The Sacred Status Of Private Health

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As the population ages, how will we pay for the increased demand for health services? Subsidising private health insurance does little but bump up costs, writes Ian McAuley.

Some bad ideas, such as building water desalination plants and privatising electricity retailing, just won't go away.

Another idea with long standing in Australia is that public policy, through subsidies or regulations, should support certain industries simply because they have become part of our landscape.

Thirty years ago the industries with such sacred status were high-cost manufacturing industries, particularly footwear, clothing and cars. The Hawke-Keating government, with support from the opposition (in those days the Liberal Party had some economic competence), asked whether support for these industries, mainly in the form of high costs imposed on consumers, was justified.

As a result tariff and other support was withdrawn. The process was painful as businesses closed or became more capital-intensive and reduced their workforces. The economy-wide benefits were significant, in terms of lower prices and general economic modernisation.

One industry which retains sacred status, however, is private health insurance (PHI). This industry in 2009-10 received $4.3 billion in Commonwealth subsidies in the form of premium rebates. The government has recently introduced a means test on the rebate (details on a government website), estimated to save public revenue of about $0.8 billion a year.

Even so, $3.5 billion a year is a lot of assistance — about $420 a household — and that doesn't include the cost of the support given through a tax break for those with high incomes. Most Australians pay a Medicare levy of 1.5 percent of income, while those with higher incomes pay a higher levy, up to an additional 1.5 percent. It phases in at a single income of $84,000, reaching its full level at an income of $130,000. This additional premium is called the "Medicare Levy Surcharge" (MLS).

Those with private insurance, however, are exempt from the surcharge. Someone with an income of $200,000, for example, with a basic $1000 PHI policy, has lost the $300 rebate, but has a $3000 subsidy in the form of exemption from the MLS. That subsidy pays the full cost of the policy with $2000 change. (A full explanation of these subsidies is in a Centre for Policy Development paper published earlier this year.)

Only a few high-income earners, presumably those who feel a strong obligation to share their health care costs with other Australians rather than retreating into the gated community of PHI, do not take advantage of the MLS exemption. Of 1.7 million Australians whose incomes would have attracted the surcharge in 2009-10, only 128,000 opted to pay the surcharge, paying a high price for their commitment to social inclusion — a commitment which is clearly stronger than the government's.

What almost amounts to compulsory consumption is an extraordinary way to subsidise an industry. Even in the days of high tariff protection we never had anything so bizarre as giving a wealthy person a subsidy to buy a car which was more than the cost of the car.

Worse, however, is that there is little value-added in PHI. Our locally made Hush Puppy shoes, Chesty Bond T Shirts and EK Holdens may have been expensive, but they were of reasonable quality by the standards of the time. PHI, however, is simply a bureaucracy sapping funds out of the health care industry. Of its $14.6 billion premium income in 2009-10, only $12.1 billion went to paying for health services. The balance of $2.5 billion went to profits and management expenses. Of every dollar passing through PHI, only 83 cents reaches a service provider. By contrast, of every dollar passing through Medicare and the Australian Taxation Office, 96 cents pays for health services.

Even worse than this bureaucratic waste is the way PHI distorts the market for health care. As research shows the more nations rely on PHI to fund health care the more must those nations spend on health care, without any better health outcomes. That is because PHI cannot control the way consumers and providers over-use a service which is "free" at the point of delivery. There is no difference in the notion "Medicare will pay for it" and "BUPA/Medibank Private/NIB will pay for it", but a single insurer, such as Medicare, can control service-providers' behaviour, and can use well-structured co-payments to bring discipline into the market for health services.

Were it not for government assistance, PHI would have gone the way of other high-cost industries. It has secured a place, for now, as the channel through which governments support private hospitals. Until 1986, the Commonwealth gave a 30 percent subsidy to those who used private hospitals, but that was scrapped in the Government's budget-tightening rounds. When the Coalition was elected in 1996, instead of restoring direct support for private hospitals, they made support for PHI their policy priority.

One of the first undertakings of the Rudd government was to promise comprehensive health care reform. Early on the Prime Minister talked of putting private and public hospitals on a similar funding basis, which would have scrapped the "two tier" funding system, but (as was to be seen later with poker machine reform), the Government got cold feet. It set up the Health and Hospitals Reform Commission, chaired by a senior executive of a health insurance firm, and which without question assumed that PHI should keep its place in health funding.

One of the Commission's suggestions was to establish "Medicare Select". This would have involved collecting revenue through taxation, but instead of using that revenue to buy health care, it would have been distributed the through health insurers.

This was in the name of "choice", in an area where we are least able to exercise choice, because it is impossible to anticipate our future health care needs. As in any fragmented insurance scheme, its administrative costs would have been high, there would have been no incentive for providing "public goods" such as prevention and promotion, and there would be no capacity for cost control. For a complete description and analysis of Medicare Select, see my 2009 conference paper (pdf) "Medicare Select — another layer of bureaucracy in health care?".

Medicare Select was such a high-cost scheme, and so obviously a contrived way to find a role for PHI, that it seemed to die a natural death. Just over a week ago, however, it re-appeared in a speech by David Mead of Australian Unity, who proposed it as a means of protecting our health system from "collapse", given the demands of an ageing population.

It is correct, as Mead and others point out, that there are increasing health care demands of an ageing population, and that we have many new and high-cost medical technologies. The policy challenge is to find the most cost-efficient way of funding that growing demand. That should not be too difficult provided we sustain reasonable economic growth. But inserting a high-cost financial intermediary into the system is no way to control costs.

As JK Galbraith said of such schemes, if you want to feed the sparrow, feed the sparrow — don't feed the horse and expect the sparrow to get fed on the horse droppings. There is a case for funding private hospitals, but not through PHI.

More broadly, we should not be distracted by simply looking at the budgetary costs of health care. To the extent we choose to share our health care costs with one another, a single national insurer is the most efficient way of doing so. It makes no sense to save $1.00 in budgetary costs if we have to spend $1.10 or $1.20 in a private mechanism to achieve the same outcome.

Also, we should carefully examine the role of co-payments — payments without any public or private insurance support — as exercising some market discipline. We have co-payments already, comprising 17 percent of health care expenditure, but they are haphazard, inequitable and distortionary in their application. We are now a much wealthier country than we were when we introduced free health care programs, and it is time to consider seriously which costs we should bear ourselves and which we should share through Medicare.

For the Left that means letting go of ideas of free services (but hanging on to the idea of universalism, which has been largely lost). For the Right that means seeing PHI in its true light — as a high-cost financial bureaucracy, with little if anything to contribute to health care.