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Treating Australia's Health Insurance System: Palliatives or Radical Surgery?

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IT seems to be an unfortunate fact of life that getting elected requires political parties to make sweeping promises in relation to any issue on which they feel vulnerable. Such promises then have a strong tendency to stifle debate and creative thinking in areas where these are plainly needed. One such area in Australia is the goods and services tax, so closely associated with the failure of the Liberal-National Coalition to win government in 1993.

This article concerns two of the Coalition's campaign promises at the March 1996 election: to retain community rating in private health insurance, and to retain Medicare in its present form. These promises have led to an absurd state of affairs in which the recommendations of the current inquiry by the Productivity Commission into the seriously ailing private health insurance industry are expressly required to take the promises as given. Constraining the inquiry thus ensures that its recommendations will be nothing more than palliative — although the Commission's draft report (Productivity Commission, 1996) makes some effort to escape from these confines.

Australia's health insurance system comprises both private insurance and public insurance (through Medicare), and should be seen as a whole. In 1983, two-thirds of the population was covered by private health insurance; now only one-third is. The exodus from private insurance is directly attributable to community rating and Medicare. The present government's response, apart from setting up the inquiry, has been to announce that, from July 1997, it will (i) subsidise through tax rebates the purchase of health insurance by those on low incomes; (ii) penalise failure to purchase it by the wealthy through a tax surcharge; and (iii) raise the threshold for the medical expenses income-tax rebate. But these moves are unlikely to reduce budgetary outlays on health significantly, if at all, and more radical surgery is needed. It is important, therefore, to open up debate about the possibility of switching from community rating to actuarial rating and, at the same time, to rethink the role of Medicare.

This article proposes a radically different health insurance system which, while sharing the broad objectives of the present arrangements, promises far greater efficiency, far less reliance on tax revenues, and far wider individual freedom of choice. These ends can be achieved quite easily, by moving to a competitive, market-based insurance system, without turning our backs on the less fortunate members of society.

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The Community Rating Principle

Until the 1970s, health care in Australia was financed mainly by direct payments from patients and from private health insurers operating on the basis of community rating. This principle requires insurers to offer everyone the same contribution rates for a given level of cover. It may be contrasted with actuarial (or experience) rating, under which different premiums are charged that reflect differences in risk. Actuarial rating applies to cars, for example: insurance for expensive cars costs more than insurance for cheap cars (other things equal), since repairing or replacing them likewise costs more. But under community-rated health insurance, the premium for a person aged 25 is the same as that for someone aged 65, even though the latter is likely to incur much larger health care costs within any given period.

Community rating has a good deal of emotional appeal. A propensity to require a high level of health care implies misfortune, and community rating lessens the misfortune by sharing the financial burden among the whole community. High-risk groups thus claim more in benefits from their insurer than they pay in as contributions, while low-risk groups contribute more than they claim. To a large degree, the high-risk groups comprise the old, the chronically ill, and larger families (who pay the same premiums as childless couples); the low-risk groups comprise the young and healthy, and singles and couples without children, who can well afford to contribute in excess of their own treatment costs.

But it is precisely this characteristic that give rise to a major difficulty with community rating: it amounts to a tax on low-risk groups to provide a subsidy to high-risk groups. Human nature being what it is, people have a desire to avoid paying taxes, and to put themselves in the position where they will benefit from any available subsidies. When only community-rated insurance is available, many low-risk people will escape the implicit tax by declining to buy insurance, while high-risk people can be expected to avail themselves of the implicit subsidy by buying insurance — perhaps with a higher level of cover than they would choose in the absence of the subsidy. As a result, the insurer ends up covering disproportionately more of the high risks: those who, as a group, make relatively more and larger claims. As the average cost of claims per member rises, contributions have to be increased if the insurer is to remain financially viable. But the higher the contribution rates, the bigger the implicit tax on low-risk groups, and the fewer the number of persons from these groups who will still want insurance. The larger the number of high-risk persons relative to low-risk persons, the more severe the problem becomes.

For this reason, the long-term viability of community rated insurance is very uncertain in the absence of compulsion. This inherent weakness arguably contributed significantly to the number of persons choosing not to be insured by Australia's community-rated private health funds in the 1960s and early 1970s. The obvious consequences were extreme financial hardship for those who required expensive treatment as a result of unforeseen serious accidents or illnesses but who had taken the risk of not insuring, and a growing financial burden for the public hospital system, which treated such people even when they could not afford to pay.

The Budgetary Consequences of Medibank/Medicare

This, in turn, was the main catalyst for the introduction of universal insurance, in the form of the original Medibank scheme of 1975. This scheme aimed to make health care available to all who needed it, even if they were not privately insured.[1] Paradoxically, however, the existence of what is now known as Medicare makes the problem even worse for private health insurance. All permanent residents have access to Medicare, for which they pay through taxes, and this significantly weakens the incentive to purchase health insurance privately. Indeed, the only reason to purchase insurance is that the quality of cover provided by Medicare is perceived to be inferior. Specifically, Medicare provides for treatment only in shared wards in public hospitals, relying on doctors chosen by those hospitals. As well, there are long waiting lists for admission. If all people thought public hospital treatment was as good as private hospital treatment in all respects, and that choice of doctor was unimportant, there would be no demand at all for private hospital treatment or private health insurance.

The strong disincentive to purchasing costly private insurance serves to compound the effect of the community rating requirement. Rather than being simply the solution to the problem of those who would choose not to insure privately, Medicare has come to be seen as an acceptable alternative form of insurance by large numbers of people who otherwise would have been happy to do so. Thus, although the charming fiction of near-free access to health care for everybody has been sold to voters in numerous election campaigns, time has shown that we are not prepared to be taxed heavily enough to make this possible. The task of governments in reality has been to find an electorally acceptable balance between taxing us to pay for Medicare, and winding back the quality of health treatment available to Medicare users.

Tax Rebates to Encourage Opting Out of Medicare

Medicare is 'free', in the sense that one has to pay income tax whether or not one calls on its resources. Those who desire merely the *increment* in quality of cover that private insurance provides therefore have to be prepared to pay the *full cost* of private insurance. A possible means of offsetting this significant distortion is to provide a tax rebate to people who purchase private insurance (and in so doing implicitly choose not to rely on Medicare). More people can be expected to purchase private insurance if by doing so they are relieved of some or all of the burden of having to contribute to Medicare. This is the approach announced in the Commonwealth Budget for 1996/97.

How big should the rebate be? The amounts announced in the Budget were fairly small, at least for relatively low-income earners: $100 for singles, $200 for

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[1] For a brief history of Medibank/Medicare, see Logan et al. (1989:28-30). The paternalistic notion that people *should* be insured, even if they would prefer not to purchase insurance if given the choice, is neither supported nor challenged here, but simply taken as given.

couples, and $350 for families (plus additional amounts for ancillary cover). This group comprises individuals with annual incomes up to $35,000, and couples and one-child families with incomes up to $70,000; the income threshold rises by $3,000 for each additional child. Much larger rebates are available to relatively high-income earners, for whom the rebate is 1 per cent of taxable income. This group comprises individuals with incomes above $50,000 and couples and families with incomes above $100,000. The marginal tax rate for this group was simultaneously increased by 1 per cent (characterised as a 'Medicare Levy Surcharge'), but since they can escape the extra tax by purchasing private insurance, the new arrangements amount to a tax rebate which is proportional to income. For example, a couple or a family with a combined income of $100,000 would receive a rebate of $1,000 — roughly equivalent to the full cost of basic private insurance cover with a front-end deductible (or excess) of $500. People with still higher incomes would actually obtain rebates *in excess of* the cost of private insurance.

The implications of the new arrangements are worth noting. Low-income individuals obtain access to (somewhat inferior) Medicare hospital cover at the cost of the tax rebate forgone, amounting to $100. High-income individuals obtain access to private insurance — with freedom to choose both hospital and doctor, and to avoid waiting lists — free of charge, or even at negative cost. In the middle, individuals earning $35,000–$50,000 get Medicare cover at no cost, but have to pay the full cost of private insurance if that is their preference. Similar implications apply to couples and families.

This strategy may or may not achieve budgetary savings. Among lower-income earners, each couple opting for private cover will cost the government $200 annually; but if their likely cost of Medicare benefits was, say, $1,000, there is an implied saving of $800. On the other hand, the rebate will also flow to those individuals who have already chosen to be privately insured. The strategy thus imposes on the government the fixed cost of giving the rebate to all existing lower-income, privately insured taxpayers. (Middle-income earners are not affected by the changes, while the number of relatively high-income earners — about 110,000 singles and 100,000 couples and families, according to a Department of Health and Family Services press release, 'Private Health Insurance', of 20 August 1996 — appears too small to have any major budgetary impact.)

A delicate balance is involved. If the rebate is too small, not many low-income earners will make the switch, and the cost of paying the rebate to existing privately insured taxpayers may exceed the gains from slightly reducing the numbers of people reliant on Medicare. If the rebate is large relative to the average cost imposed by individuals in Medicare, many could be expected to switch to private insurance; but the net gain from each person who leaves will be small and the fixed cost of the rebate to those already privately insured will be even larger than in the first case, thus again resulting in a net increase in the government's overall health budget. It is possible that there is *no* rebate capable of yielding a budgetary gain; and even if there is, the gain may be small. Indeed, the government itself has stated, in a Department of Health and Family Services press release of 20 August 1996, 'Financial

Incentives to Boost Private Health Insurance', that its primary aim is merely 'to arrest the decline' in private fund membership. This is not to say that the changes will be devoid of benefit: presumably the government is also motivated, to some extent, by a desire to mitigate the inequity involved in forcing those who are privately insured to contribute to the insurance of those who are not.

Actuarial Rating for Private Health Insurance

A more promising approach to reforming Australia's health insurance industry is to combine withdrawal of the community-rating requirement with a subsidy scheme for the purchase of health insurance.

Under actuarial rating,[2] insurers would be free to set different premiums for different sections of the population. People would be classified by various criteria such as age, sex, occupation, previous health experience — indeed, any criterion at all believed by the insurer to give some indication of the degree of health risk — and their premium levels determined accordingly.

Among existing members of private health funds, actuarial rating would raise premiums for high-risk groups and lower them for low-risk groups. Some members of the high-risk group could be expected to drop their existing cover, and rely instead on Medicare; this would *increase* the cost to taxpayers of Medicare. At the same time, some members of the low-risk group not presently insured would now choose to purchase private insurance, thus *reducing* the cost of Medicare. The net effect on the budget would depend on the relative numbers of 'movers' and differences in relative costs.

It seems quite likely that the costs of adding high-cost individuals to Medicare would outweigh the savings from shifting low-cost individuals to private insurance. High-risk individuals would have a strong incentive to drop private insurance, but low-risk individuals would have only a weak incentive to take it up, because unevenness in the distribution of risk means that the small high-risk group would see a large rise in their premiums, while the large low-risk group would see a relatively small fall in theirs. This is probably the major explanation for successive governments' reluctance to remove the community rating requirement. It would also help to explain support for this principle from the private health funds themselves: without it, they would lose market share to Medicare.

Targeting Health Insurance Subsidies

Supporters of community-rated insurance are troubled by the fact that, under actuarial rating, high-risk groups pay more than low-risk groups. Yet actuarial rating is not incompatible with the widely accepted view that high-risk groups should have their costs subsidised by low-risk groups. Actuarial rating can be combined with *direct subsidies to the high-risk groups*, sufficient to make health insurance readily affordable. Pre-

[2] For brevity's sake, the discussion that follows focuses mainly on hospital, as distinct from medical, cover. At present, the private funds are primarily concerned with the former.

sumably, however, low-risk individuals with low incomes should not be called on to subsidise high-risk, but high-income individuals. Any subsidies for gaining access to health insurance should be directed so as to benefit those who are both high health risks *and* relatively poor, and paid for by those who are both low health risks *and* relatively well off. Suppose, then, a subsidy were provided in the form of a tax rebate which increased both as the premium increased (to assist those with higher health risks) and as taxable income decreased (to assist those with low incomes). Much less tax revenue would be required to subsidise health care for those in real need than to subsidise everyone, as Medicare attempts to do.

Of course, even with the subsidy, there would still be the distorting influence of the option of staying in Medicare at the small cost of forgoing the tax rebate that would be available to those who opted out. To remove this distortion, Medicare would start charging for membership, in the same manner as private insurers, to cover actuarially estimated costs plus a margin of profit (that is, without relying on tax revenue). People who elected to stay with Medicare, of course, would receive the same subsidies, through tax rebates, as those who shifted to private insurers.

The financial details of a model of the proposed subsidy scheme are shown in Figures 1a and 1b.[3] The model is intended to illustrate the general principles only, and would need to be adjusted in the light of the full range of premiums determined by insurers, together with political judgments about a tolerable total outlay on the subsidy. Each curve in the diagrams shows the net (subsidised) premium paid for families with a given level of taxable income. Figure 1b is similar to Figure 1a, but focuses on annual premiums up to $5,000, which would account for a large majority of the population. Some figures are provided by way of illustration in Table 1.

Table 1

Net insurance premiums for selected combinations of family income and family gross insurance premiums ($ per annum)*

Gross family premium	*Taxable family income*				
	12,000	*18,000*	*25,000*	*35,000*	*50,000*
300	265	280	288	293	296
900	654	749	804	841	866
1,500	939	1132	1255	1345	1409
3,000	1,433	1,863	2,184	2,453	2,661
6,000	2,026	2,835	3,535	4,213	4,815
7,500	2,233	3,192	4,059	4,938	5,756
12,000	2,687	3,999	5,286	6,714	8,184

*Single individuals are treated as one-person 'families'.

[3] This is a more sophisticated version of a scheme initially proposed in McLeod (1987:45-50).

Figure 1a

Premiums & net premiums ($'000)

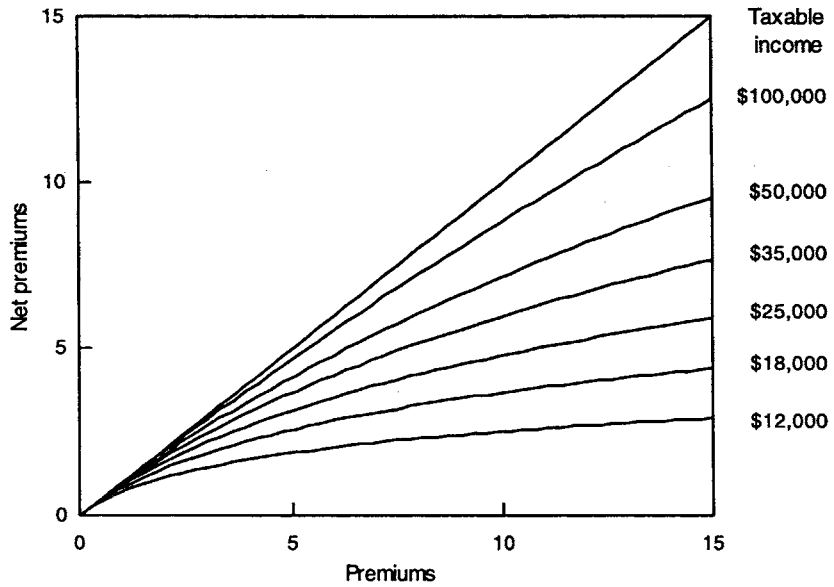
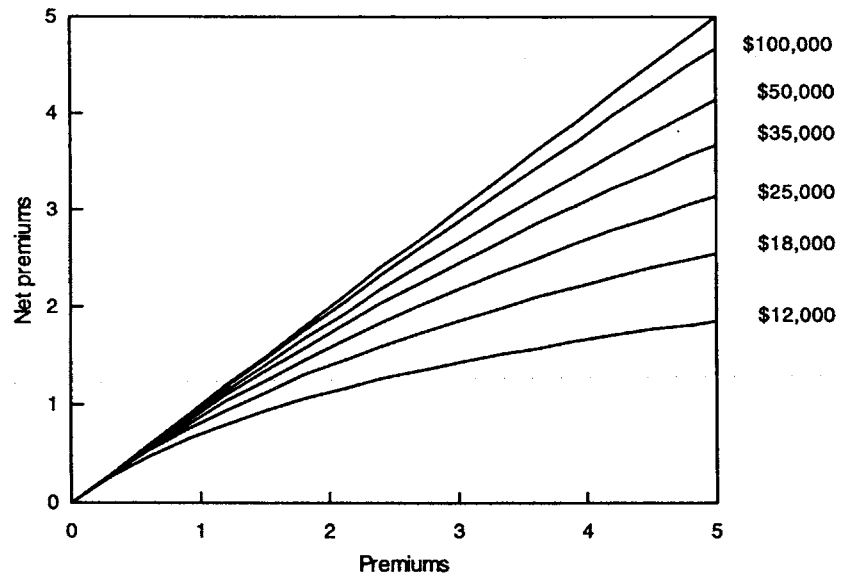


Figure 1b

Premiums & net premiums ($'000; detail)



The important characteristics of the model are as follows:

- The subsidy increases with increases in the premium (for a given income); people who are higher health risks receive higher subsidies. (The subsidy is the vertical distance between the curve and the diagonal line, along which the subsidy is zero.)

- The slope of each curve is always positive, indicating that the individual always has to pay at least some portion of any increase in the gross premium. This is important, in order to ensure that people have an incentive to shop around for the cheapest insurer and, conversely, that insurers have an incentive to keep their costs as low as possible.

- The subsidy decreases with increasing income (for a given premium); people with higher incomes receive lower subsidies.

- Although it is not apparent in the diagrams, the mathematical formulation of the subsidy is designed to ensure that the rate of decline of the subsidy as income increases is not so rapid as to remove or seriously diminish the incentive to earn additional income.[4] The disincentive effect of high marginal rates of income taxation, under which only a small proportion of each additional dollar of income earned is retained as disposable income, is well known. A problem with the present proposal (which is unavoidable, if the subsidy is to decline as income increases) is that it tends to increase the effective marginal rate of taxation: reducing the rate of subsidy as income increases has the same effect as increasing the marginal tax rate. But the addition to the marginal tax rate has been kept small, except for a very small proportion of the population who have very high health risks and very low incomes.

The subsidy scheme has been designed so that the net premium in no case exceeds an arbitrary limit of 25 per cent of taxable income. A lower or higher ceiling could be imposed, resulting in higher or lower tax revenue requirements; it would be sensible to adjust the ceiling in the light of experience with operating the scheme. It might also be necessary to set up different arrangements altogether for those who are both very poor and chronically ill, since insurance is not really the appropriate mechanism for financing health care in this circumstance. (It may be objected that everybody receives at least some subsidy, no matter how well off they may be. But the subsidy is paid for by taxation, and the wealthy pay far more tax than the poor. The relevant question, then, is the combined distributional impact of the income

[4] The net premium is given by

$$N = aY^b \ln\left[\frac{P}{aY^b} + 1\right],$$

where P is the gross insurance premium, and Y is taxable income. For the purpose of constructing Figures 1a and b, $a = 0.0002$ and $b = 1.65$.

tax and subsidy scheme taken together, not the impact of the subsidy scheme alone.)

Administrative Details

Payment of the health insurance subsidy would be administered through the existing income tax system. The subsidy takes the form of a tax rebate that either increases the end-of-year tax refund or reduces any additional tax payable. Alternatively, individuals could submit information to their employers regarding their outlays on basic insurance cover (as they do already in relation to dependants' allowances), and have the relevant subsidy amount credited against their normal PAYE deductions. Individuals who failed to produce evidence of insurance cover in their income tax returns would have to make an additional tax payment. The government would use the amounts collected to purchase insurance for the individuals concerned from Medicare or from private insurers, but the additional payment would be high enough to cover this expense as well as to impose a penalty that would provide an incentive to individuals to purchase insurance of their own accord.

The meaning of 'basic insurance cover' requires elaboration. Hospitals are in many respects akin to hotels: with both, individuals' preferences differ in relation to accommodation. Many are happy to be placed in a shared ward, others prefer a private ward using a shared bathroom, yet others would prefer their own room with extra thick carpet and *en suite* facilities. Profit-oriented hospitals can be expected to make available all standards of accommodation for which there is a demand at a price which will cover the cost of provision. But as the cost of different standards of accommodation ranges widely, health insurers would need to offer different levels of insurance cover appropriate to their contributors' diverse preferences for accommodation. The health insurance subsidy, however, like Medicare at present, is directed to the provision of a basic level of hospital accommodation consistent with effective treatment, but without non-essential frills.

Table 2

Hypothetical insurance premiums ($ per annum)

Risk category	*Premiums*			
	Basic rate	*One star*	*Two star*	*Three star*
Low	800	960	1,200	1,800
m1	1,500	1,900	2,200	3,000
m2	3,000	3,600	4,600	6,000
High	6,000	7,000	9,000	12,000

Many people, then, would want to purchase higher levels of cover. Their rebate would not be based on their actual insurance premium, however, but on what their premium would be if they were insuring at the basic level. This makes it necessary to require each insurer to inform the tax office of its schedule of charges, for each distinct risk group that it identifies, and for all levels of cover, including the basic level (a simplified hypothetical example is shown in Table 2). It would then periodically certify in respect of each of its contributors the risk category to which he or she belonged, the level of cover, and the actual premium paid. Thus, a contributor in risk category m2 would face a basic cover premium of $3,000 a year, but might choose 'two star' cover for $4,600. Nevertheless, her insurance subsidy would be based on the $3,000 figure (in combination with her taxable income).

Insurers could be expected to explore ways of increasing the size of the subsidy to their contributors, thereby attracting more business to themselves. One way would be to overstate the charge for basic cover. This could be detected by observing the level of demand for basic cover insurance (through an audit procedure): if there was little or none, the insurer could be considered to be not playing by the rules, and could be subjected to sanctions of some kind. It would not be feasible to falsely assign contributors to higher-risk categories, because the actual premiums paid and the level of cover purchased would have been certified and would be subject to audit checking.

The Proposals Summarised

Under these proposals, hospital insurance would be provided on a profit-oriented basis by the government, through Medicare, competing on equal terms with private insurers.[5] Both Medicare and private insurers would provide the basic standard of insurance plus higher levels of cover (for private ward accommodation, for example), in accordance with the demands of their contributors. But Medicare would be financed not from general tax revenue (as it is now), but from the flow of premium payments from its members.

Health insurance would be compulsory and therefore universal, but people would pay for it directly. The poor and those with high health risks would be protected by a safety net consisting of carefully targeted subsidies in the form of tax rebates. These subsidies would be administered not through Medicare but through the income tax system.

These proposals would make possible a significant reduction in both taxation and government expenditure. Commonwealth government outlays on health attributable to the Medicare system are of the order of $15 billion annually,[6] which suggests the size of potential tax savings from taking Medicare insurance (including

[5] Extension of the arguments above suggest that there is no reason why private insurers should not also compete for the medical insurance component of Medicare.

[6] This sum comprises $6.1 billion in medical benefits, $4.8 billion in Medicare Agreement financing to the States for public hospitals, and $3.9 billion in other hospital funding grants. These costs do not come close to being covered by the Medicare levy, which generates only about $4 billion annually.

the funding of public hospitals) out of the budget. If this amount were distributed over, say, 10m taxpayers, the cut in each individual's income tax could be around $1,500 (before allowing for the subsidy). Since people would now pay for health insurance directly, rather than indirectly through taxes, they could strongly influence the types and levels of insurance cover offered by virtue of their decisions as to what they bought, and from whom.

Under the proposed arrangements, Medicare would not be restricted to providing cover for treatment only at public hospitals. The public hospitals would be made to compete for patients by making them dependent for revenue on demand for their services that was no longer artificially boosted. There would then be no need for any distinction between public and private hospitals. On the contrary, the aim would be to get all hospitals to compete on equal terms, as in the case of Medicare and the private insurers. The impact on Telstra of forcing it to compete with Optus suggests that, in both cases, these would provide a significant stimulus to improvement.

The only health insurance burden on the taxpayer would be that needed to finance the subsidies to the relatively small proportion of the population who were both high health risks and poor. The government would still be in the business of operating hospitals and providing health insurance, but it would no longer have the competitive advantage of being able to offer something 'free' to the public by virtue of taxpayer support. If experience showed that it could not compete on a level playing field, of course, the next logical step would be privatisation.

Broken Promises?

If the present government were to implement these proposals, it would be accused of breaking its election promises to retain Medicare and community rating. It could justify breaking these promises, however, by arguing that it had retained the *essence* of Medicare, even though the system was being radically altered.

What then is the essence of Medicare, and how would the reform proposals preserve it?

- *Medicare ensures universal health cover. Everyone is assured of having access to medical and hospital care as needed, without facing the prospect of potentially crippling expenses.* The new scheme would be more genuinely universal, because it would get rid of waiting lists, and permit patient choice of doctor. It would be more efficient, because it would make use of all hospitals rather than only public hospitals, permitting greater patient freedom of choice in this respect also.

- *It provides free medical and hospital insurance, paid for out of general tax revenues.* Under the new scheme, individuals choose among Medicare and private insurers, and have to pay for the insurance cover chosen. In return, the income tax schedule (including the existing Medicare levy) is modified so as to generate significant tax reductions for all taxpayers.

- *It provides non-transparent cross-subsidies from the majority of the population who have low health risks to the minority who have high health risks, without regard to individual income levels.* The new scheme would also subsidise high health-risk individuals at the expense of low-risk individuals but, at the same time, would make the subsidies transparent, and modify them in accordance with differences in ability to pay.

Conclusion

Steadfast adherence to the inherently flawed community rating principle in health insurance has been responsible for an unending stream of policy interventions under successive governments, all intended to patch up the problems community rating causes. These have created a highly distorted and inefficient system of health care in Australia. The underlying aim may well have been to protect less fortunate members of the community, but this concern has not been matched by clear or creative thinking as to how best to achieve this objective. The most obvious symptom is the coexistence of long waiting lists for admission to public hospitals and excess capacity in private hospitals, but the recent proposal that newly trained doctors will not be given Medicare provider numbers will have the effect of causing an unconscionable wastage of these human resources to match the underutilisation of private sector infrastructure.

It is possible to design a system of health insurance subsidies which protects the least fortunate, but which at the same time minimises the need for tax revenues and an extensive health bureaucracy, and gives individuals freedom of choice in relation to levels of insurance, insurers, doctors and hospitals. Such a system, the broad outlines of which have been presented here, would be far more effective in providing the quality of health care people want, rather than what governments think they should have, and in bringing about considerable improvements in efficiency.

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