

Does Australia's Health Insurance System Really Provide Insurance?

By Joshua Gans
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How are we insured today

Australia has a mixed system of private and public health insurance. Alongside this, it also has a mixed system of private and public health provision. Historically, these features are related. To utilise public health insurance, you need to be treated in a public hospital. However, this link is a policy choice and not a necessity. For instance, public health insurance can be utilised for medical practitioners (e.g. GPs and specialists) who are private operators. So, as a matter of practicality, there is no reason why public health insurance could not cover treatment in private hospitals.

What the mixed system means is that patients have a choice. They can choose to accept only public health insurance – that is, Medicare – or they can take out private health cover. In addition, a patient can choose to be treated in the public hospital system or they can go to the private system. In the public system, they avoid additional payments – although, if they have private cover, their insurer may not – while in the private system, a patient can avoid waiting queues and sharing a room. There is no prohibition on a patient without private health cover opting for private treatment. It is just in this case they incur the financial pain at the same time as the health pain as opposed to some spreading of the former over time.

It is the choice of individuals to take out private hospital cover that interests us here. That choice is between paying a regular premium payment in return for not having to worry about the additional costs associated with private hospital treatment at the time a need arises. In other words, you are insured against excessive private hospital bills.

The sales pitch for private health insurance is not so much this insurance aspect but the idea that private hospitals given you better services: a choice of doctor, private

room, nicer surroundings and food, and potentially a shorter waiting list. This is somewhat surprising for, as pointed out earlier, at the time you need treatment you can decide to pay more and get all of these additional services. So not having private insurance does not preclude you from exercising this option. Instead, private cover is like paying in advance for a business class upgrade on an airline that will be automatically given should you need to travel. The alternative is to simply pay for the higher class of fare when you travel.

The objection here is that many of us know that, at the time, we won't want to pay. The marginal value from business class as opposed to economy is not worth the higher ticket price. However, that should give us pause, why then would you want to commit yourself to opting for that higher class of service beforehand? If you aren't paying for it at the time, you'll be paying for it now, as the provider has to make money. In which case, are you paying for too much?

The answer lies in the element of risk. It is not that you aren't willing to pay for the additional services per se, but that you are happy to pay for them as a shared cost with others in society. What you are doing with private health cover is paying in advance for a service you hope you do not need. Moreover, not everyone will need those services in aggregate. So in effect many people are paying for a service only a fraction of them will utilise. The provider only has to recover the latter, so the costs are spread.

The whole health insurance system – public or private – operates on this premise. Most individuals are risk averse. The consequence of this is that there are collective benefits from the pooling of risks; that is, the chance that everyone needs health care over any interval of time is substantially less than one. This means that, by having health insurance, the costs of health care are spread across individuals; so you pay for other people's care if you are not sick and your care is paid for by others if you are.

So what is the difference between public and private health insurance in this regard? In each case, the major costs of health care are spread across individuals. However, in the private case, the additional costs associated with private care, options and quality are also spread across those individuals paying for private health cover. But herein lies the twist: private hospital expenditures are only partly subsidised from the public purse, so those expenditures have to be paid for by private health insurers.

What this means is that, to encourage individuals to purchase their product, private health insurers have to convince them not only to share the costs of private extras (an easy task) but also to share the costs of private hospital expenditures (a hard task). The latter is a hard call because individuals are automatically covered for those expenditures in the public system. As these individuals are taxpayers, you are effectively asking them to *pay twice* for health insurance. To do this, they would not only have to really value the extra options but also being *insured* over those extras. For remember, the private extras are available to them even if they do not have private health insurance.

Not surprisingly this makes the private health insurance business a difficult one. Not only do you have to convince people to pay for a product part of which they already have but also you have to deal with the usual problems an insurer faces: the very people most likely to opt for cover are those whose risks of making a claim are high. This creates a common problem of adverse selection whereby the costs of insurance blow out as it becomes more and more likely any single insured person will actually incur those costs. Put simply, risk sharing requires a variety of risks. If only high risks opt to be privately insured, that won't occur.

The bigger problem

The hard sell facing private health insurers is, of course, not the main problem that arises from the way Australia has set up its mixed public/private system. The greater difficulty comes when we ask whether, from a social point of view, the system is really providing health insurance.

To consider this, think about what health insurance involves at a social level. It requires the pooling of low and high risk individuals together so that ultimately those who are most likely to fall ill are, in effect, cross-subsidised but those who are least likely to fall ill. This is socially desirable because the effect of such an arrangement is to leave all individuals – before they know their precise health risks – in the position of either having a health life incurring health payments they ultimately didn't need to or having a less healthy life but incurring much lower health costs than they would have otherwise had to pay. In effect, individuals' utilities – their value of life less health payments – are,

to some extent, insured so that if life deals them a bad health turn, the pain is eased by payments from those who are more fortunate.

Is this outcome being achieved in the Australian system? That is, are those most at risk being cross-subsidised by those least at risk? Probably not. Consider two households – one which has a higher risk of requiring health care than the other but otherwise have the same characteristics, income and wealth. The household with the higher risk is also likely to be the one most likely to take out private health cover; it is more worthwhile to incur an insurance premium if you expect to make a claim. However, that household is then paying again for hospital expenditures while the household that is at lower risk has some tax payments saved because higher risk households are ‘out of’ the public system. Therefore, rather than payments flowing from the low to the high risk, the system reverses this. So instead of insurance we have *anti-insurance*.¹

To be sure, income level also drives the demand for private health insurance with higher income households more likely than lower income households to take it up. However, unless those higher income households are also significantly less likely to have health problems – and it is not at all clear they are because they also live longer – then some measure of anti-insurance still arises.

How did this problem arise? As noted earlier, anti-insurance occurs because those most at risk take out private health insurance and effectively pay twice for hospital expenditures. But why is it the case that choosing private health insurance means opting out of Medicare completely? The probable answer is that governments saw this as a means of saving on public health expenditures. The assumption being that if the richer households in Australia opt for private cover they would in effect be providing an implicit subsidy for the public system: alleviating the burden on it. In this respect, anti-insurance was a necessary by-product of setting up an ‘opt out’ system as an attempt to reduce public expenditures on health care. However, as I will describe below, this could have been achieved without this unwelcome by-product by a more straightforward use of the tax system.

¹ ‘Anti-insurance’ is a term coined by myself and Stephen King (2003) to describe the outcome whereby high risks subsidise low risks in health insurance.

Political inertia

But the 'opt out' system and its twin goals of universal health insurance coverage and a desire to save on direct public expenditures on health care creates another set of problems: poor public choices with regard to the quality of public health care.

To see this, consider what would happen if the quality of public care were improved? That is, waiting lists were shortened, hospitals upgraded and the like. In this case, the gulf between private and public hospitals in terms of quality would be reduced and consequently, fewer households would take up private health insurance and would come back to the public system.

Improving the public system increases not only the average cost per household in that system but the total number as well. Thus, from a fiscal perspective, the cost of improving the public system is not simply those direct costs but the indirect costs as well. Not surprisingly, this ties the hands of even the most well-meaning politicians in their ability to improve public health care quality.

This inertia manifests itself on a number of dimensions. As an example, consider the issue of the choice of doctor. In public hospitals, there is no choice. In private ones, there nominally is. However, the degree of choice in the private world can be overstated. Issues of availability and timing often arise as well as the fact that some more specialist treatments take place only at the larger public hospitals. Finally, it is a simple fact that most households do not have a good idea about the trade-offs involved in choosing one doctor over another and so the empowerment given by the choice is limited. Nonetheless, despite this the choice of doctor is heralded as a primary reason to take out private cover.

But these same concerns about the actual choice given also raise an important question: why isn't there a similar choice in the public system? If that choice were available, individuals would have to face trade-offs in waiting for their choice to be available, the location of the specialist and their own lack of information about the options. Moreover, it is unclear that this would result in a significant burden on the administration of the public system.

However, to broach the idea that some choice might be given to patients in public care is simply heresy. Its feasibility has never, to my knowledge, been seriously

investigated within government. The reason is obvious: if public patients were given such a choice, there may be a significant migration away from the private health system. Moreover, if the choice that might exist in private health care was seriously evaluated and turned out to be limited, then there might be a similar migration. I am not saying for sure that either of these issues is simple, but just that from an economics perspective they are relevant. However, the possibility that the choice of doctor may not be a significant differentiator between the private and public systems is currently such a concern that not even an opportunistic politician in any party has proposed it. The potential for increased public costs appears to be too great.

Thus, the way the private health insurance system is currently being used – as a means of getting health care off the public accounts – is itself leading to poor choices regarding the quality of public health care. This clearly has widespread ramifications and alongside the continuing anti-insurance is a reason why reform is desperately needed.

Band aids

The tension faced in preserving a private system to alleviate the burden on public health expenditures has been increasing. As a result, the private system's role in this regard has been diminished. Various policies from a Medicare surcharge to a private health insurance rebate have been designed to alleviate the tension. However, in the case of the latter the effect has been to spend money in order to save money. Hardly an ideal outcome; even on narrow fiscal criteria.

Nonetheless, the private health insurance rebate does reduce the degree of anti-insurance. The rebate entitles a privately insured person or household to a refund of 30 percent of their private health insurance premiums. This rebate can come directly off those premiums or as a payment offset against income tax. Either way, the effect is the same: to provide a payment to privately insured. Given that those who are not privately insured do not receive the payment, the rebate offsets the payments by the privately insured for public hospital expenditures. For this reason, it mitigates the level of anti-insurance in the system.

To get a sense of the magnitude of anti-insurance and the effect of the rebate, consider Figure 1. The upper line represents the contribution a privately insured person makes towards public health expenditures; representing a pure subsidy from those who take out private health insurance. It is a crude measure for, on the one hand, it does not include contributions from those who were self-insured while, on the other, it assumes that the privately insured never used the public system without notification. Notice that the transfer from high risk types (privately insured) to others was between \$500 - \$650 per person (in 2001 dollars) but had risen appreciably since 1995.² This rise reflects the declining numbers of people taking out private health cover as well as the consequent rising public hospital expenditures.

Figure 1: Public Contribution by Privately Insured Individuals (1984-2002)

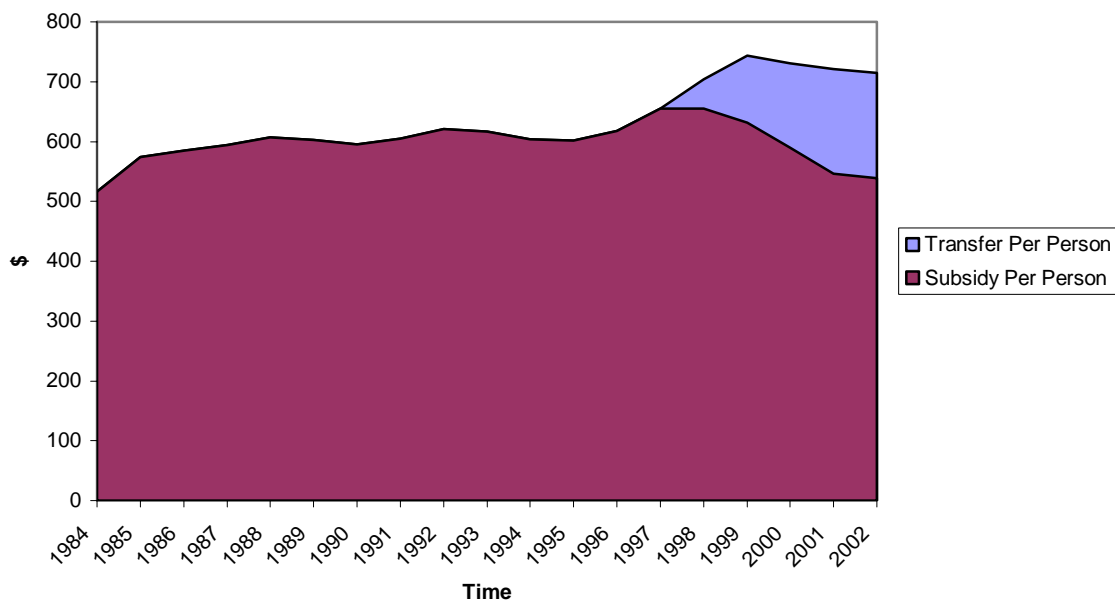


Figure 1 also demonstrates the effect of the rebate. You subtract from the transfer the extent of the subsidies to private health insurance since 1997 (the lightly shaded area). Notice that these have reduced the net transfer (the dark area) considerably. Thus, the subsidy potentially paid by high risk individuals has fallen from about \$650 per person prior to 1998 to about \$500 per person in 2002. This gives one a sense of the reduction in anti-insurance.

² For more details on the derivation of this measure see Gans and King (2004b, Chpt 3).

The rebate represents a band-aid. It is a direct attempt by the government to stem the previous flow of households away from private insurance. However, it does this in a way that continues to cost the government money. However, instead of being spent on health care, it is spent on preserving the ability of the private system to function in the midst of an effective public alternative. It stops the blood from spillover but does not close the wound created by the 'opt out' system.

A clear path

Given all of this, the better alternative is clear: to preserve its mixed public/private system, Australia has to move from an 'opt out' to a 'top up' system of health insurance. Rather than require a double payment for health expenditures, we must free ourselves of the arbitrary distinction between the ownership of health care provision – public versus private – and the operation of insurance. The government should see itself as funding all hospital procedures in much the same way as it now does for non-hospital treatment. This would allow private hospitals to claim case mix payments (essentially the government rate for treatments) in competition with public hospitals.

At the same time, this would have the effect of marginalising private health insurance to be insurance solely about the private hospital extras: quality, waiting list and maybe doctor choice. For this reason, the rebate could be dispensed with alongside other inducements such as the Medicare surcharge. In the process, however, the efficiency of these decisions at the consumer end will be enhanced as a double payment would no longer be built into private insurance premiums.

However, to preserve the current level of health care, this would surely mean an expansion of the total government health care budget. Clearly this would mean that the government would need to raise taxes. To preserve equity from the current system, this would fall disproportionately – as taxes often do – on the higher income earners. However, from their perspective, they now have more choice. They might be making the same payments towards health care but they now face a clearer choice as to whether to take out additional private health cover or not. For those with a lower risk of illness or higher value on private extras, this is a good deal.

Thus, there is a sense in which moving from an ‘opt out’ to a ‘top up’ system means that instead of high income earners being taxed in-kind (i.e., forced to pay a lot for private health insurance) they are taxed directly. For an economist, the improvement in transparency amounts to an empowerment to consumers. However, for a politician, something that was previously not called a tax would now be one—the political fear appears to be calling it one. If we want to move back to appropriate judgments of the benefits and cost of health care, we need to overcome such semantics, remove distortions and restore transparency and real choice to the system.³

References

- Gans, J.S. and S.P. King (2003), “Anti-insurance: Analysing the Health Insurance System in Australia,” *Economic Record*, Vol.79, No.248, pp.473-486.
- Gans, J.S. and S.P. King (2004a), “System Blocks Better Health Care,” *Australian Financial Review*, 22nd March 2004.
- Gans, J.S. and S.P. King (2004b), *Finishing the Job: Real World Policy Solutions in Housing, Health, Education and Transport*, Melbourne University Publishing: Melbourne.

³ For more on this type of ‘top up’ system see Gans and King (2004b, Chapter 3).