Beyond the private health rebate

A discussion paper on alternatives to private health insurance for funding private hospitals and other services

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Australian Consumers' Association

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Introduction

Private health insurance, and the 30 percent rebate, are at the heart of the present government's shift towards the privatisation of health funding and towards redefining taxpayer-funded health care as charity. The ACA and a number of others have argued that the rebate should be redirected. We will return to those arguments in detail later in this paper, but it is important first to acknowledge and address the political and policy difficulties in moving away from the rebate. Getting rid of it will be a lot harder than instituting it. Nor can it be left alone: too much money is involved, and it is at the core of a policy approach that is anathema to those who value social justice and economic efficiency in health care.

But those of us who have been arguing this way have failed dismally in two important ways. We have failed to suggest a politically practical pathway for removing the rebate; and we have failed to deal with the question of private hospitals: how they might be funded in the future and how the private and public hospital systems might be made more complementary, rather than wastefully duplicating each other. These considerations are inextricably linked.

In the longer term, the future of private health insurance is shaky indeed. It will be ultimately unsustainable because of its continuing inability to control private hospital costs, the consequent rapidly declining value-for-money for consumers, its worsening demographic profile (younger people are leaving and older people are joining) and the need of any health system, however funded, to ensure cost-effectiveness. Private insurance, in anything like its present form, is unlikely to last for another decade unless it is subsidised to an absurd degree. The need to find alternative funding arrangements for private hospitals has become urgent.

This paper argues that the new insurance initiative has not only failed to make things easier for public hospitals, but have actually made matters worse. Public hospitals are unable to compete with private hospitals for staff and resources, particularly for surgeons and other specialists, because the private system pays them so much more. The rebate has powerfully reinforced this imbalance.

The paper also examines the common arguments in favour of the health insurance initiatives and seeks to rebut them.

The Macquarie Dictionary defines "crisis" as a decisive or vitally important stage in the course of anything; a turning point; a critical time or occasion. In that sense, we are certainly at a crisis point in health policy. Many challenges face us, produced not only by the poor policies of the present government but also by broader developments in the health care system. If we are to move once more towards a system that is both socially just and economically efficient – and nothing less will do – the policy options we must now consider are complex and far-reaching. Isolated measures, whether adding a few dollars to the Medicare rebate or winding back the private health subsidy, will not in themselves be enough. In health policy, there are right and wrong ways to do things but few easy ways.

Managing the transition

Removing the rebate is not a simple or trivial process. Better use of this money is among the greatest policy issues in health, but this money cannot fix everything that needs fixing in the Australian health system.

The economic, administrative and political aspects of change will need to be managed through a carefully calculated, staged process. These principles must apply:

- The interests of consumers of private health insurance must be protected;
- At no time during the transition phase must the overall health system become less efficient or effective;
- The people's confidence in the capacity of publicly-funded health system, particularly of publicly purchased hospital services, must be restored; and
- The electorate must understand the process and consent to it.

Once this debate gets under way, it is likely that a number of scenarios will be suggested. To open the debate, we suggest eight stages for the transition:

1. Following an announcement that it will embark on this course of action, the government should remove the 30 percent rebate on ancillaries. This would immediately free up to $700 million annually which should be directed first to disease prevention and the enhancement of primary health care programs, particularly in rural/remote and indigenous areas.
2. The Commonwealth Dental Program should be revived and an inquiry begun into the practicability of bringing certain core dental services within the Medicare Benefits Schedule.
3. Medicare rebates, particularly in general practice, should be increased as part of a program to restore bulk-billing. This measure should be funded from sources other than the insurance rebate.
4. Simultaneously, and with the cooperation of the states and territories, urgent work should resume on the fundamental restructuring of the funding and delivery of health care throughout the nation, and on funding relationships between the Commonwealth and the states. All parties must realise that without more efficient structures and relationships, even large injections of funding will not necessarily produce better services or better health.
5. A process of Commonwealth or Commonwealth-State direct purchase of facilities and services from private hospitals should be devised, incorporating the AR-DRGs as a basic measure of the value of services.
6. Within twelve months of the announcement of the reform program, new Australian Health Care Funding Agreements should be signed to incorporate these principles of reform.

7. Throughout this process careful consideration must be given to the fiscal impact of the reform agenda, and to the tax base for Commonwealth health funding. Much of this reform agenda will be cost saving or revenue neutral. Nevertheless, a case may emerge for health to consume a greater share of Commonwealth taxation revenue. There are three ways of achieving this: redirect money from other government programs; increase the rate of general taxation; or increase the Medicare levy. Increasing the levy is likely to be acceptable to the electorate, which can see the immediate connection with improved health services. In 2000-01 the levy was budgeted to raise $4 580 million; a quite modest rise of between 0.25 percent and 0.5 percent, together with the $2.4 billion presently used for the rebate, would certainly be sufficient. The Australian Health Care Agreements should be used as a mechanism to ensure appropriately matched contributions from the states and territories.

8. When the stages above have been addressed, Lifetime Health Cover and the 30 percent private health insurance rebate should be abolished simultaneously. (To maintain Lifetime Health Cover while removing the rebate would be unacceptable to consumers, continuing to lock them into their policies while sharply increasing their premiums.) This money should be divided between the Australian Health Care Funding Agreements, the annual indexation of Medicare schedule fees for doctors' services according to realistic practice costs, the identified national priority areas in disease prevention, and health and medical research.

The original benchmarks

Before the introduction of the 30 percent health insurance rebate, the industry and the government promised four outcomes that in retrospect can be seen as self-imposed performance indicators. None has been delivered.

It was promised that the rebate would restore high levels of fund membership. But when the rebate came in, almost nothing happened to membership. What made people join was not the expensive rebate but the threats in the later Lifetime Health Cover policy. An earlier measure, means-tested rebates for private insurance, was also ineffective in increasing membership.

It was promised that once large numbers of people joined the funds, premiums would go down. In fact, premiums were stable for the first year only, possibly only because of intense competition between the funds for initial market share. But within a few months, the dramatic but apparently unforeseen effects of the new measures on demand and health-care inflation were evident; on average, prices in the most recent two years have risen by around 7 percent, with some consumers experiencing much greater rises.

It was promised that waiting lists in public hospitals would be shortened because patients would prefer the newly-accessible private hospitals. But as Professor John Deeble found in a report commissioned by the state and territory health ministers, the number of people making the switch accounts for only about 7 percent of public hospital patients.[1] Most of these are for simple and cheap day procedures like bronchoscopies; so public waiting lists are almost entirely unaffected.

And it was promised the rebate would encourage large amounts of private cash into the health system. In fact, Professor Deeble found the amount of private money in health has decreased by about 26 percent because private cash has been replaced by government cash. As Deeble, Duckett[2] and others have pointed out, the system would become far more efficient and better targeted if Medicare bought services direct from private hospitals, bypassing the funds.

Cost pressures on insurance funds

Unlike Medicare and the PBS, private health insurance funds have little control either over the cost or the cost-effectiveness of the health products and services for which they pay. So far, attempts to control cost have been relatively ineffective and there have been few attempts to improve cost-effectiveness. (These are not, of course, the same thing: often, measures to rein in bottom-line cost result in poorer value for money.) In the 2003-04 Budget, the Commonwealth announced a range of cost-control measures. These were partly in response to the blowout in cost of prostheses, which is rising in private hospitals by more than 40 percent a year. Three measures were announced: cost-

1. Deeble J. The private health insurance rebate: report to state and territory health ministers. National Centre for Epidemiology and Population Health, Australian National University, Canberra, January 2003 (mimeo).
2. Duckett S J and Terri J Jackson. The new health insurance rebate: an inefficient way of assisting public hospitals. MJA 2000; 172: 439-442.

effectiveness measures covering prostheses and other items; abolition of the Second Tier Default Benefit; and the institution of new reinsurance arrangements. These measures were not separately itemised but together are expected to save the Commonwealth $49.6 million over four years.[3] This is hardly an impressive contribution either towards the sustainability of private health insurance generally or towards controlling a rebate program that already costs about $2.4 billion a year.

Under these circumstances it is almost inevitable that insurance products will become less attractive. Premiums will continue to rise, benefits will be further reduced and overall value for consumers will decline. The industry has embarked on a vicious cycle of increased costs, declining value, declining membership and an unprofitable membership profile. Figures from the Private Health Industry Administration Council show that between September 2000 (when Lifetime Health Cover was introduced) and June 2003, 384,000 fund members aged under 55 gave up their private health cover.[4] Overall numbers did not decline so sharply, because these younger, more profitable customers were replaced by 234,000 people aged 55 or more.

At first sight, the net decrease of 150,000 does not seem particularly significant in a total membership of about 8.5 million. But the change in demography is significant. In the June 2003 quarter alone:

- 67,894 people aged 0-54 dropped out
- 9356 aged 55 and over joined.

This means that over a third of the net drop in membership has occurred in the three months April-June this year. Significantly, the latest round of premium increases occurred – amid much adverse publicity – on April 1.

Someone under 55 brings an average of about $570 a year in gross profits to the funds (they claim $570 a year less than they pay) and someone of 55 or over costs the funds about $500. On the basis of those figures, the younger people dropping out over the most recent quarter will cost the industry $38.7 a year and the older people joining will cost $4.7 million. In all, the industry will be about $43.4 million every year worse off as a result of the demographic shift in just those three months. This continuing shift is one of many pressures undermining the funds' cost structure and their ultimate sustainability. When combined with the effects of an ageing population, these demographic changes become more serious. Professor Stephen Duckett, dean of health sciences at Latrobe University, has calculated that to keep the average age of insured people constant, by 2010 75% of (then) 30-39 year olds will need to be insured.[5]

No health insurance program, public or private, can exist unless young, fitter people subsidise older, sicker people. We accept that when we pay tax. We like a fair and functional society and we know it comes at a price. We pay now so services like hospitals, roads and schools will be there when we need them. But when many younger people join private health funds, they deeply resent having to pay so much for so long before they start getting their money back. On average, someone's yearly claims will exceed their premiums only after they reach their mid-sixties. So someone joining at the age of 30 can expect to wait three and a half decades before their investment starts paying dividends.

3. Commonwealth Budget Papers, 2003-4, Department of the Treasury, Canberra 2003.
4. Private Health Insurance Administration Council. Quarterly statistics June 2003. PHIAC, Canberra 15 August 2003.
5. Duckett S J. Integrating the health care system: taking Medicare forward, or what to do when we (at last) accept existing health insurance polices have failed. Presentation to the Australian Health Care Summit, Canberra 17-19 August 2003.

Other cost pressures on the funds arise from the increase in hospital admissions created by the health insurance initiative and their inability adequately to control prices and cost-effectiveness in the provision of private hospital services. This is illustrated by the disparity in price paid to surgeons in the two systems. Catholic Health Australia, which runs the nation's Catholic public and private hospitals, has told the ACA that an orthopaedic surgeon will be paid about $800 in one of its hospitals for performing a hip replacement operation, but $5000 in a private hospital for the same task.[6] Disparities of this sort have powerfully contributed to the move of surgeons and other specialist staff from the public to the private sector. Since the flood of government funds into the private sector, public hospitals find themselves less than ever able to compete for personnel and resources.

Overall, it is probable that the new private health initiatives, far from leaving public hospitals better off, have made them substantially worse off. The failure of the initiatives to decrease substantially public hospital demand has been amply demonstrated elsewhere, but we are now seeing the destructive effects of increased competition for their staff that is being funded – for the time being, at least – by a private industry newly awash with taxpayer funds.

This view is supported by Professor Jeff Richardson, Director of the Health Economics Unit at the Monash University Centre for Health Program Evaluation:

> The impact of private health insurance policies upon public hospitals has not been properly analysed. There are, however, grounds for believing that it may have been perverse. In the simple, but wrong, analysis [argued by the government and the industry] an increased number of private hospital patients would reduce the "pressure" upon public hospitals and thereby decrease the length of queues. However the logic of this argument is incorrect. Queues depend upon the balance between supply and demand. While it is true that a transfer of patients between the sectors will reduce the demand for public services, a transfer of doctors between the sectors to meet this demand will decrease the supply of doctors for public patients.[7]

Richardson argues that because patients are more likely to receive expensive treatments of questionable clinical necessity in private hospitals than in the public sector, and because these extra procedures require higher levels of staffing, the shift of doctors and resources to the private sector is likely to be greater than the number of patients involved would indicate:

> Patients admitted to private hospitals after a heart attack are two to four times more likely to receive an invasive procedure (angiography, revascularisation). This implies that an expansion of the private sector will increase the number of these procedures, which will require a disproportionate transfer of doctors from the public to the private sectors. If this pattem were generally true and, for example, a ten per cent transfer of patients was accompanied by a 20 per cent transfer of doctors, then the expansion of the private hospital system would increase, not decrease, excess demand and queuing in the public sector. This scenario is highly plausible. Doctors have a strong financial incentive to give a large number of more complex services in the profitable fee-for-service, private sector than in the less profitable, salaried or sessional, public sector.[8]

6. Sullivan F. Personal communication, August 2003.
7. Richardson J. Financing health care: short run problems, long run options. Paper presented to the Health Reform Forum, Melbourne Business School, 19 September 2002. Working Paper 138, Centre for Health Program Evaluation, Monash University, Melbourne 2002.
8. Richardson *ibid*.

Funding private hospitals

Private hospitals are an indispensable part of the health system. But the present principal method of paying for them – private health insurance – is no longer capable of performing this function adequately. In the past few decades, private hospitals have become so important that the funding strategies of the 1950s must now be revised and replaced.

We can no longer rely on private health insurance to pay for private hospitals. Even with the expensive and restrictive policies of the 30% subsidy and Lifetime Health Cover – policies that are already showing signs of unravelling – the funds are not adequate to the task. They fail the tests of equity and efficiency. This would not matter so much if private hospitals were still a minor part of the health system. But they are now a major part, and national health policy can no longer accept the unfairness and inefficiency of the present arrangements.

Just as importantly, the long-term future of private health insurance – with or without the subsidy – is in doubt. The pressures of costs, the inexorable rise of premiums and the continued failure to secure reasonable cost-effectiveness from private hospitals, are destroying the public's confidence in the funds. These pressures are so great and the means of addressing them so puny that it is difficult to see how private insurance can retain a central place in the health funding scene over the next 10 or 20 years.

If the community's means of funding private hospitals are to become fairer and more sustainable, it must find a process that delivers access to everyone on the basis of need rather than ability to pay, and that ensures that the nation obtains acceptable levels of value for money from the services it buys from this sector. Also funding has to be more direct, without so much leakage into transaction costs and non-hospital services.

The government's new health policies have produced an enormous and unforeseen rise in demand for both ancillary and hospital services without reducing demand on public hospitals. The latest Australian Institute of Health and Welfare data show that public hospital admissions rose by 2.6 percent to 4.0 million during 2001-2002; private hospital admissions rose by 9.5 percent to 2.4 million. Public hospital waiting lists were unchanged. Same-day stays increased by 5.6 percent in public but by 11.8 percent in private hospitals.[9]

Most of the extra private hospital patients were admitted for same-day treatments and procedures. In a nation which already has one of the highest rates of hospital admission in the world, it must be asked whether it is in the nation's or the patient's interests for so many of these simple treatments to be carried out in an expensive and sometimes intimidating hospital setting.

The Minister for Health, Senator Patterson, has claimed that an extra 245,000 patients treated in private hospitals since the rebate was introduced is a vindication of the government's policies.[10] But at what cost? If these extra patient numbers are the government's basic rationale for the rebate, the

9. Australian Hospital Statistics 2001-02. Australian Institute of Health and Welfare, Canberra June 2003.
10. Patterson K. Private health insurance premiums. Media release March 14 2003.

cost of achieving that policy outcome is immensely high. The economist and former senior health administrator, Professor Stephen Duckett, says:

> Given the rebate costs of around $2.5 billion per annum, the government is paying over $10,000 per additional patient treated through private hospitals. This is over three times the average cost per patient treated in a public hospital. Eighty percent of the private hospital increase is in same day admissions.[11]

If private health insurance is no longer an adequate means of funding private hospitals, what would be? The only alternatives are personal funding by individuals paying for their own care, and some form of government program. While self-insurance is an increasingly attractive option for some people becoming disillusioned with the funds, it is not a viable or equitable way of funding a health system.

Some possible alternative patterns for direct government funding include:

- Block funded contracts between government and individual hospitals or hospital groups. This invites providers to manipulate the figures and cherry-pick patients.

- Service-based payment founded on casemix (AR-DRGs) would provide fair and consistent payment for both private and public hospitals. However, the cost-base in private hospitals is higher than in the public system from which the casemix system is derived: there is a question whether the private system could cope immediately with public hospital-level funding. And not only do investors have the right to expect a reasonable return on their investment, but capital infrastructure must also be paid for. Therefore, a system based solely on AR-DRGs would be unsustainable and would be rejected by hospital operators. (There could, though, be some transitional assistance.)

- A more appropriate scheme would involve fee-for-service payment in accord with AR-DRGs, augmented with block funding to recognise the total cost of running a hospital, including infrastructure and return on investment. Block funding contracts could be reviewed periodically to reflect real costs and the changing nature of the marketplace. As with Medicare, a schedule fee would be set for each item, with the benefit being paid to the patient with the capacity to assign that benefit to the provider if the provider elects to bulk-bill. A schedule fee would be set, with a discount calculated to take account for the reduced billing costs involved in bulk-billing. A cheaper and perhaps more cost-effective version of this system could be created by funding only those services which public hospitals could not adequately deliver.

The means of implementing any direct-funding system will be crucial. Strategically, a means of funding private hospitals should be found and at least partly implemented *before* the insurance subsidy is finally phased out. Otherwise, consumers will be seriously disadvantaged. This will mean the hospital operators will temporarily have greater pricing power: a publicly-subsidised private health insurance will still be there, and will still have no control on hospital costs – for the hospitals, an attractive proposition. This may mean block funding will need initially to be set at a higher level in order to be competitive.

Centralised funding of private hospitals would have the added advantage of helping create complementarity between the public and private hospital systems, rather than continuing today's wasteful duplication. Duplicate hospital systems make no more sense than duplicate pay-TV cables

11. Duckett SJ. Senate Select Committee on Medicare submission. Sourced from www.aph.gov.au. June 2003.

running past your house. The nation cannot afford two competing hospital systems. We need one system, adequately and fairly funded, of which private hospitals are an integrated part.

The arguments for private insurance: a rebuttal

The government has assumed that a decline in private insurance is undesirable. But is that the case? In fact, there is nothing done by private insurance that cannot be done better by the taxation system.

There are several reasons the Commonwealth may wish to support private insurance. We propose seven possible justifications for the government's position:

- Competition – avoiding the concentration of insurance in one national provider;
- Avoidance of administrative waste;
- Support for private hospitals and easing of pressure on public hospitals;
- Equity for the insured;
- Reduction of the tax burden;
- Reduction in the size of government;
- Choice.

All are quite easily rebutted.

The defences: competition

A great deal of privatisation in Australia has been carried out in the name of competition policy. Although competition policy is rarely used explicitly as an argument for supporting private health insurance, it has certainly contributed to a general notion of the desirability of privatisation.

Private markets work primarily through the mechanism of price signals. When a good or service is free, there is a tendency for people to over-use it. This temptation to over-use a free good is known in the insurance industry by the quaint term "moral hazard". Moral hazard is a feature of all health insurance, private or public. There is no difference in the logic of saying "Medicare will pay for it" and "HCF will pay for it". Moral hazard is particularly strong when there is no co-payment, as occurs when full cover or gap insurance is permitted.[12]

12. This raises the difficult issue of price signals in health. In publicly-funded systems, these have been shown to reduce demand, but indiscriminately: people who need to be treated will avoid treatment as well as those who do not need it. This has been shown in experiments by the US RAND Corporation and by practical (and disastrous) experience in Singapore. The ACA opposes co-payments in Medicare for this reason, and because government are likely to turn price signals into revenue-raising measures (as with the PBS).

A fragmented insurance industry is weak in a market where providers can exert market power. In the health care industry, price signals are muzzled. Health professionals generally do not advertise prices; in fact there are many regulations (authorised by the ACCC) prohibiting price advertising. There are many supply-side restrictions, such as government limitations on general practitioner numbers, and restrictions on intakes in specialist colleges.

These factors combine to give suppliers strong power in the marketplace. If there are many insurers in that marketplace, suppliers can play them off against one another. That is why those countries which centralise health care funding through public expenditure are able to keep their health care costs in check. A strong, single national insurer can use its market power to keep in check the moral hazards of over-servicing and over-charging by service providers. In theory such an insurer need not be publicly owned; Singapore offers an instance where the single insurer is heavily regulated but technically is privately owned. But there are problems in regulating a private monopoly; control and accountability are more easily achieved in a government agency.

The defences: administrative waste

Stories of administrative waste in public sector bureaucracies are legend. But private sector bureaucracies, too, can incur heavy overhead costs. Private health insurers in 2001-02 received $6 782 million in contribution income, of which $767 million or 11.3 percent was spent on administrative costs. By contrast, in the same year, Medicare with a total turnover of $8 023 million, incurred management expenses of $291 million, or 3.6 percent. To this must be added the costs incurred in the Australian Taxation Office of collecting tax – about another 1.2 percent. Therefore the total cost of collection and distribution of Medicare funds is around 4.8 percent, which is 6.5 percent lower than the administrative cost of private insurance. If the $6 782 million in contribution income had passed through Medicare rather than private insurers, there could have been a saving of $440 million, or another $440 million spent on health care services.

This is not to suggest that private health insurers are technically inefficient. If they were, then the problem of high administrative costs could be solved by technical efficiency improvements. In fact, private health insurers have a much lower administrative cost ratio than many general insurers. The problem lies in the fragmentation of private insurance. They have collection costs not incurred by the Tax Office, and promotion costs and duplication of services such as points of sale, not incurred by Medicare.

The defences: removing caseload from public hospitals

One of the myths which has nurtured the private health insurance industry is the notion that the survival of private hospitals depends on the survival of private insurance. A related argument is that private hospitals take a load off public hospitals. The Australian Private Hospitals Association, for example, has stated its commitment to "reversing the exodus from private health insurance and easing pressure on our embattled public hospitals". But private hospitals have always been free to accept public patients through contracts with state governments. Very few have chosen to exercise this option, however. In addition, there are many patients who use private hospitals without any form of private insurance, as shown in the table. Self-insurance was on the rise until 1999, when "lifetime" cover was announced.

Separations from private hospitals – percentage without insurance

95-96	19.8
96-97	20.1
97-98	22.1
98-99	24.6
99-00	21.8
00-01	19.5

Source: ABS Private Hospitals (Cat 4390.) 2000-01, "Insurance" not confined to health insurance.

It is strange that a government committed to choice, self-reliance and the encouragement of saving should penalise self-insurance. Those who choose to self-insure do not have access to the 30 percent rebate, but they can, if they know about it, receive a 20 percent rebate on health are expenses exceeding $1500. (Government information sources, such as the Tax Office website, have no shortage of information on the rebate for private insurance, but very little information on the rebate for uninsured expenses.)

Until 1986 there was a bed-day subsidy paid directly to private hospitals, bypassing private insurance. In a rigorously argued analysis, examining the interaction of self-insurance and private insurance, Rhema Vaithianathan of the Australian National University has suggested restoration of this or a similar subsidy as a more direct and equitable means of supporting the private hospital sector.[13]

Even if funds do flow to private hospitals, there is no inevitability that pressure will be taken off public hospitals, for two reasons. Funds may simply finance more services which would not have been undertaken in the public hospitals, and resources may move from the public across to the private sector.

Research by the Centre for Health Program Evaluation at Monash University has found that private hospitals are likely to employ more costly procedures than public hospitals for patients presenting with the same conditions, even though the treatment is not necessarily more effective. The same research also finds that the unit cost of these procedures may be significantly greater in the private sector than in the public sector.[14]

Even apart from these studies, there is a very basic problem with channelling funds into private hospitals in the hope of relieving pressure on public hospitals. Where *funds* go, so, too do *resources*. Confusion of funds and real resources is a common problem when governments concentrate on financial management at the expense of economic management. The most crucial resources, medical practitioners and nurses, are in short supply. Extra funding does not create extra qualified staff – from undergraduate entrance to full professional competence takes between ten and twenty years for health care professionals and in any event there are limits on university places and

13. Vaithinathan R. Will subsidising private health insurance help the public health system? The Economic Record 78:2; 277-283.

14. Richardson J et al. The reform of public hospital funding in Australia. Submission to the Senate Inquiry into Public Hospital Funding. Centre for Health Program Evaluation, Monash University, Melbourne 1999.

on provider numbers. When supply of resources is fixed in the short to medium term, the consequences of a funding boost to the private sector are likely to be some combination of price inflation and a transfer of resources out of the public sector. Either way, the result is more, not less, pressure on public hospitals.

This is not an argument for closing private hospitals. But it does strengthen the case to fund them through the same channels as public hospitals, to ensure that resources are distributed equitably and efficiently, to establish intersectoral competition (between private and public hospitals), and to prevent parts of the health care system overbidding for scarce resources.

The defences: equity for the insured

Many politicians and community groups believe that because 43 percent of the population has private insurance, it is only fair that they receive some support; after all they are paying twice – through their taxes and through their premiums. At first sight there is merit in this argument, but only if one assumes private insurance is a necessary and permanent part of the health care system.

The present system of rebates and penalties is anything but equitable. The table shows the benefit to a single contributor of taking a basic package to avoid the one percent tax penalty. Medium to high-income earners with incomes above $50 000 (or families with an income of $100 000 or more) are richly rewarded for not sharing their health care funding with the rest of the community. When we re-frame the tax penalty as a tax incentive, we can see that higher income earners are actually paid to have private insurance. (Even in the days of heavy tariff protection and subsidies for manufacturing, Australian consumers were not paid to buy Holden cars or Bonds T-shirts.)

Cost of basic insurance, by income

Income $'000	50	75	100
Annual premium	474	474	474
Less rebate	142	142	142
Net	332	332	332
Tax break (1% of income)	500	750	1 000
Net cost of insurance	-168	-418	-668

(Modelled Medicare "First Choice Saver", NSW, single, excess of $250, exclusions)

What is more absurd about the structure of such incentives is that those with basic policies will probably be wise enough never to use them. If they need hospital care, their best option is to check in as a public patient in a public hospital to avoid excesses and gap payments. Rebates for ancillary payments are also highly inequitable. The 59 percent of the population without ancillary insurance have to pay from their own resources for the big-ticket ancilliaries – dental, optical and physiotherapy services. But those who opt for dependence on private insurance are subsidised for their choice. (The rebates for insurance were introduced at the same time as the Commonwealth's dental program was scrapped.)

Although the Commonwealth could have done much better, it is extremely difficult to build equity into a system of private insurance which is supposed to co-exist with a system of public insurance. Australia's system of income tax and GST may embody some inequities, but it is still a much more equitable way to collect pooled funds than any set of structured incentives for private insurance. When we have a community-rated official tax system it is absurd to try to build in community-rating principles into a private funding system which has intrinsic incentives for adverse selection.

The defences: reduction of the tax burden

In 2000-01 private health insurance funds channelled $5 348 million into the health care system. Of this only $3 312 million went into the hospital system (mainly private hospitals).

Expenditure through health insurance funds, 2000-01, $m

	Gross	Less rebates	Net
Public hospitals	322	109	213
Private hospitals	2 990	1 022	1 968
Ambulance	181	62	119
Medical services	427	146	281
Other health professionals	333	114	219
Pharmaceuticals	53	18	35
Aids and appliances	268	91	177
Dental services	774	264	510
Total services	5 348	1 826	3 522
Administration	843	288	555
Total expenditure	*6 191*	*2 114*	*4 077*

Source: AIHW 2002

To the Commonwealth, the cost of obtaining these funds was $2 114 million worth of subsidies. In other words, the Commonwealth, instead of spending $2 114 million in subsidising private health insurance, could have put that money, plus another $1 198 million, directly into the hospital sector to provide the same amount of funding as was provided by private insurance. If that was raised solely through the Medicare levy rather than through general taxation or re-ordering government priorities, it would have involved a 0.4 percent increase in the levy.

Would an explicit tax increase be politically acceptable? The simple answer is probably "yes". If one surveys people with the simple question "do you want to pay more tax?" the answer will generally be a resounding "no". But when such questions are linked to specific benefits, quite different answers emerge. In a worldwide survey conducted by the Angus Reid Media Centre in 1999, Australians, by a small margin, were in favour of higher taxes to pay for more public services. Prime candidates for extra spending were education (78 percent wanting more public spending) and health (75 percent).[15]

These results are broadly similar to those of a major Australian survey in the early nineties. That survey found Australians were generally satisfied with their levels of taxation, and that their highest priorities for an increase in expenditure were, in order, medical and hospital (84 percent) and education (78 percent). [16]

More evidence, relating specifically to hospital funding, comes from a survey conducted for Hawker Britton by UMR Research in May 2003. When asked to choose between "a significant personal income tax cut" and "spend[ing] that money on better hospitals", the results were a resounding 79 percent in favour of public hospitals versus 16 percent for a tax cut. There was very little variation by age, region, or voting intention. In the same survey respondents were asked, more

15. Survey by Angus Reid Media Centre, February 2000. Web link from The Economist of March 18-24 2000.
16. Throsby, David and Glenn Withers. Measuring demand for public expenditure: theory, methods and preliminary results. Macquarie University Research Paper 383, July 1994.

specifically, if they would support a 0.5 percent increase in the Medicare levy (notably close to the 0.4 percent increase calculated above); 76 percent were in support of the higher levy and again there was little variation in support by age, region or voting intention.[17]

When the Labor Party has presented a strong and differentiated policy pursuing public health funding, it has reaped an electoral benefit that has sometimes been an election winner. Clive Bean *et al*, in their account of the 1996 federal election, say that:

> There is strong evidence for political support for a universally accessible, shared health system. The major parties have performed a well-controlled experiment with health care. In both the 1993 and 1996 elections health care was a major issue among voters. In 1993 the Coalition had promised private health insurance initiatives, while Labor did not. Polling researchers asked people which party was closest to their own views on various issues, including health policy. In that election, in response to that question, Labor had a 19 percent lead over the Coalition. In 1996 both parties promised support for private health insurance and the same polling found Labor's lead on health care had fallen to 5 percent.[18]

Medicare is a popular program, as revealed not only in political surveys but also in surveys of public satisfaction with the Health Insurance Commission. A satisfaction rating of 90 percent with a government agency is extraordinary in an era characterised by a general mistrust of government. Private health insurance has many of the characteristics of a tax, but few of the virtues of an official tax.

The defences: reduction in the size of government

This is perhaps the hardest theory to explain, and the easiest to refute. John Halligan of the University of Canberra refers to a philosophy of "private sector primacy"; that is, a philosophy that a transfer of functions to the private sector is desirable in its own right, regardless of any notion of costs or benefits associated with such a transfer.[19] Such a notion is given voice in statements about an unqualified need to reduce the size of the public sector. The philosophy has little logical basis. It completely overlooks the economic realities of markets – how some services, because of market failure, are more efficiently provided in the public sector than in the private sector. It turns its back on 200 years of economic theory, including the theories of Adam Smith, who clearly recognised that governments could do some things that the private sector could not do, or not do so well.

The defences: choice

This argument was put by the previous Health Minister, Dr Wooldridge, and more recently in a paper by Professor Ian Harper that was commissioned by Medibank Private.

There are two elements to the choice argument: choice between public and private, and between various private insurers. There may be some differentiation in the offerings of hospitals and medical practitioners, but consumer choice between health insurers is largely illusory. *Choice*

17. Sourced from www.hawkerbritton.com.au.
18. Bean, Clive and Ian McAllister. Short-term influences on voting behaviour in the 1996 election" Table 21.4 in Clive Bean, Marian Simms, Scott Bennett and John Warhurst (eds) *The Politics of Retribution – The 1996 Federal Election* (Allen and Unwin 1997).
19. Halligan J. Implications for the public service of the emerging Australian model. Working Group III, Public Service Reform, Annual Conference of the International Association of Schools and Institutes of Administration. International Institute of Public Administration, Paris, September 1998.

magazine's annual Best Buys in health insurance change every year; what differences there are between funds are rapidly obscured by changing premiums and conditions that, for the consumer, are obscure and unpredictable. Few consumers change funds once they join; competition is effectively limited to new customers. Entreaties by such organisations as the ACA that consumers should shop around are largely unheeded.

While there are very substantial differences between various products and levels of cover offered by each particular fund, competition *between* funds is much less discernible. In fact, the fragmentation of the market – and the inefficiency which is inherent in such duplication – is producing detriment for consumers. Interestingly, the *Choice* Best Buy list is dominated by restricted-entry sectoral funds such as funds for teachers and defence personnel that have, for instance, little need to advertise to maintain market share. Much of the apparent competition that exists in this market is unproductive and delivers neither economic efficiency nor consumer benefit.

Even more basically, in financial services, particularly when they are as heavily regulated as private health insurance, there is little scope for firms to offer real choice. Choice is of greatest benefit to consumers when markets can offer variety or significant price differentiation; these conditions do not exist in health insurance.

The ACA believes private health insurance is a commercial product that should be provided in a relatively free and genuinely competitive market. Funds should be able to price and design their products according to what they believe would be attractive in the market. Consumers should be able to choose freely between them. Since the introduction of the 30% government subsidy, that free market no longer exists. The government tries to control premium rises without attempting seriously to control the costs faced by the funds. The result of the present policies is a huge number of inefficient funds that duplicate one another, face an unending cost squeeze, and exist permanently on the verge of financial disaster. This situation cannot be in the nation's interests, and it is a very strange way of paying for something as crucial as health care.

There are two other philosophical aspects of choice. One is people's choice to use private hospitals without insurance, and the other is people's choice to share their health care costs with their fellow citizens. Those who wish to exercise such choices are severely penalized, particularly by the 1% tax levy (which cuts in at only about 20% above average weekly earnings.) To the Coalition, "choice" is to be exercised only within a constrained set of high-cost financial intermediaries.