

The Platypus Economist

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A good health economist is a bit like a platypus, or at least so-says a health economist colleague of mine.² The friendly beast must combine a clinician's medical knowledge with an economist's techniques, both theoretical and empirical, and a bureaucrat's understanding of the administrative structures within which policy operates. Perhaps the health economist's empirical techniques are not as refined as the theoretical econometrician's, just as the platypus's fur is perhaps not quite as soft as that of a kitten, but it does a good job of combining a set of characteristics that are normally not found in one place. Unfortunately, health policy instead seems set by a chimera that rather seems to have taken the design specifications for the platypus and decided that the kitten should in fact provide the beak and the duck provide the fur: we too often find combined the clinician's goal of health care, as maximand; the economics undergraduate's captivation by partial equilibrium and neglect of general equilibrium; and the bureaucrat's inadequate respect for methodological individualism. The papers in this *Agenda* Special Issue on health economics work to bring more standard economic method back into health policy analysis.

Harrison and Robson lead off by skewering one of the worst such recent chimeras: Australia's National Preventative Health Taskforce. Yes, health is a good thing; but it is hardly the only possible element in individual utility functions. Setting health as maximand and taking privately borne costs of ill-health as evidence of individual irrationality or information failure is unlikely to yield policy consistent with good welfare economics. Thus the Taskforce cites smoking as generating more than \$30 billion per year in 'costs to the economy' by relying on a study that, by assuming away private consumption benefits of smoking, deems privately borne costs to be social loss. The same report deems that alcohol costs Australia some \$15 billion per year; application of more standard method shows that less than \$4 billion of that figure consists of costs properly viewed as external, with the rest being borne by the drinker himself — and those private costs sometimes double-counted.³ But big numbers presented as 'costs' imposed on the country rather than borne by the consumer help to build a sense of public crisis that fuels demand for initiatives like the National Preventative

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2 I thank Andrea Menclova for the initial analogy. Defamation complaints from health policy architects ought, however, to be directed to me alone.

3 Crampton, E., Burgess, M., and Taylor, B. 2011, 'The Cost of Cost Studies', University of Canterbury Economics Department working paper.

Health Taskforce. The subsequent papers each take on different aspects of the interaction between the market for private health insurance and the Australian public insurance program, Medicare.

Robson, Ergas and Paolucci take on the Medicare Levy Surcharge [MLS]. A naïve economic analysis would suggest such levies are a nice way of ensuring that those who can afford their own healthcare either pay for it themselves or compensate the government for their use of the public health system. Robson *et al.* instead use standard price theory to show that, because many wealthy people would optimally self-insure a higher proportion of their health risks in the absence of the MLS, the MLS can have the perverse effect of reducing those consumers' private health insurance purchases if wealth effects are large or, alternatively, of buying more insurance than would have been optimal in order to avoid the MLS.

Paolucci, Butler and van de Ven build on the analysis of Robson, Ergas and Paolucci to argue that the combination of Medicare and private health insurance yields inefficient duplication in coverage and that purchasers of private health insurance ought to be allowed to opt out of Medicare. Because adverse selection might then plague the private health insurance market, the authors argue in favour of risk-adjusted subsidies for those privately insured, with private insurance then charging identical premiums to all potential customers (as the heterogeneity that would give rise to differing insurance charges would be covered through subsidy) and mandated to provide minimal benefits packages to prevent cream-skimming based on factors observable to the insurer but not to the subsidiser.

Finally, Paolucci and Shmueli provide a method for determining an ex-ante prospective risk-adjusted subsidy that could be used to implement the model proposed by Paolucci, Butler and van de Ven. Currently, private insurers draw public subsidy through the claims-equalisation scheme; insurers are constrained by regulation not only to take on all potential applicants but also to charge a premium that does not reflect individual risk. Adjusting the subsidy for individual ex-ante risk characteristics rather than for ex-post claims experience may have desirable efficiency characteristics.

Left to be explored is the possibility that the health system as a whole diminishes private incentives to engage in health-promoting behaviours. As the financial costs of risky behaviour and of unhealthy lifestyles are externalised to those providing the subsidy, the National Preventative Health Taskforce might find it reasonable to mandate participation in morning exercise, regardless of whether the bulk of the effect is pecuniary.⁴ (Touch your toes, Winston Smith!)

4 See Browning, E.K. 1999, 'The Myth of Fiscal Externalities', *Public Finance Review*.

But assuming the mandate is a system that ensures broad access to private health insurance, then — rather than mandating community-rated insurance premiums and compensating insurers for losses — providing instead lump-sum transfers to individuals conditioned on the exogenous elements of their risk characteristics while allowing private insurers to charge rates consistent with individual risk, could maintain the desired broad accessibility and, at the same time, preserve private incentives to make optimal choices among competing elements of a utility function broad enough to incorporate both health and other goals.

Health economists, duck-billed and otherwise, will find plenty to wrestle with in this Special Issue.