The New Zealand Experience

the approach to private health insurance in New Zealand

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1 Introduction

Canada, Australia and New Zealand take very different approaches to their private health sectors, including the regulation and subsidisation of private health insurance. In New Zealand, whether or not to take out private insurance is an individual decision about which the Government is largely silent. There is no expectation that people will take out insurance and certainly no compulsion or inducements in terms of subsidies. Regulation of the industry is minimal, with no community rating or restrictions on services that can be included in policies.

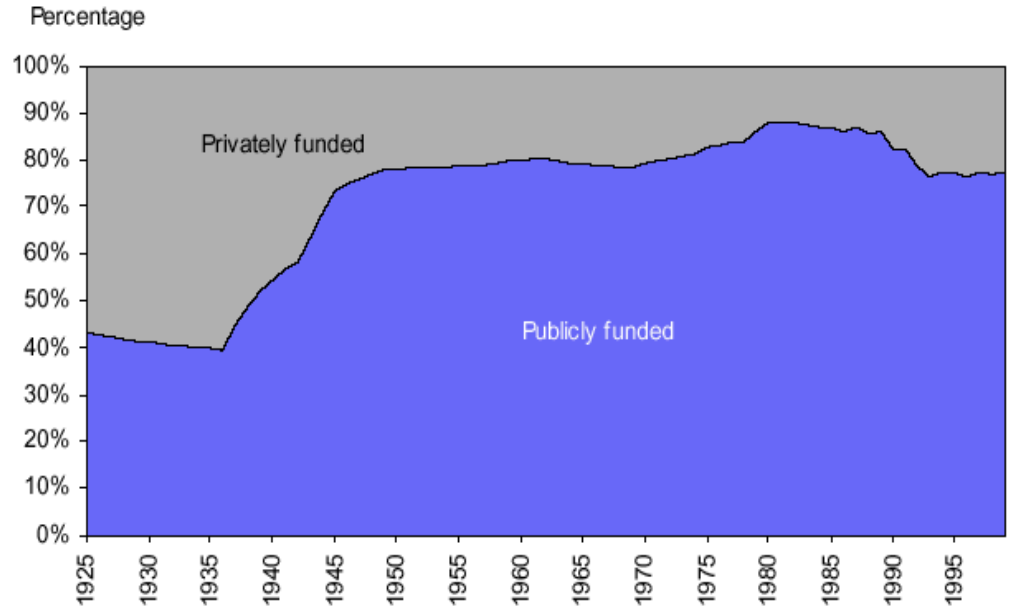
This paper describes the New Zealand approach to private health insurance and the rationale behind it. The paper starts by setting out some facts and figures about the New Zealand health sector.

2 Current arrangements

2.1 Sources of finance for health services

The first graph shows how the proportions of public and private financing have changed over the last 75 years.

Figure 1: Publicly and privately funded expenditure



Source: Health Expenditure Trends in New Zealand 1980-1999

The main sources of finance, their contributions to total spending and a brief description of their characteristics are set out in the following table for 1998/99.

Table 1: Sources of finance for health and disability services 1998/99

	Percentage of total expenditure	People contribute via	Contribution based on
Publicly funded	77% ($6.9b)	General taxation (income tax, GST, excises on tobacco, petrol, alcohol etc)	Income, expenditure, consumption of tobacco, petrol, alcohol
Out-of-pocket payments	16% ($1.3b)	GP fees, prescription charges, rest home fees, charges for equipment for people with disabilities, paying direct for private surgery	Sickness and disability. Some element of ability to pay (eg, paying to have surgery in a private hospital without a waiting period)
Private insurance	6% ($0.5b)	Private insurance contributions (may be paid by employer)	Willingness/ability to pay for more care, greater choice, less waiting etc If employer-provided, having private health insurance may not be a deliberate choice

At the end of 2001, the Government announced a 3-year funding path for Vote Health covering the period 2002/03 – 2004/05. This represented a major departure from the previous annual budget-setting process for Health and reflected a commitment to increase certainty about health funding and enable better planning and management in the New Zealand health sector.

2.2 Contribution of private health insurance

As the table shows, private insurance contributes only about 6 percent of financing for health and disability services or about $520 million in 1998/99. The proportion was as low as 1.1% in 1980. Insurers report that 1.36 million people, or about 37% of New Zealanders are currently covered by health insurance and that the average cost of a premium is about $435 per life covered.[1] This compares with 41% of New Zealanders covered by private health insurance five years ago. The main types of private health insurance plan are shown in the next table.

Table 2: Health insurance by type of plan 2001[1]

Plan	*Premiums $m*	*% total*	*Lives covered*	*% total*
Comprehensive	400	68	768,000	56
Major medical	191	32	593,000	44
Total	591	100	1,361,000	100

[1] *Future Health Care Financing and the Public-Private Interface*, NZIER December 2001 (includes GST).

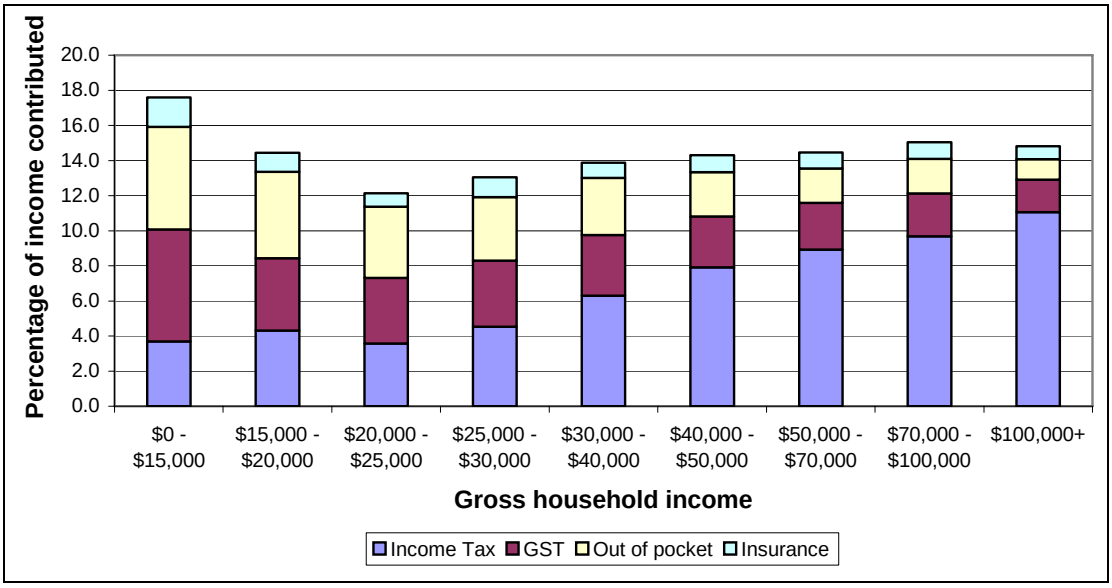
A little over 60 percent of total spending on health insurance goes towards elective care in private hospitals ($325 million in 1998/99). There is also a significant level of out-of-pocket spending ($245 million in 1998/99) on private hospital surgical and medical care. Private insurers in New Zealand do not cover acute hospital care.

After private hospital care, private insurance contributions towards GP fees come a distant second ($65 million in 1998/99), followed by pharmaceuticals ($41 million in 1998/99).

2.3 Households' contributions to health financing

The figure below shows how the contribution to health financing varies by household income and by financing source.

Figure 2: Contributions to health financing by household income



Source: Household Economic Survey 1997/98

The pattern shown above for private insurance looks somewhat counter-intuitive, with those on the highest incomes spending a similar or smaller proportion of income on insurance than some lower income bands.

However figure 3 below shows the expected pattern, with higher income households being far more likely to take out private health cover than low income households.[2] The percentage of households with insurance ranges from 13 percent for the lowest income band to 63 percent in the top band. In terms of percentage of income, the cost of purchasing insurance for higher-income households is modest.

[2] Note that this information is based on reported household expenditure. Therefore, people receiving insurance fully funded by their employers are not captured in this graph.

Figure 3: Percentage of households reporting spending on health insurance

2.4 Regulation of private health insurance

Health insurers are very lightly regulated in New Zealand. What little regulation there is relates to financial and auditing requirements to ensure the ongoing financial viability of the insurer and to protect members against insurer misuse of funds. The range and nature of cover offered by health insurers, including the regulation of premiums and membership or enrolment, are not regulated at all.

The only live issue in New Zealand around health insurance regulation centres on whether existing capital adequacy and solvency standards are provide enough protection for policyholders. Government agencies have proposed that health insurers should be governed by the Insurance Companies (Ratings and Inspections) Act 1994 while the industry has argued for self regulation. There is no active debate in New Zealand at present about requiring community rating or other forms of regulation of private health insurance.

3 Public and private roles

To consider whether the current treatment of private health insurance in New Zealand is appropriate, it is important to understand the principles underpinning New Zealand's publicly-financed health sector and the basis for determining what services are publicly financed. This is done in the following sections.

3.1 Principles for public coverage

The New Zealand Government has stated the following principles that underpin publicly-funded health and disability services:

a all New Zealanders must have access to an acceptable level of health and disability support services when they need them, regardless of ability to pay

b it is a core responsibility of the government to finance and provide (or ensure provision of) a comprehensive public health system and that commitment will be maintained.

Two current policy commitments will significantly extend public funding of health and disability services:

- a key aim of the Government's Primary Health Care Strategy is to move to low cost access for all to primary health care. This will involve a significant increase in public funding of primary health care over the next 8-10 years. (Note that as a result, the role for private insurance in providing cover for these co-payments will reduce over time.)

- the Government is committed to removing asset testing for residential care (in rest homes and private hospitals) for the elderly. This means a major shift in responsibility for financing this form of care from individuals to taxpayers.

3.2 Determining public coverage

Historically, there has been little attempt around the world to develop a principled basis for determining the boundaries of the publicly funded system. In New Zealand the level at which publicly-financed services are described, and the basis of their availability varies enormously as illustrated by the following table.

Table 3: Category and basis of availability of publicly-funded services

	Free for:	Partially subsidised for:	Access to free care/subsidy based on:	Not covered
Visits to GPs	Most children under 6	All except adults without CSC or High Use Card	Income, family size, frequency of visits	Adults without CSC or High Use Card
Breast screening	Women aged 50–64 plus those at risk	Other women referred for screening	Need and ability to benefit assessed at a population level	Women under 50 or over 64, unless identified as at risk
Maternity services	All women	Fully funded	Pregnancy	Access to specialist care where not indicated by risk factors
Emergency ambulance services	ACC patients within 24 hours and Wellington area patients	All other emergency situations	Type, timing and location of emergency	
Counselling services	People accessing services in a hospital setting	Victims of sexual abuse can receive subsidised counselling in a community setting	Where care is provided and the cause of the health need	Patients with mental illness seeking counselling in the community
Optometry	Nobody	Nobody	Whole service outside public scope	
Elective surgery	Everyone	Fully funded	Medical need and ability to benefit	Low-benefit procedures
Long term residential care for age-related disability	People under 65 and people aged 65+ with minimal assets/income in rest homes and private hospitals	People aged 65+ with rest home or private hospital costs above $636 per week	• Need for residential care • Income and assets for those aged 65+	Care provided at home by family members
Residential care for other people with disabilities	People in institutions or community homes	Fully funded	• Need • Type of setting in which care is delivered	Care provided at home by family members

As Table 3 shows, a service being 'publicly-funded' can mean a multitude of things:

- funding can be full or partial
- it can be based on age or on individual need
- it can be affected by income level or family size
- it can depend on the particular setting in which care or support is delivered.

3.3 Improving clarity

In recent years, there has been an increasing emphasis on specifying what is covered by the publicly-funded system. There are now multiple forms of documentation that make it more explicit when, and under what circumstances, services will be provided to individuals. These include:

- the document '*What Can I Expect?*' produced by the (now disestablished) Health Funding Authority and aimed at the general public
- the Service Coverage Schedule and National Service Specifications, which are used mainly by the Ministry and District Health Boards
- National Referral Guidelines and the priority access criteria for elective services, which are used by GPs and specialists
- the Pharmaceutical Schedule, which is explicit about what pharmaceuticals are subsidised, under what conditions, and which is used by prescribers and pharmacists.

Further improvements in clarity about what services are publicly-funded and on what basis would yield the following benefits:

- increase certainty and security for the public
- increase fairness by being transparent about what is available and on what basis so that people can request services with more confidence
- make it easier for people to decide whether they want or need additional arrangements such as private insurance (and if so, what the insurance needs to cover) or personal savings to enable direct payment for any services they might need that are not funded publicly
- make it easier for private providers and insurers to tailor their services to 'fill the gap'
- provide a starting point from which to improve prioritisation and to drive for better value from health and disability spending
- make it easier for the government to make funding decisions (because it will have much more certainty and clarity about what is being purchased now and what any new funding could be used for).

The development of the priority assessment system and maximum waiting times for elective surgery provides a good model of the clarity possible for publicly-funded services.

Case study: elective surgery

Elective surgery is free to patients in the public system but, because there is a capped budget, the amount of surgery provided is rationed. In the past, this rationing was largely implicit, and many people experienced long waiting times for surgery.

Over recent years, nationally consistent assessment guidelines have been developed, which help to assess a person's level of need and ability to benefit from treatment relative to other people who have been referred to the service. On the basis of this assessment, patients are either:

- given a firm treatment date within the next six months (booked)
- informed that they will receive publicly funded treatment within the next six months and that the treatment date will be provided closer to the time (certainty of treatment)
- informed that publicly funded elective treatment cannot be guaranteed to people with their level of need at this time. They are then cared for by their GP and/or specialist, which may include a review of their condition at regular intervals (active review).

There is therefore an explicit or implicit 'threshold of need' above which patients are given some form of certainty about their treatment, and below which patients are told that they will not be treated at that time. This threshold is, by necessity, set at a level determined by the budget for each particular service. Therefore, there are treatments that would be advised by specialists, but which are not done in the public sector because there are more needy cases to do.

To recap then, the aim of the New Zealand Government is to provide comprehensive publicly-financed cover and to be clear about what is included. Given this, we turn now to consider what role remains for private health insurance.

4 The role of private health insurance

As noted in the introduction, whether or not to take out private insurance is an individual decision about which the Government is largely silent. There is no expectation that people will take out insurance and certainly no compulsion or inducements in terms of subsidies. As described above, regulation of the industry is minimal. There are no restrictions on the types of services that can be covered by private health insurers and no requirements for community rating.

4.1 Criteria for assessment

As collective forms of financing, clearly both general tax financing and private insurance *spread the financial risk* associated with needing health or disability support services, and therefore protect individuals from the potential hardship

of having to pay for expensive care or missing out on care because they cannot afford it. Public forms of collective financing overcome some of the problems that arise with private insurance by:

- providing universal cover (ie, everyone is covered, including people with pre-existing illness or disability who may have difficulty purchasing private insurance or who would face much higher premiums)
- providing comprehensive cover, including the very high-cost services that might be excluded from a private insurance policy
- spreading the costs according to ability to pay (eg, through the general taxation system).

In addition, public forms of collective financing enable the government to *pursue gains in health and independence* and *reduce inequalities* through:

- prioritising services to meet specific health and independence objectives
- limiting and/or targeting co-payments.

The following criteria are suggested for assessing the performance of different forms of health financing. A source of finance should:

- support/facilitate improvements in health and independence and reductions in inequalities in health status
- raise funds equitably
- allow costs and aggregate spending to be controlled
- provide a stable and predictable flow of revenue
- be transparent and acceptable to the public
- contribute to a growing and inclusive economy by having low collection costs and minimal impact on incentives to work and save
- improve cross-sectoral co-ordination.

4.2 Assessment against criteria

Private health insurance is assessed against these criteria below.

Supports improvements in health and independence and reduces inequalities

Private insurance is generally positive for health outcomes for those using them to gain more timely access to specialists and hospital treatment. Privately-financed services are being accessed largely (and not surprisingly) in accordance with ability to pay. As already stated, higher income people are far more likely to have private insurance, leading to uneven use of the private sector by different income groups. Given that lower income people have lower health status on average, this pattern is likely to be lead to worse outcomes for the population as a whole. Inequalities are also likely to be exacerbated. The question of how the use of private health insurance impacts on health outcomes for people using the publicly-financed system is discussed further below under the heading “The overlap”.

Secondly, private insurers often exclude pre-existing conditions from cover under their policies and generally charge higher premiums for older people who make heavier demands on services. Of course, these practices are entirely understandable from the perspective of keeping the insurance business viable. But these characteristics do not measure up well in terms of supporting improvements in health and independence.

Raises funds equitably

The fact that a substantial proportion of higher-income households have private insurance, or can pay directly to access private care, has two quite different implications for equity. On one hand, many people argue that purchasing services privately amounts to paying twice: once for the public system through taxes, and again through private payments. But taking another viewpoint, people who access the private sector are more likely to be able to bypass bottlenecks in the public system, thereby gaining faster access to care. Access to services on the basis of ability to pay, rather than need, raises issues of fairness. Further issues of fairness, arising from the way the public and private systems interact, are discussed below.

Control of costs and aggregate spending

Historically, insurers in New Zealand have operated on the indemnity model, which tends to be ineffective for controlling costs, both in aggregate and at the individual service level. The problems of adverse selection, moral hazard, and a continually expanding range of services have led to increasing premiums and falling membership, making private insurance revenues less **stable and predictable** than publicly-funded options.

Transparent and acceptable to the public

Private health insurance provides a more transparent link between payment and entitlement to services than tax financing, although nowhere near as direct or transparent as out-of-pocket payments. While this is a positive feature, it is clear that there is some dissatisfaction with premium levels, especially among older people who may have paid for insurance all their lives and find that, when they most need it, insurance becomes unaffordable.

Administration costs

For private health insurance these are high relative to publicly-financed options.

Effect on incentives

Private financing of health and disability services does not affect incentives to work and save. It is therefore preferred to public financing in this respect.

Cross-sectoral co-ordination

This is not facilitated by any form of private financing of health and disability services.

To sum up, as a source of finance for health services, private insurance does not perform strongly compared with general tax financing. This is particularly so in respect of supporting improvements in health and reducing inequalities in health status between population groups – the New Zealand Government's overarching health priorities.

The preceding section looked at private health insurance in isolation, as if it financed a self-contained parallel private system with no impact on the publicly-financed health sector. In fact this is not the case – the close relationship between the public and private health sectors in New Zealand raises a number of issues that can impact on the achievement of policy objectives. These are discussed next.

5 The overlap

Since there are no restrictions on the services that can be provided or insured privately, there is an 'overlap' or parallel private system in New Zealand for some services. This overlap creates:

- a 'two-tier' system where everybody can access publicly-funded services paid for through taxes, but there is also a privately-financed option
- interdependencies, which means that activity in one sector can impact on the other
- perverse incentives and the potential for conflict of interest when health professionals work in both sectors at the same time, or have a financial stake in a private facility.

All of these features can affect the achievement of public health and independence goals, and raise concerns regarding equity.

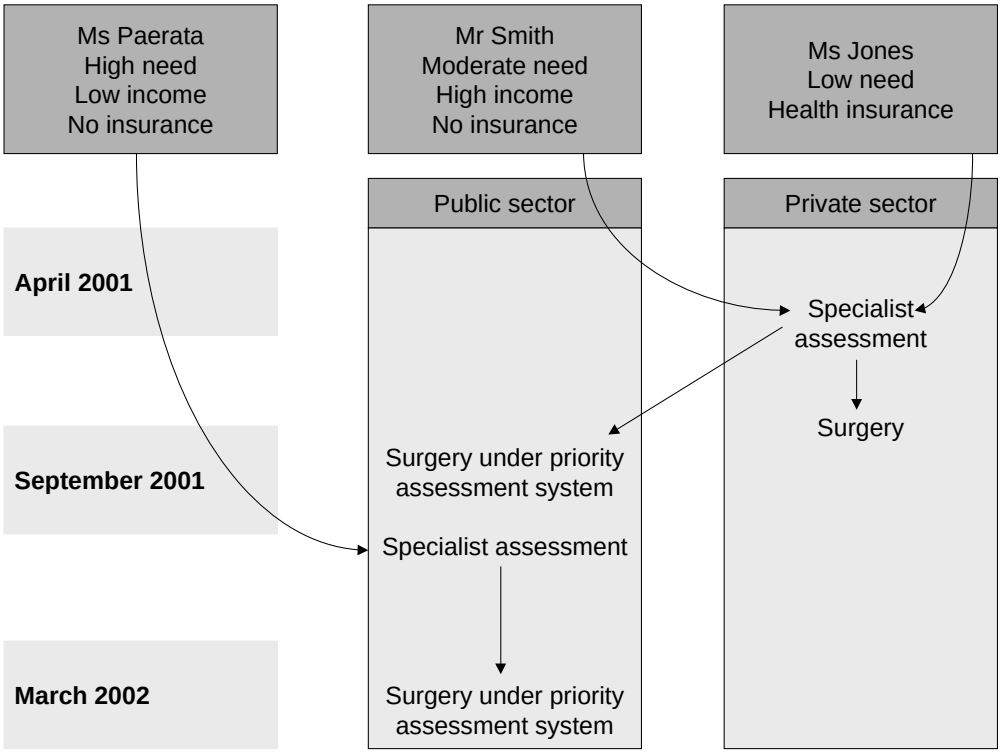
5.1 Two-tier system

The two-tier system operates where waiting lists exist for disability support equipment (eg hearing aids) or particularly expensive and rationed drugs. Paying privately in these cases will allow quicker access, at a lower level of assessed need. However the most obvious example of the two-tier system in New Zealand is elective surgery.

Case study: Elective surgery

Paying privately for elective surgery can give a person quicker access, more certainty and choice about the date of surgery, choice of specialist, more pleasant amenities and, perhaps most important, access to surgery at a lower level of need than in the public sector. The following figure illustrates the way in which the private sector can be used to gain faster access at lower levels of need, such as paying for a specialist assessment privately, then being referred into the public system (see Mr Smith below).

Figure 4: Use of public and private sectors for elective services



Differential access to services based on ability to pay appears to be a broadly accepted feature of New Zealand's health and disability support sectors. A publicly-financed system will always need to assess the benefits of particular services and then prioritise so that taxpayers' money is used effectively. At the same time, there will be individuals who want, and can afford to pay, for services that would not meet the test for public funding (eg, interventions with only a minimal chance of improving outcomes). The private option allows them to do so, either directly or through private health insurance.

Better access for those on higher incomes to cosmetic surgery or extra amenities (such as, a private, more pleasant room) may well be acceptable. After all, high-income people have better access to higher quality goods and services of all kinds. However, it is less acceptable when ability to pay affects access to necessary services such as specialist assessments and surgical procedures offering significant health benefits. Although improvements are in

progress, some of these services can still only be accessed in a timely way in the private sector.

5.2 Interdependencies

The significant overlaps and interdependencies between the public and private sectors can have important benefits. For example, in some parts of New Zealand, or in some specialties, publicly-financed work alone would be insufficient to attract a specialist. The volume of publicly-financed cases might also be inadequate to enable health professionals to maintain competency levels.

However, overlaps can also act to impede the publicly-financed system. A mixed system can create situations where people who privately finance some or all of their own care are effectively preventing others from receiving publicly-financed care.

Some of the interdependencies between the two sectors are described below.

- Some costs generated by patients being treated privately are in fact met by the public system (eg tests ordered from community laboratories or drugs prescribed following private hospital care).
- If health professionals are attracted into the private sector by increased demand, costs are imposed on the public system in training more health professionals and/or recruiting from overseas. While that happens, public patients may miss out on care.
- Patients sometimes move back and forth between the two sectors. For example, a person might pay for a specialist assessment privately, then be referred for public treatment, thus reducing waiting times and 'jumping the queue' (see Mr Smith above). In some other cases, patients treated privately may be transferred into the public sector if the case proves too complex, or something goes wrong.
- Insured patients who do not bear user charges out-of-pocket are likely to access primary care more readily than other people. While the costs of access to GP services may be met privately, the insured person may then attract further public funding for prescriptions, laboratory tests and so on.
- Insured patients will be less sensitive to professionals increasing their prices for services, which can be a disadvantage if the government aims to keep fees as low as possible for uninsured groups.

5.3 Health professionals involved in both sectors

If there were no overlap between the public and private sectors, the employment arrangements of health professionals within these two sectors would be of little public interest. However, at present there is a considerable overlap, particularly for non-acute or elective hospital services.

Many specialists work across both sectors, often half the time in each sector. In aggregate, specialists spend more time in the public hospital sector: 48.9 percent of total hours compared with 39.8 percent in private medical practice.[3] In other countries health professionals may be either fully employed in one sector or the other, or have specific constraints on the extent of supplementary employment in the private sector (eg, in the UK, National Health Service specialists are restricted to 10 percent employment as a private consultant).

Further, specialists are employed on a salary in the New Zealand public health system, while work in the private sector is remunerated based on rates for various procedures. Differing forms of remuneration for essentially the same work create their own incentives for specialists working part-time in each system. The UK and Australia also use systems of remuneration that differ between the public and private sectors.

The competitive aspect of public and private providers for non-acute services means that the types and quantity of services offered in one sector affect the production and consumption of services in the other sector. As one New Zealand health economist noted:

> *"Specialists who control both patients and resource utilisation may have vested interests (ie, perverse incentives) in achieving efficiency objectives across either sector, particularly if there exist remuneration differentials between sectors."*[4]

It is difficult to calculate the extent of any remuneration gap for specialists working in the public and private sectors. However, it was estimated that in 1999 private sector remuneration rates were $100–$200 per hour (net of practice costs) versus $50–$75 per hour in the public health sector. In the same year full-time equivalent (40 hours per week) public sector incomes for specialists rarely exceeded $200,000 while private sector incomes were often found to be above $400,000 per annum.[14]

While it is difficult to clearly demonstrate a 'waiting-time effect' arising from specialists working jointly in the public and private systems, some evidence of differential waiting times for public health specialists with private practice have been collected.

There is some evidence in the UK that lengthier waiting times are associated with NHS consultants who also have private practices.[5] But the UK picture is incomplete because of a lack of data clearly demonstrating 'cause' (private practice) and 'effect' (longer waiting times for elective surgery). A Canadian

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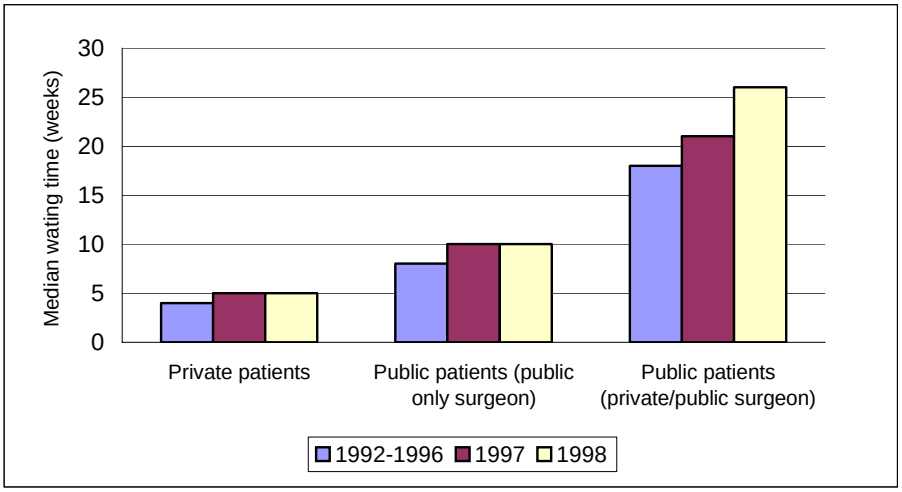
[3] Source: Medical Council, *New Zealand Medical Workforce in 2000*, December 2000, Table 4.3, page 14.

[4] Pim Borren (2000) *Healthcare Review on Line*, Vol 4(3), pp.2–3.

[5] John Yates (1995) *Private Eye, Heart and Hip*, pp.125–39.

study[6] on waiting times for cataract surgery (at a time when this services was available both publicly and privately in Canada) found that patients waiting for public sector cataract surgery would wait up to 26 weeks longer in 1998 if their surgeon also operated privately. These results are shown in Figure 5.

Figure 5: Cataract waiting time by surgeon practice-type



A related issue is that a physician may own part of a private facility, so that his or her income is affected by the facility's profitability as well as perhaps directly through fee-for-service arrangements. It has been shown that physicians with a financial stake in facilities refer patients more often for treatment or clinical diagnosis services provided at those facilities, than their colleagues with no ownership stake.[7]

However, it is also well known that a significant remuneration gap exists between many New Zealand health professionals and their colleagues in many other countries, which affects the overall level of supply of increasingly mobile health professionals in New Zealand.

It has been argued that without the cross-subsidisation by higher private sector incomes, the level of remuneration in the public sector would have to be significantly higher to retain specialists in the New Zealand public health system. That said, cross-subsidisation is not as desirable as it may seem at first sight. As noted above, it can create perverse incentives: if specialists are successful in reducing waiting times in the public sector, the demand for their better-paid services in the private sector, will fall. If the price being paid for this 'subsidy' is an inability to achieve timely treatment for elective procedures in the public sector, the price may be unacceptably high.

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[6] C DeCoster, KC Carrière, S Peterson, R Walld, L MacWilliam (1998) *Waiting Times for Surgery in Manitoba*. Manitoba Centre for Health Policy and Evaluation. Available at: http://www.umanitoba.ca/centres/mchp/reports/waits2.htm.

[7] Marc A Rodwin (1993) *Medicine, Money and Morals,* pp.67–79.

Having now considered the issues arising from the overlap or parallel private system in New Zealand, we come now to address the arguments for and against subsidising private health insurance.

6 Subsidies for private health insurance

Interest in subsidising private health insurance in New Zealand has been revived over the last year by the Health Funds Association of New Zealand, which represents health insurers. The Association commissioned a report from the New Zealand Institute of Economic Research (NZIER),[8] which argued for tax credits for people who have health insurance. This section briefly reviews the arguments for and against government subsidies for private insurance.

Arguments for subsidising private health insurance are most often based around the claim that people with insurance place reduced demands, if any, on the public health system and that this saves the Government money. Another common argument is that it is unfair for a person to pay for healthcare twice: once through their taxes and again through insurance.

6.1 Saving Money?

The cost of subsidising private health insurance is the amount paid out each year to holders of health insurance policies (the rate of the subsidy multiplied by the total value of premiums paid). An obvious alternative would be to spend this same amount to fund additional health services directly.

The benefit of subsidising private health insurance is the value of the health services provided as a result of additional health insurance coverage. However, $1 spent by the government towards health insurance premiums will not be equivalent in value to $1 spent funding the public health system, since:

- health insurance pays for some services which are likely to be of lower priority and, therefore, lower benefit than would have been funded in the public health system (eg, surgery which does not meet criteria for public provision)
- private insurers have higher overhead and administrative costs than the tax system
- privately-financed health care is generally more expensive than publicly-financed care (although some of this extra expense pays for better quality amenities) largely due to higher rates of remuneration for doctors in the private sector
- under many policies, health insurance covers charges imposed by the government in the first place, such as GP and pharmaceutical part-charges

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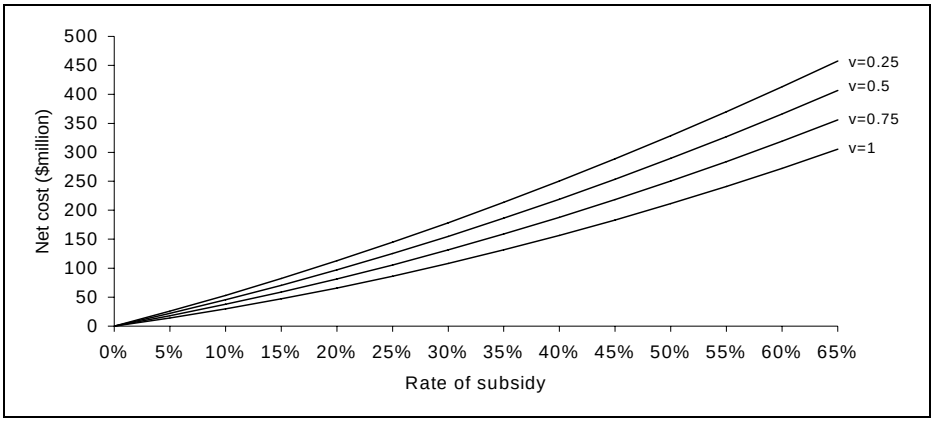
[8] *The Tax Treatment of Health Insurance Premiums*, NZIER 2001. Available at http://www.healthfunds.org.nz/Downloads/tax_treatment.pdf.

- many of those taking out health insurance will be switching from self-insurance, in which case there is no impact on demand for publicly-funded services.

When modelling costs and benefits of subsidising private health insurance, various assumptions must be made about the value of additional spending on health insurance relative to additional spending directly on the public health system. Whether the benefits of subsidising insurance exceed the costs depend on how people respond to the lower cost of insurance premiums. However, it is clear that the demand for health insurance is not very responsive to changes in the cost of premiums. The NZIER report claims that the price elasticity of demand for health insurance is –0.54.[9]

At this elasticity, the costs of a health insurance subsidy will always be greater than the value of the additional health services stimulated by the subsidy, even under the most favourable assumptions (see Figure 6 below). The main effect of the subsidy is, therefore, simply to transfer money to people who would have had health insurance anyway.

Figure 6: Net cost of subsidising private health insurance, for different subsidy rates and assumptions of relative value



Notes

1. Assumes price elasticity of demand for health insurance of –0.54.
2. The parameter 'v' varies from 0 to 1. When v=1, $1 spent on health insurance is equivalent to $1 of direct public funding. When v=0.5, $1 spent on health insurance is equivalent to 50c of direct public funding.

Example

Assume that health insurance currently covers 1.36 million people and the average cost of a premium is $435 per life covered. A 30 percent tax subsidy on health insurance premiums would:

- cost the Government $206 million per year
- realise benefits of $96 million (under the most favourable assumption that $1 spent on health insurance premiums is equivalent to $1 of direct public funding)
- resulting in a net cost of $110 million.

[9] At an elasticity of –0.54, a 10% reduction in the cost of premiums, for example, would result in 5.4% growth in spending on private health insurance.

The NZIER report claimed that the net cost of subsidising health insurance would be lessened by:

- taking into account the indirect benefits of an increased uptake of health insurance such as the reduction in lost working days as a result of earlier treatment
- targeting the subsidy at households with low incomes, in order to reduce the degree to which the subsidy gives money to those who already have health insurance.

Evidence would be needed to support and quantify any indirect benefits claimed for health insurance subsidies. Further, any indirect benefits created by an increase in insurance coverage would need to be balanced against the net cost of the subsidy. In the 30 percent subsidy illustration given above, for example, the indirect benefits accruing from an additional $96 million of expenditure on health insurance would likely be far outweighed by the net cost of the subsidy of $110m.

It is also doubtful that low-income groups would respond to a price incentive more eagerly than the population as a whole. While low-income households tend to be more price sensitive in general, it is questionable whether health insurance, even if it were subsidised, would be a priority purchase from a limited budget. Older low-income people (who are high users of the public system) face an even tougher affordability barrier, since health insurance premiums are much higher for people aged over 65 years.

6.2 Other Arguments Against Subsidies

In addition to the extra costs, encouraging private health insurance in New Zealand through subsidisation would have a number of other negative impacts; it would:

- distort choice away from the self-insurance option creating allocative inefficiencies
- exacerbate the inequities and negative health consequences mentioned above that arise in the two-tier system
- due to the interdependencies mentioned above, make it more difficult to achieve the Government's goals for timely, prioritised elective surgery in the public system.

Overall, there does not appear to be a good case for using public finance to provide tax incentives for private health insurance. The funding required for a subsidy would be better spent directly on funding the public health system.

7 Conclusion

The New Zealand Government is committed to a comprehensive publicly-funded health and disability system and this is confirmed by recent policy developments. Alongside comprehensive public cover, there is a commitment to improve clarity and certainty around what the publicly-funded system offers, and to provide more certainty about funding levels into the future.

Given these aims for the public system, the main role remaining for private insurance is to pay for faster access to elective surgery in private hospitals. An alternative for people wanting faster access than the public sector can provide is to pay directly out-of-pocket if the need arises. After all, many of the procedures paid for by private insurance are reasonably low cost.

Arguments in favour of subsidies for health insurance have not proven persuasive to any New Zealand government for many years and there does not appear to be any prospect of that changing. Perhaps a more likely focus for policy change in respect of the private health sector is the public-private interface, in particular, the negative consequences of the overlap between the two systems.

Given New Zealand's tradition of allowing a parallel private option, the elimination of the overlap, for example through a Canadian-style approach, would not be a starter. However policy options to mitigate the negative consequences of the overlap and thereby improve the ability of the public system to deliver, may be possible.