Stress on public hospitals – why private insurance has made it worse

A discussion paper by Ian McAuley, University of Canberra, for the Australian Consumers' Association and the Australian Healthcare Association

Summary

The Commonwealth has consistently claimed that its subsidies for private insurance would relieve pressure on public hospitals.

There has been some uptake of activity by private hospitals, but this rise is much more modest than the rise in participation in private insurance. The increased private hospital funding that has resulted from the subsidies is actually *less* than the outlays on the subsidies. To the extent they have paid for hospital services, the subsidies have gone largely to those who were already using private hospitals, with or without insurance.

Because of leakages to administration, ancillaries and gap payments, support for private insurance has been a high cost way to support private hospitals.

Public hospitals still have to carry the load of cases which private hospitals do not have the capacity to handle. At the same time, because of the subsidies, scarce resources, particularly skilled staff, have been drawn to the private sector. There is no relief of the pressure on public hospitals. In fact, because of the inflationary effects of private insurance, the whole health care system will bear high costs for so long as it relies on private insurance for a significant proportion of its funding.

There is a case for supporting private hospitals, but not through the use of a high-cost financial intermediary. Direct funding of private hospitals, to bring their funding more into line with public hospital funding, would result in a fairer and more efficient allocation of scarce health care resources.

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Stress on public hospitals – why private insurance has made it worse

The hard jobs are left to the public sector – Herman Leonard, Professor of Accounting, John F Kennedy School of Government, Harvard University.

Introduction

The Commonwealth has justified its support for private health insurance on the need to keep pressure off public hospitals and to prevent the collapse of the private hospital system.

Collapse of the private hospital system would indeed be disastrous. A third of Australia's 75 000 licensed beds are in private hospitals – a proportion which has been growing in recent years. The public hospital system, already under strain, could certainly not cope with a transfer of the load from a collapsing private hospital system.

But it is fallacious to argue, as the Commonwealth Government does, that the only way (or the best way) to prevent this collapse is to subsidize private health insurance. Only a small part of the Commonwealth's two billion dollar annual subsidies find their way into private hospitals. And, as a basic economic principle, where money is directed so too will real resources flow; the flight of medical staff to private hospitals is one reason public hospitals are now under stress. There are shortages of real resources, particularly professional staff, throughout the health care system.

There are more direct ways to fund private hospitals – ways which avoid the waste, leakages and inflationary pressures of the present arrangements, and which ensure scarce resources are allocated where they are most needed, without diminishing people's legitimate desire to exercise choice.

Background

From the time Medicare was introduced in 1984, the proportion of Australians holding private insurance steadily fell, from just on 50 percent of the population in 1984 to 30 percent in 1996 – an attrition of about 1.7 percent a year.

This fall resulted in political concern, particularly in the Coalition (in opposition over that period), and among some in the Labor Government who had forgotten that Medicare was built on universalism. One concern was based on the assumption that the decline would continue – possibly accelerating in a feedback process of rising fees and worsening adverse selection as the young and healthy abandoned private insurance. The second concern was that the private hospital system, being dependent on private insurance, would collapse. This, too, was based on an assumption – that the fortunes of private hospitals had to be inexorably linked to the private insurance.

It is not possible to verify or refute the first assumption with any certainty. While it has some intuitive appeal, health economists such as John Deeble, examining consumer responses to changes in insurance prices, suggest that demand for private insurance is not particularly sensitive to price.[1] The Coalition Government, elected in 1996, wasn't going to risk allowing private insurance levels fall any further, and over the next four years undertook three initiatives to stabilize and boost insurance levels.

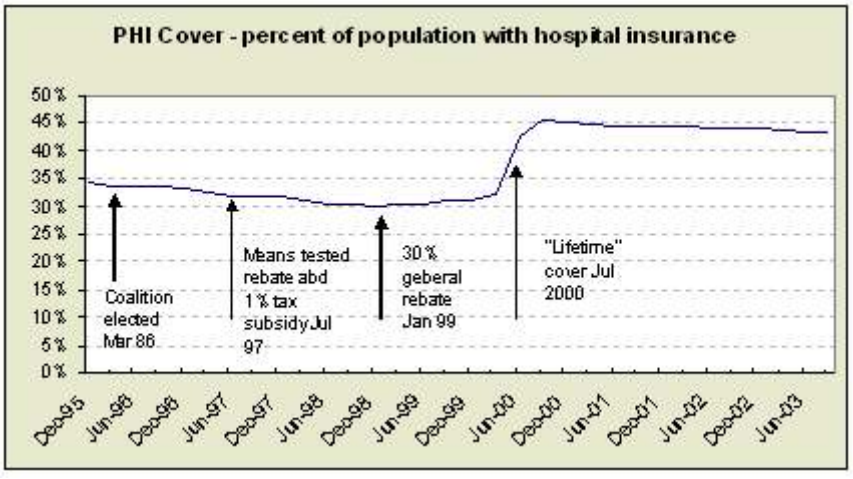
The second assumption – that private hospitals are necessarily dependent on private insurance – has been subject to very little scrutiny. Indeed, it has been in the interests of the health insurance industry to make sure it is not questioned. Lobbyists for private insurance consistently fail to differentiate between private sector *funding* and private sector *provision* of hospital services. In the minds of the public, and of politicians, there has come to be no distinction between the funding and provision of health care.

This conflation of ideas set the ground for the Coalition to focus its attention on rescuing private insurance. There were three initiatives (one could argue that there were two separate initiatives in 2000, making four initiatives) to support private insurance:

(1) A means-tested rebate for those taking out private insurance and a one percent tax penalty for those on incomes above $50 000 who do not hold private insurance. Effective from July 1997.

(2) Removal of the means test and a universal 30 percent subsidy. Effective from January 1999.

(3) Introduction of 'lifetime' cover – a two percent rise in premiums for every year delayed in taking out private insurance, starting at age 30 and capping at a 70 percent rise at age 65. Supported by a major advertising campaign 'run for cover'. Effective from July 2000.



Only the third of these was effective in boosting private insurance levels. This experience appears to confirm that demand for private insurance is not particularly sensitive to price. When asked by the Australian Bureau of Statistics (ABS) why they held private insurance, the main reason people gave was not price, but rather that they sought 'security, protection, peace of mind'. People's choices were not particularly influenced by the government incentives which reduce the price of insurance. See Table 1 below.

1. Deeble 2003.

Table 1. Reasons for holding private insurance (Percent)

Security, protection, peace of mind	72
Choice of doctor	39
Allows treatment as private patient	31
Provides benefits for ancillary services/extras	28
Shorter wait/concern over hospital waiting lists	36
Always had it/parents had it/condition of job	33
Gov't incentives/to avoid extra Medicare levy	2
Other financial reasons	6
Has illness/condition likely to need treatment	15
Elderly/getting older/likely to need treatment	15
Other	11

Source: ABS *Health Insurance Survey* (Cat 4335.0) June 1998.

This means that, in terms of boosting insurance levels, the subsidies and tax penalties have been almost entirely ineffective; only two percent of respondents mentioned them as reasons for holding private insurance. The tax penalties were particularly ineffective, because most people with incomes above $50 000 already had private insurance. The measures may have had some justification (albeit a weak one) on welfare grounds, but not as a means of boosting private insurance.

It is questionable whether the 'lifetime' cover initiatives, in themselves, boosted private insurance levels. If a 30 percent immediate subsidy doesn't influence behaviour, it is hardly reasonable to assume a 70 percent penalty over 35 years will be effective, when one considers the extent to which people discount the present value of future benefits and penalties. John Deeble suggests that almost all of the increase in private insurance membership resulted from the message of fear in the 'run for cover' campaign.

As the effects of that campaign wear off, and as people review their spending decisions, private insurance membership has started to fall again. From its peak in September 2000 to September 2003 it has fallen 2.3 percent (as a percentage of the population). And much of that fall has been among younger members. Over that period the funds lost only 134 000 members, but they lost 390 000 members under 55 (who on average are net contributors), while gaining 256 000 older members (who on average are net drawers). This is perhaps why the funds are pushing for new growth markets, such as GP gap cover, and are so strongly lobbying the Labor Opposition to retain the rebate and tax penalties. And it helps explain why the insurance funds are seeking premium rises of 7 to 8 percent in 2004, on top of steep rises in 2003.[2]

Have private hospitals taken up the load?

Nevertheless, even if the subsidies and tax penalties were unnecessary (all that was needed was a fear campaign), has the increase in private health insurance membership resulted in more use of private hospitals? Has it relieved pressure on public hospitals?

2. Fiona Tyndall "Abbott opens fire in health premium row" *Australian Financial Review* 13 January 2004.

If so, we would expect to find a steady transfer of the load from public to private hospitals, starting in 2000-01 (the first year of 'lifetime cover').

Indeed, that has happened, as illustrated in Table 2 which shows a stabilization in public hospital use, and a growth in the share being taken up by private hospitals.

Table 2 - Separations from hospitals

Number '000	**1997–98**	**1998–99**	**1999–00**	**2000–01**	**2001–02**
Private	1 793	1 875	2 026	2 271	2 426
Public	3 748	3 839	3 855	3 849	3 950
	5 541	5 715	5 881	6 120	6 376
Percentage					
Private	32	33	34	37	38
Public	68	67	66	63	62
	100	100	100	100	100

Source: AIHW *Hospital Statistics* 2001-02. Excludes psychiatric hospitals

But is this significant? In a world which is perfectly structurally separated, with all those with private insurance using private hospitals, all those without private insurance using public hospitals, and with no health or demographic differences between the two groups, we would expect a rise of fifteen percentage points in private insurance, from 30 to 45 percent, to result in a similar transfer of activity.

The transfer has been nothing of that magnitude, however; it's been only six percentage points, not fifteen.

And it's informative to consider the nature of those separations. Much of the growth in private hospital use has been in same-day procedures, which are less resource-intensive than those requiring overnight stay. When only overnight separations are considered, the rise in the private hospital share is seen to be much less significant – only three percentage points as revealed in Table 3. The pressure on public hospitals has not abated, but their capacity to respond to that pressure has been diminished.

Table 3 – Overnight separations from hospitals

Number '000	**1997–98**	**1998–99**	**1999–00**	**2000–01**	**2001–02**
Private	840	847	889	942	973
Public	2 125	2 123	2 091	2 064	2 064
	2 965	2 970	2 979	3 006	3 038
Percentage					
Private	28	29	30	31	32
Public	72	71	70	69	68
	100	100	100	100	100

Source: AIHW *Hospital Statistics* 2001-02. Excludes psychiatric hospitals

There are several reasons why the transfer to private hospitals has been so modest:

- leakages from private insurance;
- the structure of the subsidies and tax penalties;
- uptake of insurance by the self-insured;
- the nature of the services provided in public and private hospitals.

These factors are considered, in turn, below.

Leakages

Table 4, from 2001-02 data, shows the composition of funding passing through private health insurance. Only half of that funding makes its way into private hospitals. Rebates which cost the Commonwealth $1.95 billion have been associated with $3.41 billion of expenditure in private hospitals. Put another way, the Commonwealth could have used its funding of $1.95 billion to provide a 57 percent subsidy direct to private hospitals without the leakages associated with using a high cost financial intermediary.

Table 4 – Expenditure passing through private insurance funds, $m, 2001-02

	Gross	Rebates	Net
Public hospitals	375	104	271
Private hospitals	3 407	944	2 463
Ambulance	189	52	137
Medical services	598	166	432
Other health professionals	420	116	304
Pharmaceuticals	64	18	46
Aids & appliances	318	88	230
Dental services	946	262	684
Total services	6 317	1 750	4 567
Administration	718	200	518
Total expenditure	7 035	1 950	5 085

Source: AIHW *Health Expenditure in Australia* 2001-02 Table A4, recurrent expenditure only.

Much of the growth in private insurance outlays, encouraged by the fear campaigns, subsidies and tax penalties, has gone to areas other than hospitals. Table 5 shows this growth. Comparing 2001-02 with 1996-97, the last year before private insurance was subsidised, the growth in outlays on private hospitals, in constant prices, has been only $700 million – supported by a two billion dollar subsidy!

Table 5 – Growth in composition of outlays through private insurance, $m, constant prices

	Outlays		Growth	
	1996-97	2001-02	$m	Percent
Public hospitals	399	375	-24	-6%
Private hospitals	2 698	3 407	709	26%
Ambulance	103	189	86	84%
Medical services	254	598	344	136%
Other health professionals	249	420	171	69%
Pharmaceuticals	49	64	15	31%
Aids & appliances	204	318	114	56%
Dental services	660	946	286	43%
Total services	4 614	6 317	1 703	37%
Administration	587	718	131	22%
Total expenditure	5 201	7 035	1 834	35%

Source: AIHW health expenditure tables. GDP chain price deflator used for conversion to constant (2001-02) prices.

In fact, valuation of the subsidy at two billion dollars is conservative, for it takes no account of the cost of the support from the taxation arrangements applying to those with incomes above $50 000.

The Government has framed these arrangements as taxation *penalties*, but it would be no less valid to describe them as tax *incentives*. That is, to call them a tax rebate of one percent for those who take out private insurance, and to cost the measure, in budgetary terms, as a 'tax expenditure'. If that is done, using 2000-2001 taxation data, the revenue foregone through giving this tax break is another 1.3 billion dollars (see the box for the calculation). And that's a conservative estimate, because there has been nominal income growth since 2001, resulting in more Australians having an income above $50 000. The total annual government assistance to private health insurance is therefore in the order of $3.3 billion dollars – just short of the entire contribution of $3.4 billion from private insurance to private hospitals.

The surcharge as a tax expenditure

In 2000-01, when the surcharge had been in place for three years, there were 1.66 million Australians with taxable incomes above $50 000. Of these 0.02 million were eligible for Commonwealth benefits; it is a reasonable assumption that they were exempt from the surcharge on the basis that their family income was less than $100 000. And another 0.12 million Australians with incomes above $50 000 were paying the surcharge. That leaves 1.52 million who were exempt from the surcharge because they held private insurance.

The weighted average taxable income of this group was $87 000, which translates to a one percent tax exemption of $870 a head. Or, in aggretage, $1300 million (1.52 million * $870).

Source: Australian Taxation Office, *Taxation Statistics* 2000-2001. Income mid points used for weighting, except for highest bracket ($1 million plus), where low bound used.

If there were to be direct funding of private hospitals and abandonment of support for private insurance, then obviously there are implications for other items covered by private insurance, the most significant being dental services and medical gap payments.

In general, however, health funds do not provide insurance against ancillary services. Rather, they provide only partial cover up to specified limits, leaving the consumer with the open-ended risk of having to pay for outlays above these limits.[3] It is hardly valid to call this 'insurance' – at best it is no more than some bill-paying supplementation. Among ancillary items the only genuine insurance offered, whereby the insurer rather than the consumer bears the risk of high costs, is for ambulance transport.[4]

The average ancillary claim is only $76, of which the fund covers $40, and on average the 8.2 million Australians with ancillary cover claim only $240 a year.[5] There would be little pain to the community in abandoning subsidies for ancillary insurance, and there would be a resulting distributional justice for the 59 percent of Australians who do not have ancillary insurance and are not supported by government subsidies. The most pressing need is to restore dental programs for those on lower incomes. Otherwise, if there is a case for ancillary support it lies not so much in equity as in the allocative benefits in diverting services away from medical practitioners to allied health professionals, particularly physiotherapists. The most efficient and equitable way to do this is through supporting such services through Medicare rebates.

The use of private insurance to fund medical gap payments is more contentious. Private insurance is used to provide gap cover above the schedule fee, and the incidence of payment above the schedule fee has been rising steeply since the funds have been permitted to provide gap cover; only a minority of services are now provided at the schedule fee. Whether this reflects the moral hazard of 'no gaps' insurance or a lag in the schedule fee keeping up with costs is not clear. (In 2001-02, 78 percent of medical payments were 'no gaps' payments.)

Table 6 – Medical payments by insurance funds – million

	Up to schedule fee	Up to 16% above schedule fee	More than 16% above schedule fee	Total	Percentage above schedule fee
1999-00	11.1	1.2	0.8	13.1	15%
2000-01	12.8	3.9	2.6	19.3	34%
2001-02	15.1	7.7	5.4	28.2	46%
2002-03	16.4	10.6	7.8	34.8	53%

Source: Compiled from PHIAC quarterly reports

The structure of incentives and tax penalties

One of the lowest cost products is Medibank's 'First choice saver', with an annual premium of $475. Its cover is very limited, with exclusions and reasonably high deductibles by the standards of the health insurance industry.

3. For example, Medibank Private, even its highest cover, sets limits of $2000 on dental work and $700 on physiotherapy.

4. There is also a small amount of sickness and accident cover classified as 'ancillary' cover.

5. PHIAC June Quarter 2003 statistics for average costs, four quarter statistics for total annual ancillary claims.

After the 30 percent subsidy, that policy costs only $332. For anyone with an income above $50 000, there is also the one percent incentive to take a policy; for someone with an income of $50 000, the effective price of the policy is minus $168 (332 – 500). That is, one is paid to have such a policy. Someone with an income of $100 000 is paid $668. This is middle-class welfare rampant.

Costs arise only if people actually use one of these policies to cover a hospital stay. They will be liable to pay for gaps, deductibles and excluded services. Their wisest choice is to use a public hospital and not to disclose their insurance status.

The problem could be overcome, perhaps, if people were required to disclose their insurance status upon admission to public hospitals. But there are clear difficulties with such a proposal. One is the necessary invasion of privacy which would be involved. Another is that people with serious conditions may deliberately choose coordinated team-based care which is provided for public patients, rather than fragmented care in private hospitals, where there is a clear distinction between 'medical' and 'hospital' services. Country people without access to private hospitals would be particularly disadvantaged (country people with incomes above $50 000 are already penalized by being coerced into private insurance, even though it carries no benefit). And the main difficulty is that it would violate the principle of universality of access to public hospitals.

The more basic and enduring solution is to abolish the one percent tax break. That is, to set the Medicare levy at a rate of 2.5 percent of incomes above $50 000.[6] This would bring in another $1.3 billion to the health budget. The present arrangements are particularly unjust on those 120 000 higher income earners who choose to pay the levy rather than to take out private insurance. (Those who advocate a continuation of the subsidies for private insurance, particularly the one percent tax subsidy, are in effect suggesting that people should be penalized for exercising their mutual obligation of sharing their health care costs with their fellow Australians.)

But would such an explicit tax increase be politically acceptable?

The simple answer is probably 'yes'. Most people who arrange health insurance deductions from their pay packet probably don't care much whether deductions are made to HCF, Medibank Private, or the Australian Taxation Office.

More solid evidence on attitudes to taxation is available from various surveys of people's attitudes to taxation. If one surveys people with the simple question 'do you want to pay more tax?', the answer is generally be a resounding 'no'. But when such questions are linked to specific benefits, quite different answers emerge.

In a worldwide survey conducted by the Angus Reid Media Center in 1999, Australians, by a small margin, were in favour of higher taxes to pay for more public services. Prime candidates for extra spending were education (78 percent wanting more public spending) and health (75 percent).[7]

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6. A sensible design feature, absent from the present arrangements, would be for a phase-in around the $50 000 income level.

7. Survey by Angus Reid Media Center, February 2000. Web link from *The Economist* of March 18-24, 2000 .

These results are broadly similar to those of a major Australian survey in the early nineties. That survey found Australians were generally satisfied with their levels of taxation, and that their highest priorities for an increase in expenditure were, in order, medical and hospital (84 percent) and education (78 percent).[8]

Analysis of actual election results confirms these findings. In 1993 the Coalition promised private health insurance initiatives, while Labor did not. Polling researchers asked people which party was closest to their own views on various issues, including health policy. In that election, in response to that question, Labor had a 19 percent lead over the Coalition. In 1996 both parties promised support for private health insurance and the same polling found Labor's lead on health care had fallen to 5 percent.[9]

Even more compelling evidence, relating specifically to hospital funding, comes from a survey conducted for Hawker Britton by UMR Research in May 2003. When asked to choose between 'a significant personal income tax cut' and 'spend[ing] that money on better hospitals', the results were a resounding 79 percent in favour of public hospitals versus 16 percent for a tax cut. There was very little variation by age, region, or voting intention. In the same survey respondents were asked, more specifically, if they would support a 0.5 percent increase in the Medicare levy; 76 percent were in support of the higher levy and again there was little variation in support by age, region or voting intention.[10] There was predictably some variation by income, but even those with incomes above $80 000 were 75 percent in favour of a higher levy.

Medicare is a popular program, as revealed not only in such political surveys but also in surveys of public satisfaction with the Health Insurance Commission; a satisfaction rating of 93 percent with a government agency is extraordinary in an era characterized by a general mistrust of government.[11]

In terms of taxation theory, private health insurance is an example of what Naomi Caiden refers to as a 'privatized tax'. Caiden warns that, in the name of keeping official taxes low, we may be reverting to an earlier time when payment for collective goods was expensive and unfair, imposed by the caprices of kings and emperors.[12] Private health insurance has many of the characteristics of a tax, but few of the virtues of an official tax.

Uptake of insurance by the previously self-insured

Not everyone is taken in by the myth that one must have private insurance to be admitted to a private hospital. Before the private insurance subsidies were introduced, an increasing number of Australians were choosing to self-insure for their use of private hospitals.

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8. Throsby and Withers 1994.

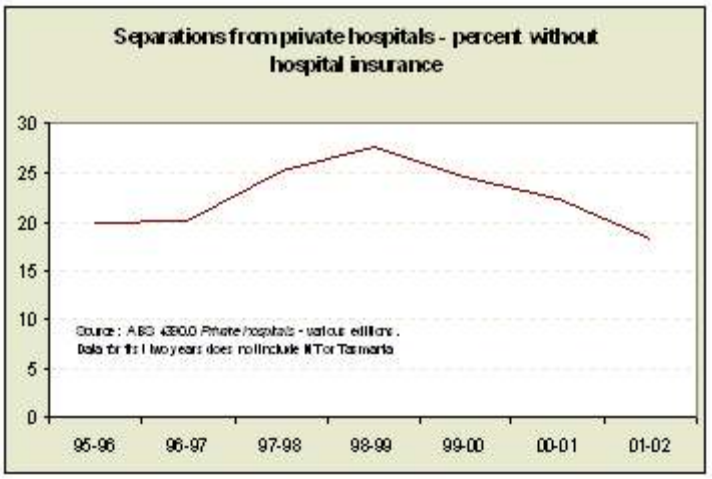
9. Bean and McAllistair 1997.

10. See www.hawkerbritton.com.au

11. 'Community satisfaction with HIC' is measured at 93% by the HIC in its 2002-03 *Annual Report*.

12. Caiden 1987.

The initiatives to subsidize private insurance have quelled this outbreak of self-reliance. Those who self-insured were already using private hospitals; once enticed into insurance they continued to use them. That means they did not shift from the public to the private system, because they were already using the private system. Presumably the insurance lobbyists do not understand the concept of self-reliance.



It serves many powerful and politically well-connected interest groups to suggest that people must depend on insurance to cope with life's contingencies. But in reality, many Australians have a reasonable level of liquid or near-liquid savings to cover expenses such as health care costs, particularly for the procedures likely to be carried out in private hospitals. Around half of all Australians live in households with $8 000 or more in deposits of various types which could be used to cope with health care contingencies.[13] (See Table 6.) When combined with the little-publicized 20 percent rebate for uninsured health expenses above $1500 a year, self-insurance became an attractive option for many people.

Table 6 – Household wealth ($'000) by wealth quintile, June 2002

Quintile	Home	Deposits	Shares	Rental property	Super-annuation	Total wealth
1	1	1	0	0	15	17
2	38	4	2	3	46	93
3	121	8	4	11	52	196
4	203	15	11	17	76	322
5	415	58	152	58	89	772

Source: Financial Planning Association/Natsem "Levels, patterns and trends of Australian household saving" 2002.

For those who abandoned self-insurance and took up private insurance the 30 percent rebate has been a windfall, which has preserved their opportunity to jump the waiting list queues and has replaced the discipline of self-insurance with the moral hazard of corporate insurance.

13. In the third quintile the mean liquidity is $8 000 – it is a reasonable approximation to suggest this is close to the median, suggesting there is $8 000 or more in fifty percent of households.

The nature of hospital services

Private and public hospitals are different. Even when private free-standing day hospitals are excluded from the base, there are significant differences, all indicating that public hospitals tend to handle more complex cases.

The basic difference is that public hospitals handle a large emergency load, while the workload of private hospitals is dominated by elective procedures. This is shown in Table 7 below.

Table 7 – Patient separations by urgency of admissions 2001-02, percent

	Public	Private
Emergency	42	8
Elective	45	86
Other	13	6
Total	100	100

Source: Allen Consulting Group, presentation to 2003 Health Summit

Out of the 30 most common conditions treated in each sector, only eight appear on both the private and public lists. The public top thirty list is dominated by emergency conditions; the private top thirty list has many elective procedures – such as knee, hip and shoulder procedures – which do not appear on the public list.

Also, for given conditions, the length of stay in public hospitals is generally shorter than it is for private hospitals. This contrasts with the fact that across all conditions, patients in public hospitals have a *longer* stay. This apparent paradox is consistent with public hospitals handling more complex conditions, requiring longer stays, and private hospitals handling less complex conditions while providing longer stays than public hospitals for those conditions.

Table 8 – Eight overnight separation DRGs common to private and public hospitals, by rank and average length of stay

AR-DRG	Description (abbreviated)	Rank Public	Rank Private	ALOS Public	ALOS Private
O60D	Vaginal delivery without complications	1	1	2.9	4.5
F74Z	Chest pain	2	26	2.0	2.5
G67B	Digestive system disorders	3	19	2.6	3.7
O01D	Caesarean delivery without complications	5	6	4.6	5.9
F62B	Heart failure and shock	8	28	6.1	8.0
H04B	Cholecystectomy	16	7	2.3	2.3
U63B	Major affective disorders	17	22	13.0	17.6
D11Z	Tonsillectomy or adenoidectomy	24	9	1.2	1.1
	All			5.5	5.2

Source: AIHW *Hospital Statistics* 2001-02 Tables 11.5, 11.6

One key difference relates to accident and emergency services. In 2001-02 public hospitals provided six million accident and emergency services, while private hospitals provided only half a million such services. Of those six million services in public hospitals at least one million involved a full admission to hospital.[14]

Also there are differences in location. Public hospitals are in both country and metropolitan regions, while private hospitals tend to be only in metropolitan regions. This imbalance was stressed in the 2003 Senate Report on Medicare.

As they stand, the two sectors do not provide similar services. The major defining difference is the separation of 'medical' from 'hospital' services in private hospitals – a difference which has been perpetuated by the way in which most private hospitals have linked their fortunes to private insurance.

For many conditions requiring emergency admission or involving complications, and for people living away from metropolitan regions, whatever their financial or insurance status, private hospitals do not offer a substitute service for public hospitals. This is not an ongoing inevitability, but it will change only if private hospitals can be placed on the same funding base as public hospitals, without the distortion of private insurance.

Have public hospitals had their load relieved?

At first sight there has been some relief for public hospitals (see Tables 2 and 3). But, as the foregoing suggests, the relief has been no more than minor, and it's only on the demand side, not on their capacity to meet demand. The public sector still has the base workload.

While the overall load has decreased a little, waiting times, the prime indicator of a mismatch between supply and demand, have continued to lengthen. This is shown in Table 9, and is confirmed in a detailed study of Victorian hospitals.[15]

Table 9 – Waiting lists

	1999-00	2000-01	2001-02
Days waited at 50th percentile	27	27	27
Days waited at 90th percentile	175	202	203
% waited more than 365 days	3.1	4.4	4.5

Source: AIHW *Hospital Statistics* 2001-02 Table 5.1

The explanation lies not only in the limited capacity of the private sector to take up the slack (covered in the previous section). It also results from more basic economic causes. A shift in funding from one sector to another is likely to result in a movement in resources, and, if achieved through private insurance, is likely to result in inflation in health care prices. These points are covered in the next two sub-sections.

14. AIHW *Hospital Statistics* 2001-02 Tables 2.5, 2.6.

15. Powers et al 2003.

Resources following funding

One of the prime misunderstandings in government policy has been a confusion of *funding* with *resources*. The Commonwealth's argument has been that if, through private insurance, more funding is provided to private hospitals, then there will be relief of pressure on public hospitals.

Such logic – the economic proposition that money can call forth resources – holds true in certain situations where supply can speedily respond to demand. If a government decides to buy a large fleet of new cars, for example, it is unlikely that this will cause a shortage in the car market. And the logic holds where resources are tied to particular activities or institutions. If a government invests heavily in rail transport, then there will be a significant oversupply of road freight capacity.

But in health care, particularly hospital care, which is intensive in skilled labour, the most crucial resources are in constrained supply. In public hospitals professional skilled labour costs comprise 56 percent of total recurrent costs.[16] There are shortages of both medical practitioners and nurses, and any replenishment of supply will take many years. When more money is directed at one sector, then there is no subsequent increase in resources in the system as a whole. Unless there are productivity improvements available, the inevitable result is some combination of movement of skilled staff from one sector to the other, or a rise in the payment necessary to retain the services of skilled staff.

The basic problem relates not to funding of hospitals (though funding is clearly important), but to real resources, particularly skilled staff who have to spend many years of tertiary study followed by supervised experience. These workforce problems need to be addressed, through initiatives linking education and health policies. Funding in itself does not create resources.[17]

If there is a major shift in funding to the private sector, public hospitals will experience some level of reduced demand, but they will also have reduced capacity to meet their demand. They will either lose staff or will have to pay staff more out of constrained budgets.

The case does not need to rely on *ex post* evidence; the existence of a supply constraint is sufficient for this to occur. There is now some evidence of this occurring. AIHW labour force surveys are somewhat dated, but there is one recent report (without attribution of sources), from the consulting firm Access Economics:

> Total full-time equivalent (FTE) staff employed in private hospitals increased by more than 14 per cent, from 39,100 in 1995-96 to 44,720 in 2000-01. Despite difficulties in attracting and retaining nurses, the number of nurses actually increased by 17 per cent, from 19,545 in 1995-96 to 22,805 in 2000-01. Over the same period, total staff employed in public hospitals fell slightly, from 184,494 in 1995-96 to 182,995 in 2000-01. However, the number of nurses employed in public hospitals increased from 80,570 in 1995-96 to 82,476 in 2000-01.[18]

16. Derived from AIHW *Hospital Statistics* 2001-02 Table 4.1, from medical, nursing and allied health costs, plus a proportion of superannuation.

17. A legitimate criticism of many governments of the 'left', such as the Whitlam Government of 1972 to 1975, is that they have attempted to solve problems by throwing money at them, usually resulting in shortages and inflation. The same criticism can be made of the current government, in its attempt to leverage funds out of private insurance.

18. Access Economics, 2002, p. 25.

Table 10 shows this movement in a structured way, aligned with separations as an indicator of activity. Because of the increasing use of same-day services in private hospitals, this indicator overstates the growth in private sector activity, and it probably understates the increased workload on public hospitals which have been left with the harder cases.

Table 10 – Nursing staff and activity

	1995-96	2000-01	Change
Nursing staff			
Public hospitals	80 570	82 476	2.4%
Private hospitals	19 545	22 805	16.7%
Separations ('000)			
Public hospitals	3 598	3 849	7.0%
Private hospitals	1 577	2 271	44.0%

Sources: Access Economics for nursing staff. Separations from AIHW Tables S32 and S33 *Australia's Health* 1998, and Table 2.3 *Hospital Statistics* 2001-02.

A transfer of resources and activity from the public to the private sector, is not in itself an undesirable outcome, but it is quite untruthful to suggest it relieves the pressure on the public sector. Pressure would be relieved only if resources were in plentiful supply.

If, however, that shift in resources and activity results in a different mix of care in the health system as a whole, the implications are more serious. When resources are limited, if resources are wasted in one sector (e.g. on unnecessary procedures), then they are being denied to the other sector where they could be more effective. That may be happening.

Research by the Centre for Health Program Evaluation at Monash University has found that private hospitals are likely to employ more costly procedures than public hospitals for patients presenting with the same conditions, even though the treatment is not necessarily more effective. The same research also finds that the unit cost of these procedures may be significantly greater in the private sector than in the public sector.[19] This suggests that the private hospital sector, sitting alongside the public sector but with different funding arrangements and incentives, may be taking resources away from where they can be more beneficially applied.

Health care price inflation

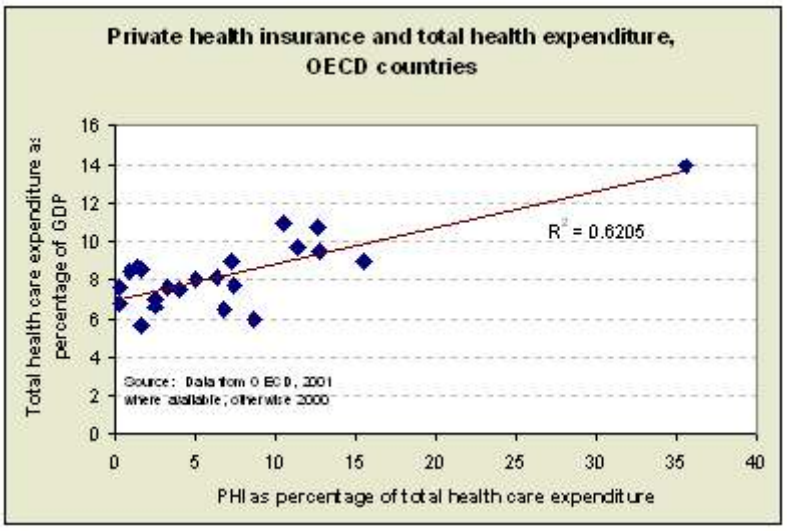
When governments consider means to fund health care they often overlook the long-term and system-wide consequences of their policies. Their policies are often focussed on immediate budgetary outlays, rather than costs which occur throughout the economy.

All forms of health insurance is subject to moral hazard – that is the tendency for people to use more of a service if it is free or low cost at time of delivery. This is a feature of all health

19. Richardson et al 1999.

insurance – public or public. There is no difference between the idea 'Medicare will pay for it' and 'HCF/MBF/Medibank Private will pay for it'.[20]

Another aspect of moral hazard comes from the supply side when health care providers believe that the fund holders have deep pockets and are able to pass on their costs. This is particularly likely to occur with private insurance; while governments, in control of a single pool of funding, can exert cost control, private insurers can be played off against one another. Even if an insurance firm would like to control service providers' charges, it has little ability to do so; if it doesn't meet the demands of service providers its rivals will meet those demands, attracting those who seek comprehensive 'no gaps' cover. Private insurance provides a permissive environment for those who seek to draw profit from the health care system.



That is why countries which have relied on private insurance to fund health care have paid a high price for this choice. The more a nation relies on private insurance to fund health care, the more will be its total health care costs, as the graph alongside illustrates for OECD countries. These are all reasonably prosperous countries, with broadly similar health care outcomes. They include countries with aged populations, such as Italy and the Scandinavian countries, which have been able to keep health care costs under control by keeping private insurance confined to the periphery of their systems. And the outlier at the extreme end is the USA, where private health insurance accounts for 36 percent of funding.

The paradox of the USA is that with health care costs out of control, because of the moral hazard created by a fragmented private health insurance system, its government has lost any capacity to control costs. Its limited government programs – Medicare for the aged and Medicaid for the 'indigent', both of which are parsimonious in their coverage, now cost the government 6.2 percent of GDP – about the same as the public outlays in those European countries with universal government-funded health insurance schemes, similar to the Medicare scheme Australia had from 1984 to 1997.[21] In early 2004 the IMF has warned the USA about runaway budgetary outlays on health care, mainly through the Medicare program, citing the political impediments to meaningful reforms in health care financing.[22] To cope

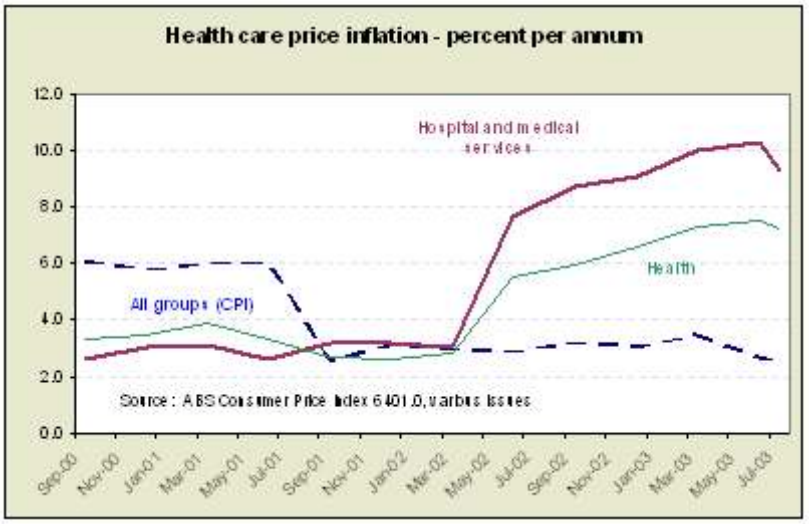
20. In fact, it is possible that with private insurance, because premiums are more clearly identified than tax payments, that some people will be enticed to make sure they get value-for-money, particularly with respect to ancillary sercices.

21. International data available from the OECD website www.oecd.org.

22. Martin Mühleisen and Christopher Towe "U.S. Fiscal Policies and Priorities for Long-Run Sustainability", IMF 2004.

with this budgetary pressure states have had to cut Medicaid payments severely, to the detriment of America's most needy.[23]

In Australia, even though private insurance has held a strong position only for a little more than three years, there is already evidence of a rise in health care price inflation, particularly for hospital services. Since early 2002 hospital and medical price inflation has been much higher than general inflation (as measured by the CPI) and in more recent times, since the Commonwealth lightened controls on private insurance fees, well above other health care inflation.



Accident and emergency wards

The other pressure on public hospitals has been on their accident and emergency wards, resulting from recent falls in bulk billing. This reduction in bulk billing has encouraged people to use hospital outpatient facilities as a substitute for GP services. After remaining at high levels (around 80 percent) from 1996 to 2000, bulk billing rates have recently fallen away sharply. It is reasonable to expect that this will result in a significant increase in recorded outpatient services in 2002-03.

Towards reform – direct funding

Private hospitals are an important part of Australia's health care system. They provide some services which are similar to those provided in public hospitals and they also provide some which are complementary. Although their range of services is increasing, they are still far

23. Bob Gerbert "Sick State Budgets, Sick Kids" *New York Times* January 9, 2004.

less comprehensive in their service provision than public hospitals. That means, for the medium term at least, their capacity to take a load off the public sector is limited.

The funding arrangements, whereby private and public hospitals receive their funding from different sources, result in different incentives and different modes of operation. In turn this has consequences in equity and efficiency. In general there are distortions which tend to be aggravated, rather than ameliorated, by reliance on private insurance.

The notion that private insurance must be maintained in order to maintain the private hospital system, while politically convenient for the private insurers, does not stand up to examination. In private insurance there are huge losses to administration, ancillary cover and medical gap payments. Given the scale of public subsidy – $2.0 billion to $3.3 billion annually – it's an absurdly inefficient way to support the private hospital sector, which, if the one percent tax incentive were abolished, could be fully funded for that same amount, bypassing the financial intermediaries and relieving the public of the premiums they are paying to private insurance. It is hard to find any justification in public policy for using the health care budget to provide a subsidy to the financial sector.[24]

For a time after the introduction of Medicare, until 1986-87, the Commonwealth supported private hospitals with a bed-day subsidy. Because it was direct it was effective in supporting the sector, and it did not discriminate against the self-insured. Restoration of such a subsidy is one option open to the government. In a rigorously argued analysis, examining the interaction of self-insurance and private insurance, Rhema Vaithianathan of the Australian National University has suggested restoration of this or a similar subsidy as a more direct and equitable means of supporting the private hospital sector.[25] Simply re-directing the rebate payments, now paid for health insurance, to private hospitals could provide a subsidy to private hospitals as high as 60 percent.

Governments need to look beyond immediate funding issues, however. In the longer term it would lead to more efficient resource allocation if private and public hospitals were funded on the same basis. The bed-day subsidy provided financial support to private hospitals, but it didn't bring them into the mainstream of hospital funding. And, while public hospitals were moving to casemix funding, the bed-day subsidy had no regard to the type of service being offered; it preserved the artificial distinction between 'medical' and 'hospital' services.

It is impractical, however, to advocate an immediate transition to full competitive neutrality between public and private hospitals, whereby all hospitals would be funded on a casemix basis. Private hospitals would have to take responsibility for hiring medical staff and for integrating medical and other services, in the same way that public hospitals do. Many smaller private hospitals would find that they lack the economies of scale to survive in such an environment. Some others would have to undergo large capital upgrades to match the quality standards state governments require of acute care hospitals. Some hospital owners would be dissatisfied with the financial returns in a market dominated by government hospitals with access to low cost capital. In any event DRG funding is still far from perfect;

24. Perhaps bureaucratic and political attitudes would change if the subsidies to private insurance were to be attributed to the budget of the Treasury Department – which is responsible for policies relating to the financial sector.

25. Vaithianathan 2002.

for example it does not provide any allowance for a return on capital. (State governments have separate capital budgets for public hospitals.)

And whatever is done in terms of funding, it should not force hospitalization into a 'one size fits all model'. Many people seek choice, and the private system offers some level of complementary variety to the public system. Some people will seek out the private system for a higher standard of residential care or for a longer stay, paid from own pockets or from unsubsidized private insurance. Some smaller private hospitals may choose to offer highly specialized care, rather than becoming comprehensive general hospitals.

Therefore, for a considerable transition period, there will have to be special funding arrangements for private hospitals, including some once-off payments to help them through the transition. Such funding would either be direct from the Commonwealth to the private hospitals (as the bed-day subsidies were), or through carefully quarantined state programs with standards set by the Commonwealth.

Some private hospitals, particularly those that don't provide high level services, may choose to stay outside the publicly-funded system. That would be their choice, and they would still be able to provide some low priority services, financed through private channels.

The result would be a much greater degree of competitive neutrality between the public and private sectors and a resulting better allocation of resources. It would draw on the public sector's ability to collect funds equitably and efficiently (the best that private insurance can achieve is community rating, equivalent to a flat tax), purchase services, and control quality, while leaving the task of providing services to a more open market between private and public providers.

Such reforms wouldn't eliminate waiting for some kinds of non-urgent or less valuable services. Rationing (or prioritising) by use of waiting lists is an essential feature of any health care system because demand for services will always exceed the community's willingness or ability to finance them, particularly when services are 'free' at the point of delivery. But it would reduce queue hopping.

Of course such a redirection of funding means that ancillary services would no longer be subsidized through private insurance. But the present arrangements are inequitable, and it is doubtful whether a system which caps payments at low levels, leaving consumers bearing an open-ended risk, should be called 'insurance' at all. If there is a case for funding ancillary services from public funds – a case which is strongest for dental services which presently cost the community $3.7 billion a year– it would be fair and efficient to do this directly, through the same mechanisms as other health services are funded.

In any changed policies there are important funding issues to be considered, but the main point is that we are paying for these services already, through some combination of taxes, private insurance and out-of -pocket expenses.

For the most part the funding issues are distributive ones (who pays and how), rather than any fundamental change in resources in the short term. But there is one significant saving if payments are to be made directly, and that's the administrative cost of private insurance. Private insurers in 2001-02 received $6 782 million in contribution income, of which $767

million or 11.3 percent was spent on administration.[26] By contrast, in the same year, Medicare with a turnover of $8 023 million, incurred management expenses of $291 million, or 3.6 percent.[27] To this must be added the costs incurred in the Australian Taxation Office of collecting tax – about another 1.2 percent.[28] This is an upper estimate of collection costs, for it is based on the average rather than the marginal cost of tax collection. Therefore the total cost of collection and distribution of Medicare funds is at most around 4.8 percent, which is 6.5 percent lower than the administrative cost of private insurance. If the $6 782 million in contribution income had passed through Medicare rather than private insurers, there could have been a saving of $440 million, or another $440 million spent on health care services.

In sum, the amounts available for the hospital (or wider health care) sector from redirection of existing funds are $3.6 billion:

- abolition of private health insurance subsidies $2.0 billion
- abolition of one percent tax rebate $1.3 billion
- saving on administrative costs $0.3 billion

  (The administrative saving is less than $0.4 billion, because 30 percent of this cost is counted in the insurance subsidies. This saving – 70 percent of $440 million – is outside public budgets, but it is a real resource saving, rather than a redistribution.)

Reforming hospital funding, to bring more competitive neutrality to private and public hospitals, is an important aspect in health finance reform, but it should be only one step in integrating all health care services, including preventative, ambulatory and pharmaceutical care. A dominant theme at the 2003 Health Summit was that many episodes of expensive (and risky) hospitalization could be eliminated through better-resourced preventative and primary care programs. Ultimately this means bringing responsibility for all publicly-supported health care programs (hospital, medical, pharmaceutical and auxiliary) under one administration. Such reforms could save very large amounts to public budgets and community outlays.

While these savings are significant in a national health bill of $67 billion, the major saving from re-directing subsidies currently spent on private health insurance is the capacity to control health costs through the power of a single national insurer. Australia's health care costs are currently at nine percent of GDP; the USA's are at thirteen percent of GDP. The four percent difference is explicable mainly by that country's reliance on private health insurance. Each one percent of GDP is equivalent to about $7.5 billion – a figure which dwarfs the amounts typically under contention in budget negotiations and pre-election policy formulation, and much larger than the $3.6 billion discussed in this paper. That is why governments and opposition parties should not allow minor re-shufflings of budgetary outlays to distract them from the opportunities for fundamental reform.

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26. PHIAC *Operations of the registered health benefits organisations* 2001-02.

27. HIC *Annual Report* 2001-02. The HIC shows a figure of 3.7 percent, but they express expenses as a percentage of benefits paid.

28. Appropriation to the ATO in 2002-03 is $2.2 billion, tax collected is $185 billion, giving a collection cost of 1.2 percent.

Conclusion

Private health insurance is the wedge the Government has used to break the universalism of Medicare. It has failed even its stated objective of shifting the burden of health service delivery from the public to the private sector.

Proposals to make private insurance work to provide equitable and efficient outcomes are bound to fail. There is little policy sense in using a high cost financial intermediary to achieve what can be so much more easily achieved through taxation and Medicare – with their low collection costs, built-in progressivity, and capacity to control cost and resource allocation.

The confusion of the issues of public funding and public provision has given rise to a policy assumption that private hospitals must necessarily be funded through private insurance. This confusion serves vested interests, for it means that any proposal to reduce subsidies for private insurance can be framed as a proposal to do away with 'the private health system'. The main purpose of this paper has been to expose that fallacy.

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