Industry debate – the contribution of the health fund rebate

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Introduction

The two main questions in the conference program are whether the rebate eases pressure on public hospitals, and what will be the effect of the higher rebate on fund membership.

The answer to the first question is that it has not eased pressure on public hospitals. The extent to which the rebate has contributed to the recovery of private insurance is questionable in itself. Furthermore, as independent researchers warned when the rebates were first introduced, and as confirmed by later empirical studies, as activity has transferred to private hospitals so too have resources. In a resource-constrained system, where money flows so too do resources. The main effect of the rise in private health insurance has been a reshuffling of queues, and possibly some worsening of the queues.

The answer to the second question, to the relief of the funds and the Commonwealth Treasurer, is that the net increase in membership of older Australians is only in the order of 8000 so far. This is against a background, however, of rapid ageing of the population covered by hospital insurance – an increase in membership of people aged 55 or more of 400 000 since the incentives came into effect in 2000. This modest uptake is not surprising – price incentives seem to have little effect in encouraging membership in any age category, and, in any event, because health insurance cover is closely related to income we would not expect many older people to have the means to take advantage of the incentives. The "lifetime rating" incentives have probably already gathered most of the price-sensitive older population.

In this session I want to broaden the debate, to question the widespread assumption that there is an undisputed case for supporting private health insurance. I want to re-examine that case, and to suggest that it has never been established. Whatever the purpose behind the subsidies to private health insurance, costing public budgets at least $3.0 billion a year[1], these purposes could have been achieved by other, less costly means.

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[1] Approximately $2.31 billion in rebates and $0.75 billion in foregone revenue associated with the one percent tax rebate.

The purpose of the rebates

The Commonwealth has never clarified the precise purpose of the subsidies for private health insurance. From ministerial statements (particularly second-reading speeches), it is possible to find the following explicit of implicit statements of purpose:

(1) To support private hospitals.

(2) To ease pressure on public hospitals.

(3) To provide choice to consumers.

(4) To save budgetary outlays.

(5) To achieve equity, compensating the "self reliant" who buy private health insurance.

(6) To direct public expenditure to those most in need.

(7) To support private insurance as an end in itself.

I would like to examine each in turn.

1. Supporting private hospitals

There are sound reasons to prevent a collapse of private hospitals; they are valuable assets. If all activity were to move to the public sector there would be a serious misallocation of resources, with some overstretched while others would be unused. While staff may move, assets such as operating theatres and other fixed capital items in private hospitals would remain idle.

If such support is the purpose behind the policy it is questionable why such an indirect means has been used. Of the $2.3 billion in rebates outlaid by the Commonwealth in 2002-03, only $1.1 billion, or less than half, made its way into private hospitals. The other $1.2 billion went into support for administration ($0.3 billion), medical gap payments ($0.2 billion), public hospitals ($0.1 billion) and ancillaries ($0.6 billion).

If the Commonwealth's purpose is to support private hospitals it could give double the financial support if it bypassed private insurers. Such support could be through DRG funding on the same basis as for public hospitals, with supplementation for capital requirements (because public hospitals receive separate capital appropriations).

2. Easing pressure on public hospitals

This is a complementary objective to supporting private hospitals, the theory being that if more activity is carried out in private hospitals there will be an easing of pressure in public hospitals.

There is a fundamental economic flaw in such thinking.

In the short to medium run crucial health care resources, particularly nursing and specialist staff, are in constrained or "inelastic" supply. Medical specialists are mobile between private and public hospitals. When more money goes into one sector, so too will resources flow into that sector.

That was the warning independent academics made before the Senate committees considering these bills when they were first presented. At that stage arguments rested on the basic deductive logic of economic theory; when resources in a system are constrained more money, private or public, does no more than to bid up the price of those resources. In terms of waiting lists all that is likely is a re-shuffling of the queues.

As *ex post* evidence has accumulated, empirical studies have confirmed these predictions. Increased private sector throughput is reducing the capacity of the public sector, while waiting times are growing. In fact, evidence is mounting suggesting that there is more than a simple transfer of activity from one sector to the other. In many cases private patients in private hospitals are receiving more services for the same condition than they would have had they presented as public patients in public hospitals. This implies some level of resource misallocation (based on the normative principle that scarce health care resources should be allocated to where they can achieve the most effective health outcomes). The differences in treatments suggest that there is either some wasteful over-servicing in the private sector or some harmful under-servicing in the public sector.

Furthermore, those who take low-cost policies with high deductibles and exclusions have no incentive to use a private hospital where they will have to make significant co-payments, when they can gain free access to a public hospital. When people behave in this way they add to the revenue of the funds but they do not take pressure off public hospitals.

There is no quick fix to waiting lists. Throwing money at a problem does not bring forth new resources – a lesson we should have learned during the extravaganza of the Whitlam Government. It doesn't matter whether that money comes from the private or public sector. We are still experiencing the consequences of past mistakes, particularly the restrictions medical training. While there are certainly efficiency gains to be wrung out of health care delivery, the main constraint is in terms of professional workforce, and it will take many years to build up our health workforce to cope with the needs of an ageing population.

3. Providing choice

Markets thrive on choice, and at first sight we can claim that as a result of the uptake in private health insurance consumers have more choice.

It is important, however, to distinguish *choice of insurer* with *choice of service provider*. There is little variety in the offerings of the private insurers; indeed it is hard to see how there could be much variety in such a highly regulated industry which is basically a financial intermediary.

Even when it comes to choice of service providers, in health care effective consumer choice is constrained in two further ways. Consumers may choose a particular GP as a "gateway" to the hospital system, but the GP will have a strong influence on consumers' choice of hospital

specialists. Health care involves strong information asymmetries; the consumer is much less knowledgeable than the provider. It is hard for a consumer to obtain any more than anecdotal information about the competence of a particular specialist. Unlike many consumer goods with repeat purchases (known as "experience goods"), in health care opportunities for consumer learning are limited. And if more health funds enter into preferred provider arrangements with private hospitals, choice is further constrained.

Perhaps the greatest constraint on choice comes when people with means no longer consider public hospitals to be suited to their needs. Shared systems, such as public schools and public hospitals, can be subject to the phenomenon of "tipping". Even if the vast majority may prefer a shared system, once a sub-critical mass of people are removed from a shared system into exclusive areas of service provision, others feel compelled to follow. The choice of the minority constrains the choice of others. Choice is constrained if it is between a run-down public system and a private system funded by costly private insurance companies. Freedom to opt out is at the expense of reduced access for those who cannot afford to opt out, and at the expense of those who are forced to opt out when they would have preferred a high quality shared system.

4. Saving budgetary outlays

Saving public expenditure would seem to be an uncontentious public policy objective.

A little consideration, however, leads one to question why there is any virtue in making a saving on public expenditure if the result is an even higher level of expenditure being required in the private sector to achieve the same outcome.

In terms of administrative costs alone, private health insurance incurs much higher bureaucratic costs than the public revenue system – around 10.9 percent of turnover compared with 4.8 percent in the tax and Medicare system.

This is not to imply mismanagement in private health insurance; 10.9 percent is much lower than most other classes of insurance. But, unlike the Tax Office and the Health Insurance Commission, private insurers must advertise for business, they have to maintain customer offices in competition with other funds, and they lack the legislative authority of taxation to collect revenue.

The stronger economic case against private health insurance lies in the capacity of a single national insurer to exercise purchasing power in the market. All insurance, public or public, carries the distortion of moral hazard – both on the demand and supply sides.

Governments, with a single pool of funding can use their concentrated purchasing power to exert cost control while private insurers can be played off against one another. Private insurance provides a permissive environment for those who seek to draw profit from the health care system.

That is why countries which have relied on private insurance to fund health care have paid a high price for that decision. The more a nation relies on private insurance to fund health care, the higher are its total health care costs. The USA, with its heavy reliance on private insurance, provides the most telling example.

The paradox of the USA is that with health care costs out of control, because of the moral hazard created by a fragmented private health insurance system, the Government has lost the capacity to control costs in its own programs – Medicare for the aged and Medicaid for the "indigent" – both of which are parsimonious in their coverage. By 2002 these limited programs cost the Government 6.2 percent of GDP which is above the OECD average of 6.1 percent and about the same as the public outlays in those European countries with universal government-funded health insurance schemes. (It isn't only the government feeling the pinch; the cost of employer-provided health insurance is hurting America's industries trying to compete on global markets.)

In Australia, there is no evidence that the private health insurance subsidies have resulted in any saving in Commonwealth or state hospital budgets. While total hospital spending has risen at an annual rate of 6.6 percent since 1995-96, Commonwealth spending has risen at a rate of 10.3 percent. Even with the subsidies, private health insurance has done no more than to sustain its share of the financing load.

The budgetary case for subsidising private insurance is weak. Even if such support were to reduce the call on public funds (an assumption not supported by evidence), there is no intrinsic virtue in shifting an activity to the private sector, particularly if the result in such a shift is more total expenditure (the sum of public and private expenditure) without any improvement in technical or allocative efficiency. Private health insurance is simply a "privatized tax". Privatized taxes are expensive to collect and they lack the benefits of transparency, cost control and fairness of official taxes. In the case of health care, the taxation system has a rating system which distributes the burden between the poor and the well-off with a degree of progressive redistribution. By contrast, the achievement of even partial community rating in private health insurance is difficult.

This is not to establish a general case against privatization. In many cases privatization and breakup of state monopolies bring benefits of competition in the form of lower prices, innovation and expanded choice. Markets work more often than they fail. But those conditions do not hold for private health insurance. Insurance is a means of buying out of the discipline of market forces; it suppresses the price signals which are vital to the operation of markets. In the absence of the discipline of the invisible hand of market forces, a single national insurer offers the best opportunity to control prices.

Nor is it to establish a case for universal, free, tax-funded health care services. There is an arguable case, in a prosperous society, for people to pay more from their own resources for health care, providing a stronger role for market forces without the distortion of insurance. The argument is that for that portion of health care funding people choose to pool, a single national insurer is the most efficient mechanism.

5. Providing equity for the insured, the self-reliant

When health insurance coverage rose from 30 percent to 46 percent, two thirds of the subsidy benefits flowed to people who already held insurance. This has been used as a point of criticism of the incentives, in that they have been an expensive way to achieve a change in

behaviour. It could also be seen, however, in terms of equity for those who have taken responsibility for their own health care expenditure.

This argument would be more credible if the taxation incentives were not structured in such a way that over-compensates the well-off. It also ignores the equity considerations of the self-insured – those people who pay for private hospital funding from their own resources.

Since there have been incentives for private insurance the proportion of people who use private hospitals without being dependent on private insurance has fallen sharply. The incentives do not provide equity for the most self-reliant who save for their own health care. The incentives *de facto* penalise private savings (when there is a national problem of low household saving). While it is a defensible ideology which sees virtue in people taking more responsibility for their own needs without depending on collective arrangements, it is a strange ideology which suggests that dependence on an insurance corporation is more virtuous than dependence on a government agency.

There is possibly a default assumption held by the community and its elected representatives, that private hospitalisation will inevitably be funded by private insurance. The funds' advertisements do nothing to dispel this assumption. Such an assumption ignores the fact that many households have high levels of liquid or near-liquid wealth. In 2002 half of all households had share and bank account assets in excess of $27 000. Such wealth tends to rise with age; the mean figure for households with a reference person in the 65 to 74 age bracket is $95 000. If a government wishes to encourage self-reliance, a starting point would be to give the same or greater incentives to those who pay for private hospitals from their own resources as they do to those who depend on private insurance.

6. Directing public expenditure to those most in need

The Commonwealth has never formally stated that it intends to develop a two tier system of health financing, with public services set aside for the poor, although during the 2004 election campaign Deputy Prime Minister John Anderson did suggest that a two-tier system might be acceptable to the electorate. Gwendolyn Gray of the ANU has collated a number of statements suggesting that within the Ministry there is a degree of hostility towards Medicare's universality.

It is important to distinguish the *effects* of a program from its *intention*. Medicare does have welfare benefits for the most disadvantaged because the poor and the old are likely to be the heaviest users of health care. But it is also a universal program.

People in the highest income households enjoy only half the absolute financial benefit from publicly-funded health programs as people in the lowest income households. Universal, tax-funded health insurance is a low cost social contract.

7. Saving private insurance

This brings us to the last plausible policy objective – that rescuing private insurance was an end in itself.

By the time the Coalition came to office the private insurance funds were struggling. Not only was their membership falling, but also their returns on invested reserves were falling. The funds' investment income fell heavily between 2001 and 2002 as they drew down reserves and as the earnings on those reserves fell – a development which the funds and the Government probably anticipated when they were drawing up the "lifetime" rating incentives.

Governments have no brief to protect particular industries. The days of paternalistic tariff protection are well over. And if the subsidies were an industry-protection measure, it is unlikely that assistance for a financial intermediary should have come from the health budget. More appropriately the subsidies and tax expenditures should have appeared in the Treasury or Industry budget.

The possible explanation is that the policy was not carefully thought through, but that it was a poorly-considered response to what was seen as an emerging problem. Policy makers and advocates generally propose solutions within existing institutional arrangements. They know their way around the existing system, and assume basic institutional arrangements to be 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 about the risk of confusing means and ends.

In short, rather than aiding the health sector, the subsidies have aided the already large and growing finance sector. *De facto* they have been an instrument of industry assistance.

Conclusion

The Commonwealth's initiatives have failed on the basis of all plausible policy objectives but for one. That one success has been the rescue, for now, of the private health insurance funds. Their coverage, at 43 percent, is restored to where it was in 1991, and is falling more slowly.

Evidence strongly suggests that even this modest outcome – the rescue of a financial intermediary – could have been achieved at lower cost. The "lifetime" incentives alone, or a similar set of measures with more modest subsidies, may have achieved the same result without spending more than two billion dollars a year on subsidies.

One cannot know the inner workings of public policy. Was the Government's aim to rescue private insurance as an industry protection measure? Or was it a textbook case of the limited policy thinking described by Lindblom – confusion of means and ends and a preference for using existing policy instruments rather than a consideration of more basic approaches?

Is the explanation more mundane? An ideology suggesting that "private" is to be preferred to "public", even if the economic and fiscal costs of a transfer from the public to the private sector are high? A failure to distinguish private health care funding from private health care provision? A failure to distinguish between funds and real resources; that is, a belief that

spending money on a problem will solve it, even if the real resources are unavailable? Or a failure to understand the true nature of insurance – that any form of insurance, private or public, carries an incentive for over-use and price inflation?

By specifying a number of purposes for the initiatives the Commonwealth has covered itself politically, but such an approach comes at the cost of clarity. There are two fundamental questions about health financing which remain unanswered; in fact they are not even being asked.

The first is what part of our health care costs should we share through insurance and what should we pay for from our own pockets? Evidence and basic economic logic suggest that a single national insurer is the most efficient and equitable way to pool our funds, but the question remains open as to the extent to which direct payments, without any insurance support, should be used to harness some of the discipline of market forces. Universal health care systems entered the policy debate around sixty years ago, in the postwar era. Since then we have become much wealthier and it is realistic to assume that we have more capacity to take on more of our own health care costs without insurance. There is no necessary conflict between universal public insurance and use of market forces for part of our costs.

The other is where to draw the boundary between those services which should be free or subsidised and those which should be left to a comparatively unsupported market. At present there is no logical consistency in our health care programs. Some are free (bulk billed services, public hospitals); some have capped co-payments (prescription pharmaceuticals); some have open-ended co-payments (most privately insured ancillary services); some have proportional co-payments (most medical services once a safety net is reached); some have no support (uninsured dental, physiotherapy and similar services).

These are the basic questions which have so far eluded both the Government and Opposition, but they are the questions appropriate for an inquiry such as that recommended by the Industry Commission in 1997.