Funding health care – taxes, insurance or markets?

Paper for Health Insurance Summit, Sydney, 12-13 June 2003

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Abstract

After a long decline in membership of private health insurance, a set of policy initiatives, particularly the "lifetime" cover arrangements introduced in 2000, restored membership to levels last seen in the early 90s.

But membership, particularly of those with the best insurance profile, has now started to decline again. This raises once more the question of whether private insurance is an appropriate means of financing health care.

This paper examines six possible policy reasons for using private insurance rather than taxation and Medicare to fund health care, and finds in favour of taxation on every count. Public funding is less costly, more equitable and enjoys popular support. A modest (0.4 percent) increase in the Medicare levy would provide the same funding to private hospitals as is presently provided through private insurance, with greater equity, tighter cost control, more opportunity for competition and far less leakage to administration.

In conclusion the paper poses a more basic question about the structure of our health care financing; what should we share through Medicare and what should we pay for from our own pockets without the distortion of insurance?

Introduction

The full conference title to this presentation reads: "Is raising higher taxes a viable solution to health care funding gaps? Evidence on the impact of health care subsidies".

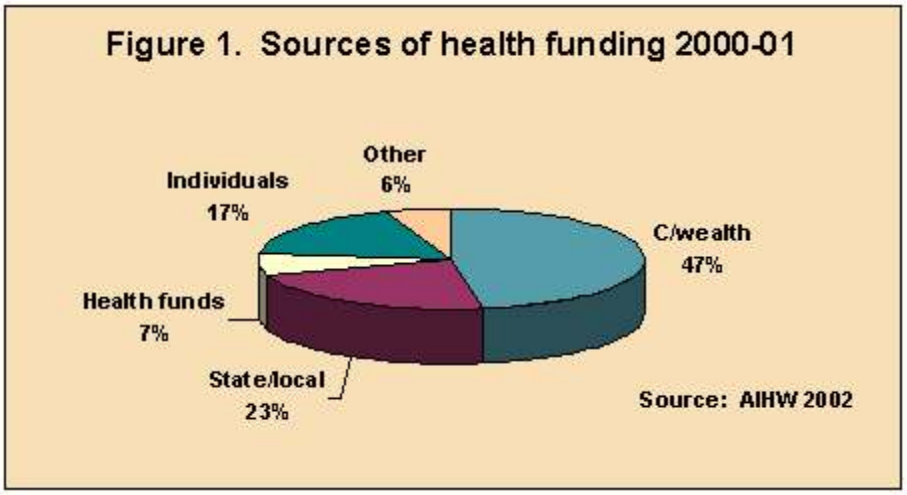
From any one perspective there are, indeed, funding gaps. The Commonwealth, concerned with fiscal outlays, sees a gap between the growing demands of an ageing population and its own desire to contain public expenditure. Individual patients, medical practitioners and politicians are concerned about the gap between Medicare rebates and medical fees.

But from a broader perspective, there are no gaps. All health care is funded, in one way or another. Inadequately, perhaps, according to some parties, and over-generously, perhaps, according to others.

The political and economic question, no doubt of concern to delegates at this conference, is how we pay for health care, equitably and efficiently.

In Australia, as in other developed countries, most health care funding is pooled. In our case we fund 70 percent through governments, 7 percent through health insurance funds, and some other small part through other pooling arrangements, such as accident compensation schemes. Only 17 percent is from individuals' direct contributions, such as uninsured stays in private hospitals, co-payments for pharmaceuticals, and gap payments for medical services.

Most of the debate on health care funding is centred on the question of government versus non-government funding. For that part of health care financing we choose to pool, should we do so through taxation or through private insurance? That question is the concern of this session, but I wish to conclude by raising the largely overlooked question of how public policy may address the broader question of the choice between markets and pooling.



Policies and consequences

Before the Commonwealth introduced Medicare in 1984, almost two thirds of all Australians were covered by private health insurance. By 1996 when the Coalition Government was elected, the proportion covered by private insurance had fallen to one third and was to fall even further before the Coalition's subsidies were to reverse the trend.

The notion that this decline was problematic was an article of faith among politicians, particularly Coalition members (though there were many Labor politicians, most prominently Graham Richardson, who shared that view). Tabloid headlines warned of a "crisis" in health care. Without a strong "private system" there would be unbearable pressure on the "public system" with increasing waiting lists. The stress on public budgets would be too great. Within two months of the 1996 election the newly appointed Health Minister, Michael Wooldridge, issued a press statement outlining the gravity of the situation:

> The continuing decline in the number of Australians with private insurance is perhaps the single most serious threat to the viability of our entire health system.[1]

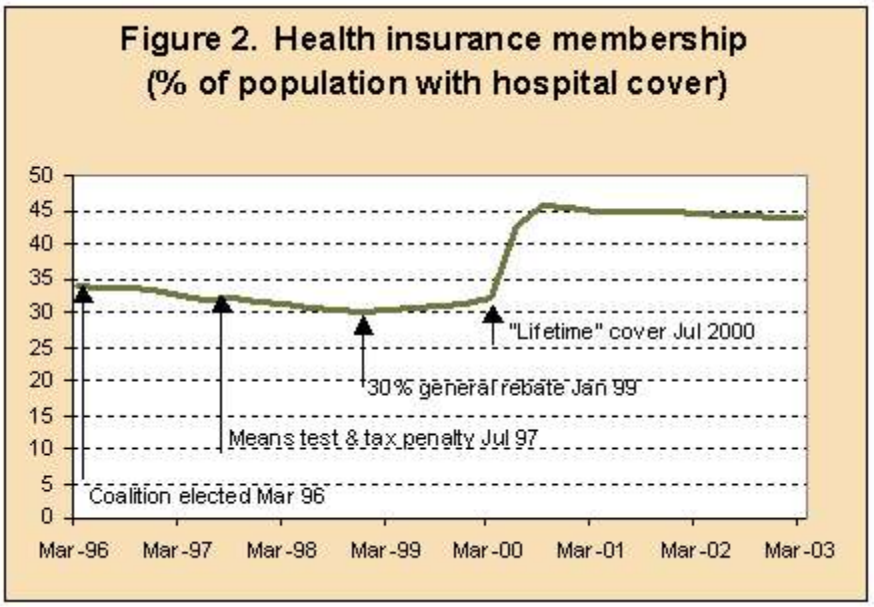
Over the next four years the Commonwealth was to introduce four policy initiatives to support private insurance.

- commencing in July 1997, means-tested fixed-rate rebates for private insurance, and a tax penalty (one percent) imposed on medium to high income earners without private insurance;

[1] Media Release, Minister for Health and Family Services May 24 1996,

- commencing January 1999, replacement of the means-tested rebate with a general rebate of 30 percent;
- commencing July 2000, "lifetime" cover agreements;
- proposed in April 2003, approval for private insurance to cover the gap in ambulatory services (after the first $1000).

Of the first three initiatives, only the third, the "lifetime" cover arrangements, resulted in a significant lift in private insurance levels. Movements in private insurance cover, including the dramatic lift resulting from the "lifetime" cover arrangements are shown in Figure 2.



It is a significant comment on the Commonwealth's policy-making process that two successive and expensive policy initiatives had virtually no effect on the uptake of private insurance. Because these subsidies did not increase membership, they must be considered as a transfer to those who already hold private insurance, rather than an injection of new funds into the health care sector. This point is stressed by John Deeble.[2]

As surveys by the Australian Bureau of Statistics confirm, price is not a prime consideration in people's decisions on whether or not to hold private insurance. The main reason is that people seek "security, protection, peace of mind". People's choice is not particularly influenced by the government incentives which reduce the price of insurance. (See table 1.)

Economists suggest that the price elasticity of demand for private insurance is low; on the other hand, the income elasticity of demand for private insurance is reasonably high. Like BMWs and Grange Hermitage, private insurance is what economists call a "superior good". That is, spending rises strongly with income. In 1995, well before there was any suggestion of subsidies for private insurance, 72 percent of Australians in households with incomes above $70 000 held private insurance, while only 26 percent of those in households with incomes below $30 000 held private insurance.[3] As a welfare measure the original means-tested rebates may have been well-targeted, but as a means of boosting private insurance they failed.

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[2] Deeble 2003.

[3] ABS *Private Health Insurance 1995* (Cat 4334.0) 1998.

Table 1. Reasons for holding private insurance (Percent)

Security, protection, peace of mind	72
Choice of doctor	39
Allows treatment as private patient	31
Provides benefits for ancillary services/extras	28
Shorter wait/concern over hospital waiting lists	36
Always had it/parents had it/condition of job	33
Gov't incentives/to avoid extra Medicare levy	2
Other financial reasons	6
Has illness/condition likely to need treatment	15
Elderly/getting older/likely to need treatment	15
Other	11

Source: ABS *Health Insurance Survey* (Cat 4335.0) June 1998.

The "lifetime" rating measures, on the other hand, were effective in attracting members. Just why they were effective is less clear – there has not been a subsequent ABS survey. John Deeble argues that if a 30 percent rebate was not going to attract members, then it was unlikely that a 2 percent annual increment would work. He suspects fear and uncertainty was a more likely reason. To quote Deeble:

> [T]he 'run for cover campaign' associated with 'lifetime health insurance' had a dramatic effect. Its basic message was that the government could not provide universal access to an adequate standard of hospital care through Medicare and that the only way to ensure personal coverage was to take private insurance now.[4]

There has been a subtle shift in health care policy over the last five years. The public rhetoric in government policy is about maintaining Medicare, which is still a universal system. But, contrasting with this notion, is the idea that publicly financed health care is essentially a welfare provision. For example, a *Sydney Morning Herald* editorial asserted that Medicare was "designed as a publicly funded safety net for the disadvantaged minority."[5] On introducing the one percent surcharge for high income earners Costello said he hoped no one would have to pay it; gone was any notion of tax-funded Medicare as a universal contract of mutual obligation. In introducing the 2003 proposals to cover ambulatory care gap payments, the Commonwealth outlined measures for the 45 percent of Australians with private insurance and the 35 percent with concession cards, but there was no consideration for the 20 percent or more of Australians who don't fall into either category. Budgetary measures speak with more authority than well-sounding promises to retain Medicare.

Private health insurance coverage is again falling, at the rate of 0.7 percent of the population a year. This is only half the rate of the fall over the period to 1997, but it does not bode well for the industry, in part because the composition of the insured is changing. From September 2000 (the start of "lifetime" cover) to March 2003 the funds have lost only 92 000 members – not serious in a total membership of 8.7 million – but this aggregate figure masks more basic changes in the funds' composition of membership. The funds have lost 317 000 members

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[4] Deeble 2003, op. cit. P.5.

[5] Quoted by Professor Stephen Leeder in SMH 1 May 1998.

aged 54 or less, while gaining 225 000 older members.[6] This is worsening the funds' risk profile, and will result in a positive feedback sequence of rising fees and more "adverse selection". That is, the tendency for people to choose whether or not to insure on the basis of their perceived risks.

It is possible to demonstrate that, in spite of the annual two percent price steps in the "lifetime" cover arrangements, there is still a significant cross-subsidy from younger to older members. The age at which it becomes rational for the "average" consumer to take up private insurance is around 65.[7] Higher income earners will perhaps be held by the tax penalties, but because most young, healthy people have incomes below the thresholds for the tax penalties, they are unlikely to entice young people to private insurance. It is possible that, over time, as people find they do not make a claim, or make claims and are disappointed, they rationally decide to drop private insurance, and decide to take it up at a later age.

The Commonwealth, therefore, will be tempted to find further measures to support private health insurance. But to do so would be to re-commit some of the mistakes of the past – to rush into expensive policy solutions without adequate research.

The Commonwealth has assumed that a decline in private insurance is undesirable. But is that the case? The next section examines the arguments for supporting private insurance, and concludes that there is nothing done by private insurance that cannot be done better by the taxation system.

Private or public taxation

There are several reasons the Commonwealth may wish to support private insurance. Possible candidates for explanation include:

- 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.

Below these reasons are examined (and dismissed), in turn.

Competition

A great deal of privatization in Australia has been carried out in the name of competition policy. Although competition policy is rarely used explicitly as an argument for supporting

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[6] These figures can be derived from PHIAC A reports.

[7] This can be deduced by comparing premiums (after the rebate) with the payouts by age group.

private health insurance, it has certainly contributed to a general notion of the desirability of privatization.

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.

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 (authorized 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 centralize 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.

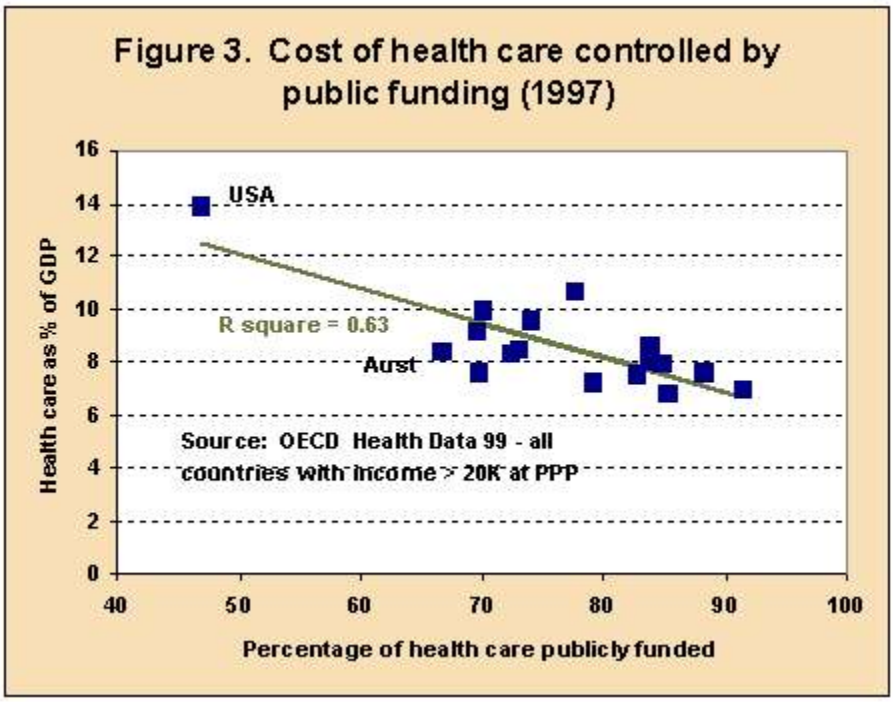

Figure 3, drawn from OECD data, shows how centralized government funding keeps control on health care costs. It shows the relationship between the proportion of health care expenditure accounted by the public sector and the total cost of health care as a percentage of GDP. All high-income (above $20 000 per capita at purchasing power parity) OECD countries are covered. All these high-income countries have good health care outcomes; there is no suggestion in this data that low expenditure results in poor health care.

The extreme point on this diagram is the USA, where health care costs are in the order of 14 percent of GDP – a result mainly of health price inflation caused by a lack of cost control in a fragmented private insurance industry. The irony of USA's situation is that its government programs, Medicare and Medicaid, which cover only limited services to a small part of the population, now account for around 6.4 percent of GDP, only a little less than the UK's 6.8 percent of GDP which buys the British a near comprehensive national health care system. The US Government is a weak purchaser in a market distorted by private insurance.

This analysis establishes the case for a single national insurer. 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.

Administrative waste

Stories of administrative waste in public sector bureaucracies are legend. But private sector bureaucracies, too, can incur heavy overhead costs.

Private insurers in 2001-02 received $6 782 million in contribution income, of which $767 million or 11.3 percent was spent on administrative costs.[8] 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.[9] To this must be added the costs incurred in the Australian Taxation Office of collecting tax – about another 1.2 percent.[10] 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.

Support for private hospitals and taking a load off 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

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8 PHIAC 2001-02.

9 HIC 2001-02. The HIC shows a figure of 3.7 percent, but they express expenses as a percentage of benefits paid.

10 Appropriation to the ATO in 2002-03 is $2.2 billion, tax collected is $185 billion, giving a collection cost of 1.2 percent.

Hospitals Association, for example, has stated its commitment to "reversing the exodus from private health insurance and easing pressure on our embattled public hospitals".[11]

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 Table 2. Self-insurance was on the rise until 1999, when "lifetime" cover was announced.

Table 2. 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 penalize 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 care expenses exceeding $1250. (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.[12]

John Deeble has estimated that because of leakages to administration costs, ancillary benefits, and medical gap payments, only a small proportion of funds passing through private health insurance have made their way into private hospitals.[13]

Deeble's research also shows that only a small proportion of funding passing through private health insurance – about 35 percent – has gone into supporting health services which may have some offset in reducing demand for public hospital services.[14]

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[11] Ian Chalmers, Executive Director of the Australian Private Hospitals Association, quoted in *The Australian* 6 May 1998.

[12] Vaithianathan 2002.

[13] Deeble 2003.

[14] Deeble 2003. Deeble quotes 40 percent after administration expenses, which equates to 35 percent before administration expenses.

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 Monsah 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.[15]

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 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.

Equity for the insured

Many politicians and community groups believe that because 44 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. Table 3 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 Chesty Bonds T-shirts.)

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[15] Richardson et al 1999.

Table 3. 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 Medibank "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 ancillaries – 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.

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).

Table 4. 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 Table 22.

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 subsidizing private health insurance, could have spent that money, plus another $1 198 million, directly to the hospital sector to provide the same amount of funding as was provided by private insurance. It could have raised that amount of money through a 0.4 percent increase in the Medicare levy.[16]

Would such an explicit tax increase be politically acceptable?

The simple answer is probably "yes". Most people who arrange health insurance deductions from their pay packet probably don't care much whether deductions are made to HCF, Medibank Private, or the Australian Taxation Office.

More solid evidence on attitudes to taxation is available from various surveys of people's attitudes to taxation. 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 Center 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).[17]

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).[18]

Political polling confirms these findings. In 1993 the Coalition 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.[19]

Even more compelling 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 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

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[16] In 2000-01 the 1.5 percent Medicare levy was budgeted to raise $4580 million. Another $1198 million would require another 0.4% (1.5 * (1198/4580))

[17] Survey by Angus Reid Media Center, February 2000. Web link from *The Economist* of March 18-24, 2000 .

[18] Throsby and Withers 1994.

[19] Bean and McAllistair 1997.

percent were in support of the higher levy and again there was little variation in support by age, region or voting intention.[20]

Medicare is a popular program, as revealed not only in such 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 characterized by a general mistrust of government.[21]

In terms of taxation theory, private health insurance is an example of what Naomi Caiden refers to as a "privatized tax". Caiden warns that, in the name of keeping official taxes low, we may be reverting to an earlier time when payment for collective goods was expensive and unfair, imposed by the caprices of kings and emperors.[22] Private health insurance has many of the characteristics of a tax, but few of the virtues of an official tax.

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.[23] 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 recognized that governments could do some things that the private sector could not do, or not do so well.

Where to for private insurance?

A unique feature of Australia's health funding system is its sensitivity to party political swings. In most countries health financing schemes are reasonably embedded. Britain's Thatcher Government, for example, was unable to demolish Britain's NHS; it was too solid a part of the British landscape. In the US the Clinton Government was thwarted in its attempts to implement modest reforms to that country's high cost system based on employer-funded private health insurance; it too was embedded.

By contrast, in Australia, the mechanisms of health care funding, and therefore the fortunes of private health insurance are governed, usually with a time lag, by the ideology of the government in office.

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[20] See www.hawkerbritton.com.au

[21] "Community satisfaction with HIC" is measured at 90% by the HIC in its 2001-02 Annual Report.

[22] Caiden 1987.

[23] Halligan 1998.

For most high-cost industries, such as clothing and footwear manufacture, the main parties have been able to come to some reasonable consensus about ways to withdraw assistance in an orderly way. Labor governments, in the late twentieth century, abandoned their long attachment to tariff and quota protection, in the interests of national economic efficiency.

Coalition governments, by contrast, while generally amenable to phasing out assistance for high cost industries, seem to have a blinkered attitude to private health insurance. That they should aim to sustain the private hospital system is entirely understandable. But it is much harder to understand why they should be so committed to sustain a high cost financial intermediary from the health care budget as a means of achieving that end. We might expect Coalition governments to encourage more self-reliance and more use of market signals in health care. But, in penalizing those who pay for their health care without insurance, and in encouraging gap insurance, they have acted against their own basic principles.

While espousing values of "mutual obligation", the Coalition has undermined one of Australia's strongest institutions of mutual obligation – a shared health care system with national pooling. Community dependence is being replaced by corporate dependence.

In Orwell's *Animal Farm* the mantra was "two legs bad, four legs good" (sometimes to be replaced by the mirror-image mantra). In health care in Australia, the mantra now is "community dependence bad, corporate dependence good", or "official taxes bad, private taxes good".

In a less ideologically laden environment there would be some scope for rational public policy. The immediate problems which could be addressed in such an environment are:

- How to sustain a high standard private hospital system, without having to do so through high cost intermediaries. Funding through public budgets (probably through Commonwealth/State health care arrangements) is the most attractive option.
- How to allow private health insurance to depart with dignity. Australia has dealt with bigger challenges in other, larger industries such as clothing and footwear; phasing out private health insurance should be comparatively painless.
- How to assure the community that they can have confidence in the hospital system, private and public, so they do not feel they have to take out insurance beyond that which is covered by Medicare.

These are the immediate issues, but I would like to conclude by referring back to the more basic question of what we should cover through pooling, and what we should cover through individual payments not covered by insurance.

Conclusion – a wider consideration

Contrary to some alarmist headlines, Australia's health care system is not in crisis, but it is in a mess, particularly in its institutional and funding arrangements. Multiple sources of funding, Commonwealth/State divisions, and professional demarcations have contributed to this mess.

As a result we have a system which, to the consumer, has little or no rationality. Some services, such as those offered by public hospitals, are free. Some, such as prescription pharmaceuticals, are subject to co-payments, but these are capped. Some, such as ambulatory services, are subject to open-ended co-payments where the consumer bears the risk. And some important services, such as dentistry and physiotherapy, receive no public insurance cover at all. Private insurance sits uncomfortably alongside public insurance, but in many cases it is a perverse form of insurance, because many benefits are capped. "Insurance" as we generally know it is about protecting people from high risk, but many private insurance policies, particularly ancillary policies, leave the consumer bearing open-ended risk.

Unfortunately those within the system, including public servants, service providers and financiers, know it too well to be able to take an outside view. They are generally comfortable with existing institutional arrangements. They know their way around the system, and assume its basic institutional arrangements are immutable. To use Charles Lindblom's famous term, they are content to "muddle through", seeking incremental change in response to problems, rather than basic change.

Lindblom's work is often taken as a defence of such an approach to policy development, but in his work he makes it clear that muddling through is flawed. He states: "... the method is without a built-in safeguard for all relevant values, and it also may lead the decision-maker to overlook excellent policies for no other reason than that they are not suggested by the chain of successive policy steps leading up to the present." He also warns about ignoring possible consequences of policies, and of confusing means and ends.[24] (This last warning is particularly relevant in the case of private health insurance, because supporting private insurance has become an end in itself, rather than seeing it as one possible means of channelling funds to private providers.)

In 1997 the Industry Commission (now the Productivity Commission), in its report on private health insurance, reported on the difficulty in looking at private insurance in isolation. Its key recommendation was that there should be a broad public inquiry into Australia's health system, covering, among other matters, financing, community rating and co-payments.[25]

This recommendation goes to the more basic question of what we should pool and what we should pay for out of our own pockets. There is a strong case for rationalizing co-payments in health care, but they should be capped, and consistent across programs. There is a strong case for more market signals, but they serve little purpose if some are encouraged to buy out of the discipline of markets by using private insurance.

To profit from such an inquiry we may all have to question some of our basic assumptions – that the present institutional arrangements are immutable, that private insurance is necessary to sustain a private health care system, that certain services can be free to all users, that price competition in health care is vulgar. That questioning will require a spirit of political openness which, right now, is lacking in our debates on health care.

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[24] Lindblom 1959.

[25] Industry Commission, 1997.

Bibliography

Australian Institute of Health and Welfare *Health Expenditure Australia 2000-01* (AIHW September 2002).

Clive Bean and Ian McAllister "Short-term influences on voting behaviour in the 1996 election" in Clive Bean, Marian Simms, Scott Bennett and John Warhurst (eds) *The Politics of Retribution – The 1996 Federal Election* (Allen and Unwin 1997).

Naomi Caiden "Patterns of Budgeting" in A Schick (ed) *Perspectives in Budgeting* (American Society of Public Administration, 1987).

John Deeble "The Private Health Insurance Rebate – Report to State and Territory Health Ministers", National Centre for Epidemiology and Population Health, ANU, January 2003.

John Halligan "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, 14-17 September 1998.

Health Insurance Commission *Annual Report 2001-02*.

Industry Commission *Private Health Insurance* Report 57. February 1997.

Charles Lindblom, "The Science of Muddling Through" *Public Administration Review* 19, 79-88, 1959.

Private Health Insurance Administration Council *Operations of the Registered Health Benefits Organisations, Annual Report 2001-02*.

Jeff Richardson, Leonie Segal, Jenny Watts, Robert Carter, Duncan Mortimer, Stuart Peacock, Iain Robertson "The Reform of Public Hospital Funding in Australia – Submission to the Senate Inquiry into Public Hospital Funding" Centre for Health Program Evaluation, Monash University, 1999.

David Throsby and Glenn Withers "Measuring Demand for Public Expenditure: Theory, Methods and Preliminary Results" Macquarie University Research Paper 383, July 1994.

Rhema Vaithianathan "Will Subsidising Private Health Insurance Help the Public Health System?" *The Economic Record* Vol 78,. #2, September 2002, pp 277-283.