Policy Forum: Reforming the Health System

New Opportunities in Health Financing and Governance

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1. Introduction

The final report of the National Health and Hospitals Reform Commission (NHHRC) (2009) provides a broad-ranging discussion of a raft of issues in health, health care, and health-care financing. Given the wide range of issues covered by the report, it is not possible to provide a thorough appraisal of it in the short space of this article. The primary focus in this article will be on the proposed reforms to health-care financing in general and hospital financing in particular. Deeble (2009, p. 10) is forthright in his assessment of the importance of the organisation and financing of hospital care in discussions of health-care reform: 'It is **the** political problem and the most controversial in terms of both media coverage and popular concern. And it is also **the** major cost issue.' (emphasis in original).

The NHHRC's proposals for financing reform are elaborated mostly in Chapter 6 of the report entitled 'Reforming Governance'. The two main recommendations of the NHHRC with respect to financing relate to the funding of public hospitals and the development of Medicare Select to allow opting out of Medicare into a private health plan.

2. Overview of Main Health-Care Financing Proposals

2.1 Funding of Public Hospitals

The NHHRC's proposal for reform of public hospital financing comes under the rubric of a Healthy Australia Accord. The 'Accord' refers to an agreement that is to be struck between the Commonwealth and state governments

regarding the assignment of functions between the two levels of government.¹ While the NHHRC (2009, p. 147) sees an important aim of this Accord as 'driving better integrated primary health care, dental care and aged care', it also encompasses a proposal to redesign the funding arrangements for public hospitals. Specifically, it is proposed that the Commonwealth Government pay state governments 100 per cent of the 'efficient cost of care' for hospital outpatient attendances up to an agreed activity level and activity-based benefits using casemix classifications for inpatient episodes. Initially, the activity-based inpatient benefits would be set at 40 per cent of the 'efficient cost of each episode of care', with state governments funding the remainder, but the NHHRC sees this proportion increasing to 100 per cent over time. Even with a Commonwealth contribution of 100 per cent, the application of this proportion to the efficient cost of each episode of care potentially leaves a gap to be funded by states because the actual cost of episodes may exceed the efficient cost. Leaving this gap to be covered by states rather than patients ensures that public patients will continue to receive public hospital inpatient treatment at no charge. Interestingly, the NHHRC sees the Commonwealth as having the option of making activity-based payments directly to public hospitals rather than to the state governments which would retain ownership of the hospitals.

The NHHRC (2009, p. 151) sees these changes as resulting in a 'single government funding system' for public hospitals. It extols the virtues of this arrangement as being the efficiency incentives stemming from case-based funding of inpatient treatment, the containment of the budgetary cost of health care, the

reduction or elimination of disputes about the adequacy of the Commonwealth's contribution to the funding of public hospitals and the assignment of responsibility for funding a range of health services at the Commonwealth level.

2.2 Medicare Select

The Medicare Select proposal would allow consumers a choice of remaining in the Medicare public health insurance plan or opting out and receiving a subsidy to enrol in a private health insurance plan of their choice. The subsidy would be risk-adjusted to reflect the expected cost of services that would have been incurred had the person chosen to remain in the public plan. The expected cost of services would include medical services funded through the Medicare Benefits Schedule, drugs funded through the Pharmaceutical Benefits Scheme and public hospital care. Private plans would be subject to an open enrolment regulation (cover cannot be refused to anyone who applies for it).

A question that immediately arises is whether private plans would be required to accept the risk-adjusted subsidy as full payment for the premium or whether they would be allowed to charge a premium that exceeds the subsidy. If the latter, there is a possibility that consumers will face an out-of-pocket expense or gap payment for the insurance premium on top of any out-of-pocket expenses incurred for health services. The NHHRC (2009, p. 158) appears to envisage gap payments on premiums emerging when it states that 'copayments for mandatory coverage would also be limited by regulation'. The mandatory coverage referred to here relates to another proposed regulation—a 'universal service obligation' (a minimum benefits package) that would have to be provided by any plan. The purpose of this is to prevent competition between health insurers from driving down premiums by excising services from the benefits package.

Conspicuous by its absence in the report is any mention of community rating—the regulation that currently requires private health insurers to charge the same premium for the same policy to all purchasers of that policy.² Implicitly then, a community rating regulation

would not be imposed under Medicare Select, so individuals and families choosing to opt out would be confronted with risk-rated premiums. Indeed, it is difficult to envisage how a community rating regulation could be imposed when the risk-adjusted subsidy for opting out is to be provided to the consumer and not directly to the health plan. This is in contrast to the Dutch reforms of 2006, under which the risk-adjusted subsidy is passed directly to the health plan of the consumer's choice and health plans are subject to a community rating regulation in setting premiums for the basic benefits package.³

The advantages of Medicare Select are argued to derive from the competition that it would inspire, both between health plans themselves (competition in the insurance market) and between health plans and service providers (competition in the service market). Consumer choice of health plan is expected to boost competition between plans and it is envisaged that plans will become active 'purchasers' of care on behalf of their enrollees. Although the description of plans 'purchasing' care on behalf of their enrollees is common in the literature,⁴ it is presumably not meant to be taken literally. The idea is that health plans will become more active negotiators with service providers to obtain more favourable terms on which services are provided to a plan's enrollees so that, for example, the enrollee may have zero out-of-pocket expenses for services purchased from a supplier who is a member of a preferred provider organisation.

3. Assessment

3.1 Funding of Public Hospitals

As the NHHRC's proposal for funding hospitals is specifically designed for public hospitals, the financing of private hospitals would not be brought within the single government funding system. An important feature of current hospital funding arrangements is that, by and large, the type of hospital ownership (public or private) and the type of insurance (public or private) available to finance hospital treatment are tied together (Gans and King 2004, ch. 3). Public insurance mostly finances

treatment in public hospitals and private insurance mostly finances treatment in private hospitals.⁵ Treatment of a public patient in a private hospital is not at the patient's behest. It is usually a result of a contract between a public hospital or state health department and a private hospital. These tied funding arrangements inhibit the ability of private hospitals to compete for public patients and, coupled with compulsory enrolment in the public plan but voluntary purchase of private health insurance, also inhibit competition in the insurance market. The exclusion of private hospitals from the NHHRC's proposal therefore misses an opportunity to enhance competition between hospital providers.

The NHHRC's proposal also does not guarantee that the putative benefits of a single government funding system will eventuate for two reasons: (i) the Commonwealth contribution is initially set at 40 per cent of efficient cost; and (ii) even if the Commonwealth contribution rises to 100 per cent, states will continue to be involved in hospital financing of expenditures above efficient cost. It is important to note, though, that the states will bear 100 per cent of the cost of hospital episodes in excess of efficient cost regardless of the proportionate contribution from the Commonwealth. This provides a strong incentive at the margin for states to contain the unit cost of hospital episodes.

The proposed shift to activity-based funding will provide an incentive for efficiency as long as the measures of activity are output-based (for example, an episode of hospitalisation) and not input-based (for example, per diem). Again, the exclusion of private hospitals from coverage by public insurance is a missed opportunity because the incentives for efficiency from this shift to activity-based funding will not flow through to these providers. They may be secured within the Medicare Select initiative, to be discussed further below. The proposal for activity-based funding for public hospitals would appear to be uncontroversial. In a communiqué issued following the March 2008 meeting of the Council of Australian Governments (COAG), it was announced that COAG had agreed 'for jurisdictions, as

appropriate, to move to a more nationally-consistent approach to activity-based funding for services provided in public hospitals' (COAG 2008, p. 1). A National Partnership Agreement on Hospital and Health Workforce Reform affirming this (among other) commitments subsequently emerged from the November 2008 COAG meeting.

3.2 *Medicare Select*

The possibility of allowing individuals to opt out of the compulsory public plan and obtain a subsidy to enrol in a private plan has been considered before, and implemented before, in Australia. In the run-up to the implementation of the national health insurance scheme called Medibank in 1975, Scotton and Deeble considered at one point that an opting-out proposal was the preferred way around the fierce opposition to the introduction of compulsory national health insurance from some quarters, although they considered it to be a second-best policy (Scotton and Macdonald 1993). As it transpired, an opt-out policy did not need to be invoked, but following the change of government in 1976, an opt-out option was introduced into Medibank with an income-related tax penalty applying to those who did not opt out.⁶ In terms of the history of health economics thought in Australia, it is interesting to note that Deeble has continued to regard an opt-out option as a second-best policy while Scotton subsequently became a staunch advocate of the concept following Enthoven's writings on managed competition.⁷

Medicare Select offers the prospect of redressing the duplication that is endemic to current health insurance arrangements in Australia. Individuals who purchase private health insurance 'pay twice' for their health insurance (Gans and King 2004, p. 55) as membership of the public plan is compulsorily retained. While the 30 per cent private health insurance rebate goes some way toward redressing this situation, Medicare Select would allow individuals to take the full value of their expected annual subsidy under the public plan and opt out of it altogether, thereby avoiding duplicate coverage.⁸

Although Medicare Select offers the prospect of enhanced competition in the health insurance market, it is not clear that the benefits which flow from this will be large relative to the enhanced competition in the service provision market. As Van de Ven and Schut (2009, p. 253) point out with regard to the Dutch reforms, 'The ultimate goal of the reform . . . is not to increase the efficiency of providing health insurance, but to encourage health insurers to increase the efficiency of the health care provision . . . '.

The NHHRC (2009, p. 159) has listed a number of issues and risks 'that must be thoroughly evaluated and resolved'. The following six points add to and/or elaborate upon these issues and risks.

3.2.1 Popularity

If Medicare Select were introduced, what proportion of the population would opt out? It is instructive to consider the experience with opting out under Medicare in the United States, a public plan that covers American citizens aged 65 years and over, along with some people with disabilities and people with end-stage renal disease. Medicare in the United States has allowed, for some time, beneficiaries to opt out of its plans and enrol in a health maintenance organisation or other private plan. Notwithstanding legislative changes in 2003 that have resulted in the opt-out subsidy being greater than 100 per cent of the risk-adjusted cost to the traditional Medicare plan, only 20 per cent of beneficiaries opted out in 2007 (Pauly 2008, p. 54). In Australia, with a considerably smaller population than the United States but with a similar land area, opt-out proportions of this size may well result in thin markets with little scope for either competitive forces to operate or for private plans to negotiate with multiple suppliers of any service.

3.2.2 Complexity

Competition under Medicare Select would extend, subject to meeting the universal service obligation, to all facets of plan design and therefore product differentiation can be expected to emerge. Plan switching by enrollees would

be an integral part of competitive behaviour in these markets. Choice between plans could therefore be complicated and may be a factor that affects the popularity of the opt-out option.

3.2.3 Selection

If there is asymmetric information between plans and enrollees regarding risk, strategic behaviour may result. If enrollees possess superior information, they will attempt to find a plan that charges a premium that is less than actuarially fair for them, resulting in an adverse selection of risks for such plans. If plans possess superior information, cherry-picking strategies can be expected as such plans attempt to achieve a favourable selection of risks.

3.2.4 Out-of-Pocket Expenses

Since plans can charge premiums above the risk-adjusted subsidy, enrollees may be confronted with out-of-pocket expenses for their insurance coverage in addition to any out-of-pocket expenses for health services. If out-of-pocket expenses for premiums increase through time, a public policy debate can be expected to develop around who is 'at fault' for this—the plans for being inefficient or the government for being too miserly with respect to the value of the risk-adjusted subsidy.

3.2.5 Self-Insurance

In considering opt-out options, the NHHRC's report has ignored one potentially important option; namely, opting out into self-insurance rather than private insurance, with the risk-adjusted subsidy being deposited in a medical savings account (MSA) for the individual or family. A particular issue that arises with MSAs is catastrophic cover—how to deal with individuals whose illness results in their MSA being exhausted and who face considerable out-of-pocket expenses for further treatment. One approach to dealing with this would be for the government to withhold a small proportion of the risk-adjusted subsidy for individuals deciding to self-insure, the proceeds of which would be used to underwrite catastrophic cover for

them. The NHHRC could well have considered options such as this, even if only to reject them in their final recommendations.⁹

3.2.6 Integration with a Single Government Funding System

The NHHRC does not view its proposals for the funding of public hospitals and Medicare Select as being alternative reform options. Indeed, it states explicitly that they should be ‘pursued concurrently’ (NHHRC 2009, p. 146). It is difficult to understand how these two proposals could be introduced concurrently, as they seem to be contradictory in some respects. In particular, under Medicare Select, private plans ‘would be responsible for caring for people’s full health needs’ (NHHRC 2009, p. 158), including public hospital treatment. Presumably, this means that private plans will be negotiating with public hospitals on the payment basis for inpatient treatment but, if so, then what role will the Commonwealth play with respect to activity-based funding? And if the Commonwealth is negotiating the payment basis with public hospitals and setting prices for inpatient treatment, why not have the Commonwealth pay the hospital directly (which, as discussed earlier, is envisaged by the NHHRC), rather than passing funds through a private plan? It seems, therefore, that the concurrent pursuit of these two proposals needs to confront some serious issues and requires considerably more work.

4. Conclusion

In considering reforms for the Australian health-care system, the NHHRC has cast the net wide and considered a range of issues and solutions. The result, at least with respect to the ‘governance’ and financing proposals, is that the proposals that are put forward are not extensively developed and a range of issues remains to be addressed before they could be considered for implementation. Also, there appear to be aspects of the hospital funding and Medicare Select proposals that would make concurrent implementation of the two, as proposed by the NHHRC, difficult. It would perhaps have

been more useful if the ambit of the NHHRC’s work had been narrower, with more concentration on key design issues and implementation. As it stands, the report is at risk of becoming an opportunity lost.

November 2009

Endnotes

1. In this article, the term ‘state governments’ should be taken to refer to both state and territory governments unless stated otherwise.
2. More specifically, the community rating regulation applies per product with exceptions arising from the age penalty applying to first-time purchasers of private health insurance over 30 years of age, and policies for families with dependant children where the premium is double that for single individuals.
3. However, in the Dutch scheme, neither the community rating nor the open enrolment regulations apply to supplementary insurance policies that provide cover for services not included in the basic benefits package. For an extensive discussion of the Dutch reforms, see Rosenau and Lako (2008).
4. For example, Van de Ven and Schut (2009, p. 253) refer to private plans under the Dutch reforms as ‘becoming prudent buyers of health services on behalf of their customers’.
5. Private health insurance does finance private patients in public hospitals and public patients are treated in private hospitals (a public patient being one whose cost of treatment is covered by public insurance), but the cross-over is limited. In 2007–08, 14.0 per cent of discharges from public hospitals were classified as being for private patients and, of these, 62.6 per cent received funding from private health insurance. In the same financial year, 2.4 per cent of discharges from private hospitals were classified as being for public patients. See Australian Institute of Health and Welfare (2009, Table 7.2).
6. The levy was set at 2.5 per cent of taxable income with exemptions for low-income earners. Although it was not capped, higher-income individuals could avoid the levy and remain in Medibank by paying an annual premium of \$150 (\$300 for families). See Scotton and Macdonald (1993, p. 241).
7. With reference to Medicare Select and other reform proposals, Deeble states: ‘All of these alternatives have major problems . . .’ (Deeble 2009, p. 12). For examples of some early forays by Scotton into the managed competition arguments, see Scotton (1990a, 1990b). In his evidence presented to a Senate Select Committee in 1990, Scotton described himself as being ‘virtually a total disciple of Enthoven’s view’ (Scotton 1990a, p. 968).

8. Some might argue that duplication in coverage does not characterise current financing arrangements because, for any given hospital episode, an individual will occupy either a public hospital bed or a private hospital bed but not both. Therefore, two policies are necessary to cover treatment in both types of hospital. As the two types of provider are separate and distinct, the public and private insurance plans are not duplicative. However, in the absence of compulsory membership of the public plan, it is unlikely that many individuals would voluntarily purchase two separate policies to cover treatment in the two types of institution. A welfare loss therefore arises in comparison with a situation where an individual faces unconstrained choice of health insurer. Ergas (2008) summarises the problem as follows: '... [the] insured are not able to shift the avoided cost of their public use over to private use; hence if they want to use private facilities, they face the full cost of these, rather than [the] "full cost minus avoided cost to public sector of displaced use"'.

9. For a discussion of this reform option in the context of US Medicare, see Aaron and Lambrew (2008, ch. 6).

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