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AUSTRALIAN CENTRE
FOR
ECONOMIC RESEARCH
ON HEALTH

'Brief introduction to European social insurance principles and models'

Francesco Paolucci, PhD.

ACERH @ ANU

Francesco.Paolucci@anu.edu.au

Presentation to a Public Forum organised by the Menzies & ACERH @ANU on:

"Strengthening the governance of Australia's healthcare system"

The Finkel Lecture Theatre, The John Curtin School of Medical Research Building,
Building 131, Garran Road, ANU

Wednesday 15 April, 5.30-9.00pm



THE UNIVERSITY OF
WESTERN AUSTRALIA





NHHRC Interim Report (Feb. 16th, 2009)

- Strengthening bureaucratic systems:
 - Option A: Status quo with shared responsibilities between Commonwealth and State and Territory but re-aligned and clearer accountability.
 - Option B: Commonwealth to be solely responsible for all aspects of health care, delivering through regional health authorities.

- Strengthening health insurance system, Option C:
 - Commonwealth to be solely responsible for all aspects of health and health care, establishing tax-funded compulsory insurance with consumer choice of multiple competing public & private health plans.

Chapter 12 "Strengthening the governance of health and health care", page 273-298.



Option C in other countries: Social Health Insurance

- What is social health insurance?
- Principles:
 - **Universal Mandatory Coverage for a Minimum Benefits Package.**
 - **Solidarity**, ie. cross-subsidies:
 - Income-solidarity (income-related cross-subsidies);
 - Risk-solidarity (risk-adjusted cross-subsidies).
 - **Consumer choice** of competing (public/private, for-profit/not-for-profit, mutual/non-mutual) funds.



Social Health Insurance: Consumer Choice yes/no?

- Two models:
 1. National Health Programs (NHP): France, Hungary, Poland etc.
 2. National Health Insurance (NHI): Belgium, Germany, Israel, The Netherlands, Switzerland etc.



1. France

■ Features:

- Integral part of the Social Security System (Systeme de Securite Sociale);
- Employer-based enrolment with no consumer choice of health funds (ie. mutualites, not-for profit);
- Universal/uniform coverage for a broad package of services (including medical, hospital, drugs, LTC services, some dental and physiotherapy)
- Funded via payroll (employees's contribution is about 25%, employers 15%) and income-taxes;
- Unemployed and low-income individuals have free access to health care services;
- It covers 80% of the costs and for the remaining 20% individuals can choose to purchase voluntary complementary health insurance from competing public and private carriers:
 - » Community-rating + open enrolment;
 - » Income- and risk-related subsidies.
- Public provision with government regulated prices.



2. National Health Insurance

From the mid-1990s citizens in Belgium, Germany, Israel, the Netherlands and Switzerland have a guaranteed periodic choice among risk-bearing social health funds, who are responsible for purchasing their care or providing them with medical care.



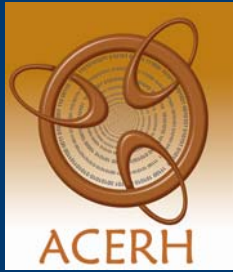
Rationale

The rationale for consumer choice is to stimulate the social health funds to improve efficiency in health care production (ie. prudent buyer of care) and to respond to consumers' preferences.

For the full background paper see:

Van de Ven et al. 'Risk adjustment and risk selection in Europe: 6 years later'

Health Policy 83 (2007) 162-179.



Switzerland

	CH
Universal individual-mandate to take out coverage	Yes (1% uninsured)
Standard basic package	Yes (GP, Specialist, hospital, drugs, partly CAM, dental, physio; 80% has VSI)
Consumer choice of insurer	Yes Annual with open enrolment
Insurers; Market structure	<ul style="list-style-type: none"> •Not-for profit & Swiss-based; •5-largest with 50% market share; •5% switching.
Regulations & subsidies	<ul style="list-style-type: none"> •Risk-equalisation (age/gender/hospital stay) •Community-rating •Yes stop loss
Deductibles	Yes choice of deductible amount range from \$300 to \$2125
Financial risk & selective contracting	100% Yes



Conclusions

- Social health insurance models with consumer choice of health funds:
 - Good balance of the different types of *supply*-side oriented and *consumer*-side oriented incentives.
 - Consistent with nearly any public-private mix in funding (including Australia): partly private premiums and partly subsidies which can be risk and/or income-related.
 - Main criticism selection...



Conclusions

- Response:
 - *Good risk equalisation;*
 - Adequate competition policy;
 - Consumer information (price, quality);
 - Transparency (e.g. insurance products);
 - Supervision of quality of care;
 - Sufficient contracting freedom (price, quality, selective contracting);
 -



Developing Risk Equalisation in Australia

Francesco Paolucci, PhD

Research Fellow (ACERH, ANU)

Francesco.Paolucci@anu.edu.au

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Universal mandatory insurance with consumer choice of competing health plans

- Belgium, Chile, Czech Republic, Germany, Israel, Netherlands, Slovakia, South Africa, Switzerland, ...
- Australia and Ireland?
 - About 50% of the population purchase voluntary health insurance (VHI);
 - Competing health funds;
 - Highly subsidised & regulated (community-rating, premium subsidies, tax-penalties for non buyers, “risk-equalisation”).



Unregulated competitive insurance market

In a free market without external intervention:

- a system of implicit cross-subsidies, e.g. community-rated premiums, can not be sustained because unrestricted competition minimizes the predictable profit per contract;
- consequently individual health insurance may be unaffordable for the (low-income) high risks in a competitive insurance market because of risk rating and risk selection.



Agenda

1. How to make individual health insurance affordable in a market with consumer choice of competing health funds?
2. Risk-equalisation in Australia.



Part 1.

How to make individual health insurance affordable?



Four strategies (to organise subsidies): HOW?

- Consumer choice of competing health funds requires the enforcement of regulations/subsidies to make individual health insurance affordable.
- Four strategies:
 1. Risk-adjusted premium subsidies;
 2. Premium-adjusted subsidies;
 3. Ex-post claims-based subsidies;
 4. Premium rate restrictions;

Combination of the above mentioned strategies.



Regulator

- A subsidy system is organised by a regulator (e.g. government) such that high-risk individuals receive a subsidy from a Subsidy Fund that is filled by mandatory contributions.

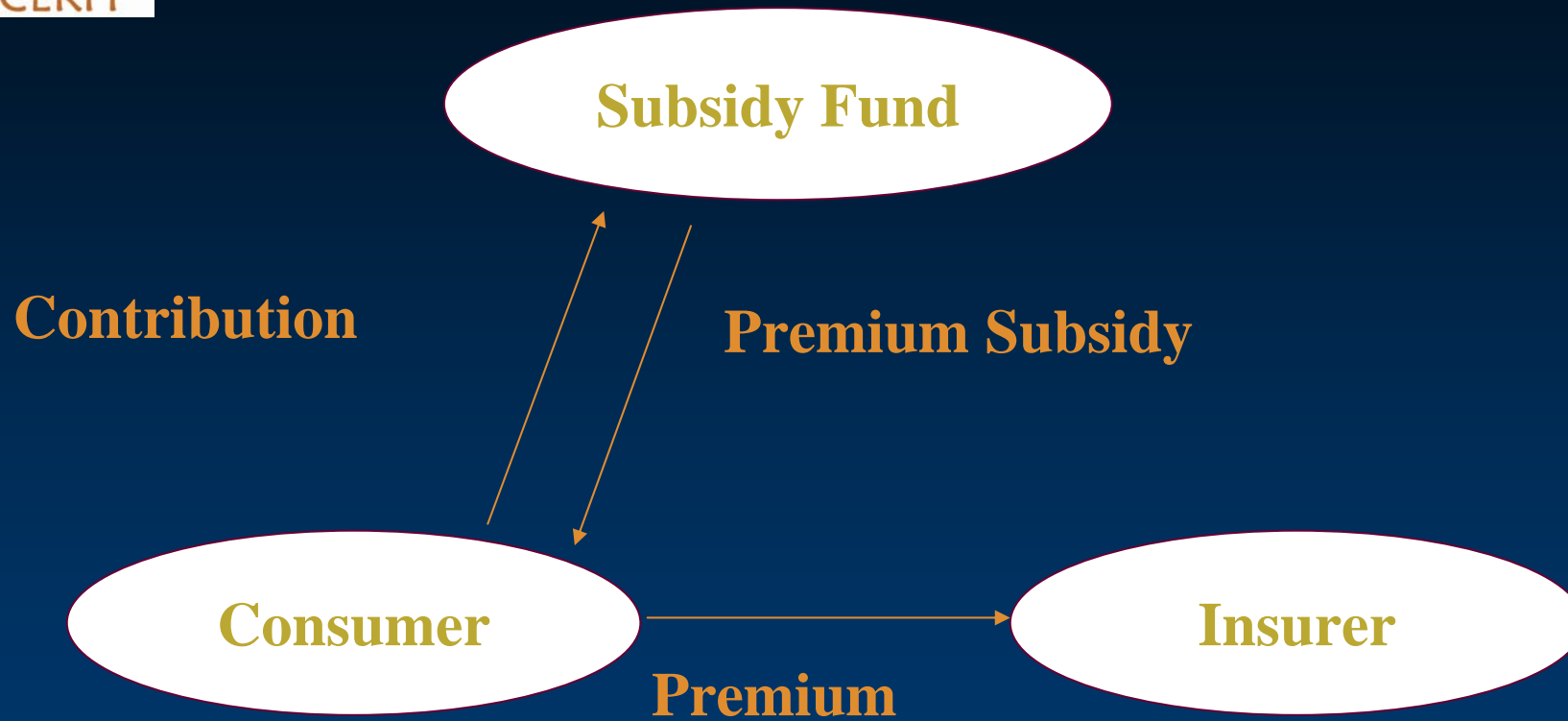


1. Risk-adjusted subsidies

- Risk-adjusted subsidies are based on the risk factors X that insurers use, such as age and health status.
- E.g. the subsidies are equal to the predicted expenses based on X minus a fixed amount. Such subsidies do not distort the premium competition because the consumer is fully price sensitive at the margin.



Premium Subsidy





Risk Equalisation

All countries that apply risk-adjusted subsidies give the subsidy to the insurer who deducts it from the premium. In this way the different *risks* that consumers represent for the insurer are *equalized*. We refer to this as *Risk Equalisation (RE)*.

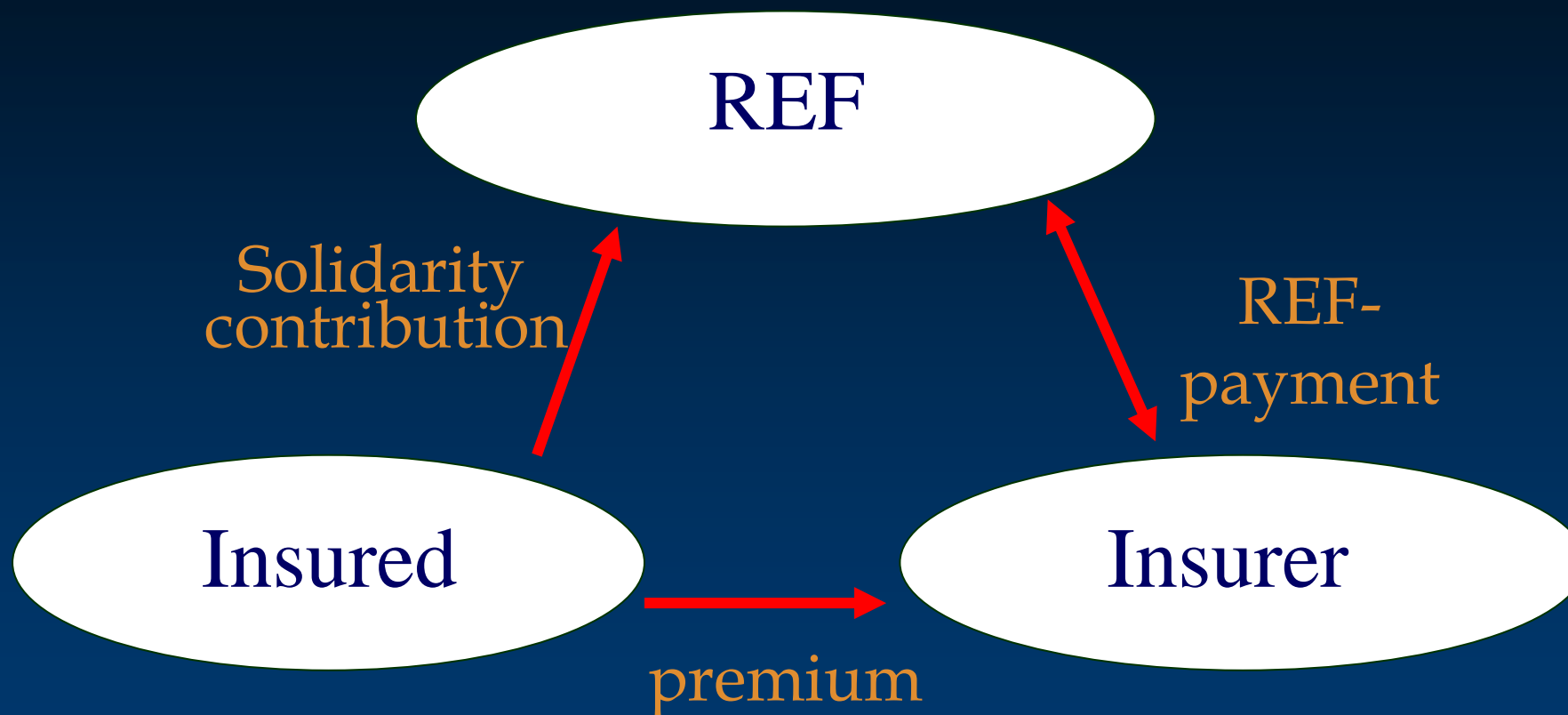
Two modalities of RE are observed:

- The consumer pays the contribution C directly to the Subsidy Fund (REF) (*Modality B*);
- The consumer pays the contribution C to the REF *via* the insurer (*Modality C*).



RE - Modality B

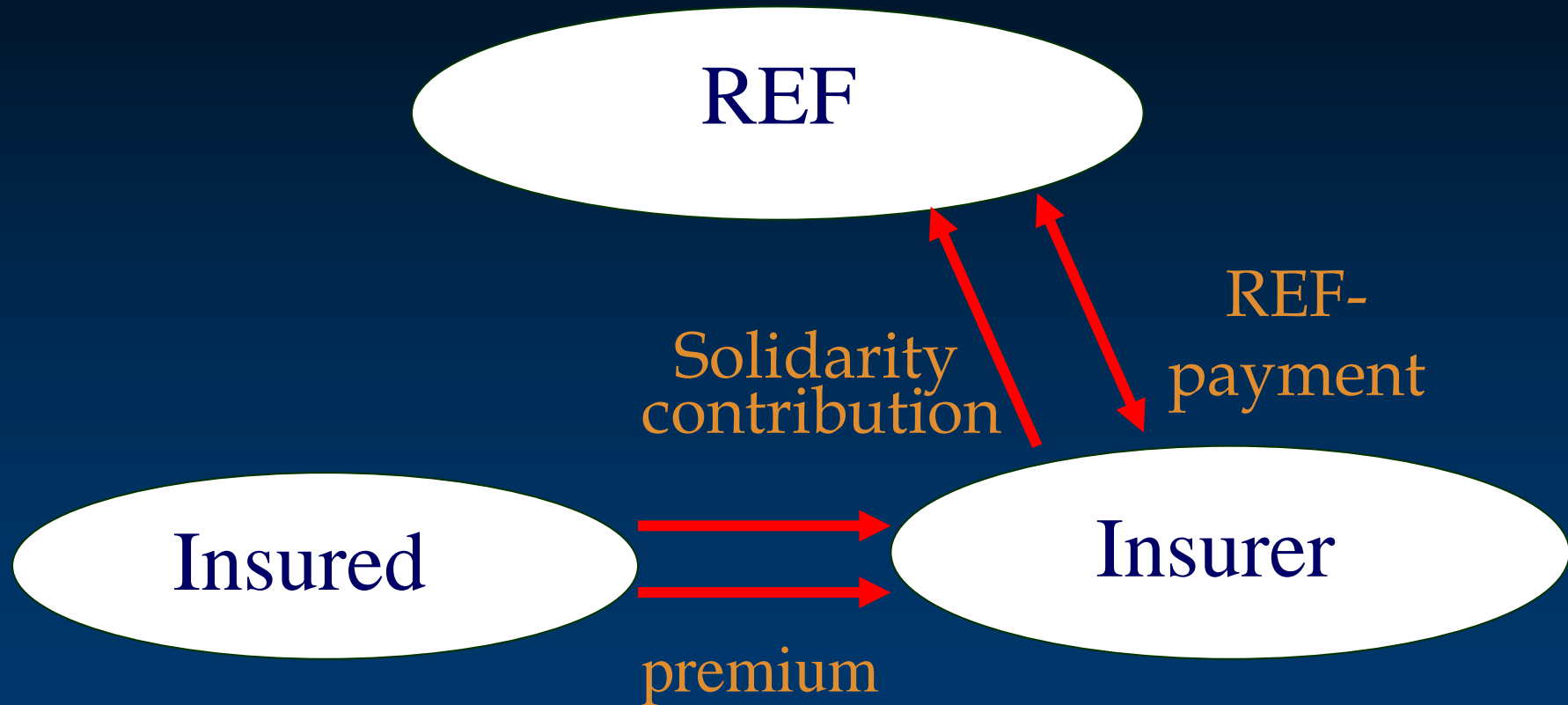
Belgium, Israel, the Netherlands:





RE - Modality C

Germany, Switzerland:





Risk Equalisation in 2006

	Belgium	Germany	Israel	Netherlands	Switzerland
Risk adjusters	Age/gender, Disability, Invalidity, Chronic illness, Mortality, Employment status, Social status, Income, Urbanization.	Age/gender, Disability, Registration in a certified Disease Management Programme, Entitlement for sick leave payments, Income.	Age/ gender	Age/gender, Disability, Pharmacy-based Cost Groups, Diagnostic Cost Groups, Self-employed, Urbanization.	Age/gender, Region.
Quality of Risk Equalization	Moderate / fair	Moderate	Low	Fair / good	Low



2. Premium-adjusted subsidies

- Effective in achieving affordability.
- But, not optimal:
 - They reduce the consumers' and insurers' incentives for efficiency:
 - » Less effective price-competition and risk of premium inflation;
 - » A welfare loss because of the moral hazard due to over-insurance.
 - They create a misallocation of subsidies.

→ tradeoff affordability - efficiency



3. Premium rate restrictions

- Goal: to create implicit cross-subsidies from the low-risks to the high-risks.
- Effect: Such pooling of people with different risks creates substantial predictable profits and losses for subgroups → and thereby create incentives for risk-selection.

→ tradeoff affordability - selection



4. Ex-post claims-based subsidies

- The regulator subsidises some or all expenses e.g. above a certain threshold for each individual.
- For practical reasons, the regulator provides the subsidy to the insurer ('excess loss compensations') resulting in a reduction of the premiums, in particular for the high risks.

→ tradeoff affordability - efficiency



The preferred strategy

- Risk equalisation (RE) first-best regulatory tool to escape from the tradeoffs between affordability, efficiency and selection (van de Ven & Schut 2008-7; Paolucci et al. 2006):
 - In the case of perfect risk equalisation there is no need for any other strategy and no tradeoff exists.
 - Each of the other strategies inevitably confronts policymakers with a tradeoff.



Part 3.

Risk equalisation in Australia



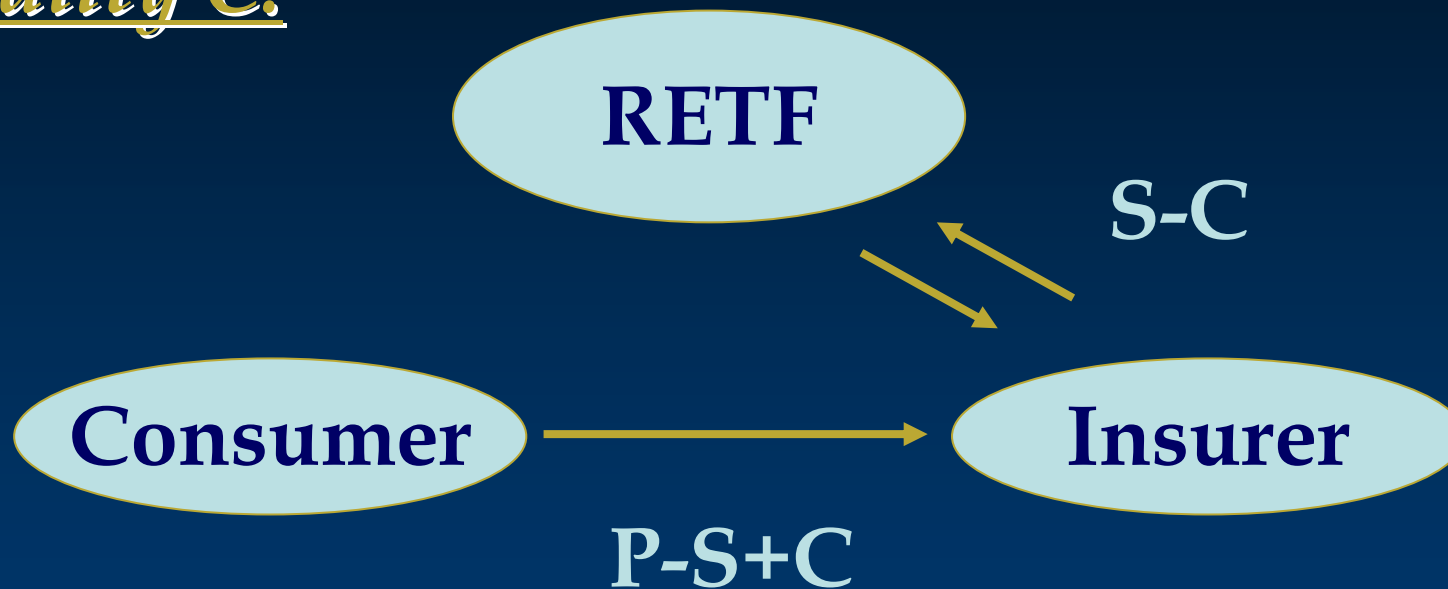
a.

RE features



RE modality

Modality C:



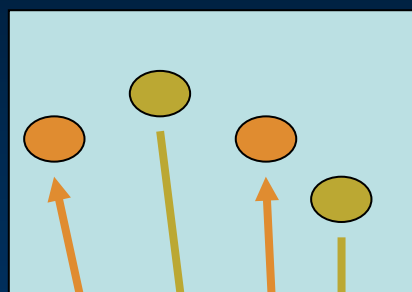
RETF=Risk Equalisation Trust Fund
C=Contribution; S=Subsidy; P=Premium



RE per State

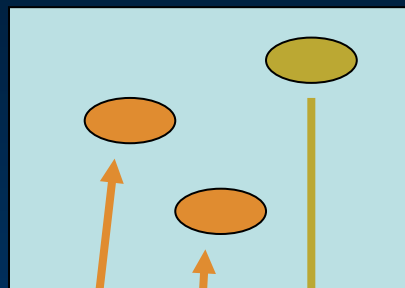
Australia

State A



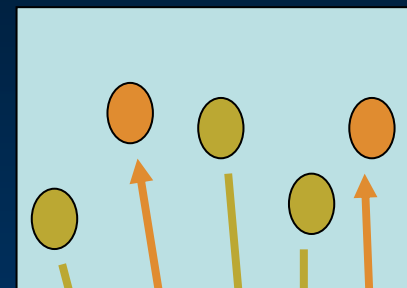
RETF

State B



RETF

State C



RETF



Benefits and risk-factors

■ Benefits:

- Hospital benefits (97.6%);
- Hospital substitute benefits (0.05%);
- Chronic Disease Management Program benefits (0.07%);
- High Cost Claimants benefits (2.19%).

■ Current risk-factors:

- Age – 8 age bands (ABP);
- Crude proxy for chronic conditions (HCCP).



b.

*Limitations & potential
developments*



Is it RE?

- In RE schemes the “total budget” is set *a priori* according to society’s priorities, and is allocated to the insurers only on the basis of the selected risk factors’ of their insured population.
- Most countries in the world adopt *ex-ante* (prospective) RE in Belgium, Germany, Israel, Switzerland, US etc.



Is it RE?

- Current RE system is *ex-post* (retrospective) claims-equalisation scheme (CE) that re-distributes *a posteriori* a budget made of (mainly) age-based contributions of all insurers derived from their actual claims (costs) according to their market share.
- The age structure of the population determines the contributions rather than the transfers.
- The age-based contributions are *arbitrarily defined percentages* of the claims increasing with age.



Effects of CE

- Highly imperfect matching with the 'true' risk structure of insurers' population resulting in over/under compensations (i.e. misallocation of subsidies).
- Strong incentives for selection (historically a constant threat to the stability of PHI market in Australia).
- Lack of incentives for efficiency.



Potential developments

- From ex-post CE to ex-ante RE:
 - Transfers between insurers based on the 'true' population risk profile rather than benefit costs:
 - Improved predictability & incentives for efficiency;
 - Fairer equalisation & reduced incentives for selection (i.e. better matching with insurers' population risk profiles).



Potential developments

- Additional risk-adjusters in line with other countries (The Netherlands):
 - Expand age-bands;
 - Gender;
 - Health status (e.g. (multiyear) DCGs, PCGs, DTCs, DRGs, disability etc.);
 - Socio-economic status (e.g. self-employed);
 - Yes/no voluntary deductibles;
 - Region?
 - Product type?
 - Etc.



Data sources

1. Insurers' claims data;
2. Individual records on public health care utilisation (MBS, PBS);
3. Breakdowns of utilisation of public health care services/benefits (NHS, PHIAC, AIHW).

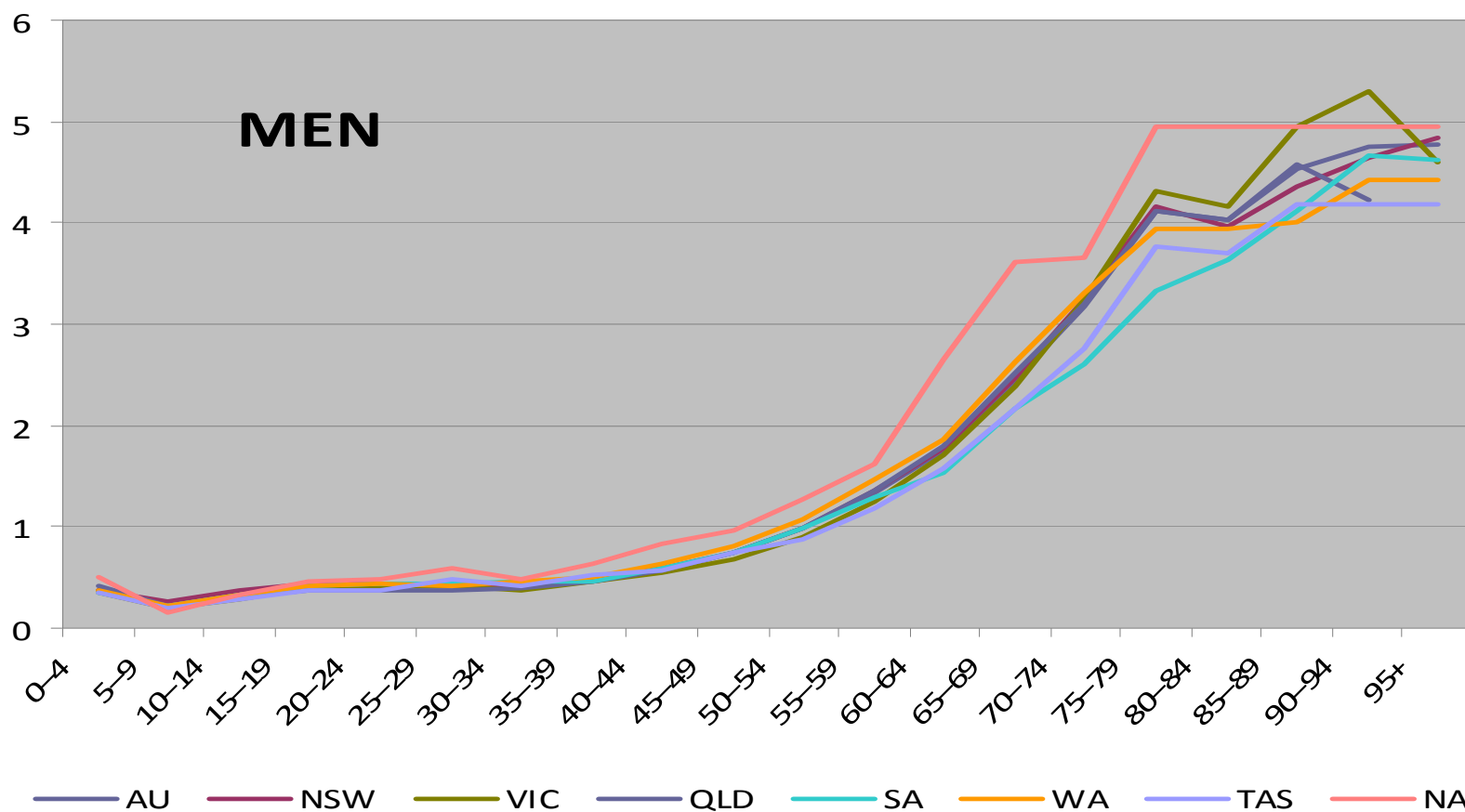


So far...

- “Demographic scales for ex-ante RE in the Australian PHI market using” (Paolucci, Shmueli, Butler, 2009).
- Expanded age-gender scales constructed by using 3. breakdowns of utilisation of public health care services/benefits (NHS, PHIAC, AIHW).
- Simulations of the implications of switching from *ex-post* CE to *ex-ante* RE on the RETF transfers across insurers by using aggregate age-gender health expenditures data per insurer (PHIAC, 2008).

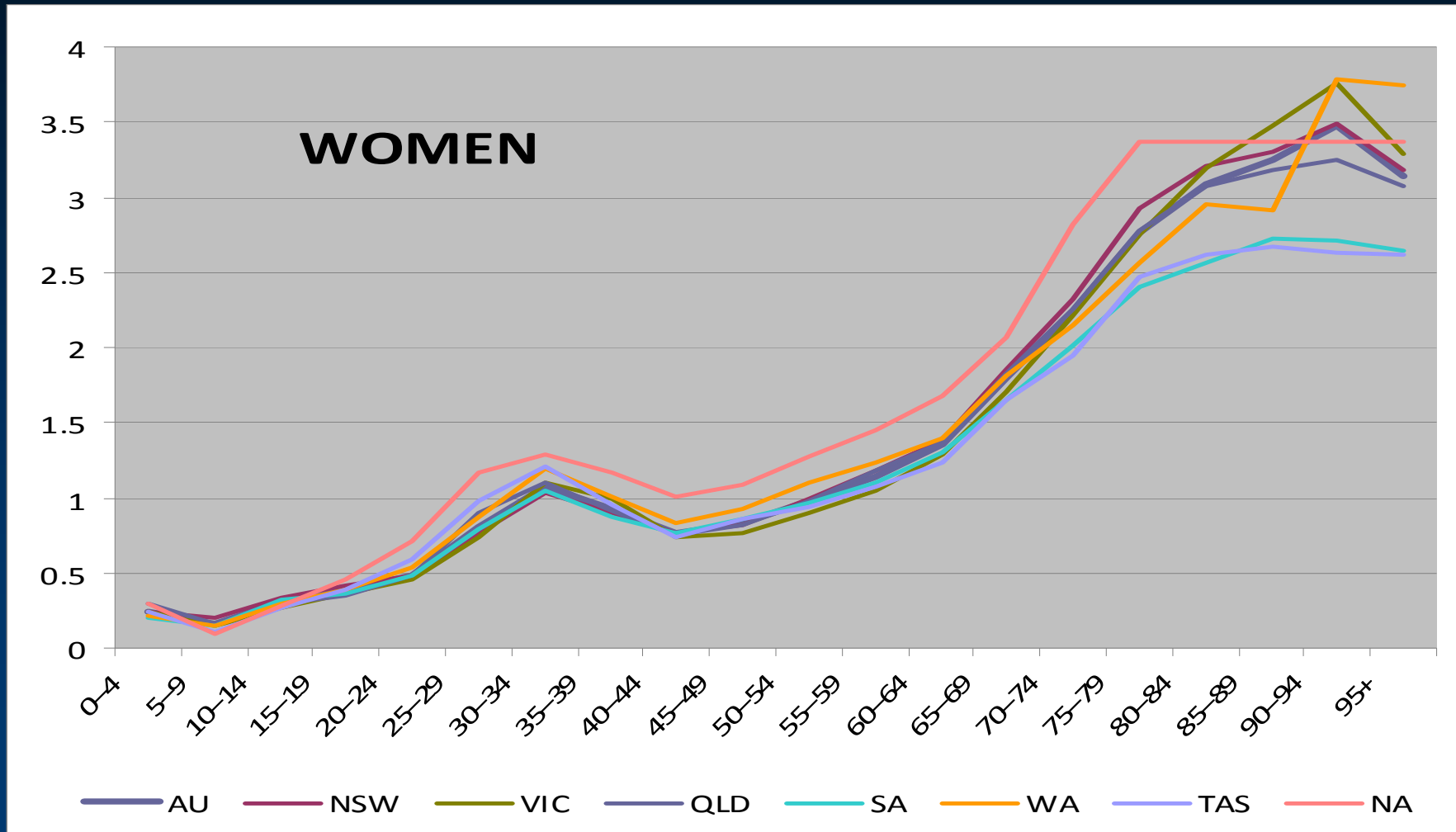


Overall PHIAC scales





Overall PHIAC scales





Simulations

- Based on the overall PHIAC age-gender scales and the actual CE allocation of benefits, we calculated the gain or loss for each insurer as the difference between the ex-ante RE size of benefits and the benefits resulted from the current RE distribution.
- The results show that there will be gainers and losers from a switch from ex-post CE to ex-ante RE.
- The identity of these gainers and losers differ across states.



Relevance of future research on RE

- Theory has shown that 'good' *ex-ante* RE is an essential precondition for consumer choice of competing health funds to provide incentives for efficiency and achieve affordable access to coverage.
- Empirical research on RE in Australia is as essential to show its potential in achieving these goals.



Based on...

1. Paolucci, Butler, van de Ven (2008), 'Subsidising Private Health Insurance in Australia: Why, How and How to Proceed?', ACERH WP2.
2. Paolucci, Prinsze, Stam, van de Ven (2009), 'Premium range of risk-rating in supplementary health insurance markets', IJHFE.
- 3.a. Paolucci, Connelly, Butler, Collins (2009), "'Risk equalisation" in Australia Private Health Insurance Markets', mimeo.
 - b. Paolucci, Butler, Shmueli (2009), 'Demographic scales for ex-ante risk-equalisation in the Australian private health insurance market', mimeo.