

## REGULATION, PRIVATE HEALTH INSURANCE, AND THE AUSTRALIAN HEALTH SYSTEM

*Fiona McDonald & Stephen Duckett\**

In the 40 years since the introduction of universal public health insurance in Australia, there has been an ongoing political debate about the design of the Australian health care system, particularly about the appropriate role of the private sector in the funding and provision of health services. Australian governments have erected a regulatory framework that encourages Australians to purchase private health insurance (PHI). This framework is based on the belief that PHI is an essential element of a balanced two-tier health care system that is funded and provided by public and private actors. This article has three aims: (1) to critically examine the complex regulatory framework that has been created to encourage Australians to purchase PHI, (2) to critically examine some of the impacts of this regulatory framework, and (3) to provide information for other countries about the costs and consequences of government promoting PHI. Reviews have indicated concerns as to whether the framework achieves its stated ends, about acceptability to purchasers, and about whether the system as it currently

Durant les 40 ans depuis l'introduction de l'assurance santé publique universelle en Australie, il y a eu un débat politique continu sur la conception du système de soins de santé australien, particulièrement concernant le rôle approprié du secteur privé dans le financement et la fourniture des services de santé. Les gouvernements australiens ont érigé un cadre réglementaire qui encourage les Australiens à acheter une assurance santé privée (ASP). Ce cadre est fondé sur la croyance que l'ASP est un élément essentiel d'un système de soins de santé à deux niveaux équilibré qui est financé et fourni par des acteurs publics et privés. Cet article a trois objectifs : (1) d'examiner de façon critique le cadre réglementaire complexe qui a été créé pour encourager les Australiens à acheter une ASP, (2) d'examiner de façon critique quelques-uns des impacts de ce cadre réglementaire, et (3) de fournir de l'information aux autres pays sur les coûts et les conséquences pour les gouvernements de promouvoir l'ASP. Les critiques ont signalé des inquiétudes quant à savoir si le cadre atteint ses fins déclarées,

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stands is sustainable. This analysis indicates some of the issues in respect of the regulation of PHI that will have implications for countries contemplating intervening in PHI markets.

concernant l'acceptabilité aux payeurs et quant à savoir si le système tel qu'établi est durable. Cette analyse indique quelques-uns des problèmes quant à la réglementation de l'ASP qui auront des implications pour des pays contemplant intervenir dans les marchés d'ASP.

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## INTRODUCTION

On an international level, arguments continue about whether some, or all, health services should be (1) solely publicly funded and delivered in a public system, (2) funded and delivered by a mix of public and private funders/providers, or (3) privately funded and supported by a public safety net.<sup>1</sup> There are three broad approaches. The first is that public and private funding are complementary: that private funding is only allowed for services not covered by public funding. This is the predominant model in Canada,<sup>2</sup> where private funding is restricted to cosmetic procedures, pharmaceuticals bought outside hospitals, and certain other services. In this model, private funding could be used to pay for additional amenities in publicly funded hospitals or for services not covered by the public sector,<sup>3</sup> such as robotic surgery or certain genetic tests. The European/Bismarckian social insurance model also follows this approach.<sup>4</sup> The underlying principle is that

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<sup>1</sup> See e.g. Carolyn J Tuohy, Colleen M Flood & Mark Stabile, “How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations” (2004) 29:3 J Health Pol Pol’y & L 359 at 360–61 [Tuohy, Flood & Stabile, “Private Finance”]; Colleen M Flood, Mark Stabile & Carolyn Hughes Tuohy, “The Borders of Solidarity: How Countries Determine the Public/Private Mix in Spending and the Impact on Health Care” (2002) 12:2 Health Matrix 297 at 351–53 [Flood, Stabile & Tuohy, “Borders of Solidarity”]; Jeffrey Simpson, *Chronic Condition: Why Canada’s Health-Care System Needs to be Dragged into the 21st Century* (Toronto: Penguin Canada, 2012) at 224–29; Lauren Vogel, “Medicare on Trial”, News, (2014) 186:12 CMAJ 901; Colleen Fuller, “Cambio Corp. Goes to Court: The Legal Assault on Universal Health Care” (2015) Canadian Centre for Policy Alternatives at 11–13, online: <[www.policyalternatives.ca/publications/reports/cambio-corp-goes-court](http://www.policyalternatives.ca/publications/reports/cambio-corp-goes-court)>.

<sup>2</sup> See e.g. Colleen M Flood & Tom Archibald, “The Illegality of Private Health Care in Canada” (2001) 164:6 CMAJ 825 at 828–29; Flood, Stabile & Tuohy, “Borders of Solidarity”, *supra* note 1 at 300–01; William Lahey, “Medicare and the Law: Contours of an Evolving Relationship” in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: LexisNexis Canada, 2011) 1 at 46; *Canada Health Act*, RSC 1985, c C-6, ss 2, 9.

<sup>3</sup> See Lahey, *supra* note 2 at 39.

<sup>4</sup> See e.g. Colleen Flood, Mark Stabile & Carolyn Tuohy, “Seeking the Grail: Financing for Quality, Accessibility, and Sustainability in the Health Care System” in Colleen M Flood, Mark Stabile & Carolyn Tuohy, eds, *Exploring So-*

all people are entitled to a given level of services that aim to achieve the same outcomes, and that private funding cannot, or should not, be used to obtain better or quicker outcomes.<sup>5</sup> It is possible for privately operated services to function within a complementary model, either under contract to the public funder or by providing services that are not covered by public funding. For example, a privately owned hospital (such as an incorporated religious institution) might contract with a provincial government to provide public hospital services. A critique of this model, which was expressed in *Chaoulli v Québec (AG)*,<sup>6</sup> is that government should not prevent its citizens from purchasing private medical care if the government cannot provide acceptable and timely access through the public system.<sup>7</sup>

The second broad approach is that public and private funding can, and should, overlap – that the core health services can be funded and delivered either publicly or privately as a two-tier system. For example, the Australian health care system has overlapping public and private funding and service provision. There are a number of arguments that are made to support this approach. For instance, it is argued that a private system may allow enhanced consumer “choice”<sup>8</sup> and that private funding will offer speedier access than public service provision.<sup>9</sup> It is sometimes also claimed that private

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*cial Insurance: Can a Dose of Europe Cure Canadian Health Care Finance?* (Montréal: McGill-Queen’s University Press, 2008) 1 at 2–3.

<sup>5</sup> See Lahey, *supra* note 2 at 37; Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa: Health Canada, 2002) at 14, 48, online: Government of Canada <[www.publications.gc.ca/site/eng/237274/publication.html](http://www.publications.gc.ca/site/eng/237274/publication.html)>.

<sup>6</sup> 2005 SCC 35, [2005] 1 SCR 791 [*Chaoulli*].

<sup>7</sup> *Ibid* at paras 123–24. See also Lahey, *supra* note 2 at 55.

<sup>8</sup> See e.g. Ian McAuley, “Private Health Insurance and Public Policy” (Paper delivered at the 2016 Health Insurance Summit in Sydney, 28 July 2016) at 7 [unpublished], online: <<https://cpd.org.au/wp-content/uploads/2016/07/PHI-conference-July-2016.pdf>> [McAuley, “Public Policy”]; Aafke Victoor et al, “Determinants of Patient Choice of Healthcare Providers: A Scoping Review” (2012) 12 BMC Health Serv Res 272 at 273; Omar Paccagnella, Vincenzo Rebba & Guglielmo Weber, “Voluntary Private Health Insurance Among the Over 50s in Europe” (2013) 22 Health Econ 289 at 298.

<sup>9</sup> See e.g. Austl, Commonwealth, Department of Health, “Issues for Consideration at Roundtables on Private Health Insurance - November 2015” (13 November 2015), online: <[www.health.gov.au/internet/main/publishing.nsf/](http://www.health.gov.au/internet/main/publishing.nsf/)>

hospitals are more efficient than public hospitals, but the evidence for this claim is weak.<sup>10</sup> Some might believe that private funding could substitute for public funding in that an increase in private funding would reduce the need for public funding.<sup>11</sup> A question may then arise as to whether government should (1) tacitly accept a market for the private funding or delivery of health services<sup>12</sup> or (2) actively try and facilitate, or enable, the growth and continuance of a “strong” or “significant” market for private funding and/or private provision of health services.<sup>13</sup> The Australian government has chosen the latter approach. The overlapping model, particularly the variant where government actively intervenes to support a system for private funding and/or service provision, may raise a series of critical questions about fiscal sustainability, such as whether private financing for private service provision reduces demand on the public system or siphons resources from the public system.<sup>14</sup>

The third broad approach is a preference for a private health insurance (PHI) market to fund the access of individuals to health services, depending on the terms and conditions of their policy. This is the approach that has been adopted in the United States. The government’s role is to provide a

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Content/healthcare-provider-roundtable> [Department of Health, “Issues for Consideration”].

- <sup>10</sup> See e.g. Yauheniya Varabyova & Jonas Schreyögg, “International Comparisons of the Technical Efficiency of the Hospital Sector: Panel Data Analysis of OECD Countries Using Parametric and Non-Parametric Approaches” (2013) 112 *Health Policy* 70 at 77. See also Sanjay Basu et al, “Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review” (2012) 9:6 *PLoS Med* at 10.
- <sup>11</sup> See e.g. Stephen J Duckett & Terri J Jackson, “The New Health Insurance Rebate: An Inefficient Way of Assisting Public Hospitals” (2000) 172:9 *Med J Austr* 439; McAuley, “Public Policy” *supra* note 8 at 5–6.
- <sup>12</sup> This is the case in New Zealand, where the government has chosen not to regulate the private health sector or provide tax rebates to incentivize the purchase of private health insurance. See Jacqueline Cumming et al, “New Zealand: Health System Review” (2014) 4:2 *Health Syst Transit* 1 at 80–81.
- <sup>13</sup> In the United Kingdom, for example, the National Health Service is increasingly commissioning services to the private sector. See Séan Boyle, “United Kingdom (England): Health System Review” (2011) 13:1 *Health Syst Transit* at 113.
- <sup>14</sup> See Tuohy, Flood & Stabile, “Private Finance”, *supra* note 1 at 391.

safety net to support those who cannot afford to access the PHI market, those for whom the market will not or may not provide insurance coverage, or groups for whom the government has a special responsibility, such as indigenous peoples or military veterans.<sup>15</sup> This model has been extensively critiqued on a number of grounds: it has been considered to be inequitable, to be inefficient, and, on the aggregate, to result in poorer health outcomes.<sup>16</sup>

This article focuses on the second approach. Australia has a two-tier public and private health care system. Australia is unique amongst OECD countries in the extent to which successive federal (Commonwealth of Australia) governments have used their legislative powers, pursuant to the Australian *Constitution*, to enact a comprehensive regulatory framework that encourages citizens to purchase PHI.<sup>17</sup> The government has done this by enacting a series of inducements and penalties designed to persuade people to purchase and renew PHI. Purchase is not mandatory. This article examines how Australian federal governments have used their regulatory powers to encourage the take-up of PHI and, through this, to support the continuance of a strong private sector within the larger two-tier system. This article moreover assesses whether the PHI regulatory framework achieves its policy aims, whether the public perceives this framework as legitimate, and whether it is sustainable. A number of other issues also warrant an-

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<sup>15</sup> See Thomas Rice et al, "United States of America: Health System Review" (2013) 15:3 Health Syst Transit 1 at 31, 44.

<sup>16</sup> See e.g. Karen Davis et al, "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally" (2014) The Commonwealth Fund at 8–9, online: <[www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror](http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror)>; Gerard F Anderson & Bianca K Frogner, "Health Spending In OECD Countries: Obtaining Value Per Dollar" (2008) 27:6 Health Aff 1718 at 1725–26; Ellen Nolte & C Martin McKee, "Measuring the Health of Nations: Updating an Earlier Analysis" (2008) 27:1 Health Aff 58 at 69; Cathy Schoen et al, "U.S. Health System Performance: A National Scorecard", online: (2006) 25:6 Health Aff w457 <[content.healthaffairs.org/content/25/6/w457](http://content.healthaffairs.org/content/25/6/w457)>.

<sup>17</sup> See generally Adrian Kay, "Tense Layering and Synthetic Policy Paradigms: The Politics of Health Insurance in Australia" (2007) 42:4 Australian J Political Science 579 (for an analysis of the reintroduction of financial subsidy to support private health insurance [PHI] in Australia); Jane Hall, Richard de Abreu Lourenco & Rosalie Viney, "Carrots and Sticks: The Fall and Fall of Private Health Insurance in Australia", Guest Editorial, (1999) 8:8 Health Economics 653 at 655.

alysis, such as equity, but these are not the focus of this article. This analysis can provide valuable lessons for other countries that are considering systemic reforms to the funding, organization, and regulation of their health care systems and/or are considering creating or intervening in their PHI markets.<sup>18</sup>

This article has three aims: (1) to critically examine the complex regulatory framework that has been created to encourage Australians to purchase PHI, (2) to critically examine some of the impacts of this regulatory framework, (3) and to provide information for other countries about the costs and consequences of the government promoting PHI. In the first Part of this article, we provide a brief overview of Australia's two-tier health care system. In the second Part of the article, we discuss the elements of the regulatory framework designed to "encourage" Australians to purchase PHI. In the last Part, we examine some of the impacts of that framework, noting that there are concerns as to whether the framework achieves its stated ends, whether some PHI products are acceptable to purchasers, and whether the system is sustainable. We conclude with an assessment of the implications for other nations who are examining the role of PHI in health care delivery.

## I. THE AUSTRALIAN HEALTH CARE SYSTEM

Strong opposition to the creation and maintenance of a publicly funded universal health care system has long been a feature of the Australian political landscape at the federal level.<sup>19</sup> Traditionally, the conservative (to the

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<sup>18</sup> See generally Flood, Stabile & Tuohy, "Borders of Solidarity", *supra* note 1.

<sup>19</sup> The Australian Medical Association and many members of the medical profession have shared this opposition, as they see their interests as being "best served by a free enterprise, private practice, fee-for-service model" (George Palmer & Stephanie Short, *Health Care and Public Policy: An Australian Analysis*, 5th ed (South Yarra: Palgrave Macmillan, 2014) at 74). Also opposed were, unsurprisingly, the PHI industry and the private hospitals. See e.g. Stephen Duckett & Sharon Willcox, *The Australian Health Care System*, 5th ed (South Melbourne: Oxford University Press, 2015); Fran Collyer, Kirsten Harley & Stephanie Short, "Money and Markets in Australia's Healthcare System" in Gabrielle Meagher & Susan Goodwin, eds, *Markets, Rights and Power in Australian Social Policy* (Sydney: Sydney University Press, 2015) 257 at 260–61; RB Scotton & CR Macdonald, *The Making of Medibank* (Sydney: School of Health Services Management, University of New South Wales, 1993);

right on the political spectrum) Coalition (the Liberal and National political parties) were strongly committed to a United States style model, where the private sector should provide health services funded by individuals through the purchase of PHI and governments should only provide social safety nets.<sup>20</sup> Historically, the Labor party (to the left on the political spectrum) has supported the development of a publicly funded and delivered health care system (where a parallel private system is allowed) based on an equality argument.<sup>21</sup>

In 1943, the federal (Labor) government sought to introduce a program to subsidize pharmaceuticals.<sup>22</sup> A constitutional referendum in 1946 gave the federal government the power to enact legislation about “pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription)”<sup>23</sup> and in 1948 the Labor government implemented a national pharmaceutical benefits scheme for the universal public subsidy of approved medications.<sup>24</sup> From 1949 to 1960, the

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Anne-marie Boxall & James A Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia* (Sydney: NewSouth Publishing, University of New South Wales Press, 2013); Stephen Duckett, “The Continuing Contest of Values in the Australian Health Care System” in AP den Exter, ed, *International Health Law: Solidarity and Justice in Health Care* (Antwerp, Belg: Maklu, 2008) 177 at 190 [Duckett, “Contest”].

<sup>20</sup> See Michael RL Wooldridge, *Health Policy in the Fraser Years: 1975–83* (MBA Thesis, Monash University Faculty of Economics and Politics, 1991) [unpublished] at 5 [Wooldridge, *Health Policy*]; JA Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910–1960* (Cambridge: Cambridge University Press, 1991) at 253–54.

<sup>21</sup> See E Gough Whitlam, “The Alternative Health Programme” (1968) 3:4 Australian J Social Issues 33. See generally Duckett, “Contest”, *supra* note 19.

<sup>22</sup> See Fiona McDonald & Deanna Sedgwick, “The Legal Framework of the Australian Health System” in Ben White, Fiona McDonald & Lindy Willmott, eds, *Health Law in Australia*, 2nd ed (Sydney: Thomson, 2014) 69 at 73.

<sup>23</sup> *Commonwealth of Australia Constitution Act 1900* (Cth), s 51(xxiiiA); *Constitution Alteration (Social Services) 1946*, 28 Sept 1946, online: Parliament of Australia <parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22handbook%2Fnewhandbook%2F2014-10-31%2F0049%22>.

<sup>24</sup> See *Pharmaceutical Benefits Act 1947* (Cth), as repealed by *National Health Act 1953* (Cth), ss 7–8. See also Clyde Sloan, *A History of the Pharmaceutical*



Coalition government (the Liberal and National Parties who are in permanent coalition) maintained a modified safety net model that provided free access to selected pharmaceuticals.<sup>25</sup> The model also granted funding for hospitals to provide safety net services to classes of patients who would be otherwise unable to access health care, and subsidized PHI.<sup>26</sup> Kay has argued that PHI subsidies created a vested interest for the Coalition in a multi-payer financing structure.<sup>27</sup> The Coalition government's approach was extensively criticized on a number of grounds, but most critiques focused on equity and complexity.<sup>28</sup>

A federal Labor government was elected in 1972 promising to create a universal, compulsory, national health insurance scheme (Medibank, a publicly funded health care system). After the dissolution of both Houses of Parliament, a federal election, and a joint sitting of both Houses of Parliament,<sup>29</sup> the *Health Insurance Act 1973 (HI Act)* was enacted.<sup>30</sup> The *HI Act* established a national, government administered, health insurance program for medical services to be funded from taxation revenue on a fee-for-service model. Using its powers under section 96 of the *Constitution* (the making of conditional grants to the states) the federal government, by agreement with the states and territories, also negotiated the provision of public hospital services without direct patient payment (free public hospital care), including outpatient medical care.<sup>31</sup> People could still choose, if they

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*Benefits Scheme: 1947–1992* (Canberra: Commonwealth Department of Human Services and Health, 1995) at 2–3.

<sup>25</sup> See Duckett & Willcox, *supra* note 19 at 304.

<sup>26</sup> See TH Kewley, *Social Security in Australia 1900–72*, 2nd ed (Sydney: Sydney University Press, 1973) at 355–59; Luke B Connelly et al, “Risk Equalisation and Voluntary Health Insurance Markets: The Case of Australia” (2010) 98:1 Health Policy 3 at 4; Collyer, Harley & Short, *supra* note 19 at 261.

<sup>27</sup> *Supra* note 17 at 582–83.

<sup>28</sup> See Duckett & Willcox, *supra* note 19 at 361–64; Kewley, *supra* note 26 at 504.

<sup>29</sup> See Duckett & Willcox, *supra* note 19 at 361–64.

<sup>30</sup> (Cth) [*HI Act*].

<sup>31</sup> This was most recently done through the Council of Australian Governments: Austl, Commonwealth, Council of Australian Governments, *National Healthcare Agreement 2012: Intergovernmental Agreement on Federal Financial*

could afford it, to purchase PHI and/or to be treated privately by specialists or in private hospitals. In 1975, a newly elected Coalition government began to dismantle Medibank, and it ceased being universal in 1981.<sup>32</sup>

The election of a Labor government in 1983 saw the reintroduction of a national insurance scheme (it was renamed Medicare).<sup>33</sup> Medicare is universal, compulsory, and funded by taxpayers through general taxation revenue and a specific tax (a means-tested Medicare levy currently at 2% of taxable income).<sup>34</sup> It is administered by a federal government agency based on a fee-for-service structure for general medical services<sup>35</sup> and, more recently, for services prescribed by midwives or nurse practitioners<sup>36</sup> and

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*Relations* (Canberra: COAG, 2012), online: Council on Federal Financial Relations <[www.federalfinancialrelations.gov.au/content/npa/health/\\_archive/healthcare\\_national-agreement.pdf](http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/healthcare_national-agreement.pdf)> [COAG, *NHA 2012*], as amended by Austl, Commonwealth, Council of Australian Governments, *Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding* (Canberra: COAG, 2016), online: <[https://www.coag.gov.au/sites/default/files/agreements/Heads\\_of\\_Agreement\\_between\\_the\\_Commonwealth\\_and\\_the\\_States\\_on\\_Public\\_Hospital\\_Funding-1April2016.pdf](https://www.coag.gov.au/sites/default/files/agreements/Heads_of_Agreement_between_the_Commonwealth_and_the_States_on_Public_Hospital_Funding-1April2016.pdf)> [COAG, *Agreement on Public Hospital Funding*].

<sup>32</sup> See *Health Acts Amendment Act 1981* (Cth), s 8. See also SJ Duckett, “Chopping and Changing Medibank: Part 1 – Implementation of a New Policy” (1979) 14:3 *Australian J Social Issues* 230 at 235, 237.

<sup>33</sup> See *Health Legislation Amendment Act 1983* (Cth). See also Palmer & Short, *supra* note 19 at 67.

<sup>34</sup> The levy initially began in 1984 at 1% (*Medicare Levy Act 1984* (Cth), s 6(1)). It was increased to 1.25% in 1986 (*Medicare Levy Act 1986* (Cth), s 11(3)(a)), to 1.4% in 1992 (*Medicare Levy Amendment Act No. 2 1992* (Cth), s 3), to 1.5% in 1995 (*Medicare Levy Amendment Act 1995* (Cth), Schedule 2, ss 1, 7), to 1.7% from 1997–1998 to cover the cost of the gun buyback (*Medicare Levy Amendment Act 1996* (Cth), Schedule 1, ss 1, 3), and in July 2014 it rose to 2% to partially offset the cost of the newly introduced *National Disability Insurance Scheme* (*Medicare Levy Amendment [DisabilityCare Australia] Act 2013* (Cth), Schedule 1, ss 1–3).

<sup>35</sup> See *HI Act*, *supra* note 30, s 4.

<sup>36</sup> See *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010* (Cth), amending the *HI Act*, *supra* note 30.

for some mental health services.<sup>37</sup> Public hospitals, and some other services and programs, are provided to the public for free, pursuant to the Medicare program and the *Agreement on Public Hospital Funding*,<sup>38</sup> which were negotiated between the federal government and the states and territories under the federal government's section 96 constitutional powers to make conditional grants to the states.<sup>39</sup> Included in these services are, for example, outpatient specialist clinics run by private hospitals. The Medicare system and the funding agreements for hospitals fund what might be described as "medically necessary services." They do not fund services such as cosmetic surgery, medical examinations for the purpose of obtaining life insurance, and so on. Doctors, or other providers, with a Medicare billing number (including those who are providing for-profit private services) may bulk bill the government directly for the Medicare scheduled fee, or they may bill the patient directly. If they bill the patient, they may charge more than the scheduled fee. The patient then seeks a refund from the government, and the patient either pays the gap fee from their own pocket or, if their policy covers this, their PHI may pay some or all of the difference. In the 2015 financial year (July 2015 to June 2016), 78.2% of all Medicare scheduled services were bulk billed.<sup>40</sup> However, while 85.1% of general practitioner (i.e., family doctor) consultations were bulk-billed, the levels of bulk billing for private specialists, obstetrics, and surgery were lower at 30.2%, 53.1%,

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<sup>37</sup> See generally Ian Hickie & Grace Groom, "Primary Care-Led Mental Health Service Reform: An Outline of the *Better Outcomes in Mental Health Care Initiative*" (2002) 10:4 *Australas Psychiatry* 376 at 379; Bridget Bassilios et al, "Achievements of the Australian Access to Allied Psychological Services (ATAPS) Program: Summarising (Almost) a Decade of Key Evaluation Data" (2016) 10:61 *Int J Ment Health Syst* 1 at 2.

<sup>38</sup> COAG, *NHA 2012*, *supra* note 31; COAG, *Agreement on Public Hospital Funding*, *supra* note 31 at 2.

<sup>39</sup> Hospital funding has been subject to a round of reforms, most notably in 2011. See Duckett & Willcox, *supra* note 19 at 124–26; McDonald & Sedgwick, *supra* note 22 at 77–78.

<sup>40</sup> See Austl, Commonwealth, Medicare Australia, "Quarterly Medicare Statistics" (Canberra: MA, 2015) at Table 1.1a, online: Department of Health <[www.health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics](http://www.health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics)>.

and 42.2%.<sup>41</sup> If a service was not bulk-billed, patients had an average out-of-pocket cost of AUD\$58 per item.<sup>42</sup> Across all components of the fee schedule in 2015, approximately 19% of services were billed above the Medicare schedule fee.<sup>43</sup>

## II. STRUCTURE OF THE PRIVATE HEALTH INSURANCE REGULATORY FRAMEWORK

But what of PHI and private health care? Prior to the introduction of Medicare in 1983, PHI offered two distinct products: insurance against the cost of treatment in public hospitals and, for a higher premium, in private hospitals.<sup>44</sup> With the introduction of Medicare the first product became otiose. Figure 1 shows the significant reduction in those holding basic coverage for public hospital care after the introduction of Medicare in 1983. PHI uptake for private hospital coverage also began to decline (see Figure 1), especially during the early 1990s when Australia was in recession.<sup>45</sup> Between 1983 and 1996 the Labor government passively allowed PHI to decline.<sup>46</sup>

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<sup>41</sup> *Ibid.*

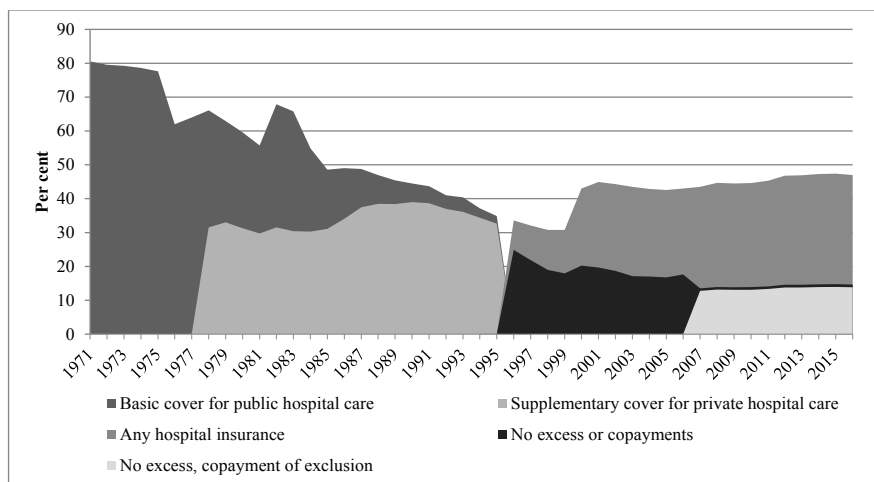
<sup>42</sup> *Ibid.*

<sup>43</sup> *Ibid.*

<sup>44</sup> There were many offerings, for example single room accommodation in public hospitals. A review of insurance arrangements in 1969 found the offerings “unnecessarily complex and beyond the comprehension of many” (Austl, *Health Insurance: Report of the Commonwealth Committee of Enquiry* by JA Nimmo (Canberra: Commonwealth Government Printing Office, 1969) at 9).

<sup>45</sup> See Sharon Willcox, “Promoting Private Health Insurance in Australia” (2001) 20:3 *Health Aff* 152 at 155–56; Ian McAuley, “Private Health Insurance: Still Muddling Through” (2005) 12:2 *Agenda* 159 at 159–60 [McAuley, “Muddling Through”]; Francesca Colombo & Nicole Tapay, “Private Health Insurance in Australia: A Case Study” (2003) OECD Health Working Paper No 8 at para 16; Palmer & Short, *supra* note 19 at 70–71. See also Duckett & Willcox, *supra* note 19 at 80; Collyer, Harley & Short, *supra* note 19 at 263. As to the impact of the recession, see Casey Quinn, “The Pasts and Futures of Private Health Insurance in Australia” (2002) National Centre for Epidemiology and Population Health Working Paper No 47 at 9.

<sup>46</sup> See Duckett & Willcox, *supra* note 19 at 80.

**FIGURE 1. PERCENTAGE OF POPULATION WITH PRIVATE HEALTH INSURANCE, AUSTRALIA, 1971–2016<sup>47</sup>**

In 1996, the Coalition parties acknowledged the political reality that public support for Medicare was so strong that they needed to support the continuance of a universal national publicly funded health care system.<sup>48</sup> However, the Coalition parties continued to believe that PHI to enable access to private health care is an essential element of a balanced two-tier (public and private) health care system. A two-tier health care system in this view is, and should be, funded and provided by public and private actors.<sup>49</sup>

<sup>47</sup> Data sourced from Duckett & Willcox, *supra* note 19, Figure 3.14 and updated with data from Austli, Commonwealth, Australian Prudential Regulatory Authority, *Statistics: Private Health Insurance Membership and Benefits* (Sydney: APRA, 2017), online: <[www.apra.gov.au/PHI/Publications/Documents/1708-MemBens-20170630.pdf](http://www.apra.gov.au/PHI/Publications/Documents/1708-MemBens-20170630.pdf)>.

<sup>48</sup> The Coalition is comprised of the National and Liberal parties. The then-Health Minister Wooldridge had studied health policy under the previous Liberal government and had identified the strong public support for Medicare as one reason the Liberals lost elections against Labor in the ensuing period. See Palmer & Short, *supra* note 19. See also Collyer, Harley & Short, *supra* note 19 at 263–64. The current Coalition government, headed by Malcolm Turnbull, has stated that Medicare “is a core Government service” (Jane Norman, “Election 2016: Malcolm Turnbull Says ‘Every Element’ of Medicare Will Stay in Government Hands”, *ABC News* (18 June 2016), online: <[www.abc.net.au/news/2016-06-18/medicare-will-never-be-privatised,-turnbull-says/7523242](http://www.abc.net.au/news/2016-06-18/medicare-will-never-be-privatised,-turnbull-says/7523242)>).

<sup>49</sup> See Willcox, *supra* note 45 at 152.

The former Coalition Prime Minister, Tony Abbott, proudly proclaimed in 2012, while in opposition, that support for PHI was “in the DNA” of the Coalition.<sup>50</sup> Kay argues that the Coalition’s platform is in part based on a legacy effect of supporting PHI in preference to what was seen as a socialized health care system supported by Labor. The Coalition traditionally has had deep ties with the PHI industry and the Australian Medical Association (formerly the British Medical Association) (a group deeply opposed to “socialized” medicine and state control over doctors’ fees).<sup>51</sup> McAuley also argues that the Coalition is driven by “‘private sector primacy’ – a belief that if a function *can* be provided in the private sector, even if it could be provided more efficiently in the public sector, then it *should* be provided in the private sector.”<sup>52</sup>

In 1996, the newly elected Coalition government focused on the maintenance and support of the PHI industry and, as a consequence, the private hospital sector.<sup>53</sup> The newly appointed Minister of Health, Michael Wooldridge, issued a press statement indicating the importance the government placed on ensuring a public-private balance: “The continuing decline in the number of Australians with PHI is perhaps the single most serious threat to the viability of our entire health care system.”<sup>54</sup> This implies that the government considered it vital to the sustainability of the health care system that a strong private health care sector was maintained in parallel to a public one. He subsequently noted, “Australia’s very successful universal health care system was predicated on a substantial part of the population having private health coverage.”<sup>55</sup> The Minister’s speeches on the second reading of the Bills in 1996 and 1998 introducing PHI incentives and sub-

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<sup>50</sup> Michelle Grattan & Mark Metherell, “Abbott Vows to Scrap Health Rebate Means Test”, *The Sydney Morning Herald* (16 February 2012), online: <[www.smh.com.au/federal-politics/political-news/abbott-vows-to-scrap-health-rebate-means-test-20120215-1t6q0.html](http://www.smh.com.au/federal-politics/political-news/abbott-vows-to-scrap-health-rebate-means-test-20120215-1t6q0.html)>.

<sup>51</sup> See Kay, *supra* note 17 at 585.

<sup>52</sup> McAuley, “Public Policy”, *supra* note 8 at 3 [emphasis in the original].

<sup>53</sup> See Colombo & Tapay, *supra* note 45 at para 17.

<sup>54</sup> Michael Wooldridge, Minister for Health and Family Services, Media Release (24 May 1996) [Wooldridge, Media Release], cited in McAuley, “Muddling Through”, *supra* note 45 at 160.

<sup>55</sup> John K Iglehart, “An Activist Health Minister in a Conservative Government” (2001) 20:3 *Health Aff* 146 at 149.

sides also referred to a belief that PHI would take pressure off public hospitals, preserve consumer choice, restore “balance” between the private and public sectors, and help the private sector (although it is not quite clear why a supposedly free market government would intervene to prop up a private industry).<sup>56</sup>

Between 1996 and 2007 the Coalition government instituted a number of measures to improve the uptake of PHI. These measures, and the current regulatory framework to encourage PHI uptake, are outlined in the following Sections. While income thresholds (see below) were changed by the Labor government (2007–2013), it continued the private health insurance rebate, the Medicare Levy Surcharge, and lifetime cover.<sup>57</sup>

### A. Insurance

The federal government has constitutional power under subsection 51(xiv) to regulate insurance.<sup>58</sup> This enables the government to regulate the operations of the private insurance market directly. The PHI market was initially regulated through the *National Health Act 1953*, and is currently directly regulated through the *Private Health Insurance Act 2007 (PHI Act)*.<sup>59</sup> The *PHI Act* “(a) provides incentives to encourage people to have [PHI]; and (b) sets out rules governing [PHI] products.”<sup>60</sup> One focus of these rules is to encourage Australians to take out PHI to cover private hospital services in

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<sup>56</sup> Austl, Commonwealth, House of Representatives, *Parliamentary Debates* (13 December 1996) at 8573 [*Debates* 1996], cited in McAuley, “Muddling Through”, *supra* note 45 at 166; Austl, Commonwealth, House of Representatives, *Parliamentary Debates* (12 November 1998) at 263 [*Debates* 1998], cited in McAuley, “Muddling Through”, *supra* note 45 at 166. See also Duckett & Jackson, *supra* note 11 at 439.

<sup>57</sup> See Duckett & Willcox, *supra* note 19 at 81–82.

<sup>58</sup> Wheelwright has noted that the Commonwealth also has a corporations power under s 51(xx) of the Constitution which could support the regulation of corporations providing PHI or private health services more generally (“Commonwealth and State Powers in Health: A Constitutional Diagnosis” (1995) 21:1 *Monash UL Rev* 53 at 57, 80).

<sup>59</sup> (Cth) [*PHI Act*].

<sup>60</sup> *Ibid*, ss 3-1(a) to (b).

order to maintain a thriving private hospital sector.<sup>61</sup> Private hospital insurance coverage in Australia may cover all services that are provided by public hospitals in Australia, including accident and emergency care. Some PHI policies allow for certain health services not to be part of the insurance package. For example, a person may choose to purchase PHI that does not cover obstetric services if, because of their gender or age, they may never or no longer need such services. Policies may also cover gaps – for example, for the gap between the Medicare schedule fee (reimbursed by government) and the actual amount charged by the service provider. In order to protect their revenue base by offering policies that might be more attractive to purchasers, PHI plans may also include coverage for extras, such as physiotherapy, chiropractic, optometry, and dental care, and more controversially, unproven natural therapies such as homeopathy. Another policy objective of the reforms was to increase rates of people holding PHI for hospital care so as to reduce pressure on the public system.<sup>62</sup> If a PHI plan providing coverage for both hospitals and extras induced individuals or families to acquire private hospital coverage, it appears that the government was prepared to cross-subsidize the extras in order to achieve this policy objective.<sup>63</sup>

## 1. Community rating

Since 1953, the Coalition government has chosen to intervene in the PHI market to ensure affordable and equal access by requiring PHI companies to offer PHI products to the public on the basis of a

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<sup>61</sup> See *Debates* 1996, *supra* note 56 at 8573, cited in McAuley, “Muddling Through”, *supra* note 45 at 166; *Debates* 1998, *supra* note 56 at 263, cited in McAuley, “Muddling Through”, *supra* note 45 at 166.

<sup>62</sup> See McAuley, “Muddling Through”, *supra* note 45 at 166; *Debates* 1996, *supra* note 56 at 8573, cited in McAuley, “Muddling Through”, *supra* note 45 at 166; *Debates* 1998, *supra* note 56 at 263, cited in McAuley, “Muddling Through”, *supra* note 45 at 166.

<sup>63</sup> It was only in 2015 that the federal government began to scrutinize whether it should subsidize PHI policies that provide coverage for unproven therapies. See Austl, Commonwealth, Department of Health, *Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance* by Chris Baggooley AO (Canberra: Department of Health, 2015), online: <[www.health.gov.au/internet/main/publishing.nsf/content/phi-natural-therapies](http://www.health.gov.au/internet/main/publishing.nsf/content/phi-natural-therapies)> [Department of Health, Baggooley Review].



community rating.<sup>64</sup> This means that PHI companies cannot stratify the price of their products on the basis of an individual risk assessment. The *PHI Act* requires that they do not price discriminate on the basis of health status, gender, age (except in relation to the lifetime health cover provisions), and other specified grounds.<sup>65</sup> This is said to act as an inducement for those who are older or have health-related issues to purchase PHI, but it may act as a disincentive for those who are younger as they are in effect subsidizing people with increased health needs.<sup>66</sup>

## 2. Reductions in premiums

In 1998, the federal government began offering incentives for persons to take out PHI hospital coverage in the form of a premium reduction scheme.<sup>67</sup> Individuals or families may be eligible for a premium reduction if they take out approved PHI hospital coverage. The *PHI Act* provides a sliding scale of subsidies currently at 25.93% for those under 65 years of age, 30.26% for those 65–69 years of age, and 34.58% for those 70 years and older.<sup>68</sup> The subsidy rate is adjusted annually<sup>69</sup> in an attempt to moderate the rate of growth of government outlays on PHI.<sup>70</sup> The subsidy is also means-tested. For example, for a single person the subsidy is reduced by about 10% if one earns over AUD\$90,000, 20% if one earns over AUD\$105,000, and

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<sup>64</sup> See *PHI Act*, *supra* note 59, s 55-1. Early community rating schemes in the *National Health Act 1953*, *supra* note 24, prevented private health insurers from declining coverage but limitations based on risk profile could still be imposed. See also Connelly et al, *supra* note 26 at 4; Willcox, *supra* note 45 at 157.

<sup>65</sup> *PHI Act*, *supra* note 59, ss 55-5(2)(a) to (h).

<sup>66</sup> See McAuley, “Muddling Through”, *supra* note 45 at 160, 164.

<sup>67</sup> Initially in the *Private Insurance Incentives Act 1998* (Cth); now in the *PHI Act*, *supra* note 59, s 20-1.

<sup>68</sup> Austl, Commonwealth, Private Health Insurance Ombudsman, “Australian Government Private Health Insurance Rebate” (2017), online: <[www.privatehealth.gov.au/healthinsurance/incentivessurcharges/insurancerebate.htm](http://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/insurancerebate.htm)> (subsidy rates applicable from 1 April 2017–31 March 2018).

<sup>69</sup> *PHI Act*, *supra* note 59, ss 22-15(5A) to (5E), 22-30 to 22-45; *Tax Laws Amendment Act (Medicare Levy Surcharge Thresholds) Act (No 2) 2008* (Cth), Schedule 1, ss 2, 7.

<sup>70</sup> See McAuley, “Public Policy” *supra* note 8 at 3.

completely eliminated if one earns more than AUD\$140,000.<sup>71</sup> The premium reduction also applies if people take out hospital and extra (ancillary services) coverage. Despite the generosity of the subsidy, it appears to have only had a relatively small upwards impact on PHI coverage.<sup>72</sup>

### 3. Lifetime health cover scheme

A further way in which the federal government, from 2000, has strongly encouraged the uptake of PHI is through the imposition of higher premiums on persons who do not have PHI hospital coverage from an early age<sup>73</sup> thus in effect penalizing those who delay getting private health insurance. This part of the *PHI Act* states that PHI companies must increase the premiums to be paid by individuals if those persons have not taken out PHI hospital coverage by age 30<sup>74</sup> or cease to hold PHI hospital coverage for a period when they are over 30 years of age.<sup>75</sup> This initiative led to a significant

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<sup>71</sup> See *PHI Act*, *supra* note 59, ss 22-15(2) to (4), 22-35; Austl, Commonwealth, Australian Taxation Office, “Income Thresholds and Rates for the Private Health Insurance Rebate” (29 June 2017), online: <[www.ato.gov.au/Individuals/Medicare-levy/Private-health-insurance-rebate/Income-thresholds-and-rates-for-the-private-health-insurance-rebate](http://www.ato.gov.au/Individuals/Medicare-levy/Private-health-insurance-rebate/Income-thresholds-and-rates-for-the-private-health-insurance-rebate)>. For example, the subsidy for a single person aged under 65 with an income less than \$90,000 is 25.93% but declines to 17.9% (8.65 percentage points, rounded to 10%) for a person with income in the range \$90,001 to \$150,000.

<sup>72</sup> See James RG Butler, “Policy Change and Private Health Insurance: Did the Cheapest Policy Do the Trick?” (2002) 25:6 Aust Health Rev 33 at 37. See also Austl, Commonwealth, *Senate Economics Legislation Committee – Inquiry into the Fairer Private Health Insurance Incentives Bills: Submission to Senate Committee* by John Deeble (Canberra: Senate Economics Legislation Committee, 2009) at 3, online: <[www.aph.gov.au/~media/wopapub/senate/committee/clac\\_ctte/completed\\_inquiries/2008\\_10/fairer\\_private\\_health\\_09/submissions/sub06\\_pdf.ashx](http://www.aph.gov.au/~media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/fairer_private_health_09/submissions/sub06_pdf.ashx)>; Hall, Lourenco & Viney, *supra* note 17 at 659; Willcox, *supra* note 45 at 155–56, Rachael Elizabeth Moorin & Cashel D’Arcy J Holman, “Does Federal Health Care Policy Influence Switching Between the Public and Private Sectors in Individuals?” (2006) 79:2 Health Policy 284 at 293.

<sup>73</sup> See *PHI Act*, *supra* note 59, s 31-1.

<sup>74</sup> *Ibid*, s 34-1.

<sup>75</sup> *Ibid*, s 34-5.

increase in coverage from around 30% to around 45% of the population, with most of the increase being in less expensive products with deductibles or exclusions (see Figure 1).<sup>76</sup> This increase following the institution of lifetime cover and the uptake of less expensive policies that did not provide full coverage suggests that consumers acted strategically to avoid the financial impacts of this regulatory change.<sup>77</sup> It does not suggest that consumers wanted or preferred private coverage, as the products themselves did not change.

### **B. Taxation**

The taxation power in subsection 51(ii) of the Constitution supports the imposition of levies and the creation of tax incentives.<sup>78</sup> In addition to the 2% of taxable income levy paid by most Australian taxpayers to fund the Medicare system, since 1997, the government has used its taxation powers to impose an income tested additional levy (up to 1–1.5% of taxable income), the Medicare Surcharge, on individuals who do not have PHI hospital coverage.<sup>79</sup> This penalizes those individuals who choose not to purchase PHI hospital cover. The fact that this penalty exists also creates an incentive for people to purchase PHI to avoid the additional tax, but appears to only have a marginal effect on take-up.<sup>80</sup>

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<sup>76</sup> See also Butler, *supra* note 72 at 36, 38. Policies with exclusions have increased from less than 5% of policies in 2003 to over 30% in 2015. See Austl, Commonwealth, Private Health Insurance Administration Council, *Risk Sharing in the Australian Private Health Insurance Market* (Canberra: PHIAC, 2015) at 11, online: Australian Prudential Regulation Authority <[www.apra.gov.au/PHI/PHIAC-Archive/Documents/Risk-Sharing\\_June-2015.pdf](http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Risk-Sharing_June-2015.pdf)>.

<sup>77</sup> See Duckett & Willcox, *supra* note 19 at 81–82.

<sup>78</sup> *Supra* note 23.

<sup>79</sup> See *Medicare Levy Act 1986*, *supra* note 34, ss 6, 8B–8G.

<sup>80</sup> See Andrew Johnston & Kerrie Sadiq, “Incentivising Private Health Insurance through the Income Tax Regime: Capitalising on Behavioural Models” (2011) 26:4 Australian Tax Forum 633 at 641; Olena Stavrunova & Oleg Yerokhin, “Tax Incentives and the Demand for Private Health Insurance” (2014) 34:1 J Health Econ 121 at 124. The legislation also requires that the insurance coverage does not come with too high an excess, also known as a co-payment. See *Medicare Levy Act 1986*, *supra* note 34, ss 3(5)–(7).

### *C. Medicare*

The federal government has also used subsection 51(xxiiiA) of the Constitution<sup>81</sup> to provide indirect subsidies to the PHI system by subsidizing the medical services to private in-patients. Medicare pays 75% of the Medicare scheduled fee for patients who are hospitalized or who are receiving hospital-substitute treatment,<sup>82</sup> including for those persons with PHI hospital coverage.<sup>83</sup> This means that PHIs are only paying the gap between the cost of the medical consultation or procedure, and the amount that is being reimbursed under the Medicare scheme (less, of course, any excess,<sup>84</sup> coverage cap, or coverage limitation).<sup>85</sup> In short, the government is subsidizing the operating costs of PHI.

## **III. IMPACT OF THE PRIVATE HEALTH INSURANCE REGULATORY FRAMEWORK**

This section assesses the impact of the PHI in respect of whether it achieved the stated policy objectives, the perceived legitimacy or acceptability of the PHI regulatory framework, and its impact on the sustainability of the health care system.

### *A. Achieving policy objectives*

Did the PHI regulatory framework, outlined in the previous Section, achieve its primary stated purpose to avert the decline in the numbers of Australians with PHI hospital coverage? In short, at first glance, yes it did. Figure 1 illustrates the expected decline in coverage from the introduction of Medicare in 1983. Figure 1 also shows the decline in coverage for private hospital care from the early 1990s. This decline was reversed when the

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<sup>81</sup> *Supra* note 23.

<sup>82</sup> Defined in the *PHI Act* as “general treatment that ... substitutes for an episode of hospital treatment” (*supra* note 59, s 69-10(a)).

<sup>83</sup> See *HI Act*, *supra* note 30, s 10(2).

<sup>84</sup> Some policies are purchased with an excess, also known as a co-payment, e.g., the first AUD\$1,000.00 must be paid by the policyholder.

<sup>85</sup> Some policies have a coverage cap or limitation, e.g., policyholders may only claim AUD\$25,000 per year for cancer treatment, etc.

PHI regulatory framework was revised in late 1996 with a sharp increase in coverage after the introduction of lifetime health cover in 2000. However, amongst the 11.3 million Australians covered by hospital insurance in September 2015, 4.0 million had products which did not cover certain procedures (“exclusionary policies”) and, of the balance, 5.6 million had to pay an excess, or co-payment, if they claimed on their insurance.<sup>86</sup> This means, as Figure 1 illustrates, that only 11% of those with insurance had first-dollar coverage for any hospitalization. This suggests that the combinations of “carrots and sticks,” which has been used to characterize Australian health insurance policy,<sup>87</sup> has resulted in many people purchasing cheaper and less comprehensive PHI plans solely to avoid tax or future premium increase penalties, rather than basing purchase decisions on the actual product or their personal need for coverage.<sup>88</sup> PHI arguably does give patients a choice as to their preferred health provider. However, as McAuley notes, people tend to rely on expert opinion in making these choices – in this context, general practitioners refer their patients to a specialist.<sup>89</sup>

One of the policy rationales supporting a strong PHI sector in Australia has been the idea that a strong private health sector can reduce demand on the public system. Did the regulatory framework achieve its goal of reducing public hospital utilization? This is a complex question as many factors impact utilization, including population change and demand-related factors, so what follows is at best indicative. As the public hospital system in Australia is free at point of use, many people with PHI still seek treatment in public hospitals, especially for emergencies and complex care. The big increase in PHI occurred with the introduction of lifetime cover, with the increase largely occurring in exclusionary policies or policies with no payment requirements (or both) (see Figure 1). This probably explains why there was little impact on public hospital utilization associated with the increase in the proportion of the population covered by PHI.<sup>90</sup> After all, there is little

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<sup>86</sup> See Australian Prudential Regulation Authority, *supra* note 47 at 2.

<sup>87</sup> See Hall, Lourenco & Viney, *supra* note 17.

<sup>88</sup> See Duckett & Willcox, *supra* note 19 at 82.

<sup>89</sup> McAuley, “Public Policy”, *supra* note 8 at 7.

<sup>90</sup> See Kate Brameld, D’Arcy Holman & Rachael Moorin, “Possession of Health Insurance in Australia: How Does it Affect Hospital Use and Outcomes?” (2006) 11:2 J Health Serv Res Policy 94 at 97; Moorin & Holman, *supra* note 72 at 284; Rachael Elizabeth Moorin & Cashel D’Arcy James Holman, “Modelling Changes in the Determinants of PHI Utilisation in Western Australia

incentive for people with PHI to use private hospitals if they will have to make a significant copayment to supplement their PHI coverage, especially if they can receive the surgery free of cost in a reasonably timely way in the public hospital system.<sup>91</sup> People with PHI have subsidized access to private specialists (generally with minimal wait times) to jump the “hidden” wait list (there is no public data about the length of wait time for these services) for publicly funded outpatient appointments for surgical assessment. There also may be no incentive if the quality of the treatment is as good, or better, than would be received privately.

Another justification was to reduce wait times in the public hospital sector, but this too is difficult to assess due to complex causation. Most countries with public health care systems are confronting issues concerning the management of wait times and there have been legal cases challenging governmental approaches in several countries, including Canada.<sup>92</sup> McAuley argues that the assumption that higher rates of private hospital usage would relieve public hospitals was flawed as it considered only demand side factors.<sup>93</sup> However, supply side factors suggest that resources will go where the

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across Five Health Care Policy Eras between 1981 and 2001” (2007) 81:2 Health Policy 183 at 188; McAuley, “Muddling Through”, *supra* note 45 at 167–68; Stephen J Duckett, “Private Care and Public Waiting” (2005) 29:1 Aust Health Rev 87 at 92 [Duckett, “Private Care”].

<sup>91</sup> See McAuley, “Public Policy”, *supra* note 8 at 11.

<sup>92</sup> *Chaoulli*, *supra* note 6, challenged Québec’s Medicare system by arguing that wait times were unreasonable. Currently, another case is before the Supreme Court of British Columbia, challenging the ban on private insurance by arguing that the ban violates patients’ constitutional rights as they must endure long wait times in the public system. See Geordon Omand, “Landmark Private Health Care Lawsuit Heads to Court”, *CBC News* (5 September 2016), online: <[www.cbc.ca/news/canada/british-columbia/landmark-private-health-care-lawsuit-heads-to-court-1.3749117](http://www.cbc.ca/news/canada/british-columbia/landmark-private-health-care-lawsuit-heads-to-court-1.3749117)>. See also Colleen M Flood, “Canada’s Approach to the Public/Private Divide and the Perils of Reform via Court Challenge” (2012) 8:2 Public Policy Rev 191 at 196–98. A case was brought before the Court of Justice of the European Communities, for instance, in which the applicant sought reimbursement for the cost of hip replacement surgery received in France. The applicant sought the surgery in France after having been put on a long waiting list in England. See *R (on application of Yvonne Watts) v Bedford Primary Care Trust and Secretary of State for Health*, C-372/04, [2006] ECR I-4376).

<sup>93</sup> McAuley, “Public Policy”, *supra* note 8 at 6.

money is.<sup>94</sup> Research indicates that when medical practitioners allocate more hours of work to the private sector, the number of hours they are available to work in the public sector decreases.<sup>95</sup> While PHI may reduce wait times for individuals who hold PHI, McAuley argues that PHI re-assigns queues for services on the basis of ability to purchase a PHI policy rather than on the basis of clinical need.<sup>96</sup> There is no evidence that the increase in the insured population has led to a reduction in public sector waiting times. Research from 2015 indicated that a higher proportion of private admissions to hospital is associated with higher public hospital waiting times, not lower.<sup>97</sup> Despite the PHI regulatory framework being in place since 2000, in 2009, the federal government entered into an agreement to provide the states and territories with additional funding to manage elective surgery wait times in the public system,<sup>98</sup> which implies that wait times continued to be a problem – even nearly ten years later – and may still be a problem.<sup>99</sup> It seems

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<sup>94</sup> See *ibid.*

<sup>95</sup> See e.g. Terence Chai Cheng, Guyonne Kalb & Anthony Scott, “Public, Private or Both? Analysing Factors Influencing the Labour Supply of Medical Specialists” (2013) Melbourne Institute of Applied Economic and Social Research Working Paper No 40/13 at 16, online: <[www.melbourneinstitute.com/downloads/working\\_paper\\_series/wp2013n40.pdf](http://www.melbourneinstitute.com/downloads/working_paper_series/wp2013n40.pdf)>; McAuley, “Muddling Through”, *supra* note 45 at 168.

<sup>96</sup> McAuley, “Public Policy”, *supra* note 8 at 6.

<sup>97</sup> See Duckett, “Private Care”, *supra* note 90 at 92.

<sup>98</sup> Austl, Commonwealth, Council of Australian Governments, *National Partnership Agreement on Elective Surgery Waiting List Reduction Plan* (Canberra: COAG, 2009), online: Council on Federal Financial Relations <[www.federalfinancialrelations.gov.au/content/npa/health/national-partnership/past/elective-surgery-waiting-lists-NP.pdf](http://www.federalfinancialrelations.gov.au/content/npa/health/national-partnership/past/elective-surgery-waiting-lists-NP.pdf)>.

<sup>99</sup> See Gary L Freed, Erin Turbitt & Amy Allen, “Public or Private Care: Where do Specialists Spend their Time?” (2017) *Aust Health Rev* [forthcoming]; Carla Saunders & David J Carter, “Right Care, Right Place, Right Time: Improving the Timeliness of Health Care in New South Wales through a Public–Private Hospital Partnership”, *Aust Health Rev* [forthcoming]; Chris Johnson, “Public Hospitals Report Card Fail Due to Funding”, *Australian Medicine* (3 Mar 2017) at 3–4, online: Australian Medical Association <<https://www.ama.com.au/ausmed/public-hospitals-report-card-fail-due-funding>>; Austl, Commonwealth, Australian Institute of Health and Welfare, *Elective Surgery Waiting Times 2015–2016: Australian Hospital Statistics*, Health Services Series No 73 (Canberra: AIHW, 2016), online: <<https://www.aihw.gov.au/reports-statistics>>.

clear that there are continuing questions about the impact of PHI on wait times in public hospitals.

### ***B. Legitimacy or acceptability***

A key element of health policy evaluation is the perceived “legitimacy”<sup>100</sup> or “acceptability” of the policy to the public.<sup>101</sup> A recent media release by the Coalition acknowledges that many Australians are frustrated with the PHI system for a variety of reasons. One such reason is that despite the tax benefits that accrue, premiums are rising rapidly and policies are becoming less affordable.<sup>102</sup> The Australian Competition and Consumer Commission (ACCC) and the PHI Ombudsman argue that the market failures in the PHI industry are due to the asymmetric and imperfect information provided to purchasers.<sup>103</sup> These asymmetries result in the market for PHI being unduly complex. This may reduce a purchaser’s ability to compare policies and make informed choices about their PHI needs. The ACCC also suggested that the current regulatory framework for PHI can change consumers’ incentives when purchasing PHI.<sup>104</sup> Rather than purchasing

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<sup>100</sup> See Lester M Salamon, “The New Governance and the Tools of Public Action: An Introduction” in Lester M Salamon, ed, *The Tools of Government: A Guide to the New Governance* (New York: Oxford University Press, 2002) 1 at 24.

<sup>101</sup> See Duckett & Willcox, *supra* note 19 at 368–69.

<sup>102</sup> Liberal Party of Australia, Media Release, “Coalition’s Plan to Ensure Private Health Insurance Delivers Value for Money” (12 June 2016), online: <[www.liberal.org.au/latest-news/2016/06/12/coalitions-plan-ensure-private-health-insurance-delivers-value-money](http://www.liberal.org.au/latest-news/2016/06/12/coalitions-plan-ensure-private-health-insurance-delivers-value-money)> [Liberal Party of Australia].

<sup>103</sup> The term asymmetric means that one party will know more than another. In this case, an insurer will know much more about health insurance and consumer law, as well as hidden terms in contracts, than the average purchaser. See Austl, Commonwealth, Australian Competition and Consumer Commission, *Information and Informed Decision-Making: A Report to the Australian Senate on Anti-Competitive and other Practices by Health Insurers and Providers in Relation to Private Health Insurance* (Canberra: ACCC, 2014) at 1, online: <[www.accc.gov.au/system/files/981\\_Private%20Health%20Report\\_2013-14\\_web%20FA.pdf](http://www.accc.gov.au/system/files/981_Private%20Health%20Report_2013-14_web%20FA.pdf)> [ACCC]; Austl, Commonwealth, Private Health Insurance Ombudsman, *Private Health Insurance Ombudsman 2013–2014 Annual Report* (Sydney: PHIO, 2014) at 29, online: <[www.ombudsman.gov.au/\\_\\_data/assets/pdf\\_file/0027/29295/PHIO-Annual-Report-2014.pdf](http://www.ombudsman.gov.au/__data/assets/pdf_file/0027/29295/PHIO-Annual-Report-2014.pdf)>.

<sup>104</sup> ACCC, *supra* note 103 at 39.



the best product to meet their health needs, consumers may purchase a product primarily to reduce their tax liabilities.<sup>105</sup> Some PHI companies market products by highlighting tax minimization benefits.<sup>106</sup> As a consequence of the complexity associated with PHI plans, purchasers may be unpleasantly surprised by the policy limitations they experience when they make a claim, resulting in them being dissatisfied with the PHI system.<sup>107</sup> This was acknowledged by the federal government when it announced a 2016 review of PHI.<sup>108</sup>

Issues of equity have also been indirectly raised in the context of the PHI review.<sup>109</sup> The Department of Health's paper identifying issues for consultation noted that rural Australians raise questions about the purpose of having PHI when they cannot easily access these services.<sup>110</sup> Putting in place a regulatory framework that strongly "encourages" people to purchase PHI and penalizes those who do not assumes that these policies offer some benefit to all those who hold them. If some people cannot easily access any benefit from their PHI policy this raises equity concerns. That public discontent threatens the ongoing acceptability and legitimacy of the PHI regulatory framework was implicitly acknowledged by the current Coalition government when it announced purchaser focused reforms to: (1) simplify and standardize policies, (2) weed out junk policies by requiring a mandated minimum level of coverage, and (3) address the needs of rural Australians.<sup>111</sup> The lesson seems to be that if a government intends to use regulation to encourage its citizens to purchase a product, it also needs to pay attention to the quality and usability of that product to ensure continuing public acceptance of the regulatory framework.

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<sup>105</sup> See *ibid.*

<sup>106</sup> See *ibid.*

<sup>107</sup> See *ibid* at 2.

<sup>108</sup> Austl, Commonwealth, Department of Health, "Private Health Insurance Consultations: Scope of Consultations" (3 December 2015), online: <[www.health.gov.au/internet/main/publishing.nsf/content/phi-consultations-scope](http://www.health.gov.au/internet/main/publishing.nsf/content/phi-consultations-scope)> [Department of Health, "PHI Consultations"].

<sup>109</sup> *Ibid.*

<sup>110</sup> Department of Health, "Issues for Consideration", *supra* note 9.

<sup>111</sup> Liberal Party of Australia, *supra* note 102.

### C. Sustainability

Fiscal sustainability is the ability of a government to sustain its current spending and its policies in the long term.<sup>112</sup> It is another criterion against which policy can be assessed. The concept of sustainability drives much discussion about health care system reform in Australia<sup>113</sup> given that it is faced both with rising costs and fiscal constraints. The expectation is that Australian governments will continue to provide high quality, universal, and affordable health care.<sup>114</sup> The entire design of the system is under consideration. While the uptake of PHI is slowly increasing, the cost to the government of the subsidy is also increasing. However, the direct and indirect cost of PHI has not been subject to economic scrutiny of the sort applied in other areas.<sup>115</sup> The federal government subsidy for PHI is expected to grow 7% in real terms over the period 2015–2016 to 2018–2019.<sup>116</sup> When one consid-

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<sup>112</sup> See OECD, “Government at a Glance 2013”, (OECD Publishing, 2013) at 50, online: <[www.dx.doi.org/10.1787/gov\\_glance-2013-11-en](http://www.dx.doi.org/10.1787/gov_glance-2013-11-en)>.

<sup>113</sup> See e.g. Department of Health, “Issues for Consideration”, *supra* note 9; Austl, Commonwealth, Department of the Prime Minister and Cabinet, *Reform of the Federation White Paper: Roles and Responsibilities in Health*, Issues Paper No 3 (Canberra: Commonwealth of Australia, 2014) at 3, online: Analysis & Policy Observatory <[apo.org.au/system/files/56123/apo-nid56123-53961.pdf](http://apo.org.au/system/files/56123/apo-nid56123-53961.pdf)> [Department of the Prime Minister and Cabinet, *Roles and Responsibilities*]; Austl, Tasmania, Department of Health and Human Services, *Delivering Safe and Sustainable Clinical Services: Sustainability and the Tasmanian Health System*, Supplement No 1 (Tasmania: Department of Health and Human Services, 2014) at 3, online: <[www.dhhs.tas.gov.au/\\_data/assets/pdf\\_file/0007/179053/OHS-OP01-Sustainability\\_vF\\_141208.pdf](http://www.dhhs.tas.gov.au/_data/assets/pdf_file/0007/179053/OHS-OP01-Sustainability_vF_141208.pdf)>; “Executive Summary” in Committee for Economic Development of Australia, *Healthcare: Reform or Ration* (Melbourne: CEDA, 2013) 6 at 6, online: <[www.ceda.com.au/CEDA/media/ResearchCatalogueDocuments/PDFs/15366-healthcarefinal1.pdf](http://www.ceda.com.au/CEDA/media/ResearchCatalogueDocuments/PDFs/15366-healthcarefinal1.pdf)>.

<sup>114</sup> See Department of the Prime Minister and Cabinet, *Roles and Responsibilities*, *supra* note 112 at 3.

<sup>115</sup> See McAuley, “Public Policy”, *supra* note 8 at 4.

<sup>116</sup> See Stephen Duckett, “Aged and Confused: Why the Private Health Insurance Industry is Ripe for Reform”, *The Conversation* (10 November 2015), online: <<https://theconversation.com/aged-and-confused-why-the-private-health-insurance-industry-is-ripe-for-reform-50384>> [Duckett, “Aged and Confused”]; Austl, Commonwealth, *Budget 2015–16: Budget Strategy and Outlook*, Budget Paper No 1 (2015) at 5-13, 5-23, online: <[www.budget.gov.au/2015-16/content/bp1/download/Budget\\_Paper\\_No\\_1.pdf](http://www.budget.gov.au/2015-16/content/bp1/download/Budget_Paper_No_1.pdf)> [Austl, *Budget 2015-16*].

ers that federal government health spending growth is 3.2% overall, and its spending on public hospitals is expected to grow at 6.7% from the years 2015–2016 to 2018–2019,<sup>117</sup> the rate of the growth in the PHI subsidy gives cause for concern about whether it is an effective use of taxpayers' funds<sup>118</sup> and whether it is sustainable.<sup>119</sup>

Questions have long been raised about whether it is still desirable to have government directly supporting PHI, or if it would be more cost-efficient to directly subsidize private health care providers, especially private hospitals.<sup>120</sup> In 2005, of the AUD\$6.8 billion that was paid to the PHI companies, only AUD\$3.6 billion went to private hospitals, the rest went to private specialists and providers of ancillary services. This expenditure was supported by AUD\$2.3 billion of public expenditure.<sup>121</sup> The administrative costs are also high as the funds pass through an intermediary. About 85 cents in the dollar funds health services compared to around 95 cents when funded through Medicare.<sup>122</sup> Additionally, Duckett has noted that government advisors believe that the efficiencies gained in the publicly funded health care system through the introduction of activity-based funding models could also be achieved in the private sector.<sup>123</sup> This was canvassed by the government in a recent report.<sup>124</sup> However, in order to achieve this, direct

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<sup>117</sup> Duckett, "Aged and Confused", *supra* note 116; Austl, *Budget 2015-16*, *supra* note 116 at 5-23.

<sup>118</sup> See McAuley, "Muddling Though", *supra* note 45.

<sup>119</sup> See Department of Health, "PHI Consultations", *supra* note 108.

<sup>120</sup> See e.g. McAuley, "Muddling Though", *supra* note 45 at 167; Rhema Vaithianathan, "Will Subsidising Private Health Insurance Help the Public Health System?" (2002) 78:242 *The Economic Record* 277.

<sup>121</sup> McAuley, "Muddling Through", *supra* note 45 at 167.

<sup>122</sup> McAuley, "Public Policy" *supra* note 8 at 5.

<sup>123</sup> Stephan Duckett, "Health in 2016: A Cheat Sheet On Hospitals, Medicare and Private Health Insurance Reform" *The Conversation* (31 January 2016), online: <[www.theconversation.com/health-in-2016-a-cheat-sheet-on-hospitals-medicare-and-private-health-insurance-reform-53868](http://www.theconversation.com/health-in-2016-a-cheat-sheet-on-hospitals-medicare-and-private-health-insurance-reform-53868)>, citing Austl, Commonwealth, *Efficiency in Health: Productivity Commission Research Paper*, (Canberra: Productivity Commission, 2015), online: <[www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf](http://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf)>.

<sup>124</sup> Austl, Commonwealth, Department of the Prime Minister and Cabinet, *Reform of the Federation: Discussion Paper 2015* (Canberra: Commonwealth of

subsidies to private hospitals or to private health providers would be required and, presumably, this would require an end to, or at least a curtailing of, subsidies to the PHI industry.

The breadth of the rebate is also of concern. In the 2012–2013 budget, the federal government announced a review of the Australian government rebate on PHI for natural therapies (the Baggoley Review), such as homeopathy and naturopathy, which are covered by some PHI plans.<sup>125</sup> This review was prompted by a concern about the appropriateness of having taxpayers subsidize services where there is no evidence to support their clinical efficacy and no, or minimal, evidence of actually improving health outcomes – rather than funding services that have been demonstrated to be clinically effective. By subsidizing such “therapies,” the government could also be implicitly sending a message that these therapies are actually credible which, if there is evidence to the contrary, may be inconsistent with the government’s duties to its citizens. The Baggoley Review suggests that rebates will be paid only if the Chief Medical Officer for the Commonwealth of Australia finds clear evidence that the specified natural therapies are clinically effective.<sup>126</sup>

### CONCLUSION

It is clear that for the foreseeable future Australia will retain an overlapping system of public and private provision of health services. The federal Department of Health has noted: “The Government is committed to ensuring consumers can access affordable, quality and timely health services through [PHI] alongside universal access to Medicare.”<sup>127</sup> This indicates the government’s continuing commitment to a public–private system. The question is therefore whether Australia will continue to actively subsidize and incentivize Australians to purchase PHI. The current PHI regulatory framework was introduced only when the creation of Australia’s public health care system in 1983 saw rates of PHI coverage

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Australia, 2015) at 37–38, online: Analysis & Policy Observatory <apo.org.au/node/55457>.

<sup>125</sup> Department of Health, Baggoley Review, *supra* note 63.

<sup>126</sup> *Ibid* at 3.

<sup>127</sup> Department of Health, “PHI Consultations”, *supra* note 108.

decline.<sup>128</sup> This implies that the Australian public health care system was so satisfactory that some Australians began to believe that PHI was no longer required. To change that perception the government had to intervene in the market and incrementally develop a series of incentives and penalties embedded in law to encourage people to purchase PHI coverage.

The PHI regulatory framework has been a success, if success is measured only in terms of there being a reversal of the decline in the numbers of persons with PHI. The government claimed that the scheme would increase choice for those who hold PHI, and this is probably so. But claims that the PHI framework would reduce public hospital utilization and reduce workloads are more difficult to assess, because there are many variables at play. It does not appear on the face of the limited evidence that the revised PHI regulatory framework has had a significant impact on either utilization or wait times. The limited evidence also suggests that the cost of direct and indirect subsidization of PHI may be rising, and in an environment where it is claimed that costs need to be contained, subsidization may be fiscally unsustainable. It is also an oddity that in a country that is committed to reducing industry protectionism and supporting free markets, the PHI industry is supported to such an extent by taxpayers. If government wants to sustain a private health sector, it might be more efficient to directly pay hospitals to provide services, as this will reduce the cost of the overhead of corporate actors in the insurance industry. It also appears that the legitimacy or acceptability of the PHI regulatory framework, in the eyes of the Australian public, has come to be increasingly questioned due to affordability concerns, a lack of clarity around policy inclusions, “junk” policies, and questions about the fairness of being encouraged by government to purchase a product that is difficult to use when one lives in some rural areas.

What lessons should be learnt from the Australian experience by other countries who may be contemplating moving to a two-tier system, or within a two-tier system contemplating intervening in PHI markets? If a country does desire to intervene in the PHI market, it needs to consider acceptability/legitimacy, and sustainability. First, it will need to either work with the industry, or regulate to ensure that PHI products provide value for money, are usable, and are affordable, and thus to ensure that the regulatory framework continues to be perceived as acceptable by the public. Second, thought should be given to the scope of services within PHI products that should be subsidized by government. The arguments against subsidizing products that

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<sup>128</sup> See Wooldridge, Media Release, *supra* note 54, cited in McAuley, “Muddling Through”, *supra* note 45 at 160.

reimburse policyholders for accessing unproven natural therapies appear to be strong. Indeed, a government has an obligation to use taxpayers' funds wisely, and does not have an obligation to enable its citizens to access any product or service that they desire. Some may argue that if the purpose of the intervention is to reduce public hospital utilization, then only private hospital coverage should be subsidized. Others might argue that a broader extension of coverage to ancillary services (those with a strong evidence base) may prevent people from subsequently accessing hospital services.

There are larger questions about whether government intervention in a PHI market is desirable. Why should government support an industry, such as the PHI industry, if it is no longer viable, or not as profitable, in changed market conditions? The private sector would not disappear if the PHI regulatory framework were removed. Some Australians would presumably continue to purchase PHI. Many services would continue to be provided by the private sector and would continue to be purchased by Australians. Australian state and territory governments have the option to purchase private hospital services (which they currently do through workplace insurance coverage schemes), as does the Commonwealth government (through the Department of Veteran's Affairs). Additionally, there are some obvious concerns about the costs and effectiveness of the PHI regulatory framework. A nation contemplating directly supporting the PHI industry would do well to take the step that Australia has not yet taken: to undertake a full and open inquiry into the direct and indirect costs of a PHI regulatory framework, and the costs of other options, such as direct payment of private hospitals or additional funding to the public health care system, to inform public debate.