Private health care in Australia: why the government should intervene

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The 30 percent health insurance rebate is popular. Both major political parties are committed to it. However, merely pump priming health funds will not guarantee that essential private services remain available to relieve the pressures on public hospitals. It is time for a more interventionist role by government to ensure essential private hospital services remain affordable and accessible for vulnerable people.

The rebate was born in the context of winning a GST-charged national election. Its appeal was a handy counter to the wariness of a new tax. Along with income tax cuts, a discount on health insurance made the GST easier to swallow. Now it is entrenched in the electorate's psyche and too volatile to be tinkered with.

Its popularity goes beyond its cash back appeal. People are buying, or at least hoping to buy health cover because they want the assurance of access to hospitals. Regardless of whether they support the Medicare system, they still know the reality of public hospital waiting times, nursing shortages and overloaded services. The promise of Medicare has never been matched by government funds. On this point, state Labor and Liberal health ministers have been in unison. It is this reality which now finds the Federal ALP cautiously acquiescent about public subsidies for health insurance.

In short, both parties have accepted that private hospital services must be encouraged, not just tolerated. The capital investment, service coverage and supply benefits of private hospitals are indispensable to the health system. To this end, it is the ALP that has travelled the most.

Labor in government traditionally provided limp support to the private health industry. In the late 1980s they withdrew private hospital bed-day subsidies, along with public assistance to the reinsurance pool. These measures were counterproductive. They pushed up prices. Lower income people were alienated from private care and this placed further strain on the public sector.

The micro-economy of private health needed to be addressed. Insurers covered hospital costs plus any desired margin and made up their shortfall through increased contributor premiums. Medical fees above the Commonwealth schedule were paid directly by patients. The drivers of hospital and medical costs were the same as for the public sector: ageing patient profiles, new medical technology and greater utilisation of the services. There were no effective measures to restrain costs. Even the market disincentive of uninsured medical and hospital fees did not contain the situation. Consumers wanted direct relief from extra fees and the price of health cover.

This led both Labor and the Coalition to embrace micro-economic strategies to arrest the membership decline and contain costs in a bid to make private health care more attractive. In 1995, Dr Carmen Lawrence's insurance reforms created the legal framework whereby hospitals and health funds were obliged to negotiate case payment contracts. This was a deliberate attempt to make health insurers act more as proactive payers of services, rather than merely idemnifiers of costs. Thus the era of 'cost plus' payments to hospitals was replaced by a more exacting capitated payment based on workload. Efficiencies were found, but uninsured hospital and medical charges continued.

In 1997, Dr Michael Wooldridge continued the strategy but introduced means-tested insurance subsidies to lure members back to the funds. The insurance reforms had not at that stage revitalised the benefits of community rating for the funds. More than efficiency measures were needed. His strategy was based on making health funds financially sound and robust within the negotiated environment established by his predecessor. Even though hospital patient expenses were reduced, doctors' fees remained uninsured. Membership levels still faltered until the introduction of the 30 percent rebate and financial penalties for people choosing to join health funds later in life.

This tortuous history demonstrates that both sides of the federal parliament are set on empowering health funds to be the de facto health planners in the private sector. This begs the question over the future role for government in private health.

Intervention by public subsidy is justified if for no other reason than to ensure market failure is ameliorated. However, whether it is the Coalition or the ALP, a subsidy should be accompanied by greater government involvement incorporating a stringent focus on the delivery rather than the insurance end of private hospital care.

Health care is far more than another commercial commodity that can maximise return on investment. It is a social good. As such, it forms part of the social fabric to which all citizens, regardless of circumstances, can lay claim by virtue of the fact that they are members of the community. Rather than being exploited for profit, health services should be available to enhance the dignity of people. This does not discount the fact that non-government owned services must be commercially sound, but it does distinguish between the health care interests of a community and the investment concerns of shareholders.

Given the massive public investment through the medical and pharmaceutical benefits schedules and now the health insurance rebate, the notion that the private health sector is somehow beyond government participation is false. Whereas a truly private health sector would be deregulated, open to market strategies and free enterprise gains, private hospital care is now heavily government-subsidised. This market increasingly determines services on the basis of their profitability rather than their health benefits for local communities.

This reveals the dilemma for both major parties. Supporting insurance rather than health services will not manage the pressure points in the delivery system. Taking a 'hands off' approach and placing faith in the evolving market of private health insurance will only skew benefits in favour of the fit and well off.

Already the private health system demonstrates a stark divide between the 'winners' and 'losers'. A close look at the investment strategy of the listed health companies shows a heavy concentration on high-technology surgical services. It is here that maximum returns are made on investment. Very few of the for-profit companies place major effort in the medical end of the hospital market. Often these services are expensive, unpredictable in length of stay and needed by patients with complicated conditions. This is a recipe for low or no return on investment. Inadequate health fund benefits only exacerbate the situation.

In most instances, hospitals are paid more to provide orthopaedic, ophthalmological and cardiac services than for those such as oncology. Little wonder these lucrative niches are keenly sought. As more insured people become eligible to use their benefits, the incentive to capture their patronage will intensify.

The capacity of the private sector then becomes problematic. The new health fund members will pressure for quick access to private services. Queue jumping (avoidance of public hospital waiting lists) has always been the main marketing strategy of the funds. New members will want the rhetoric delivered. However, since hospital benefits are disproportionately applied across hospital services, the likelihood that adequate medical, rehabilitation and extended care services will remain in the private sector is uncertain.

This is not new to casemix-based funding systems. Extended care, co-morbidities and medically based acute treatments have proved difficult in a casemix environment. When profitability is added to the scenario, cases where the hospital carries unpredictable financial risk become more commercially precarious.

This is the area of market failure in which the government must move. It basically has two options - to become a direct purchaser of hospital services or to regulate prices for specific services.

Since many of the areas of market failure can be associated with elderly people suffering chronic or complicated conditions, there is a strong case for the Commonwealth to subsidise their hospital stay. This would compensate for the inadequate health fund benefits paid for these services. It would also contain any shift back to the public sector by people needing more complex and extended hospitalisation.

When the Commonwealth government sought to purchase private hospital beds for public patients in the past, it was stridently opposed by medical specialists and health funds. They argued such a scheme would undermine the attractiveness of health insurance. Yet a similar program run for veterans has been very successful.

Consequently, the Commonwealth government could limit its purchasing plan to people over 70 years of age. It could increase its subsidy for all insured persons over 70 and pay for it by means-testing the 30 per cent rebate for younger contributors. In this way, not only will elderly people be given more certainty, but also the public subsidy will actually purchase a health service rather than just an insurance product.

In the shorter term, both political parties are committed to avoiding means testing of the subsidy. Ultimately the federal budget pressures will force their hands. However, there is still room to move. Already health funds are obliged to pay hospitals a default benefit for services received by fund members when the hospital and the fund are out of contract. This was meant to be a safety net payment, particularly to cover emergencies. It is very ineffective as a negotiating tool, but it sets a precedent of price fixing. The health funds pay a prescribed benefit regardless.

Governments could use a similar mechanism to ensure that essential services for the elderly and chronically ill remain in the private sector. A legislated schedule of services with commercially viable benefits could be a fallback in cases where negotiated contracts fail to cover the real costs of care. This would be a less satisfactory approach than the direct purchasing option, but at least it would ensure that a level of security was in place for frail and elderly patients. To remain consistent with the policy direction, the industry should periodically review benefit levels. A competitive edge can remain where those hospitals and funds that particularly wish to specialise in chronic care services can negotiate better than schedule benefits.

The 30 per cent health insurance rebate has raised many impassioned responses. For the near future it will remain part of the private health landscape. It also gives the government an opportunity to temper the market in the interests of its frailest and sickest patients.