

Private Health Insurance and Public Policy

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Summary

Private health insurance has generally been quarantined from the economic scrutiny that successive governments have applied to other sectors of the economy. Rather than being based on any firm economic model, financial support for private health insurance has been based on partisan preferences, with Coalition governments notably more enthusiastic than Labor governments to support it.

So it stands as part of the complex mix that characterizes our health care funding. There is no integrated health care “system” in Australia: rather we have a set of programs with different legacies, different loci of responsibility and different funding principles.

Within that mix private health insurance has taken its place, and there is an assumption that the funding of private hospitals is inexorably linked to private insurance.

Because governments have been becoming increasingly concerned about the budgetary costs of the private health insurance rebate, they are shifting towards the incentives in the Medicare Levy Surcharge as a way to support private insurance.

This makes assistance to private insurance more opaque, particularly in a political environment where there is undue emphasis on fiscal outcomes (rather than economic management). *Use of such hidden assistance is a retreat to the policies of the 1960s, before the cost of tariff and quota assistance for manufacturing was brought to account.*

In the absence of economic analysis of the costs and benefits of private insurance, governments, particularly Coalition governments, have argued to defend its privileged position – relieving pressure on public hospitals, providing choice, protecting the “private system” – and have suggested that publicly-funded health should be re-defined as distributive welfare for the needy rather than as a shared universal service.

But as a means of sharing health care costs, private insurance is a high-cost and inequitable mechanism to achieve what the tax system and a single insurer can do far better. Its administrative overheads are high, and it lacks the incentives or capacity to control moral hazard and to contain health care costs.

There is mounting evidence, revealed in the recent election campaign, that public opinion is coming to align with economists’ view that a single insurer such as Medicare is the most appropriate way to share health care costs. There is little point in saving the public \$1.00 in taxes paid to the ATO if instead they are cajoled into paying \$1.10 or \$1.50 to private insurers – essentially privatized tax collectors.

Australia needs exposure of the cost of support for PHI, and, an open debate about health care funding – not the emotive “private” vs “public” rhetoric that often takes place, but rather the basic question about how much we should take personal responsibility for paying for our own health care, without insurance, and how much we should share through Medicare. If the options are explained clearly Australians may accept a reasonable regime of co-payments, so long as they are not seen as a wedge to allow private insurance to destroy Medicare.

Introduction – an industry unexamined

While there have been inquiries into important aspects of our economy, covering most sectors subject to government regulation and subsidies, there has never been an inquiry into how we finance health care. Basic questions, such as how much we should pay from our own pockets through normal market transactions, and how much we should share with others through insurance (private or public), remain unexamined.

There have been partial inquiries into health financing, but these have generally been constrained by an assumption that private health insurance (PHI), should be exempt from economic scrutiny.

The 1969 Commonwealth Committee of Inquiry into Health Insurance (the “Nimmo Committee”) was constrained to make its recommendations “in the context of a voluntary health insurance scheme”.²

In 1996 the newly-elected Howard Government asked the Industry Commission (the forerunner of the Productivity Commission) to examine private health insurance, but its terms of reference were about how government measures could most effectively arrest the decline in PHI membership, rather than to inquire about its role in funding health care. The Commission’s final recommendation was that there should be a “broad public inquiry into Australia’s health system”,³ including health financing, but that recommendation has never been acted upon.

Similarly in 2008 the newly-elected Rudd Government established a National Health and Hospitals Reform Commission, but without explanation the Commission stated that it wanted “to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained”.⁴

In the recent election campaign Labor proposed establishing a permanent healthcare reform commission, but it is not clear if it would have been posing fundamental questions of funding.

In an economy that has gone through tremendous transformation over the last fifty years – the virtual abolition of tariff and related assistance, financial and labour market deregulation, application of competition policy – our health funding arrangements have never been subject to the basic scrutiny that has applied elsewhere in our economy.

That’s not to say there haven’t been policy changes: anyone involved with health policy knows about the Whitlam Government’s introduction of universal publicly-funded health insurance, its abolition by the Fraser Government, its re-introduction by the Hawke Government, and the Howard Government’s restoration of strong support for PHI. But these changes have been based more on partisan tussles than on consideration of the basic questions of how we fund health care.

When it comes to health financing successive governments, rather than pursuing fundamental reform as the Hawke-Keating Government did with tariffs or as the Howard Government did with indirect taxes, strike compromises between leaving existing programs in place and placing their partisan stamp on those programs.

Funding arrangements for health care therefore tend to encapsulate the fashions, the sources of political power, and the fiscal priorities at the time various schemes were introduced.

Fifty years of muddling through

As a result we have a set of funding arrangements (to say we have a funding “system” would imply coherent policy design, when we don’t even have an integrated health system) that is confusing and incomprehensible to those who need health care, that involves high transaction costs (particularly but not only because of split Commonwealth and state responsibility), that results in duplication of

services and gaps in services, and inevitable resource misallocation resulting from perverse incentives on providers and patients.

As a partial illustration of this mess, Figure 1 alongside – “Who pays for what” – shows the mixture of funding for our main areas of health care. Any detached observer would find it impossible to infer any sense of intelligent

design from these arrangements. Why, for example, do governments pay the bulk of outlays for “unreferred medical services” (mainly GPs) while paying so little for dental services? Those involved in health care may take these arrangements for granted, as if they are part of a natural order, but most Australians find them bewildering.

Some services are free at the point of delivery, including those provided by bulk-billing clinics and those funded by “no-gaps” private insurance. For some services, most notably those covered by the Pharmaceutical Benefits Scheme (PBS), the patient contribution is capped while the funder bears the open-ended cost. For many services, however, (including most services covered by ancillary PHI) the patient is left bearing the open-ended risk. As my colleague Jennifer Doggett wrote about patient co-payments “the way we manage them is complex, unfair and inefficient”.⁵

Thirty years ago, commenting on health funding, the economist Sidney Sax – one of the designers of Medibank (the forerunner of Medicare) – described the situation as a “strife of interests”.⁶ My metaphor for health care is an old rambling country homestead that’s been extended and modified over the decades – sometimes when the fashion was Federation, sometimes when the fashion was minimalist, sometimes when the seasons were bountiful, sometimes when times were tough.

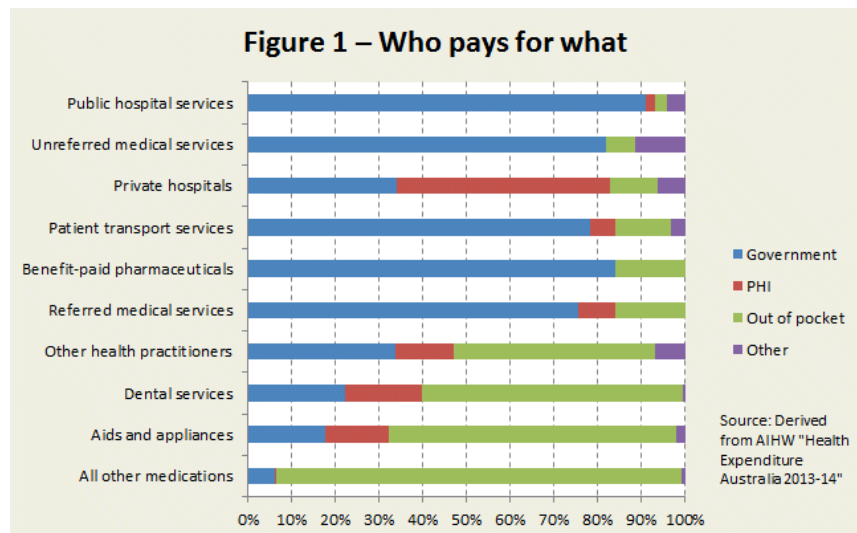
The academic term for such policy processes is “disjointed incrementalism” or “muddling through” – Charles Lindblom’s terms for policy processes that attend to successive problems and opportunities without ever going back to basic re-design.⁷

Still muddling through – increasingly hidden assistance to PHI

In 1998 there was a Steven Spielberg movie *Saving Private Ryan*, in which extraordinary military resources are devoted to finding and saving one soldier who has to be found somewhere in the confusion following the 1944 Normandy landings.

The Commonwealth’s policy obsession could be titled *Saving Private Insurance*, and just as military campaigns are rarely governed by a dispassionate consideration of costs, neither is there much accounting for the cost of the Commonwealth’s support for private insurance.

The Commonwealth has two concerns – one political, the other fiscal.



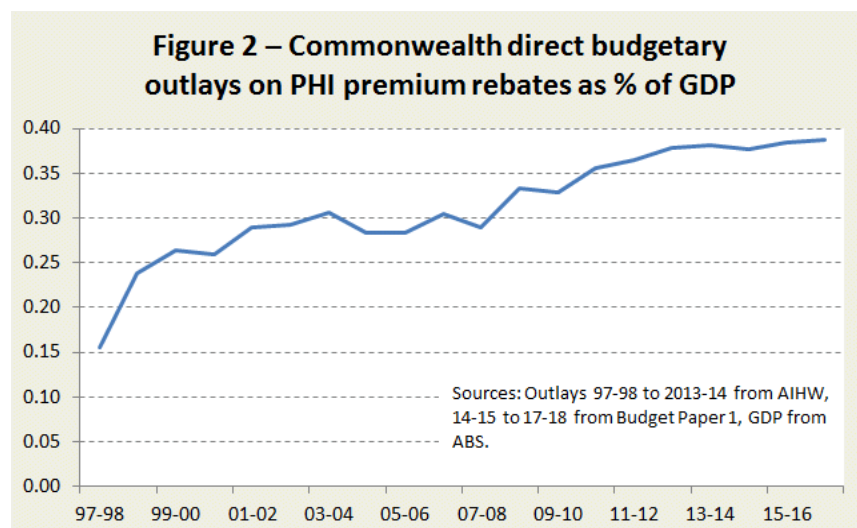
The political concern, expressed most strongly by Coalition governments, is simply to preserve PHI. “Private health insurance is in our DNA” said Tony Abbott in 2012, when he was in opposition, as if the case for supporting PHI is self-evident, not needing the scrutiny of cost-benefit analysis or any other form of economic justification.

There is also the philosophy known as “private sector primacy” – a belief that if a function *can* be provided in the private sector, even if it could be provided more efficiently in the public sector, then it *should* be provided in the private sector. The Howard Government adopted what Minister for Administrative Services David Jull called a “Yellow Pages” test for what should be in and out of government: if an activity appeared in the Yellow Pages directory it should be left to the private sector. It’s the mirror-image of the central-planning philosophy that dominated the former Soviet Union, where primacy was to be given to state provision.

Then there is the fiscal concern, on full display in the recent election campaign, when the Minister for Health, in a rare exposure of the sources of power in government, complained that Treasury and Finance weren’t allowing her to unfreeze the freeze on Medicare rebates.

While the Commonwealth has managed to contain health expenditure as a proportion of the budget (at around 16 percent of outlays), there are concerns with specific items, most notably payments to the states for public hospitals and rebates for private health insurance.

Commonwealth spending on PHI rebates are shown in Figure 2 alongside. The initial steep rise is attributed to the uptake of PHI when the Howard Government re-introduced subsidies in the form of rebates, but the ongoing rise, when coverage has stabilized around 45-50 percent, was probably not what the Howard Government expected.



That goes some way to explaining why, from 2014, the Commonwealth has adjusted the rate of the rebate, so that the higher the rise on PHI premiums the lower is the rebate.⁸ This year the base rebate, which was originally 30.0 percent, has now fallen to 26.8 percent.

That will save the Commonwealth’s direct budgetary outlays, and unless PHI premiums rise no faster than the CPI (unlikely given that on average premiums have risen by 3.2 percent above the CPI over this century so far), the rate of rebate will continue to fall.

In a move that has had little publicity because it is buried within budget papers is another saving measure. The income threshold for phasing-out of the rebate, which was set at \$90 000 (for singles) in 2014-15, has not been indexed for wage or CPI inflation, and is to be frozen at that level until 2020-21. The means test for the rebate will effectively be lowered in real terms as nominal incomes rise.

In 2014-15 average full-time adult ordinary-time earnings were just over \$77 000,⁹ meaning the threshold was about 17 percent higher than average earnings. If nominal earnings go on rising by 2.75 percent a year (the long-term wage price index in this year's budget), by 2020-21 average earnings will be around \$90 000,¹⁰ meaning the threshold will cut in at average earnings.

In a point missed by most journalists, the threshold for the rebate is also the threshold for the Medicare Levy Surcharge (MLS). By 2020 a "high income earner" for the purpose of the MLS will be anyone with an income above average weekly earnings.

This means that assistance to PHI will slowly move from the exposure of budgetary outlays – this year \$6.5 billion in direct outlays for the rebate, and \$1.6 billion in "tax expenditures" (because the rebate does not count as taxable income) – into the dark world of hidden subsidies. My calculation, based on data from Tax Office statistics, is that the annual cost of exempting those with "high incomes" from the MLS is presently between \$1.2 billion and \$3.9 billion.¹¹ (A more precise estimate would require the research capacity of a body such as the Productivity Commission.) That cost will rise as more people are caught by the lowering MLS threshold. And even though at any one time only 20 percent of taxpayers have incomes above \$90 000, many people have these high incomes at some stage of their lives.

The MLS is framed as a penalty for those who do not have PHI insurance, but it is no less reasonable to see it as a subsidy for those with high incomes who do have PHI. For example, a household with two professional incomes of \$150 000 would have an incentive of \$4500 to hold PHI, enough to buy the most expensive family cover. In fact, because most such households are reasonably wealthy and would have no trouble meeting minor outlays, they would be wise to take a high deductible hospital-only policy and keep the change.

This form of assistance has echoes of assistance to manufacturing in the days before the economic cost of tariffs and import quotas were brought to account.

Over the last eighteen years, starting with the *Charter of Budget Honesty* Act in 1998, Australian economic policy has become dominated by the annual budget's fiscal outcomes, with other economic considerations pushed aside. This fiscal focus has been a major political issue since 2008 when, in response to the global financial crisis, the Commonwealth responded with a substantial stimulus, resulting in the first deficit for several years, and the budget has been in deficit ever since.

Hence, what has passed for an economic debate in the last two elections has been mainly about the size of the deficit – "your deficit is/would be bigger than mine".

That focus encourages cost-shifting and resort to what are known as "privatized taxes". It prioritises bookkeeping and accounting legerdemains over responsible economic management. If a cost can be shifted off-budget, even if it would be more efficient and equitable to use taxes and public expenditure finance a service, the cosmetics of fiscal rectitude override the economics of efficient resource allocation.

To many people the daily reminder of such cost-shifting off-budget is in the form of toll roads in our eastern capitals. We pay dearly for those new roads, funded by expensive private-public partnership deals, because governments are obsessed by keeping their reported debt level down.

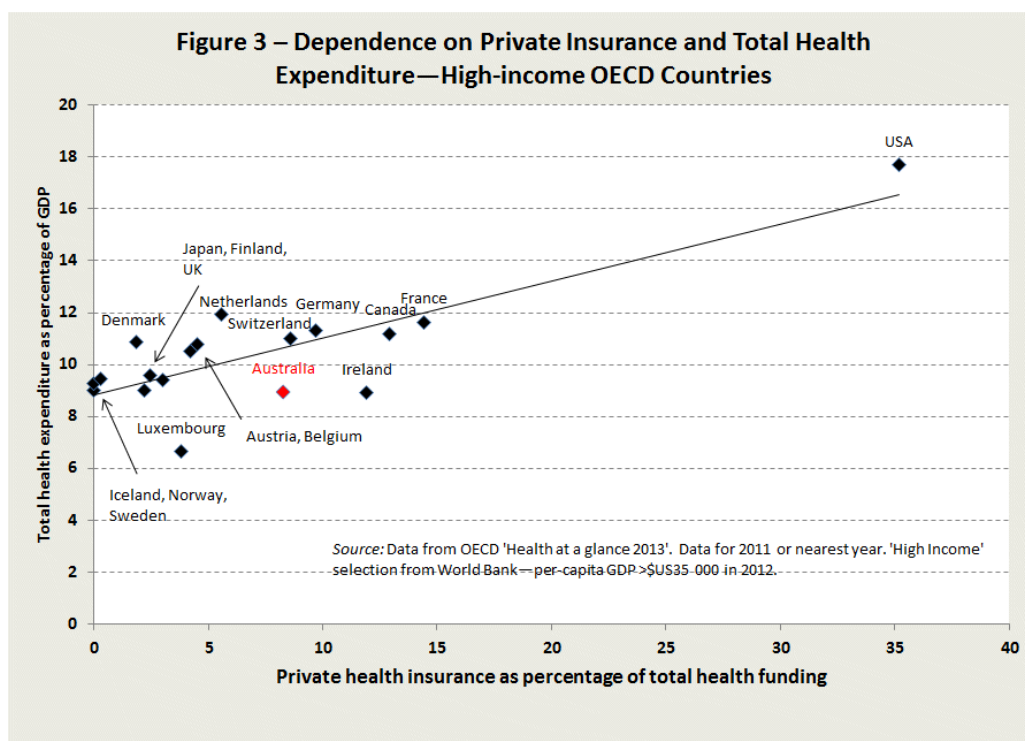
Private health insurance is in the same category. It is essentially a privatised tax, designed to achieve some of the same outcomes as Medicare, but without the exposure of public scrutiny and without the automatic community rating built into the tax system. And it achieves this at high cost.

Private health insurance – a high-cost privatized tax

As pointed out in the Centre for Policy Development study “Private Health Insurance: High in cost and low in equity”,¹² a multitude of competing insurers leads to significant market failures, most notably an incapacity to control moral hazard and an inability to act in the consumers’ interest when insurers are confronted by the strong power of provider interests.

In addition to these problems is the high bureaucratic cost incurred when health funding is churned through a corporate financial intermediary: only around 85 cents in the dollar passed through PHI makes its way to fund health care, compared with around 95 cents when health care is funded through taxation and Medicare.

Among prosperous developed countries like Australia, all of which have much the same health outcomes, there is a strong and direct correlation between countries’ reliance on PHI to fund health care and the total cost of health care. Those countries that rely on a single national insurer, generally in association with a well-structured system of consumer co-payments, manage to fund health care equitably and at low cost, as shown in Figure 3. (The Nordic countries are the stand-out examples).



In spite of that evidence, and the government’s own experience in finding that rebates for PHI to be running out of control, lobbies for insurers and politicians with a partisan bent mount up a number of superficially plausible arguments in support of PHI. These are summarized below.

PHI relieves pressure on public hospitals

A perennial argument is that PHI takes pressure off public hospitals, but after fifteen years of high membership of private insurance there are still long waiting lists and waiting times for public hospitals. That is not necessarily problematic, so long as those with urgent needs are

attended to promptly. A hospital with no waiting list would probably have under-used capacity, or would be providing unnecessary services.

The notion that private health insurance, through supporting private hospitals, would relieve public hospitals, was at best fanciful and at worst deceptive, because it considered only the demand side, while neglecting the supply side of health services. So long as medical specialists, nurses, operating theaters and other resources are in limited supply, resources will go to where the money is. This point is supported by the peak body for public hospitals, the Australian Healthcare and Hospitals Association, which opposes continued subsidies to PHI on the basis that they do not benefit the public health system.

Also, for accidents and emergencies, and in cases involving complex needs, people are likely to use public hospitals regardless of their insurance status, and of course those who take out the cheapest cover to avoid the MLS are generally better off financially and in terms of care by not revealing that they hold private insurance.

The result of subsidising PHI has simply been to re-assign queues for service, allowing some to jump the queue, thereby shuffling everyone else a little further back. Such re-assignment is not neutral, for there is no reason to believe that the person promoted has greater therapeutic needs than the people displaced. Most probably it results in a worsening allocation of scarce resources (particularly in light of the fact that those with PHI tend to have higher incomes and therefore enjoy better health than those without it).

Of course there are people who value an opportunity to jump the queue, but public policy that encourages such behaviour is absurd. The point was illustrated by a caller to an ABC Radio National talkback program, who said:

I have heard that academic chappie [I was the lead discussant] talking about private health insurance. A little while ago I needed some minor surgery, and with the help of private insurance I was able to get right to the front of the queue. It's a wonderful product – I think everyone should have it!

Public services are for the poor

Another argument is that publicly-funded services are for the “poor” (or “indigent” to use the American term). On a recent ABC radio interview the present Health Minister said “We support the public system for those who can't afford private health”.¹³

The flip side of positioning “the public system” (whatever is meant by that term) as a service for the poor or the “indigent” is to ascribe some virtue to “the private system”, whatever that encompasses. In the current arrangements “the private system” is almost surely about PHI and private hospitals.

Such exhortation is akin to encouraging people who are well-off to live in gated communities, to the extent of applying a 1.0 to 1.5 per cent tax surcharge on those who can afford to but do not. It is hard to conceive of a policy position that is more destructive of community values, and that is more morally offensive for those who wish to contribute to the public good through their taxes. (Two hundred thousand Australians with incomes above the MLS threshold in fact pay the MLS surcharge, almost certainly to their personal financial detriment.¹⁴)

No matter how hard administrators try to maintain standards, services designed to serve only the “poor” or “indigent” inevitably deteriorate. When the well-off use the same public services as everyone else those services are bound to be kept up to high standards. The well-off

inevitably have more political clout than the poor, and because many are in professional employment themselves, they may have a more reasonable expectation of what constitutes an acceptable standard of service. When they never experience certain public services, however, the well-off have no awareness of deterioration of those services.

PHI provides choice

There is an argument about “choice”. Some people, in some situations, value choice of medical practitioner. But by and large people rely on expert opinion – their own GP’s recommendation, or the clinicians who work in public hospitals. The real issue lies in sustaining high levels of professional standards so that consumers don’t have to go shopping around for a competent doctor.

There are, however, situations where continuity of care is important – particularly maternity and some chronic conditions. There is no reason models cannot be developed within public hospitals and their support services that address this need more thoroughly than is happening at present. This is already being achieved to some extent in midwife-led maternity services and could easily be expanded into other areas of health care where the evidence supports the benefits of continuity of care.

Indeed, the government’s *Reform of Federation Green Paper* canvasses the possibility of the Commonwealth and states developing individual care packages “for people with, or at risk of developing chronic or complex conditions”.¹⁵ I understand that there is some enthusiasm among state governments who are examining this possibility further. But private insurers also want to be involved in such services, without providing any evidence of how they could perform the task at lower cost than those in the public sector.

Regarding choice of health insurer, there is little to be gained in choice in such a highly-regulated industry, where firms are constrained in their offerings. In fact, if the government does succeed in reducing the confusopoly in PHI offerings with its gold/silver/bronze categorization, market theory suggests that there won’t even be much price dispersion among insurers.

There are proposals on the table that would allow more variation in health insurers’ offerings, such as the *Medicare Select* idea that emerged from the 2009 Report of the Health and Hospitals Reform Commission, essentially allowing people’s taxes that they presently contribute through Medicare to be re-directed to health insurers.

Medicare Select was characterized by its high overhead costs, involving two levels of administration, with money already collected through the taxation system being churned through the administrative layers of the health insurers.

It was not clear how those who would opt out of Medicare and into health insurers would be covered for the services presently available only in public hospitals. More basically, it was even less clear how anyone can make a sensible choice about the sort of cover they may need in the future. As has been revealed in the regular ACCC reports on private health insurance, people have enough trouble making choices involving simple monetary issues and a limited set of exclusions. When it comes to more complex contingencies, who has more than a vague (and often incorrect) idea of what their future needs will be?

PHI supports the private system

The most misleading claim for PHI is the implication that in its absence the “private system” would disappear. In the most extreme cases critics of PHI are said to be “ideologically opposed to the private sector”, to quote from a letter to the *Canberra Times* penned by a representative of a private health care organization.¹⁶

That argument conflates the *funding* of health care with the *delivery* of health care. Under any politically and economically realistic policy scenario, however, the bulk of health care services will continue to be provided by the private sector. GPs who bulk-bill are private providers funded by the public sector, as are corporate clinics that bulk-bill. Pharmacists are largely funded by the public sector.

There is no reason why a single national insurer cannot fund private hospitals, just as the Commonwealth funds public hospitals. Indeed that was an option canvassed by the Government’s *Reform of Federation Green Paper*, and the Department of Veterans’ Affairs acts as a single funder, purchasing most of its hospital services from the private sector.

There is also the thinking that because PHI is in the private sector it provides a market solution to allocating health care resources. But that is to misunderstand the operation of markets, which rely on the discipline of price signals at the time of purchase to ration resources. Insurance, by its very nature, is what we use to buy out of the discipline of market forces. There is no difference in the patient or doctor thinking “Medicare will pay for it”, and “HCF/BUPA/Medibank Private will pay for it”.

All insurance involves some degree of moral hazard. A tax-funded single insurer, subject to the fiscal discipline of a treasury department, has more incentive to control that moral hazard than a private insurer that can pass on costs to contributors, particularly when those contributors are coerced into holding PHI through strong financial incentives.

Also, a single national insurer has an incentive to contain system-wide costs, particularly through investment in public-good services such as health promotion. A private insurer, holding only part of the market, has little incentive to fund such services, because most of the benefits will flow to its competitors. (In economic terms this is a classic “free rider” public-good problem.) In fact, if health promotion is successful, people may become confident enough to believe they don’t need the benefits of private insurance – particularly when a major area of privately insured activity is hip and knee surgery, both of which are partly lifestyle-related. Contrary to commercial incentives for expansion, the incentive on a publicly-owned single national insurer is to reduce its market and to reduce system-wide costs.

It is because the economic case for supporting PHI is so weak that the industry, and the governments that are determined to support it, have never subjected it to a full and open inquiry. It has always enjoyed a protected status.

But just as in the 1980s the public came to realize that tariff and quota protection came at high cost, even if those costs weren’t revealed in budget papers, people may be coming to realize that support for PHI is costly. That realization may explain, in part at least, the effectiveness of Labor’s emphasis on Medicare in the election campaign.

The election campaign and public opinion

When the Coalition realized that Labor's campaign about privatizing Medicare had been effective their immediate reaction was to see it as no more than an opportunistic scare tactic ("Mediscare").

A dispassionate policy analyst would indeed judge Labor's Medicare campaign as misleading. After all the Coalition had no plan to privatise Medicare, and contracting out the payments system hardly amounts to privatization.

But well before Labor embarked on its "don't privatize Medicare" campaign, opinion polls were showing that on health care Labor enjoyed a strong lead over the Coalition.

Election campaigns see complex issues reduced to simple and often meaningless slogans, and in the public mind "privatize" becomes shorthand for something much less sharply-defined than a change in ownership from the public to the private sector – a "floating signifier" as linguists say.

"Privatization" as an accountant would define the term was not the issue in the campaign.

For example older voters recall the Fraser Government's promise to retain Medibank. It did retain it, but only in name, by transferring the name "Medibank" to "Medibank Private", a private health insurance firm, virtually indistinguishable from other insurers, except that the Commonwealth held its equity (until it was eventually privatized in 2014). Universality, an essential aspect of Whitlam's Medibank (and later of Medicare) was gone, because people with income above a certain level were essentially compelled to hold PHI. But the government was able to say it "retained Medibank".

In the voters' collective mind the word "privatization" is less about ownership of specific entities and more about the transfer of functions to the private sector. Even when a government service is kept, if it becomes underfunded and if its quality deteriorates to the extent that people feel they have to pay more from their own pockets, or to turn to the private sector, that's "privatization".

As the Prime Minister was to admit, the Coalition had provided "fertile ground" for Labor's campaign.

Those who kept an eye on public policy noticed in 2014 the Coalition Government's Commission of Audit recommendation that "Higher-income earners should be required to insure [through private insurance] for basic health services in place of Medicare".¹⁷ Even if they did not dig into the Commission's website to find that recommendation, people were well aware of the Commission's recommendation for a \$15 compulsory co-payment, later to become a government proposal for a \$7 co-payment.

At first sight the public reaction to a \$7 co-payment appears absurd, in light of the much higher \$38 co-payment for prescription pharmaceuticals. Seven dollars would hardly cover the cost of parking or a public transport fare for a GP visit. But it was seen as a wedge to break bulk-billing, and the present freeze on Medicare payments is no doubt seen in the same way.

Similarly, those who take an interest in public policy will have noticed the freeze in the MLS threshold, and they would be aware of the report to government (the "Hambleton Report") recommending that private insurance becomes involved in financing primary care for people with chronic and complex conditions.¹⁸

Those who manage political spin for governments cleverly try to bury policy proposals in budget documents and in websites that get mounted during the Christmas period where only policy wonks will find them, but eventually the message comes out, and the message in its simple form is about "privatizing Medicare".

At the same time there is growing consumer dissatisfaction with PHI, particularly around people's experience when they come to make claims on their policies, as revealed in the regular ACCC reports on consumer experience.

There is a view, implicit in the ACCC reports, that the problems of unexpected exclusions and gap payments can be solved by the provision of more standardised and legible information at the time of purchase, so that consumers are well-informed on exclusions and deductibles. Hence the minister's gold/silver/bronze proposals.

But the ACCC also reveals broader concerns than can be addressed by better product description.

It shows there is concern about affordability of PHI, particularly in these times of tightening real incomes, revealed in Figure 4. Between 2000 (shortly after PHI subsidies were re-introduced) and 2011, per-capita Gross National Income rose by almost \$20 000, interrupted only by the 2008 financial crisis. Since 2011, however, per-capita GNI has fallen by \$2600.

Over that growth period incomes were rising at an average annual rate of 2.5 percent – almost enough to keep up with PHI price rises of 3.2 percent. But once incomes started falling, PHI started to look like a product one could do without.

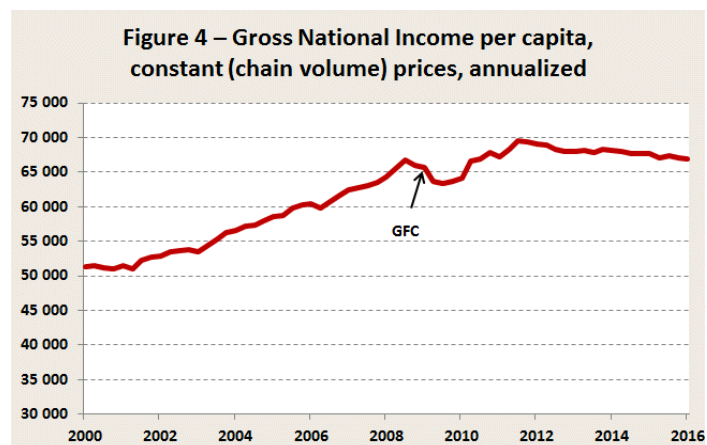
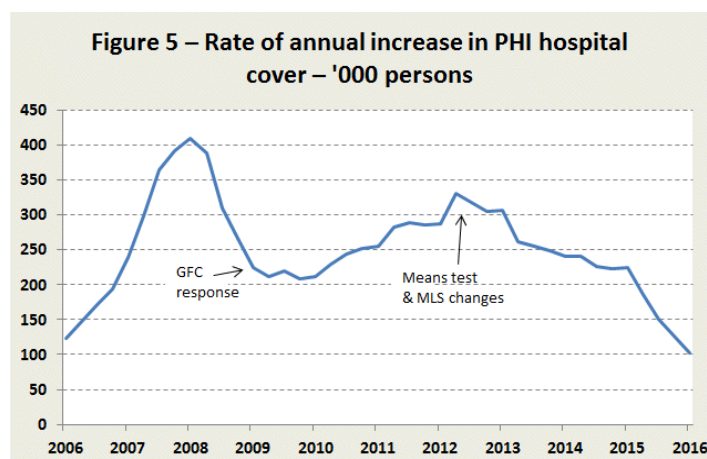


Figure 5 – a figure which is probably familiar to people in PHI marketing divisions – shows how the growth in PHI membership has been falling over the last few years. (It is now falling a little behind population growth.) Evidence of price or income elasticity is also evident in the response of membership to the GFC.

Financial incentives aren't the only factors influencing people's decision to hold PHI. When, in 1998, the ABS surveyed people's reasons for holding PHI, the dominant reason, cited by 47 percent of respondents, was "security, protection, peace of mind".¹⁹ Financial incentives hardly rated. As John Deeble put it in 2003:

[T]he "run for cover campaign" associated with "lifetime health insurance" had a dramatic effect. Its basic message was that the government could not provide universal access to an adequate standard of hospital care through Medicare and that the only way to ensure personal coverage was to take private insurance now.²⁰

Although never explicit, the message in the "run for cover" campaign, and in the ongoing promotion of lifetime cover, is that without PHI you'll be left uninsured. (Not even in the days of tariff and



quota protection did the government mount a campaign advertising Holdens and Falcons, while implicitly warning that Toyotas and Mercedes were unreliable.) “Run for cover” was probably the most successful and deceitful scare campaign a government has ever run.

Insurance is a product largely taken on faith. When we buy car or house insurance we hope we never have to make a claim. In marketing terms insurance is called a “search good”, in contrast to an “experience good” for which we can make a rapid judgement of the value of the product: restaurants, clothing and books would all be classified as “experience goods”.

The same “search good” classification holds for health insurance, particularly for the reasonably healthy young and middle-aged people who took up PHI earlier this century, many of whom would never have used it. As time has passed people have learned: some have made a claim and have learned about exclusions and co-payments (the subject of the ACCC reports); some have found, perhaps through presentation at a public hospital accident and emergency department, that they are still eligible for treatment at a public hospital; some may have done their sums and have realised that they would have been better off to have dropped PHI and have bought private hospital care from their own savings.

The other factor that may be turning the public away from PHI is the image of the industry as one more concerned with corporate profits and executive perks than health care. Medibank Private’s first half-year profit of \$228 million went down well with shareholders, and its new building is stunning in its innovative design, but the impression on policy holders is no doubt less positive. (If it meets its full-year \$470 million profit that will come to \$250 per policy-holder). And the current ACCC action against Medibank Private for alleged misleading and unconscionable conduct does nothing to bolster public trust in private insurance.

Not many years ago most health insurers were mutuals or publicly-owned, but any sense of attachment people once had for such businesses does not necessarily carry over once they become for-profit enterprises. Private health insurance firms may like to posit themselves as somehow involved in health care, but the reality is that they are financial intermediaries, and can expect no more affection from the public than is shown to the banks and general insurers.

The political process comes back to Labor’s message in the election – it may have been loud but it wasn’t particularly clear. I suggest the success of that campaign had to do with the fear that people believed they could be cajoled into taking PHI, even if they didn’t necessarily want it and would prefer Medicare as a tax-funded system.

The prevailing political wisdom among Coalition politicians and among some lobbyists is that in funding government services and reducing the fiscal deficit, the Commonwealth cannot raise taxes. The reality, however, is that among high-income developed countries, Australia has close to the lowest public revenue of all such countries (only the USA is lower by some measures).

Some policymakers and advisers to both main political parties assume that people always resist tax increases. Evidence reveals a different story. If researchers ask people “do you want to pay more taxes”, the answer is an overwhelming “no”. If, however, people are surveyed about higher taxes for particular purposes, a more complex pattern emerges. Health and education generally receive very positive responses, followed a fair way down the scale (but still positive) by support for public transport, roads and environmental protection.²¹

Australian political experience supports these findings. The Medicare Levy has generally been well-received, as has its increase to fund the national disability insurance scheme. Another example is provided by a gasoline levy of three cents a liter to fund roads, introduced by the NSW Government

in 1989. It was originally intended to last three years; hence it was known as the “3 × 3” levy and around the state signs appeared at roadworks announcing “3 × 3, your levy at work”. In the 1991 state election the opposition initially proposed abolishing the levy, but it backed off once its internal polling found that the levy was quite popular.

We should hardly be surprised that a political message of not raising taxes fails to impress when the alternative to a tax rise is an inescapable private expense to pay for the same or a poorer service. Regarding administrative costs alone, for every tax dollar saved in shifting health funding to PHI, people are hardly enthused about paying a dollar and ten cents for private insurance. Or, to take the road example, people are almost certainly more comfortable with a higher gasoline tax than having to pay road tolls. It is patronising for a government to tell the public “even though you want to pay for health care through your taxes, we won’t let you”.

A basic explanation for the public’s support for Medicare as a universal tax-funded scheme is provided by the Harvard philosopher John Rawls. He referred to our attitudes when we are placed in an “original position” – when we are asked to choose the rules on distribution in a society when we don’t know what place we will occupy. In such situations we tend to be more in favor of pooling our fortunes with others.²² (Indeed, that is the whole basis of insurance.)

In a society like Australia, rather than thinking of people as “left” (in favor of more sharing) or “right” (in favor of more self-reliance), it’s generally more informative to think about people’s different attitudes in different areas of their life. For the most part people generally go along with trusting their fortunes to markets, but when it comes to health care, where people have no reliable idea of their future needs, sharing is more likely to be the dominant attitude.

That still leaves open the question “how much do we want to share”?

Community engagement – sharing or self-reliance?

Rather than the question “public” or “private”, the basic question to be faced is the extent to which our payments for health care should come from our own resources as a normal good (i.e. without insurance) and the extent to which they should be pooled through Medicare or a similar national single insurer.

At first sight, we might infer from the rejection of the proposed \$7 co-payment and the popularity of bulk-billing that the answer is that we want a fully tax-funded free system and have developed an attachment to bulk-billing. But a contrary conclusion is supported by the acceptance of the relatively high level of co-payments under the PBS.

We cannot conclude much from these cases. As explained, the \$7 co-payment was most likely seen as the thin end of a wedge to see ever-increasing medical co-payments, probably paving the way for PHI to move into primary care. That is, effectively, the “privatization” of Medicare. And the attraction of the PBS co-payment is that it is capped and accompanied by a safety net.

It is possible that people like a free health care system as an expression of solidarity: in the UK many see their national health service as something that holds the country together, distinguishing them from Americans who have idiotic gun laws and weird ways to fund health care. It is also possible that just as people pay gym fees in an annual subscription, people like the low transaction costs associated with a tax-funded service that’s free at the point of delivery – a particularly important consideration for those who lead a life on the edge of having no immediate liquidity.

If the public seek a system that's free at the point of delivery, there would have to be attention to deal with possible moral hazard of free services, and to make sure that excessively long queuing does not become the rationing mechanism.

On the other hand the public may accept co-payments if they trust the government's intentions. In Norway and Sweden, countries with single national insurers and strong norms of social democracy, there are compulsory co-payments for health services for all but the most needy. But these are countries where people reasonably trust their governments not to hand over their successful publicly-owned insurers to PHI. Similarly in the UK its national health service seems to be embedded – to the extent that conservative politicians campaigned on the spurious basis that leaving the EU would protect the NHS.

Perhaps people would accept a reasonable level of co-payments, provided they do not impede those without means from accessing health care. A system with co-payments would need to be accompanied by a prohibition on the provision of gap insurance, which would remove the advantage of price signals and which would risk bidding up the price faced by those who pay from their own resources.

A system with substantial co-payments would be a break from the assumption that for most health services someone else – a private or public insurer – should pay the bill. That assumption would be replaced by an assumption of self-reliance for manageable expenses.

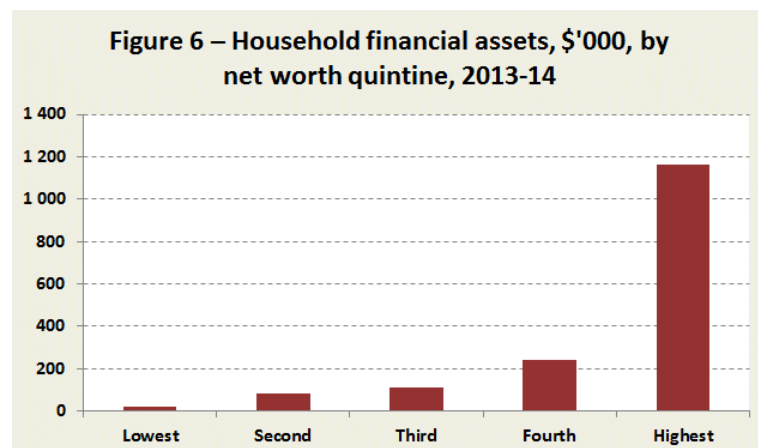
Most Australians are wealthy. Sixty percent of households have more than \$100 000 in financial assets, and the wealthiest twenty percent of households have more than a million dollars in financial assets. Most people, most of the time, should be able to cover the full cost of their health care without depending on insurance, public or private.

Those who remember the 1987 election can recall that the Liberal Party proposed a \$250 uninsurable upfront annual co-payment – about \$800 in today's terms – before Medicare picked up the bill.

It was sound policy, consistent with the Liberal Party's platform of self-reliance, but it was poorly explained. Under pressure from health insurers, they dropped the proposal.

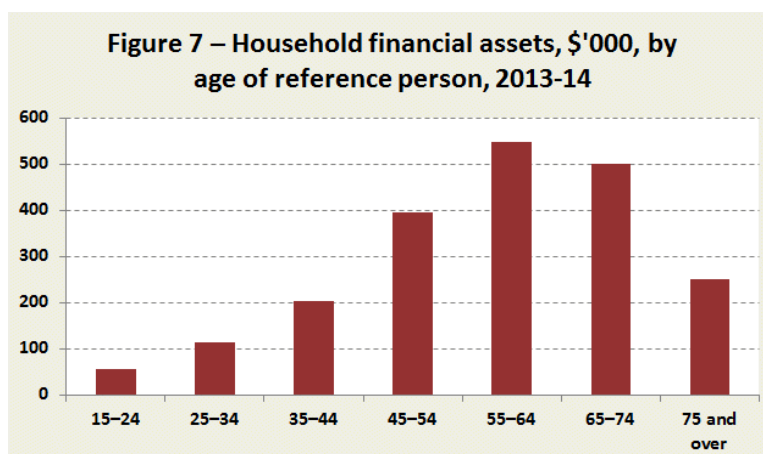
It seems that on that occasion, as now, the Liberal Party's attachment to business interests overrode their platform of self-reliance. Once an insurance premium or a tax is paid, one is dependent on some other party to finance one's health care. There is nothing more "self-reliant" about paying for PHI than there is about paying taxation. Or, to put it in more emotive language, there is little difference between dependence on the "nanny state" and the "nanny corporation".

One advantage of a reasonably high co-payment is that most people, in most years, would not be drawing on government services. (Governments would still have a role in price regulation where there is strong market power.) In view of the skewed distribution of health services, there would be



only modest savings in public expenditure in the short term, but in ensuring that people are more price-conscious it would make for more informed public opinion.

It would also place more responsibility on those wealthy older people, who, thanks to the generosity of superannuation policies, are well-off, and at present are paying little or no income tax and therefore don't even pay the Medicare Levy. On average households with people in the 55 to 74 age range have half a million dollars or more of financial assets.



The government isn't going to find out what people want, however, unless it engages in an open process of community consultation, explaining options, using independent and trusted bodies such as the Productivity Commission to analyze costs and benefits, and allowing the process to take time.

Conclusion

There is a pressing need for a thorough consideration of the way we fund health care. The fundamental question isn't about "public" or "private" – delivery of health care will always be predominately through the private sector.

Rather, it should be about the extent we pay from our own pockets and the extent we share the funding of health care through Medicare or a similar tax-funded single insurer.

There is also a need to bring PHI under thorough economic scrutiny, as has been the case for most other industry sectors. A starting point should be to expose the full cost of public support for PHI, including the subsidies built into the MLS arrangements, the transfers from young to old in the "lifetime rating" system, and any government-communicated impressions that those with means have a moral obligation to hold PHI, or that without PHI people will not be covered for health care expenses.

For many reasons – ageing, the availability of new technologies, rising expectations – the cost of health care will almost certainly go on rising in the foreseeable future. That should not be of concern. Even a modest rate of economic growth would still see areas of expenditure other than health care – education, housing, recreation and so on – growing. And it's natural that over time our areas of expenditure change: no one sees our greater expenditure on foreign travel or eating out as "problematic".

Many will make the claim that because of that rising cost we cannot afford a tax-funded insurer, but that is to confuse the meaning of "affordability". Cost-shifting does not make a function more affordable. If, as evidence shows, a single national insurer can fund health care more efficiently than a multiplicity of private insurers, then it is a *more* affordable alternative. That's the most assured way of keeping health care costs under control.

Endnotes

1. Any opinion, findings, and conclusions or recommendations expressed in this submission are those of the author and do not necessarily reflect the views of the Centre for Policy Development.
2. "Report of the Committee of Inquiry into Health Insurance", (The "Nimmo Report"), Commonwealth Government Printer 1969.
3. Industry Commission, *Private Health Insurance*, Report #57, February 1997.
4. National Health and Hospitals Reform Commission, "A healthier Future for all Australians", Final Report, June 2009.
5. Jennifer Doggett, "Out of pocket: rethinking health co-payments", Centre for Policy Development, July 2009.
6. Sidney Sax, *A Strife of Interests: Politics and Policies in Australian Health Services*, George Allen & Unwin, 1984.
7. Charles E Lindblom, "The science of 'muddling through'", *Public Administration Review*, 19, pp. 79–88, 1959.
8. The rebate is adjusted on April 1 each year by the factor $(1+CPI)/(1+Average\ premium\ increase)$.
9. In November 2014 average full-time adult ordinary time earnings, trend series, were \$1474.50 a week (ABS 6302.0), equivalent to \$77 043 a year (weekly x 52.25).
10. In November 2015 average FT adult OT earnings were \$1499.30 a week or \$78 321 a year. Five years of compound growth at 2.75 percent brings this to \$89 596.
11. The calculations are available in the submission by Jennifer Doggett and Ian McAuley, to the Department's 2015 consultations on private health insurance.
<http://www.ianmcauley.com/academic/cpd/phissubmission2015.pdf>
12. John Menadue and Ian McAuley, "Private Health Insurance: High in cost and low in equity", Centre for Policy Development, 2012.
13. ABC RN *Breakfast* "Fed Govt considers 'lifestyle factors' in cost of private health insurance: Sussan Ley".
14. In 2012-13, 199 460 Australians paid the surcharge, according to the ATO 2012-13 Taxation Statistics.
15. Australian Government, *Reform of the Federation Discussion Paper*, 2015.
16. Dr Rachel David (CEO of Private Healthcare Australia), "Rebate reduces stress", *Canberra Times*, 13 July 2016.

17. Australian Government, "Towards Responsible Government: The Report of the National Commission of Audit", 2014.
18. Department of Health, "Primary Health Care Advisory Group Report: Better Outcomes for people with Chronic and Complex Health Conditions", December 2015.
19. ABS, *Health Insurance Survey 1998*, Cat 4335.0, 1999.
20. John Deeble, "The Private Health Insurance Rebate — Report to State and Territory Health Ministers", National Centre for Epidemiology and Population Health, ANU, 2003.
21. For details of research, see Ian McAuley and Miriam Lyons, *Governomics: Can we afford small government?*, Melbourne University Press, 2015.
22. John Rawls, *A Theory of Justice*, Harvard University Press, 1971.