Private Health Insurance Bill 2006 and related Bills

Submission by Ian McAuley, Adjunct Lecturer in Public Sector Finance, University of Canberra

Private insurance – a costly way to provide choice and to support the private sector

It is evident, not only from the Minister's Second Reading Speech on this Bill, and from previous policy statements, that the Government sees choice and support for the private sector as important policy objectives.

It is also evident, however, that the Government has allowed these objectives to become subordinate to support for private insurance *as an end in itself*.

In support of that contention my reasoning and research are published in a 2005 journal article in *Agenda*[1], which accompanies this submission. The essence of that argument is that there are more efficient and equitable ways of providing consumer choice and supporting private service providers than churning funds through a financial intermediary, such as private insurance. If the Government wishes to support community rating, then the most equitable way of doing so is to use a single national insurer. If the Government wants to encourage the operation of market forces, then it should recognize that insurance, of any form, private or public, is a means of buying out of the market discipline of price signals.

Greater reliance on market signals would be consistent with the Liberal Party's encouragement of "individual initiative". But health insurance, through making services "free" at the point of delivery, suppresses the normal market mechanisms of price signals, and encourages over-use of services. The "nanny corporation" (in this case the health insurer) takes the place of the "nanny state".

Support for private insurance is particularly discriminatory against those who pay for their own care. It is easy for a government, obsessed with budgetary outlays, to forget that 21 percent of recurrent health care expenditure, or $16 billion a year, is made from consumers' own pockets, without the support of either public or private insurance.[2]

This proportion has been rising steadily in recent years; in 1998-99 it was only 19 percent, and such growth is natural as the population becomes more wealthy. Table 1 below shows household liquid wealth, which could be spent on health care, with particular attention drawn to older age groups, who are likely to be heavier users of health services.[3] As a consequence of the changes announced in the 2006-07 Budget, for those aged 60 or more, superannuation can now be considered as a source of liquid wealth, as there are no longer any restrictions on the amount than can be drawn. Most Australian households have a considerable buffer of wealth to enable them to pay for a significant proportion of their health care costs, without recourse to insurance.

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1. Ian McAuley "Private Health Insurance: Still Muddling Through" *Agenda*, Volume 12, Number 2, 2005, pages 159-178.

2. Australian Institute of Health and Welfare *Health Expenditure Australia 2003-04*, AIHW 2006.

3. Bruce Heady, Gary Marks and Mark Wooden "The Structure and Distribution of Household Wealth in Australia" Melbourne Institute Working Paper 12/04.

Table 1. Average liquid wealth per household, $000, 2002

	Age of household reference person			
	55-64	65-74	75+	All households
Superannuation	140	65	20	77
Equity investments	62	60	42	31
Bank accounts	42	35	33	22
	244	160	95	130

Source: Heady et al 2004

In short, for reasons of equity and efficiency, subsidies presently paid to health insurers should be re-directed to service providers, with the following benefits:

- bypassing the administrative overhead of private insurance;
- enabling the Government to monitor and control cost and usage;
- providing equity to those who prefer self-reliance to insurance;
- enabling consumers to choose between insurance and self-reliance, without their choice being artificially biassed towards insurance;
- relieving the Government of the need to regulate the private health insurance industry (and relieving the Government of the political odium of premium rises).

The present Bill – another wedge

The foregoing is a general case against public support for private insurance. If a government wishes to achieve a sharing of health care costs through community rating, then there is an overwhelming case for doing so through a tax-funded universal insurer. If a government wishes to achieve more of a market outcome, then it should encourage direct payments, without the support of insurance, with public insurance reserved for those with limited means or high expenses.

For many of the out-of-hospital services targeted by this legislation and mentioned in the Minister's Second Reading Speech, including "tailored programs that support and sustain healthy lifestyles, services such as personalised health checks, dietary guidance, exercise supervision, and support to quit smoking", people's choices should not be distorted by the incentives provided by insurance.

Whatever guidelines are developed, there will be a financial incentive for people to use those services which are covered by insurance, while there will necessarily be equally effective or better services excluded from insurance. For example, it appears to be the Government's intention to see insurance cover supervised exercise régimes, or dietary consultations, but these are high cost compared with self-help, such as unsupervised exercise or, say, internet-based diet research. Far from encouraging self-reliance, insurance for such services directs people's choice towards institutional means of attending to their health needs, with accompanying misallocation of resources. Such services, because of their discretionary nature, should not be covered by insurance.

Conclusion

The Government should re-examine its policy assumptions – that provision of consumer choice and support for the private sector can be achieved only through private insurance.

While the mechanical provisions of these Bills are innocuous, the overall trend is to see an expansion of private insurance, with its resulting distortions of resource misallocation and inequities, into territory it has not so far occupied by private insurance.

It is now ten years since the Government introduced its first round of tax incentives for private insurance. Over that period more and more interventions have been used to prop up this industry, including "lifetime" rating, the creep of the $50,000 penalty threshold, and the extra subsidies for older contributors. It's a situation analogous to the growing levels of tariff assistance in the 1950s and 1960s; there is no end to the level of support which private will require.

The Government needs to ask why it is directing scarce public fiances, appropriated for health care, into supporting a high-cost financial intermediary, and to return to the values expressed in its policy platform as a basis for public policy.

Ian McAuley

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