Public Health Association
AUSTRALIA

PRIVATE HEALTH INSURANCE OR PUBLIC HEALTH?

Background Paper

This paper provides background information to PHAA's Public Funding of Private Health Insurance Policy Position Statement, providing evidence and justification for the public health policy position adopted by Public Health Association of Australia and for use by other organisations, including governments and the general public.

Summary

There are three key arguments underpinning the policy proposal that PHAA actively opposes government support for private health insurance (PHI):

- PHI is an inefficient mechanism for funding health care services compared to universal public health insurance.
- PHI is an inequitable mechanism for the distribution of scarce health care resources and it contributes to health inequity.
- Government funding for PHI via the premium rebate is a poor use of substantial public monies which could produce better and more equitable health outcomes by directly funding health care and implementing healthy public policy.

There is an additional concern that the tendency for PHI funded private providers to be promoted as the health care pathway of choice for those who can afford it implicitly casts the universal public services as second class, eroding social capital and contributing adversely to the social determinants of health.

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Contents

A public health issue

A major public expense

1. Around 46% of the Australian population has some form of PHI.[1] They benefit through reimbursement of out-of-pocket costs for some specialist medical, private hospital care and various other health services such as dental, optometric etc.

2. However, unlike most other forms of private insurance, PHI is heavily subsidised by public funds via a tax rebate on premiums. The rebate is now tiered based on wage thresholds as well as being indexed based on a complex weighted average ratio meaning the rebate paid is currently averaging 27.82% of the cost.[1]

3. However, as premiums rise, the total cost of the rebate has been growing and reached $6.148 billion in 2014-15 and was expected to be $7.3 billion by 2018.[2] For comparison, this is greater than the $5.247 billion annual Commonwealth contribution to government schools and is of a magnitude sufficient to cover a national dental scheme or around a third of the cost of a fully implemented NDIS.

Inefficient

4. PHI is provided in Australia by 34 entities. The economies of scale experienced by Medicare are not available for the multiple, smaller PHI entities. In addition, unlike Medicare, they incur costs in competing with each other (through advertising and promotion). While 22 of the 34 are not-for-profit organisations, a number of large PHI for-profit entities controls 70% of the market. Of these, just three, BUPA, Medibank Private and NIB have 64% of the total. All the for-profit entities and must take a margin as profit and pay taxes.[3]

5. The additional administrative burden of PHI (born by policy holders via premiums) through profit taking, taxes and inefficiencies of small scale operation, above that of Medicare is around 10% or about $1.6 billion pa.[4]

6. The argument that PHI saves public budget outlays is spurious. PHI operates very much as a tax does, collecting funds from policy holders to redistribute via claims. Funding is still taken from the public, it just needs to take a bit more to cover the additional administrative costs.

7. However, it is the inability of private insurers to effectively control the costs – and the quality of care, imposed by providers that represents the greatest risk to the efficient use of funds. Essentially, the PHI funds must compete with each other in the market place for health care services. This gives providers a market advantage compared with a monopsony setting where a single public insurer is the sole purchaser (and price-setter).

8. Competition between PHI entities purchasing health care services not only puts upward pressure on costs in the private health care sector. This pressure flows on to the public health care sector as well. For example, medical salaries in public hospitals need to compete with those paid in the private sector if they are to retain staff. Gap insurance in Australia enabled the largest increase in specialist fees in 25 years.[4]

The path to managed care

9. It should be acknowledged that private health insurers are attempting to counter the disadvantage of being competitive 'price-takers' by group purchasing arrangements and increasingly by entering into agreements with 'preferred providers' that mean consumers receive higher rebates for using these providers.

10. In early 2018, BUPA announced its intention to only deliver no-gap or known gap rebates for care with private hospitals who have contracted with BUPA. Following a public backlash, the insurer re-adjusted the changes.

11. The closer the commercial relationship between the preferred provider and the insurer, the stronger is the incentive on the provider to under service. The logical extension of this trend is to managed care or health maintenance organisations. Any role that provider (private hospital) then has in assuring quality of care is severely constrained. Where patients must use a specified provider, as the US experience indicates, underservicing is a major issue.

12. At a national level, OECD statistics comparing similar countries reveal a strong relationship between economy wide costs of health care and the extent to which PHI is used to pay for it.[4]

13. A US study concluded that a key explanatory factor for the very high level of health care spending in the USA was fragmentation and weakening of the demand side, as embodied in the dominance and proliferation of PHI.[5]

14. The evidence at both the Australian and international level is that PHI is a very expensive and fundamentally inefficient way to fund health care.

Competition or obfuscation

15. Nor does PHI offer meaningful choice or effective competition between PHI providers. While approaches to advertising and promotion may vary, insurers are highly regulated and there is little real product differentiation.[4] It is difficult for consumers to make meaningful comparisons and there are low rates of switching between funds.

16. The former Australian Competition and Consumer Commission head, Prof Graeme Samuel, a former adviser to the federal government's private health insurance review, says there are about 40,000 variations of private health insurance policy available.

17. The private health insurance ombudsman reports that it received 4,265 complaints from consumers in the 2014-15 financial year, an increase of 24% on the previous year. Prof Samuel has observed that: There is market failure when there is such a gap of information that the consumer can't easily find what it is that they're getting and compare the cost of the insurance with the extent of the cover.[6]

18. Supporters of PHI frequently argue its value in reducing demand for over-stretched public hospital services. However, any reduction in demand for public hospitals is offset by diminished capacity through the transfer of skilled medical personnel to better paid positions in PHI funded private hospitals.

19. An OECD report has noted that median waiting times in Australian public hospitals actually increased slightly in the decade to 2010.[7]

20. The crucial efficiency question is whether the savings from reduced public hospital use exceed the cost of the rebate itself. However, econometric modelling by the Melbourne Institute indicate the reverse: that savings from reductions in the rebate would exceed the predicted increase in public hospital costs by a factor of roughly 2.5 .[8]

Fragmentation

21. PHI has exacerbated the fragmentation of health care. Public hospitals (especially larger ones) provide a broad range of (variably) integrated services including emergency, medical, surgical, rehabilitation and other services including vital professional education. While they may offer a range of health care services, the core role of private hospitals is to provide a nursing and accommodation infrastructure for procedural medical specialists.

22. PHI policy holders make up the vast majority of private hospital patients. Private hospitals tend to deal with (profitable) acute procedural matters rather than costly chronic conditions which largely remain within the public sector. For example, having private health insurance is a predictor of caesarean births[9] and incentive schemes in Australia to increase public health insurance membership led to increases in caesarean deliveries and births with longer infant hospital stays.[10] Commercial considerations play an important part in driving this pattern.

Inequity

23. Given the focus in private hospitals on elective surgery and the limited number of medical specialists, PHI provides a queue-jumping facility for those who can afford it. Instead of a lengthy wait for an operation in a public hospital, one can be seen in weeks with PHI. Access is enabled via having PHI (which is strongly correlated with wealth) rather than according to patient need. Equity of access is thus compromised.

24. Equity is further eroded by the PHI rebate. PHI is held disproportionately more by wealthy Australians. Indeed, the Medicare Levy Surcharge makes it more expensive for high income earners not to have PHI than to have it.

25. There is evidence that, compared with the rest of the population, those with PHI are richer, better educated, more health conscious, in better health and more likely to use certain discretionary health services. Hence, PHI use is generally highest among those with the least need for health care.[11, 12]

26. A further dimension of inequity is found in the distribution of cost reduction strategies by insurers and providers. The lower premium plans, which may be more attractive to those on lower incomes, have higher underservicing risk associated with cost cutting via excluded services, fund holding, capitation and restriction on approved providers.

27. Dental treatment is excluded from Medicare, so those without ancillary PHI dental cover (which is subsidised by the rebate) generally pay the entire cost themselves. There are heavily subsidised dental services offered by state health authorities and a Child Dental Benefits Scheme for some low-income groups. However disadvantaged people have serious access problems and there are extensive waiting times for most of these services. Wealthier Australians with PHI are subsidised via the rebate and receive good access with little waiting. It is difficult to justify this arrangement on equity grounds.

28. There is evidence that health inequities may be increasing in Australia and that PHI may have some role in this.[13, 14] Menadue and McAuley (2012) have referred to an:

> *implicit message of social division: PHI and therefore private hospitals are for those who have the means; public hospitals are for the poor. This is a reversion to the 'charity ward' system, which, in time, will morph into something akin to the US Medicaid program for the indigent. (p15).*[4]

Background and priorities

Health Inequity and the PHAA position

29. Health is a fundamental human right which has as its prerequisites social justice and equity.

30. Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people,[14] resulting in macro politico-economic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.

31. Free market economic approaches to health care provision have been shown to widen socio-economic and health inequities.

32. PHI is a free market economic approach to funding health care. Given the effects of PHI on health equity, it is very difficult to reconcile silence on, and therefore, tacit support for PHI, with PHAA's Health Equity Policy.

Policy priorities

Healthy public policy for funding health care

33. Public funding of health care should be managed to optimise both allocative and technical efficiency so as to deliver the maximum population health benefit per dollar spent.

34. Subsidising PHI is an inefficient use of public funds. PHI heightens rather than reduces inequities in health.

35. Those inequities in access to health care contribute to a wider social inequity. The more unequal society becomes, the worse its overall population health.[15]

36. Health care services should be organised so as to contribute to building social capital and cohesion rather than to eroding them. Good quality health care should be available to all, promptly provided on the basis of need, regardless of ability to pay, free at the point of delivery, and funded by progressive general taxation.

37. PHAA has an important role to play in raising public awareness of the inefficiency and inequity of government funding for the PHI industry, and of the potential for improving Australia's population health and health equity through the abolition of the PHI rebate and the reallocation of those public funds.

Current situation

38. There is widespread dissatisfaction with the current arrangements for PHI. Consumer complaints to the PHI Industry Ombudsman rose 24% in 2015-16. Many of these relate to exclusions that are not readily apparent to consumers until they attempt to make a claim – a common complaint in the US managed care model.

39. The high cost of policies combined with tax incentives appears to have encouraged a proliferation of 'junk' policies which provide little cover, but enable consumers to avoid tax penalties designed to encourage PHI.

40. The Australian Health Care and Hospitals Association has called for a Productivity Commission Review of the industry, arguing that should there be no net public health benefit for the rebate, it should be abolished, and funds transferred to the Medicare Benefits Schedule to include extended primary care and dental services.

41. Meanwhile the largest for-profit PH insurer, BUPA recently announced, and then withdrew a proposal to only pay gap or known-gap benefits for treatment at private hospitals contracted to BUPA. The AMA has warned that this sets up incentives for underservicing under a US-style managed care system.

42. The ALP has said a Labor government would limit PHI premium rises to 2%pa, provoking opposition from the PHI industry.

Recommended action

43. The Political Economy of Health SIG recommends that PHAA maintain the current policy position whereby:

    PHAA will advance its mission and objectives by advocating for the transfer of the public funding of private health insurance to universal health care services.

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