Medicare: badly injured, but resuscitation is possible

Ian McAuley – University of Canberra

Paper prepared for ANF National Delegates Conference, 17 October 2003

Introduction

Medicare – a term I use to cover our publicly-funded health services – has suffered some severe blows over the last few years. Most of its injuries have been inflicted by the Coalition Government, elected in 1996, but Medicare could possibly have withstood these assaults had it been nurtured better by the Hawke/Keating Government.

It has been easy for the Coalition Government to state its commitment to "a fairer Medicare", while fundamentally re-defining Medicare as a welfare or charity system, rather than as a shared national health care system. History, as Orwell demonstrated, is easily re-written by the ruling party.

At first sight we may see some wisdom in directing health care funds to those who are least well-off, as occurs in programs such as public housing. But this is to take a superficial view of Medicare – a view which overlooks the values embodied in a national health care system, and which ignores the case in economic efficiency for using governments to pool our health care funding.

It is this economic point that I wish to emphasize this morning, because we need to rebut the notion, popularized by the Coalition, that somehow public sector activity is less worthy than private sector activity, and that social programs such as Medicare have to be sacrificed in the name of economic progress.

Economics and the public purpose

Among community and welfare groups it has become fashionable to criticize economics as the root of many of our ills. When a program such as Medicare is cut, we blame "economic rationalism" (a peculiarly Australian term). Such criticism only reinforces the zeal of neoconservative governments, who can claim that "rational" economics is very much preferable to some form of economic irrationalism. It's an unfortunate choice of words and an unnecessary denigration of economics.

The fault lies not in economics itself, which has liberal as well as conservative traditions. What many people call "economic rationalism" is in fact profoundly irrational, being based in blind ideological prejudice rather than in any rational process.

Just as religious zealots quote selectively from sacred texts, neoconservatives, such as the Republican Government in the USA and the Coalition Government here, have taken the discipline of economics out of its context. They ignore the fact that economics is primarily a social discipline, and they conveniently forget that economics posits a perfectly valid role for public enterprise.

The notion that somehow we have to tradeoff or balance economic and social goals is bunkum; it makes no more sense than the infamous quote from the Vietnam War "we had to destroy the village in order to save it". So-called "economic" success, if it comes at a social cost, is worthless. Economics, as Adam Smith pointed out, should be subservient to society. Unfortunately, most of those who invoke Smith's name to justify their programs of privatization have read no more than a few out-of-context extracts from his work, about the workings of the "invisible hand".

The "invisible hand" of market forces does a tolerably good job of bringing us cars, hotel rooms, and hi-fi systems, but it has its limits, which were well recognized by Adam Smith who wrote extensively on the need for public goods and by more recent mainstream economists such as Keynes, Samuelson, Galbraith and Stiglitz.

Herman Leonard, Professor of Accounting at the Kennedy School, Harvard University, has said "the hard jobs are left to the public sector". I suspect his statement is hardly news to an overworked nurse in an acute care public hospital, or, for that matter, to a schoolteacher or police officer. But it is not what neoconservatives, particularly those in the Coalition Government, would have us believe. We are supposed to see the public sector as some deadweight burden, reluctantly supported by the "productive" private sector. (In the case of Medicare it is particularly ironic to find that the government is subsidizing a bloated financial intermediary, the private health insurance industry, which spends $800 million a year on bureaucratic overheads.)

Medicare – our mutual obligation

The strongest case for Medicare is that health funding is something we wish to share through our taxes. Those who trot out the rhetoric of "choice" in defence of private health insurance conveniently overlook the fact that we sometimes wish to make collective choices.

This collective desire to share our health care costs is revealed in public opinion surveys, most recently in 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; 76 percent were in support of the higher levy and again there was little variation in support by age, region or voting intention.[1]

Even some in the Labor Party, the epitome of political timidity, are cautiously raising the possibility of increasing the Medicare Levy. (I have calculated that a 0.4 percent increase in the Medicare levy would provide the same funding to private hospitals as is presently provided through private insurance.)

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

[1] For the poll, see www.hawkerbritton.com.au

90 percent with a government agency is extraordinary in an era characterized by a general mistrust of government.[2]

As a lecturer in public sector finance, I would like to think that such sentiments reflect an economic maturity in our population – that four out of five Australians understand the evidence and arguments about the economic benefits of a taxpayer-funded health care system. But I suspect they are revealing a deeper commitment – a commitment to share with other Australians their health care resources. That's what one may refer to as "mutual obligation".

Beyond charity

At first sight we might see health care as a welfare program – indeed, we often trot out the term "health and welfare" as an inseparable pair of words.

Health care certainly has redistributive benefits, but that does not make it a welfare program. Table 1 shows the clear redistributive effects of Australian publicly-funded health care programs; high income households use far less publicly-funded hospital care and pharmaceuticals than low income households.

To an extent that may reflect means tests already built into programs, but that is unlikely to explain much of the distribution, for programs such as public hospitals are not subject to means tests. In pharmaceuticals there are means tests in relation to concession card holders, but the distribution predominantly reflects the fact that concession card holders are the highest users of pharmaceuticals, accounting for 83 percent of PBS prescriptions in 2002-03.[3]

Table 1 – Average weekly value of publicly-funded health benefits, 1998-99, by household income quintile, $.

	Lowest 20%	Second quintile	Third quintile	Fourth quintile	Highest 20%
Hospital care	43.46	52.79	35.50	34.15	34.99
Medical clinics	20.13	28.53	28.26	30.54	33.25
Pharmaceuticals	11.07	13.24	6.89	5.01	4.77
Other health benefits	4.67	7.20	8.47	9.55	10.56
Total health benefits	79.33	101.76	79.12	79.25	83.57
Private income	14.85	205.90	612.34	1 059.55	1 953.52
Health benefits as percentage of private income	534%	49%	13%	7%	4%

Source: ABS *Government benefits, taxes and household income 1998-99* Cat 6537.0. "Private income" is income before taxes and government benefits. ""Benefits" measured by ABS as amount of budget inputs into Commonwealth and State programs.

If we see health care as charity, then perhaps it is reasonable to suggest that we could achieve more for our money by getting the better-off out of the system. But that is to confuse purpose with effects. A completely different interpretation is that because the well-off are relatively

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

[3] Department website on pharmaceutical statistics.

low users of the system, it costs little to keep them in to achieve the benefits in having everyone in the one system.

The clearest benefit is that the well-off are likely to be the most assertive champions of the system. If they are included in the system they will not be gripped by what Fred Argy calls "downward envy" – a sneaking contempt for those drawing on welfare programs, leading to a loss of commitment to those programs.

An example of the benefit of keeping the well-off in one system is provided by experience during the 1960s, when many students from middle-class families found themselves imprisoned for draft evasion and similar offences. That experience spurred a significant and effective push for prison reform.

There is another and economically even more compelling reason for a single system. As any nurse knows, health care resources are not in unlimited supply. If my rich neighbour goes out and buys a Lamborghini, his action doesn't make it any more difficult for me to buy a Nissan. Cars can be produced to meet demand. Not so for health care, particularly skilled labour in health care. If I tie up the services of a plastic surgeon for a nip and tuck in a private hospital, some burn victim will have to do without or wait longer.

Eva Cox, in her opposition to subsidies for private insurance, has made both these points:

> The idea of buying the privilege of queue jumping offends me. It also means that the public sphere loses its articulate advocates if it becomes merely a safety net. If all those who can afford to move out do so, then the service becomes residual and a poor alternative. So those with the worst health indicators end up with the worst services.
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> I am particularly offended by statements which imply I should pay health insurance to free the public system up for those who can't afford it. Given limited numbers of specialists who serve both sectors, it seems to me that the more not-so-sick queue jumpers there are in the private sector, the longer will be the queues in the public sphere. So I will wait my turn, or pay heavily if I panic and use my savings to buy privilege, which is also unfair to those who have no savings.[4]

In this statement Eva Cox is articulating what economic philosophers refer to as a "Rawlsian" view on health care. Even if we are generally inegalitarian, accepting the slings and arrows of life's outrageous fortunes, we may have a different attitude to health care. We may know our inheritances of material wealth and of physical and intellectual talent, but we do not know what lies around the corner when it comes to health. In the terminology of Harvard philosopher John Rawls, in relation to our health care needs we are in an "original position", and are likely to choose to share our lot with others.[5]

In a program of social engineering, however, the Coalition is trying to re-define health care as charity. The term "a fairer Medicare", at first reading, seems to be no more than another of

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[4] Eva Cox, quoted in "On health insurance and private choice" *Australian Health Review* Vol 22 # 1, 1999, P 3.

[5] John Rawls *A Theory of Justice* (Harvard University Press 1971).

the Coalition's insipid political epithets, but it is more than a throwaway line, for it carries a new meaning of "fairness". According to the Coalition Medicare was never a universal program; it was simply there for the poor, the indigent, the no-hopers. We first saw this re-writing of history in statements such as Peter Costello's introduction of the Government's plans to impose a one percent levy on high income taxpayers without private health insurance, when he said "This is the levy which the Government hopes no-one will pay".[6] We see it again in the current proposals for increasing Medicare rebates for those medical practitioners who choose to bulk-bill concession card holders; the medical surgery becomes a part of the welfare system. And we see it in the proposals to increase pharmaceutical co-payments for general users, a measure which would save only $270 million in a seven billion dollar program; its purpose is to remove healthy and well-off people from any sense of identification with the PBS.

If the Coalition gets its way, through the Senate buckling under, or through a double-dissolution election, then the consequence is a health care landscape of gated communities and poorhouses – a landscape of a divided Australia, and one we have already started to develop with the private health insurance subsidies.

It is surprising that this destruction of Medicare is not causing more political backlash, particularly when there was such pain and passion in the introduction of Medibank, our first universal system, in 1974. In the UK, for example, while the Thatcher Government was able to wreck the rail system and many other utilities, the NHS was healthy enough to survive with very little injury. Similarly, in Canada, the Romanov Commission re-asserted a commitment to a national health care system.

These national systems have been well-embedded, in contrast to our Medicare system, twice developed and twice knocked down, which is subject to political whims. The Canadians, at least, have the example of the USA just over its border, where a health care system, dominated by private insurance, is costing that country 14 percent of GDP, compared with 10 percent in Canada, while producing no better health outcomes.

The USA system is instructive for the trade union movement, for its expensive and inequitable system has coopted the union movement. Health insurance is part of enterprise deals, particularly in industries dominated by large corporations. Automobile companies, for example, pay $US9000 a year per worker for health insurance.[7] This not only threatens the competitive viability of the industry; it also comes at the expense of other cash benefits. Auto workers could be $3000 a year better off if they had a Canadian-style tax-funded system. Unfortunately here in Australia some irresponsible unions are being coopted into bargaining for employer-funded health insurance. Fortunately the ANF is wiser.

I suggest that the political problem in Australia is that while the Labor Party, to its credit, has twice gone to the trouble of introducing a national health care system (involving a huge political struggle in 1974), it has been half-hearted in defending it or even explaining it.

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[6] Budget Speech 1996.

[7] "Employers' liability" *The Economist* 20 September 2003.

For example, over the period 1983 to1997 the level of private insurance fell from 50 percent to 30 percent of the population. But rather than seeing this as a success, as an endorsement of Medicare, the Government of the time allowed this to be framed as a "problem". The real problem was that when Labor lost office in 1996 there was still enough of a constituency holding private insurance to bring it back to life; a medical analogy is an infection which has been suppressed but not eradicated by an inadequate dose of antibiotics. And it was a Labor health minister, Graham Richardson, who tried to re-define health care as a welfare program.

But it was the Coalition which addressed the "problem" with strong action; within two months of the 1996 election the newly appointed Health Minister, Michael Wooldridge, issued a press statement outlining what the Coalition saw as 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.[8]

Rebutting the neoconservatives – the economic case for public finance

We don't have to justify all government programs by the strict criteria of the discipline of economics. It would be difficult (perhaps not impossible) to use economic benefit-cost analysis to justify military bands or state funerals, but in the case of health care, there is a clear economic case for publicly funded programs and the exclusion of private insurance.

I don't want to take this session over with an economics lecture – I do that elsewhere. For those who wish to pursue the economic case in detail they can see a paper I presented at a health insurance summit in June this year.[9]

But if I can be permitted a short excursion into what some call "the dismal science", I do want to examine and rebut some of the claimed or implied economic "benefits" in withdrawing budgetary support for Medicare.

"*We cannot afford it*"

It is correct that health care has been costing placing a higher and higher burden on public budgets. Over the ten years to 2001-02 budgetary outlays on health care (Commonwealth and State) doubled in real terms. This has caused some alarm to treasurers.

But just as public outlays have doubled, so too have private outlays doubled. The public share of health care has moved very little.

Shifting more costs off-budget would not result in any savings in our total health care bill; in fact it would probably increase our health care bill, as international experience illustrates. Figure 1, using data from the nine countries surveyed by the Institute of Health and Welfare, shows that those countries which have placed more of their health care financing in public budgets have tended to have lower total outlays on health care. It is notable that out of these

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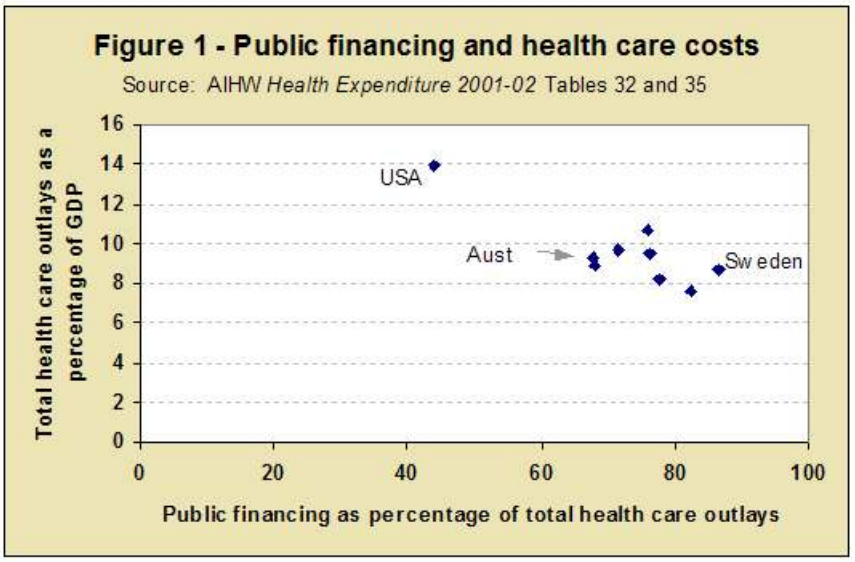
[8] Media Release, Minister for Health and Family Services May 24 1996.

[9] Available at http://resources.dmt.canberra.edu.au/imcauley/confs/hcconf.pdf

countries only the USA has a lower proportion of public health care financing than Australia. The success story at the other end of the diagram is Sweden, which, while having one of the world's most aged populations, has managed to keep its health care costs to less than nine percent of GDP through controlling 87 percent of those outlays through public budgets.

All nine are developed countries with good health outcomes. The differences relate to what they pay for those outcomes, and the explanation lies in the capacity of governments to do what the private sector cannot do so well – to control costs and usage, particularly where insurance is used to spread costs.



In general, people choose to use insurance – private or public insurance – to share a large part of their health care burden. Private insurance, however, has three costs which public insurance, such as Medicare, can avoid.

First, there is the administrative cost. Australia's private insurers in 2001-02 received $6 782 million in contribution income, of which $767 million or 11.3 percent was spent on administration.[10] In the same year, Medicare, with a total turnover of $8 023 million, incurred management expenses of only $291 million, or 3.6 percent.[11] To this must be added the costs incurred in the Australian Taxation Office of collecting tax – about another 1.2 percent.[12] Therefore the total cost of collecting and distributing 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 rather than on bureaucracy.

Second, there is what insurers know as "moral hazard". That is the tendency for people to use more of a service when it is free at the point of delivery. Moral hazard is a feature of all insurance, private or public. It is aggravated by the presence of "no gaps" cover, which the government has been encouraging. There is little difference between the notion "Medicare" will pay for it and "HCF or NIB will pay for it" – except that in the case of services covered

[10] PHIAC 2001-02.

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

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

by private insurance there is less incentive for a provider to suggest the procedure may be unnecessary.

Third, because private insurance is fragmented, it has less capacity to control costs than a single national insurer has. National health care systems work because the government, as a concentrated source of purchasing power, has strength in the market. The most recent example is the way liability insurers have dipped their fingers further into the health financing till. Anticipating the end of the discipline of bulk-billing, the liability insurers realize that medical fees will become uncapped, particularly if the Coalition's proposals to allow private insurance for medical fees goes through. Subsidised health insurance to cover the cost of liability insurance! Not even the Marcos or Suharto Governments were so ingenious in their cronyism.

"But we must support private hospitals"

One of the most successful myths perpetrated by the Coalition and the private insurers is the notion that we need private insurance to support private hospitals. Russell Schneider, the lobbyist for the private health insurers, uses every media opportunity to assert the notion that without private insurance we would not have private hospitals.

The reality, revealed in research conducted by John Deeble, is that because of leakages to administration costs, ancillary benefits, and medical gap payments, only about a third of funds passing through private health insurance have made their way into private hospitals.[13]

Bill Hayden, who, as Minister for Social Security, brought us the original Medibank, expresses this wastage eloquently. In a speech to the Fabian Society last month he said:

> Private health insurance is prodigiously wasteful. Leakages of over 60 percent of your $2.25 billion subsidy provided no more health services, had no offsets on the public side, in fact had nothing to do with health.
>
> Look at it another way. The genius of the corporate health insurance sector is that for each new $10 of your money it spends, it gets $4 of new health services.
>
> The Howard Government's dry economics is giving us the financial management of a drongo. If you ran a business you'd sack an accountant who designed that sort of result.[14]

There is a good case for subsidizing private hospitals, particularly those that meet high quality standards. But to do so through a high cost financial intermediary makes no economic sense. John Kenneth Galbraith has a saying "if you want to feed the chicken, feed the chicken; don't feed the horse and rely on the trickle down effect to feed the chicken".

We need to see support for private health insurance not so much as support for the health care sector, as support for the financial sector – a sector which has enjoyed largesse from both

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

[14] ""Has Medicare a future,..." Address by Hon Bill Hayden to the Victorian Fabian Society, 10 September 2003.

main parties in recent years, and will enjoy even more support if the proposals to allow private insurance to cover medical services pass through Parliament. As the financial sector grows it places a higher and higher burden on the productive sectors of the Australian economy – on those who work in factories, farms, schools and hospitals who have to support an ever-growing class of financial bureaucrats.

There are many ways to support private hospitals without using private insurance as the funding mechanism. Perhaps the Coalition's real target of support is the financial sector, but it is more politically acceptable to dress up the subsidies as support for health care.

"And we must take the pressure off public hospitals"

This argument has some glib appeal, until we realize that when resources are constrained, those resources will move to where the money is. Money does not always bring forth new resources; when there is a fixed pool of resources all that money does is to shift them around. Unfortunately politicians and senior Treasury officials, particularly in the Commonwealth, do not understand the difference between money and real resources. To a nurse working in the real world of a hospital or clinic, this may seem to be an extraordinary shortcoming, but the rarefied atmosphere of Canberra's offices is a long way from the real world of hospital wards.

If more money is directed to the private sector, then that's where the resources will go. And the situation is aggravated by the fact that those with private insurance, particularly low-cost private insurance, have no incentive to use the private system – a point explained in the next section.

"*But what about equity for those with private insurance?*"

The rebates and incentives are truly perverse. There is no equity for the 20 percent of Australians who choose to use private hospitals without insurance. Nor is there any equity for the 60 percent who pay for their own ancillary services – particularly when part of the saving to fund private insurance has involved scrapping the Commonwealth dental scheme.

Those on high incomes who take out private insurance are ridiculously over-compensated. When we realize that the one percent levy on high income earners is actually a tax incentive, we can see that someone with an annual income of $100 000 is paid $1 000 to have private insurance, while basic cover with exclusions and co-payments can be bought for as little as $350 after the rebate. And the ultimate absurdity is that one who has such a policy has no reason to use it – it's better to use a public hospital to avoid the co-payments. (Chris Cuffe, who has so far taken first place in the corporate payout stakes, would have enjoyed a $300 000 benefit from taking up private health insurance.)

"*We must reduce taxes*"

What is private health insurance, however, if it isn't a tax? In essence, it's a privatized tax. When people look at their payslips they find private insurance is deducted in the same way as PAYG taxation. Only it's more expensive to collect, less equitable in its impact, less effective in cost control, and less democratically accountable than taxes collected through the Australian Taxation Office. There is nothing that private insurance does that the tax and Medicare system cannot do much better.

In *Animal Farm* Orwell parodied political dogma of blind favoritism of one sector with the mantra "four legs good, two legs bad"; in health care the Coalition's mantra is "corporate dependence good, community interdependence bad".

"*We must reduce the size of the public sector*"

This is the argument put forward by those who, like the Taliban, have substituted religious zeal for independent thought.

There is no intrinsic benefit in smaller government. There are countries, such as the northern European democracies, with big governments and successful economic performance. There are countries, many in South America, with small governments and poor economic performance.

What numerous studies have found is that what counts is the composition of government spending, and its management. Big military budgets, subsidies to cronies and unsustainably generous welfare payments to buy patronage, all tend to make for poor economic outcomes. On the other hand well-managed investment in physical infrastructure, health and education make for stronger societies and therefore stronger economies. In Australia our public expenditure is going in the wrong direction; we are having to spend more and more on welfare to compensate for our poor economic performance, while we are cutting back on those programs which could lift economic performance.

Investments in health care and in public health pay very high dividends – a return which will rise as we come to face labour shortages in the coming years. This point, particularly in relation to public health, was stressed by many speakers, from all political perspectives, at the recent Health Summit.

"*People want choice*"

Defence of choice to justify privatization of health funding is the last refuge of scoundrels, who conflate choice of health services and choice of financial institution. People do indeed value choice in markets for cars, restaurants, clothes and many other goods and services. They value choice in health care delivery – as illustrated from cases ranging from choice of obstetrician through to choice of alternative therapies. But there is nothing of great value to differentiate the 30 or so look-alike private health insurers. At best they offer slightly different combinations of packages and different advertising jingles.

The choice which is increasingly being denied is the option for us to use our taxes to share our health risks and health care costs with other Australians. Those on high incomes have to pay dearly to exercise this choice.

There are a quarter of a million Australians, however, who seem to place mutual obligation ahead of narrow self interest, and pay the levy rather than moving to the gated community.[15] One who pays the levy is former health minister, Carmen Lawrence, a politician who understands Medicare. In explaining why she opted for the surcharge she said:

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[15] In 1999-00 there were 238 000 taxpayers paying the levy, including 74 000 with incomes above $70 000, who would have had a very strong financial incentive to take out private insurance. (Data from ATO *Taxation Statistics*.)

> Despite the additional levy now imposed on higher income earners and the substantial rebate for private health insurance, I do not intend to change this position. It is a carefully considered and rational view based on my commitment to three key principles in public policy: the goal of reducing inequality, the need to ensure the universal provision of key services on the basis of need, and the need to deliver such services as cost-effectively as possible.[16]

Towards recovery

Medicare is not dead. The Coalition has mounted many attacks on our public institutions, but they don't die easily. And the Howard Government was too clever, in 1996, to announce that it intended to destroy public institutions. Slow starvation and progressive amputations are much more effective political strategies.

Nurses and other health professionals, like academics, are fiercely loyal to their institutions, and have sacrificed much over the past seven years to keep them viable, hoping that the current political climate will change. (That dedication has allowed the Coalition to justify their cutbacks. The rhetoric peddled through talkback radio is they have been able to get lazy nurses, teachers and other public sector workers off their backsides.)

That climate won't change of its own accord. Some may pin their hopes on a Labor government, but the Labor Party is at best apologetic when it comes to public expenditure, and, at worst, timid about criticizing the government. Like a rabbit caught in a spotlight, it is mesmerized by the cleverness of Howard's policies. Conversely, some see no hope in the Coalition, but it has not always been characterized by economic irresponsibility and a desire to open up cleavages in Australian society.

The solution will be political, but the work will not be primarily in the partisan arena. It will require those who seek change to engage in the economic debate, rather than standing on the sidelines and using the term "economic rationalism" as a term of derision.

One of the great myths, revealed in several opinion polls, is the popular notion that the Coalition is competent in economic management. This is wrong; the present government is reasonably good at producing a few impressive headline economic indicators, such as GDP growth and commodity inflation. Many other economic indicators, however, are going the wrong way – house price inflation, inequality, depletion of capital, and external balance. But while people believe the Coalition is economically competent, they are going to be reluctant to change, particularly when they are feeling economically insecure. They may want Medicare, but not if they think it may cost them their job.

The challenge is for those who seek change to re-engage with the economic debate, to argue the case for our public health system, and to get Medicare embedded so that no future government – not even one headed by Tony Abbott or Graham Richardson, can destroy it.

Then we will all be able to get on with the serious work of making Medicare work better.

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[16] Quoted in "On health insurance and private choice" *Australian Health Review* Vol 22 # 1, 1999, P 3.