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Private Health Insurance: A look under the bonnet

AN IMAGE PROBLEM

Australian private health insurers (PHI) have an image problem. They are never out of the headlines for long, are criticised for inappropriately profiteering from a $6 billion government handout and still their products seem to offer poor value and satisfy no one. And despite an ongoing debate about whether Australia should continue to support our current blended public/private health financing arrangements, a recent raft of PHI reforms has signalled the government's intention to maintain the status quo for now—albeit with a bit of fine tuning and finessing here and there to see if we can hang on a little longer. But is it sustainable?

Australia's health system is still widely regarded as one of the best in the world and given our GDP spend on health at 10% compares favourably with other OECD countries, it is not surprising that major reform seems unlikely from either side of politics. So, if one accepts that, for now, we are going to continue to have PHI, then it is reasonable to suggest that creating the necessary conditions to allow the PHI market to succeed is a sensible debate to be having.

Since the 1950s Australian PHI has been community-rated, which means PHIs cannot charge more for higher risk individuals. Every insured Australian pays the same rate for the same PHI product regardless of expected claims costs.

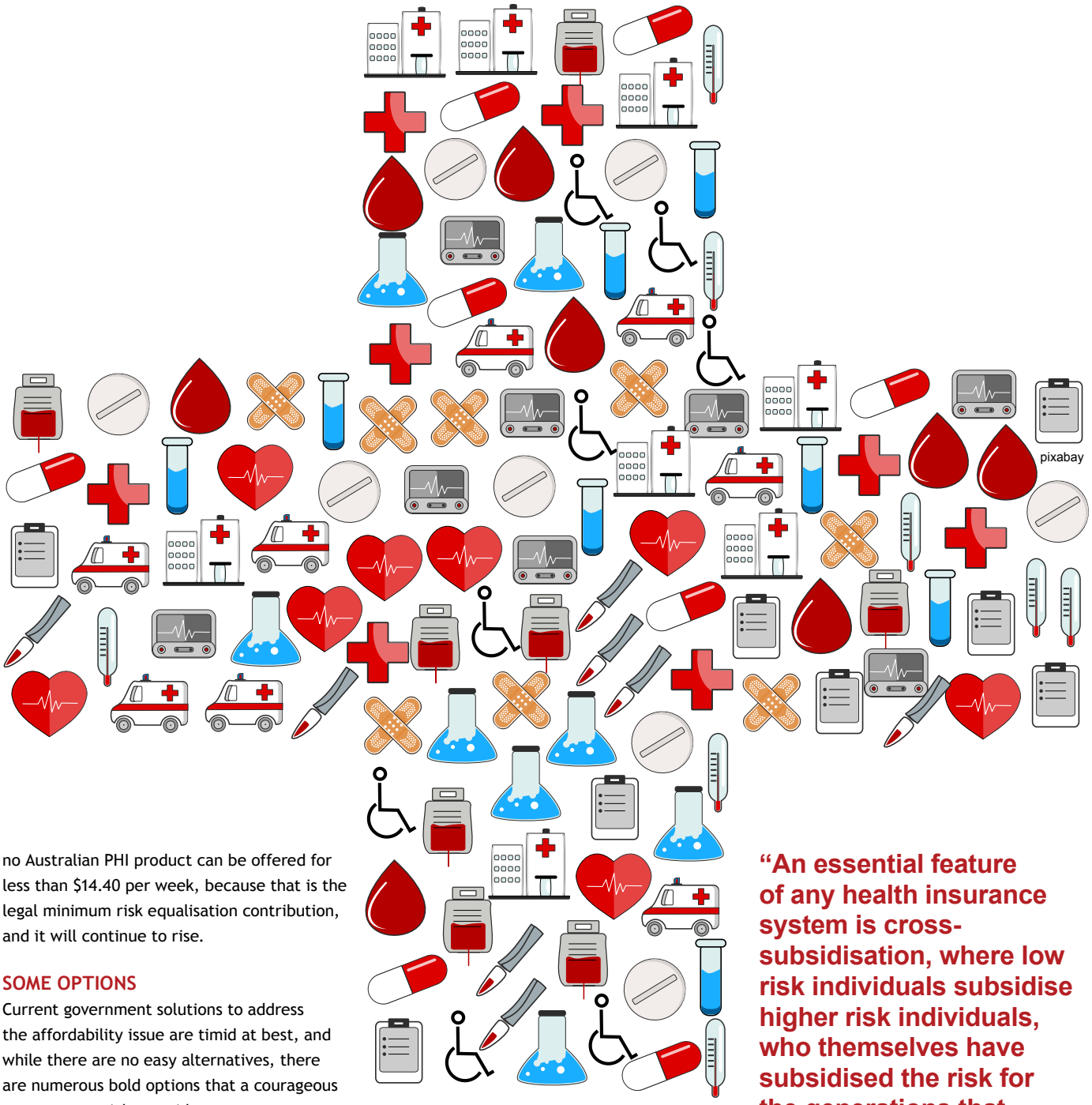
An essential feature of any health insurance system is cross-subsidisation, where low risk individuals subsidise higher risk individuals, who themselves have subsidised the risk for the generations that came before them. Put simply, the healthy subsidise the sick.

RISK EQUALISATION

In a competitive health insurance market, some form of regulatory intervention is required to ensure health insurance remains affordable for low income, high risk individuals because without it, these people would be priced out of the market. And as a matter of public policy we accept that everyone should have access to proper health care irrespective of their ability to pay.

The preferred solution employed in many countries, including Australia, is risk equalisation. It is basically a method whereby instead of making high risk individuals pay more, the risk is adjusted beneath the surface between the insurers. It's a bit like the way server hosts load balance when one server has too much data. Cloud platforms like Facebook and Drop Box balance data loads without our knowledge, by shifting data to and fro across many servers to prevent system crashes. Similarly, when one PHI is burdened with too much risk and high claims costs, the load is balanced by sharing the risk across other PHIs to prevent the industry crashing. When risk equalisation is perfectly optimised health economists believe it balances affordability, insurer efficiency, and minimises 'cream skimming' behaviours (where insurers select low risk individuals). But achieving optimal risk equalisation is hard, and no country can yet claim victory in achieving a perfect balance.

Risk equalisation in Australia is one of many moving parts under the PHI bonnet supporting community rating. Together with the PHI rebate, Lifetime Health Cover loading and Medicare Levy Surcharge, it is the linchpin keeping the entire PHI industry afloat. Without it the industry would collapse. But the entry point into PHI has become too expensive over time, particularly for young people. Currently



no Australian PHI product can be offered for less than $14.40 per week, because that is the legal minimum risk equalisation contribution, and it will continue to rise.

SOME OPTIONS

Current government solutions to address the affordability issue are timid at best, and while there are no easy alternatives, there are numerous bold options that a courageous government might consider.

Firstly, there are too many PHIs—38 for 24 million Australians. Many are small not-for-profits running very expensive boards, and a consolidation would save considerable administration costs.

A more contentious suggestion would be risk rating like the New Zealand health system, with inbuilt regulatory safeguards to protect vulnerable groups and ensure affordability.

Less contentious would be partial community rating, like our current compulsory third party (CTP) motor insurance, where premiums are varied based on expected claims costs, but the full risk is not loaded onto premiums. Implementing this would require care to avoid the problems the UK motor insurance industry suffers. The UK's risk-rated car insurance system means the cost of car insurance for a young male driver is often more than the car.

There are many other options, such as the prospective risk equalisation system used in the Netherlands (rather than our retrospective system)—this improves PHI efficiency, but depends on reliable data to succeed. In time, the government's My Health Record could facilitate consideration of this option, but until then, we will continue to tinker—because currently our government does not seem to have a clear plan for PHI and its role in the health of our nation. ha

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