

# The effects of increased private health insurance: a review of the evidence

Don Hindle and Ian McAuley

## Abstract

Private health insurance membership declined steadily between 1984 and 1997, after which major government interventions caused it to increase. We review some of the literature and conclude that the increases in membership were probably associated with a loss of equity and cost-effectiveness for the health care system as a whole.

We attempt to explain why the government made the changes and conclude that the main factors were vested interests of those who have benefited and a confusion of objectives.

The changes may have resulted in a more balanced use of available resources (such as the balance between government and private hospital utilisation) but these and other desirable objectives might have been better achieved in other ways. We advocate that a more serious effort be made in future to ensure that policy takes more account of evidence, logic, and system-wide design and coherence.

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## Recent changes in membership of private health insurance schemes

Coverage of the population by private health insurance (PHI) fell gradually from 50% in 1984 to 31% in 1997, mainly as a consequence of the creation of Medicare — a compulsory government-operated health insurance scheme that requires progressive contributions and largely free access to care in accordance with need.

Shortly after coming to office in 1996, the Coalition Government made important changes. In 1997 it introduced a means-tested subsidy for those holding PHI, and a one percent tax penalty for high income earners who did not hold PHI. In January 1999 the means-tested rebate was replaced by a general 30% rebate for people holding PHI. In June 2000 the government introduced 'lifetime community rating' (whereby premiums are positively correlated with age at entry), with a strong advertising campaign to support the new policy. Coverage rapidly rose to reach a peak of 45% in September 2000 (a rate far higher than in the great majority of countries similar to Australia), and there was an improvement in the risk profile through a fall in the average age of those holding PHI.

The main cause of the increased coverage was probably lifetime community rating, although some people argue that the combination of lifetime community rating and the 30% rebate had the strongest effect. For those on higher incomes, the 1% tax levy had some impact. Duckett (in Coote et al 1999) explained why he chose to take out PHI although he has long been an advocate for public insurance and public hospital care. "I chose an insurance package which almost forces me to be admitted to a public hospital as a public patient: it is a package which has a high front-end

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**Don Hindle**, PhD, Visiting Professor. Editor *Australian Health Review* 1998–2002.

Centre for Clinical Governance Research in Health, University of New South Wales, NSW.

**Ian McAuley**, Lecturer.

School of Business and Government, University of Canberra, ACT.

Correspondence: Professor Don Hindle, Centre for Clinical Governance Research in Health, University of New South Wales, NSW 2052. [don.hindle@pobox.com](mailto:don.hindle@pobox.com)

deductible and does not cover the costs of accommodation in a private hospital. As a result, this package is relatively cheap, about half the tax penalty I would otherwise have faced. Effectively, it means that I rely on the public hospital system but avoid the tax penalty”.

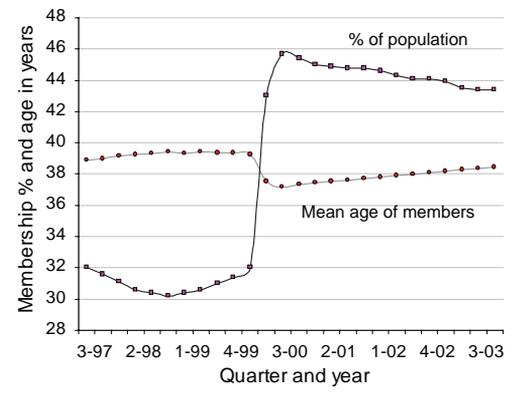
The financial logic to which Duckett refers is that many basic PHI policies, with exclusions and high deductibles, are available for prices as low as \$500. The 1% tax levy means that higher income earners save money by taking out such policies; someone with an income of \$75,000, for example, is ahead by \$400 with such a policy (a \$150 rebate plus a net \$250 tax incentive). The holder of such a policy would generally be wise not to use it, but to choose admission as a public patient to avoid paying out-of-pocket costs.

This may be an example of policy losing its way: why not compel high-income earners to pay the additional tax (which would add more to the health sector financing)? The present policy allows those on high incomes to contribute less to health care financing, and puts that reduced amount of funding through channels that may be less efficient. We suspect there was a greater concern for the health of the private health insurance industry than for the wellbeing of the health care system.

A slow downward trend in coverage of about 0.7% per year has occurred since September 2000. It declined at a rate of 1.3% per year between 1984 and 1996. The risk profile is also deteriorating, as illustrated in the Box.

Some people who had private health insurance used it to obtain earlier access to care. Private hospitals increased their share of inpatient episodes: for example, their share of overnight separations rose from 28% to 32% (McAuley 2004). Private medical specialists increased their patient numbers and incomes. Private health insurers increased their membership, but not all of them increased their financial control or stability. One coincidental problem for the insurers was the decline in nominal interest rates over the period 1995 to 2000, which reduced their reported income from invested reserves.

**Trends in average age and percentage of population with private health insurance, 1997 to 2003**



### A review of the evidence

We review the literature to determine the extent to which there is evidence to support the increased government support for PHI. We concentrate on issues of equity of access to health care and efficiency, but also make brief mention of equity of contributions and quality of care.

### Equity of access to health care

There are always risks of reduced equity of health care and health status in any model that permits some degree of choice. In most markets those with more means can afford more goods and services, and economists and policymakers (other than those representing an extreme egalitarian fringe) do not see this as problematic. For health care, however, it is widely believed that for essential health care one’s means should not determine availability. The test of an economically efficient health care market is the degree to which it allocates resources according to need. In health care there is a strong convergence between equity and efficiency criteria.

The risks of poorer equity and efficiency outcomes may now be greater as a consequence of the increase in PHI membership since 1997. Some of the most obvious adverse effects can be deduced from the simplest of statistics. Take the

case of the Aboriginal population, which is the most disadvantaged segment of the Australian population in terms of health status. Few Aboriginal people have PHI, and hardly any benefited from the \$2.2 billion per year provided as health insurance rebates. Nor can one argue that they have benefited from increased access to private hospitals or more rapid access to elective surgery. As is the case for most people in rural and remote Australia, incomes are lower and there are few easily accessible private hospitals.

The literature consistently shows that people who happen to have PHI have less need for health care on the average after control for other factors, as a consequence of health status determinants like socioeconomic status. Recent Australian clinical literature shows that people with PHI have less likelihood of chronic pain (Blyth et al. 2001), better outcomes from laparoscopic fundoplication (O'Boyle et al. 2002), lower levels of diabetes (McKay, McCarty & Taylor 2000), less visual impairment (Livingston, McCarty & Taylor 1997), fewer urinary symptoms and incontinence (Muscatello, Rissel & Szonyi 2001), better smoking hygiene relating to infant exposure (Ponsonby, Couper & Dwyer 1996; Bai et al. 2000), better self-monitoring of blood glucose in diabetes (Hoskins et al. 1998), lower rates of disturbed mood during pregnancy and after birth (Kermode, Fisher & Jolley 2000), fewer pregnancy complications (hypertension, threatened preterm labour, antepartum haemorrhage, and excessive vomiting) that require hospitalisation (Adelson et al. 1999), and less risk for newborn encephalopathy (Badawi et al. 1998).

There is a similarly a consistent pattern of higher levels of use of health services after control for need. Recent Australian literature shows that possession of PHI is associated with more dental health care in children (Slack-Smith 2003), more likelihood of breast reconstructive surgery (Hall & Holman 2003), more likelihood of having a breast examination by a health care provider (Redman et al. 1990), higher rates of hysterectomy (Byles, Mishra & Schofield 2000), more attendances at sports medicine clinics (Finch & Kenihan 2001), more attendances at antenatal

education programs (Redman et al. 1991), more attendances at a colposcopy clinic after referral for an abnormal pap smear (Kavanagh & Simpson 1996), higher instrumental birth rates and caesarean section rates (Shorten 2001; Shorten A & Shorten B 2002; Fisher, Smith & Astbury 1995), higher rates of use of eye care services (Keeffe et al. 2002), and higher attendance rates at a secondary prevention clinic for cardiac patients (Worcester et al. 2003).

The causes of the higher levels of use vary to some degree across the cases cited above. However, the most common explanatory factors appear to be greater capacity to pay, higher levels of knowledge, and supplier-induced demand. We will return to this matter later.

In total, this evidence suggests that those who have PHI (and who tend to be more wealthy) have less need for health care services but make more use of them. Because most health care services are constrained in supply, a reasonable inference is that at least some services for those with PHI are provided at the expense of services for those without PHI, but whose needs are greater.

Another aspect of increased inequity has been simply explained by Cox (in Coote et al. 1999). Cox says that "The idea of buying privilege of queue jumping offends me. I am particularly offended by statements which imply I should buy health insurance to free the public system up for those who can't afford it. Given the 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".

Colombo and Tapay (2003) put the same idea a little more cautiously, as might be expected because they are employees of the Organisation for Economic Cooperation and Development. In their review of the Australian health system, they note that "Higher payments for professionals when treating private patients may affect the elasticity of the supply of doctor time between the public and private sector. In public hospitals, despite rules of access to care based on medical need, there may be incentives for providers to offer preferential treat-

ment to private patients because of the revenues and higher payment they bring”.

Perceptions of equity might also be important. Schoen et al. (2000) compared the views of a sample of people in five countries (Australia, Britain, Canada, New Zealand and the United States). *Inter alia*, they found that health care experiences were more unequal in the USA, Australia and New Zealand “... where systems have relatively greater reliance on private health insurance and markets”. They also found that “... reliance on private insurance and patient user fees appears to lead to more divided views of the overall health system as well as inequity in access to care”.

In short, the Australian evidence shows that people with private health insurance have less need for health care on the average and yet consume a disproportionately large share of services. Social insurance schemes like Medicare have been directed at reducing the differences, whereas PHI tends to increase them.

### **The cost of health care**

The second main effect of increased PHI membership that one might expect is that the cost to the community will increase, in terms of the average cost of health care per episode of treatment. Competing private health insurers have to spend much more on administration than government schemes, medical specialists' charging rates are generally higher when they are treating private patients, and so on.

The literature overwhelmingly confirms this logic. For example, Duckett and Jackson (2000) estimated that the 30% rebate cost \$2.19 billion in 2000, to which had to be added a further \$1.2 billion of Medicare benefits expenditure in hospitals. They argued that the available evidence shows that “... public hospitals are more efficient than private hospitals” and suggested that “If the insurance subsidy and the Medicare Benefits Schedule rebate expenditure were applied to purchasing public hospital treatment at full average cost, 58% of current private sector demand could be accommodated”. They concluded that the objective of “taking pressure off public hospitals”

could be more efficiently achieved by direct funding of public hospitals rather than through subsidies for private health insurance.

This analysis makes a conservative estimate of the cost of support for PHI, because it excludes the cost of revenue foregone through not applying the 1% tax levy to high income earners with PHI. An accurate figure is hard to obtain, but a first order estimate, based on 2000–01 taxation statistics, is that the annual cost of this incentive is \$1.3 billion (McAuley 2004).

Deeble (2002) analysed changes in hospital activity between 1998–99 and 2000–01. He found that there had been only a small increase in public inpatients, whereas the number of privately insured inpatients increased by 16%. Private hospitals accounted for the larger share of privately insured inpatients, but 76% of cases were for same-day procedures. Thus the increase was mainly in respect of low-cost and relatively simple cases, and public hospitals continued to provide care for the more complicated cases.

Deeble estimated that, at the most, the 30% rebate (and other measures directed at increasing PHI membership) had reduced the cost of treating public inpatients by less than 4%. He noted that the cost of the rebate alone was four times this amount. Thus “... most of the Commonwealth government's outlays went to people who were already being treated privately”.

The results obtained by Deeble were more or less consistent with those predicted by Hindle (2000). The most relevant result was that “... 3 to 12 times more health care could have been provided for the same cost if it had been allocated instead directly to public hospitals (or even better made available for competitive tendering by both public and private hospitals)”. He noted that “... the rebate may have been a sensible taxation policy [but] it was entirely unhelpful to the health care system. It involved spending around \$1.7 billion per year, of which the larger part would never find its way to health care providers”. In other words, the rebate was mostly a tax cut for people who already had health insurance.

Harper et al. (2000) studied the relative costs in detail for a specific case type — elective coronary

angioplasty and stenting (CAS) — for one public teaching hospital, a collocated private hospital, and a freestanding private hospital. They found that the immediate and six-month health outcomes were similar for the public and the private patients.

The average cost of CAS in the public teaching hospital was \$5516 for publicly insured patients and \$5844 for patients with PHI. The length of stay, number of stents per case and use of non-stent consumables was similar for both groups. The private hospitals were significantly more expensive. The average charge was \$13 347 in the collocated private hospital, and \$14 978 in the freestanding private hospital.

They concluded that "... despite similar treatments and similar treatment costs, CAS in the private system, as a consequence of the charges levied, is more than twice as expensive as in the public system". The cost differentials are further increased because CAS is performed more frequently on privately insured patients. The authors conclude that "... encouraging more people to take out private health insurance will, paradoxically, increase government costs for CAS as well as increasing overall health expenditure".

Homer (2002) studied the relationship between private health insurance and the likelihood of having a normal childbirth. It was concluded that "... as the proportion of low-risk primiparous women with PHI increases, the rate of normal birth may decrease with a subsequent increase in rate of caesarean section" and a consequent increase in hospital and post-discharge costs of care.

The OECD report is relatively outspoken on the matter of cost control. Colombo and Tapay (2003) state that private health insurers "... have not effectively engaged in cost controls. They seem to have limited tools and few incentives to promote cost-efficient care, and there are margins for some funds to improve administrative efficiency, thereby reducing administrative costs. PHI appears to have led to an overall increase in health utilisation in Australia as there are limited constraints on expenditure growth. Insurers are not exposed to the risk of managing the entire

continuum of care. The Medicare subsidy to private in-hospital medical treatments has also reduced funds' accountability for the real cost of private care. Policies to reduce medical gaps have led to some price increase and may have enhanced supply-side moral hazard incentives. Finally, the rebate on PHI premiums has posed pressures on public cost, as it represents tax resources that have alternative uses".

### **Equity of contributions**

It is difficult to give an objective opinion here: progressivity of contributions is mostly a matter of values. We will simply note that the increase in PHI had the inevitable consequence of reducing the gap in contributions between the rich and the poor because the compulsory government scheme involves contributions in proportion to income whereas PHI is flat-rated. Even the 30% rebate is, of course flat-rated and therefore both the rich and the poor are equally compensated. Both are regressive, as indeed is the 1% tax levy.

In passing, we note that the Slovenian government has recently decided to move an increased proportion of financing from PHI to the government's universal scheme (Slovenian Ministry of Health 2003). One of the aims was to increase overall progressivity: as in Australia, the compulsory scheme is income-rated whereas the voluntary insurance schemes are flat-rated.

### **Quality of care and outcomes**

Little can be said on the matter of quality of care and outcomes because the evidence is inconclusive: we have hardly any evidence to indicate whether outcomes are better for people with PHI. One technical factor is that there are large numbers of correlates: for example, the privately insured might be healthier on average at the time of admission.

There is some evidence of greater levels of servicing, as noted earlier. Some commentators suggest this must lead to better outcomes, whereas others suggest it could reduce outcomes in some circumstances. An example of the latter comes from Shorten A and Shorten B (2000). They found that, after controlling for clinical and other factors,

privately insured women were almost twice as likely to experience episiotomy as publicly insured women. They concluded that "... episiotomy rates among privately insured women in Australia may be higher than is clinically appropriate, and severe perineal trauma within this study was associated with this practice".

Another study that found increased costs but no evidence of better outcomes has been reported by Robertson and Richardson (2000). They compared the experiences of publicly and privately insured patients in Victoria who presented to hospital with a heart attack. Bypass surgery rates were similar in the two groups, but privately insured patients were twice as likely to undergo coronary angiography and three times as likely to undergo balloon procedures. The authors argue that this is more a consequence of over-servicing in the private sector than of under-servicing in the public sector. Whatever the case, the fact that the same presentation results in different interventions in the two sectors suggests that there is less than optimal resource allocation.

In total, however, we simply do not know whether there are differences in outcomes. We would have preferred governments to have given more attention to measuring and improving outcomes and less to PHI, but that is again a matter of opinion.

### **Experiences in other countries**

There is hardly any aspect of the Australian debate that is not replicated in most similar countries. Jost (2001) reviewed experiences in Australia, Canada, Chile, France, Germany, the Netherlands, the UK, and the USA and concluded that PHI "... is more expensive than public insurance from the outset because it must cover costs not experienced by public systems, such as marketing, increased risk, and underwriting". It also tends to be less effective in purchasing of health care. Jost notes that, in most of the countries he reviewed, private insurance companies "... have been unwilling to engage in aggressive bargaining with providers". They tend to be "... price takers, and often pay higher prices than do public programs for practitioner services because

their primary selling point is that they offer a better class of services than does the public system".

Even strong proponents of PHI are concerned about efficiency. For example, Havighurst (1993), commenting on the future of the US health care system, argues that "... although a single-payer system might be only a second-best solution to our cost problems, a strong argument can be made for preferring it over the current regime of private intermediaries that lack — and do not appear even to want — the tools that are needed to tackle the cost problem at its root".

One particularly relevant recent study by Woolhandler, Campbell and Himmelstein (2003) involved a detailed comparison of administrative costs in the USA (where insurance is predominantly voluntary and private) and Canada (which has a strong government-run compulsory scheme). They found that, in 1999, health administration costs totalled at least US\$1059 per capita in the USA, compared with US\$307 per capita in Canada. Private insurers in the USA had administrative costs of 11.7%, compared with 13.2% for private insurers in Canada. In contrast, the Canadian government's compulsory scheme had administrative costs of only 1.3%. The authors note that "... all the extra money ploughed into the American system is not making patients any healthier. Health insurance schemes with the highest administration costs tend to have the lowest clinical quality". There could be large savings in the USA "... by implementing a Canadian-style health care system".

The findings were criticised by Aaron (2003) of the Brookings Institution in Washington. He argued that the administrative costs in the United States might be 24% less than reported by Woolhandler, Campbell and Himmelstein. However, Aaron's estimates did little to affect the conclusions: his statistics would indicate that US administrative costs would be 2.6 (rather than 3.0) times higher than in Canada. We note in passing that comparisons of administrative cost are frequently questioned because of concerns about the methodology. For example, many different views are taken on the matter of attributing a share of

tax administration costs to the health sector. A commonly used statistic in Australia is that the Australian Taxation Office has an average cost of 1%. Fortunately, it is not important in the present context to debate the level because the overall differences between PHI and government-run insurance systems are so large for other reasons.

Evans (2002) notes that the cost differences exist in almost all countries to a similar degree. Contrary to the belief of many, a given level of health care funded by private insurance and provided largely by private specialists and hospitals will always cost more, for reasons of higher administrative costs, typically lower levels of control over total costs and utilisation, and so on. In short, he concludes that "... international experience over the last forty years has demonstrated that greater reliance on the market is associated with inferior system performance — inequity, inefficiency, high cost, and public dissatisfaction (Evans 1997).

Ham (1996) makes similar arguments. He notes that a group of the world's leading health economists were invited to China in 1993 by the Chinese government to give advice on the approach it should take towards health care financing. The experts were unanimous in advising China to follow the lead of most of the established market economies and use market mechanisms only here and there when it is safe to do so, to ensure that competition and markets remain the means to an end rather than ends in themselves, and to retain control in government hands. Finally, China should avoid the development of commercial health insurance. The only major market economy that has not done so, the USA, is "... desperately trying to escape from the negative consequences" (Ham 1996). China has, in fact, only partly taken note of the advice: there are increasing numbers of middle- and upper-class Chinese who are motivated by personal interest and the opportunities offered to buy better access through PHI.

The experiences with PHI in the European Union may be particularly relevant. Mossialos & Thomson (2002b) note that public policy in the EU has traditionally valued the principle of health

care funded by the state or social insurance and made available to all citizens, regardless of ability to pay. As a result, PHI has not had a dominant role in funding to the same extent as in the USA, Australia and Switzerland. Richardson (2003) has referred to a continental European and Canadian notion of health care as a "solidarity good" — this being an expression of mutual support, concern and cohesion.

Mossialos and Thomson note, however, that a school of thought emerged in the late 1980s in some EU countries that suggested current methods of funding were unsustainable and therefore it was advisable to place greater reliance on private expenditure through PHI. This should be expanded as an alternative to publicly funded health care. In some countries, this view was manifested in part by the introduction or extension of financial incentives from the government for the acquisition of PHI (as was the case in Australia after 1997).

One of the underlying ideas was that, beyond some threshold, the marginal cost of collecting tax becomes very high. This is in terms of political cost (on the not wholly robust assumption that people do not like taxes), political responsibility (the government can blame the insurers), and evasion and corruption among tax authorities. The last cost is more relevant to (say) Haiti than to Australia.

A related development was the liberalisation and deregulation of the PHI market in 1994. This greatly reduced the government's right to intervene, except where PHI was a substitute for publicly funded health care. In fact, substitutive PHI is available only for high earners and some self-employed people in the Netherlands and Germany, and for civil servants in Spain. Most PHI arrangements in the EU are like Australia's: complementary (covering services excluded or not fully covered by the state) or supplementary (for faster access to non-crucial services and better amenities).

It had been expected there would be benefits through increased competition — and this would lead to greater efficiency and improved consumer choice. However, the authors argue that "...

deregulation has actually exacerbated significant information failures that limit its potential for competition and efficiency, and has reduced equity. Deregulation has also stripped regulatory bodies of sufficient power to protect consumers” (Mossialos & Thomson 2002b).

Another problem that became of increasing concern to EU legislators during the 1990s was a lack of easily understood information about the price, quality and conditions of PHI. As a result of market deregulation, insurers had less reason to reduce confusion and increase transparency through introducing standardised terms and benefits packages. Non-standardised presentation of consumer price information, resulting in high search and switching costs, is a common problem in the financial services sector. The health insurance industry is no exception to this form of market failure.

More recently, interest in PHI has declined in almost all EU countries. Mossialos and Thomson (2002a) note that governments are tending “. . . to reduce or remove tax incentives that encourage the take-up of voluntary health insurance, finding them to be expensive, regressive, and largely unsuccessful”. It is administratively complex and generates additional transaction costs, distorts price signals, and may create opportunities for fraud and tax evasion. PHI is an example of what Caiden (1987) calls a “privatised tax” — a private, off-budget mechanism to provide for a collective good. Governments can collect tax with more progressivity and accountability and at lower administrative cost than the private sector.

Contrary to expectations, tax relief for PHI did little to stimulate demand. This appears to have been the case in Australia: as noted earlier, it was the lifetime community rating policy (and the associated powerful marketing campaign) that was the major factor in increased PHI membership. There is currently no tax relief in Belgium, Denmark, Finland, France, Sweden and the UK, and only very limited tax relief in Germany and the Netherlands.

Only Ireland has a level of tax relief approaching that of Australia. Tax relief costs the Irish government around 62 million Irish pounds a

year (the equivalent of 2.5% of public expenditure on health in 1997), and removing this subsidy would increase the net cost of premiums by as much as 32% (Mossialos & Thomson 2002b).

The underlying problems with PHI in the EU are much the same as elsewhere. Mossialos and Thomson (2002b) argue that services are expensive when compared with those provided by compulsory government schemes. They give the example of the UK, where the average premium per person covered by PHI was £442 in 1998, whereas the average per capita NHS expenditure on health and community health services in England for individuals aged 16–64 years was £365. Yet the NHS offers comprehensive benefits, whereas PHI does not usually include cover for pre-existing or chronic conditions such as diabetes, emergency admission, normal pregnancy and childbirth, kidney dialysis, organ transplants, HIV/AIDS, outpatient drugs and dressings, infertility, preventive treatment, and drug misuse.

The administrative costs of PHI in the EU are higher than those of US health maintenance organisations and have not declined significantly since deregulation in 1994. The authors provide several comparative statistics. For example, they note that administrative costs were 4.2% of total NHS expenditure on hospital and community health services in England in 1995. In comparison, just after the Irish PHI market was liberalised in 1996, the administrative costs of the quasi-public Voluntary Health Insurance Board were only 2% of premium income, whereas those of a major private insurer, BUPA Ireland, were 12%. By 1999 administrative costs had risen for both insurers, but the Voluntary Health Insurance Board’s costs were still considerably lower than those of BUPA Ireland (4.7% compared with 14.2%). In 1998, another private insurer (PPP Healthcare) had even higher administrative costs (16.9%).

Incidentally, the German insurers spend only about 6.5% of revenues on administration. This seems to be mainly a consequence of the tight limitations on what they can do: for example, almost all benefits are defined by the government,

and it has been suggested that German private insurers are little more than agents of a universal government scheme.

In the absence of the kind of government financial support we are experiencing in Australia, the proportion of people with PHI is much lower in the EU. While there was some growth in the PHI sector during the 1990s, this has mainly been due to the rapidly rising cost of PHI premiums rather than to increased numbers of subscribers. Indeed, total membership has been stable or falling in most EU countries. Growth in PHI membership has occurred only in those countries where governments have chosen to provide incentives along the lines of those in Australia.

Mossialos and Thomson (2002a) also note growing concerns about the impact of PHI on the health care system as a whole. For example, they argue that, if doctors engage in both private and public practice "... they may spend more time with private patients, leading to shorter treatment time or delayed treatment for public patients. In the UK it was found that the 25% of specialists that did the most private work carried out less NHS work than their colleagues".

As in Australia, members of PHI in Spain tend to use PHI for minor health problems, but turn to the public sector for more serious problems and therefore "... the state pays twice for their health care". Furthermore, PHI "... may undermine attempts to improve efficiency in the health care system by responding to demand for non-evidence based health care, eroding gatekeeping systems and negating the effect of co-payments introduced to reduce demand". The authors are also concerned about the possibility that PHI "... might increase inequality in health care provision if it ensures faster access". They note that Spanish women with PHI have more cancer screening tests and dental services.

Finally, the experiences in the more wealthy Latin American countries seem to be much the same. For example, Barrientos and Lloyd-Sherlock (2000) discuss the reforms of the late 1980s in Argentina and Chile that included allowing private health insurance funds to compete with the government schemes. The main aims were to

increase competition and hence efficiency and consumer choice.

The authors note that the PHI sector has expanded, but this has had little effect on demand for care under the government schemes. PHI has largely been taken by the well-off and the employed, and the low health-risk groups. Society has thus become more segmented.

The authors conclude that "... the evidence indicates that the reformed health insurance systems will not prove to be more adept at cost containment. The marketing strategy and purchaser role of private insurers reduce their effectiveness in containing health expenditures (mainly because they cannot be seen to be careful purchasers or 'rationers' for fear of losing the support of private doctors and the members themselves). The private insurers are less effective purchasers in many ways — for example, by still retaining fee-for-service payment methods. The private sector accounts for a disproportionate (and rising) share of total health expenditures. These are not the outcomes that were expected by the reformers".

One lesson from the USA is that in a market dominated by PHI, with insurers competing for market share, there is such a loss of cost control that in the end even government outlays for comparatively meagre welfare programs become expensive. Statistics recently published by the Australian Institute of Health and Welfare show that the USA's government-run insurance programs (predominantly Medicare for the elderly and Medicaid for the otherwise seriously disadvantaged) are spending nearly the same as the total spending on health of many similar countries ([www.aihw.gov.au/publications/hwe](http://www.aihw.gov.au/publications/hwe)). The same publication shows that Australia's government health expenditure was the second-lowest of the ten countries that were compared. Only the USA has a lower level of government spending. If one of the aims of the Australian government was to reduce government spending, then one might assume there was a belief that moving closer to the USA was preferable to moving closer to countries like Canada, France, Germany, Japan, The Netherlands, New Zealand, Sweden, and the UK.

In summary, the evidence from the Australian literature is much the same as that from other similar countries around the world. As Jost (2001) puts it, there is simply no evidence from anywhere in the world that the added value of private insurers (if any) justifies its unavoidably higher costs and social divisiveness. As Ranade (1998) puts it, in her brilliant book on markets and health care, "... the policy lesson which bears repeating over and over again is that financing health care mainly through private insurance is neither equitable nor efficient, and the USA is clear witness to this. Insurance overheads and a competitive market have made the US system the most costly in the world, yet it still fails to cover the health care needs of millions of its citizens".

### **Have we missed the point, in spite of the evidence?**

Before stating our conclusions, we will make one more attempt to be sure nothing important has been missed, by taking great care to note and reflect on views of supporters of the changes. Unfortunately, this is easier said than done. There are many articles but they are typically brief and lacking evidence. Indeed, we could find only four recent papers that had some degree of empirical rigour.

The first is an analysis of the effects of increased PHI on the Victorian public hospital surgical waiting list (Hanning 2002). He studied trends before and after the government's actions to increase membership and found that the total number of waiting patients had been hardly affected because the rates of addition and removal had fallen. There was a sharp increase in the number of elective surgeries performed by the 'private sector', and this coincided with "... the fall in additions to the public sector waiting list and in public sector elective surgical cases". He noted that limited data from other states suggests the Victorian trends are representative of all Australia.

A few of the results have been questioned by Cromwell (2002), but this might not be important in the context of this paper. Hanning's conclusion that some patients have moved from a

public hospital waiting list and into a private hospital must be true to some degree. Our concern is that he does not discuss the cost, quality, and equity implications of such a move.

Consider, for example, the situation where a new government in 2005 decides to eliminate the 30% rebate and transfer the \$2.2 billion per year directly to public hospitals. It would not be surprising to see a change. Some patients who would otherwise have been treated as privately insured patients in private hospitals would then seek their care in a public hospital — and the public hospitals would be able to provide more services as a consequence of receiving the \$2.2 billion. This would not, however, prove the policy change was sensible. Hanning assumed the move of patients from public to private hospitals was beneficial, and simply tried to measure it.

Another paper by Hanning (2003) throws some useful light on administrative efficiency. He analyses the extent to which there could be reductions in the administrative costs of PHI if the companies were to amalgamate. In his best-case scenario, where the number of companies were reduced to five, he estimates at most a 'one-off' saving of 2.5% while "... funds are facing cost increases of 4 to 5% per year". He questions whether the creation of fewer and larger companies would have any significant effect by itself. *Inter alia*, he notes that the smaller companies actually have lower administrative costs as a proportion of total revenues than the larger ones. On the basis of this statistic, one might argue for disaggregation.

Hanning is surely correct in arguing that the problems are inefficiencies that are largely unrelated to size. He is also correct in saying that "... the major reasons for fund cost increases ... [are those] ... over which health funds have little if any influence". Indeed, they are the same factors noted above — weak bargaining positions, poor techniques for the structuring of contracts, and an independent (or recalcitrant?) private medical profession that supported the 30% rebate partly in order to increase their incomes.

The second serious attempt to measure the effects of increased PHI was written by Harper

(Harper 2003). It shares ideas and conclusions with another paper (Murphy, Harper & Hagan 2003), both of which were sponsored by a major private health insurer (Medibank Private). We will consider them together here for convenience, and refer to them as the 'Medibank Private papers'. They have been among the most commonly quoted sources of academic support for current arrangements.

### **The Medibank Private papers: a critical review**

One of the difficulties in understanding the arguments in these articles is that they are not always clearly presented. For example, it is stated that "... if people abandon private health insurance, the cost of providing public health care and the cost of PHI both rise, reflecting the loss of the implicit subsidy paid by those who take out PHI in addition to paying taxes to fund public health treatment".

It is hard to imagine why the costs of (say) public hospitals would rise if there were less private health insurance. We assume he means to say there would be an increase in the total cost of funding health care from government sources, although no evidence or argument is provided in support of this proposition.

#### **Presenting a biased view**

A more important weakness is that of failing to mention important parts of the story. For example, a few more consequences of a decline in membership should have been noted, because they are obvious and indisputable. First, the people who gave up private health insurance would now have more money in their pockets. This is not a trivial point: many more people have much more money in their pockets. Second, the government would also have more money in its pocket by not having to pay the 30% rebate.

No mention is made of the fact that all the money for health care comes from the community at large. If one assumes that roughly the same services will be provided at the same cost per unit of service, then it is fundamentally important that

we look at the relative efficiency of the channels through which the money is transferred from citizens' pockets to the care providers. Shifting collection of revenue for health care from the Australian Taxation office to private health insurers — essentially private tax collection agencies — in itself represents no saving to the community, and to the extent that health insurers have higher collection costs, it represents a small loss.

The Medibank papers note PHI's administrative costs, but not in comparison to other insurance schemes. Rather, it is simply observed that the costs have fallen from 13.0% to 10.5% in the period from 1999–00 to 2002–03. Such a finding could have been compared with Medicare's 3.6%.

The papers suggest there would be efficiencies through reducing the number of insurance companies. It is not noted that fewer insurers means less choice, and this is unfortunate given that 'increased choice' is perhaps Harper's main argument for encouraging PHI. However, choice is a difficult idea: for example, Cox has noted one context in which more choice for some means less choice for others, in terms of improved access for people with PHI to the best surgeon or the front of the queue (Coote et al. 1999). In any event, while consumers may seek choice of hospital or of medical practitioner, it is questionable whether people seek choice of financial intermediary, particularly in such a regulated market.

It is noted that premiums have been rising by about 7.5% per annum in recent years due to "... the rising costs of medical services and utilization rates". Unlike Hanning, the authors make no mention of the insurers' lack of control (and hence no acknowledgement that this might be a fundamental weakness of PHI — premium rises are not simply an exogenous variable).

No comparison is made of costs in the public sector, where costs per case have risen much more slowly. There is no mention of the possibility that public insurers are more effective purchasers than private insurers, or that PHI costs might be higher as a consequence of over-servicing.

We note in passing that, although one of the stated aims of the Australian 30% rebate was to increase choice, the economic perversities mean

that the consumers' views are seldom accepted without question. For example, many public hospitals have a financial incentive to urge their arriving patients to use their choice wisely — and choose to be treated as private patients (Sullivan, Redpath & O'Donnell 2002). Private medical specialists have been known to be even more supportive of the patient's right to choose (and especially to choose their services). Private insurers, however, have often made it clear they would prefer patients to choose a public rather than a private hospital, and to choose to be a public patient when they arrive. The current government has spent large amounts of time and effort encouraging citizens to choose to have PHI (and nothing at all on encouraging them to choose the public system).

Harper and his colleagues correctly argue that, if people abandon private health insurance, the cost of private health insurance will rise. However, several relevant points are ignored. One is that the total risk rating of the population is unchanged, no matter how many people have private health insurance. If the low-risk people move to private health insurance, then the risk profile of private health insurance improves. If they move towards compulsory government insurance, then its risk profile improves. It may be good for the private health insurance industry to have large numbers of low-risk members, but there are no free lunches.

The biases may simply reflect the authors' desire to answer questions that seem to be unimportant. For example, the authors conclude that, if PHI membership "... were to fall away, then clearly the looming pressures on Commonwealth and State government outlays on health services will be even more intense". It is important to know whether Australia can afford to spend (say) 10% of its GDP on health, but it is largely irrelevant to ask whether governments can afford it.

Another accurate answer is that the cost of public hospital services would be higher if private hospitals disappeared. However, the question is irrelevant in its context. Private hospitals do not require PHI. Rather, they exist to the extent that

people need health services that cannot be provided in public hospitals for reasons of capacity. It should be obvious that there are other ways of financing private hospitals than through PHI. In a political debate impoverished by self-interest and an absence of imagination, private health insurers have been effective in leading the community to believe that without PHI there would be no "private sector". Any questioning of PHI is an attack on the private sector. This assumption is so embedded that many academics and politicians have difficulty in seeing that the link between PHI and private care is a contrived one, and that there are other options for funding private hospitals.

A related problem is that of defining objectives that seem to us to be misguided. For example, the authors express the view that "... lifetime health cover makes the market for PHI more actuarially [sic] fair". This is because it will "... reduce the extent to which premiums of young persons are used to cross-subsidise the higher expected benefits of older persons". While some people might welcome a reduction in cross-subsidisation, the overwhelming majority of Australians (and citizens of every other similar country) actually want the young and healthy to subsidise the care of the old and the sick.

### **Using loaded words and catch phrases**

The authors say that people who take out private health insurance or pay directly for private hospital treatment "... pay twice for health care" (Murphy, Harper & Hagan 2003). This is one of the catch-phrases that supporters of PHI like to hear and say, but it is illogical or irrelevant or both.

It is true that people with PHI make their contributions in more than one way, but most of us contribute through multiple paths. Most citizens pay several taxes that contribute to general revenue — and hence in part to health care funding. High-income earners who choose not to purchase private health insurance contribute by having to pay the special Medicare levy. In fact, many high-income earners pay more if they avoid purchasing private health insurance than if they take out low-cost policies that they never

intend to use. In these cases, it would be fair to say that high-income earners do the community a service by *not* taking out private health insurance. About 120 000 high-income Australians do in fact choose to pay more (presumably for ethical reasons).

The language about 'paying twice' is loaded and has no analytical value. It could be said that we are treating Greg Norman unfairly because he chooses to use his private jet rather than travel on public roads. Harper and colleagues would presumably wish to point out Norman is paying twice for his transport. It is irrelevant for several reasons. The most obvious is that Norman uses his more expensive private jet not because he wants to relieve the pressure on public roads but because he wants a better level of service for himself.

The Medibank papers say that private health insurance "... allows those who value keeping their options open in health care to subsidise overall health capacity". The use of 'value' is loaded to say the least. He might have said that 'people fortunate enough to be able to afford private health insurance' but that is not the picture he wishes to paint. He presumably wants to imply that people with private health insurance have more praiseworthy values rather than larger incomes.

Yet another example is the statement (made several times) that reduction of PHI would 'threaten the collapse of the PHI system'. 'Threaten' and 'collapse' are intended to imply disaster, although no evidence is presented to show that there would be disastrous effects. The level of membership has swung from 65% to 31% and back to 45% without any disastrous effects that we can see (apart from changes in equity and cost-effectiveness at the margins). Walker et al. (2003), of the National Centre for Social and Economic Modelling, used rigorous estimates of demand elasticity for PHI to estimate that "... had the new PHI policies not been introduced, the proportion of Australians with private hospital insurance would have declined from just over 33% in 1998 to around 20% in 2010".

### **Weak logic**

The authors argue that people may value privately funded and delivered services more highly than those provided under Medicare by government care providers. He says that "... the community spends more on health care *in toto* when the private sector exists" and this "... provides some evidence that people value the private alternative more highly than the 'one size fits all' public offering they may be forced to take up were the private alternative not available (or not available at an affordable price)".

This is careless logic at best. It ignores the possibility that people pay more than they need to because of marketing. The difference in marketing expenditures for the private and the public products is very large. Most people who visit supermarkets know that branded goods sell at higher prices than their no-brand equivalents because many shoppers are influenced by the advertising.

The Medibank papers are also weak in that they fail to consider other reasons why people spend more when the private sector exists. There is no mention of the possibility (widely discussed) that it is simply less cost-effective.

There are some aspects of weak logic that might conceivably reflect simple ignorance. For example, it is claimed that, without the 30% rebate, membership might fall to 18%, in which case "... the viability of the PHI system would be in question". In fact, PHI exists (and is often more profitable) in other countries where membership is below 10%. We do not know whether the absence of references to other countries' experiences of this matter is accidental or deliberate. The same might be said of the absence of references to studies of equity, clinical outcomes, and so on.

### **Avoiding difficult questions**

The core argument of the supporters of more PHI appears to be simple: the 30% rebate is good because it reduces government's share of health care funding. If the rebate were to disappear, the number of people with PHI would decline, and this would be bad.

If so, there seems to be the need to consider whether the rebate should be higher. If 30% is good, then would 40% be better? Indeed, why do the authors fail to consider whether the government should pull out of health care financing altogether? The government could simply state that it will reduce taxes and cease to fund health care, in which case PHI would rise to cover perhaps 95% of the population. The looming pressures on government outlays would be solved overnight, and PHI would be viable in the extreme.

In fact, we have seen no analysis of this matter from proponents of PHI. This is in marked contrast to those commentators who have concluded that the rebate is undesirable overall. They have been consistent in arguing that a 0% rebate would be optimal, and that performance would decline as the percentage increased.

Harper and colleagues could also have presented a view about what might represent a reasonable number of insurers. They presumably do not take the view that the number should be determined by the market, since they strongly support direct government intervention through the 30% rebate and in other ways.

Similarly, if (as noted above) they favour lifetime community rating because it introduces an element of risk rating, they might have proposed the level of risk rating they consider optimal. A higher level would eliminate even more of the cross-subsidisation that they consider undesirable. Our view has been precisely expressed: we believe the optimal level of risk rating is 0% for all services that are clinically cost-effective.

### **Why are questionable policies enacted?**

If, as the evidence suggests, the 30% rebate represented poor health policy, how is it that mistakes of this magnitude can be made?

We suspect that weak appraisal processes were a contributing factor in this case: the 30% rebate policy was not well-founded in knowledge about experiences in other countries, or indeed on any kind of serious research. During Senate hearings in 1998, as recorded in Hansard (Senate, Community

Affairs, 4 Dec 1998, pp. CA76–CA91) (<http://www.aph.gov.au/hansard/senate/commtee/s2009.pdf>), it emerged that the Commonwealth Department of Health and Aged Care had only made crude and short-term estimates of the cost of the 30% rebate, and were unsure as to whether it would be much more or less than \$2 billion. The problems were compounded by the largely unexpected impact of lifetime community rating (Hindle 2000). The succession of three major policy interventions (two of which were ineffective) within three years suggests that the Commonwealth was not basing its policies on sound research.

Ranade (1998) notes that it is common for little to be learned by one country on the basis of experiences in another. Where ideas have been borrowed, they have hardly been analysed or even fully understood. She gives the example of managed competition (which is distinguished by competition among insurers as well as care providers): it was "... seized on as a quick fix to solve diverse problems of health systems in the importing countries (like Holland and the UK), with remarkably little evidence as to its feasibility in its country of origin (the USA) or transferability to very different context". She says that, if policymakers are to improve their capacity to draw lessons from international experience they must be able to distinguish the circumstances in which a particular policy innovation succeeded or failed and therefore whether there is any point in trying to transplant it into foreign soil. This requires strengthening the capacity for critical analysis and the testing of alternatives. It is only through these clashes of perspectives and confrontation of ideas that real learning can take place.

Willcox (2001) observes that "... policy making on private health insurance has been characterized by insufficient attention to research that might provide a stronger evidence basis for policy reforms". Similar views are expressed by Bridges (2003). Palmer (2000a, 2000b) says that "... analysis of recent hospital funding and private health insurance initiatives shows the limited role of evidence in the making of these decisions".

Clarke (1999) undertook a prospective study of the likely effects of the 30% rebate and was more

accurate in his predictions than the government, in spite of its greater resources (and responsibilities). Butler (2002) suggests that it was lifetime community rating that stimulated increased membership: by introducing the 30% rebate before lifetime community rating, the government incurred an unnecessarily high increase in its costs.

One might also argue that a reluctance or inability to evaluate perpetuates mistakes. The evaluation questions are easy to define in this case. One of us had the opportunity recently to ask groups of Slovenian medical and nursing students how they might answer the question as to whether the Australian government's reforms had been beneficial, and they had no difficulty in suggesting three simple statistics: the cost per unit of production for the entire health system (are we paying more or less for our health care), equity of access (the distribution of services across various groups defined by their health and socioeconomic status), and the balance of financial contributions. As far as we know, the government has made no objective attempt to answer any of them.

The Slovenian students also suggested it was necessary to establish a basis for comparison: what are the alternative options to the current level and type of private health insurance, and how might they perform relative to the model that actually exists? For example, several students wanted to know whether there were other feasible ways of financing care in private hospitals, along the lines recently proposed by McAuley (2004).

However, we believe weak research and evaluation are symptoms rather than the causes. Evans (1997) argues that the main reason why policies that favour the private over government-run health systems is that private systems benefit influential groups in three main ways. First, a more costly health care system yields higher prices and incomes for suppliers — doctors, drug companies, and private insurers. Second, private payment distributes overall system costs according to use (or expected use) of services, costing wealthier and healthier people less than finance from (income-related) taxation. Third, wealthy

and unhealthy people can purchase (real or perceived) better access or quality for themselves, without having to support a similar standard for others.

Thus there has always been a natural alliance of economic interest between service providers and upper-income citizens to support shifting health financing from public to private sources. Analytic arguments for the potential superiority of hypothetical competitive markets are simply one of the rhetorical forms through which this permanent conflict of economic interest is expressed in political debate (Evans 1997).

Incidentally, we do not question the right of individuals and organisations to promote self-interest, as long as they declare it. In this regard, Harper and colleagues do the right thing by clearly stating that "... the research was commissioned by Medibank Private". One might ask whether it is ethical for an academic to become involved in this way. However, this is a difficult matter: community values change over time, and perhaps Australians now embrace (or at least tacitly accept) a more market-based view of the world. We are uncomfortable with this in a matter so important as health care.

However, it is probably sensible to accept that some people's views can be bought, and that those parties that favour PHI tend to have more money to buy opinions (or are more willing to divert it away from health care). We should see it as a challenge and take it up with more energy and rigour.

In fact, it seems at least equally likely that the views of Harper and colleagues are ethically founded, and what appear to us to be biased views are a consequence of having no particular opportunity to consider other options. For example, they seem not to have considered the possibility that the link between PHI and private care provision is a contrived one. They might also have taken the view that increased PHI or reduced government spending were useful ends in themselves.

Bureaucratic inertia might also have contributed to the current set of policies. After all, the decline in PHI from 1984 to 1996 was very slow;

there is no evidence of the Labor Government, which oversaw that decline, being anxious to push it any faster — in fact one Labor Health Minister (Graham Richardson) sought to arrest the decline. If PHI had fallen to a very low level the Commonwealth might have had to design fundamentally new funding arrangements for private hospitals. As Lindblom (1959) pointed out, policy advisers are more comfortable with incremental change than with system redesign, even though in many cases such redesign results in “. . . ignoring possible consequences of possible policies”, and the risk of confusing means and ends.

### **The best (or the worst) of both worlds?**

In a speech in Chicago in 1999, UK Prime Minister Tony Blair said “. . . the political debates of the twentieth century — the massive ideological battleground between left and right — are over”. British economist Robert Skidelsky observes that Blair “. . . was too tactful to say that the debates had been largely won by the right”.

This may be the case in some sectors and some countries, but we doubt very much whether the debate about PHI in Australia is over. There is an enduring argument for tax-funded public goods, and in some spheres of their lives people may seek more government involvement than in others. Even if Blair and Skidelsky are correct in suggesting that we have generally become less egalitarian, we may have a different attitude to health care. Rawls (1971) says we are in an “original position” when it comes to health care, and are likely to choose to share our lot with others to the extent that we are able to do so.

One sign of a continuation of the debate in future is that the Australian Labor Party has said it will retain the 30% rebate if elected but (given the demonstrable problems) a Labor government would undertake a serious review. Given that the Fraser and Howard coalition governments both promised not to harm Medicare, we might reasonably interpret Labor’s remarks as being equivalent to a promise of change. If so, what possibilities might it consider?

At this stage, it is useful to quote the rather fundamental question raised by Jost (2001): is there in fact a comfortable balance to be found between public and private insurance? This was the question asked by a brilliant reforming health minister in Slovenia a year ago. Once he had answered it to his satisfaction, he felt that every mixed option could only be supported if you compromised on the logic.

Jost argues that public insurance is essential, and therefore great care must be exercised in avoiding its demise. There is no way that private markets can insure entire populations. Public insurance systems are more equitable, and they usually do a better job of controlling costs.

If one then allows PHI to exist, it will inevitably be increasingly regulated in a social democracy. (This is evidenced by experiences over the last few years in Australia: the Howard government has argued for deregulation and freer markets on many occasions but has in fact regulated PHI to a greater extent than perhaps any government in recent memory.)

Jost says that “. . . this seemingly irresistible impulse towards equity drives government intervention in private health insurance markets to become increasingly intrusive, and private insurance begins to resemble ever more closely a public program” as insurers are conscripted to serve the redistributive goals of government. The arguable benefits of private health care finance — its agility, flexibility, and capacity for innovation — are crippled as the government increasingly dictates the terms of the insurance relationship. At the limit, when publicly regulated and subsidised systems resemble public systems so closely, what justifies the added cost of private systems?

This is a question that deserves to be asked and answered with care, but such is the political and institutional inertia in most countries we suspect it will not happen in the foreseeable future. We must therefore accept the plausible argument in favour of a dominant, government-run, compulsory health insurance scheme but with the opportunity for individuals to purchase additional insurance from private companies. We would

argue that, if there is to be optional additional insurance, it might better be operated by the government — but that is another story.

The difficulties arise in the detail, and particularly with regard to the services considered optional (and therefore covered by PHI) and how they are best funded. At present, Australia's approach to PHI is a confusing mix of complementary, supplementary, and substitutive. It finances some essential services as well as those of lower clinical value for money. Financing is largely regressive. It is not as cost-effective as it might be.

In the case of (say) Canada, the dominant view is that PHI should be largely supplementary, contributions should be less regressive than in Australia, and it should mainly cover non-essential services (meaning services are of low value for money) to avoid denying anyone in the community the access to important services. The last view has recently been upheld in court: it was found to be entirely appropriate that the Quebec government should continue to apply a total ban on PHI for hospital and medical services covered by the government scheme. *Inter alia*, the court noted that if the wealthy are permitted to opt out of the public system they may withdraw their political and financial support from the public system as well, causing it to wither.

National President of the Australian Labor Party, Dr. Carmen Lawrence, has made similar observations in the Australian context: moving more people into PHI "... has the effect of diminishing the number of articulate and educated advocates for quality and universal provision, and also encourages what Galbraith has called 'the culture of contentment' — resistance to the expenditure of tax dollars on services which you do not receive. The fact that the payment of the rebates for private health insurance has been at the expense of funding for publicly provided health services underlines this point" (in Coote et al 1999). The establishment of two systems has many consequences, including the fostering of what Argy (2003) rather neatly terms 'downward envy'.

Thus we envisage a serious debate about the extent to which covered services might be reallo-

cated between compulsory and voluntary health insurance, and about the extent to which contributions should be progressive. We envisage a process in which the various views are formally and openly rated against predetermined criteria — more or less those that the Slovenian medical and nursing students suggested after brief thought. We also envisage reaching agreement about the need to have 'evidence-based economic policy' with its essential components, such as adequate experimental designs and a commitment to objective evaluation.

There is a need to follow this kind of debate as far as we can and to involve more people in it. One way in which the debate might be improved is through ensuring there is a more vociferous promotion of other models than those promoted by the well-off or commercially interested. The excellent analysis of press coverage during the debate about the 30% rebate by Carter and Chapman (2001) reports that "the anti-rebate case was presented less memorably" than the government's case, and that "universal health care was not promoted as fair or necessary". They conclude that "... there is an urgent need to promote the value of the public health care system and make the future of Medicare compelling for news editors and the public".

However, they do not make any suggestions as to how this goal might be achieved. We suspect that one important contribution could be made by those who work in the health system, many of whom seem to think that they can do little. It might not be good enough to sit back and trust that the pendulum will eventually swing back. We would like to think so, but then many of our American colleagues have been waiting for a hundred years.

We suspect it would make sense progressively to remove the 30% rebate and to transfer the money to both government and private health care providers through a fairer and otherwise refined process of competitive contracting. It might be advisable to do what the governments of many countries have done and impose some requirements on health insurers regarding their methods of operation in the interests of improv-

ing their cost-effectiveness. One that comes to mind is the capping of administrative expenses.

We do not know for sure, because serious debates have been rare in Australia. However, we agree with the former Minister for Health, Neil Blewett, who said the main advantage of the 30% rebate is that "... it provides a wonderful nest egg for a reforming government to do something really creative within the health system" (Blewett 2000).

We will use the words of Jost (2001) as the basis for our concluding remarks. He argues that "given the evidence, we have every reason to proceed cautiously in embracing policies that would throw more tax money at an inefficient private insurance system, especially those based on individual insurance policies. Perhaps if we cannot limit private insurance to the margins, we might at least consider expanding the public systems without posing too great a threat to the private insurance establishment, rather than further expanding public support for private insurance".

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