

## A caller from Tusmore: Clarifying the issues in private health insurance

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Every teacher knows what it's like to lose a class, when the content isn't getting through. I had such an experience when I was the so-called "expert" on a radio talkback program in Adelaide. The topic was private health insurance, and there was a steady stream of callers, mostly recounting their negative experiences with insurers and hospitals.

Some callers complained about premium price rises. One complained that although he had not made a claim in 14 years he couldn't get a no-claim bonus. One caller, who didn't hold private health insurance, was indignant that he had to pay full price for his dental care, while high income "bludgers" got a 30 percent subsidy for their dental insurance. Some complained about excess payments: they were incensed to find that because they were "insured" they faced extra payments.

As the "expert", I was trying to pull these threads into some general observations on public policy, showing why support for private health insurance was bad policy, but my own academic conditioning was getting in the way; I was slipping into abstract terminology such as "technical inefficiency" and "resource misallocation". Although my case was strong, only the small minority of daytime radio listeners familiar with economic analysis would have had the slightest understanding of what I was talking about.

Rescue came from an unlikely quarter. The last caller was a lady from Tusmore (a genteel and leafy suburb), with an accent that removed any doubt about the veracity of her postcode.

"I've been listening to that academic chappie talking about private insurance, and to all those people complaining. I disagree entirely. I have private insurance, and just two months ago I needed surgery. There was a huge waiting list in the public hospitals, but with private insurance I was able to get treated straight away; I was brought right up to the front of the queue. It was wonderful for me, and it would be wonderful for all those who now have to hang around in queues. I think everyone should have private insurance."

Only a few seconds remained of the program, and the presenter asked if I had any response. All I said was to thank the caller for explaining what was wrong with private insurance – with a clarity which had eluded me over the previous twenty minutes.

When we use supermarkets, airline check in counters and banks, we take a dim view of queue jumping. Much of the rhetoric about border protection is about "queue jumping". Yet when it comes to health care, not only is queue jumping approved by public policy, but it is actually encouraged through tax breaks and subsidies, and, more extraordinarily, the higher our income the stronger is that encouragement because of the Medicare Surcharge Levy.

If Australia were a plutocracy, governed by and for a small rich elite, this support for private insurance may be understandable, if not morally justifiable. But, last time we checked the brand name, we had a Labor Government, with a Minister for Social Inclusion. How does a policy of social inclusion sit alongside what is essentially an encouragement for the well-off to live in a gated community? And what has happened to Labor's clear thinking of the 1970s and 1980s when it fought so hard to introduce Medibank and Medicare, understanding that only a single national insurer can protect us from the inequities and waste that have dogged other countries, particularly the USA, which rely on private health insurance?

## Political explanations

One possible explanation is that the Government is afraid of alienating the 45 percent of the population who hold private insurance. But to assume high membership is synonymous with popularity is an error. If, through fear, or in a belief they can buy protection, many people are paying money to an extortionist, that doesn't mean people approve of extortion. Similarly for private insurance; its membership is supported by extraordinary financial incentives and by fear – a personal fear that without private insurance one is denied access to health care, and a general policy fear that private insurance is all that protects us from a North Korean style health care system. Insurers and their advocates perpetrate a deceitful notion that without private insurance we would be left with some dystopian “socialised medicine”.

But private insurance is simply a means of *funding* health care; we can have a thriving private hospital system *delivering* health care without private insurance. Without private insurance all we would lose is a bloated (and heavily subsidised) financial intermediary, costing \$1.8 billion a year in bureaucratic overheads and profits.

Another explanation is that the present Government is simply carrying on the policy of the previous Coalition Government; indeed, in the 2007 election campaign, in a major departure from previous policy, the Labor Party promised to maintain the rebates for private insurance.

Even if that explanation holds, however, it begs the question why the Coalition is so enthusiastic about private insurance. On coming to office in 1996 they went to extraordinary lengths to support private insurance. A year after being elected, in 1997, they introduced the 30 percent subsidy and the one percent Medicare Levy Surcharge on those with annual incomes above \$50 000 (equivalent to about \$80 000 now). Even though, on introducing the levy, the Treasurer said “This is the levy which the Government hopes no-one will pay”, these incentives failed to lift membership of private insurance. Two years later the means test was abolished, but there was only a feeble response. Then, in 2000, the Government introduced “Lifetime Rating”, whereby premiums rise by two percent for every year a person aged 30 or more fails to take up private insurance – effectively an incentive for the young and well to subsidise the old and unwell (adding to the already high burdens young people bear to provide for older people). At the same time there was the publicly-funded “Run for Cover” advertising campaign. Those measures were effective, in that private insurance membership quickly rose from around 30 percent of the population to 45 percent, where it has remained since.

It was clear that subsidies alone didn't work. If people rightly consider a product to be useless, then no amount of subsidy will encourage them to buy it. Harsher measures had to be used. Researchers differ in their analysis of the reasons for the effectiveness of the 2000 changes, however. Was it "Lifetime Rating" or "Run for Cover"?

The distinction is unimportant, for both are based on fear. Research in behavioural economics shows that fear, no matter how irrational, rather than calculation of risks, costs and benefits, drives demand for insurance of all types. A 1998 Australian Bureau of Statistics (ABS) survey found that half of those who held private insurance did so for "security, protection, peace of mind", while the financial incentives then in place hardly rated (only one percent of respondents nominating "Government incentives/to avoid extra Medicare levy").

The fear campaign was extraordinary, in that it was based on undermining confidence in the public hospital system. We could hardly imagine a state government urging us to hire private security guards, because the police force is underfunded and incompetent, but that was the message when it came to health care.

Although the present government has discontinued such advertising, it has done nothing to counter it, and, in retaining and strengthening incentives for people to hold private insurance, it implicitly supports the message. In my own contacts with students and other young people on limited incomes, I have been dismayed to find that many are struggling to pay for private insurance because they are unaware that we have a free public hospital system, but on reflection, this is understandable, for no state government has any incentive to publicise this fact.

To return to the question why the Coalition supports private insurance, one's first response may be to say that it's obvious that the Coalition, particularly the Liberal Party, supports private markets over monopoly government services, and prefers choice to centralised allocation. Private markets, however, work mainly through the mechanism of price signals, and insurance, by its very nature, suppresses price signals. People buy insurance to remove from their lives the discipline of price signals. There is no difference in the thinking "Medicare will pay for it" and "HCF/MBF/Medibank Private will pay for it". That thinking, known by insurers by the quaint name "moral hazard", means there is an incentive on patients to over-use a service, and there are incentives on providers to over-service and to over-price, when another party, an insurer, is paying the bill. Similarly with "choice". Most markets thrive on choice, but health insurance, if it is not to run out of control, has to be so heavily regulated that there is little choice between competing firms. Financial services, such as health insurance, cannot offer the sort of choice we enjoy when we buy food, cars or CDs; at best they can offer choice of brand name, but in reality it's "choice" without variety.

Private insurance is not a "market" solution to funding health care. To use the language of economic libertarians, the "nanny corporation" (the health insurer) replaces the "nanny state", without the benefits that single national insurers can bring to the market.

The Liberal Party's platform says that Party believes in "the need to encourage initiative and personal responsibility", but its support for private insurance goes right against its stated philosophy, most notably in the Medicare Levy Surcharge, which places a high penalty on high income earners who do not hold private insurance. It is no credit to the present Government that it is increasing this surcharge, but it is downright contradictory for the

Liberal Party to have introduced it in the first place, for higher income earners are the very people who could take more personal responsibility for their health care and pay for much more themselves without insurance.

According to the most recent ABS survey on wealth, households in the highest 20 percent of income (with annual incomes above about \$140 000) have on average more than half a million dollars in financial wealth (i.e. excluding housing). About \$200 000 of this is in superannuation, but that still leaves \$300 000 in liquid wealth, and, in any event, those aged 60 or more can consider their superannuation to be liquid. A sum of \$300 000 could cover everything up to and including a heart transplant, and replacement of all moving joints into the bargain.

In fact, before private health insurance membership rose in 2000, 25 percent of admissions to private hospitals were by people funding themselves without insurance. By 2006-07 that proportion had fallen to 12 percent. It's ironic that a result of the Liberal Party's policies was to stamp out this vestige of self-reliance. And, by any concept of distributive justice, it's indefensible that those who are well-off should be subsidised between 30 and 40 percent for dental and other ancillary services, while those with lesser means who pay for these services from their own resources have to pay the full amount. (At least the Government's means testing of the rebates will partly remove this distortion.)

From the ideological principles of the Liberal Party, support for well-functioning private markets, where prices help inform consumer decisions, and where there is genuine choice between alternatives, makes good sense. But support for the private sector as an end in itself, even when these conditions do not hold, is at best a confusion of means and ends, and at worst is a mirror image of the ideologically rigid doctrine of Soviet politicians who saw all good in central planning and all evil in private markets.

## **Pragmatic explanations**

If these political explanations do not hold, is there a pragmatic budgetary explanation for supporting private insurance?

There is a glib appeal in the idea that in supporting private insurance some pressure can be taken off public hospitals and that governments can save on their budgetary outlays.

It is correct that, since there have been subsidies for private insurance, a greater proportion of people have been using private hospitals. But that doesn't mean public hospitals have been relieved of pressure, for where the money and patients have gone, so too have the resources – particularly medical specialists and nurses. In some cases they have physically moved to private hospitals, and in others they have benefited from the more generous payments offered by the private sector, which public hospitals, with constrained budgets, have tried to match.

Also, the incentives embodied in private insurance have expanded the market for health care, with a high growth in elective services, such as joint replacements and caesarian deliveries. While low priority services are being performed for those with health insurance, those resources are not available for people with greater needs in public hospitals. That goes beyond queue jumping; it actually slows down the whole queue. (Imagine if, at a bank, the

tellers gave privileged attention to those disorganized customers who not completed their documentation, allowing them to jump ahead of other customers.)

Long waiting times remain a problem, because private insurance has sucked resources out of public hospitals.

Only if Australia had an excess supply of surgeons and nurses, would the notion of relieving pressure have some validity. In any event, if the policy aims to support private hospitals, there is no justification in churning funds through private insurers, who cream off 15 percent of income in overheads and profits.

Perhaps there may be some budgetary relief if, because of private insurance, people were to pay more for their own health care. Those who mount such an argument, including many staff in the Treasury Department, fail to understand that, painful as taxes may be, they are no more painful than private insurance, and taxes are much cheaper to collect. Using private mechanisms to pay for collective goods such as health care, is essentially privatising the operations of the Australian Taxation Office. Official taxes have a distinct advantage over privatised taxes, in part, because the ATO does not have to pay a profit to shareholders and does not have to advertise its services in competition with rivals.

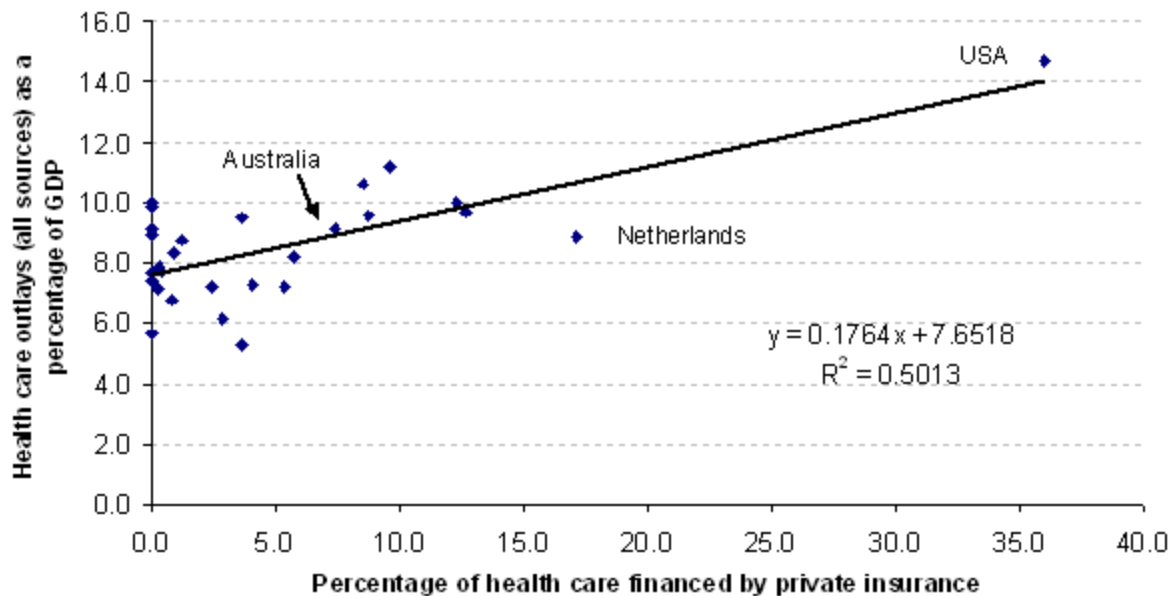
Private insurance advocates point out that an ageing population will require more expenditure on health care. That is correct, but they then go on to say that, in order to relieve the burden on taxes, private insurance will have to play a greater role in funding health care. That is illogical, for the insurers, in reality, are part of the tax system – an inefficient and inequitable part of the tax system. If we can afford to pay taxes to private insurers we can more easily afford to pay taxes to the ATO.

Besides administrative costs there are other advantages in using official taxes rather than private insurance to fund health care. One is that official taxes are “community rated” – that is, we all pay taxes in accordance with principles such as our ability to pay. It’s much easier to sustain equity in official taxes than in mechanisms such as private insurance. In private insurance there is always the opportunity to practise “adverse selection” – that is to take out policies with a high chance of being advantageous to the customer. One example is what is known as “hit-and-run”, whereby one with an expected need for elective care takes insurance just long enough to cover the episode. Another, resulting from the perverse incentives of the Medicare Surcharge, is for high income earners to take a minimum policy (costing about \$700) to avoid the surcharge, and never using it. Efforts to achieve community rating in private insurance are at best complex (involving reinsurance mechanisms and varying levies) and at worst ineffective.

The worst aspect of private insurance, however, is its inability to contain costs. As the OECD has said of Australia’s health insurers:

Private funds have not effectively engaged in cost controls. They seem to have limited tools and few incentives to promote cost-efficient care, and there are margins for some funds to improve administrative efficiency, thereby reducing administrative costs. PHI appears to have led to an overall increase in health utilisation in Australia as there are limited constraints on expenditure growth. Insurers are not exposed to the risk of managing the entire continuum of care.

**Figure 1. Total health care outlays and private insurance, OECD countries 2002**



The Medicare subsidy to private in-hospital medical treatments has also reduced funds' accountability for the real cost of private care. Policies to reduce medical gaps have led to some price increase and may have enhanced supply-side moral hazard incentives. Finally, the rebate on PHI premiums has posed pressures on public cost, as it represents tax resources that have alternative uses. [Francesca Colombo and Nicole Tapay "Private Health Insurance in Australia: A Case Study" OECD 2003.]

Similarly, just last year, Michael Armitage, CEO of the Australian Health Insurance Association, said:

They [private insurers] are going to be faced with a huge tsunami of costs for the ensuing twelve months, over which they have no control. They have to go to their fund members and say "we need more money".

To be fair to the Australian health insurers, their powerlessness in controlling costs is one faced by private health insurance companies around the world, because they are mere conduits for costs imposed by service providers. Public insurers, by contrast, can use their market power to exercise price and utilisation control, thereby lessening the moral hazard of health insurance. Among developed countries, there is a strong correlation between countries' total health care expenditure and the proportion of expenditure financed through private insurance. (See Figure 1.)

There is little variation in health outcomes in different OECD countries. In fact the USA, which has by far the greatest dependence on private insurance, has some areas of very poor health performance. Private health insurance buys more expensive health care but it doesn't buy better health care.

While other OECD countries contain health care costs to the range of 8 to 10 percent of GDP, in the USA health care costs now take 15 percent of GDP. Because health insurance, for the most part, is paid by employers, its high cost is contributing to the woes of large firms, such as General Motors. Around 50 million Americans, unemployed, self-employed or employed by businesses without health care agreements, are uninsured, covered only by the publicly-funded Medicaid program, and the Medicare program for older Americans. These programs, particularly Medicaid, are parsimonious in comparison with the universal programs of other developed countries, but, even so, they are now costing the US Government seven percent of GDP, about the same as European and Canadian governments pay for universal and generous coverage through single insurers, and costs in the USA are rising at an alarming rate.

The problem in the USA is that, having let private insurance dominate the market, the government is a passive agent in a market with inflated prices. It's little wonder that health reform is a priority of the Obama administration, and that American opinion leaders are calling for a Canadian or European-style single-insurer model. But here we are slowly drifting to the USA model: another five percent of GDP would cost every household \$8000 a year, dwarfing the much talked about burden of repaying the debt of the current stimulus payments.

Besides exercising controls on price and utilisation, a single insurer has a strong incentive to engage in health promotion and illness prevention, because doing so can reduce its outlays on claims. When there are multiple private insurers, there is a financial disincentive for such activity, for if a firm does spend money on promotion or prevention it incurs the costs while most of the benefits go to its competitors.

Private health insurance is an expensive, inequitable and ineffective way for people to share their health care costs. It's not that the insurance firms are badly managed or greedy; in fact, by comparison with general insurers, they are remarkably efficient. But the model simply doesn't work.

It is strange that our Government persists with its support for private insurance, particularly in view of the struggle previous Labor Governments have endured in introducing Medibank and Medicare. Its most recent move to increase the Medicare Levy Surcharge to 1.5 percent further entrenches "two tier" health care, and penalises those on medium and high incomes who prefer to share their health costs with other Australians, rather than escaping to the gated community of private insurance. That does not tie in with a policy commitment to "social inclusion". Nor does it tie in with rhetoric about "universalism".

And it's strange for the Opposition to persist with its support for private insurance. Just after the Budget was brought down, the Opposition Leader, in what may have been an unguarded statement, said "In my Australia everyone would have private [health] insurance." [Malcolm Turnbull ABC radio 15 May] It may be excusable for a caller on talkback radio to fail to recognise the mechanics of queue jumping, and the problems of moral hazard, but it's inexcusable for a contender for the position of Prime Minister.

## **Administrative explanations**

The present government went to the 2007 election promising health care reform, but, once in office, it became timid. It appointed a Health and Hospital Reform Commission, but its

interim report, released in late 2008, does no more than recommend some incremental changes and fails to acknowledge the problems associated with private health insurance. In one place it says, without any supporting evidence or argument, that the Commissioners “want to see the overall balance of spending through taxation, private health insurance, and individuals’ out-of-pocket contributions maintained.” In its conclusions, particularly its “Option C”, it advocates compulsory enrolment in private insurance, based on the naive assumptions that these financial institutions can somehow transform themselves into care coordinators and that people are incapable of managing their own health care.

The Commission is not the path to reform. Its members are too enmeshed in health insurance and program delivery to take a broad view. They cannot see the contradictions in funding arrangements, the lack of integration between programs, or the distortions introduced by private insurance.

The Government itself displays little understanding of or competence in health economics. Treasury seems to be too concerned with short-term budgetary outlays rather than long-term economic performance, and lacks an understanding of the moral hazard of private insurance. The Department of Health and Ageing has some areas of economic competence, but it seems to be incapable of looking at health care broadly – it sees health care as a number of unconnected programs, such as hospital funding, the Pharmaceutical Benefits Scheme and the Medical Benefits Scheme, a program structure based on provider rather than consumer interest, and which gives providers an easy platform to pursue their self-interest.

In particular the Department cannot break from the mindset that private hospitals must, of necessity, be funded by private insurance. It would be fair to say that the Department officials and others advising the Minister suffer a deficit of imagination. They are incapable of imagining anything beyond a few incremental changes, and are terrified of alienating interest groups.

Within the Commonwealth there is one agency, however, the Department of Veterans’ Affairs, which operates on a well-integrated single insurer model. It is a public funder, but it purchases most of its services, including most of its hospital services, from the private sector. We don’t have to look to Canada or Europe for a successful single insurer model; we have one here. But each government agency is so isolated that there is little chance for public servants in Treasury or Health and Ageing to learn from this experience.

## **Conclusion – towards reform**

If we are to have reform of health financing we need to expose some untested assumptions and to engage the community in some basic questions. At present health financing is seen in terms of a traditional “left/right” issue, with the right supporting private insurance and the left supporting “socialised medicine”. Politically there are only two camps – Medicare and private insurance.

The fundamental question we should be asking, however, is about the extent we wish to pool our health care expenses with other Australians. How much should we fund collectively, through insurance, and how much should we fund personally? That is, from our own savings, without the support of any public or private or public insurance.



There are coherent arguments for a completely free system, and there are coherent arguments for a system with much more individual responsibility where consumers make decisions with their own money at stake, rather than the open cheque books of public or private insurers.

There is no coherent argument, however, for the current mess of private insurance, free services, capped co-payments (prescription pharmaceuticals), open-ended co-payments with partial safety nets (medical services), free services (public hospitals), unsupported services (dentistry for those without insurance, non-prescription pharmaceuticals). Such a mess encourages resource misallocation, with people attracted to services which are free at the point of delivery (through public or private insurance) and under-utilisation of other potentially more efficient and lower-cost services. This mess of funding arrangements and its consequences are obvious to any outside observer, but not to those within their own public and private organisations – all trying to make their own program work, but lacking any encouragement for taking a system-wide view. And there is no coherent argument for separate channels of funding for private and public hospitals.

Australians have a capacity for fundamental reform. We have demonstrated as much with massive changes in our industry policies in the 1980s, with tariff reductions and financial market reforms. And in the 1990s we undertook a huge overhaul of our indirect taxes. But on health care we seem to be stalled, captured by myths such as the notion that private insurance carries the benefit of a “market solution”, or that some services (but not others) must be provided free.

We need to find what Australians want.

If we want to share our health care expenses with others, then the most equitable and efficient way is through a single national insurer, supported by adequate tax collections, and without the distortion of private insurance. That would not mean the demise of private hospitals; in fact a single insurer should be free to buy services from wherever they are best delivered.

We need to clarify what is meant by “universalism”. Politicians from both sides, particularly Labor, say they support universalism, but when public and private hospitals operate on separate funding models, with the wealthier discouraged from using public hospitals, it’s a strange form of “universalism”.

When collective funding comes from multiple sources, in a mix of public and private insurance, universalism is sacrificed. To extend the gated community analogy, when the gated community has so divided society that the open suburbs have degenerated, it’s meaningless to say we are all free to live outside the gated community.

A truly universal system should be one in which we all use the same high quality services, supported by a single national insurer, but that does not mean those services all have to be free, or that there cannot be individual payments based on means.

It is possible that we could accept a greater role for individual responsibility, with the single insurer operating as a safety net. After all, most of our existing programs, such as subsidised pharmaceuticals and free public hospitals, were introduced when Australia was a much less prosperous country. Most Australians are much wealthier than their parents or grandparents were. On average, Australians have about \$60 000 in liquid assets; most of us could easily afford to take more responsibility for our own health care outlays, without insurance, and it is

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becoming apparent that when we recover from the current recession we will do so with stronger household liquidity. Sweden, for example, has introduced a system of universal co-payments, with public insurance being available only after ceilings on individual payments have been reached. Such a system, which brings some market signals to health care, and encourages self-reliance, would be undermined by the intervention of private insurance

Engaging with the public to find what we want – where to draw the borderline between universal insurance and personal responsibility – is not difficult. All our government needs to do is to ask some simple questions, and to clarify the consequences of our decisions, as did the caller from Tusmore.