

PRIVATE HEALTH INSURANCE: HIGH IN COST AND LOW IN EQUITY

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Summary

Government proposals to apply a means test to private health insurance subsidies have re-ignited the debate about the role of private insurance.

The proposals have the benefit of removing a glaring inequity in our present arrangements which direct subsidies disproportionately to the well-off. The worst such inequity relates to dental care. They would alleviate the inequities imposed on country people who, while being poorly provided with private hospitals, subsidize high-income metropolitan dwellers who have access to private hospitals.

The proposals have shortcomings, however, because they don't go far enough. They would have hardly any impact on membership of private insurance, they would sustain a separation of private and public hospitals, and they would sustain a social division with one hospital network for the well-off, and another for the other 45 percent of Australians. This division is at odds with the Government's social inclusion policy.

Private health insurance is an expensive and clumsy way to do what the tax system and Medicare do so much better – that is to distribute funds to those who need health care. In itself it is an expensive financial overhead – a \$3 billion annual burden on the health care system. Its even greater economic impost is its general impact on the cost of health care. International experience shows that private health insurance buys more expensive health care than tax-funded health insurance, but it doesn't buy better health care.

Nor has the increased uptake of private insurance succeeded in its claimed purpose of easing pressure on public hospitals. That was an impossible task, because while demand has indeed shifted to private hospitals, so too have health care staff. The main result has simply been a re-shuffling of the queues for limited resources, and that re-shuffling has put private insurance membership ahead of clinical needs.

In our criticism of private insurance we are not accusing the insurers of inefficiency, greed or profiteering. Rather, their failure is an inevitable feature of private insurance. We are not advocating what some may call "socialized medicine". Private hospitals serve an important function: they should be funded by means other than through private insurance. Nor are we calling for universal "free" health care – there are many sound arguments in favour of those with means paying more from their own resources, without private or public insurance. Our main message is that to the extent we choose to share our health care costs, a single national insurer provides the most efficient and equitable means of doing so.

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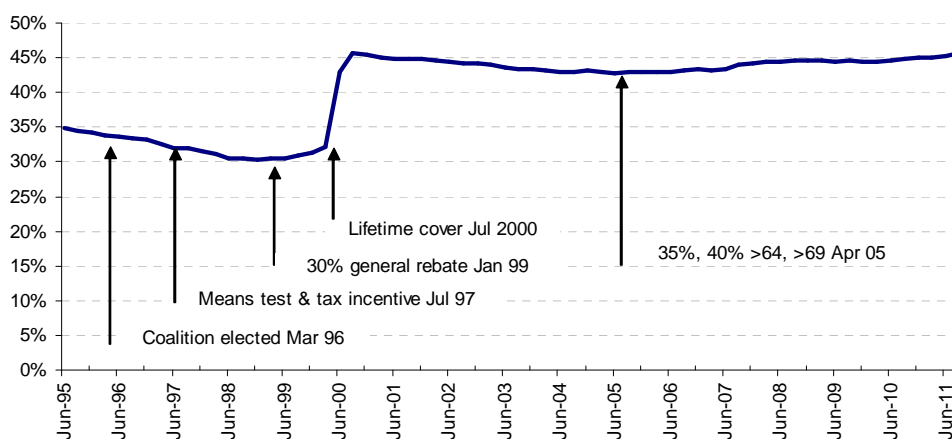
Introduction: How private health insurance has escaped scrutiny

The Health and Hospitals Reform Commission, established by the Rudd Government, failed to consider broad questions of health funding. In its recommendations, it simply said "We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade."¹ Even though the role of private health insurance (PHI) has been a major issue since 1969 when the Nimmo Report² was tabled, and has often been the subject of significant policy differences between the major political parties, the Commission was strangely silent on its reasons for its accepting the funding *status quo*.

The current Commonwealth Government too seems to have accepted without question that PHI should be maintained at its current level of around 45 percent of the population – a percentage which has been creeping upward since 2005. (See Figure 1). The proposals currently before Parliament to re-introduce limited means testing for PHI subsidies, while removing some inequities, are clearly designed to maintain the level of PHI coverage. Treasury modelling suggests that only 0.3 percent of the 10 million people with PHI would drop their cover.³ In fact, these same Bills propose to raise the Medicare Levy Surcharge from 1.0 percent to 1.5 percent, which would increase the incentive for many with high incomes to hold PHI. (See page 15 for a full description of the surcharge)

The original vision of Medibank, introduced after a struggle in 1975, was that national tax-funded health insurance would obviate the need for PHI. Support for PHI was temporarily re-introduced in 1981 by the Fraser Government, but the Hawke Government again introduced universal cover under Medicare in 1984. Coverage of PHI slowly slipped to about 30 percent, until it was boosted significantly by the Howard Government with a series of measures. The timing of these measures and cryptic descriptions are shown in Figure 1.

Figure 1: PHI Hospital Coverage (% of population)



It is notable that these measures were introduced without evaluation. Apart from an untested notion that increasing PHI coverage would ease pressure on public hospitals and save outlays through public budgets, there has not been a clear policy principle behind support for PHI.⁴ The Howard Government did commission an Industry Commission study into PHI, but it was about how to boost PHI coverage, not whether it was desirable to do so on economic or equity grounds. In fact the Government had already announced that it would provide incentives for people to hold PHI. The Commission made recommendations in line with its restricted terms of reference, but its final recommendation was that there should be "a broad public inquiry into Australia's health system", including "health financing" and an "assessment of the role of private insurers".

Neither the Coalition Government, nor the present Labor Government, have opened up the industry to such scrutiny. It has been allowed to keep on drawing heavy subsidies, which cost \$4.7 billion in budgetary support in 2010-12.⁵ The present proposals would reduce annual outlays by around \$0.7 billion,⁶ but they would retain the position of PHI, with all its other costs – costs imposed on the community but not brought to account in budget documents.

The costs of private insurance: largely unseen

The immediate budgetary costs of PHI are brought to account. Of the other costs, only administrative costs are reasonably well recorded. The main costs of PHI stem from its inability to control the costs imposed by health service providers.

Administrative costs

In 2010-11 PHI funds received \$16.0 billion in premium income and paid \$13.2 billion in benefits. The balance, \$2.8 billion, was split equally between administrative costs of \$1.4 billion and \$1.4 billion profit before tax. Of that 1.4 billion profit, \$0.3 billion came back to the community as taxes.⁷ That means Australians paid \$2.5 billion, or 16 percent of PHI premiums, in administration and profits. In addition to the administrative costs of the PHI firms, there are search and transaction costs incurred by consumers.

These costs, because they are the costs of competition, are largely inescapable. Firms must advertise and maintain shopfronts, not only to compete with other insurers, but also to persuade their customers that insurance is of value.

Medicare, of course, has its own costs, including the costs of tax collection. Medicare's costs are about 4.7 percent,⁸ and tax collection costs are about 1.0 percent.⁹ Together these come to 5.7 percent.

That means that the additional administrative burden of PHI above that of Medicare is around 10 percent of premium income. Had the \$16 billion of premiums paid to PHI been channelled through the tax system and Medicare, another \$1.6 billion could have been available for health care.

This is not to suggest some administrative inefficiency in PHI; if that were the case then savings would be possible. Rather, it reflects the economies of scale in Medicare, the fact that Medicare doesn't have to promote its services, the fact that a government agency does not have to carry large financial reserves, and the compulsion of taxes.

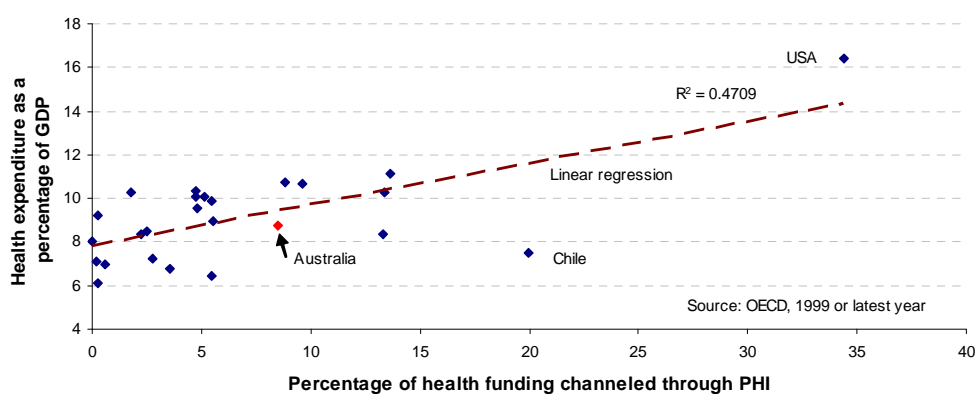
Inability to control providers' costs

While administrative costs are easily identified, they are not the main problem. By far the greatest cost of PHI results from its impact on health costs generally, both in terms of utilization and prices.

When a product is "free" at the point of delivery, there is an incentive for consumers to over-use the service and for providers to over-charge for the service. In the terminology of insurers, this incentive is known as "moral hazard".

Moral hazard is a feature of all third-party payment systems, public or private, but when a country operates a single national insurer such as those operating in the Nordic countries and Britain, the insurer has the capacity to use its market power to control service-providers' costs. When there are many insurers operating in the market, they have little power to resist the concentrated power of service providers.

Figure 2: National health expenditure and funding through PHI - OECD countries



Among OECD countries, which generally have similar health outcomes, the economy-wide cost of health care is closely related to the extent that PHI is used as a means to pay for health care, as is shown in Figure 2 which is compiled from OECD statistics. The same broad relationship was reported by *The Economist* in a recent extended article on health costs. It reported that PHI pushes costs up, explaining "The biggest factor behind the cost conundrum is that insurers lack market power. Health-care providers hold all the cards."¹⁰

Australia, since it re-introduced support for PHI, has been suffering the same pressures. In a review of Australia's health financing in 2003, the OECD commented:

Private [insurance] 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. Private health insurance 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. The Medicare subsidy to private in-hospital medical treatment

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.¹¹

Similarly, in a report on medical technology and other factors driving health care costs, the Productivity Commission has said:

Increased levels of private health insurance membership have been associated with a marked increase in the number of services performed and reimbursements for those services.¹²

The standout example of PHI resulting in high costs is the USA, where PHI dominates health funding (while still leaving many Americans uninsured until the Obama initiatives take effect). America's health care costs as a proportion of GDP are almost twice that of other developed countries, even while in terms of life expectancy and many other indicators its health outcomes are poorer than those in many other prosperous countries. The main explanatory factor, according to an OECD paper, is the dominance of PHI.¹³ Health insurance costs are placing a huge overhead burden on America's industries – they were a significant contributor to General Motors' bankruptcy.

PHI is intrinsically inflationary, while single national insurers are able to use their market power to countervail the power of service providers. That is not to suggest a single insurer is the only mechanism to control costs. Some countries such as Korea contain health care costs by requiring significant out-of-pocket contributions, a true market approach. But to the extent that people choose to share health care costs with one another, PHI is an expensive means of doing so.

The public good problem

It is in the interests of insurers to see that those holding insurance policies engage in behavior which will minimize their chance of having to make a claim. In health care that may involve attention to diet, exercise, and avoiding smoking. In some situations insurers may be able to discriminate against those with high-risk lifestyles, but such discrimination is often not permitted (including in PHI in Australia), and even if it were permitted, insurers would have little opportunity to monitor people's behavior.

If an insurer engages in health promotion or research, there are two costs borne by the insurer. One cost arises because it is hard to confine the benefits of such activity to one's members. Some of the benefits flow to one's competitors. That means there is every incentive for other insurers to free ride off their competitors' efforts. The result is a classic "prisoners' dilemma" situation; every company may wish to do these things, but the individual incentives are such that no company does it. The other cost is that if promotion or research are effective in reducing people's demand for services, or even simply engendering a belief that they are less likely to need health care, the company essentially undermines its own market. There is little doubt that staff of health insurance funds would like to see a healthier population, but in a competitive market their efforts, no matter how well-intentioned, will be constrained by the harsh realities of competitive markets.

A single national insurer with compulsory enrolment through the tax system is free of such disincentives. In economists' terms, they can "internalize the externalities".

The claimed benefits of private insurance: vastly overstated

The claimed benefits of private insurance, particularly as it operates in Australia, are that it saves budgetary outlays on health care, eases pressure on public hospitals, provides choice and rewards self-reliance. These are all overstated.

Saving budgetary outlays?

Even if PHI were to save budgetary outlays (there is evidence that it does not), there is no conceivable economic principle, from either a "left" or "right" perspective, which suggests that saving budgetary outlays, in itself, is desirable if costs are simply shifted off-budget with no discernable benefit.

PHI, as it operates in Australia and other countries with strong community rating, is simply doing what the taxation system does, but at higher cost and almost inevitably without the progressive redistributive mechanisms of the taxation system. It is essentially a "privatized tax". There is no virtue in saving a taxpayer \$1.00 in official taxes, if the same taxpayer has then to pay \$1.10 or \$1.50 for the same benefits.

This is not an argument for taxation to replace all private transactions. Rather, it is specifically about trying to use private mechanisms for redistribution. Official taxes come with the benefits of accountability, strong administrative control, a degree of equity and low collection costs.

In any event, in the long run PHI does not even save budgetary costs. The OECD study on America's costs referred to on the previous page found that America's publicly-funded programs, Medicare and Medicaid, were costing the same amount as some countries' comprehensive single-insurer programs. Far from saving budgetary costs, PHI in America has allowed the service providers to become so strong that the publicly-funded programs have to go along with prices set in a market dominated by private insurers who have no choice but to accept service providers' prices. According to the same *Economist* article referred to on Page 7 "there is evidence that private insurance can lead to even higher public spending on health—compromising governments' objective of bearing down on the costs of health care."

Had the USA adopted a budget-funded single-insurer model, not only could its national health care costs be much lower; even its budgetary costs would be no higher (and no doubt not subject to the cost runaway that USA's Medicare now faces.)

Easing pressure on public hospitals?

Easing pressure on public hospitals was the other of the two major claimed benefits of support for PHI because, in Australia, PHI and private hospitals are closely linked. If more patients used private hospitals, the load on public hospitals would be eased.

In spite of the takeup of PHI and the increased share of services performed in private hospitals, there has been no letup on the pressure on public hospitals. Nor should it have been expected to happen. Even when the Government was planning to introduce PHI subsidies in 1997, independent academics were warning that there would be no easing of

pressure on public hospitals, because where the funding goes so too do the resources. If some patients move from public to private hospitals, so too do resources.

The subsidies for PHI which are mainly passed through private hospitals, have allowed those private hospitals to attract professional staff away from public hospitals. This has been facilitated by gap insurance provided by PHI. This gap insurance has facilitated the largest increase in specialist fees in Australia in the last 25 years. This has resulted in remuneration paid to specialists, particularly orthopaedics in private hospitals, being four to five times higher than orthopaedics in public hospitals.

Because of the regional distribution of public and private hospitals, the stress on public hospitals is probably most heavily experienced in country areas. While 64 percent of Australians live in state and territory capital cities, 74 percent of private hospital beds are in those capital cities.¹⁴ By contrast, the supply of public hospital beds is skewed away from capital cities. Because people in country and remote regions are generally not as well-off as city dwellers, this regional imbalance amplifies inequities already in PHI subsidies. Prosperous urban dwellers are being subsidized by less well-off people in rural and outback Australia.

Improving choice?

The "choice" PHI offers to consumers is between almost identical high-cost financial intermediaries. They have to be very similar, because of the regulations associated with community rating. For example, all insurers are subject to the same conditions on pre-existing conditions.

Markets work best when there is genuine choice, when competition can spur innovation, variety and other responses to consumer needs. But all that community-rated PHI offers is choice between brands – between look-alike firms which all provide the same service.

Some argue that PHI allows for "doctor of choice" in hospital. It is correct that private hospitals generally allow for doctor of choice, but such arrangements come at a cost, in that the business model of private hospitals is such that the locus of care is the individual's doctor, who will generally have one speciality. That is why private hospitals tend to specialize in standard procedures such as hip replacement while public hospitals take the more complex cases requiring a team approach. In any event one does not have to have PHI to use a private hospital. The issue in the public sector is not so much about "choice" as about discontinuities of care between primary care and hospital care. For example women often want the doctor who looks after them in pregnancy to be involved in their delivery. This problem can be overcome with better integration of primary and hospital care, rather than relying on the indirect mechanism of using private insurance.

Rewarding self-reliance?

Markets work best when consumers make their own choices, spending their own money, in competitive markets. Prices provide the signals that allocate resources in competitive markets.

Insurance of any kind, private or public, suppresses price signals. There is no difference in the notion "NIB/HCF/Bupa will pay for it" and "Medicare will pay for it". One is reliance on a corporation, the other is reliance on government. Neither form of payment could be called "self-reliance". Those who call Medicare the "nanny state" would be consistent in their criticism if they called private insurance the "nanny corporation".

Incentives for private insurance seem to have dealt a strong blow to self-reliance, in fact. In 1998-99, the last year before the Howard Government incentives for PHI membership took effect, 28 percent of separations from private hospitals were by people who were self-funded (i.e. without insurance). That proportion has steadily fallen: in 2009-10 it was 11 percent.¹⁵

This has occurred over a period when Australians have generally been building up their savings, and since 2007 older Australians with account-based superannuation pensions have had no limits on what they can draw from those accounts. In 2009-10 households with two persons and with the "reference person" aged 65 or more had average financial assets of \$354 000, including \$192 000 in superannuation.¹⁶ But since 2005 these same older Australians have been even more strongly encouraged to use PHI rather than their own finances, because their subsidy was increased from 30 percent to 40 percent. Similarly the Medicare Levy Surcharge encourages those with high incomes, who are likely to include those with high financial wealth, to take PHI – in fact it penalizes those who don't have PHI.

One aspect of the regulations around community rating is that insurance firms may not offer policies with a deductible (the amount the consumer pays before insurance kicks in) higher than \$500. That low ceiling, which has not been indexed, discourages any form of significant risk-sharing which might reduce moral hazard (deductibles are good at discouraging frivolous claims) and encourage self-reliance.

Deliberately or otherwise, quite at variance with any rhetoric, PHI incentives have discouraged and penalized self-reliance. The incentives seem to have simply been a form of industry assistance.

Australian peculiarities: we make it even worse

As explained above, PHI has inbuilt problems which make it far from an ideal way to fund health care. In Australia we have disingenuously made some of these distortions worse. The most bizarre feature of our arrangements is the way it has supported a division of our hospitals into two very different systems. Almost as odd is the way it has subsidized queue-jumping. And it has promoted inequity.

The public-private division

In Australia there are two different hospital systems, with different types of governance and different payment systems. Public hospitals operate as integrated establishments, providing emergency, medical, pharmaceutical, rehabilitation, accommodation and other services. Private hospitals, by contrast, essentially provide accommodation and nursing platforms for other service providers, particularly medical specialists.

Although successive governments, Commonwealth and state, have pursued competition policy, they have allowed the division between public and private hospitals to remain. Private patients – that is those who have PHI or are self-funded – overwhelmingly use

private hospitals. And while private hospitals can theoretically provide services for public patients hardly any have chosen to do so. In Victoria in the early 1990s the Kennett Government sought to contract private hospitals to provide services to public patients, and when Prime Minister Rudd launched the Commonwealth health reforms he mentioned the possibility, but the systems have remained separated.

In fact, as pointed out above, the business model of private hospitals would make it hard for them to provide an integrated range of services. Then there is fear in the PHI lobby that if people without insurance could find themselves in private hospitals, their incentive to hold PHI may be weakened. One myth in Australia, a myth convenient to insurers, is that one must hold private insurance in order to be served in a private hospital. In a survey in 1998 (summarized on Page 14), the ABS found that 25 percent of people with PHI held it because they believed they needed PHI to be treated as a private patient.¹⁷ Also, there are many cases of specialists refusing to accept people as private patients if they do not have insurance, even if they have the means to pay.

What this means is that the private hospitals, in the public mind at least, have tied their fortunes and survival to the fortunes of private insurance. Any criticism of PHI is construed as a criticism of "the private sector", and, more emotionally, as a call for "socialized medicine", evoking images of some soviet-style system of health care. Australian governments of different persuasions have generally embraced the notion of funder/provider split – the notion that public funding does not necessarily link to public provision. But not in hospital care.

The only exception is in health services for war veterans, where the Department of Veterans' Affairs acts as the funder for services, which they purchase from public or private hospitals, with active management in care integration. In fact, they purchase two thirds of their hospital services from private hospitals. We can and do operate a single insurer model, but it appears most of our policy makers are locked into thinking that for the general public private hospitals must be linked to private insurance, as if they lack the imagination to think more widely.

Queue jumping

PHI as it operates in Australia essentially subsidises queue jumping. Indeed, it is often promoted as way to get priority treatment for elective surgery. What that means is that for some procedures health resources are allocated on the basis of people's insurance status rather than their needs. For every patient who gets priority service, someone else is pushed further back.

If Australia had an excess of medical specialists, all seeking business, that wouldn't be occurring. But we are not in such a situation, and by no stretch of the imagination is it possible to contemplate our ever being in one.

By any reasonable notion of equity, subsidized queue jumping is poor public policy, but it is not the only violation of principles of equity in the PHI arrangements.

Equity

It is some time since the ABS studied the income distribution of those who hold PHI. Their last official study was in 1998. Since then there have been no official surveys of PHI. The 2009-10 ABS Household Expenditure Survey found, unsurprisingly, that expenditure on PHI rises steeply with income – households in the top 20 percent income range spend almost four times as much on PHI as households in the lowest 20 percent income range, which means that the subsidies would be similarly distributed.¹⁸ But this survey says only how much people spend on PHI, not on who has it and why.

In 2005 The Australia Institute reported on a survey by Roy Morgan Research, which found that around 80 to 90 percent of individuals with annual income above \$100 000 held PHI – another unsurprising result, given the strength of the incentives, particularly the Medicare Levy Surcharge.¹⁹ The Australia Institute concluded that at least 53 percent of the benefit of the PHI rebate accrued to those households with incomes above \$70 000. (That would equate to about \$95 000 in 2012.)

One particular injustice relates to insurance for dental care and other "ancillary" services. Those with PHI are effectively subsidized for dental care, the level depending on their policy. Around 53 percent of people are covered for "ancillary" services, a higher level than for hospital cover. This means that 47 percent of the population without such cover have no support for dental care, unless they are eligible for the Medicare Chronic Disease Dental Scheme. Given the income distribution of PHI coverage, that means that for dental care those who are well-off are subsidized, while most of those with lower incomes have to fund their dental care entirely from their own saving. There is no principle of equity, "left" or "right", which could justify the well-off being subsidized while others are left to fend for themselves.

The Morgan data shows that people's propensity to hold PHI seems to be highly dependent on income, because up to an income of \$100 000 the relationship between income and the holding of PHI is almost directly proportional to income. This aligns with findings relating to all insurance, not just health insurance. Expenditure on insurance rises steeply with income. If people were rational in an economic sense, we may expect those with very high incomes to spend less on insurance, on the basis that they can afford some level of self-insurance, but that is not the case.

In terms of public policy, that suggests that within reason subsidies don't count much for people with higher incomes. Indeed, looking back to the Howard Government's initiatives, the subsidies in themselves had hardly any effect on takeup of PHI. It was only the later initiatives, the "lifetime rating" (by which premiums rise by two percent a year for those aged above 30 who take up PHI for the first time), and the associated "run for cover" campaign, which saw a takeup of PHI (see Figure 1). Researchers are still in dispute as to whether it was the lifetime rating measures or the publicity of the "run for cover" campaign which resulted in the jump from 32 to 46 percent in PHI membership in six months, but they do agree that the subsidies had hardly any effect. The Medicare Levy Surcharge came into effect at the same time, but it applied only to high income earners; it doesn't explain the takeup by people on lower incomes.

The insensitivity of PHI to subsidies is confirmed in the 1998 ABS survey of reasons people held PHI – when the subsidies were in place. These reasons are shown in Table 1 over the page. Financial incentives just don't count. What counts is "security, protection, peace of mind", which confirms the notion that the "run for cover" campaign was probably the most

effective mechanism in boosting membership. It also confirms the proposition that withdrawing the subsidy for those with high incomes is unlikely to have much effect.

Table 1: Reasons for holding private health insurance - percent of contributors, June 1998

Government incentives/to avoid extra Medicare levy	1
Other financial reasons	4
Has illness/condition likely to need treatment	10
Elderly/getting older/likely to need treatment	10
Provides benefits for ancillary services/extras	18
Allows treatment as private patient	20
Always had it/parents had it/condition of job	22
Shorter wait/concern over hospital waiting lists	23
Choice of doctor	25
Security, protection, peace of mind	47
Other	7

Source: ABS 4335.0 Health Insurance Survey Table 11

The reason "always had it" is also telling. Once people hold insurance they are unlikely to drop it, for two reasons. If they have recently made a claim, they reflect on its recent benefits (perhaps ignoring many previous years of premiums without claims). If they have not made a recent claim they may still be subject to what economists call the "sunk cost" phenomenon – the converse of the gambler's belief that past losses heighten the chance of a win.

This all lends credibility to the modelling by Treasury which suggests that withdrawing the subsidy for people with high incomes would have little effect on PHI membership. Rationally, some may drop back to very basic hospital cover, just to avoid the surcharge, and rely on public hospitals. And some may judge ancillary cover to be a poor deal, because even on top tables payments are capped, leaving the consumers with open-ended risk – hardly "insurance" in any sense of the term. PHI cover would remain roughly where it is, a few may downgrade their cover, and some degree of equity would be restored.

But the surcharge would remain. In fact, for those with incomes above \$93 000 it would rise from 1.00 percent to 1.25 percent, and for those with incomes above \$124 000 it would rise to 1.50 percent. (These thresholds are for singles; the family thresholds are double.)

To illustrate the effects of the current and proposed arrangements, it is informative to consider the surcharge not as a penalty, but as a tax incentive. That is, someone with a high income can be seen as having a one percent incentive to buy PHI.

Table 2 on the following page models the effects of the combination of the surcharge and subsidies from this frame. It models single policies at two ends of the spectrum – a very basic hospital policy, with exclusions and the maximum deductible, costing about \$900, and a very top cover policy at around \$3500 (assuming no "lifetime rating" penalty applies). The negative figures in red indicate a net saving or overcompensation.

From Table 2 it can be seen that those with high incomes have a very high incentive to hold PHI. Financially they are heavily overcompensated for basic policies, and those with very high incomes are heavily over-compensated for holding maxim-cover policies. It's as if those with very high incomes are given free policies, with change left over after being given those

free policies. The proposed changes reduce the incentives a little for those with moderately high incomes, but they actually increase the over-compensation for those with very high incomes.

Table 2: PHI incentives for those with high incomes - net costs after incentives and subsidies

Income	Medicare Levy Surcharge		Net cost of basic (\$900) policy		Net cost of highest (\$3500) policy	
	Existing	Proposed	Existing	Proposed	Existing	Proposed
60 000	0	0	630	630	2 450	2 450
80 000	800	800	-170	-80	1 650	2 000
100 000	1 000	1 000	-370	-190	1 450	1 800
120 000	1 200	1 500	-570	-690	1 250	1 300
140 000	1 400	2 100	-770	-1 200	1 050	1 400
160 000	1 600	2 400	-970	-1 500	850	1 100
180 000	1 800	2 700	-1 170	-1 800	650	800
200 000	2 000	3 000	-1 370	-2 100	450	500
250 000	2 500	3 750	-1 870	-2 850	-50	-250
300 000	3 000	4 500	-2 370	-3 600	-550	-1 000
400 000	4 000	6 000	-3 370	-5 100	-1 550	-2 500
500 000	5 000	7 500	-4 370	-6 600	-2 550	-4 000

The surcharge presently is 1.0% of income starting at \$80 000. The proposals involve new rates -- 1.0% from \$80 000 to \$93 000, 1.25% to \$124 000, 1.25% for higher incomes. The rebate would reduce to 20%, 10% and 0 at these thresholds.

The table shows the effective incentive cost of taking a policy. For example, someone with an income of \$200 000 at present pays \$630 for a \$900 policy, but has an extra \$2000 incentive to buy it, resulting in a net incentive benefit of \$1370. Under the proposed policy she would pay the full \$900 for the policy, but would have an incentive of \$3000, resulting in a net incentive benefit of \$2100.

It is strange for a government with a stated policy of "social inclusion" to provide incentives for the well-off to opt out of sharing their hospital costs with other Australians. It's akin to a local government subsidizing people to live in gated communities. Those with high incomes, who embrace the spirit of social inclusion and choose to share their health care costs with the wider community, pay a penalty for that choice. (Ironically, so too do those who choose self-reliance.) The implicit message is one of social division: PHI and therefore private hospitals are for those who have means; public hospitals are for the poor. This is a reversion to the "charity ward" system, which in time will morph into something akin to the US Medicaid program for the "indigent".

Conclusion: There are better ways

To satisfy criteria of efficiency and equity, the best policy for the Government would be to withdraw all support for private health insurance. It is administratively expensive (technically inefficient in economists' terms), distorts incentives and choices (allocatively inefficient), and does not satisfy any reasonable criteria of equity.

This is not to advocate a complete replacement of PHI with Medicare. It is simply to point out that, to the extent we choose to share our health care expenses, a single national payer is the best way.

It may be that, given the choice, Australians would prefer a completely tax-funded system. Or they may accept some level of direct payments, without insurance, with national insurance acting as a safety net. We have expressed no view on this matter, because the question has never been put to the Australian community.

Medicare and its predecessor Medibank have been presented politically as if they offer "free" health care, and, because the Medicare Levy covers only a small proportion of the health care budget, the public may underestimate the proportion of their taxes going to health care. Private insurance has been represented as a saving on public revenue, but it is an imposition very similar to taxation, and results in a higher cost than a tax-funded system, without delivering the claimed benefit of easing pressure on public hospitals. In neither case have politicians been frank with the community.

Rather than meaningless political rhetoric about private/public options – rhetoric which does not distinguish between funding and provision, and which suggests that without private insurance there would be no private sector in health care – the public debate should be about the division between use of market mechanisms and community sharing. PHI is not a market mechanism.

We have pointed out that when it comes to sharing health care costs a single national insurer has the capacity to control prices and usage, and to ensure that a health care system allocates resources equitably and efficiently. That is not to suggest that Medicare, as it exists at present, would perform that role well. It has drifted in function, to become a mechanism for providing some support for medical costs, with haphazard outcomes: some services are fully funded, while for others consumers are left paying high out-of-pocket costs. It has failed to achieve integration of health care services around consumer lines. Health care programs remain fragmented between Commonwealth and state governments, and even the Commonwealth's main programs, relating to medical and pharmaceutical services, operate separately.

Ideally, the Commonwealth should embark on a comprehensive program of reform, as it has done with other sectors of the economy. Health care is too important to be insulated from the economic reform process. And such reform should involve engagement with the community on basic questions of sharing versus individual responsibility. The research, consultation, exploration of ideas, costing and analysis should be undertaken by a body with some detachment from our present systems – inquiries by "insiders" tend to produce timid recommendations, often designed more to appease vested interests rather than genuine reform. Among important issues to be covered is to find a way of bringing private and public hospitals into the same funding streams.

In relation to the present Bills before Parliament, the best approach would be to remove all subsidies and surcharges supporting private insurance. As an interim measure, however,

there would be benefits in implementing the proposed means tests, while abolishing the Medicare Levy Surcharge, or even building the surcharge into general tax rates, without any conditionality relating to private insurance. In that way public revenue for health care would be significantly improved, and the Government's principle of social inclusion would not be violated.

Sources and notes

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