

A new approach to health funding

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Introduction

In these times of policy convergence between our two main political parties, the way we fund health care is one of the few remaining areas of division. In the community at large there is the paradox of strong support for Medicare alongside an increasing uptake of private health insurance. Our health funding arrangements are a hybrid, or more accurately a mongrel, embodying a compromise between two conflicting ideas about how we should share our health care costs – ideas held so strongly and unquestioningly that their proponents seem to have blocked out wider considerations of health policy.

On the ‘left’ are those who stand up for Medicare as a universal, free, tax funded system, while on the ‘right’ are those who would see private insurance take over the dominant role in funding health care. A stark binary choice between two entrenched positions.

The conflict between these ideas has been like Europe’s Hundred Years War of the fourteenth and fifteenth century, with advances and retreats over the years, and long periods of truce, but without any decisive victory. In health care the fight has been going on for almost 70 years without any signs of resolution.

In 1945, as Australia addressed the task of postwar reconstruction, the Chifley Government proposed a national health scheme, entitling all Australians, regardless of means, to free medical care – very similar to Britain’s National Health Service also under development at the time. That was headed off by a concerted campaign by the medical lobbies on the basis that it would involve ‘civil conscription’. In 1973 the Whitlam Government fought a huge battle to introduce ‘Medibank’, which became one of the pieces of legislation passed in the 1974 double dissolution election. (Anyone who thinks Gillard had a hard time getting legislation through Parliament should spare a thought for Whitlam.) The Fraser Government demolished Medibank as a universal insurance scheme (retaining the name for a government-owned but corporatised private insurer). Medibank was restored by the Hawke Government under the name ‘Medicare’. The Howard Government, elected in 1996, restored tax breaks for private insurance, which were only partially wound back – again after a hysterical campaign about an ‘exodus’ from the funds – by the subsequent Labor Government.

These were the major conflicts. There have also minor skirmishes such as those around the Menzies Government’s 1960 introduction of a five shilling co-payment for previously free pharmaceuticals – a figure which equates to about \$7 in today’s terms, and the Hawke Government’s 1991 introduction of a compulsory co-payment for medical services under Medicare, reversed the following year by the Keating Government.

Each side in the conflict has tried to hold ground, supported by strong beliefs. As is the case with so many long-enduring conflicts, the protagonists get bogged down into rigid

'positions'. They lose sight of their original principles and objectives and therefore they lose sight of opportunities for solutions which may satisfy both sides' principles.

We trust that we can express these principles and objectives clearly.

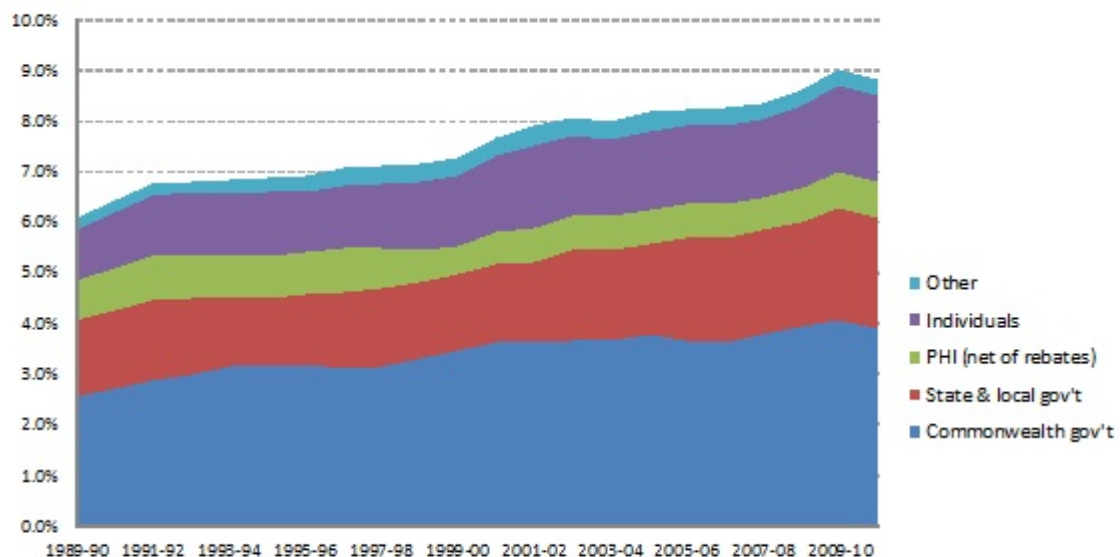
The 'right' and its myths

The strong principle of the 'right' has been around the need to support 'personal responsibility', to use the words of the Liberal Party platform. There is also concern about the fiscal impact of health spending, which, according to the most recent projections in Treasury's *Intergenerational Report*, will see Commonwealth spending on health care rise from four per cent of GDP at present to seven per cent of GDP by 2050. Taken as beyond question is the idea that when there are so many other demands on public budgets, and taxes are already such a heavy burden, that expenditure must be reduced.

Curiously there is little research which supports this position on health funding. It appears to be based more on a belief in the general principle of small government, and the greater efficiency of the private sector than on any actual research.

Advocates from the 'right' are correct that health care costs are rising. Figure 1 shows the sources of recurrent health care expenditure over the 22 years to 2011 – the period for which reliable data is available. (The rise and dip over the last two years results more from volatility in the GDP than any trend in health expenditure.)

Figure 1: Recurrent health expenditure as a share of GDP



Source: Derived from AIHW *Health Expenditure* publications and ABS *National Accounts*. Excludes capital expenditure and aged care expenditure

However, as often pointed out by John Deeble, one of Medibank's two main designers, there is no reason to be worried if our health expenditure is rising. As a proportion of our income we spend more on eating out and travel and less on clothing and food than we used to, but that is no cause for alarm; shifting expenditure is a feature of economic life. If, in round terms, health care expenditure were to rise from 10 per cent of GDP to 20 per cent of GDP between now and 2050, unless economic growth were miserably low the remaining 80 per cent of GDP in 2050 would still be higher than 90 per cent of GDP in 2013. In other words, a growing economy should be able to cope with growing health care expenditure without sacrificing other needs.

More basically, the often-stated argument that we must cut government expenditure on health care because it is becoming unaffordable has no logical basis. Shifting costs off-budget (for example, to individuals in the form of co-payments or through private insurance), in itself, does nothing to save health care costs, and, if it results in more expensive bureaucratic expenditure or less efficient allocation of resources it may actually increase the community's total costs. The *Intergenerational Report* would be a useful contribution if it covered all health expenditure, including state government and individual expenditure, but in its present form it is no more than a shallow fiscal projection laying the ground for cost-shifting – as if the interests of the government and the community which elects it are separate.

In particular, shifting health expenditure from public insurance to private insurance is simply shifting from one re-distributive mechanism (the tax and expenditure system) to another (the health insurance system), which can properly be described as a 'privatised tax'. As we have pointed out, in research for the Centre for Policy Development and other organisations, private health insurance is a very expensive and inequitable way to share health care expenditure.

In administrative costs alone it is expensive. Of every dollar spent through our taxes to fund Medicare, 94 cents is spent on health services. Of every dollar spent on private health insurance, only 84 cents is spent on health services. Only one who holding an Orwellian 'private sector waste good, public sector waste bad' could justify a preference to see private insurance take over the distributive role of Medicare.

The greater cost of private insurance stems from the dynamics of markets distorted by the presence of insurance. Insurance of any kind, public or private, carries what economists know by the quaint term 'moral hazard'. That is, the tendency for people to use more of a service when it is free or subsidised at the point of delivery than they would if they were paying from their own pockets. It applies to both patients and to doctors suggesting services, and is amplified in health care by consumers' tendency to over-estimate the effectiveness of therapies while under-estimating their non-financial costs, such as the risk of infection or long periods of convalescence.

A single national insurer has the capacity to contain moral hazard through usage and price controls, but when there are competing insurers such stringency would be a marketing disadvantage: an insurer who refused to cover a popular but ineffective therapy would lose business to competitors. And, so long as certain resources such as surgeons are in short supply, hospitals can use such short supply to their advantage to demand high prices from insurers.

That's why we find that among prosperous countries like Australia, the more countries entrust health insurance to the private sector, the more do those countries spend on health care, without getting any better health outcomes.

The standout example is the USA, where private insurance accounts for 40 per cent of health funding and total health expenditure is now 18 per cent of GDP – twice the proportion of other countries, whose expenditure is in the range of 8 to 10 per cent of GDP. In other words, the American Government spends on health care as much as or more than the Nordic countries – which, for those outlays, provide good quality care without the need to rely on private insurance. Allowing private insurance to dominate the market, because it has let providers' costs rise, has made health care twice as expensive as it need be, and hasn't saved any government money.

It is hard to understand the right's attraction to private insurance. It makes no economic or policy sense. Perhaps it is explained by the politics of appeasing those who might complain if privilege is withdrawn. Private health insurers are now receiving a massive public subsidy of \$7 billion a year (\$5.6 billion in direct subsidy and \$1.4 billion in income tax on benefits foregone), and, unlike most other industries, has never been subject to a study by the Productivity Commission to assess the justification for support. (A 1997 inquiry was simply about how to subsidise private health insurance, not whether it should be subsidised, and the Rudd Government's Health and Hospitals Reform Commission explicitly assumed that there was to be no change to the mix in health funding.)

Perhaps it stems from a deficit in imagination – a difficulty in seeing any way to fund private hospitals other than through private insurance. We find that whenever we criticise private insurance in public forums our views are represented as a call for the private hospital sector to be shut down. It has been convenient for private insurers to shelter behind the false idea that without private insurance there would be no private health care industry, and to allow to develop the image of some soviet-style 'socialised' system in the absence of private insurance. But we are talking about who funds health care, not who provides it. And we are not talking about denying 'choice'. To consumers choice of therapy is important, but there is little benefit in having choice of high-cost look-alike private insurers.

Perhaps those on the 'right' have become convinced by their own propaganda about Australia being a high tax country, when, in reality, we are one of the lowest taxed of all developed countries. Of course there is community resistance to higher taxes, but there is a good deal of research and practical precedent (such as easy acceptance of the national disability scheme surcharge) to show that people are willing to accept tax increases when they know they will be directed to a desired service.

Perhaps the 'right's' attraction to private insurance is simply rooted in the notion that the private sector always does a better job than the government because it is subject to the discipline of the market. But, as any first year economic student knows, that discipline operates through the price mechanism, and insurance, by its very nature, suppresses price signals. People insure to buy out of the discipline of markets. And many other conditions of competitive markets, such as the idea that consumers are well-informed, are absent from health care.

Whatever the reason, those on the ‘right’ seem to have difficulty in accepting the evidence of the failure of private health insurance to control costs and to provide meaningful choice. Currently in vogue, waiting for a government willing to expand the role of private insurance, is a proposal from the health insurance industry called ‘Medicare Select’, which would see a virtual conscription of the population into private insurance. Funds collected through the tax system would be re-allocated to people’s ‘choice’ of health insurer, one of those insurers being a publicly-owned insurer. That publicly-owned insurer would be just another corporation, perhaps retaining the name ‘Medicare’ in the same way as the Fraser Government retained the name ‘Medibank’ for the government-owned private insurer.

Medicare Select is based on a similar system introduced into the Netherlands, but its proponents have ignored the evidence emerging from that country. Over the four years following introduction of their scheme in 2006, health care expenditure rose from 9.7 per cent to 12.0 per cent of GDP – a measure second only to the USA where private insurance has had 70 years to wreak its damage. And, while the Dutch have the ‘choice’ of insurer – a fairly meaningless choice when one does not know what one’s future needs will be – they are finding they have less choice of provider than they had under the old system which was more like our Medicare.

The ‘Left’ and its myths

Compared to the ‘right’, the ‘left’ has been more concerned with the social equity of health care. The costs of health care fall unevenly and unexpectedly. Even small unexpected outlays, such as the need to attend to a child’s infection, can be an intolerable burden for someone living from pay-to-pay, and large outlays can be ruinous even for the well-off. Whatever our general attitudes to self-reliance may be, we tend to be more socialistic when it comes to health care because we don’t know our future needs. In the terms of Harvard philosopher John Rawls, when it comes to health care we are in what is called an ‘original position’ where we don’t know our future needs or resources.

The ‘left’ view is supported by research which shows that direct payments for health care, particularly payments for initial services, discourage early diagnosis and attention to conditions which, if untreated, go on to have major and expensive consequences. Research also shows a strong correlation between poor health and poverty, although the direction of causality is disputed. And there is a more general argument that shared health care is an important aspect of ‘social solidarity’, although this notion is more strongly developed in other countries than in Australia.

However, those on the ‘left’ who so vigorously defend free bulk billing, and who protest at every increase in co-payments, overlook two key facts. Firstly, that there is no such thing as a ‘free’ health system (whether through taxes, insurance or co-payments we still pay for our health care). Secondly, most countries today require direct contributions from individuals for their health care. Even in the Nordic countries with long traditions of generous social spending individual payments still make a significant contribution. What distinguishes them more starkly is the almost complete absence of dependence on private insurance, as shown in Table 1.

Table 1: Expenditure on health care by source: Australia, USA and Nordic countries

	Government	Out of pocket	Private insurance and other	Total	Expenditure on health as percentage of GDP
Australia	67.5	18.6	13.9	100.0	9.1
Denmark	85.1	13.2	1.7	100.0	11.1
Norway	84.1	15.0	0.9	100.0	9.4
Sweden	81.0	16.8	1.2	100.0	9.6
USA	48.2	11.8	40.0	100.0	17.6

Source OECD 2013. 2010 or latest year.

In opposing the introduction of new direct contributions to health care, the ‘left’ argues that this will reduce access to essential care and erode the value of public health services, resulting in a two-tier system with the public system delivering second-rate care. None of these arguments are necessarily true. They also ignore the fact that when some forms of health care are quarantined from even modest co-payments (public hospitals, bulk billed GP services), funders will seek larger individual contributions from other services, resulting in a system of co-payments that is illogical, inefficient and inequitable.

This is the situation with our current co-payment arrangements, as pointed out by Jennifer Doggett’s work for the Centre for Policy Development ‘[Out of pocket: rethinking health copayments](#)’. Someone with an ongoing chronic condition may have to spend several thousand dollars a year from their own pocket for health care, while people whose needs can be satisfied by bulk-billing practitioners and free public hospitals pays nothing. Some co-payments, such as those for pharmaceuticals, are capped, while many others leave the consumer bearing a high and open-ended risk. The original vision of Medibank was as a universal insurance scheme, but it has drifted in its purpose to become more a scheme to help people cope with health expenses – in some areas giving generous support, while in others leaving consumers with open-ended risk..

There is a good case for reform of co-payments. This should include the option to introduce new co-payments in services which are presently free, such as public hospitals, unless there is a clear case to oppose them. Those who oppose specific co-payment proposals should be encouraged to look more broadly at the distributive and economic consequences of the whole way we fund health care.

The need for a different approach

The basic flaw in both ‘right’ and ‘left’ thinking is that when it comes to health care there is the idea someone else will pay the bill. To the ‘right’ that someone else is a private insurer; to the ‘left’ it is the government. Those who so strongly argue against the paternalistic government ‘nanny state’ and who call for personal responsibility and self-reliance, fail to see

that the private insurer is simply a corporatised version of the ‘nanny state’. There is no difference in the notion ‘Medicare will pay for it’ and the notion ‘HCF/NIB/Medibank Private will pay for it’.

If the two sides can get away from their positions of ‘health insurance’ and ‘free public health care’ we might make progress towards policies which satisfy both the right’s desire for personal responsibility and the left’s desire for social equity. In the language of negotiation experts, there is a lot of money on the table.

The assumption of a third party payer was probably a reasonably robust one in 1945 when Australians were much poorer.

But even if the combatants in this 70 year old war don’t realize it, the world has changed. Australians are wealthier than ever before, and, particularly over the last five years, have started saving again. That’s in addition to the balances they are accumulating in superannuation.

In 2009-10 the average financial wealth of Australian households was \$234 000, of which half was in reasonably liquid assets – that is, not including superannuation. Even households in the middle income quintile had about \$30 000 in liquid assets. And couple households aged 65 or more had on average \$350 000 in financial assets, all of which would be reasonably liquid, because they face no restriction on withdrawal of superannuation.

When this data on financial assets is combined with data on health service utilisation, which shows that in any one year most people make very little use of health services, it is a reasonable proposition that most people, most of their lives, could pay for all of their own health care needs without the assistance of any form of insurance, public or private.

Clearly, those not able to afford their health care costs (either because of high health care needs or low levels of liquid assets) would need to be subsidised but this would be a minority of the population.

This would leave a role for health insurance to provide cover only for unexpected and unlikely health care expenses with other minor and more predictable expenses becoming part of households’ normal budgeting. This is similar to the way we insure our cars for theft but not for regular services and tyre changes.

A potential solution

By re-defining Medicare as a genuine insurer (rather than a co-funder) of health services, the benefits of individual autonomy and responsibility and the discipline of the market within the health sector can be maximised without compromising the universality and equity of our public health system. This can be achieved through requiring all individuals with the means to do so to meet the ‘average and predictable’ costs of their health care themselves, with Medicare covering only those costs above these .

This re-definition of Medicare would take a degree of political nous and careful engagement with the community. Consumers would need to understand that this change would give them greater power and influence over the allocation of health resources than they have currently

and therefore would have the potential to drive changes within the health system that benefit users rather than providers. It would also need to be supported by clear principles for our health system which articulated a commitment to universal access and equity. Otherwise, those on the 'left' would see it as a retreat and would be no less opposed than they were in 1987. And the health insurers, once they realise that this is a philosophical shift from 'insurance' to self-reliance, would oppose it, even if their subsidies were initially untouched. The fiscal hawks of Treasury would not necessarily be in favour, because it would not result in large budgetary savings in the short term: because of the skew in health expenditure towards heavy users and towards those of limited means who would necessarily be exempt from upfront payments, any realistic safety net would not result in an immediate budgetary saving.

Its benefits would be longer term, however. It would condition people, spending their own money, into making more careful choices, and becoming more aware of the costs of health care. It would help dispel the idea that whatever bad choices people make in their lives about smoking, alcohol, diet or exercise, there is someone – a public or private insurer – ready to pick up the tab. It may bring some discipline to those areas of health care which operate as high-cost cottage industries. It would reduce transaction costs throughout, and would allow governments to focus their attention on those whose needs are heaviest, for at any one time most people would be outside the fiscal reach of government programs. Most importantly, it would pave the way for the phasing out private health insurance in favour of a single national insurer. This would deliver a mechanism for sharing those health costs which are beyond our individual means that maximises equity, efficiency and individual choice – a goal that should be supported by those from both the 'left' and the 'right' of the political spectrum.