. The reference sources concerned are not liable to misinterpretation of data and information if so occurs in this synopsis.

for eligible PHI plans that fulfill the statutory requirements. Employees whose PHI plans are paid by their employers are also eligible for the rebate.

5. On the "carrot" side, eligibility for premium rebate was initially means-tested, with the rebate amount depending on the household size of those eligible. Yet as from 31 December 1998, the rebate has become non-means-tested so that it can be enjoyed by all Australian residents. Concurrently, the rebate amount has become open-ended at 30% of the premium amount, meaning that a more expensive PHI plan attracts a larger amount of rebate. Since April 2005, the rebate percentage has been increased to 35% for age 65-69 and 40% for age 70 and above.

6. On the "stick" side of the two-pronged approach, the government has since July 1997 been imposing a 1% Surcharge on top of the standard 1.5% Medicare Levy (applicable to all Australian residents) on high income earners who do not have an adequate level of PHI hospital/medical cover. The thresholds of high income earners and adequacy of insurance cover are subject to regular review. Currently, a high income earner refers to one whose annual taxable income is greater than a specified amount (A$77,000 for singles and A$154,000 for couples, increasing by A$1,500 for each additional child after the first). PHI hospital/medical cover is considered inadequate if it includes an annual upfront deductible of more than A$500 for an individual and A$1,000 for a family/couple.

7. Since the budgetary pressure of providing premium subsidy is mounting in recent years while its universal coverage continues to be criticized to subsidize the rich, the Australian government has proposed a bill to re-introduce means-testing element to the subsidy system by re-setting the premium rebate rate from 30-40% by age to 0-30% by means and age, and raising the Medicare Levy Surcharge for high income earners without adequate hospital/medical cover from 1% to 1-1.5%. However, the bill has been rejected twice by the Senate. The government keeps striving for legislative passage and is targeting its implementation by July 2011.

8. Targeting at the young population in particular, the government introduced the Lifetime Health Cover (LHC) program applicable to hospital/medical plans in July 2000. By LHC, an individual starting to take out a hospital/medical plan before age 30 can lock in the prevailing premium which is unaffected by increase in age, while a person starting to take out a PHI plan after age 30 is charged a loading on his insurance premium. The loading is 2% on top of the annual premium for each year a person delays joining after age 30, subject to a ceiling of 70%. The loading is removed after 10 years of membership. For example, a person starting to purchase PHI at age 40 would be charged 20% above the basic premium that applies to those starting to enroll at age 30 or below, and this 20% loading would apply until age 50.

Regulatory Framework

9. The Private Health Insurance Act provides a legislative framework to regulate pricing, products and other aspects of PHI business in Australia.

Guaranteed Issue, Renewal and Portability

10. To ensure that people with high health risks can gain access to PHI protection, insurers are prohibited from selecting customers. There is no right of refusal on the part of insurers in handling new enrolments and renewals of insurance contracts. Moreover, no premium loading except LHC loading is allowed, and the entry age is not restricted. This enables consumers to enjoy guaranteed access to PHI regardless of age and health status.

11. PHI coverage is guaranteed for life. Insurers do not have the discretion to cancel insurance contracts or refuse their renewals so long as premium payments are not overdue.

12. The insured persons can move from one insurer to another without barrier. The new insurers must provide continuity for the waiting periods that the insured have already served, and cannot impose additional waiting periods unless the new PHI plans have extra benefits.

Standardized Coverage

13. PHI is supplementary to Medicare. Currently, Medicare finances Australian residents in full the costs of being a public patient in a public hospital. Based on the Medicare Benefits Schedule (MBS)[2], it also finances 75% of doctor fee for a private patient in a public or private hospital[3], 85% of doctor fee for out-patient care by a specialist and 100% of doctor fee by a general practitioner. Medicare also partially pays for the costs of most prescription medicines under its Pharmaceutical Benefits Scheme (PBS)[4]. However, Medicare does not cover hospital charges for private patients, such as room accommodation and operation theatre fees. It also excludes ambulance and emergency services, dental care, and ancillary services such as physiotherapy and home nursing.

---

[2] Medicare Benefits Schedule provides a comprehensive list of health service fees determined by the Commonwealth government in consultation with professional bodies. Based on this Schedule, Medicare benefits are provided to patients in the form of reimbursement on fees paid to private medical practitioners for both out-of-hospital and in-patient services.

[3] Different from a public patient, a private patient has the choice of doctor in public or private hospitals.

[4] The Pharmaceutical Benefits Schedule (PBS) provides the basis for Medicare to reimburse part of the cost in buying medicines. The PBS now has an agreed list of over 2,600 prescription medicines. Except for some very high-cost medicines which are dispensed only through hospital pharmacies, most of subsidized medicines can be dispensed through private community-based pharmacies.

14. To be eligible for premium rebate, a PHI plan may be a hospital/medical treatment plan, a general treatment plan, or a plan bundling hospital/treatment coverage with general treatment coverage. Hospital/medical treatment plans supplement Medicare by paying for that part of doctor fees that Medicare does not reimburse, and also hospital charges for private patients that Medicare does not cover. General treatment plans pay for non-hospital care that Medicare does not cover.

15. There are mandates on what insurers must cover in PHI plans, mainly for the sake of encouraging the insured patients to receive treatments in the private market. As a pertinent example, all eligible PHI plans must cover at least the 25% co-payment of doctor fees for private patients according to MBS. Besides, all insurers are required to offer at least one "no medical gap" or "known medical gap" hospital/medical plan[5]. They are also required to offer at least one hospital/medical plan which covers the so-called default benefits, which is equivalent to the amount that a public hospital would charge a private patient in a shared room.

16. There are also mandates on what insurers must not cover in PHI plans. All PHI plans are prohibited from covering out-of-hospital medical services that are funded by Medicare (including consultations with specialists and general practitioners) and co-payments on pharmaceuticals listed in PBS under Medicare. These restrictions are intended to contain moral hazard which is inherently more severe for outpatient care.

17. Notwithstanding the aforesaid standardization measures, insurers are allowed to expand or reduce PHI coverage to suit different customer needs and affordability. For example, insurers may provide more affluent enrollees with increased offer that pays for doctor fees considerably in excess of the MBS level. They may also provide reduced coverage excluding obstetrics and cataract to target at young singles.

Benefit Limits

18. No overall benefit limit in a year is permitted for hospital/medical plans. However, an insurer is allowed to enter into contract with selective hospitals and doctors that specify maximum amount payable for a care item or episode which can be defined by Diagnosis-Related Grouping (DRG), International Statistical Classification of Diseases and Related Health Problems (ICD) or MBS. It is quite common nowadays for insurers to make use of case-based payment model as the basis to reimburse healthcare providers in Australia.

19. Overall benefit limit is permitted for general treatment plans. Some insurers set their benefit limits by calendar year or contract year. Some insurers also put

[5] Medical gap refers to the difference between actual in-hospital doctor fees and the sum of Medicare benefit and PHI benefit. If a patient's doctor has a gap cover arrangement with his insurer, the patient enjoys no or limited known out-of-pocket payment due to the medical gap. The doctors participating in this arrangement are required where possible to make known their fees to their patients before treatments or procedures.

a lifetime limit on certain elective benefits, such as orthodontic benefits.

20. All benefits of PHI plans cannot exceed the actual costs spent. This regulation adheres to the principle of indemnity, meaning that the insured persons cannot pocket income through PHI.

Limitations Against Exclusion of Pre-existing Conditions

21. Insurers are not allowed to exclude coverage of pre-existing conditions after the insured have served the waiting period. The length of waiting period allowed is up to 12 months on hospital/medical benefits for any medical condition the signs and symptoms of which existed during the 6 months before the insurance contract commences. The insurers are allowed to impose a waiting period up to 12 months for treatments relating to an obstetric condition, and up to 2 months for all other benefits when a person first takes out PHI.

22. Under the general treatment plans, insurers are permitted to impose a longer waiting period, usually 2-3 years, for certain expensive items such as blood glucose monitors and hearing aids.

Cost-Sharing Arrangement

23. There is no restriction on the cost-sharing arrangement in the PHI contract. However, hospital/medical plans with deductible exceeding a certain level would not be considered adequate to exempt high income earners from the Medicare Levy Surcharge.

24. Insurers are free to introduce cost sharing components such as deductible and co-insurance in the PHI contracts with the effects of lowering the insurance premium. Many insurers also make use of such components to prevent claims caused by moral hazard.

Premium Control

25. PHI premium is community-rated by law. It means that each insurer is required to charge all its customers regardless of age and health risks a flat premium for the same product. This control can prevent insurers from using prohibitive premium loading to drive away high-risk enrollees without breaching the guaranteed issue rule in principle. Also, community-rated premium is more affordable to people with higher health risks due to implicit cross subsidy by people with lower health risks. Insurers are allowed to set their own premium levels for their products and adjust the premium levels of same products across state/territory (but not regions within a state). Insurers can also vary premium by six classes of membership: singles, couples, single-parent families, no-parent families and families with three or more adults.

26. Increases in the community-rated premium rates of PHI products have to be approved by the Commonwealth Department of Health and Ageing (CDHA) in advance. Applications for premium rise have to be filed with CDHA and the regulator of the PHI industry i.e. Private Health Insurance Administration Council (PHIAC), about 6 months prior to the date of increase (usually April 1). Upon the advice from PHIAC, CDHA will ask those insurers to re-submit applications if the rate of increases are deemed excessive. After all applications and re-applications are approved, CDHA will announce to the public the average increase for the industry and for each insurer.

27. In processing the premium increase applications, CDHA is concerned with whether the increase is in public interest and is obliged to disclose the reasons for not approving an application. The public interest in relation to premium adjustment pertains to the minimum rise necessary to ensure insurer solvency, support benefits outlays, and meet prudential standards concerning capital adequacy, while also ensuring the affordability and value of PHI as a product.

Risk Equalization

28. Because of the guaranteed issue requirement and community-rating of insurance premium, an insurer may have a relatively older and less healthy customer profile compared with its competitors. This will put the financial position of the insurer concerned and hence the interest of their consumers at risk, and will distort market competition. In order to enable level playing and maintain financial viability of the PHI funds, PHIAC administers a risk equalization system which transfers and shares costs across all insurers according to their risk profiles. In a nutshell, the system transfers payment from those with lower-than-average risk exposure to those with higher-than-average risk exposure.

29. The risk equalization system has two major components. The first is the pooling of the claim costs for people aged 55 and above who receive hospital care within a state. The proportion of claim costs for this pooling usually rises with age, from about 15% for age 55-59 to more than 80% for age 85 and above. The second component is a high cost claims pool whereby claims over A$50,000 for one year for a person are pooled for payment transfer, except those that are already pooled by the first component.

30. To enable a fair distribution of costs, PHIAC obtains from each insurer an enormous amount of summarized data in every quarter to calculate the appropriate amount to be received or paid by an insurer under the system.

Market Transparency

31. Market transparency is achieved through mandatory disclosure of information.

Each year, all insurers are required to report the up-to-date key features of each product they offer to the Public Health Insurance Ombudsman (PHIO) in a standard format that is uploaded on the government website for public information. PHIO also publishes an annual report on the state of the PHI industry, showing the number and types of complaints received for each insurer and ranking them in terms of complaint incidents per policyholder.

32. Besides, CDHA announces the average approved premium increase for the PHI industry every year. Starting from 2010, it also makes available for public information the approved average premium increase for individual insurers to show how it compares with their competitors and the industry average.

33. PHIAC positions itself as a collector, repository and publisher of useful information about PHI. It regularly collects and disseminates financial and statistical data about the PHI industry and individual insurers to assist consumer decision.

Quality Assurance

34. Insurers normally do their own quality assurance of hospital providers and do not contract with providers who are not up to the mark. They would not establish or renew contracts with hospitals that are not accredited with the Australian Council of Healthcare Standards (ACHS). Insured patients can use hospitals not contracted with their insurers but the benefits are usually much lower.

35. Insurers also use extensive utilization review procedures to examine lengths of stay and re-admission rates by procedure in hospitals, and may refuse to renew contracts with those hospitals that do not measure up to established norms even though they are ACHS-accredited.

36. Insurers are allowed to establish contractual agreement with individual medical practitioners covering provision of medical services under hospital settings. Such an agreement facilitates price negotiation and enables the insurers to offer 100% insurance for in-hospital doctor fees when they exceed the MBS level.

37. Insurers are prohibited from interfering with the clinical freedom of medical practitioners. However, they may refer suspected cases of inappropriate practices, such as excessive order of services, to the Professional Services Review (PSR) so long as the care also attracts Medicare benefits. PSR is a statutory authority set up by the Parliament to examine health practitioners' conduct to ascertain whether or not they have practiced inappropriately in relation to services and drug prescriptions which attract Medicare benefits, including those linked with MBS and PBS. The assessment is conducted through a peer review mechanism and the results may lead to sanctions for the practitioners.

Appeals Mechanism

38. PHIO is responsible for resolving complaints related to PHI and acts as an umpire in dispute resolution. It is involved in disputes on medical necessity and other disputes between insurers and healthcare providers where the insured are caught in the middle. Though it does not have direct coercive power, his annual report could lead the naming and shaming of recalcitrant insurers in the press.

39. Reporting directly to the Minster of Health and Ageing, PHIO can alert the Minister of an insurer causing industry dispute and draw closer regulatory attention on its business conduct, financial position and premium rise application.

Regulators

40. PHIAC is an independent statutory authority that regulates the PHI industry. By the Private Health Insurance Act, PHIAC aims to achieve an appropriate balance between the following objectives: (i) fostering an efficient and competitive health insurance industry; (ii) protecting the interests of consumers; (iii) ensuring the prudential safety of health insurance funds.

41. PHIAC positions itself as a custodian of both public and consumer interests in dealing with the PHI industry and as an effective and valued adviser to the government and the parliament. In advising CDHA on premium increase approvals, for instance, PHIAC examines the applications to ensure that the premium increases sought are compatible with the continuing prudential security of the insurer, while protecting consumers from unwarranted or unjustified increases.

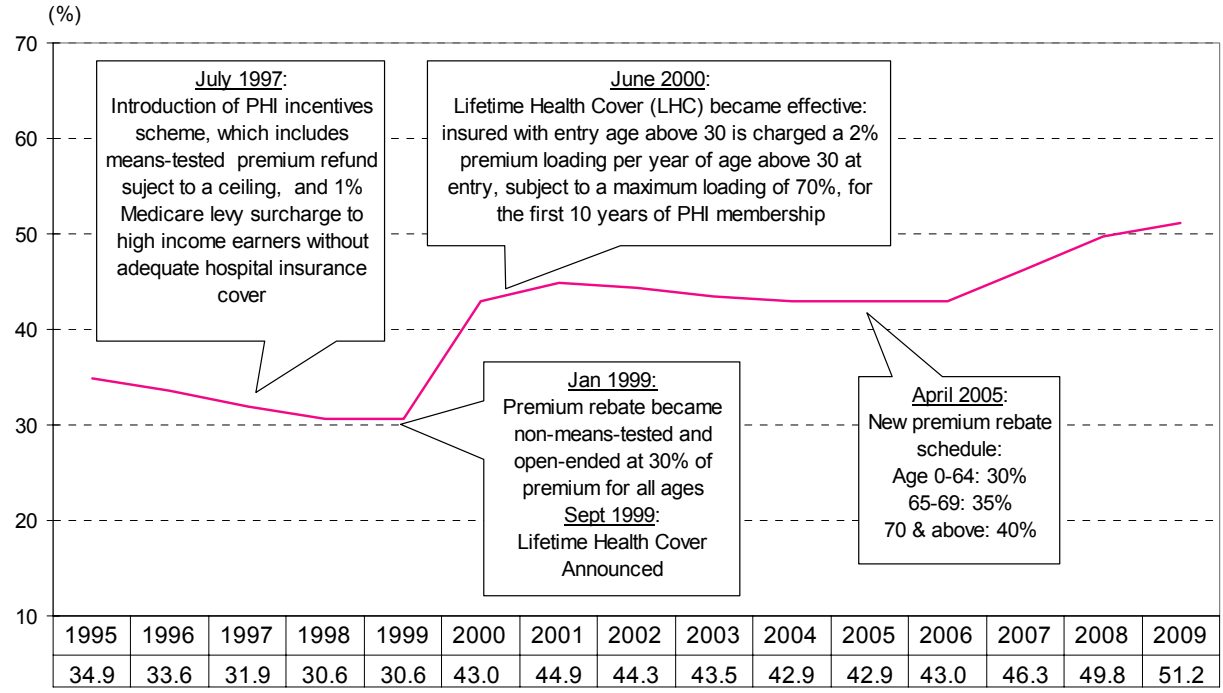
42. For the sake of prudential supervision, PHIAC obtains informal advice from the Australian Prudential Regulatory Authority (APRA) which is the prudential regulator of the entire financial services industry and oversees life and general insurance as well as banks, building societies, credit unions and the like.

Population Coverage of PHI

43. The incentive from premium rebate and the disincentive from Medicare Levy Surcharge initially had limited effects on the population coverage of PHI in the late 1990s which stayed low at around 30% (Chart 1). Yet the coverage subsequently surged to 43% in 2000 when the government implemented LHC and concurrently launched a massive public promotion campaign with the theme "Run for Cover". Some observers opine that these efforts created a sense of urgency and made the final push for some people especially the young to enroll and avoid the LHC loading. Yet after this spurt, the coverage of PHI stabilized at 43-45% until 2007. From 2007 to 2009, the coverage resumed increase and reached 51% in 2009. This pick-up was partly due to the stimulus of higher old-age premium rebate to elderly enrolment as from April 2005. Also contributed was increased

enrolment of young to middle-aged population amidst steady economic growth.

Chart 1: Percentage of Population with PHI cover in Australia, 1995 to 2009



Source: Organisation for Economic Cooperation and Development (OECD) Health Data 2010

44. Statistics on population coverage of PHI by age are available only for hospital/medical plans from 1999 onwards. Compared with a decade ago, the share of population covered by hospital/medical plans increased markedly across all age groups in 2009, with the most profound increase for age 20-34 (Table 1). However, in absolute terms, the coverage for this age group was persistently the lowest, at 35.5% in 2009, meaning that almost two-thirds of people remained uninsured. The population coverage is highest for the older age groups of 50-64 and 65 and above, at 56.2% and 47.6% respectively. This situation owes much to the community-rated premium, under which older-age population find it attractive and to their interest to join while the younger population are less motivated despite the availability of premium subsidy.

Table 1: Percentage of population with hospital/medical cover by age group, 1999 to 2009

(%)

Age group	1999	2004	2009
0-19	29.0	41.1	42.1
20-34	21.3	31.9	35.5
35-49	33.6	47.5	47.5
50-64	43.5	56.2	56.2
65 and above	36.9	41.9	47.6

Sources: PHIAC; Australian Bureau of Statistics (ABS)

Competition and Profitability in the PHI market

45. As at June 2009, there were 37 private health insurers operating in Australia, including for-profit and not-for-profit organisations. The six largest insurers accounted for a market share of 78% in terms of PHI policies. The largest insurer was the Medibank Private Limited, a government enterprise independently operating, which had a market share of almost 30%.

46. The loss ratio of the PHI industry, as measured by the ratio of total claims to total premiums, held stable at about 84-86% in recent years (Table 2). Management expenses accounted for about 10% of premium revenue in the industry. The underwriting margin was about 3-6%. However, the profitability was also affected by the other revenue such as investment income and income from associated businesses such as care referrals and lending to the insured members to pay for co-insurance. With the reversal from investment return from gain to loss in recent years, the total operating profits for the PHI industry declined sharply from A$1.3 billion in 2006/07 to A$0.4 billion in 2008/09.

Table 2: Health insurance funds' reported expenses and revenues, 2006-07 to 2008-09
(A$ million)

Operating expenses and revenue of funds	2006/07	2007/08	2008/09
(i) Total expenses	**10,500**	**11,667**	**12,660**
	(94%)	**(96%)**	**(97%)**
Of which:			
Total cost of benefits i.e. claim costs [(a)]	*9,306*	*10,248*	*11,203*
	(84%)	*(84%)*	*(86%)*
State levies	*126*	*137*	*146*
	(1%)	*(1%)*	*(1%)*
Management expenses	*1,068*	*1,282*	*1,311*
	(10%)	*(11%)*	*(10%)*
(ii) Total Premium revenue	**11,127**	**12,189**	**13,078**
(iii) Underwriting Margin (=(ii)-(i))	**627**	**522**	**418**
	(6%)	**(4%)**	**(3%)**
(iv) Other income	**672**	**49**	**-9**
Of which:			
Investment income	*648*	*-11*	*-84*
Health related business e.g. care referral, financial services	*24*	*60*	*75*
(v) Operating profit (loss) before abnormal and extraordinary items (≈ (iii) + (iv))	**1,288**	**562**	**405**
	(12%)	**(5%)**	**(3%)**

Notes: Figures in bracket represent the percentages to total premium revenue.

(a) Includes the adjustment to provisions for outstanding claims accruing in the year and non-health benefits.

Source: PHIAC.

Financing Role of PHI

47. Along with rising population coverage of PHI, the share of total health expenditure financed by PHI went up from 9.9%[6] in the financial year of 1998/99[7] to 11.1% in 2008/09 (Table 3). The increase was relatively modest compared with that for the PHI population coverage. Supplementary function of PHI is a major reason as it finances only a small part of in-hospital private doctor services that simultaneously attracts Medicare benefits. Besides, the government health expenditure other than premium rebate kept rising remarkably in recent years due to population ageing.

48. The premium rebate accounted for 4.6% of government health expenditure in 2008/09. After rising distinctly from 3.0% in 1998/99 to 4.3% in 1999/2000, the share stabilized at 4.5-5.0% for most of the time in the past decade (Table 3).

Table 3: Share of PHI in financing health expenditure, 1998/99 to 2008/09 (%)

Financial Year	(i) Premium rebate as % of government health expenditure	(ii) Premium rebate as % of total health expenditure	(iii) Health insurance funds (net of premium rebate) as % of total health expenditure	(iv) = (ii) +(iii) PHI as source of financing total health expenditure in %
1998/99	3.0	2.0	8.0	9.9
1999/00	4.3	3.0	6.9	9.8
2000/01	5.1	3.5	7.1	10.6
2001/02	5.0	3.4	8.0	11.4
2002/03	4.8	3.3	8.0	11.2
2003/04	4.8	3.2	8.1	11.3
2004/05	4.8	3.3	7.7	10.9
2005/06	4.9	3.3	7.6	10.9
2006/07	4.8	3.2	7.6	10.8
2007/08	5.0	3.5	7.6	11.1
2008/09	4.6	3.2	7.8	11.1

Source: Australian Institute of Health and Welfare (AIHW) Health expenditure Australia 2008-09.

49. In line with global trend, the ratio of total health expenditure to gross

[6] To avoid double-counting, the health expenditure financed by PHI funds under private health expenditure category does not include the government premium rebate which is instead classified under public health expenditure category. The total health expenditure financed by PHI is equivalent to the sum of these two financing items.

[7] The financial year of Australia starts at 1 April.

domestic product (GDP) in Australia increased from 7.8% in 1998 to 8.5% in 2003 and further to 8.7% in 2008 (Table 4). It is unclear however to what extent the increases were caused by the more active role of PHI in the healthcare system, as health expenditure growth is driven by various factors, positive or negative.

Table 4: Total health expenditure as a proportion of GDP in Australia vs. OECD median[(a)], 1998 to 2008 (%)

	1998	2003	2008
Australia[(b)]	7.8	8.5	8.7
OECD Median	7.8	8.4	9.1

Notes: (a) Expenditure based on the OECD System of Health Accounts (SHA) framework.
(b) The official figures published by Australian government are usually in financial years. The relevant figures have been adjusted to fit the timeframe of calendar year adopted by OECD and OECD'S definition.

Sources: AIHW health expenditure database; OECD Health Data 2010

50. When compared with other member countries within Organisation for Economic Cooperation and Development (OECD), the ratio of total health expenditure to GDP in Australia was similar to the OECD median in earlier years but drifted to below the median in 2008. From 1998 to 2008, total health expenditure growth in Australia actually outpaced that of many other major OECD countries (Table 5), implying that the relatively lower ratio to GDP in recent years was likely related to its relatively faster economic growth. By disaggregating the average expenditure growth in the past decade by major component, it is further observed that volume growth was the major contributory factor. Population component reflecting mainly the population ageing factor is more prominent than several other OECD countries. Meanwhile, medical inflation in Australia appeared to be under good control, averaging at 3.2% per annum during 1998-2008, less than the corresponding figure of 4.0% for general inflation[8].

Table 5: Components of growth in health expenditure, Australia vs. selected OECD countries, 1998 to 2008 [(a)] (%)

		Average annual inflation			Average annual real growth		
Country	Average annual nominal change	General[(g)]	Excess health	Health	Population component	Utilisation component	Total
Australia	**8.6**	**4.0**	**-0.7**	**3.2**	**1.4**	**3.7**	**5.2**
Canada	7.2	2.7	-0.2	2.6	0.9	3.6	4.6
Denmark[(b)]	5.7	2.4	-0.2	2.2	0.3	3.1	3.4
Finland[(c)]	6.4	1.1	2.5	3.7	0.3	2.3	2.6
France[(d)]	5.1	1.7	-0.2	1.5	0.6	3.0	3.6
Italy	5.3	2.5	0.4	2.9	0.3	2.0	2.4

[8] On the other hand, there are on-going complaints about rapid premium rises which were consistently higher than inflation in Australia. For example, the premium rise for 1999-2008 averaged at 5.2%. Yet it is worth of note that apart from inflation pressure, PHI premium adjustment is also affected by other factors such as the age profile of customers (that influences community-rated premium level) and claim experiences.

Country	Average annual nominal change	Average annual inflation			Average annual real growth		
		General[(g)]	Excess health	Health	Population component	Utilisation component	Total
Spain[(b)]	7.7	3.4	-1.0	2.4	0.8	4.3	5.1
Sweden[(e)]	8.2	1.6	2.2	3.8	0.2	4.0	4.3
Switzerland[(f)]	4.4	0.8	-0.2	0.6	0.6	3.1	3.8
United States	7.0	2.4	1.1	3.5	1.0	2.4	3.4

Notes: (a) Expenditure based on the OECD SHA framework.
(b) 1998 to 2001.
(c) 1998 to 2005.
(d) 1998 to 2006.
(e) 1998 to 2002.
(f) 1998 to 2003.
(g) Measured by GDP deflator.

Sources: AIHW health expenditure database; OECD Health Data 2010.

51. Although the Australian government had predicted that the policy of subsidizing PHI take-out would heighten fiscal burden initially, the government share in total health expenditure turned out to ease slightly in the early years of policy implementation, from 66.8% in 1998 to 66.1% in 2003 (Table 6). This was mainly attributable to downsizing of public hospital capacity in response to the demand shift from the public to private hospitals. Yet the government share has rebounded in recent years and reached 68.5% in 2008, as public hospital capacity has been increasing to cope with rising demand pressure, especially from the expanding old-age population[9]. According to some observers, some elderly take out PHI mainly for selective non-urgent surgeries such as hip replacement surgery, and continue to rely on the public hospitals for other treatments especially for catastrophic diseases. Besides, the increase in premium rebate for the elderly since April 2005 heightened the fiscal burden in recent years. Yet compared with the OECD median of 74.2% in 2008, the government share in total health expenditure in Australia remained on the low side.

Table 6: Share of total health expenditure financed by government, Australia vs. OECD median, 1998 to 2008[(a)] (%)

	1998	2003	2008
Australia	66.8	66.1	68.5
OECD Median	74.8	74.5	74.2

Note: (a) Expenditure based on the OECD SHA framework.

Sources: AIHW health expenditure database; OECD Health Data 2010

[9] According to OECD statistics, the elderly share in Australia's population rose from 11.9% in 1995 to 12.3% in 1999 and further to 13.3% in 2009.

Impact of PHI Policy on Private Healthcare Market

52. The Australian government's policy to promote PHI should have notable impacts on various aspects of its private healthcare market and the interaction between the public and private healthcare sectors in Australia. However, due to data and information constraints, and the complexities of the subjects involved, no information on any thorough analysis is readily available. Based on the limited information available, a general picture is attempted as follows.

53. The policy stimulus has diverted some healthcare demand from the public to private sector, especially for hospital treatments. Manifesting this, the share of public hospital admissions in total hospital admissions fell from 62% in 2001/02 to 60% in 2008/09, while the corresponding share of private hospital admissions went up from 38% to 40% (Table 7). Yet the public-private split in total number of patient days held largely unchanged at 70:30 over the period. This phenomenon was due to a larger drop in the average length of stay for private hospital admissions than public hospital admissions. In 2008/09, the average length of stay for private hospital admissions was 2.4 days, much shorter than that of 3.7 days for public hospital admissions. The corresponding figures in 2001/02 were 2.9 days and 4.1 days.

Table 7: Admissions and patient days in public and private hospitals, 2001/02 to 2008/09

	2001 /02	2002 /03	2003 /04	2004 /05	2005 /06	2006 /07	2007 /08	2008 /09
Hospital admissions								
Public hospitals ('000)	3,966	4,091	4,201	4,276	4,466	4,661	4,744	4,891
% of total admissions	62.0	61.6	61.4	60.9	61.1	61.3	60.2	60.0
Private hospitals ('000)	2,433	2,554	2,641	2,742	2,846	2,942	3,130	3,257
% of total admissions	38.0	38.4	38.6	39.1	38.9	38.7	39.8	40.0
Total ('000)	**6,399**	**6,645**	**6,842**	**7,019**	**7,312**	**7,603**	**7,874**	**8,148**
Patient days								
Public hospitals ('000)	16,237	16,425	16,419	16,662	16,993	17,439	17,836	17,889
% of total patient days	70.0	69.8	69.6	69.9	69.8	70.0	69.6	69.4
Private hospitals ('000)	6,964	7,115	7,165	7,166	7,338	7,485	7,807	7,893
% of total patient days	30.0	30.2	30.4	30.1	30.2	30.0	30.4	30.6
Total ('000)	**23,201**	**23,541**	**23,583**	**23,829**	**24,331**	**24,925**	**25,643**	**25,782**

Sources: AIHW Australian hospital statistics 2008-09, and earlier editions.

54. The shorter length of stay for private hospital admissions is due to a larger portion of them being related to elective surgeries that often do not require long hospitalization. In the past several years, the private hospitals have performed a more active role in handling elective surgeries as many insured patients have a greater tendency to go private for non-urgent treatments. In 2008/09, the private hospitals accounted for 64% of all hospital admissions related to elective surgeries, larger than the shares of 62% in

2004/05 (Table 8). These stood in stark contrast to the 40% share of private hospitals in terms of total hospital admissions. It is crudely estimated that elective surgeries accounted for about 35% of admissions in private hospitals and just about 13% of admissions in public hospitals in 2008/09.

Table 8: Admissions for elective surgery, 2004/05 to 2008/09

	2004/05	2005/06	2006/07	2007/08	2008/09
Public Elective Surgery					
No. of admissions	596,849	608,267	617,170	619,522	638,898
% of total admissions	37.8	37.4	37.0	35.6	35.7
Private Elective Surgery					
No. of admissions	983,234	1,016,851	1,051,556	1,120,506	1,152,628
% of total admissions	62.2	62.6	63.0	64.4	64.3
Total					
No. of admissions	1,580,083	1,625,118	1,668,726	1,740,028	1,791,526

Source: National Hospital Mortality Database

55. On the supply side, private hospital capacity expanded as public hospital capacity contracted along with demand shift in the early years of policy implementation. The number of private hospital beds rose from about 24 000 in 1997/98 to 27 000 in 2001/02 whereas the number of public hospital beds dropped from about 56 000 to 51 000 (Table 9). In more recent years, the government resumed expansion of public hospital beds to cope with rising demand from the growing old-age population. Yet compared with 30% in 1997/98, the private share in hospital beds in 2007/08 was still visibly higher, at 33%.

Table 9: Supply of Hospital Beds, 1997/98 to 2007/08

	1997/98	1999/00	2001/02	2003/04	2005/06	2007/08
Public hospitals	55,736	52,947	51,461	53,599	54,601	56,467
% of total beds	69.6	67.7	65.2	66.8	67.6	67.0
Private hospitals	24,367	25,246	27,407	26,589	26,227	27,768
% of total beds	30.4	32.3	34.8	33.2	32.4	33.0
Total	**80,103**	**78,193**	**78,868**	**80,188**	**80,828**	**84,235**

Sources: AIHW Australia's health 2010, and earlier editions.

56. Because of the concurrent increase in demand due to various factors (including demographic changes and induced demand), and reduction in the public hospital capacity in earlier years, the effect of policy stimulus for PHI and the resultant shift of service demand to private hospitals on waiting time in public hospitals was not apparent. Available data since 1999/2000 revealed that the median waiting time for elective surgeries in public hospitals lengthened from 27 days in 1999/2000 to 35 days in 2009/10, possibly as a result of the combination of the aforementioned factors. The long public hospital queue has induced some uninsured patients to take out PHI and target at some selective surgeries of which the waiting period for PHI cover is shorter than the waiting time in public

hospitals, such as hip replacement surgery. According to some observers, this situation is quite common for the elderly in Australia.

Table 10: Waiting times for elective surgery in public hospitals, 1999/2000 to 2009/10

	1999/2000	2001/02	2003/04	2005/06	2007/08	2008/09	2009/10
Days waited at 50th percentile	27	27	28	32	34	34	35
Days waited at 90th percentile	175	203	193	237	235	220	246
% waited more than 365 days	3.1	4.5	3.9	4.6	3.1	3.0	3.6

Sources: AIHW Australian hospital statistics 2009-10, and earlier editions; AIHW National Elective Surgery Waiting Times Data Collection

57. As for manpower supply, no much data can be found regarding how the public-private split in the supply of healthcare workers has changed since implementation of the policy to promote PHI. Anecdotal evidence shows that the total number of salaried doctors and other diagnostic health professionals in private hospitals rose by 23% cumulatively from 2001/02 to 2008/09. However, most of the private medical doctors engage in solo practice or work for health maintenance organizations instead of being hired by private hospitals directly in Australia. Thus the change in labour market condition for the majority of private medical doctors remains unclear. As regards the public sector, the number of salaried medical practitioners in terms of full-time equivalents in the public hospitals showed a sustained rise which accumulated to 57% from 2001/02 to 2008/09.

Concluding Observations

58. The policy to promote PHI achieves to a certain extent its intended objective of motivating private hospital development in Australia. Data reveal that the private hospitals have shared out somewhat the burden of the public hospitals particularly in handling elective surgeries. The specialization of private hospitals in non-urgent treatments has become more apparent. Some observers also opine that the private hospital developments have helped to keep medical talents from flowing to the more remunerative environments abroad. As to whether the policy has led to a significant brain drain from the public to private hospitals, information available is insufficient to clarify the situation, but it is worth of note that the number of doctors in public hospitals has increased considerably faster than public hospital admissions during the past decade or so.

59. The policy implications for the health system as a whole in Australia are difficult to assess. As health system performance and development are always simultaneously influenced by a host of policy, economic and demographic factors, it is difficult to assess the impacts of the proactive policy towards PHI in isolation. The multi-faceted and inter-related nature of the PHI policy and its objectives also makes it difficult to single out any one dimension (e.g. public hospital waiting time) for evaluation

independent of other aspects (e.g. overall system capacity and financing). Moreover, the policy effectiveness involves both efficiency and equity dimensions which sometimes pertain to different values and do not align in measurement. Advocates of PHI tend to focus on how the PHI policy brings about a viable private hospital sector that enhances access to care and increases patient choice, while opponents tend to focus on whether it would be socially justified to subsidize the more affluent people for private healthcare.

60. Community-rated premium in Australia is a notable case demonstrating the policy dilemma. The mandate involves significant cross-subsidization across age which fulfills community expectation from an equity perspective. However, from an efficiency perspective, it aggravates adverse selection, exposes the PHI system to long-term funding risk in an ageing population, and requires substantial premium subsidy to prevent insufficient participation of the younger population that in turn invites challenges on the issue of equity and results in more significant public funding outlay for healthcare, partially offsetting some of the effects of the PHI policy itself. The involvement of societal values makes it difficult to evaluate the policy objectively from a cost-benefit perspective.

61. Observations about the changes in public healthcare sector after implementation of the PHI policy in Australia should be viewed in perspective. The relief of PHI policy to public expenditure tends to be less significant when the role of PHI is meant to supplement rather than substitute the predominant publicly funded system, as in the case of Australia and some other OECD countries. In fact, it is common within OECD that the privately insured continue to rely upon the public system for more expensive services, such as the treatments of catastrophic diseases to which the growing elderly population is more vulnerable. As in the case of Australia in earlier years, the diversion of service demands especially for elective surgeries to private hospitals was also accompanied by a reduction in public hospitals capacity. The resultant implications for resource allocation makes it difficult to establish any causal linkage between the impact of PHI policies and the waiting time for elective surgeries in public hospitals, which is not apparent in some OECD countries including Australia.

Research Office
Food and Health Bureau
January 2011

Major references:

1. Australian Government. (2009) Private Health Insurance Act 2007. Available at: http://www.comlaw.gov.au/ComLaw/Legislation/ActCompilation1.nsf/all/search/3EBFE1E5DC4FCB77CA2575F6000B223A

2. Australian Bureau of Statistics. (2010) 3201.0 Population by Age and Sex, Australian States and Territories, Jun 2010. Available at: http://www.abs.gov.au/Ausstats/abs@.nsf/mf/3201.0

3. Australian Institute of Health and Welfare. Australia's health publications. Available at: http://www.aihw.gov.au/publications/index.cfm/series/13

4. Australian Institute of Health and Welfare. Australian hospital statistics publications. Available at: http://www.aihw.gov.au/hospitals/publications.cfm

5. Australian Institute of Health and Welfare. (2010) Health expenditure Australia 2008-09. Available at: http://www.aihw.gov.au/publications/index.cfm/title/12364

6. Australian Institute of Health and Welfare. National elective surgery waiting times data collection. Available at: http://www.aihw.gov.au/hospitals/waitingtime_data.cfm

7. Australian Institute of Health and Welfare. National hospital morbidity database. Available at: http://www.aihw.gov.au/hospitals/nhm_database.cfm

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

9. Francesca Colombo and Nicole Tapay. (2003) OECD HEALTH WORKING PAPERS No.8 Private Health Insurance in Australia: A Case Study. Available at: http://www.oecd.org/dataoecd/5/54/22364106.pdf

10. Medicare Australia. http://www.medicareaustralia.gov.au/

11. Milliman Limited. (2010) Local Market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views. Available at: http://www.myhealthmychoice.gov.hk/pdf/studyreport/insurance_background_research.pdf

12. Origanisation for Economic Co-operation and Development. (2010) OECD Health Data 2010. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html

13. Private Health Insurance Administration Council. (2008) Insure? Not sure? Available at: http://www.phiac.gov.au/for-consumers/insure-not-sure/

14. Private Health Insurance Administration Council. (2009) Private Health Insurance: People with Hospital Treatment cover by age. Available at: http://www.phiac.gov.au/for-industry/industry-statistics/annualsurvey/

15. The Private Health Insurance Ombudsman. http://www.phio.org.au/

16. Professional Services Review. http://www.psr.gov.au/

For information

Legislative Council Panel on Health Services

OECD Study on Private Health Insurance

Purpose

In response to request from Members of the Panel, this note summarizes the findings of the study on private health insurance (PHI) by the Organisation for Economic Cooperation and Development (OECD) in 2001-2004 ("OECD Study")[1].

Overview

2. The OECD study reveals that PHI if positioned as a health policy tool can present both opportunities and challenges. While PHI can help governments attain health system performance goals, it can also put them at risk. The effect depends, in part, on the role of PHI, in terms of market size and function within the healthcare system, and the policy and regulatory framework for PHI and healthcare delivery.

3. In countries where PHI plays a prominent role, it can be credited with injecting resources into health systems and helping to make them more responsive. However, it has also given rise to considerable equity and cost control challenges in most of those same countries, especially when PHI overtakes other financing means and becomes the predominant mode of financing healthcare.

4. The OECD study assesses the strengths and weaknesses of PHI in contributing to health system performance in several perspectives. It also sets out useful practices for policy makers to help direct PHI markets to contributing towards health system performance. However, it does not conclude with any hard-and-fast rule or one-size-fit-all solution in making use of PHI to achieve health system goals.

Contribution of PHI to Health System Performance

5. Based on the experiences in the OECD countries gathered, the OECD study identifies strengths and weaknesses of PHI in contributing to health system performance,

---

[1] For details, see
(i) OECD (2004), Private Health Insurance in OECD Countries, Paris.
(ii) Colombo, F. and Tapay, N. (2004), Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems", OECD Health Working Papers, No. 15, OECD Publishing.
(iii) OECD (2004), Private Health Insurance in OECD countries, Policy Brief, Paris.

which are summarized below.

(a) Access to health coverage and healthcare

- Contribution of PHI to access to health coverage within OECD has varied depending on how large a PHI market has developed, how broad is the risk pool, and the scope of regulations of health coverage and care delivery system.

- When public healthcare cover is not comprehensive or universal, PHI has enhanced access to timely care for the insured. There is however no clear evidence that PHI would necessarily reduce overall waiting times in the public sector. It is because the impact of PHI on waiting times depend on several factors, such as the evolution of demand and need, changes in supply of healthcare services, the way people are added to or removed from the waiting list of the public system, and whether those receiving privately financed care are included in the public waiting list.

- Access to healthcare through PHI is often not equitable across income groups, largely because PHI is typically purchased by higher income groups. Moreover, where the private sector offers higher remuneration levels to healthcare providers and attracts more resources within the healthcare system, this can divert resources from the public system resulting in reduced capacity of the public system and access to care for those who cannot afford PHI.

- With light or little government regulation, risk selection by insurers is typical in PHI markets so that higher-risk individuals face access difficulties.

(b) Consumer choice and health system responsiveness

- PHI has enhanced choice and responsiveness of health systems in many OECD countries, especially those with duplicate PHI markets (i.e. PHI provides largely the same coverage as the public system). PHI has often improved individuals' choice over healthcare providers and timing of care. The scope of this added choice depends on the regulation of health care delivery system, freedom of choice already existing within public systems, and insurers' contractual terms with healthcare providers.

- For consumers to exercise meaningful choice among a wide array of PHI products in the market, insurers' marketing and product informational materials need to be transparent and enable comparisons.

- There are trade-offs between system responsiveness and access concerns. To avoid vulnerable groups from being priced out of PHI markets, policy makers have sometimes limited the scope for insurers' flexibility and innovation in PHI product design. Standardization of benefit packages is a way to facilitate informed choices of consumers as well as reduce risk selection activities of insurers, though insurance product innovation in response to market changes may be inhibited in consequence.

(c) Quality of healthcare

- There is only weak evidence that PHI has promoted the delivery of high-quality care in the OECD area, mainly due to lack of regulatory and financial incentives for insurers to oversee care delivery. If insurers are to play a role, they need adequate incentives, regulatory or financial, to invest in quality-improvement initiatives and foster value-based competition.

- Limited market experiences about the use of managed care to control quality of care and cost reflect that the relevant techniques such as selective network with approved healthcare providers, pre-approval requirement of services ordered by healthcare providers and promotion of preventive care, are often resisted by consumers and healthcare providers. The former resistance stems from the restraints on choices of care while the latter resistance stems from the influence on decisions over application and appropriateness of care. Overall evidence of the impact of managed care on quality of care is mixed.

- PHI may not be the best lever to improve healthcare quality, particularly where its role in a health system is small.

(d) Health expenditure

- PHI has not significantly assumed financing burdens from the public sector in the OECD area. In most countries where PHI plays a prominent role, it has resulted in higher total health expenditure due to higher medical prices, increased utilization, or both, accompanied by continued increasing public health expenditure to fund the public healthcare system and provide incentives for PHI. Yet the study opines that the desirability or acceptability of expenditure increases depends on what benefits they can bring about.

- Cost shifting from publicly to privately financed providers in systems with duplicate PHI market has remained limited. The insured have often continued to rely upon publicly financed hospital services, especially for the most expensive services as

private hospitals have often focused on a limited range of elective services. Meanwhile, delisting of services from public coverage to shift cost onto the private sector has generally remained confined to less expensive services.

- PHI has often added to total health expenditure mainly because most OECD countries apply less tight governmental control over private sector activities and prices compared to public programmes and providers, while private insurers have relatively less bargaining power over the price and quantity of care. Besides, private insurers need to incur higher administrative costs in marketing, customer services, product innovation and networking with healthcare providers.

- PHI has added to public health spending in some cases. Main reasons include public subsidies to encourage PHI take-out and PHI-induced utilization of public services when PHI also pays for user fees.

Useful Practices to Help Direct PHI Markets to Good Performance

6. The OECD study observes that policy makers in the OECD area have resorted to a variety of government interventions through regulatory and fiscal instruments to cope with the challenges presented by PHI. Based on the experiences gathered, it identifies a number of useful practices to help direct PHI markets to contributing towards health system performance, which are summarized below.

- Access related PHI challenges can be overcome by setting up a combination of insurance and risk rating rules. These may help promote insurance coverage for high-risk individuals and may be particularly useful in PHI markets where the role of PHI is primary. A public system providing near-universal coverage and safety net will also reduce the challenges to access.

- Fiscal incentives and subsidies can boost the purchase of PHI but compared with other types of policy interventions, they may not be the most cost-effective way to increase PHI enrollment. If large incentives are needed to spur purchase of PHI, the cost involved need to be weighed against the savings in public health spending due to increased PHI enrollment.

- Policy makers can intervene when PHI creates disparities in access to care between those with and those without PHI cover. The intervention can relate to regulating price differentials between publicly and privately financed medical practices, specifying healthcare providers' obligation to public patients, and monitoring compliance with those obligations.

- When cost sharing in public systems is high (meaning higher user fees), PHI enhances access to care. However, if PHI offers full coverage of high cost-sharing levels on public programmes, it may reduce cost awareness of the insured and lead to moral hazard-induced utilization, thereby creating trade-off with cost-containment goals.

- Effective choice within PHI system can be maximized if policy makers foster disclosure of PHI product benefits such that it can be easily understood by consumers. Disclosure requirements can work together with benefit standards to promote and reinforce consumers' understanding of their PHI products and coverage.

- Policy makers can maximize cost shifting between the public and private sector by encouraging the insured not to rely on public systems for PHI-covered services. Applying cost control measures within the overall health system, including the private sector, improves the ability to control cost within the PHI markets.

- Policy makers can make use of incentives or regulatory requirements to promote cost effectiveness of care, for instance by providing incentives for insurers to be involved in care management or preventive care. Besides, improved consumer information can facilitate effective competition among insurers. Systems to compensate insurers with a worse risk structure (e.g. risk equalization mechanism) can also help reduce insurers' incentives to engage in risk selection, thus promoting equitable risk pooling and value-based competition, though they can also remove or reduce incentive to improve efficiency.

Research Office
Food and Health Bureau
January 2011