Senate Community Affairs Committee

Submission to the Inquiry into Private Health Insurance Incentives Amendment Bill 2004.

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INTRODUCTION

This inquiry is crucial to the welfare of Australians. It deals with the broad issue of health system financing, an issue of major national importance that is set to become increasingly urgent and controversial in the short to medium future. The key question is whether private health insurance is to be increasingly subsidized from the public purse. An equally important but broader question is whether access to hospital and medical services should be publicly or privately financed.

The policies of the Howard government have been directed consistently towards increasing the coverage of private health insurance in Australia, simultaneously reducing the role of the public insurer, Medicare. The Private Health Insurance Incentives Amendment Bill 2004 aims to shore up the role of private insurance by preventing the cost of premiums moving out of the reach of certain, relatively well off, older people. As such, the Bill would further entrench private insurance, with undesirable implications for access, equity and cost control.

If access, equity, defined as paying for health care according to income, and cost control are deemed to be desirable health system objectives, then the case for public funding through national health insurance or a national health service are incontrovertible. In Contrast, there is no evidence, either in Australia or overseas, suggesting that the public funding of private insurance helps to achieve any of these objectives. Indeed, the contrary is the case. The public subsidisation of private

insurance reduces access by diverting resources, both financial resources and trained personnel, it undermines equity by assisting the already well off to queue jump at general taxpayer expense and it increases the costs of hospital and medical services for the whole community.

The increase in private insurance coverage since 1999 *has caused* Australian health care costs to rise more rapidly than other costs. Without the spiralling costs of private health insurance, the Private Health Insurance Incentives Amendment Bill 2004 would not be necessary.

The health inflation created is unnecessary because public health insurance systems, such as Medicare, have the capacity to contain health care costs, as demonstrated by the good cost control record of the system between 1984 and 1999. Costs are now rising considerably faster than inflation and are moving far ahead of the OECD average, where Australia was once firmly positioned, as research undertaken by the Australian Institute of Health and Welfare clearly demonstrates.

Health cost inflation, of itself, is not necessarily a cause for concern. A country might choose to spend more of its national income on health, especially if that income is increasing, without necessarily provoking undesirable outcomes. However, experience in Australia and elsewhere has shown that there is a strong political tendency to offload costs onto consumers in the face of health inflation. A good example of this propensity is the large increase in user charges for medicines that was passed by the Parliament in 2004 and is to come into operation on 1 January, 2005. Because the costs of subsidising the pharmaceutical benefits scheme is increasing, both major parties considered it appropriate to shift costs to consumers, notwithstanding that there are many more equitable ways to influence spending increases. Such offloading, which customarily takes the form of user charges, is not a problem for the economically well off but creates great difficulties as one moves down the income scale. Less well off people, who suffer the most illness, become increasingly unable to afford to pay for services.

Thus, the access and equity problems already created by private health insurance systems are likely to be severely exacerbated in the face of rampant health inflation.

A striking example of this inefficient and inequitable cost spiral is provided by longstanding experience in the United States, the OECD country with the largest private health insurance sector. The United States system is by far the most expensive in the OECD, its coverage of the population is the most limited and the benefits available, even to many who are heavily insured, are severely restricted. I refer you to my recent book, *The Politics of Medicare, Who Gets What, When and How*, University of New South Wales Press, 2004, where I outline recent evidence of the gross inefficiencies and inequities that characterise the health financing system of the United States, the defining characteristic of which is that it is primarily based on private insurance. It is not coincidental that the country with the second largest private insurance sector in the OECD, Switzerland, is the second most expensive. Nor is it coincidental that Luxembourg, the country with the highest proportion of public funding, at 92 per cent, is one of the lowest spenders, with health care costs only marginally higher than two countries, Mexico and Japan (Australian Institute of Health and Welfare, (2004) *Health Expenditure Australia, 2002-03,* pp 60-63).

ACCESS

Increasing the role of private insurance through public subsidisation, which is the aim of the present Legislative proposal, decreases access for Medicare only citizens because it diverts resources away from the public system. Approximately $2.5 billion of public money is currently being spent annually to subsidise private insurance. In addition, approximately another $1 billion of tax expenditures can be attributed to the waiving of the levy surcharge for people who hold private health insurance. Thus, $3.5 billion could be made available to improve services, or increase the funding of services, provided through Medicare. Improved services could take the form of increased funding for public hospitals or community health centres. Increased funding could be provided in the form of incentives to encourage doctors to bulk bill.

Privately funded systems do not necessarily need to utilise user charges as a financing mechanism. It is possible to imagine a system where private insurance covered the full cost of services. In practice, however, private health insurance systems typically rely heavily on user charges, partly to offset the high cost of insurance premiums, partly as a mechanism through which providers can charge additional fees and partly

as an instrument of cost control. From an access perspective, the problem with user charges is that they deter service usage. Studies all over the world demonstrate clearly that user charges reduce utilisation of both essential and discretionary services, especially for the poor. For example, in the Province of Saskatchewan in Canada, a "natural" experiment occurred in the 1960s and 1970s when charges were first eliminated, then small charges were reintroduced, after which they were eliminated again. It was found that charges reduced utilisation by between 6 and 7 per cent across all income groups. However, amongst low-income families, access was reduced by 12 per cent and among very low income families, by 18 per cent.

In Australia, as bulk billing has been allowed to decline, user charges have risen to the third highest in the OECD. A group of researchers, undertaking comparative international studies two years ago, found that 14 per cent of Australians did not go to the doctor when they needed to because of cost, 17 per cent of people reported having problems paying medical bills, 23 per cent did not fill prescriptions because of cost, 9 per cent of those taking medications skipped doses to make their pills last longer, 17 per cent of people did not get a recommended test, treatment or follow up because of cost and 44 per cent of Australians reported being unable to afford dental services (Blendon, Robert et al, "Inequities in Health Care: A Five Country Survey", *Health Affairs*, Vol 22, Issue 5, 2003). Further evidence of low levels of utilisation of hospital, medical and diagnostic services by those on low incomes is to be found in the expenditures on the Medicare safety net in the first three months of operation. By far the highest payouts were made in the richest electorates, with the lowest payouts in low income electorates. For example, the payout in Australia's richest electorate, Bradfield, was $911,000, whereas the payout in low income Bonython was $36,000, strongly suggesting that many low income people cannot afford to pay for enough services to qualify for the safety net.

EQUITY

The way health care is financed has implications for equity. Public financing is "progressive", while private financing is "regressive". The public subsidisation of private insurance can be seen as "ultra regressive" because it provides additional, publicly financed benefits for those who are disproportionately well off. These

publicly financed benefits are not available to people who cannot afford private insurance.

Equity can be defined in many ways. A popular approach from a neoliberal perspective is to say that individuals should be free to spend their own incomes as they please. They should not be forced to contribute to the welfare of others through tax systems and, to the extent that taxation is necessary at all, it should be levied at a flat rate. If applied to health care, these ideas would mean that health services would be bought and sold in the market like any other goods, such as potatoes or motor cars.

A contrasting social liberal, or social democratic perspective, holds that essential services, such as health and education, should be funded according to the principle of ability to pay, because access to such services is a fundamental requirement of democratic citizenship. This idea forms the very basis of a progressive tax system, such as that in Australia, from which a bundle of public goods is financed. As in most OECD countries, health is considered to be a merit good that should be distributed according to medical need, not according to ability to pay. Judging from opinion polls and from research undertaken by the Health Insurance Commission, Australians are strongly persuaded by social liberal, rather than neoliberal, ideas. Approximately 90 per cent of people support Medicare and they do so because it is perceived to be "fairer". Research done in 1998 showed that the two main reasons for supporting the system were that "everybody is covered by it" and that "it helps low income earners".

The private financing of health services is at odds with social liberal principles. Private financing is levied at a flat rate, *not according to ability to pay*. Whether the financing channel is private health insurance, user charges or full cost payments, a flat levy is exacted, irrespective of income. In contrast, public funding is based on ability to pay. Private funding, all other things being equal, is of most benefit to the wealthy, who would make a greater contribution to a nation's health funding where financing is tax based. Given that the well off are typically much healthier than the poor and use fewer services, they benefit from any movement away from public financing. From this perspective, the promotion of private health insurance, even if, as in other countries, it is not publicly subsidised, can be viewed as highly inequitable. This

point is made by Canada's leading health economist, Professor R. G. Evans, who has argued that

> a shift from tax to private funding lowers the share of cost that is carried by the healthy and the wealthy -- the two are correlated -- while giving them better access. A small contribution buys your way to the front of the line. And it increases the income of those who can charge for services (RG Evans, 2000, *Financing Health Care*: *Taxation and the Alternatives*, Health Policy Research Unit, University of British Columbia at http://ideas.repec.org/p/fth/brichs/200015d.html).

The intentional promotion of private health insurance through direct public subsidisation is even more inequitable, because the benefits of public subsidisation are directed, primarily, to high income earners. Research done by the Melbourne Institute for the Government of Victoria in 2004, shows, as commonsense would lead us to expect, that income is a strong determinant of health insurance status: over 80 per cent of families in the highest 10 per cent of income earners hold private health insurance, whereas 25 per cent of families in the bottom 20 per cent of earners are privately(http://www.dpc.vic.gov.au/CA256D800027B102/Lookup/RecentPrivateHealthInsurancePoliciesinAustralia/$file/phi%20report.pdf). This means that most low income earners are being deprived of the benefits of public subsidy because they cannot afford private insurance and, at the same time, the services available to them through Medicare are more limited than they would be, if public money were not being diverted to the private sector.

For all practical purposes, the public subsidisation of private health insurance is the public subsidisation of queue jumping. The rebate, at 30 per cent or 35 per cent or 40 per cent -- the differences are marginal -- allows predominantly well off people to avoid the waiting lists of the public hospital system. Nor is it accidental that the system is so strongly supported by the private health insurance industry, private hospitals and organised medicine. The lack of effective cost control in the private sector translates neatly into higher incomes for providers.

In another sense, the public funding of private insurance can be seen to be inequitable because it draws personnel away from the public hospital system towards the private, making it harder and more expensive to retain doctors and nurses in the public Sector. Personnel are drawn to where profits and incomes are higher. Australia may have a two tier health system and it may have two different hospital sectors but it has only

one medical profession and only one nursing profession. The evidence is that elective surgery is increasingly being undertaken in the private hospital system, Where Staff Are More Readily Available and more willing to work, making it harder and harder for Medicare only citizens to access such services. The situation is exacerbated by the fact that the increase in private insurance coverage has not taken pressure off the public hospital system, as the Government argued it would. All major studies of the impact of the rebate, including the Melbourne Institute study cited above, have demonstrated the failure of the rebate in this respect.

Finally, it is not often recognised in public debate, that Australia actually pays high income people to take out private insurance. Take the case of a person earning $100,000 per year, who, without private insurance, is required to pay $1000 per year in the form of the Medicare levy surcharge. If such a person were to take out $1000 worth of private insurance, the surcharge would be avoided and $300 would be reimbursed by the Treasury through the rebate, making the person $300 better off than if they had not taken out private insurance. This policy is unique to Australia and, as Professor Jeffrey Richardson from Monash University has argued, could be entered into an international "strange but true" competition, along with the echidna and the platypus.

COST CONTROL

Countless studies across the OECD show that "single payer systems", such as national health insurance systems or national health services, have the capacity to control health care costs (which, of course, is why providers always argue against them: controlling health care costs necessarily constrains increases in profits and incomes). In contrast, so-called "multipayer systems" have a poor record of cost control. Multipayer systems are financed through a variety of channels, including private insurance, user charges, full cost payments, certain government subsidies and, in some systems, employer contributions. Whereas in single payer systems, a single entity, such as a government or a health commission, has control of the resources devoted to the system, in multipayer systems, no agency has the capacity to oversee and manage investment and no agency has exclusive buying power. Such systems are without mechanisms, such as global budgeting and have fewer instruments to control

incomes and profits, which leads insurers, governments and employers to try to shift the costs on to other payers: cost shifting replaces cost control. Another reason that multipayer systems are expensive to is that administrative costs are much higher than in single payer systems and this is an OECD wide phenomenon. In Australia, the administration costs for Medicare are 3.6 per cent of benefits paid whereas private health insurance administration costs are 10.5 per cent.

Health inflation has increased significantly since 1999. Throughout the 1990s, health inflation and general inflation increased at almost exactly the same rate. After 1999, when privatisation was set in place in earnest, however, a gap opened up. Health costs began to increase faster than GDP and are predicted to continue to do so. More detailed evidence of the reasons for Australian cost inflation since 1999 is available in my book, *The Politics of Medicare*, at pages 52-64.

CONCLUSION

Compared with a tax funded system, private financing of health services is inequitable and regressive. The situation is exacerbated by the peculiar Australian invention of direct public funding of private insurance, the benefits of which flow primarily to high income earners. These people are publicly subsidised to avoid waiting lists. Providers gain higher incomes and profits. A rebate of 30 per cent or 35 per cent or 40 per cent, as the case may be, has serious and untoward implications for access and equity, particularly for low income people, and for cost control. The Private Health Insurance Incentives Amendment Bill 2004 should not be passed into law because it will exacerbate the inequities and inefficiencies of present arrangements. Instead, a major inquiry into the financing of the Australian health system should be established, in order to draw to the attention of both the public and policymakers the volumes of national and international evidence that shows very clearly that private financing is inefficient, inequitable and unnecessarily costly. Australian health policy needs to be moved towards public funding and public control and not in the opposite direction.