

Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada

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Abstract

Canada's restrictions on the role of private health insurance for publicly insured physician and hospital services are unique among countries with universal, publicly funded health care systems. Pressure is mounting in Canada, however, to loosen these restrictions and create a parallel system of private finance. Advocates argue that creation of a parallel system of private finance will ensure the sustainability of the public system (by reducing public cost pressures), improve access to the public system (e.g., by reducing wait times), and improve quality in the public system (through competition). Opponents of parallel private finance argue that it will create "two-tiered" medicine, increase costs, compromise equity and reduce quality and access to publicly financed health care as those with the financial means (and often the strongest voice) exit to private insurance. Australia provides a particularly promising case study for Canada regarding the dynamics of parallel systems of public and private finance.

This paper examines Australia's experience with parallel finance for inpatient hospital services to provide insight regarding: (a) the effectiveness of a parallel system of private finance in reducing costs and wait times in the public system; (b) risk selection between the parallel public and private insurance sectors; (c) the financial redistribution associated with the introduction and maintenance of a parallel system of finance; and (d) the dynamics of the broader political economy associated with parallel systems of finance. Australia's experience provides a number of lessons for Canada, including: (1) the potential for cost savings through introduction or expansion of a parallel private sector is very limited; (2) the introduction or expansion of a parallel private finance is unlikely to reduce wait times in the publicly financed system; (3) there is no simple way to regulate private insurers to pursue public objectives; (4) it is impossible to create an independent, isolated parallel system of private finance is false -- interactions between the public and private insurance sectors are complex and unavoidable; (5) quality plays a key role in driving the dynamics between the public and privately financed sectors; and (6) it is essential to articulate clear policy objectives for health care financing and to design public and private roles consistent with these objectives. Our overall conclusion is that the Australian experience provides a cautionary tale regarding the risks, costs and benefits of a parallel private system of health care finance.

1. Introduction

Canada's restrictions on the role of private health insurance for publicly insured physician and hospital services are unique among countries with universal, publicly funded health care systems (Flood and Archibald 2001; Tuohy *et al.* 2001). Pressure is mounting in Canada, however, to loosen these restrictions and create a parallel system of private finance (Senate of Canada 2001; Gratzen 1999; Orován 1999; Bliss 1996; Gray 1996). Advocates for a system of parallel private finance argue that it will ensure the sustainability of the public system (by reducing public cost pressures), improve access to the public system (e.g., by reducing wait times), and improve quality in the public system (through competition). Canadians, they argue, can have greater choice and higher quality without compromising the fundamental goal of ensuring universal access to needed health care services. Opponents of parallel private finance argue that it will create "two-tiered" medicine, increase costs, compromise equity and reduce quality and access to publicly financed health care as those with the financial means (and often the strongest voice) exit to private insurance (e.g., Rachlis 1999; Deber 2000).

Although aspects of this debate are rooted in ideological views largely impervious to evidence, policy development aspires to be based on evidence regarding the expected effects of parallel financing. The development of evidence-based policy in this area, however, is hampered by the potentially limited generalizability of the experiences of other countries with mixed systems of finance. The interactions between parallel public and private insurance sectors are complex. They result from strategic behavior by insurers (both public and private), providers and individuals, which themselves depend crucially on the insurance, tax and regulatory environments, the organization of the health care system more generally, and the broader

political and governance structures found in a country (Tuohy et al. 2001).

Australia, however, provides a particularly promising case study for Canada regarding the dynamics of parallel systems of public and private finance. Australia is, like Canada, a federation in which responsibility for health care is split between the federal and state governments. Its system of Medicare (introduced in 1984 and modeled in part on Canadian Medicare) combines universal, public financing for medically necessary physician, hospital and drug services with predominately private delivery. Its overall split between public and private finance is also similar to Canada's (about 70:30). But, unlike Canada, Australia allows a regulated, parallel system of private finance for inpatient hospital care. Indeed, believing that a strong parallel private system of finance will reduce costs in the public system, increase quality and reduce wait times, Australian federal health policy makers have since the mid-1990s actively encouraged the parallel private insurance sector through public subsidies for the purchase of private insurance.

In this paper we examine Australia's experience with parallel public and private health care finance to draw lessons for the Canadian debate on public and private roles in health care financing. Our aim is to provide insight into a number of aspects of parallel private finance, including: (a) the effectiveness of a parallel system of private finance in reducing costs and wait times in the public system; (b) risk selection between the parallel public and private insurance sectors; (c) the financial redistribution associated with the introduction and maintenance of a parallel system of finance; and (d) the dynamics of the broader political economy associated with parallel systems of finance. Our overall conclusion is that the Australian experience provides a cautionary tale regarding the risks, costs and benefits of a parallel private system of health care

finance.

2. Australia's Health Care System

From a health care financing perspective, the current Australian health care system can, like Canada's, be divided into three parts. The first part comprises health care services included within Australian Medicare, its universal, publicly financed health care system to which national standards apply. Australian Medicare comprises medical insurance, inpatient hospital insurance, and pharmaceutical benefits (Donato and Scotton 1998). The second part includes non-Medicare health care services for which public financing predominates though no national standards apply. Such services include residential long-term care (nursing homes) and home care services. The third part includes those services that are predominately privately financed, such as non-physician professional services (e.g., dental care, physiotherapy).

The Commonwealth (federal) government and state governments share responsibility for financing and administering the three plans that constitute Medicare. The Commonwealth government finances and administers the medical insurance plan and the pharmaceutical benefits plan, and it shares with state governments in financing hospital-based care. State governments administer hospital-based services. The Commonwealth government enforces national standards for the state-administered hospital plans through a system of conditional block grants (like Canadian Medicare).

The medical insurance plan covers community-based physicians services, which are delivered predominately by physicians in private practices paid by fee-for-service through a Medicare Schedule of Benefits (MSB). Out-patients face two potential types of out-of-pocket costs: the difference between the Medicare reimbursement rate to physicians (85% of the MSB

fee) and the MSB fee; and/or charges related to extra-billing, whereby a physician charges a fee higher than that listed in the MSB.¹ Approximately two-thirds of acute care hospitals are "public" (i.e., publicly funded and owned by the State governments or by private not-for-profit religious and charitable organizations) and employ the physicians who provide care to inpatients. Australians distinguish two types of inpatients: (1) public patients, who receive care paid by Medicare in a public hospital free of charge; (2) private patients, whose care is paid for privately by the patient or by the patient's private insurance with one exception: even for private patients Medicare covers inpatient physician services at the rate of 75% of the MSB.² Public inpatients have no choice of physician while in hospital; they are treated by a physician employed by the hospital (Private patients do have a choice of physician). The pharmaceutical benefits plan covers the costs of listed prescription drugs obtained on an outpatient basis through community pharmacies, less a fixed per-prescription charge (with an annual maximum out-of-pocket expenditure limit). Drugs received in hospital by public inpatients are free and are funded through the hospital budget.

¹Low-income patients are exempt from user charges. In addition, general patients face a maximum annual out-of-pocket costs (Aus\$280.30 in 2001) beyond which they are exempt from user charges associated with ambulatory physician services (Commonwealth Department of Health and Aged Care 2000). In the mid-1990s, physicians accepted the MSB fee as payment in full (i.e., patients faced zero out-of-pocket charges) for just over 70% of physician services provided (Donato and Scotton 1998).

²Unlike the out-patient sector, private insurance can cover the gap between the Medicare payment and inpatient physician fees.

Australia has two types of private health care insurance. The first, private ancillary insurance, covers services not publicly insured such as dental care, physiotherapy, and upgrades from ward accommodation in public hospitals. Such ancillary insurance in Australia is prohibited from covering user charges associated with Medicare-insured physician services and drugs.

The second is private parallel insurance for inpatient hospital-based services also insured by Medicare. A private patient can receive care in either a public or a private hospital. The key advantages of being treated as a private patient in-hospital is choice of inpatient physician and quicker access to treatments for which public patients face a queue.

Table 1 compares financing approaches in the Australian and Canadian health care systems, with an emphasis on differences between the two with respect to services included within Canadian Medicare (i.e., those services subject to the Canada Health Act) and Table 2 provides a summary of Australian health care expenditures across the sectors and sources of finance.

3. The Evolution of Health Care Financing Policy in Australia

From the early 1950s through the mid-1970s health care in Australia was primarily privately financed through a system of subsidized private insurance markets regulated under the 1953 National Health Act. Australian health care financing policy strove, through regulation and subsidy, to make private insurance accessible to all Australians (Donato and Scotton 1998). Two of the most important regulations in this respect were a common carrier requirement and community rating of health insurance premiums. The common carrier regulation required that insurers accept all applicants within certain membership categories (e.g., they could not discriminate on the basis of a person's age, sex, health status, and so forth). Community-rated

premiums required that the premium charged to an individual not be based on the person's risk status. Rather, all Australians who purchased a given insurance policy in a given state were charged the same premium.³ Government efforts to increase access to private health insurance also included subsidies for the private insurance sector (e.g., a per diem subsidy for each day of private hospital care and subsidies to the reinsurance pool for insurers) and tax deductions for premium payments by individuals (Owen 1998).

Throughout this period Australians actively debated a larger role for public financing, a larger role that was vigorously opposed by the Australian Medical Association and the private insurance funds. But in 1974, a Labour-party-led federal government introduced Medibank, a universal public insurance plan. This lasted less than a year, however, before a newly elected coalition government ended universality in the public program, though the role of public financing remained above the pre-Medibank levels.

The current universal Medicare program for inpatient hospital services, physician services and prescription drugs was introduced (again by a Labour government) in 1984. Under Medicare the private insurance sector offered ancillary insurance for services not covered by Medicare and hospital inpatient insurance that covered services also insured by Medicare. However, the introduction of Medicare, the elimination in 1986 of explicit subsidies to private

³The premium for a given policy can vary across states and across insurers within a state, and within a state the premiums can vary across policies. An insurer cannot, however, charge different premiums to different individuals in the same state for the same policy.

hospital care and a large premium increase in the late 1980s⁴ caused uptake of private hospital insurance to fall steadily. By the mid-1990s less than one-third of Australians held private hospital insurance (compared to 80% in 1974).

In the mid-1990s the private Australian health insurance sector was in crisis. In addition to fall in uptake of private insurance, the sector appeared to suffer from adverse selection whereby high-risk Australians were more likely to purchase private insurance than the average Australian. Adverse selection commonly occurs when private insurance markets operate alongside systems of publicly financed care (Shmueli 2001; Ettner 1997; Cutler and Zeckhauser 2000), and in Australia's case this tendency was thought to be exacerbated by the community-rating requirement, which prohibited insurers from risk-rating premiums. During the contraction of the private insurance sector, persons under age 65 were more likely to drop private health insurance (Hall 1999b) and premiums increased at rates well above the consumer price index (nearly 10% per year between 1989 and 1996 vs 2.9% for CPI), yet the industry has displayed a remarkable lack of profitability (Industry Commission 1997). Conventional wisdom in Australia is that adverse selection was responsible for the premium spiral in the 1990s and that it posed a considerable threat to the financial viability of the private insurance sector (Hall 1999a; Industry Commission 1997).

⁴The premium increases were associated with the introduction of coverage for the gap between the Medicare fee payment to physicians and the physician fees for inpatient physician services.

More recent evidence suggests that adverse selection has not been as severe as initially thought, in part because of strategic responses by private insurers which also had the effect of partially subverting the community rating requirement. Barrett and Conlon (2001) found evidence of adverse selection, but the magnitude was smaller than expected by the policy debate.⁵ Vaithianathan (2000b), argues that more severe adverse selection was averted by private insurers' strategic (non-price) responses that allowed them to separate low- and high-risk pools, charge different premiums to each, and thereby retain a broader distribution of risk in the market with premiums that more closely reflected risk status. Unfortunately, this response also thwarted the public policy objective of community rating. Through strategic plan design, for example, insurers could selectively induce older individuals to choose an expensive, comprehensive plan by restricting joint-replacement (and other services required predominately by the elderly) to such a plan while crafting less comprehensive plans to appeal to a younger population.⁶ Such a response should increase the number of types of policies offered. A comparison with New Zealand, which also has a parallel private health insurance sector but does not impose community rating, found that although the overall coverage rates are similar in the

⁵They found that for both singles and families the likelihood of purchasing private insurance increased with age and the number of chronic conditions. This adverse selection was partially counterbalanced, however, by a greater tendency of those who practice healthy habits and those of higher income to purchase private insurance and the lower tendency of those with fair and poor self-reported health to purchase private insurance. The first phenomenon may reflect risk attitudes as those who practice healthy habits may, on average, be more risk averse than the general population; the latter phenomena reflect the effects of ability to pay and the negative correlation between income and health status. On balance, however, the former effect quantitatively dominated the latter, causing moderate adverse selection into private insurance over the 1989-95 period.

⁶ One private insurer advertized as follows: "If you're healthy, young and single then Bodyguard Young Singles cover is an excellent hospital and extras package. You save on your premiums because Bodyguard provide hospital benefits for services that young singles normally require. By reducing the level of cover on those services you are unlikely to need in a private hospital we keep your premiums lower" (See http://www.nib.com.au/index_about.html -- what day accessed.)

two countries, the largest Australian insurer offers almost double the number of different policies as does the New Zealand insurer (Vaithianathan 2000b).

In any event, this crisis in the private insurance sector, growing wait lists and fiscal pressures in the public system and the election of a conservative Liberal federal government in 1996 marked the beginning of the latest phase in health care financing policy, which is designed to expand the role of private insurance. The Liberal federal government of the mid-1990s believed fervently that a robust parallel private insurance system is necessary to reduce costs and wait times in the public system. One federal health minister commented that:

“... the health of the publicly funded health sector depends upon a vital private sector. . . If there were no private sector, the extra costs borne by the taxpayer would simply be incalculable and the increased demand on public hospitals would be unsustainable.” (Federal Minister of Health, Wooldridge (1998)).

It therefore established an Inquiry into the private insurance sector and, on the recommendation of the Inquiry, it introduced tax incentives in July 1997 to encourage the purchase of private hospital insurance (The Private Health Insurance Incentives Scheme - 1997 [PHIIS-1997]). The incentives included tax rebates of up to \$125 per single, \$250 per couple, and \$450 per family for low-income households that purchase private health insurance and a tax surcharge of 1 percent of taxable income for singles earning over \$50,000 and families earning over \$100,000 who failed to purchase private health insurance.

This plan was subsequently replaced by a more extensive system of subsidies and incentives embodied in the Private Health Insurance Incentive Act of 1998 (PHIIA-1998). The PHIIA-1998 included:

- *Insurance Subsidy*: a 30% universal rebate (i.e., no income test)
- *Tax Penalty*: 1% tax surcharge on high earners who do not purchase private hospital insurance
- *Lifetime Community Rating*: after July 1, 2000 a person's premium is to be based on the age at which private insurance is first purchased; the inflation-adjusted premium will remain fixed over a life-time (with the inflation adjustment approved by the Minister of Health).
- *No gaps policy*: Health insurers were required to provide a full indemnity policy by 2000 to qualify for the rebate. The purpose was to reduce the large (and often poorly understood) cost-sharing in private insurance policies.

This Act provided a major subsidy to the private health insurance industry -- over \$2.0 billion per year, a sum larger than the combined federal subsidy to the natural resource, mining and agriculture sectors (Smith 2000). As noted, the official rationale for the policy was that increased private insurance use of private health care facilities would reduce costs and waits in the public hospital system. It is still too early to know the long-run impacts of the 1997 and 1998 subsidy schemes, but we do have some early evidence.

4.0 The Effects of the Subsidies to Private Hospital Insurance

We examine three effects of the subsidy schemes: on expenditures in the public hospital system, on wait times in the public hospital system and on redistribution of income.

4.1 The Effect of the Incentive Schemes on Public Sector Costs

Subsidizing private insurance can reduce costs in the publicly financed sector only if three logically-related conditions hold: (1) the subsidies increase the uptake of private hospital insurance; (2) the uptake of private hospital insurance reduces costs in the publicly financed sector; and (3) the savings associated with (2) exceed the costs of the public subsidies to private insurance (otherwise, the same monies could be directly invested in the publicly financed system).

4.1.1 *The Effect of the Incentive Schemes on the Uptake of Private Insurance in Australia*

Evidence suggests that the initial subsidy scheme in effect from July 1, 1997- December 1998 had little or no effect on the uptake of private health insurance (Figure 1). The secular decline in private coverage continued uninterrupted between July 1997 and December 1998, when coverage reached its lowest level (30.1%). Starting January 1, 1999 the stronger incentives provided by the PHIA-1998 (i.e., the 30% subsidy) reversed the secular decline in coverage but did not lead to a large increase in the uptake of private insurance -- private insurance holdings increased from 30.1% of the population in December 1998 to 32.2% in March 2000.

Unquestionably the most effective component of the PHIA-1998 for increasing the uptake of private hospital insurance was the lifetime community rating policy, which is associated with a 40% jump in coverage (from 31% to 43% of the population between January and September 2000).⁷ Coverage peaked in the Fall 2000, however, and the pre-policy downward trend has resumed from this new, higher level of private coverage. It is unknown if this decline is a short-term phenomenon and private holdings will stabilize, or whether this represents the start of adverse selection caused by the still considerable cross-subsidization from low- to high-risks even under lifetime community rating (Butler 2001).⁸

4.1.2 *The Reduction in Public Hospital Costs Associated with an Increase in Private Insurance Coverage*

⁷It is clear that the subsidy alone was not effective. It is tempting to conclude that the lifetime cover alone would have been effective, but we can not know as we only observe the lifetime cover offered jointly with the subsidy.

⁸Butler (2001) suggests that it could be a short-term phenomenon if it is the result of people dropping out who purchased private insurance as a result of lifetime community rating but who then missed the first premium payment.

To analyze the potential effect of an increase in insurance coverage on costs in the public sector, it is helpful to divide the Australian population into three groups: (1) those who prior to the incentive scheme purchased private insurance; (2) those who prior to the incentive scheme chose to self-insure for private care (i.e., use private inpatient care if desired and pay out-of-pocket); and (3) those who prior to the incentive scheme relied solely on publicly financed hospital care. The behaviour of those in the first group is unchanged by the subsidies,⁹ so the cost savings to the public sector depends on who from groups (2) and (3) is, at the margin, induced to purchase private insurance by the incentive scheme.

⁹They could make changes at the intensive margin, by purchasing additional coverage in response to the subsidies, but such effects are likely to be small.

Vaithianathan (2000a) shows that, under fairly general assumptions, the initial effect of a public subsidy for private insurance is to induce those who previously self-insured (i.e., paid for private services out-of-pocket) to purchase insurance. Such individuals have a strong taste for private sector services and the subsidies simply cause them to change from private self-insurance to private formal insurance. The uptake of private insurance by these individuals, however, has little or no effect on costs in the public system because they previously used privately financed services rather than public services. Data suggest that the number of people who self-insure in Australia is large. Between 8-10% of private hospital admissions in the early 1990s were for those who self-insured (Hall et al. 1999a, 1999b; Industry Commission 1997). The exit from private insurance in recent years was concentrated amongst wealthier families (Barrett and Conlon 2001; Department of Health and Aged Care (undated), many of whom may have been opting out of formal insurance and into self-insurance.¹⁰ Because those with high-incomes were most likely to self-insure prior to the incentive schemes, the 1% tax surcharge on high-income earners is particularly likely to have induced purchases among those who previously self-insured. The cost-savings to the public health care system associated with purchases induced by the 1% tax surcharge were further mitigated by the fact that for a high-income earner the tax savings from avoiding the surcharge is independent of the amount of private coverage purchased. Hence, the rational response by high-income earners would simply be to purchase a policy with a large deductible that charges a premium less than the tax surcharge avoided and continue their

¹⁰During the 1985/86 - 1995/96 period, overall growth of total private admissions (in public and private hospitals) was positive during a period of declining private insurance coverage (Hall et al. 1999b).

prior care-seeking behaviours.¹¹ Hence, it is possible to observe substantial jumps in private insurance coverage that generate few savings to the public hospital system.

¹¹This did in fact occur, so the policy was changed to require that a high-income household purchase a low-deductible policy to avoid the tax surcharge.

Finally, among those in group 3 above who have historically relied solely on the public system, the most effective element of the 1998 PHIA for inducing the purchase of private insurance has been the lifetime cover provision. The lifetime cover provision provides the greatest incentive to relatively young individuals to purchase private insurance (the premium for the remainder of an individual's lifetime is based on the age at which insurance is first purchased). The number of persons covered by private hospital insurance, for example, increased by 54.9% between December 1998 and September 2000, but the percentage increase was 60.7% for those aged less than 30, 64.3% for those between 30 and 64; and 9.3% for those over age 65 (Health Insurance Administration Council 2001). Because the young are, on average, low users of health care services, in the short run even a substantial increase in the uptake of private insurance among the young who previously relied solely on the public system may have only a small marginal effect on costs in the public hospital sector.¹²

4.1.3 Costs of the Subsidies vs Cost Savings to the Public Hospital System

¹²The undiscounted longer run savings may be more substantial if such individuals retain their private coverage as they age.

The incentive schemes will have been effective in reducing pressure on the public system only if the savings to public-sector expenditures exceed the associated costs. Ignoring for simplicity second- and higher-order effects,¹³ the costs to the public purse associated with the PHIS-1997 and the PHIA-1998 arise from the subsidy payments while the savings to the public purse derive from reduced demand on the public hospital system and new tax revenue from the 1% Medicare surcharge for high-income earners who fail to purchase private insurance.

Butler (2001) estimates that the costs of the rebates in 1999-00 were nearly \$2.3 billion while the revenue collected from the 1% Medicare surcharge was \$110 million, leaving net expenditure of the incentive scheme of just under \$2.2 billion (Table 3). Treasury Department forecasts that the expenditures associated with the 30% subsidy will increase while the revenue from the 1% levy will fall, causing net expenditures on private health insurance subsidies by 2003-04 to exceed \$2.3 billion (Butler 2001). This represents 17.5% of 1998-99 annual current public spending on public hospitals. Duckett and Jackson (2000) calculate that, had the tax subsidy been allocated to spending in the public hospital system, between one-half and two-thirds of all private sector demand could be met through the public sector.

Vaithianathan (2000) estimates that, based on the rates of uptake across age groups and the average hospital utilization by age group, the annual public hospital expenditures potentially saved by new insurance purchases was AU\$800 million. Segal (2000) also concludes that the cost of the rebates far exceeds any savings to the public hospital system. The subsidy plan is

¹³E.g., increased input prices as a result of competition between the private and public sectors for scarce health care inputs, the Medicare subsidy to private inpatient physician care (for which payments could increase as a result of greater private insurance coverage), and the subsidy to private patients in public hospitals resulting from the fact that charges are often less than costs.

unquestionably not self-financing. On balance, it likely costs the public purse almost \$1.5 billion annually (\$2.2 billion net cost less approximately \$800m in savings to hospital sector).

4.2 Effect on Wait Times

One of the motivations for the subsidy to private insurance was long wait times for certain procedures in the public system. Analogous to the cost-savings argument discussed above, many argued that by shifting utilization to the private sector, waiting times would be reduced in the public system, increasing access for those who must rely on the public system. The data on wait lists for services in public hospitals are of variable quality and the most recent data are for 1998-99, just prior to the increase in private insurance coverage identified above (but two years after the first subsidy scheme was introduced). The only consistently defined national data series that spans pre- and post-policy periods pertains to the proportion of patients whose wait time before admission for an elective procedure exceeded the recommended length given the urgency of their health condition. The data indicate virtually no change in this wait time measure between 1995-96 and 1998-99 (the wait exceeded the recommended length for 10.0 percent and 9.9 percent respectively). The State of New South Wales (which is the largest in Australia) publishes its own wait list information. A comparison of the average wait times in October 2000 (just around the time of the increase in private insurance coverage) and November 2001 also suggest no change in wait times (New South Wales Department of Health 2000; New South Wales Department of Health 2001).

4.3 Income Redistribution Induced by the Private Insurance Subsidy

Because high-income earners purchase more private health insurance than do those with low income (Barrett and Conlon 2001; Propper 2000; Besley, Hall and Preston 1999), the subsidy

results in a redistribution from middle- and low-income Australians to high-income Australians. Data indicate that for 1997-98 nearly one-half of the tax concessions for private health insurance went to those in the highest one-third of the income distribution while less than one-fifth of the subsidies went to those in the lowest one-third of the income distribution (Smith 2000). The change to a universal rebate scheme which took effect in January 1999 (after these data) will have caused even more redistribution to higher income earners. Smith (2000) also argues that the tax statistics understate the subsidy to private insurers (and the benefits to high-income earners) because, for instance, they do not include tax expenditures.¹⁴

5.0 Lessons for Canada

Australia's experience with parallel insurance for hospital services provides a number of lessons for Canada (Table 4) as it wrestles with the difficult issues related to the roles of the public and private financing in Canadian health care. In drawing lessons for Canada, we focused on those aspects of the Australian experience consistent with either predictions drawn from theory (e.g., economic models of insurance markets) or experiences in other jurisdictions. Hence, we have reason to believe that these findings represent phenomena not unique to Australia and its institutional arrangements.

5.1 *Lesson 1: The potential for cost savings through introduction or expansion of a parallel private finance is limited*

¹⁴Tax expenditures refer to forgone tax revenue associated with tax concessions.

Australia's policy of subsidizing private insurance to save costs in the publicly financed hospital system has been a dramatic failure that, on balance, annually costs the public purse billions of dollars. This is consistent with evidence that in the UK subsidies to private insurance are not self-financing (Emmerson, Frayne and Goodman 2001) and that tax subsidies are a very expensive way to expand private insurance coverage in the US (Gruber and Levitt 2000). Subsidies to private insurance proved expensive in each of the above-noted contexts in part because they must be paid both to people who already had some form of private insurance (whose behaviour is little changed) as well as those who newly take up insurance, substantially raising the cost per new case of coverage. This is not a concern in the Canadian context, where parallel private insurance does not currently exist; nor do many of the calls for parallel private finance in Canada advocate a system of subsidy.¹⁵

A number of factors already discussed, however, suggest that the potential for public sector costs savings is limited even in the absence of subsidies to private insurance. At issue is cost-savings holding quality constant in the public sector. As will be discussed in more detail below, quality plays a pivotal role in the dynamic between the public and privately financed sectors. If there is little or no perceived quality difference between the public and private sectors, no economically rational person would choose private finance in the presence of a free alternative (Besley and Gouveia 1994). Hence, if quality remains high in the public system, the private parallel system plays at best a minor role that could not deliver substantial cost savings to the

¹⁵It is important to note, however, that the federal government and 9 of 10 provinces currently subsidize private ancillary health insurance through the tax system. Introducing parallel private insurance without subsidy would therefore require either asymmetric treatment of the two types of private health insurance or repeal of the existing subsidy (which has previously proved difficult due to lobbying by the insurance industry).

public system even under favorable assumptions. This conclusion is reinforced by the tendency for parallel private insurers to develop niche markets, offering a limited range of policies that focus on relatively simple, elective procedures, leaving the truly expensive cases and those requiring more comprehensive care to the public system. In the UK, for instance, fewer than two dozen procedures accounted for over 70% of all private operations in the late 1980s, and the private insurance policies restricted the conditions covered, in one case, to only 17 specific procedures (Propper and Maynard 1989). The only scenario under which parallel private finance leads to cost savings to the public sector is one in which quality in the public sector is allowed to deteriorate.

The potential for cost savings is further limited by the effect of a parallel private sector on health care input prices and the financial externalities arising from complementary aspects of the publicly and privately financed sectors. The supply of many health care resources (e.g., physicians, nurses, technicians) is relatively inelastic in the short run. The public and private sectors must compete for these limited resources, and the resulting competition can increase input prices. Physicians in the UK can earn 3-4 times more working in the private sector than in the NHS (Propper and Green 1999). Anecdotal information suggests considerable differences in earnings potential in the private and public sectors in Australia.¹⁶ Although the public sector normally cannot match private sector money wages, it may adjust other aspects of the compensation contract such as total hours of work or the time allowed to work in the private sector with no reduction in public-sector salary (Propper and Green 1999). Adjustments such as

¹⁶ The Australian Society of Anaesthetists, for example, says qualified anaesthetists entering the hospital system can expect a starting salary of \$115,000, while those working privately can earn more than \$200,000. (Thursday, July 1, 1999 "Weird Science" *Sydney Morning Herald*).

these raise the real wage for the public sector even if they leave the published money wage unchanged. Such price effects mean that a fixed nominal public sector budget can purchase fewer real resources and provide fewer services (Chiu 1997). The net result is that, in the presence of a parallel private insurance sector, the publicly financed sector must either provide fewer services or increase funding to maintain the previous real servicing levels.

In addition, health care services offered through the private sector (and covered by private insurance) are often complements to public sector services. This is widely observed for supplemental private insurance policies. Medigap coverage in the US, for example, increases Medicare expenditures (Christensen *et al.* 1987), and those with private drug insurance in Canada consume 10% more physician visits than those without such in insurance (Stabile 2001). In the case of parallel private insurance, a privately financed surgical procedure is often associated with a variety of related pre- and post-op health care services such as visits, diagnostic tests, many of which are obtained from the public system.¹⁷ Hence, the private insured services provided in parallel can often generate costs to the public system.

Finally, the diversion of real resources to the private sector can mitigate the public sector's ability to deliver services. This is particularly a problem where supply is inelastic. Globerman and Vining (1998) cite examples from New Zealand and South Africa where temporary shortages of physicians and nurses in the public sector were caused by their being bid away to the private sector. This can affect wait times (see below). But even if supply can be increased in the longer run, this often translates into higher public sector costs associated with training, which

¹⁷ Research on the demand for privately provided services in parallel systems of finance and delivery consistently find that the vast majority of those who use private services also use public services (Propper 2000).

is often heavily subsidized (and/or higher input costs as per above).

5.2 Lesson 2: The introduction or expansion of parallel private finance will not reduce wait times in the publicly financed system

Although conclusions regarding the effect on wait times of Australia's subsidies to private insurance are tentative at this time, the evidence of little or no effect on public sector wait times is consistent with experiences in other jurisdictions (Tuohy *et al.* 2001). A consistent shortcoming of policy debates on wait lists (including those that argue that more public resources will necessarily fix the problem) is a reliance on simple, deterministic, engineering-based models of the wait lists that fail to incorporate the behavioural responses of patients, providers and health care institutions to policy changes. Both theory and evidence (e.g., Farnworth 2000; Tuohy *et al.* 2001) indicate that creating a parallel private sector can actually increase wait times, especially when providers can work simultaneously in both the public and private sectors. In Canada we have already witnessed this in the nascent private ophthalmologic sectors in Manitoba and Alberta. In both provinces, wait lists were substantially longer for physicians who provided services through both the public system and private clinics (with an additional "tray" or "facility" fee) than they were for physicians who provided services only through the public system (DeCoster *et al.* 2000; Alberta Consumers' Association 1994; Canadian Health Services Research Foundation 2001).

5.3 Lesson 3: There is no simple way to regulate private insurers to pursue public objectives

It is commonly proposed that private insurers be regulated to mitigate negative effects. The recent report of the Canadian Senate Standing Committee on Social Affairs, Science and Technology, for example, identifies parallel finance as a financing option to be pursued in

conjunction with specific regulations designed to limit adverse effects (Senate of Canada 2001).

The Australian experience with community rating, however, illustrates how difficult it can be to regulate in the private interest given the substantial informational problems in the health care sector (Hurley 2000). These informational problems often preclude the design of effective regulatory approaches in the insurance sector that avoid both unintended negative effects and countervailing responses by insurers.

5.4 Lesson 4: The image of an independent, isolated parallel system of private finance is false; interactions between the public and private insurance sectors are complex and unavoidable

Advocates for parallel private insurance in Canada often propose the creation of a private insurance sector independent of the public system -- an innocuous add-on for those who want it.¹⁸ This vision of "independent parallelism" is false. Economic analysis documents that there cannot be an isolated, independent parallel system of finance that does not interact with the public system. The Australian policy of extensive, explicit subsidies for the purchase of private insurance and subsidy to private inpatient physician services represents a particularly glaring case of cross-subsidy (but not entirely atypical --- as noted above, through the tax system Canada currently subsidizes private health insurance at the rate of approximately \$1 billion annually (Stabile 2001)). But even in the absence of such explicit subsidies, financial and real resource interactions are unavoidable.

As discussed above, prices for health care inputs and the financial externalities associated with use of private services complementary to publicly financed services inescapably link the private insurance sector and costs in the public system. These interactions arise even in the

¹⁸To the extent that there might be feedback to the public system, these effects are argued to be wholly beneficial (e.g., reduced wait times).

absence of explicit subsidies to private care or private insurance, and even if providers are not allowed to work in both the private and public system. Allowing providers to work in both the public and private system increases the extent and range of interactions between the sectors. The complex sources of interaction between the privately financed sector and the publicly financed sector mean that although the two sectors may grow in parallel, numerous tendrils inevitably entwine them.

5.5 Lesson 5: Quality plays a key role in driving the dynamics between the public and privately financed sectors

The introduction of Medicare caused private insurance coverage in Australia to fall; indeed, even quite large financial subsidies did little to increase private insurance purchases. Why? Overall, Australians rate their publicly financed system quite highly. In the mid-1990s over 90 percent of those surveyed supported Medicare (Botsman 1999), though there is some suggestion of reduced confidence by the late 1990s associated with constrained public sector spending (Donelan *et al.* 1999). Unless there is perceived to be a quality difference between the public and private sectors, no economically rational person would choose private finance in the presence of a free alternative (Besley and Gouveia 1994). High levels of satisfaction by Australians (and the secular decline in private insurance following the introduction of Medicare) suggest that perceived quality is relatively high, so that maintenance of a large parallel private insurance sector in Australia therefore requires public subsidy.¹⁹

¹⁹Quality in health care is difficult to define. Patient satisfaction may be one part, but it certainly does not equate with quality as individuals are often do not have requisite knowledge to judge quality. We emphasize perceived quality, as that is what is important for individual decision making.

The dependence of the parallel private system on a real or perceived difference in quality for its economic viability raises difficult issues given that most individuals do not have the requisite information to judge quality in health care (see, e.g., Evans 1984 or Hurley 2000 for a discussion of the informational problems in the health care sector). Both providers and private insurers have incentive to exploit this informational advantage for economic gain by generating real or perceived differences in quality. In an individual patient encounter, patients may be in a poor position to judge provider claims that a privately financed and delivered service is of higher-quality than that available in the public system. This has been a recurrent concern, for instance, for private sector ophthalmologic services in Alberta where some physicians have exaggerated the differences between publicly insured lenses and privately available lenses (Evans *et al.* 2000). At the level of public policy, citizens' informational disadvantage makes them less able to adjudicate claims regarding lower quality in the public system made by those with an interest in the erosion of the public system. Given the relative infrequency with which a typical person uses the hospital system, media and other services can play an important role in shaping public attitudes. The recent study of public attitudes toward health care in Manitoba, for example, found that those who had relied on media reports regarding the functioning of the health care system rated it much worse than those who had actually used the system within the previous year (Shapiro *et al.* 2000). Furthermore, this pivotal role of quality and the alignment of private sector economic interests means erosion of quality in the public sector may not arise simply from a passive loss of "voice" as better off, better-connected and more vocal citizens exit to the private system; rather, a more active process is possible that serves private interests (Hirshman 1970).

5.6 Lesson 6: It is essential to articulate clearly the policy objectives set for health care financing and design public and private roles consistent with these objectives.

The need to articulate clearly policy objectives and to design public and private roles consistent with these objectives may seem so banal that it does not merit discussion. But obfuscation of policy objectives is widespread, is at times deliberate and strategic because it serves certain stakeholders, and is the source of much trouble. Australia's Industry Commission (1997), for example, observed that until Australians resolve whether private insurance is intended primarily to be a complement to or a substitute for Medicare it will be impossible to develop coherent health care financing policies. This confusion has generated a set of mutually incompatible financing policies in Australia whose objectives cannot simultaneously be met. Australian Medicare has provided access to a comprehensive range of publicly financed physician, hospital and drug services at low point-of-service cost. Current federal government rhetoric commits itself to this ideal while simultaneously fostering a strong, broadly accessible, parallel private health insurance sector. This has required the introduction of massive subsidies to expand a struggling private insurance industry, and a continuation of community rating in an effort to make private insurance accessible. Community rating has exacerbated adverse selection into the parallel private insurance sector, which in turn has generated strategic plan design by private insurers which offsets the effectiveness of community rating (Vaithianathan 2000b). This mix of objectives and associated policies may well result in a failure to achieve any of the government's stated policy goals.

Canadian Medicare appears thus far to have avoided such a confusion of objectives. Private health insurance since the middle 1960s, and especially since the 1984 Canada Health Act (CHA),

has been limited to a complementary role providing ancillary coverage for services not included within Medicare. Canadian policy has effectively prohibited parallel private insurance for those services included in Medicare.²⁰ So why is Australia's experience pertinent to Canadians? Because the fact that Canada has maintained a clear vision for its Medicare system since its inception does not guarantee that it will do so in the future.

²⁰Six of ten provinces legally prohibit private insurance for publicly insured physician and hospital services. A seventh province permits such insurance but does not allow physicians to charge fees greater than the public plan. See Flood and Archibald (2001) for details.

The alternative visions for public and private roles that have animated the Australian debate in the last two decades also compete for dominance in the Canadian debate, and there is always pressure to shift among these visions, particularly once strong private sector interests become established. One vision, which reflects the current arrangement in Canada for CHA-covered services, limits private insurance to ancillary services not included in Medicare and which are not central to the goal of providing universal access to medically necessary health care. The policy interest in private insurance under this vision is limited to regulatory policies to ensure good practice in the complementary private insurance sector (i.e., no fraud, adequate reserves, etc.). A second vision would allow private insurance for publicly insured services, with no *explicit* subsidy to such parallel insurance.²¹ Parallel private insurance is to be tolerated and regulated but not encouraged. Parallel private insurance responds to those with particular tastes (and incomes) and serves as a safety valve. This vision corresponds roughly with the immediate post-Medicare period in Australia, in which parallel insurance was allowed but explicit subsidies to such insurance (and private care) were reduced or removed. Finally, a third vision sees parallel private insurance as an alternative to (or substitute for), public insurance. This vision requires policies to create broad access to private insurance so that everyone has the option to choose between obtaining services through Medicare or through the private sector. The language of Australia's ruling conservative federal government in the 1990s has at times reflected this vision. In Canadian debates, this vision is perhaps reflected best by calls for medical savings accounts

²¹We emphasize *explicit* because in fact there is nearly always some form of cross-subsidization from public to private insurers (more on this below).

and related financing mechanisms (e.g., Premier's Advisory Council on Health for Albertans 2001; Senate of Canada 2001; Coffey and Chaoulli 2001; Gratzen 1999; Ramsey 1998).

Although post-war Australian health care policy represents an extreme case of alternating among these competing visions, every jurisdiction experiences pressures to shift among them. Maintaining equilibrium in the middle ground of "tolerate but do not subsidize" private insurance may be particularly difficult (Evans 2000). Interest group political theory argues that there will be continual pressure to introduce or expand subsidy to the private sector. Private health insurers and health care providers (particularly physicians) and health care suppliers (e.g., pharmaceutical companies) are well-resourced, well-connected, and have a concentrated interest in health policy that contrasts starkly to the diffuse interests of the general population (Stone 1997). In this setting, both provider and private insurance interests align to push for expansion and subsidy to private insurance, especially when the public sector is effective in exercising cost control. The UK, for instance, has shifted back and forth in providing explicit subsidy to its parallel private health insurance sector (Emmerson, Frayne and Goodman 2000). Closer to home, we see this general dynamic in sectors outside health care, such as in the education sector in Ontario where the government has recently proposed tax credits for parents who send their children to private schools instead of the universal public system (Smith 2001).

Maintaining clear objectives and assessing fit between objectives and policy is vital also because a series of individually small changes, each of which does not obviously compromise major objectives, can add up to large effects that contradict stated objectives. Recent changes in the rehabilitation sector in Ontario exemplify this dynamic. In the mid-1980s rehabilitation services were predominately publicly financed as an integral part of the publicly financed health

care system. Within a decade, however, out-patient rehabilitation services had become almost entirely privatized, largely without public discussion or awareness (Gildiner 2001). The change was not ideologically driven -- it occurred under three ideologically different administrations (Liberal, NDP, Conservative). Nor was it primarily driven by public-sector fiscal constraints -- much of the change predated the fiscal retrenchment of the early and mid-1990s. Rather it was rooted in a series of policy decisions related to workers' compensation and automobile casualty insurance that set in place a self-perpetuating dynamic of gradual detachment of out-patient rehabilitation from the public system and growing attachment with priorities and needs of workers' compensation and the casualty insurance sector, and with growing private sector interests in both delivery and financing that attracted new, larger and more powerful private sector stakeholders.

7.0 Conclusions

Australia's experience with parallel systems of public and private finance provides a cautionary tale for Canadians. Cautions arise particularly when Australia's experience is placed in the context of evidence from other jurisdictions regarding the dynamics of insurance markets and system of health care financing. Effects observed in Australia are consistent with broader international experience, which provides little evidence to support the claim that introducing a parallel system of private insurance in Canada would decrease wait times, improve quality, or reduce costs in the publicly financed system. Australia's experience illustrates how difficult it can be to regulate private insurance to prevent adverse effects in each of these dimensions of the performance of the publicly financed system. The evidence suggests that the introduction of a parallel system of finance would redistribute income (in general, from sick, low-income individuals to healthy, high income individuals, and from members of society more generally to health care providers and

insurers), increase inequality in access to health care, and increase choice for those who can afford private insurance. In summary, experience in Australia and elsewhere, consistent with much health economic analysis, fails to support the claim that parallel public and private finance will advance commonly stated objectives for Canada's health care financing policy (e.g., improve access to care, ensure access is based on need, improve population health, and increase system efficiency and equity).

Arguments in support of parallel private insurance appear limited to two bases. The first is a rights-based argument: that every individual has the right to purchase health care on whatever terms are acceptable to them, and that the primary obligation of our society is to protect and respect this right, irrespective of the negative consequences to a public system of enforcing this right (Hurley 2001). That is, this line of reasoning simply deems irrelevant any negative effects of the parallel private sector on the public system -- the right trumps any utilitarian or consequentialist reasoning. The Canadian public and policy makers to date have not shown much sympathy for this argument (Giacomini *et al.* 2001).

A second possible line of argument focuses only on consequences and emphasizes responsiveness to diverse preferences among members of society. A criticism of a single-payer system public insurance system is that it forces everyone to consume the same level of health insurance, failing to respond to heterogeneity in preferences for desired levels of health insurance and thereby imposing a welfare loss on society (Danzon 1992). If there is a great diversity across members of society in preferences with respect to health insurance, and society places great importance on responding to diverse preferences, a parallel system of private finance has the

potential to improve welfare over a single-payer system (Hurley 2001).²² Within this line of reasoning, health care financing policy rests on a trade-off between possible gains in welfare from responding to diverse preferences against losses in welfare associated with the above-documented negative effects of parallel private finance.

Canadian society has not historically placed great importance on responding to diverse preferences. Certainly relative to the U.S., the collective has received more weight than the individual (Lipset 1990). Further, as Evans (1983; 1984) demonstrates, once one integrates special features of health care into the analysis as well as social objectives such as income redistribution and the desire allocate health care resources in response to health need, the economic case for a single-payer public insurance system becomes much stronger than is indicated by analyses of insurance markets using standard neoclassical economics models.

Whether Canadians will find either of these arguments persuasive remains to be seen. Polling evidence indicates that Canadians continue to support strongly the principles embodied in the Canada Health Act, but are worried about the health care system (Conference Board of Canada 2000). What remains vitally important is clearly articulating the goals we have set for our health care financing policies, fairly assessing the evidence of how alternative financing arrangement serve to advance (or detract from) these goals, and conveying to Canadians the real options and their related effects.

²² Hurley (2001) places a lower bound on insurance.

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Table 1: Summary of Canadian and Australian Health Care Systems

SERVICE	AUSTRALIA			CANADA
CHA, Publicly Insured Services				
<i>Community-based Physician Services</i>	<ul style="list-style-type: none"> - private insurance coverage not legal - physician fees unregulated - extra-billing permitted - individuals liable for out-of-pocket payments for: <ul style="list-style-type: none"> a. 15% gap between listed Medicare fee and reimbursement to MD paid by Medicare b. MD charges above Medicare fee 			<ul style="list-style-type: none"> - private insurance coverage not legal - physician must accept public fee as payment in full - extra-billing illegal - individuals face no out-of-pocket costs for CHA mandated community-based physician services
<i>Hospital-based Services</i>	Public Patient, Public Hospital	Private Patient, Public Hospital	Private Patient, Private Hospital	
Physician Services	<ul style="list-style-type: none"> - no choice of MD - MD services free 	<ul style="list-style-type: none"> - choice of MD - MD fees unregulated - Medicare pays 75% of MSB fee - priv ins legal for 25% gap and/or charges above MSB fee 	<ul style="list-style-type: none"> - choice of MD - MD fees unregulated - Medicare pays 75% of MSB fee - priv ins legal for 25% gap and/or charges above MSB fee 	<ul style="list-style-type: none"> - choice of MD - physician must accept public fee as payment in full - extra-billing illegal - private insurance coverage not legal - individuals face no out-of-pocket costs inpatient physician services
Drugs	- free of charge	- patient liable for all costs; priv ins legal	- patient liable for all costs; priv ins legal	- free of charge
Other health care services	- free of charge	- patient liable for all charges; priv ins legal	- patient liable for all charges; priv ins legal	- free of charge
Hotel and related services	<ul style="list-style-type: none"> - basic services free of charge - priv ins for 	<ul style="list-style-type: none"> - patient liable for all charges - priv ins legal 	<ul style="list-style-type: none"> - patient liable for all charges - priv ins legal 	<ul style="list-style-type: none"> - basic services free of charge - patient can purchase upgrades (e.g., semi-private room) - private insurance coverage for upgrades legal

	upgrades legal			
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Non-CHA Services	Australia	Canada
<i>Outpatient Prescription Drugs</i>	<ul style="list-style-type: none"> - universal coverage as part of Medicare - financed by Commonwealth - beneficiary co-payments - private insurance to cover co-payments prohibited 	<ul style="list-style-type: none"> - not included in Canadian Medicare - provincially based plans for defined populations, with co-payments - private insurance coverage legal for individuals not covered by provincial plans; coverage often benefit of employment although not prohibited, little if any private insurance to cover copayments required in provincial plans
<i>Residential Long-Term Care</i>	<ul style="list-style-type: none"> - not included in Australian Medicare - administered by states; joint Commonwealth/state financing - public financing constitutes about three-quarters of expenditures - private insurance allowed but not common 	<ul style="list-style-type: none"> - not included in Canadian Medicare - public financing constitutes about three-quarters of expenditures - private insurance allowed but not common
<i>Home Care</i>	<ul style="list-style-type: none"> - not included in Australian Medicare - administered by states with joint Commonwealth/state financing - public financing constitutes about three-quarters of expenditures - private insurance allowed but not common 	<ul style="list-style-type: none"> - not included in Canadian Medicare - private insurance allowed but not common

Table 2: Recurrent Health Expenditures¹ in Australia by Source and Sector, 1998-99 (\$ million-Aus)

	Public			Private				Total Recurrent
	Commonwealth	State and Local	Total Public	Private Insurance	Individual Out-of-Pocket	Other ⁷	Total Private	
Hospital	7,101	6,516	13,617 (75.5%) ²	2,738	739	938	4,415 (24.5%) ²	18,032 (38.0%) ³
Public	6,598	6,516	13,113 (93.2%)	289	297	374	960 (6.8%)	14,073 (29.6%)
Private	503	--	503 (12.7%)	2,524	367	565	3,456 (87.3%)	3,959 (8.3%)
Professional Services								
Physician Services	7332	-305	7,332 (81.5%)	253838	9362831	48011	1,669 (18.5%)	9,001 (19.0%)
Other Professionals ⁵			505 (12.1%)				3680 (87.9%)	4185 (8.8%)
Drugs	3,086	--	3,086 (53.0%)	36	2,697	--	2,733 (47.0%)	5,819 (12.3%)
Prescription	3,086	--	3,086 (83.7%)	--	601	--	601 (16.3%)	3,687 (7.8%)
Over-the-Counter	--	--	--	36	2,096	--	2,132 (100%)	2,132 (7.8%)
Nursing Homes	3011	244	3,255 (80.1%)	--	789	22	811 (19.9%)	4066 (8.6%)
Other ⁶	1950	2371	4321 (67.7%)	978	481	598	2057 (32.3%)	6378 (13.4%)
Total Recurrent	22,680 (47.8%) ⁴	9,436 (19.9%)	32,116 (67.6%)	4,843 (10.2%)	8,473 (17.8%)	2049 (4.3%)	15365 (32.4%)	47481 (100%)

Notes to Table 2:

Source: Australia Institute of Health and Welfare, (2001b), Table A10.

1. Recurrent expenditures excludes capital outlays and tax expenditures.
2. The percentage is the proportion of expenditures in the relevant health care sector financed through public (private) sector.
3. The percentage is the proportion of total expenditures accounted for by the relevant health care sector.
4. The percentage is the proportion of total expenditures accounted for by the relevant source of finance.
5. Includes dental services, chiropractic, etc.
6. "Other" includes ambulance services, aids and appliances, community and public health, administration, and research.
7. Includes workers compensation and automobile insurance payments.

Table 3: Subsidies to Private Health Insurance in Australia, 1997-98 to 1999-00
 (all figures are \$million at nominal prices)

	1997-98	1998-99	1999-00
<i>Subsidies Provided</i>			
PHIIS - 1997	411.6	188.2	-
PHIIA - 1998 (30% Rebate)	-	1278.3	2306.9
<i>Revenue for 1% Tax Surcharge</i>	105	140	110
<i>Net Cost of Incentive Scheme</i>	306.6	1326.5	2196.9

Sources: Adapted from Butler (2001)

Table 4: Lessons for Canada from Australia's Experience with Parallel Finance

1. The potential for cost savings through introduction or expansion of a parallel private sector is limited.
2. The introduction or expansion of a parallel private finance will not reduce wait times in the publicly financed system.
3. There is no simple way to regulate private insurers to pursue public objectives.
4. Quality play a key role in driving the dynamics between the public and privately financed sectors.
5. The image of an independent, isolated parallel system of private finance is false; interactions between the public and private insurance sectors are complex and unavoidable.
6. It is essential to articulate clearly the policy objectives set for health care financing and design public and private roles consistent with these objectives.