



# The history and purposes of private health insurance

July 2019

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## Overview

Australians are dissatisfied with private health insurance. Premiums are rising and consumers are dropping their cover, especially younger people, who are less likely to need health services. Those who are left are more likely to use services, driving insurance costs up further. Government subsidies and financial penalties to encourage people to take out private insurance are becoming less effective. The industry fears a death spiral. A new framework for private health insurance is needed urgently.

If current trends continue, more younger people will drop their cover. This will put insurers under still more pressure to contain costs, and governments under still more pressure to tackle rising premiums and out-of-pocket costs. Inevitably, government will be faced with the question of whether more subsidies are the answer.

Before responding to the impending crisis, government needs more clarity about the purposes of private health insurance (PHI). PHI has an ambiguous role within Australia's universal health care system. Is it a substitute for public funding? Or is it a complement, offering access to different providers and a wider level of service, as well as cover for non-medical services? Or is it both? Failure to clearly define the role of PHI since the introduction of Medicare has resulted in a health care system riddled with inconsistencies and perverse incentives.

As a prelude to future Grattan Institute work on PHI, this working paper provides context for policy makers as they confront the industry's woes. It highlights some of the deep-seated questions Australia needs to be asking. It provides a conceptual framework for justifying government intervention in the sector, particularly the case for further industry assistance, based on the dual role of PHI.

Firstly, it argues that future reforms to PHI should be made based on a clear view of the desired role of private health care and PHI given that

it functions alongside a universal publicly funded scheme, Medicare. To what extent is private hospital care a substitute for public hospital care? To what extent is it a complement to the public system?

If the purpose of private health care is to *complement* the public system – providing services, facilities and amenity beyond those considered necessary for public funding – then the argument for public subsidy is weak. If the purpose of private health care is to *substitute* for the public funding and provision of service then the argument for public subsidy is stronger.

Subsidising private health care might also be justified on the basis that it reduces the net cost of health care to government. Even if the overall service is less efficient, and costs more, the costs to government might be lower if individuals are prepared to pay for some of the care that would otherwise be publicly funded in the universal public system. Individuals may be prepared to pay for these substitute services because they are bundled with services that complement the health care in the public system.

Secondly, do the current design features of the PHI system, including incentives, penalties and regulation, support its desired role (as a *complement* or *substitute* or both) in the overall health system? If not, what other mechanisms or combination of arrangements are needed?

Lastly, does government support for PHI and private hospital care promote overall economic efficiency and the most effective and equitable use of government and community resources? In the long run, are there better ways of providing support to the sector? The question then becomes whether to support private health care directly or via PHI.

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## 1 The context: a muddled system

### 1.1 The Australian health care system is a complex mix of public and private

Australia's health care system is a complex mix of public and private financing, and public and private service provision. It comprises the universal public health insurance scheme Medicare and a voluntary private health insurance system. Under Medicare, all Australians are entitled to taxpayer-funded<sup>1</sup> free access to public hospitals, subsidised medical services provided by private medical practitioners, and subsidised prescribed medicines.

Medical practitioners are free to set their fees. But under Medicare, patients are reimbursed only for a portion of the government schedule fee (the Medicare Benefit Schedule, or MBS), which includes fees for all services and procedures. This subsidy is equal to 85 per cent of the MBS for out-of-hospital medical services, and 75 per cent of the MBS for in-hospital medical services provided to private patients.

Responsibility for the health system (both funding and provision) is shared between the Commonwealth and state governments. The states are responsible for most of the government-run health services, including funding of public and community health services and patient transport services. Public hospitals are jointly funded by the Commonwealth and the states, but managed by the states. Private hospitals are owned and operated by the private sector, but licensed and regulated by governments.

Together, the Commonwealth and the states fund 68.7 per cent of health services. A further 8.8 per cent is funded by private health

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1. Medicare is financed by general taxation and by the Medicare levy, which is set at 2 per cent of taxable income. This will increase to 2.5 per cent from 1 July 2019.

insurance premiums.<sup>2</sup> Individuals also fund a significant proportion of health care from their own pocket. Out-of-pocket payments are 16.5 per cent of total health spending,<sup>3</sup> with the remaining 6 per cent coming from other sources, including accident compensation schemes.<sup>4</sup>

### 1.2 Private health insurance is designed to be available across the community

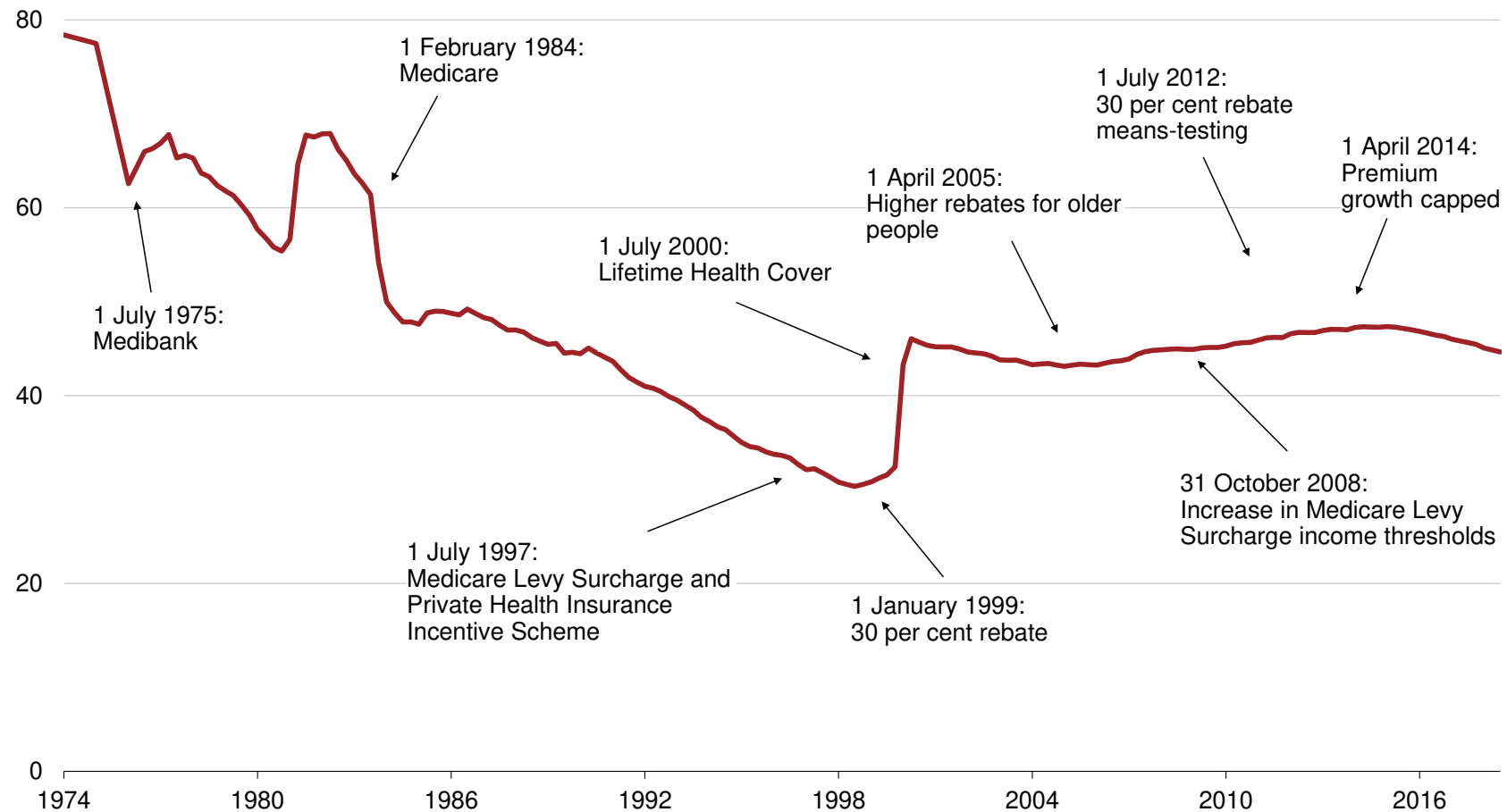
There are 37 private health insurers in Australia, although 80 per cent of consumers are covered by five insurers (BUPA, Medibank Private, HCF, NIB, and HBF).<sup>5</sup> Private health insurance provides two main types of cover. The first, hospital insurance, provides cover against the costs of fees charged for accommodation and medical fees in private hospitals or, if admitted as a private patient, in public hospitals. The second, general insurance, provides cover for a range of non-medical services offered by health professionals other than medical practitioners, including dental, optical and allied health. About 45 per cent of the population has hospital insurance, and slightly more than half the population has general insurance.<sup>6</sup>

PHI and associated Commonwealth Government subsidies are an important source of revenue for private hospitals. PHI represents about

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2. This does not include the Private Health Insurance Rebate; about 12 per cent of total expenditure is through private health insurance organisations, including the value of the rebate to the premiums paid by consumers.
  3. Out-of-pocket costs incurred by individuals for health care services over and above any refunds from Medicare and private health insurance funds. This includes out-of-pocket payments on hospital services, medical services, pharmaceuticals and other health services.
  4. Health Expenditure Australia 2016-17, AIHW (2018).
  5. APRA (2019b).
  6. As at 31 December 2018, 44.6 per cent of the population was covered for hospital treatment, and 53.9 per cent for general treatment. APRA (2019a).

**Figure 1.1: Carrots and sticks boosted hospital insurance coverage from the mid-1990s, but recently coverage has declined**

Proportion of the population with hospital treatment cover, per cent



*Note: There is a discontinuity in the series in 1996: before then the series reports insurance for public hospital treatment; after then the series reports any form of hospital cover.*  
*Source: APRA (2019a).*



76 per cent of total private hospital income,<sup>7</sup> and therefore more than one quarter (28 per cent) of private hospital income is provided by the PHI rebate.<sup>8</sup>

Private health insurers must charge a higher premium to people who take out PHI later in life. Apart from that single exception, they must charge all consumers the same premium for the same product: they are not permitted to discriminate based on health risk (*i.e.* age, gender, health status, or claims history); and they cannot refuse to insure an individual. These rules give effect to the government policy of ‘community rating’ – a key regulatory feature of Australia’s voluntary PHI system – which provides for equal access to private health insurance for all members of the community.<sup>9</sup>

In mandating constant premiums for all Australians under community rating, the young and healthy (*i.e.* low users of health services) cross-subsidise the old and sick (*i.e.* high users of health services). Ultimately, PHI is more attractive to people with high health care costs, and less attractive to people with low health care costs.

Risks are shared across insurers by ‘equalisation’ payments that are transferred from insurers with lower-than-average claims costs to those with higher-than-average claims costs. Community rating and risk sharing are intended to ensure that high-risk patients are not excluded from PHI.

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7. ABS (2018); Private Hospitals, Australia, 2016-17, catalogue number 4390.0. Refers to private acute and psychiatric hospitals (excludes freestanding day hospitals), and includes the impact of the PHI rebate subsidy. Total income includes patient revenue, recoveries, and investment income. About 56 per cent of income of private freestanding day hospitals is from PHI.
  8. Health Expenditure Australia 2016-17, AIHW (2018). Assuming the rebate share of private health insurance revenue for private hospitals and for procedures performed in private freestanding day hospitals is the same.
  9. Medicare provides access to all Australians as well.

### 1.3 Private health insurance coverage has been trending down

Before the universal health care system was introduced, Australia had relatively high levels of PHI coverage – about 80 per cent of the population had some type of cover for hospital treatment. This dropped to about 50 per cent after Medicare was introduced in 1984 – because people no longer had to insure for public hospital care – and continued to fall to about 30 per cent by the mid-1990s.

Any decline creates the risk of an ‘adverse selection’ spiral, where higher-risk people purchase insurance and lower-risk people do not join (or leave) to avoid subsidising the higher risks.<sup>10</sup> This in turn increases the average risk profile of the remaining insured population, premiums rise, more healthy people drop out, and the cycle continues.

To stabilise PHI coverage, the Commonwealth Government introduced a range of incentives and penalties (described in more detail in Chapter 2) designed to encourage people to take out insurance. These include an age-adjusted, means-tested rebate for PHI premiums, tax penalties (the ‘Medicare Levy Surcharge’) for higher-income earners who do not take out insurance, and premium surcharges for people who take out PHI after age 30.

The PHI rebate costs the Commonwealth Government about \$6 billion a year.<sup>11</sup> In addition, the Commonwealth spends an extra \$3 billion on private in-patient medical services, through the Medicare Benefits

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10. Productivity Commission (1997).
  11. Health Expenditure Australia 2016-17, AIHW (2018). Commonwealth Government expenditure on health insurance premium rebates for 2016-17 was \$5.85 billion (see table A3). This comprises health insurance rebates claimed through the taxation system, as well as rebates paid by the Commonwealth Government directly to health insurance funds that enables them to reduce premiums. This also includes portions of the rebates that relate to health activities.

Schedule rebate for in-hospital fees. Without private health care, some of these costs would be incurred in the public system.<sup>12</sup>

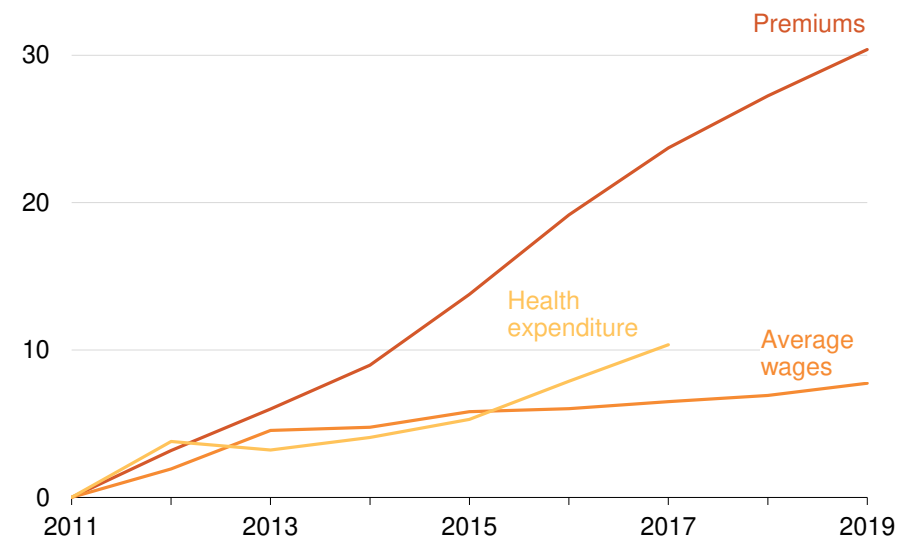
The current levels of PHI have been maintained largely due to these incentives and penalties. Over the past two decades, PHI coverage has been basically stable (Figure 1.1 on page 8). But in recent years there has been a downturn, concentrated among younger people. In the two years from December 2016 to December 2018, the number of 20-29 year-olds with hospital cover fell by 8 per cent. By contrast, the number of 70-year-olds with hospital cover increased.<sup>13</sup>

Despite the rebates and subsidies, the cost of private health insurance has continued to rise significantly faster than wages. In Australia, and overseas, health care spending is rising much faster than inflation.<sup>14</sup> But premiums have gone up even faster than health care spending and faster than wages every year over the past decade. Figure 1.2 shows the cumulative real increase in premiums. Since 2010-11 private health insurance premiums have increased by 30 per cent, compared to a 8 per cent real increase in wages.

Insurers have responded by offering consumers a broader range of products, including products with ‘excesses’ or ‘deductibles’ – where a consumer must pay the first \$500 of the cost of a hospital treatment – and products which have exclusions – where a procedure is not covered by the policy. The proportion of policies with excesses or deductibles and out-of-pocket payments has increased. Twenty years ago, only one third of policies had an excess or exclusion. Today, more than 84 per cent of policies have some form of excess or exclusion.<sup>15</sup>

**Figure 1.2: PHI premiums have consistently grown by more than wages over the past decade**

Cumulative real growth in average PHI premiums, wages, and health expenditure per person, per cent



Notes: All series deflated using the Consumer Price Index. PHI increase is the industry weighted average per year. The effective premium payable by consumers would be even higher, because premiums are covering less today than a decade ago. Wages series is the average weekly ordinary time earnings of full-time adults in the year to the November quarter. Health expenditure is the average health expenditure per person. Sources: Department of Health (2018b), ABS (2018), AIHW (2018), PHIAC (2013) and Grattan Institute analysis.

12. Annual Medicare Statistics 2017-18, Refer to Table 2: National Figures. <http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics>, Department of Health (2018a).

13. APRA (2019a).

14. OECD (2017).

15. APRA (2019a).

This is starting to unwind the principle of community rating. Healthy people are more likely to take out cheaper policies with more deductibles or exclusions. People more likely to need health care – often older – tend to take out more comprehensive insurance.<sup>16</sup>

#### 1.4 The role of private health insurance is contested

The history of health care funding policies has been tumultuous, as is described in more detail in Chapter 2. PHI has served a dual role in Australia's muddled health care system.

On the one hand, it provides a source of private funding for health care which *complements* (tops up) public funding for services, facilities and amenity beyond that available under the publicly-funded system. For example, hospital insurance can cover the extra amenity available in some private hospitals – such as single rooms and different food choices – and treatment by a specific, chosen specialist. A second type of *complement* is where there is no public universal program which provides unrestricted access to the services covered by private insurance, such as dental, chiropractic, physiotherapy, and optical services. Health insurance may also cover services that would not be provided in some circumstances by the universal system, such as when the patient's condition is less severe.

On the other hand, PHI provides a source of funding which *substitutes* (replaces) public funding of services, by duplicating the coverage in the public system. For example, it can cover treatment in a private hospital which might otherwise have occurred in a public hospital.

Of course, the distinction between services being a complement or a substitute can be a bit muddled. Some hospital admissions are a substitute with complementary elements – for example a necessary hip replacement with some top-ups.

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16. Vaithianathan (2004); and Temple (2004).

The emphasis on each of these roles has varied over time, reflecting attitudes to the role and size of government at the time.

Coalition governments have directly supported PHI as both a *substitute* for and a *complement* to the public system. Former Health Minister Tony Abbott declared that 'private health insurance is in our DNA'.<sup>17</sup> Some Coalition governments have also expressed a view that public funding and provision should be available only to people who couldn't afford PHI. On this view, access to publicly-funded and provided services should be means-tested, because they are meant to provide only a 'safety net' for the disadvantaged.

Labor governments have tended to focus on supporting the public system, while allowing PHI to operate alongside as a *complement*. Labor has tended to promote a universal, public insurance model and public provision of hospital services.

The basic design of the health system has become less contested over time. At least since 1996, Australia's two major political parties have both been committed to public hospital care accessible to all without means-testing, and an option for PHI with at least some level of government subsidy.

But as the parties have converged towards today's health care system, it has become riddled with inconsistencies and perverse incentives. It is increasingly unfair, costly and confusing. For people with PHI, premiums and out-of-pocket costs have gone up. Meanwhile, the government began footing an increasing share of the PHI bill to try to make insurance more attractive to consumers. Despite all this, the viability of the PHI industry is in doubt.

Successive governments have failed to define the role of PHI in the funding and delivery of health care in the context of a widely supported scheme for universal access to public hospital care. Policy changes

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17. Packham and Dunlevy (2012).

have generally focused on expanding the role of either the public or the private system, with limited attention given to the interaction between the two. Government support of one often meant limited or no policy attention for the other.

If PHI coverage continues to decline, placing health insurers under increasing pressure to constrain premium costs, then sooner or later the government will be faced with the question of whether more subsidies and greater industry support is the solution.

The industry must confront a number of long-term challenges. But it is not clear that more subsidies are the answer. Subsidies are not free – someone pays for them either in the form of increased taxes or as opportunities foregone in the health sector or other areas of public spending.

This working paper identifies the issues that should be front of mind for policy makers as they confront the industry's woes. This paper does not diagnose the problem, nor provide the answers. Rather, it provides a framework for justifying government support for the sector, based on the dual role of PHI.<sup>18</sup> Future Grattan Institute work will identify in more detail the problems facing PHI, and propose potential solutions.

At the most basic level, government needs to ask a fundamental question: do the benefits of further subsidies for PHI justify the costs? Answering this question requires confronting the issue of the role of private health care and private health insurance, given the existence of a public, universal health insurance scheme.

Government must first ask 'What is the purpose of private health care within the universal system?' If the purpose of private health care is to *complement* the public system – providing services, facilities and

amenity beyond those public funding is prepared to cover – then the argument for any public subsidy is weak. If the purpose of private health care is to *substitute* for public funding and provision of services – because it is more efficient to do so – then the argument for public subsidy is stronger.

Private health care might also be justified on the basis that it reduces the net cost of health care to government. The costs to government might be lower even if the service is less efficient, and overall costs are higher, because individuals are prepared to pay for some of the care that would otherwise be publicly funded in the universal public system, because it is bundled with additional health care not available publicly.

After the purpose of private health care has been defined, government can consider how to support the sector, if at all. And this should include consideration of whether to support private health care directly or via PHI.

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18. Sekhri and Savedoff (2006) and Motaze et al. (2015). Government will also need to regulate private health insurance, as it does other forms of insurance, to protect consumers, facilitate risk pooling, and promoting cost containment.

## 2 The history: the rocky road to a universal system

PHI has been a contested policy zone for more than 70 years. In the 1940s, a federal Labor government tried but failed to introduce a publicly-funded health care system.<sup>19</sup> The muddle of Australia's private and public health system today can be understood only by tracing the politically contested path that led to the current arrangements.

Changes in government have been accompanied by significant changes to funding arrangements (Table 2.1 on the next page). This can be broken down into seven distinct periods: private insurance with public subsidies (before the election of the Whitlam government in 1972); publicly-financed universal health insurance (Medibank, introduced during the 1972-75 Whitlam government); predominantly private insurance with public subsidies (under the Fraser government, 1975-83); publicly-financed universal health insurance (Medicare, introduced at the start of the 1983-96 Hawke/Keating government); publicly-financed universal health insurance with publicly-subsidised voluntary PHI (under the Howard government, 1996-2007); with tightening of PHI subsidy growth (under the Rudd/Gillard/Rudd government, 2007-2013); and publicly-financed universal health insurance with reform of PHI products (under the Abbott/Turnbull/Morrison Government, 2013-present).

### 2.1 Menzies: a system dominated by private health insurance

Voluntary health insurance dominated health care from the early 1950s until the mid-1970s, reflecting the ideological preference of the government of the time for private enterprise and individual 'self-reliance'.<sup>20</sup> During this period the Coalition government introduced subsidies to hospital care and medical services obtained under

voluntary insurance, and free access to selected pharmaceuticals.<sup>21</sup> Government support for access to hospital care was means-tested, with free access to public hospitals restricted to pensioners.<sup>22</sup> The 'safety net' services were provided only to people who would otherwise be unable to access health care and health insurance. The dominant rhetoric and funding during this period, especially from the Commonwealth government, supported a system of subsidised voluntary health insurance, notably described as 'private practice publicly supported'.<sup>23</sup>

By the late-1960s, health insurance arrangements had become increasingly complex and inequitable;<sup>24</sup> they were 'beyond the comprehension of many'.<sup>25</sup> Growing public dissatisfaction with the difficulty of getting access to hospital and medical care<sup>26</sup> prompted two inquiries,<sup>27</sup> the findings of which reignited a national debate on the financing and costs of health care. The Coalition responded by making changes designed to reform but continue the voluntary scheme. These included introducing a national fee schedule (based on the 'most common fees') and rationalising health insurance offerings.<sup>28</sup> But the stage was set for change.

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21. Kewley (1973, pp. 340-373).

22. Kewley (ibid., pp. 353-359). Queensland operated a 'free public hospital service' throughout this period.

23. Fox (1963).

24. Scotton and Macdonald (1993, pp. 11-18).

25. Committee of Enquiry into Health Insurance (1969).

26. A major reason for dissatisfaction was that a large proportion of the population had no health insurance and relied on charitable provision or faced catastrophic costs if they needed health care. Sax (1984) and Scotton and J. S. Deeble (1968).

27. Committee of Enquiry into Health Insurance (1969); and Senate Select Committee on Medical and Hospital Costs (1970).

28. Kewley (1973, p. 528); and Sax (1984, pp. 79-96).

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19. Sax (1984).

20. Ibid. (p. 86).

**Table 2.1: 70 years of health policy choices**

<b>Political period</b>	<b>Rhetoric</b>	<b>Policies</b>	<b>Role of private health insurance</b>
<b>1949-1972</b> Coalition (Menzies)	<ul style="list-style-type: none"> <li>• ‘Private practice publicly supported’</li> </ul>	<ul style="list-style-type: none"> <li>• Dominated by voluntary health insurance</li> <li>• Selective and residual policies</li> <li>• Reform of voluntary health insurance with ‘most common fees’ and rationalising health insurance offerings</li> </ul>	<ul style="list-style-type: none"> <li>• Predominantly voluntary PHI with public subsidies</li> </ul>
<b>1972-1975</b> Labor (Whitlam)	<ul style="list-style-type: none"> <li>• ‘Universal health insurance’</li> <li>• Emphasis on equity and universality</li> </ul>	<ul style="list-style-type: none"> <li>• Medibank introduced</li> </ul>	<ul style="list-style-type: none"> <li>• PHI not publicly supported given universal health insurance</li> </ul>
<b>1975-1983</b> Coalition (Fraser)	<ul style="list-style-type: none"> <li>• Promise to ‘maintain Medibank’, but reduced to ‘safety net’</li> </ul>	<ul style="list-style-type: none"> <li>• Medibank dismantled</li> <li>• Support for private health insurance for both hospital and medical care</li> <li>• Targeting of subsidies</li> </ul>	<ul style="list-style-type: none"> <li>• Predominantly voluntary PHI with public subsidies</li> </ul>
<b>1983-1996</b> Labor (Hawke/ Keating)	<ul style="list-style-type: none"> <li>• ‘Universal health insurance’</li> <li>• Emphasis on equity and universality</li> </ul>	<ul style="list-style-type: none"> <li>• Medibank reintroduced under new name Medicare</li> <li>• Withdrawal of subsidies for private health care</li> </ul>	<ul style="list-style-type: none"> <li>• PHI an un-subsidised complement to publicly funded universal health system</li> </ul>

*Continued on next page.*

<b>Political period</b>	<b>Rhetoric</b>	<b>Policies</b>	<b>Role of private health insurance</b>
<b>1996-2007</b> Coalition (Howard)	<ul style="list-style-type: none"> <li>• ‘Run for cover’ campaign</li> <li>• ‘Carrots and sticks’ to encourage private health insurance</li> <li>• ‘Choice’ about private health services</li> <li>• ‘Relieve unsustainable burden on public system’</li> </ul>	<ul style="list-style-type: none"> <li>• Extensive financial support for private health insurance and private delivery</li> <li>• Targeting of financial support for medical services</li> </ul>	<ul style="list-style-type: none"> <li>• Extensive subsidies for PHI to complement and substitute for publicly financed universal health system</li> </ul>
<b>2007-2013</b> Labor (Rudd/ Gillard/ Rudd)	<ul style="list-style-type: none"> <li>• Health reform within the context of Medicare</li> </ul>	<ul style="list-style-type: none"> <li>• Limits to growth in rebate subsidies</li> </ul>	<ul style="list-style-type: none"> <li>• As per above</li> </ul>
<b>2013-present</b> Coalition (Abbott/ Turnbull/ Morrison)	<ul style="list-style-type: none"> <li>• ‘Medicare is unsustainable’</li> </ul>	<ul style="list-style-type: none"> <li>• Continued support for private health insurance</li> <li>• Reform of PHI products</li> </ul>	<ul style="list-style-type: none"> <li>• Extensive subsidies for PHI providing an increasingly patchwork complement and substitute for publicly financed universal health system</li> </ul>

## 2.2 Whitlam: the introduction of Medibank

Labor was elected in 1972, promising a universal, compulsory, national health insurance scheme to replace the voluntary arrangements. The universal scheme met fierce opposition from the Coalition, private health insurers, and the Australian Medical Association (AMA). Despite this strident opposition, the policy was eventually legislated in a joint sitting of parliament in 1974, and implemented under the title of Medibank in 1975, just months before the Whitlam government was dismissed.<sup>29</sup>

Under Medibank, all Australians were provided with access to hospital and medical services free of charge and without means-tests. The universal scheme was funded from taxation revenue on a fee-for-service model. People could still choose, if they could afford it, to take out private health insurance and/or be treated privately by specialists or in private hospitals. Tax concessions on health insurance contributions were abolished, and Commonwealth benefits (paid as supplements) to subsidise medical or hospital benefits withdrawn. A Commonwealth bed-day subsidy to users of private hospitals and for a risk equalisation ‘reinsurance’ pool were retained.<sup>30</sup> With a publicly-funded, universal scheme in place, the role of private funding took a back seat – but only for a short time.

When Medibank was introduced an important issue remained unresolved: the appropriate role of private insurance alongside a universal scheme. The architects of Medibank, Melbourne economists John Deeble and Richard Scotton, proposed that the role of PHI was to provide ‘supplementary benefits’ (consistent with this working paper’s definition of *complement*) to Medibank. They considered that the need for subsidies, community rating and anti-competitive regulation was ‘greatly weakened’ in the presence of a universal program that took

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29. Scotton and Macdonald (1993).

30. Ibid. (pp. 241-242).

over ‘the social function of effecting transfers between different risk groups’.<sup>31</sup> But the universal scheme was short-lived.

## 2.3 Fraser: the end of Medibank

Despite a commitment in the 1975 election campaign to ‘Maintain Medibank’, the newly-elected Coalition government gradually dismantled the universal scheme, until it was abolished in 1981.<sup>32</sup> The Fraser government strongly supported the private funding and provision of health care. Elements of the universal scheme were retained, but government support was considered a ‘safety net’, reserved for the disadvantaged.<sup>33</sup> Means-tests for medical services and hospital care were reintroduced, and rebates payable for medical services were reduced.<sup>34</sup>

The changes during the Fraser years reduced people’s access to the universal scheme and encouraged PHI membership, thus promoting the role of private care as a *substitute* for the public system for those who could afford to pay.

## 2.4 Hawke: the introduction of Medicare

The election of the Hawke government in 1983 marked another shift in health policy. After the 1984 election, the re-elected Labor government restored the publicly-funded universal scheme, under its new name ‘Medicare’, providing free access for all to public hospitals, without means-tests, and through a non-means-tested rebate for medical care. PHI continued to operate alongside the universal scheme, as a *complement*, providing additional cover for services and amenities not

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31. Ibid. (p. 274).

32. Sax (1984, pp. 147-173).

33. Segal (2004a).

34. Boxall and Gillespie (2013, p. 79); and Duckett (2008, p. 197).



covered or reimbursed by Medicare.<sup>35</sup> But Labor gave little thought to the interaction of the public and private sectors, or the role of PHI.

In its early years, the Hawke government's focus was on quick implementation of universal publicly-financed health insurance, a core element of the 'Accord' negotiated with the trade union movement. The Accord secured union support for wage restraint (which was needed in the fight against inflation) in exchange for improvements in the 'social wage', which included a universal health insurance scheme.<sup>36</sup>

After the introduction of Medicare in 1984, PHI coverage began to decline as people dropped coverage for public hospital care – an unnecessary product under the universal scheme. In contrast, coverage for private hospital care marginally increased, to a peak of about 38 per cent in 1989,<sup>37</sup> although it then started to decline to about 33 per cent by 1996. This prompted industry concern about the long-term viability of insurance for private hospital care. Labor responded by making minor changes to the regulatory regime and promoting efficiency in the sector, rather than with subsidies and tax incentives to boost membership levels.<sup>38</sup> The most significant changes, known as the 'Lawrence reforms' after health minister Carmen Lawrence, allowed insurance funds to negotiate contracts with hospitals and doctors to reduce patients' out-of-pocket costs.<sup>39</sup>

Under both Medibank and Medicare, Labor allowed PHI to operate in parallel to the universal scheme. PHI was viewed as a *complement* to Medicare, providing additional insurance for private hospital and/or

general services not covered by Medicare. PHI enabled the more affluent to opt for private treatment without 'opting out' of Medicare.<sup>40</sup> John Deeble, one of the co-architects of Medibank and Medicare, in a report to ministers, explained the unsubsidised role intended for PHI:

*In the design of Medicare and its predecessor, [PHI] was seen as a practical way of allowing better-off people and those with a strong preference for private treatment to 'opt-up' without 'opting out' of the universal scheme to which they all contributed. Private insurance could fund their extra demands and those of their doctors, but in a regulated way. It was not subsidised, but subsidising insurance is not the only way of supporting private care.<sup>41</sup>*

The *complementary* role of PHI was generally accepted within the Labor Party, but uncertainty remained regarding what the policy should mean for PHI coverage levels. Some suggested that PHI was only a complement and there was no reason to be concerned if coverage drifted down to its 'natural level', which was expected to be about 30 per cent.<sup>42</sup> Others were more concerned, implicitly accepting a view of private care as a substitute for public care and hinting at the need for a policy response if coverage dropped too much.<sup>43</sup> In the event, Labor adopted a damage-control approach to PHI; there was no clear view on the role of PHI alongside the universal scheme.

When Medicare was introduced, a subsidy was paid to private hospitals, and the Commonwealth indirectly subsidised PHI through contributions to the reinsurance (risk equalisation) pool. But by the late-1980s these subsidies were phased out, and PHI remained unsubsidised until the Howard government initiatives of 1997.

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35. Private health insurers were not allowed to cover any medical services, including in-hospital medical services, until 1985, at which point insurers were required to cover 15% (this increased to 25% in 1987) of the Medicare Benefits Schedule fee for private in-hospital medical services.

36. Boxall and Gillespie (2013); and Duckett (2008).

37. Duckett and Willcox (2015, Figure 3.14).

38. Boxall and Gillespie (2013, p. 149).

39. Gath (1999).

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40. J. Deeble (2003).

41. J. Deeble (ibid., p. 3), cited in Majda (2008, p. 204).

42. The level of PHI coverage that previously prevailed in Queensland.

43. Hall (2001); and Hall et al. (1999).

## 2.5 Howard: the introduction of ‘carrots and sticks’

After five successive election defeats (from 1983), the Coalition decided to abandon its long-held opposition to Medicare in the lead-up to the 1996 election. John Howard promised to keep ‘Medicare in its entirety’ but introduce measures to promote PHI and strengthen the role of the private sector.<sup>44</sup> In its policy platform for the 1996 election the Coalition stated:

*We see the private sector as a vital complement to the long-term viability of Medicare and the public hospital system. This is why a Coalition government will take active and positive steps to ensure that private health insurance remains an affordable and realistic choice for those Australians who wish to have it.*<sup>45</sup>

The election of a Coalition government in 1996 marked a significant change to the way private health care was funded. The Coalition saw PHI as a *complement* to Medicare, allowing people choice of doctor and additional amenity. But Coalition rhetoric also described private care as a *substitute* for public care, ‘taking the pressure off the public hospital system’ and public funding of health care.

The Coalition regarded the falling levels of PHI coverage<sup>46</sup> as a crisis threatening the ‘future viability of the Australian health system’, placing unsustainable demand on public funding and services. To fix the perceived crisis and arrest the decline in PHI, the Howard government introduced a series of policy initiatives for PHI – often referred to as ‘carrots and sticks’ – while also maintaining the universal entitlements of Medicare. The carrots and sticks took the form of financial incentives and tax penalties, as well as a restructuring of the community rating principle, and were implemented in three stages:<sup>47</sup>

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44. Boxall and Gillespie (2013); and Zinn (1996).

45. Liberal and National Parties (1996).

46. Private health insurance coverage had fallen to 30 per cent by 30 June 1997.

47. Hall et al. (1999).

- In 1997, the **Private Health Insurance Incentive Scheme (PHIIS)** was introduced. It provided tax subsidies (in the form of a means-tested rebate for premiums) to low-income earners who purchased health insurance, and imposed a 1 per cent tax penalty (in the form of a Medicare Levy Surcharge) on high-income earners who did not purchase health insurance. The cost to government was estimated at \$500 million a year.<sup>48</sup>
- In 1999, the PHIIS was replaced with a general **30 per cent rebate** for people holding private health insurance. The rebate was extended to all health insurance premiums (not just limited to hospital cover) and was not means-tested.<sup>49</sup> The cost to government was estimated at an additional \$1 billion a year.<sup>50</sup> The surcharge for high-income earners without PHI was retained (and from May 2000 people have had to meet certain eligibility criteria<sup>51</sup> to avoid the surcharge).<sup>52</sup> The range of products health funds could offer was also expanded to include policies with larger front-end deductibles. As with the PHIIS, the 30 per cent rebate did little to increase coverage levels.<sup>53</sup>
- In 2000, **Lifetime Health Cover (LHC)** was introduced. It modified the community rating rules, allowing insurers to charge differential premiums based on the age at which people first took out health insurance. Funds could charge higher premiums for people joining

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48. Budget Statement 1, Table 4: Major spending and savings measures, pp. 1-19. Commonwealth of Australia (1996).

49. This meant that individuals with annual taxable incomes of \$50,000 or more (or, for families, \$100,000 or more) now both qualified for a subsidy and avoided a tax penalty by purchasing private health insurance.

50. Costello (1998, p. 35).

51. Hospital policies where people had to pay up-front if they used services (‘front-end deductibles’) greater than \$500 for singles or \$1,000 for families did not enable purchasers to avoid the surcharge.

52. Butler (2002, p. 36).

53. Segal (2004b).

after age 30 (a loading of 2 per cent for each year joined after age 30).<sup>54</sup> Faced with the threat of higher premiums, people rushed to join before the loading came into effect, leading to a significant increase in the take-up of health insurance and rendering LHC the most effective of the three policies.<sup>55</sup> The introduction of LHC was supported by an aggressive ‘Run for cover’ advertising campaign, which played on people’s fear of higher costs in future. The campaign was credited with contributing significantly to the success of LHC in boosting PHI membership.<sup>56</sup>

Community acceptance of the government’s strong support for PHI and the private sector was grounded in a narrative suggesting that a decline in PHI would threaten Medicare.<sup>57</sup> In 1996, Health Minister Michael Wooldridge told Parliament that the Private Health Insurance Incentive Scheme was:

*the centerpiece of the Government’s strategy to assist Medicare from collapsing under the weight of demand for publicly-funded hospital and medical services.*<sup>58</sup>

In 2000, commenting on LHC, he said:

*Clearly, the Australian public overwhelmingly support what the Government is trying to do to restore the balance between public and private health. . . . What is so great is that people are acknowledging that the Government’s private health insurance reforms are about a better health system overall, and a stronger public system for people who need it.*<sup>59</sup>

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54. The maximum loading is 70 per cent, and the loading is removed after 10 years continuous membership.

55. Palangkaraya and Yong (2007); and Butler (2002).

56. Hall et al. (1999); and Ellis and Savage (2008).

57. Elliot (2006).

58. Wooldridge (1996a).

59. Wooldridge (2000).

This narrative suggested a far more significant role for private funding and private provision than the *complementary* role it had played during the Labor years. The private sector was playing an ‘essential’ role,<sup>60</sup> Wooldridge said, by providing a *substitute* for publicly available services, thus returning the system to its natural balance. He argued:

*. . . the health of the publicly-funded health sector depends upon a vital private sector. Having some 6 million Australians with private health insurance directly pays for around one-third of the costs of hospital care in Australia. If there were no private sector, the extra costs borne by the taxpayer would simply be unsustainable.*<sup>61</sup>

Prime Minister John Howard argued that the best way to take pressure off the public system was to support the private sector. Subsidising private health insurance meant more people could afford to use private hospitals, thereby relieving the strain on the public health system:

*. . . the more people drift out of private health insurance, the greater the strain you are putting on the public health system. So, what we need to strengthen Medicare, to buttress it, to protect it, is to give people taxation incentives. . . . to . . . remain in private health insurance.*<sup>62</sup>

People who could afford to pay their own way were expected to do so and not use public hospitals; the Coalition suggested this would ‘save’ Medicare. Launching the Coalition’s 1996 health policy, Howard said:

*. . . to the extent that we provide people with incentives to stay in private health insurance, we are not only helping those people through those incentives, but we are helping other people who don’t*

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60. Wooldridge (1996b). *Address by the Hon Michael Wooldridge to the 16th Congress of the Australian Private Hospitals Association, Melbourne, 3 October*, as cited in the Productivity Commission Report on Private Health Insurance, Productivity Commission (1997, p. 25).

61. Wooldridge as quoted in Quinn (2002, p. 4).

62. Howard (1996), as cited in Elliot (2006).

*have private health insurance by taking the load off the public hospital system.*<sup>63</sup>

The Coalition (and insurers) also promoted PHI as a *complement* to Medicare – an ‘enabler of choice’.<sup>64</sup> Committed to ‘restoring balance’ and increasing ‘choice’, the Coalition successfully differentiated its policies from Labor. In launching the 30 per cent rebate, Wooldridge said:

*... the fundamental difference between the two sides of politics [in health care is that] we believe in choice... We will fight for choice. The essence of the 30 per cent rebate is choice. We are giving the Australian population the choice of whether to take out private health cover.*<sup>65</sup>

Introducing the National Health Amendment (Lifetime Health Cover) Bill 1999, he said:

*The government is committed to ensuring balance between public and private health sectors. This balance will ensure Australians have a level of choice as well as universal access to excellent health care.*<sup>66</sup>

The second element of the Howard government’s changes – the Medicare Levy Surcharge – marked the return of the ‘residual’ thinking of the Menzies and Fraser years. The wealthy should not receive government subsidies and should not use public hospital services; they should effectively be forced to take out insurance. In effect, the scheme requires higher-income earners to pay a greater share of their Medicare hospital costs (as averaged through public insurance) by an extra levy on their income. But high-income earners don’t pay this

extra if they don’t *intend* to use public hospitals (as evidenced by taking out PHI). The precise policy design has some bizarre outcomes. PHI costs high-income earners less than nothing if they choose policies with large deductibles: they can avoid paying extra tax by taking out a lower-priced policy that costs less than the extra tax penalty for high-income earners who fail to take out private health insurance.<sup>67</sup>

The Howard changes fortified the foundations of Australia’s two-tier system of health care. Emerging from the Howard era was a system in which PHI was described as both a *substitute* for and *complement* to Medicare – a more complex role than during the Labor years, when it was predominantly a *complement* to Medicare.

In the early years of the Howard government, the Productivity Commission warned of the structural problems inherent in Australia’s mixed system of health care. It cautioned against future piecemeal reforms, saying that a ‘long-term solution would require more’ and that the problems facing PHI could not be addressed without wider consideration of the broader health system. The Commission said:

*Private health insurance is a cog in a machine. One can burnish the gears of that cog, but ultimately its performance and functioning depend on the rest of the machine. There are grounds therefore for looking at other aspects of the health system through a wider public review.*<sup>68</sup>

Alas there has been no such review. The Coalition, like Labor before it, failed to consider the interaction between the private and public health sectors. The Coalition instead chose to focus on supporting and expanding the role of the private sector; there were no major initiatives to expand the public sector.

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63. Howard (1996), as quoted in Elliot (2006).

64. Stoelwinder (2002).

65. Wooldridge (1999a).

66. Wooldridge (1999b).

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67. Duckett (2018).

68. Productivity Commission (1997), p. 384.

While the Howard era reforms did not directly modify Medicare, the introduction of additional means-tested financial support for access to medical care<sup>69</sup> effectively reduced the universality of Medicare.<sup>70</sup>

## 2.6 Rudd/Gillard/Rudd: Labor ‘squibs’ on private health insurance

In 2007, the Rudd Labor government established a broad-ranging National Health and Hospitals Reform Commission (NHHRC).<sup>71</sup> Australia’s unique combination of public and private financing, as well as its competitive mix of public and private service provision, were starting to show signs of unravelling. The legacy of ad hoc and piecemeal changes, driven by ideological differences between the two major parties, had complicated an already complex system and exacerbated the unresolved tensions between private health insurance and the public system. The NHHRC noted:

*... there are signs that the competitive tension between public and private hospitals has become unbalanced. More and more, patients who can afford it are seeking planned surgical and procedural care in the private sector as they face long waiting lists and competing demands for emergency care in public hospitals. The attraction of better financial rewards and conditions in the private sector has resulted in surgeons and other proceduralists moving increasingly or exclusively to the private sector.*

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69. A decline in bulk-billing by medical practitioners, resulting in increasing out-of-pocket costs for medical services, prompted the government to introduce several ‘safety net’ arrangements. These included an additional rebate for bulk-billed GP services for concession-card holders, safety net thresholds for segments of the population after which Medicare met 80% of out-of-pocket costs, and a 100% rebate (against the schedule fee) for GP services.

70. Duckett (2008).

71. Stephen Duckett, a co-author of this paper, was a member of the Commission.

*There are increasing concerns that a two-tiered health system is evolving, in which people without private health insurance have unacceptable delays in access to some specialties.<sup>72</sup>*

Despite these concerns, the NHHRC focused on maintaining the ‘overall balance of spending through taxation, private health insurance and out-of-pocket contributions. . . over the next decade’. It made no recommendations for changes to PHI policy.<sup>73</sup> This was yet another missed opportunity to consider the role of private health insurance alongside the universal public system.

Labor retained many of the ‘carrots and sticks’ supporting private health insurance. Its approach to private provision and funding remained passive. The private sector – despite having grown into a large sector, ranging from day surgeries, hospitals and community-based specialists to allied health providers – remained largely outside the government’s policy purview.<sup>74</sup>

In October 2008 Labor increased the income thresholds, above which people were required to pay the Medicare Levy Surcharge, thus removing the ‘sticks’ for low- to middle-income households. But the main change Labor made to PHI was to rein-in the growth rate of the government subsidy. It reduced the health insurance rebate for people on higher incomes, withdrawing the ‘carrot’ from everyone earning more than \$150,000 a year.<sup>75</sup>

Labor also made changes to reduce the value of the health insurance rebate over time. Rather than being linked to premium increases, the

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72. National Health and Hospitals Reform Commission (2009, p. 51).

73. Ibid. (p. 30).

74. Productivity Commission (2009).

75. Four tiers of rebate were introduced, declining to zero rebate for individuals and families in the highest tiers. The same tiers applied for the MLS, which increases with income. People in the highest income tier were to pay a 1.5 per cent surcharge. Duckett and Willcox (2015).

increases in the rebate were indexed to the lesser of the Consumer Price Index and the annual average increase in premiums for hospital cover.<sup>76</sup> Rising premiums and large out-of-pocket costs continued to fuel discontent among consumers, and Labor eventually responded by looking at premium setting, pricing and competition within the industry.

But, like the previous Coalition government, the Rudd/Gillard government failed to confront the fundamental issue of the increasing tension between public and private provision. Labor focused instead on strengthening the public system through a new National Health Reform Agreement, which introduced sharing between the Commonwealth and the states of the costs of growth in public hospital activity.<sup>77</sup>

### 2.7 Abbott/Turnbull/Morrison: same challenges, more inquiries

It has been a decade since the NHHRC squibbed the issue of private health insurance. In the meantime, the problems facing the industry have continued. Rising costs per person have placed private health insurers under increasing pressure. Premiums have become less affordable, while products with deductions and exclusions have burgeoned. Consumers face high, unpredictable and often unexpected out-of-pocket costs, which fuels dissatisfaction with private health insurance. PHI membership has started to decline.

There have been more inquiries into aspects of private health insurance.<sup>78</sup> Each inquiry identifies issues but falls short of identifying long-run solutions to the escalating tensions between the public and private sectors:

- In 2014, the Senate Community Affairs References Committee, in an inquiry into out-of-pocket costs in health care, considered the issue of PHI but made no recommendations.
- In 2015, the Productivity Commission's Efficiency in Health report recommended a review of PHI regulation.
- In 2016, the then Coalition Health Minister, Sussan Ley, established the Private Health Ministerial Advisory Committee (PHMAC), which was asked to look at ways to increase competition in the sector and provide consumers with value for money.
- In 2017, in response to the PHMAC review, Coalition Health Minister Greg Hunt announced policies to increase consumer information about PHI and to relax the regulations. The reforms included introducing 'gold', 'silver', 'bronze' and 'basic' classifications for PHI products, developing standard definitions of medical procedures, and expanding hospital insurance policies to include travel and accommodation benefits.
- In 2018, the Ministerial Advisory Committee on Out-of-pocket Costs recommended creation of a government-funded website and education campaign to make out-of-pocket costs more transparent.

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76. Department of Health (2014); and Biggs (2012).

77. Council of Australian Governments (2011).

78. Senate Community Affairs Committee (2014); Productivity Commission (2015); Ley (2016); Hunt (2017); and Ministerial Advisory Committee (2018).

### 3 The purposes: a first-principles approach to private health insurance

As highlighted throughout this paper, PHI has served dual roles, at times with competing and overlapping objectives. Immediately after the introduction of Medicare in 1984, PHI was seen as peripheral to the public system, providing access to services (predominantly non-medical) not offered publicly. It also offered coverage for wider dimensions of service and amenity, including choice of doctor, choice of hospital, better accommodation and shorter waiting times. These additional dimensions were sometimes available in both public and private hospitals (e.g. to private patients in public hospitals). But PHI is also seen as duplicating the coverage available publicly, and to the extent that it shifts public demand (and cost), it facilitates substitution of private for public provision.

#### 3.1 Subsidising private health insurance can provide value in certain circumstances

Future reforms to PHI should be made based on a clear view of the desired role for private health care given a universal system. The current level of PHI has been achieved partly by the policy of lifetime health cover, implemented in 2000, which penalises people who join private health insurance after they turn 31.<sup>79</sup> PHI coverage has been maintained largely due to the government support provided to the sector. That support has significant budgetary and social costs. This has prompted questions about the justification for providing support, and whether the resources currently supporting private care could be used more efficiently.

Government intervention in the health system and health insurance has generally been justified on the basis of broader social objectives such

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79. Although almost 65,000 people dropped health insurance in 2018, the number recorded as having joined before turning 31 increased by 37,000.

as promoting equal access to health care, better health outcomes for the population, and ensuring the budgetary sustainability of the public health system.

Government intervened to promote access to PHI for older age groups through community rating and risk equalisation, and intervened to promote use of PHI more generally through subsidised premiums (the Private Health Insurance Rebate), tax incentives (the Medicare Levy Surcharge Exemption), tax penalties (the Medicare Levy Surcharge), and regulations to support the viability of the industry (Lifetime Health Cover, premium setting, and product definition).

The cost to government of providing this support has been significant, and now represents almost 8 per cent of Commonwealth Government health expenditure. From its introduction in 1997, the cost of the rebate, in constant dollar terms, increased from \$0.6 billion to a peak of \$5.9 billion in 2012 (Figure 3.1). The cost of the rebate per head of population over this period increased by more than 500 per cent. And by 2012, premiums were growing faster than overall health expenditure. The Labor government responded by capping, from 2014, rebate growth to the lesser of the Consumer Price Index and the annual average increase in premiums. Since then, government expenditure on the rebate has been constant in real terms.

There are valid reasons for subsidising PHI, but there are also downsides. A competing private sector, underpinned by PHI, may drive up costs for public hospitals. Private insurers are often constrained – including through regulated minimum prices – in how they fund providers, and so cannot fully drive efficiency in the costs of providers, resulting in significant funding inefficiencies in private care too.<sup>80</sup> PHI

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80. Insurers are required to pay for all services for which there is a Medicare rebate. Despite the recent review of the Medicare schedule, there are many examples

facilitates queue-jumping for people who can afford it, providing access to health care based on PHI status rather than patient need.<sup>81</sup>

The benefits of government support for PHI should be carefully weighed against the potential and actual shortcomings and side effects.<sup>82</sup>

### 3.2 If PHI is solely a complement to public funding, the case for subsidies is weak

One of the key roles of PHI in the current system is to *complement* public funding. PHI *complements* public funding and provision by providing access to services not covered by Medicare and by providing access to a different type of service from that provided in the public system. These complementary roles include:

- providing improved access to private services which are not reimbursed under Medicare. These are predominantly non-medical services, such as dental, physiotherapy, optical and allied health;
- subsidising access to services which give people choice of treating doctors;
- providing access to facilities and amenities beyond what is otherwise available under the public system, such as single rooms and better accommodation;<sup>83</sup> and

of 'questionable care'. See Duckett et al. (2015); and Schilling et al. (2018). Private care is paid for by insurers, government Medicare rebates and patient out-of-pocket payments. This fragmentation of funding potentially makes cost control even harder.

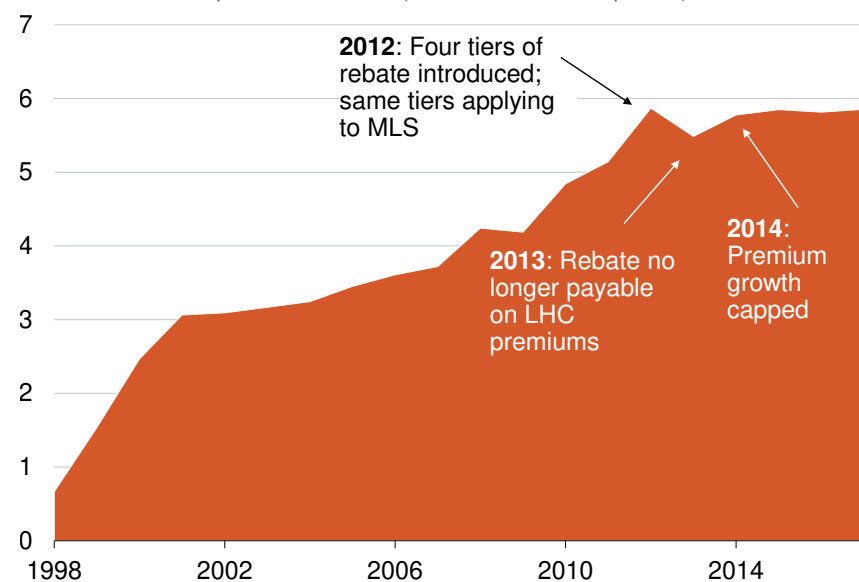
81. Menadue (2017).

82. Segal (2004b); Walker et al. (2005); Hopkins and Zweifel (2005); Denniss (2005).

83. Although the additional amenity benefits, such as of single rooms, is declining as new public hospitals are being built with a higher proportion of single rooms than public hospitals in the past.

**Figure 3.1: The cost to government of providing the rebate has been significant**

Health insurance premium rebate (\$billions; 2016-17 prices)



Notes: MLS = Medicare Levy Surcharge. LHC = Lifetime Health Cover. Comprises health insurance rebates claimed through the taxation system, as well as rebates paid directly to health insurance funds by the Australian Government. This includes portions of the rebates that relate to health activities. Adjusted in line with level of health inflation.

Source: AIHW (2018).



- subsidising faster access to care, by bypassing public hospital waiting lists.<sup>84</sup>

Central to the PHI value proposition is the idea of choice.<sup>85</sup> Government and health insurance funds have promoted PHI as an ‘enabler of choice’.<sup>86</sup>

The former Coalition Health Minister, Michael Wooldridge, said that ‘the essence of the 30 per cent rebate is choice’. Implicit in this is the assumption that you cannot have access to private health care without private health insurance.

The current system of ‘carrots and sticks’ is to some extent the opposite of choice: some people are coerced into private health insurance, others are encouraged, and yet others, who may want to choose private hospital care, can’t because of where they live.

Although consumers may regard some choice as better than none, the choice provided by PHI may be worth relatively little, because in the absence of full information about options of treating doctors and their fees and complication rates, patients (and referring doctors) are rarely able to make an informed choice based on the relative merits of hospitals or practitioners. This raises questions about the efficiency of standards relating to informed financial consent and fee transparency. The Government recently announced measures to improve the transparency of fees charged and provide consumers with greater access to information about the costs of specialist services,<sup>87</sup> but it remains to be seen if these measures will have the desired effect.

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84. Subsidising faster access is classed here as a complement, because it is a different ‘product’ to that provided by the public sector. The potential for faster access is one of the key reasons people take out PHI. From the point of view of government, services provided with shorter waiting times are substitutes.
85. Almost half the people who take out health insurance do so to use private hospitals. ABS (2017).
86. Stoelwinder (2002).
87. Hunt (2019).

And not everyone with PHI gets the choice they want. Choice is limited for people in regional areas. Benefit restrictions and benefit caps limit the choices people with PHI can make. Industry attempts to manage cost pressures through preferred-provider or contracted arrangements also diminish people’s choices.

Choice does not necessarily result in better-informed decisions by patients or lead to better health outcomes.<sup>88</sup> The complex nature of products often leads patients to irrational choices, such as selecting a product with a higher deductible when an equivalent product with a lower deductible is available for the same price.<sup>89</sup>

Under the universal, publicly-funded system, all Australians are entitled to receive care in the public system. Where people choose to take out PHI and seek treatment as a private patient because they prefer the additional dimensions of service provided in private care, subsidisation seems illogical. If private care is solely a *complement* to public care, it seems more logical that people who prefer more than the care provided under the public system should bear the full cost of that choice.<sup>90</sup> A person’s right to choose private care remains, with or without a subsidy. Therefore, it would be more equitable for the costs to be borne by those who make that choice, and get the benefits of that choice.

People on higher incomes are more likely to take out PHI.<sup>91</sup> Therefore, even though the subsidy is means-tested, it tends to disproportionately

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88. Schram and Sonnemans (2011).

89. Bhargava et al. (2017).

90. As noted above, some services may be complements from the consumer point of view, but substitutes from the government perspective.

91. Doiron et al. (2008) noted the positive effect of income on both the probability of having insurance cover and higher health status; see also Butler (1999).

benefit people on middle-to-higher incomes.<sup>92</sup> Yet people on middle-to-higher incomes are the people whose decision to take up PHI is least likely to be influenced by the government subsidy.

People with PHI also gain greater access to hospitals and health services, which undermines the principle of access to service based on clinical need.<sup>93</sup> To the extent that PHI facilitates faster access to care by encouraging ‘queue jumping’ and allowing people to bypass public hospital waiting lists, based on PHI status and ability to pay, this is inequitable. It raises the question of whether a better use of public funding is to expand public access directly. And to the extent that it reduces the availability of doctors in public hospitals, subsidisation undermines the principles of a universal public system.

General insurance (for ancillary services and extras) is only a *complement* – there are no government programs which provide unfettered access to the services covered by private insurance.<sup>94</sup>

If the purpose of PHI is merely to *complement* the public system by providing people with improved access and choice of services, facilities and amenity beyond those considered necessary under the publicly funded system, the argument for subsidising PHI is weak. Complementary insurance is by definition for services over and above

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92. The private health insurance rebate skews to upper-middle income households. ABS (2017).

93. Hall et al. (1999); Willcox (2001); Segal (2004a); Segal (2004b); and Menadue and McAuley (2012).

94. General insurance is clearly a complementary product, because there is no national scheme for these services, therefore no substitution. But it could be argued that in the absence of a public scheme for these products, it may be more cost effective for government to subsidise insurance for these products than to introduce a public scheme. Government expenditure for general insurance was about \$1.4 billion in 2016-17. This includes Commonwealth expenditure on dental services, medications, transport services, other health practitioners, and aids and appliances. Refer to AIHW (2018), Table A3: Total health expenditure, current prices, by area of expenditure and source of funds, 2016-17.

the government-prescribed standard. If government is not prepared to provide those additional services universally, it is illogical to subsidise for a subset of the population through PHI, especially when that subset is not the most disadvantaged in the community.

However, where *substituting* private for public service provision reduces demand for (and cost of) public services, the justification for a subsidy is stronger. This is discussed in the next section.

### 3.3 If PHI is a substitute for public funding, the case for subsidies is stronger

In 2016-17, there were more than 11 million admissions to hospitals in Australia. More than one third were to private hospitals (see Table 3.1 on page 28). Private hospitals tend to focus on less complex elective procedures, such as knee and hip replacements for people without additional diagnoses (‘comorbidities’).<sup>95</sup> Only a very small proportion of emergency patients are admitted to private hospitals. But for surgical procedures the reverse is true; more surgery is done in private hospitals than public hospitals.

Private care is not a perfect substitute for public care. Complex procedures requiring specialised equipment or skills are rarely available in private hospitals. Private hospitals tend to refer out complex patients to public hospitals and receive referrals for less complex patients from public hospitals.<sup>96</sup>

Particularly for less complex elective procedures, people who have the means to pay for a private hospital admission – either because of their PHI coverage or by paying for the admission out of their own pocket – may have a choice of public hospital care or admission to a private hospital, depending on the procedure.

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95. AIHW (ibid.)

96. Cheng et al. (2015); and Brameld et al. (2006).

The substitution-based argument for a subsidy is stronger if:

- it results in a cost saving for government; or
- private provision is economically more efficient than services that are provided universally through the public system.

Any such advantages must be weighted against any adverse impact on the public system including:

- additional costs to the public system;
- reductions in quality in the public system; and
- adverse impacts on the principle of universal access.

### How might subsidies for private health care reduce government costs?

Subsidies probably induce some people to take out PHI and rely less on the public hospital system.

Of course, a significant number of people, particularly high-income earners and high users of health care services – the elderly and people suffering from chronic health conditions – would probably retain insurance and continue to rely on private hospitals even if there were no subsidy.<sup>97</sup> Even without PHI, it is unlikely that public hospitals would need to accommodate all private hospital activity.<sup>98</sup>

Nevertheless, without PHI there would be more patients in the public sector. The cost of their admissions would have to be paid in full by the public sector rather than paid only in part through a subsidy.

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97. An ABS survey asked people why they held PHI and found the most common reasons were 'security, protection, and peace of mind' rather than financial incentives. This supports the idea that a significant proportion of insured people, and particularly middle-to-high income earners, would retain insurance even if the subsidy ended. ABS (2015).

98. Yu et al. (2019); Butler (1999); and Doiron and Kettlewell (2018).

More public sector patients might also require new capital stock, but additional demand might also be met by increasing the use of private hospitals under contract to the public sector.

### Does private health care save costs overall?

For those who care a lot about minimising the size of government, PHI would be justified if it saved the government money. But for those unconcerned about the size of government, this is not enough. For them, PHI would be justified only if it reduced total spending on health, even if government spending were higher because there were more public and fewer private services.

If private hospitals are more efficient overall than public hospitals, then encouraging people to use private hospitals would contribute to the overall efficiency of the health system.<sup>99</sup>

Differences in institutional arrangements, case-mix, and treatment complexity make it hard to compare the efficiency of the two sectors.<sup>100</sup> One study found that, for a similar case-mix, public hospitals are 10 per cent less costly than private hospitals.<sup>101</sup> The Productivity Commission has done two studies on the relative efficiency of public and private hospitals. One found there was virtually no difference; the other found private hospitals were less costly.<sup>102</sup>

It is unlikely that PHI reduces total spending on health. It pays for some services that would not meet thresholds of 'clinical need' in the public system.

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99. If private hospitals are more technically efficient at providing certain procedures (i.e. they achieve what economists call economies of scope), this may also contribute to overall system efficiency.

100. Wright (2001); and Palmer (2000).

101. Duckett and Jackson (2000).

102. Productivity Commission (2009); and Productivity Commission (2010).

**Table 3.1: Types of treatments in public and private hospitals, 2016-17**

	Public hospitals			Private hospitals			Total hospital activity
	Episodes	Per cent of public hospital activity	Per cent of total hospital activity	Episodes	Per cent of private hospital activity	Per cent of total hospital activity	Episodes
Surgical	1,047,376	16	10	1,522,042	34	14	2,569,418
Medical	4,516,182	69	41	1,365,615	31	12	5,881,797
Other	1,023,782	16	9	1,538,810	35	14	2,562,592
<b>Total</b>	<b>6,587,348</b>	<b>100</b>	<b>60</b>	<b>4,426,467</b>	<b>100</b>	<b>40</b>	<b>11,013,815</b>
<i>Emergency</i>	<i>2,682,081</i>	<i>41</i>	<i>24</i>	<i>234,517</i>	<i>5</i>	<i>2</i>	<i>2,916,598</i>

*Notes: Includes same-day facilities. 'Episodes' are the total number of episodes of care for admitted patients. Episodes are assigned to the surgical, medical or other categories based on the type of procedure. Surgical and medical include both emergency and non-emergency acute episodes only. An episode is classified as surgical if it involves an operating-room procedure, and medical if there is no procedure. 'Other' includes other acute care not classified as surgical or medical, and sub-acute and non-acute episodes, such as obstetrics, rehabilitation and palliative care. Components will not add to the totals due to missing values for separations with an unknown care type.*

*Source: AIHW (2018).*

The Medicare principles specify that access to public hospital services is to be based on clinical need.<sup>103</sup> If PHI did not increase total health spending then patients would be admitted to private hospitals based on the same standards of clinical need as applied in public hospitals.

But in practice, thresholds for admission in private hospitals are often lower than for public hospitals, because there is more demand for public hospital care relative to capacity. Patients can be admitted to a private hospital for a procedure that the patient and the treating doctor

think is clinically desirable even if it would not meet the thresholds for admission to a public hospital.<sup>104</sup>

Private hospital use increased after the PHI incentives were introduced. Private hospital patients were more likely to receive a greater number of in-hospital medical services than patients in public hospitals.<sup>105</sup> It is unclear how much of the additional activity in private health care is due to the unmet needs of patients in public hospitals and how much is the

103. The Medicare principles contained in the *Medicare Agreements Act 1992* specify that: eligible people must be given the choice to receive public hospital services free of charge as public patients; access to public hospital services is to be based on clinical need; and public hospital services are to be provided equitably, to all eligible people, regardless of their geographical location.

104. A study by Brameld et al. (2006), which looked at the effect of having PHI on hospital use in Western Australia, found that for all major diagnostic categories, other than treatment on an emergency basis, privately-insured patients had a higher rate of access to surgical procedures. The study suggests that the higher level of intervention for privately-insured patients may be a result of lower thresholds for treatment in the private sector. These treatments may well have been in the patient's interests; but it is possible that some were not, and were the result of supplier-induced demand.

105. Productivity Commission (1997).

result of medical specialist-induced demand, based on patients' ability to pay rather than their clinical needs.<sup>106</sup>

Some of the additional activity funded by PHI may not improve patient outcomes. And in some cases it appears that private health care is adding cost but not improving outcomes. Private maternity patients are more likely to have caesarean sections,<sup>107</sup> and private patients are likely to have more rehabilitation days than public hospital patients, and yet the outcomes are no different.<sup>108</sup>

Apart from the volume of services, private health care may also increase the price paid for services (in economic terms, it transfers surplus from consumers to producers). The limited incentives for funds to promote cost-efficiencies, and the inability of insurance funds to control the costs of health providers, may push up the fees charged for medical services,<sup>109</sup> thereby contributing to the growth in gap fees and out-of-pocket costs incurred by patients.

Even if private health care adds to total costs, it might be seen as valuable when it supports clinically worthwhile outcomes that the public system would not have provided. But why should other taxpayers subsidise these outcomes?

The most plausible argument is that subsidising private health overcomes consumer myopia: perhaps people systematically pay less for health services than is in their own interests. But government

should be wary of over-riding individuals preferences like this. And it should be particularly reluctant to intervene given that this subsidy is not available to everyone. Politically, the most powerful argument may be that the subsidy is provided to more than half of all people over the age of 40 – although it is not a principled argument for the young or poor to subsidise people who are older or have higher incomes.

### Does private health care reduce the quality of public health care?

The argument for subsidising private health care is weaker if it adversely affects public care.

Subsidising private health care may divert medical professionals away from the public system, reducing its capacity to meet patient needs. Higher remuneration in the private sector encourages doctors to allocate more time to private patients and to offer preferential treatment to private patients in public hospitals.<sup>110</sup> When doctors work more hours in the private sector, they are available to work fewer hours in the public sector.<sup>111</sup>

In a tight labour market, if doctors are attracted away from the public system, public hospitals may have reduced capacity to meet patient needs. The higher remuneration for medical specialists in the private sector may give an incentive to doctors working in both sectors to maintain waiting lists in the public system, so as to encourage patients to be treated privately.<sup>112</sup>

Private hospitals may engage in 'cream skimming' – the selection of patients whose treatment will yield higher profit margins.<sup>113</sup> Hospitals may engage in 'vertical' cream skimming or patient selection, by focusing on patients who yield the same revenue, but are lower cost to

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106. Robertson et al. (1998).

107. Einarsdóttir et al. (2013); and Eldridge et al. (2017).

108. Schilling et al. (2018).

109. It has been suggested that the introduction of the 'Gap Cover Scheme' in 2000, designed to minimise the unexpected out-of-pocket costs and fee gaps incurred by patients, contributed to the increase in medical prices, having an inflationary effect on fees charged by medical specialists. Evidence suggests that some specialists responded to the scheme by increasing the fees charged, which in turn led to increases in benefits payable by insurers for medical charges over the Medicare Benefits Schedule. Hopkins and Frech (2001).

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110. Cheng et al. (2015).

111. Cheng (2013).

112. An example of what Ferrinho et al. (2004) refer to as predatory practices.

113. Cheng et al. (2015).

serve because their conditions are less severe. Hospitals and doctors may engage in ‘horizontal’ cream skimming by choosing to specialise in more profitable medical procedures.

Public hospitals must accept all patients, so they have little or no scope to cream skim.<sup>114</sup> Consequently, cream skimming by private hospitals may leave public hospitals with higher-cost patients. This reduces the surplus on funded services that would otherwise be used in the public sector to support additional services.

#### Does private health care undermine the principle of universal access?

It has been suggested that PHI has subsidised ‘queue jumping’, meaning some people get access to health care based on their insurance status rather than clinical needs.<sup>115</sup> If a subsidy provides people who can afford it with the opportunity to bypass public sector waiting lists, which are based on the greatest clinical needs, a subsidy operates to undermine the universality of the system and reduces equity of access to health care.

### 3.4 The form of government funding for private health services

Thus the arguments for government subsidies for private health services are weak if private health services only *complement* public health services. The argument would be stronger if the private sector delivers health services more efficiently than the public sector, but the evidence of this is contested. It is reasonable to argue for private health subsidies if they reduce the cost of health services to government – but only if minimising the size of government is seen as an important objective.

If there is a valid argument for subsidising private health services, then a subsidy targeted at private health insurance premiums may not be

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114. Ibid.

115. Menadue and McAuley (2012); and Hindle and McAuley (2004).

the most effective mechanism. An alternative approach could be to re-institute a direct subsidy to private hospitals, perhaps paid as a proportion of the price used as the basis of Commonwealth payments for public hospitals.<sup>116</sup>

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116. There are a number of options for how such a payment could be made. It could be restricted to admissions for people with private health insurance, or paid for all admissions. The payment could be available for all admissions to all private hospitals and day procedure centres, or limited to private hospitals.

## 4 The question: does the Government need a new approach to funding the private health sector?

Australia's health care system needs reform. The current system is an unhappy mix, in which private care *complements* the public system by offering additional services and dimensions otherwise not publicly available, but also to some extent competes with the public system by offering *substitute* services.

This working paper explored the contested history of publicly funded health care in Australia. It described the dual role of private health care as a *complement* to and *substitute* for public care. The emphasis on each of these roles has varied over time, reflecting attitudes to the role and size of government at the time.

This paper provides a new way of thinking – a first-principles approach – offering policy makers a framework for weighing up the benefits and costs of government support or intervention in the private health sector.

If private care is a substitute for public funding and provision, then the case for industry support and subsidies is stronger, particularly where the benefits of providing a subsidy outweigh the costs. The case for subsidies is stronger if a subsidy results in cost savings for government or if private provision is more economically efficient than public provision. But this must be weighed carefully against any adverse impacts on the public system.

If PHI is solely a complement to public funding, the case for subsidies is weaker. To the extent that subsidies support people's access to additional dimensions of service, over and above the government-prescribed standard provided publicly, it would be more equitable for the costs associated with such preferences to be borne by those who receive the benefits.

Ultimately, the final judgement about the value of subsidies for PHI will involve balancing the net benefit relative to the net costs, both

to government and society, taking into account who pays, the role of government, and the value placed on the complementary role of private care.

But setting this aside, at the most basic level, Australia needs to be asking the following questions:

**First**, what is the purpose of private health insurance and private health care in a universal, publicly funded system? Is it to complement public care? Is it to substitute for public care? Or some combination of both?

**Second**, do the current design features of the PHI system, including incentives, penalties and regulation, support the desired role of PHI in the overall health system? If not, what other mechanisms or combination of arrangements are needed?

**Third**, does government support for PHI and private hospital care promote overall economic efficiency and the most effective and equitable use of government resources? Government subsidies inevitably carry an opportunity cost, and in the long-run there might be better ways of providing support to the sector.

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