Legalizing Health Insurance

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IN this year's Budget, the Commonwealth Government announced the introduction of 'Lifetime Health Cover'. Like the 30 per cent rebate scheme, it is aimed at slowing or reversing the decline in private health insurance.

Critics, of course, claim that the rebate is pumping money ($6 billion over 4 years) into the private system, at the expense of the public system. This has some ideological appeal, but is economic nonsense. As with education, private places (beds) can be provided more cheaply to the public purse, because consumers share the cost. So more money is in fact available per user to the public system.

But unlike education, health-care costs are not only large but unpredictable, discouraging use of the private system. Insurance is the obvious answer, so much so that almost no-one uses private hospitals without private health insurance. So the survival of private hospitals depends on viable health insurance.

There are two main problems with the viability of private health insurance:

- it is subject to 'community rating' (all customers pay the same);
- the government's own health 'insurance' system, Medicare, competes unfairly with the private sector.

The results are predictable. Imagine we had Medicare for cars. If you had a prang, you could go to a 'Medicar' garage, and have it fixed for nothing. But you'd have to settle for the salaried duty panelbeater. And if the car was still drivable, you might have to wait. People with private car insurance, on the other hand, could have panelbeater of choice, and faster service on small dings, for a standard premium. But they'd still have to pay an excess.

Who then would insure?

The wealthy might be prepared to pay more for choice, and to avoid having to drive around in a dented Mercedes. Inexperienced or reckless drivers who had regular accidents (who in the real world would pay higher premiums or excess, or be refused insurance) might also pay more to avoid the inconvenience of waiting for repairs.

Of course, premiums would go up. Then people would drop out, leaving the *really* bad, or really rich, drivers still in the insurance pool. So premiums would go up again. And so on.

Clearly a system where insurers could not charge higher premiums to high-risk drivers would be virtually unworkable. Yet this is what happens in health insurance under 'community rating'.

The new scheme of 'lifetime community rating' will work more like life insurance. The older you are when you join, the more you'll pay.

People who take out health insurance at or before age 30 all pay the standard rate, indefinitely. Others pay an extra 2 per cent for every year they're over 30 at joining, to a maximum loading of 70 per cent.

The approach was described in the Commonwealth Health Department's January discussion paper *Lifetime health cover: an unfunded lifetime community rating model for private health insurance*.

The paper proposed a slightly different cutoff age, 'age step', and maximum loading, but we are assured that this doesn't matter. Any of the numbers could be changed.

Now health insurance will be more like insurance. But not much more. Other factors affecting risk, such as drinking, smoking or exercise, are excluded. Even on age, all insurance companies must stick to the one formula.

You might think it simply didn't occur to Health Minister Wooldridge or his advisers to let the insurers set their own age rates. But you'd be wrong.

The paper does consider a 'free market option', if only as a straw man. It is dismissed with the claim that 'funds do not have the data to … undertake the rigorous analysis needed to establish soundly based premium rates set in a competitive environment'. Health funds will 'chas[e] the market', producing 'volatile premium rates' and 'considerable consumer confusion'—the old arguments for price-fixing.

It is not clear, however, that governments have the data either, let alone that they have done the rigorous analysis. The figures used (and the statement that actual figures do not matter much) sound more like someone has said 'how about 2 per cent a year over 30?'

But do they need rigorous analysis? After all, the Medicare levy doesn't go close to paying for Medicare, and no-one seems to mind. The Government doesn't have to break even, so does it need to get the sums right?

Well, yes. Even if one accepts that government businesses can run at a loss, here we are talking about setting fees for private businesses. Justice aside, the Government may not care whether insurers make a profit, but they will if the industry folds.

When they say that the funds don't have the data, they may be quite right. Life insurance companies employ actuaries to work out who's likely to die when, so they can charge premiums based on risk. But actuaries aren't needed for hospital cover. Community rating and reinsurance mean that there's no point to estimating risk. The Government has created the conditions where health insurers no longer act like insurers. Change those conditions, though, and they'll soon learn.

It seems that the Government may know that lifetime health cover is no more of an answer than the 30 per cent rebate was. They are talking about a range of other measures to prop up the industry:

- *Loyalty bonuses* to encourage long-term members;
- *Co-ordinated care and early discharge programmes* to increase control over patients' use of services; and
- *Simplified billing* to control the surprise out-of-pocket expenses faced by private hospital patients.

All of these may continue to arrest the decline, perhaps even stabilizing the ailing industry. But the Government created the illness in the first place. It regulated its premiums, and set up a publicly-funded system in competition with it.

Until this is changed, it is hard to see how there will ever be a viable insurance market in health.

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