Submission to Senate Standing Committee on Economics – Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

Ian McAuley

Centre for Policy Development
and University of Canberra

A) The impact of changes to PHI membership

Considering experience to date we cannot claim to know the impact.

No-one can give a categorical answer. Economists refer to the concepts of price elasticity and income elasticity, and, in a gross sense, price and income changes in most markets do follow the directions suggested by economists.

But in health insurance the best we can say is that we cannot predict the effect of changing financial incentives. It is reasonable to assume that the previous government had estimates concerning the effects of various policy initiatives, but its first two attempts to use financial incentives to encourage people to take up private insurance had no effect. The first intervention, in July 1997, was the one percent tax surcharge combined with a means tested fixed-rate subsidy. The second, in January 1999, was the general subsidy of 30 percent.

Neither intervention increased the coverage of private insurance; in fact coverage continued to decline. Then, in July 2000, the government introduced "lifetime cover", following which there was a rapid and huge uptake of private insurance. At the same time there was a massive advertising campaign "run for cover". Even with the benefit of hindsight, it is not possible to determine what was responsible for this rise. Was it that "lifetime cover", with its deadline to get in before there were age-related premiums, was seen as closing options and forcing a decision? Was it that the intense advertising worked? Were there other factors, such as horror stories from public hospitals or encouragement from the Treasurer?

Some insight is given by an ABS survey, taken after the initial incentives had been in place for one year. Financial reasons, including the surcharge, are hardly relevant.

Reasons for holding private health insurance -- percent of contributors June 1998

Gov't incentives/to avoid extra Medicare levy	1
Other financial reasons	4
Other	7
Has illness/condition likely to need treatment	10
Elderly/getting older/likely to need treatment	10
Provides benefits for ancillary services/extras	18
Allows treatment as private patient	20
Always had it/parents had it/condition of job	22
Shorter wait/concern over hospital waiting lists	23
Choice of doctor	25
Security, protection, peace of mind	47

Source: ABS 4335.0 *Health Insurance Survey 1998* Table 11

One point from this table is that many people seemed to be poorly informed about private insurance. The reasons "Allows treatment as a private patient" and "Choice of doctor" are

clearly wrong. Anyone has these options, whether they are insured are not. It is possible that people have been misled by advertising, which, while not explicitly false, can leave the strong impression that one must have private insurance to enjoy these benefits. It is notable that following the "lifetime cover" initiatives and "run for cover campaigns", the proportion of people without private insurance being treated in private hospitals steadily fell from a peak of 27 percent in 1998-99 to 12 percent in 2006-07, even while Australians became wealthier.[1] Private insurance, it appears, contrary to government claims about "self reliance", has actually allowed corporate reliance to displace self-reliance. This is possibly because of the subsidies, and possibly because people erroneously believe that they need private insurance to be treated in a private hospital.

Rough estimates to establish bounds

If people were purely financially rational and risk-neutral, I estimate that about 16 percent of Australian's 9.4 million people covered by PHI would drop it as a result of the changes to the surcharge thresholds. That is 1.5 million people. (See the box for the calculation.)

Estimate of number of households in $100 000 to $150 000 range

The table below is derived from 2005-06 household income distribution (ABS 6532.0 *Household Income and Distribution*). To bring it to 2008-09 figures the brackets have been indexed upwards by 13%, the three year movement in average weekly earnings.

2005-06 household weekly income lower range	Indexed to 2008-09	Annual	Number of households	Percentage with higher incomes
1600	1 807	94 312	495	29.7%
1800	2 033	106 101	379	23.5%
2000	2 259	117 890	651	18.7%
2500	2 824	147 362	359	10.5%
3000	3 389	176 834	284	5.9%
4000	4 519	235 779	86	2.3%
5000	5 648	294 724	99	1.2%
Total number of households			7926	

Taking the mid point between $94 312 and $106 101, suggests that about 26.6 percent of households have incomes above $100 000. About 10.5 percent of households have incomes above $150 000 ($147 362 to be precise). That suggests about 16 percent of households will no longer be subject to the surcharge. Assuming the distribution of insured persons by household is the same as the distribution of population by household, this means about 16 percent of people currently holding PHI would no longer be required to pay the surcharge if they dropped it.

It is reasonable to assume that almost all individuals with incomes above the new thresholds are employed, and are therefore likely to be healthy. Statistically, they gain little from holding

[1] Source ABS 4390.0 *Private Hospitals*, various editions. Acute and psychiatric hospitals.

PHI; the age at which PHI becomes a reasonable financial deal (when, even with "lifetime rating", average claims exceed average premiums) is around 60 – 65.

But people are not risk-neutral; evidence shows that in insurance markets people are risk-averse, and typically over-insure.[2] Nor are they rational in relation to insurance. They are influenced by the vividness of events such as accident or illness, resulting in subjective over-estimation of their likelihood of needing insurance. Also, people are subject to what is known as the "endowment effect". Once they have a product such as an insurance policy they are likely to hold on to it, even if they would not purchase it if they did not already have it. And, as shown above, many people seem not to understand that they can use private hospitals without having private insurance. So a figure in the order of 1.5 million people must be considered to be an extreme upper bound.

A much more conservative estimate is provided by considering the number of people with minimalist policies, which are sufficient to avoid the one percent surcharge. These people, rationally, would hold hospital only policies, with exclusions, excesses and co-payments. There are only 3 000 such people according to PHIAC figures. A higher estimate would be to include all with hospital cover (rather than "hospital only"), which comes to 528 000 persons, or about one third of the 1.5 million estimate.

We do not know, any more than policymakers knew ten years ago. There will be other influences tending to reduce PHI membership:

- higher premiums, quite apart from those resulting from loss of younger and healthier members attributable to the shift in the surcharge. There are the usual price rises, which in 2008, have been a modest two percent above inflation. They have generally been higher, and it is probable that 2007-08 will see very poor returns on insurers' reserves, which will have to be made up by premiums. Also, with de-mutualization, some insurers will face a higher cost of capital.
- general economic conditions, in particular higher interest rates, higher food prices, and higher gasoline prices, putting strains on household expenditure.
- a possible recovery in the confidence of Medicare and public hospitals, particularly if the government's funding boost starts to show effects. Also, there has been a withdrawal of the government-provided advertising for PHI.

Undoubtedly, as membership falls, those with partisan or financial interests will try to attribute the cause to the shift in the threshold, but it should be realized that PHI is a high-cost industry, which can survive only with ever-increasing levels of subsidy – a point to which I return in the final part of this submission.

---

[2] There are many studies to this effect. See, for example, 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.

F) The impact of the changes on hospitals

The main point, missed by the media and most interested parties, is that changing sources of hospital funding has no immediate effect on the level of resources devoted to providing health care. Whatever the government does with funding there will still be the same number of doctors, nurses, operating theaters etc. The supply of these resources is inelastic in the short to medium term.

If demand shifts to public hospitals, then skilled staff will probably move from the private to the public hospitals. When the previous government used private insurance to encourage people to move to private hospitals, so too did resources move to the private hospitals. That's the main reason the incentives never achieved their claimed benefit of relieving pressure on public hospitals. If that demand shifts back to public hospitals, so too will the resources.

In any event, the government has promised that in its waiting list program it can purchase beds from private hospitals. If the private hospitals respond (rather than refusing the offer as they did when the Kennett Government in Victoria made an offer to buy services from the private hospitals), it will be a policy breakthrough. It has been a long-standing distortion to have two separate, quarantined, funding streams for private and public hospitals. Intersectoral competition, encouraged by a central and powerful public insurer, should deliver significant benefits in both technical and allocative efficiency.

In all probability, however, there will be little change in the public/private mix of services resulting from this initiative. It is likely to have a modest impact on membership as indicated above. High income individuals, and those in high income households, are generally healthy people of working age, with little need of hospitalization. If they do need hospitalization it is likely to result from an illness or accident emergency, with priority access to public hospitals (rather the discretionary services which can be provided at short notice in private hospitals). And, those who drop insurance for tax reasons would probably never have used private hospitals anyway, even in the unlikely event of their needing care. (That, of course, is why they are attractive members; even if they pay minimum premiums, they represent almost pure profit to the funds.)

In fact, it is puzzling why the government has kept the surcharge at all. People with high incomes are also people with high wealth. Households in the highest income quintile have financial assets on average of $500 000. This includes $200 000 of superannuation assets, which are necessarily quarantined, but they are still left with $300 000 to spend on health care or other contingencies.[3] Governments need to break from an assumption, perpetrated by insurers, that private insurance is the only path to private health care.

Fii) The ongoing viability of PHI.

There is an unstated assumption that it is desirable for PHI to have a significant presence in health care funding.

Certainly it is desirable to sustain the investment in private provision of health care, but, as pointed out above, there is no reason for private hospitals to tie their fortunes to private

---

[3] See ABS 6554.0 *Household Wealth and Wealth Distribution* Table 8.

insurance. They can be funded by governments (as is the case with the Department of Veterans' Affairs) and from direct patient payments (as was increasingly the case until private insurance suppressed this outbreak of self-reliance). Certainly consumers want choice, but the choice they seek is choice of service provider. It is hard to imagine that people gain benefit from choice of insurer, which, because of government regulations to sustain community rating, all have look-alike products.

Governments have somehow believed that having a multiplicity of insurers will bring benefits of market competition, but the reality is that insurance of any type, private or public, is a means consumers and their agents (medical practitioners) use to buy out of the discipline of market competition. All insurance incorporates moral hazard – that is the tendency to over-use a product because it is "free" or heavily subsidized at the time of delivery. This moral hazard drives up prices, particularly in markets such as in health care, where there is constrained supply of resources.

If governments want to contain health care costs they have two effective paths. One is to bring in more direct payments, without insurance, before a safety net cuts in. For such a market system to work insurance for services not covered by the safety net has to be prohibited. The other is to use the power of a single national insurer, as has been done in most countries which have successfully contained health costs while maintaining high quality services. And, of course, the two approaches can be combined, with the national insurer system operating a safety net, requiring co-payments before there is cover. (Some private insurance products, particularly for ancillary products, operate on the reverse principle; the so-called "insurer" caps its liability, while leaving the "insured" liable for the open-ended risk. It is doubtful whether it should be permissible to refer to such products as "insurance".)

In this regard, I stress that in advocating a single national insurer, I and many others who mount the same argument, are not advocating "socialized" medicine. That is an emotive misrepresentation of our arguments, but it is likely to be made by defenders of private insurance. A single national insurer can (and should) support the private sector, can offer choice, and can exert strong controls on price and waste. Also a single national insurer, funded from taxes, is under the fiscal constraint of the Treasury and Finance Departments. A single national insurer has an incentive to contain costs and to engage in activities, such as health promotion and investment in early intervention, which may reduce the need for expensive hospitalization. Private insurers, even though they may be staffed by competent and thoughtful people who appreciate the value of such interventions, have no incentive or reward for spending on such public goods. Any insurer making such outlays would be compromising its own competitive position, and any benefits in terms of reduced demand would flow mainly to its competitors ("free rider" and "externality" effects).

The case for a single insurer has been made by many economists. My voice is no more than one among many. My most recent contribution is a paper to be presented to the Health Insurance Summit in July 2008, sent with this submission, and available from the Centre for Policy Development.[4] Its main points have been summarized in this submission.

---

[4] Ian McAuley "More than one health insurer is too many: the case for a single insurer" http://www.cpd.org.au/paper/the-case-a-single-insurer

The previous government never seemed to understand why it was subsidizing private insurance; in fact, support for private insurance became an end in itself, quite separate from any notion of other policy objectives, such as relieving pressure on public hospitals, containing health care costs or encouraging self-reliance, for it failed on these and other stated objectives.[5] This government has simply inherited the previous government's policies, and, it too seems to have no defensible reason for supporting private insurance.

In supporting this industry the government has been caught in round after round of escalating public budgetary and regulatory assistance, with no end in sight. These include:

- the initial surcharge and rebates in 1997;
- the general rebate in 1999 (now, wiped out in real terms, by premium rises ahead of inflation);
- lifetime rating in 2000;
- "run for cover advertising" in 2000 and ongoing advertising;
- extra subsidies (35 percent and 40 percent) for older people in 2005.

And all the time been the inflationary creep of the surcharge, which has been the most generous assistance made to any industry in Australia's history. Not even in the time of high tariff protection were people actually over-subsidized to buy a product. In fact, they will still be over-subsidized, for at the $100 000 individual cutoff point avoiding the surcharge will still be worth $1000 a year, and there are many PHI products on the market for far less than $1000. More absurdly, the subsidy and therefore the over-compensation increases with income. That is another reason why the surcharge should be abolished altogether. Some will argue, correctly, that the movement in the surcharge thresholds simply restores assistance to about the same level as existed in 1997, but it had no justification then and it has no justification now.

This industry needs to be weaned off public assistance, and if it cannot exist on its own it should be allowed to phase out – just as many economically inefficient industries phased out as tariff and other support was withdrawn in the 1980s.. Raising the surcharge threshold is a useful first step, but it is far too timid. If PHI disappears from the Australian landscape, or is relegated to a minor role, all that will have been lost is an expensive financial overhead from the health sector. The government's policy priorities should be to ensure that the private health care sector can survive and thrive from funding other than PHI.

In this regard it would be useful if the government can come to understand the true nature of the PHI industry, as a part of the financial services sector rather than as part of the health care sector. Any subsidies for PHI, so long as they last, should come through the Treasury portfolio, for Treasury has regulatory responsibility for the financial services sector. In that way the government's health care budget can be devoted to health care, rather than being diverted to assistance for the financial sector.

---

[5] Ian McAuley "Private Health Insurance, still muddling through" *Agenda* Vol 2 No 2, 2005.