MORE THAN ONE HEALTH INSURER IS TOO MANY:

the case for a single insurer

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Summary

This paper presents the case for a single national health insurer to replace the 38 private insurers now operating in the market. Although there would be scale economies, primarily in administration costs, in a single national insurer, such savings would be modest. The case for a single insurer rests on the intrinsic problems associated with having a number of insurers in the market. These include the under-provision of public goods which can reduce insurance claims (particularly public health initiatives), the incapacity of insurers to control price and utilization, and the moral hazard associated with insurance, which is more easily contained by a national public sector insurer.

This is not to claim private insurance is mis-managed, or that it is exploiting consumers. In fact, private insurance is placed in a difficult situation by government policy which seeks to achieve community rating, to restrain budgetary outlays, and to contain inflationary pressures. Nor is it to argue for a nationalized health care sector. The delivery of health care services is separate from the funding of health care services, and there is no reason why the presence of a single insurer should alter the balance between private and public provision of services.

Australia already has such a model administered by the Department of Veterans' Affairs, which provides health services for 300 000 veterans and their dependants. The Department acts as the single insurer, but most services, including two thirds of hospital services, are provided by the private sector. There would be significant economies and improvements in equity in extending the single insurer model to the delivery of all health programs.

Introduction – a disclaimer

Informed debate on health funding is impeded by misunderstandings and misrepresentations of the views and analysis of reformers. For example, in the USA in 1993, the modest reforms proposed by the Clinton Administration were stymied by a very successful but untrue series of advertisements which scared people into believing that the reforms would deprive them of choice.

So, at the outset, I want to make it clear that those of us who advocate a single national insurer, are *not* arguing for:

- *a socialized health care system*. It is easy to evoke an image of the UK National Health Service, with long queues of people sitting on cold wooden benches in dingy clinics.[1] But Australia is likely to continue to have a mixture of private and public health care delivery. In fact, there is no reason why a single insurer cannot *increase* the role of the private sector in delivering health care services. There are single insurer systems in other countries where the private sector dominates in delivery, and even here in Australia the Department of Veterans' Affairs operates as a single insurer on a purchaser/provider model, acquiring most services from the private sector;
- *a free system*. There are advocates of a free system, but there are strong arguments for having people pay for some health care from their own pockets. Australians already fund 19 percent of recurrent health expenditure from their own pockets (apart from the 8 percent they spend through private insurance). These payments are messy, introduced for budgetary control rather than for achieving equity or economic efficiency. There is therefore a case for reform of co-payments but not for their abolition. It should be noted that the arguments against a free system rest on moral hazard, in particular the absence of price signals or personal financial choices at the time of health care delivery. *These are exactly the same problems as we find in private insurance*.
- *a system without choice*. There is no reason why a single national insurer should restrain choice of therapy any more than the many private insurers.

Nor are we suggesting that health insurers are evil or greedy. In fact, by the standards of the wider insurance industry, they are models of technical efficiency, and we know that in such a competitive industry, with a high degree of media exposure, there are intense pressures to perform. The point is that a single insurer can fund health care much more efficiently and equitably than a fragmented private insurance industry.

In this paper I want to examine five shortcomings of private insurance – shortcomings that are inevitable when a nation tries to use private insurance to fund health care. These are:

(1) High administrative costs – though this is a comparatively minor issue.

(2) An inability to contain service providers' costs.

1. A dated image, but one which evokes a response.

(3) An inability and a disincentive to provide public goods.

(4) Difficulties in achieving equity ("community rating").

(5) Fragmentation of health services delivery.

In conclusion, I will suggest what Australia's health care arrangements could look like with a single national insurer – with private insurance playing either a very minor role (as in the UK and Nordic countries) or a supplemental role (as in Canada and France). The private sector can still thrive in delivering services, choice can be maintained or improved, equity can be improved and costs can be contained.

1. Private insurance carries high administrative overheads

Industry spokespeople are enthusiastic about consolidations and de-mutualizations. There are 38 private health insurers in Australia, including 13 "closed" funds, generally serving particular groups of employees. Once the mergers between BUPA and MBF, and Medibank and Australian Health Management are finalized and if the , there will be three dominant insurers – Medibank Private, BUPA/MBF, and HCF – with a combined 65 percent of the market.[2] MBF chairman, John Conde, claims that "the combined business will be in a stronger position to provide affordable health insurance, greater efficiencies and improved services".[3]

That is primarily an argument based on scale economies, but, as will be shown in this paper, the gains from scale economies are minor. The case for a single insurer rests more strongly on the very nature of private insurance and the costs imposed by the mechanisms the Commonwealth uses to achieve some level of community rating.

Certainly the administrative cost of private insurance stands out as a heavy overhead on the health sector. In 2006-07 these expenses were $1 068 000, or 9.6 percent of premium income.

But the possible gains from consolidations which may realize scale economies are small. Figure 1 shows, for Australia's 24 open membership funds, their management expenses per member. Visually, there is no clear evidence of a scale economy effect, and mathematically the measured effect is statistically insignificant.[4] The average annual management expense per member is $102, while the largest fund (Medibank Private), has expenses of $97. If a $5 saving could be achieved across all 10 million people covered by private insurance, the savings would be only in the order of $50 million a year. When premiums average around $900 per member, and are rising at around seven percent a year, a $5 saving is trivial.

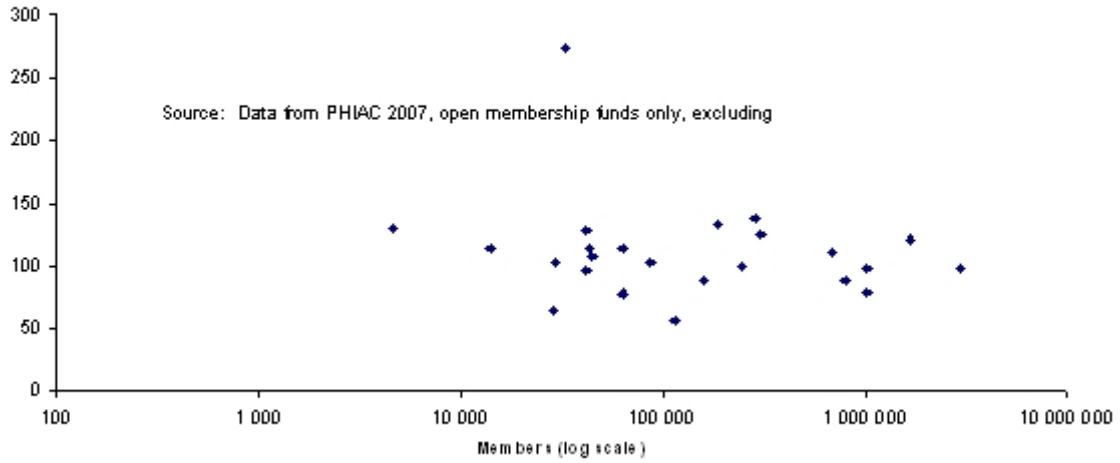
In fact, while the billion dollar overhead stands out, private health insurance does well by the standards of the insurance industry. Its claim percentage (claims as a

2. As measured by membership, PHIAC 2007 numbers.

3. Quoted by Rhys Haynes "Health funds talk up merger savings", *Daily Telegraph* 15 December 2007.

4. $R^2 = 0.016$.

Figure 1. Management expenses $ per member 2006-07



percentage of premium income) is significantly higher than for most other classes of insurance, which means its administrative overhead is lower. In part this is because, so far at least, health insurance still operates on a not-for-profit basis. This is in contrast to most other classes of insurance. Some cost increase is inevitable as funds move to a for-profit basis, but costs are unlikely to rise to the level seen in other classes of insurance, where claims are often accompanied by costly investigations and legal disputes. Table 1 shows the ratio of claims to premiums in general insurance, compared with health insurance.

Table 1: Premium income and claims 2006-07 $million

	Premium revenue	Incurred claims	Claims/ premiums
Houseowners/householders	3 773	2 627	70%
Commercial motor vehicle	1 390	1 196	86%
Domestic motor vehicle	5 207	4 687	90%
Travel	467	181	39%
Fire	2 770	1 471	53%
Marine and aviation	615	323	53%
Mortgage	861	211	25%
Consumer credit	262	39	15%
Other accident	1 040	410	39%
CTP motor vehicle	2 330	1 721	74%
Product and product liability	2 029	437	22%
Professional indemnity	1 266	610	48%
Employers' liability	1 141	585	51%
Other	796	328	41%
Average all general insurance	23 151	14 498	63%
Health insurance	11 127	9 432	85%

Source: General insurance data from APRA, health insurance from PHIAC

In sum, we can not expect much more gain from consolidation – unless we move to a single insurer model, for which Medicare provides the model. Medicare's administrative expenses are 3.1 percent of outlays, or around $30 per member,[5] to which should be added around one percent collection cost by the Australian Taxation Office. This does not necessarily reflect better management in Medicare than in private insurance. Rather, it reflects the fact that Medicare has a captive membership and the benefit of budgetary appropriation. It does not have to compete for members.

The argument for a single insurer does not lie primarily in scale economies, however. It has more to do with the inescapable problems associated with the very nature of private insurance.

2. Multiple insurers cannot contain costs

When there are many insurers operating in a market where supply is constrained, as in health care, it is difficult for insurers to contain costs.

Dr Michael Armitage, the CEO of the Australian Health Insurance Association, clearly explained the problem in an interview on the ABC *Breakfast* Program, when he was defending the insurers' claims for a significant price increase:

> They are going to be faced with a huge tsunami of costs for the ensuing twelve months, over which they have no control. They have to go to their fund members and say "we need more money".[6]

This is a valid point. Perhaps, in saying insurers have *no* control, he may have overstated the case, but the general point is that when there are many health insurers in the market, no single insurer has significant control over cost or utilization. Insurers complain about rising costs of surgery and medical appliances (prostheses and stents in particular), but as dispersed buyers they have little market power.

This lack of market power is illustrated strongly in the case of hip and knee replacements, which have been the subject of research by the Australian Orthopaedic Association. Between 1997-98 and 2005-06 the number of hip and knee replacements in Australian hospitals rose by 66 percent, but that rise was not uniform. In private hospitals, where most patients would have been covered by private insurance, the rise was 92 percent, while in public hospitals the rise was a more modest 39 percent.[7]

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5. In recent years Medicare has not published its expense ratio, but in 2006-07 its total management expenses were $624 million. Outlays on the MBS are no longer separately identified in budget papers, but based on projections of AIHW data, I estimate them to be $12 728 million, to which is added the $7 669 million for the PBS.

6. ABC *Breakfast* 29 February 2008.

7. Australian Orthopaedic Association *Annual Report 2007* Table G8. At first sight it may be assumed that this is simply a result of more people having private insurance, but the growth has continued well into the 2000s, when private insurance levels stabilized.

It is hardly surprising, then, that private health insurance premiums have been rising steeply since the rebates and other forms of support were introduced in 1997. On average, since 2000, they have been running at more than three percent above inflation, and by now they have almost completely absorbed, in real (inflation-adjusted) terms, the original 30 percent rebate.[8]

Table 2: Health insurance premiums - price increases

	Health insurance premium rise (lagged)	CPI previous calendar year	Excess health insurance
2001	6.9%	3.1%	3.7%
2002	7.4%	3.0%	4.2%
2003	7.6%	2.4%	5.1%
2004	8.0%	2.6%	5.3%
2005	5.7%	2.8%	2.8%
2006	4.5%	3.3%	1.2%
2007	5.0%	3.0%	2.0%

Source: ABS CPI data and Health Minister. On the assumption that health insurance premiums are a catch up, they are recorded against the previous year.

It is not an enviable position for the industry. On the one hand the firms have to cover costs, including the cost of capital (whether the firms are mutual or shareholder-owned). On the other hand is a government which is concerned with budgetary control, for it pays at least 30 percent of the insurers' premiums, and which is concerned with inflation, for health care comprises 7.5 percent of the base of the consumer price index.

By contrast, single insurers, as exemplified by (usually government operated) national health insurers, can have a great deal of control over price and utilization. In Australia's case, the Commonwealth's Pharmaceutical Benefits Scheme has successfully used its purchasing power to keep pharmaceutical prices and utilization in check, and the Department of Veterans' Affairs operates as a successful single insurer model for 300 000 Australians eligible for benefits, while purchasing most services from the private sector, including two thirds of hospital services. It has contracts with 443 private hospitals, including all major private hospitals. And its administrative cost as a proportion of outlays is only 2.7 percent.

The cost of not having the cost control which can be exercised by a single insurer is demonstrated most sharply by the USA, where health care costs (as a proportion of GDP) are much higher than in any other developed country, and where, in spite of a

8. The accumulated excess PHI inflation is 27 percent.

general rejection of big government, there is emerging strong public support for a single national insurer.[9] Health care costs in the USA have reached 15 percent of GDP, even while 40 to 50 million are left uninsured. By contrast, health care costs in Australian are 9 percent of GDP, but are rising sharply. Among OECD countries with similar health indicators, there is a strong and clear correlation between the extent to which health care is funded from private insurance and the total cost of health care.[10] In short, private insurance, while costing more, does not buy better health care. It simply buys more expensive health care, and the dominant explanation for this failure lies in its incapacity to control the costs of service providers.[11]

One problem for private insurance, and for health care as a whole, stems from the tendency for people to seek complete insurance cover – that is cover without any co-payment or excess. Those who can afford to do so use insurance to buy out of the discipline of markets, and, therefore, particularly when people have comprehensive "first dollar" cover, the price signals which normally serve to allocate resources in market transactions are muzzled. In spite of the rhetoric extolling the market virtues of private insurance, it is no more a market mechanism than the "free" tax-funded schemes. The logic "HCF/MBF/Medibank Private will pay for it" is no different from the logic "Medicare will pay for it". This phenomenon, known in the insurance industry as "moral hazard", applies to patients, hospitals, suppliers and health care providers alike, and is a major pressure for utilization and price increases.

Co-payments for insured services can introduce some market discipline, and, indeed around three quarters of private health insurance contributors have policies with some level of excess or co-payments, but these are small; for policies to attract the full subsidies the "front end deductible" is limited to $500 per person by government regulation. This cap is an attempt to preserve community rating, for the availability of high excess policies would lure some of the healthy and well-off into very low-cost policies (but still using free public hospitals), while community rating is designed to ensure they pay high-cost policies to subsidize those with high needs. But when people are highly covered, with low deductibles, there is not much room for market signals.

In any event, even in an unregulated market insurers might not offer policies with significant deductibles. In the unregulated car and house insurance markets high deductible policies are unobtainable, in part because companies seek not just profit (which could be achieved by using co-payments and deductibles to weed out moral hazard) but also revenue and growth (which are achieved by promoting

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9. In an *Economist* poll published in early December 2007, in response to the question "Would you prefer a plan that replaces the current health care system with a "single-payer" program where all health care costs are paid by the government or a plan the maintains the current system where most health care costs are paid by individuals or employers?" 42 percent were in favour of a single payer scheme, while 41 percent were opposed. www.economist.com/yougov

10. See CPD "Paying for Health Care" April 2007 http://cpd.org.au/article/paying-for-health-care

11. For the most recent exposition of health care costs in the USA, see Paul Krugman *The conscience of a liberal* (W W Norton 2007).

comprehensive policies); achieving high revenue often comes a close second to trading profitably.

Besides these ongoing cost pressures, there are some immediate cost challenges for private insurance in Australia, where for ten years there has been a very generous policy environment and very supportive economic conditions.

The Coalition Government went out of its way to subsidize private insurance, with a 30 percent rebate, "lifetime rating", additional rebates for older members, free advertising ("Run for cover"), and a one percent tax penalty with a threshold which fell away in real terms. Even in the heyday of tariff protection no Australian automobile or clothing manufacturer was so generously supported, with so little accountability.

The Commonwealth's decision to lift the cut-in point for the Medicare surcharge does no more than to restore it to roughly the same real point as it was when introduced in 1997, when only around 12 percent of households had incomes above $100 000. Now, around 6 percent of households have incomes above the new threshold of $150 000: it's only a little less generous. In fact it always been hard to justify the surcharge, for it has vastly over-compensated the better-off – including the very people who could afford to use a private hospital without insurance cover. For example, the cheapest hospital policy from Medibank is just $462 after the 30 percent subsidy, which carries a reward of one percent of income as a tax inducement. A young, healthy person with an income of $100 000 taking such a policy gets a $538 tax rebate in addition to a "free" policy. Never in the days of tariff assistance were the well-off offered a free Holden plus a cash subsidy!

There are claims and counter-claims about the effect of bringing the surcharge threshold back up to a higher level. My own back-of- the-envelope estimate is that up to 1.8 million people would be better off without private insurance[12], but we know that immediate financial inducements did not bring people into private insurance and are therefore unlikely to cause them to abandon it. A more realistic estimate of exit numbers is around 0.4 million, based on the 0.5 million people covered by exclusionary policies with co-payments and excesses, which are almost certainly held primarily for taxation purposes. [13]

Removal of such people from the pool of the insured will place cost pressures on insurers, for, while they hold cheap policies, they probably provide almost pure profit for the funds, because they would almost all be of working age with few health care needs, and, because of exclusions, excesses and co-payments, they would mainly use public hospitals when they need care. Insurers may complain that this is a hard blow, but when a government fails to index a threshold there will inevitably be a day of reckoning, and the longer it is delayed the harder the blow will be. (And other claims about waiting times are hard to sustain, for, whatever happens to private insurance,

12. Based on around 18 percent of households with incomes between $100 000 and $150 000.

13. Based on 24 percent of households with incomes > $100 000, 6 percent of households > $150 000, and 527 000 people covered by such policies. (527 * 18/24 = 395)

there is no change in the real resources – doctors, nurses, operating theatres etc – providing health care for Australians.)

There are other cost pressures on insurers relating to general economic conditions. Returns on funds' reserves will probably fall from the highs of recent years, and many people, faced with higher mortgage payments, will be reviewing their discretionary outlays, including health insurance. Also, the industry no longer has the free advertising provided by the previous Commonwealth Government, and, to the extent that the present Government can restore some faith in public hospitals, many people will feel a little easier about dropping private insurance. Those people suffering financial stress are likely to be heavily represented among the younger age groups.

Another change making for higher costs is de-mutualization. As pointed out the mergers and acquisitions will bring some minor scale economy benefits, but de-mutualization comes with the burden of the need to make a higher return on capital – both to satisfy shareholders (who, in such a highly regulated industry, will demand a high premium to cover sovereign risk) and to provide for company income tax.

It may seem tough to the industry that so many cost pressures are accumulating in 2008, but they are doing so after an extremely good run of fortuitous economic conditions and generous subsidies. In the 1980s many manufacturers came to realize that governments would no longer go on giving increasing levels of subsidy; this may be the reality which health insurers will have to confront. These subsidies are approaching an annual budgetary cost of $5 billion, and would be even more if the creep of the lowering surcharge threshold had not been corrected.[14]

3. Competing firms cannot provide public goods

At the 2008 *Financial Review* Health Congress, Dr Christine Bennett (then with MBF) gave a well-supported presentation on the value of health promotion, with a strong emphasis on the benefits to all, including health insurers, if people were to take more responsibility for their own health care.

Few would dispute this reasoning. Indeed, MBF and all other insurers and their contributors would benefit if there were lower claims. It is notable that the Commonwealth is now placing much more emphasis on public health, particularly on education and prevention.

The question arises, however, whether any health insurer will engage in the necessary promotion campaigns to achieve such a shift in responsibility and to promote behaviours which discourage use of high-cost services. In economists' terms, can a private firm provide public goods? In business terms, can one firm provide collective goods for the whole industry?

14. Based on projecting AIHW expenditure information, the rebates will cost $4.6 billion in 2008-09. The precise allocation is not revealed in budgetary figures because of "commercial sensitivities".

We can imagine if one of the big three insurers did undertake campaigns to improve health behaviour and to encourage people to take more care of themselves. If successful, there would be two consequences.

First, only part of the benefit would accrue to the firm in question. That firm would incur all the costs but would obtain benefits only in proportion to its market share; the rest would be enjoyed by its competitors. Economists refer to this as the "free rider" effect; its consequence is that no firm has any commercial incentive to undertake such an activity; in fact all firms have a strong disincentive to provide services for which they receive only part of the benefit.

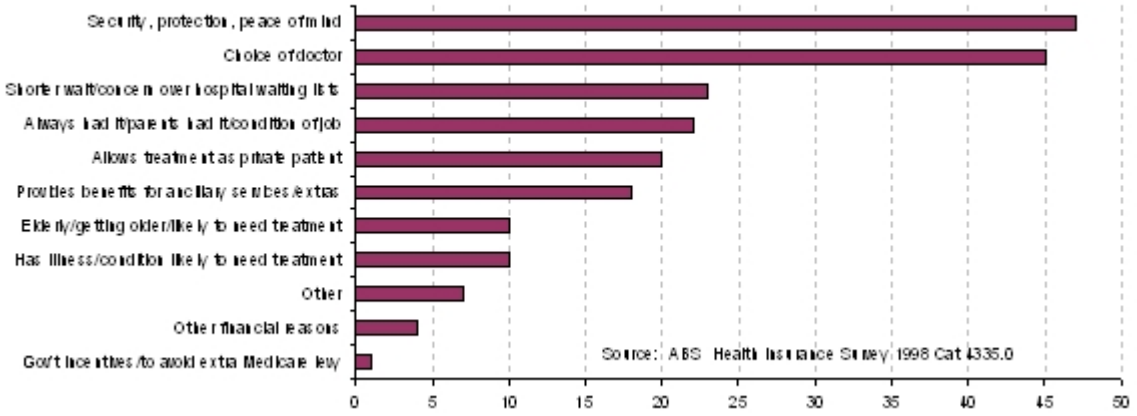
Second, any promotion of self-reliance undermines the very motivation people have for taking out insurance. People do not make a "rational" decision based on their assessed needs, their financial resources and the probability of having to make a claim. If rationality prevailed, few well-off people would have comprehensive car insurance, for example. Trying to promote insurance and self-reliance at the same time is akin to promoting alcohol and temperance in one package.

Evidence from behavioural economics shows people are far from "rational" in insurance markets. People have difficulty in assessing risk, and are unduly influenced by events with high vividness but low probability. Even if people can afford not to insure for certain events, they tend to seek enough insurance to buy out of all financial worries.[15]

Specifically, when it comes to health insurance, the motivation for buying insurance is not a rational cost-benefit approach, but, rather, the need to buy "security, protection and peace of mind" (Figure 2), as identified in a 1998 ABS survey of private health insurance. Economists refer to this as the *pseudocertainty* effect. We use insurance to ease our fear and to protect us from what may happen to us, and to insulate us from the harsh discipline of the market. The "Run for cover" advertising campaign of the previous Commonwealth Government played on this fear, and insurers receive a free promotional boost whenever there is a media story about public hospital incidents or long waiting times.

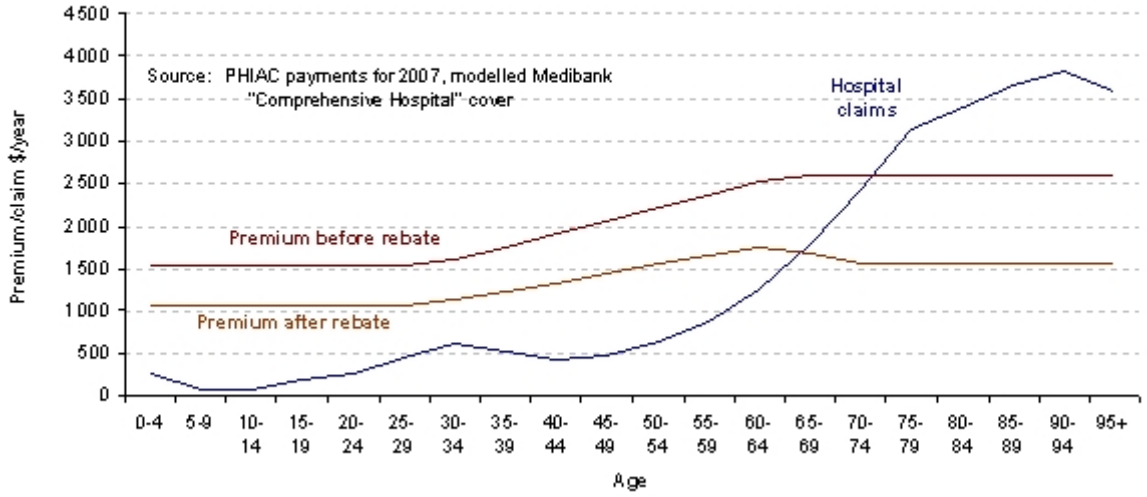
15. For the general findings on non-rationality in insurance markets, see the writings of Amos Tversky amd Daniel Kahneman on Prospect Theory. For a specific application in general insurance see Justin Sydnor "Abundant Aversion to Moderate Risk: Evidence from Homeowners Insurance" http://wsomfaculty.case.edu/sydnor/deductibles.pdf presented to US Federal Trade Commission Behavioral Economics Conference April 2007.

Figure 2: Reasons for holding PHI (Percent)



Any message that presents one's possible need for health care in a more rational context will tend to dispel this fear factor, and may encourage people to ask whether they really need insurance. In terms of government policy, there is a fundamental conflict between its avowed emphasis on primary care, public health and prevention, and its subsidization of a service which is directed at hospital care and which has a commercial incentive to remind people of their possible need for hospitalization.

Figure 3: The value of private hospital insurance



For commercial reasons private insurers have to over-emphasize the need for hospitalization, but in actuarial terms, private insurance does not become of value until one is around 60 to 65 years old – in spite of the "lifetime cover" penalties which increase starting premiums in two percent annual steps from age 30 to 64. Figure 3, modelling a Medibank hospital policy, shows that on average such a hospital policy does not pay for itself until the lines cross over at age 65.

4. Equity is hard to achieve – the Tax Office does it better

To be viable, private insurers rely on a cross-subsidy from the young to the old; this is the essence of community rating – the requirement to offer insurance to all who seek it, with no price variations other than those allowed by the "lifetime cover" formula. Community rating relies on overriding more rational risk-rating behaviour. Unregulated risk-rated insurance would remove these cross-subsidies, resulting in very low premiums for the young and healthy, and with private insurance being unaffordable for the old and frail.

What is community rating?

"Community rating" refers to the requirement that insurers are not permitted to discriminate on the basis of risk indicators, such as existing health, occupation, or dietary habits. In most classes of insurance insurers practice "risk rating". For example, motor vehicle insurers may discriminate on the basis of past claims, postcode etc.

In health insurance the only permitted departure from community rating relates to age, where there is a highly regulated "lifetime rating" system, whereby the entry price of insurance rises by two percent a year for each year up to age 65.

Figure 4 shows the age profile of the insured and of all Australians. The jump in cover at age 30 is evident – the effect of "lifetime cover". Only so long as private insurance retains this profile, and so long as the 30 percent rebate remains in place, will private insurance remain viable from a demographic viewpoint. For some time after the incentives were introduced the age profile of the insured worsened but it has since tended to stabilize – illustrated in Figure 5 which shows the proportion of the insured aged 55 or more.

Community rating, as reflected in an age profile that more or less matches the population, can be sustained only with very complex regulation, expensive incentives and exploitation of consumers' fear that they may need high-cost medical care – a notion that cuts across the Commonwealth's emphasis on promotion and prevention.

Figure 4: Population profiles, privately insured and all Australians

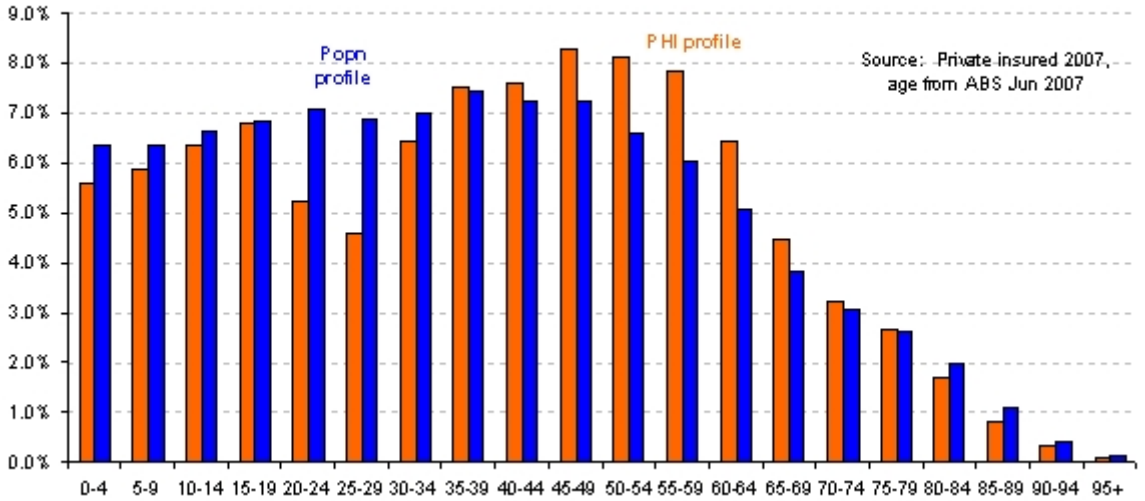
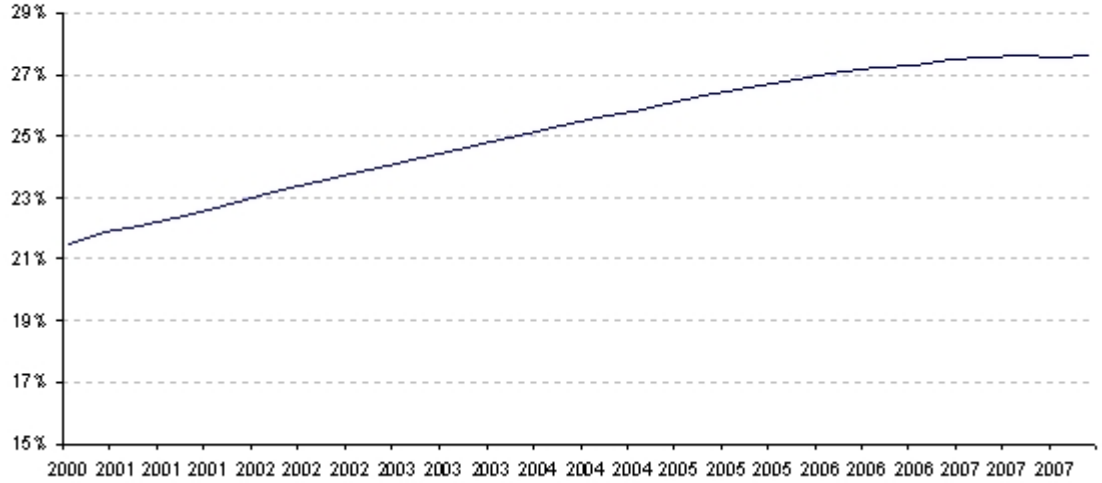


Figure 5: Percentage of insured aged 55 or more



The "community rating" so achieved is messy and inequitable. There remain many perverse incentives in the interactions between consumers and insurers. There are incentives for "hit and run" behaviour: that is taking a policy to coincide with a known short-term need. There are incentives for consumers to buy the most basic policies with high excesses and with exclusions, and never use them (which mocks the notion that private insurance takes pressure off public hospitals).

There are blatant injustices in a system which subsidises those who insure, while leaving the uninsured who pay the full price for services, particularly ancillary services, with no support. In view of the skew of the incentives towards the well-off, and the fact that the well-off therefore have higher levels of private insurance, the subsidies for ancillary services are particularly inequitable. There is no known notion of equity which suggests the wealthy should have subsidized dentistry, physiotherapy, podiatry and other services, while the less fortunate have to cope from their own resources, in a market where the demand from the well-off is inevitably putting upward pressure on prices.

Contrary to the rhetoric from some quarters, private insurance is not about self-reliance; rather it is about corporate reliance, as if the "nanny corporation" can claim some moral superiority over the "nanny state". It is absurd for governments, bearing the political opprobrium of long waiting times, to subsidize people to jump the health queues, thereby pushing others back.

Tax systems are far from perfect, but whatever their flaws they are generally far more equitable and efficient in paying for shared services than private health insurance. There is no adverse selection, for we are all selected. Barring migration (to another country with its own tax system) there is no "hit and run" behaviour. And collection costs are low; the Australian Tax Office does not have to advertise to get and hold customers.

There are those who suggest that we cannot afford to go on paying taxes to fund health care. But, if we can afford private insurance we can afford taxes. After all, private insurance simply attempts to do what official tax systems do far better – and that is to collect revenue for collective services. In fact, it reasonable to call private insurance a privatized tax,[16] but privatized taxes come with high collection costs and opaque accountability. If people mean we cannot go on paying more and more for health care, that is a valid concern, but it is separate from the question of the way we fund health care. And if people mean we may not be able to fund health care collectively that too is a valid concern – perhaps we should fund more from our own pockets, without the masking effect of insurance – a point to which I return in the conclusion. But that is not an argument for private insurance; it is an argument *against all insurance*, private or public.

There is no evidence, however, that Australians resent paying taxes for health care. Poll after poll puts health care at the top of preferences for increased public funding – even ahead of education and environmental protection – and that proportion has been rising over the last ten years, possibly in response to government withdrawal from health care funding.[17]

5. Private insurance fragments health service delivery

In Australia we have two privileged streams of health funding – private insurance for private hospitals and public insurance (through Commonwealth/State agreements) for public hospitals. There is only a little crossover and therefore no real opportunity for intersectoral competition for patients.

There is competition for scarce resources, however, particularly health care professionals, and that is why the shift in the private/public balance since private insurance levels rose has not alleviated public hospital waiting times.[18] Where the activity and money have gone, so too have the resources.

Conclusion – how a single insurer can fund health care

What this analysis means is that the business incentives on private insurance go against an economically sound allocation of health care resources and contribute to health care price inflation. It is *not* to suggest private insurers are inefficient, greedy or exploitative. Rather, the incentives they face, the constraints imposed by

16. A term coined by Naomi Caiden "A new perspective on budgetary reform" *Australian Journal of Public Administration* March 1988.

17. For the most recent poll evidence, see "Public Opinion Towards Governance: Results from the Inaugural ANU Poll" Australian National University 2008.

18. Peter Dawkins, Elizabeth Webster, Sandra Hopkins and Jongsay Young "Recent private health insurance policies in Australia: Health resource utilization, distributive implications and policy options." Melbourne Institute Report # 3, March 2004, University of Melbourne.

community rating, and the interests of the Commonwealth in controlling inflation and budgetary outlays, conspire to put them in a difficult position.

There are disincentives for investment in public health measures and in encouragement of self-reliance which would reduce the demand for medical services. And there is a strong moral hazard driving cost pressures.

These problems can be overcome with a single national insurer, and the natural candidate is a public insurer, funded by taxation. It is theoretically possible for that entity to be a private firm, but that would bring significant problems in competition and regulation, and, unlike a private firm which may have an incentive to expand, a government insurer will always be under pressure from financial departments such as Treasury to contain its outlays. Taxes are community rated; we cannot practice adverse selection or "hit and run" behaviour with the Tax Office. A single insurer has an incentive to reduce utilization and to impose cost control, for all the benefits of such activity accrue to the insurer.

More importantly, the single insurer has the market power to impose utilization and cost control; it is not in the difficult situation of the multiple insurers who are reduced to pleading that they don't have control of costs. A single insurer can exercise some degree of market discipline by requiring co-payments – as is done at present with the Commonwealth's PBS.

It may appear ironic that this market-based discipline is available to a single government insurer, but not to competing private insurers, who, commercially, feel obliged to promote a high level of cover. That's the way incentives can work themselves out. A government can introduce some market discipline by prohibiting insurance for small outlays, thus eliminating the moral hazard of services which are free at the time of delivery.

There is no reason why a single public insurer should prefer public to private provision of services. The notion of purchaser/provider split is well-established in public administration, and as pointed out, the Department of Veterans Affairs already operates a viable single insurer model.

And there is no reason why choice of service or of service provider should be constrained within a single insurer system – any more than it is constrained in a multiple insurer system. (There is a trivial argument that people may want choice of insurer, but, particularly when there is necessarily such heavy regulation of the sector, choice between look-alike insurers is nothing more than choice without variety.)

There are those within the insurance industry who represent any criticism of their industry as an attack on the private sector. Insurers in Australia have been particularly strong in establishing the notion that without private insurance there

would be no private health care, and sometimes their attacks on their critics have verged on hysteria.[19]

Claims of that nature are hardly contributing to a rational debate, and they are making it hard for the Commonwealth Government to reverse a very expensive and ill-advised decision when its predecessors re-introduced subsidies for private health insurance.

Since subsidies were introduced in 1997 hardly a year has gone by that the Commonwealth has not increased support for private insurance, all for a very unclear purpose. The subsidies have not relieved pressure on public hospitals, they have not introduced market disciplines in health care, they have actually penalized self-reliance, they have split private hospitals off from public hospitals, they have been highly inequitable, and they have been costly. Their only purpose seems to have been to support private insurance as an end in itself.[20]

Just why a government should divert scarce public funds to support a financial intermediary is not clear – the present Commonwealth Government has not explained why it subsidizes private insurance, and the reasons given by its predecessors lacked foundation. By any reasonable principle of public policy it is hard to justify. Public policy should be moving to a single national insurer.

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19. For an extreme example, Russell Schneider AO, former CEO of the Australian Health Insurance Association, is on record as saying "Health economists are dopes. I've yet to meet any of them who are rational. Most of them are extreme left wing ideologues. If they were any good, they'd be in the private sector. All they can do is get jobs in the universities." *Crikey* 31 Jan 2008.

20. The possible reasons for public support for private insurance are examined in Ian McAuley "Private Health Insurance, still muddling through" in *Agenda* Vol 2 No 2, 2005. The only viable reason is that the objective is to support private insurance as an end in itself.