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The public view of private health insurance

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Professor Hall serves in an advisory capacity to the NSW and Commonwealth governments. She is currently a member of the Australian Medical Workforce Advisory Committee and the Teaching and Research Implementation Group of the NSW Health Department. Previously, she was a member of the NSW Cancer Council Board, the Council of the Australian Cancer Society, the NSW Health Economic Reform Committee, the National Health and Medical Research Council, the Evaluation Working Party for the National Mental Health Strategy, and consultant to the National Strategic Review of Health and Medical Research. She has served on the NSW Health Council, advising the NSW Minister for Health on health systems reforms. In 1991, she received the Australasian Society for Evaluation Award for her contribution to evaluation in Australia. Since 1997, she has been the Commonwealth Fund's Harkness Fellowship representative in Australia.

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Summary

Until the 1996 Federal election, the Liberal Party remained committed to the repeal of Medicare. In that election the Liberal platform endorsed the continuation of Medicare, and support for private health insurance. Since then the Government has pursued a strategy of support for private health insurance involving three stages: one, rebates for the poor and penalties for the well-off; two, universal rebates; and three, departure from community rating to what has been described as 'lifetime health cover'.

This paper reviews the coverage by the quality media of the private health insurance issue from the beginning of 1996 (prior to the beginning of the formal election campaign) to the end of 1999 (after the announcement of lifetime health cover).

Over 500 articles were reviewed. Federal elections and budgets are most likely to trigger articles on private health insurance. The topic has become newsworthy, with stories now appearing which report only changes in insurance coverage. Most articles report differing perspectives on the issue; however, opposing views are frequently given little column space and appear at the end of the article. While many articles report events in a factual way, there are a significant number which provide only one perspective or viewpoint. The media rely heavily on authoritative experts and these are usually spokespersons for the private sector and the organised medical profession. When independent figures are quoted, there has been no disclosure of any financial or other links with the private health sector.

The story angle was generally conflict between the various stakeholders, although the politics of health policy was also a major theme. The editorials, in contrast, urged a view of what was good for the country, rather than the winners/losers in a political conflict. The *Age* and the *Sydney Morning Herald (SMH)* took quite different stances on the issue of access, hospital costs and the importance of community rating.

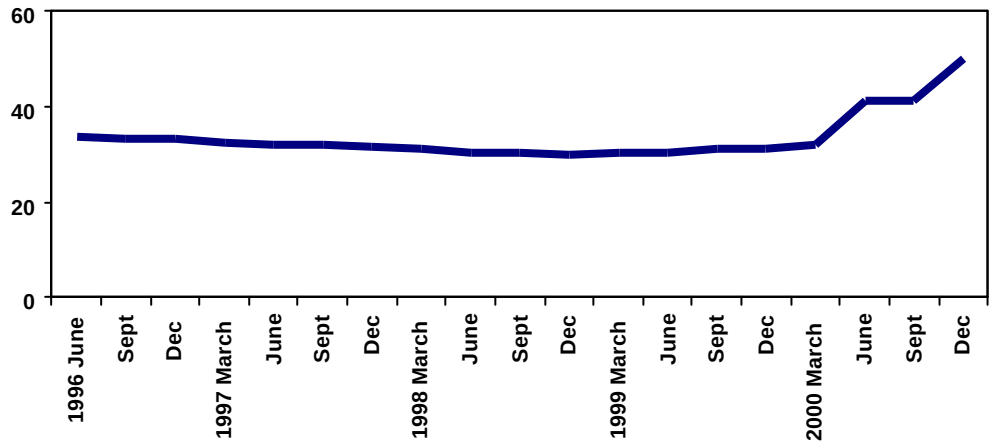
Clearly, the media has a role to inform. Many articles are a means of disseminating new policies, or explaining their detail, or advising individuals of the implications for them. However, the media has also defined what and why private health insurance is a problem, floated unpopular policy responses, defined the solution and popularised it.

For those concerned to see public debate on private health insurance, to promote information and evidence as a basis for policy, and to see community values inform health policy, there is little here to encourage.

Introduction

The proportion of the Australian population purchasing private health insurance has fallen steadily, from 80 per cent in 1970 (Australian Institute of Health and Welfare (AIHW), 1992) to 50 per cent in 1984 when Medicare was introduced, to a low of 30 per cent in 1998 (PHIAC, 1998). At the time of the 1996 election, there was considerable concern about 'health'. Rising premiums and well publicised cases of privately insured patients facing very large out-of-pocket expenses were set against media and community concerns over public hospital waiting lists and tight budgets. Private health insurance was not seen as good value. The Liberal Government, elected in 1996, embarked on a strategy to arrest and reverse the decline in private health insurance coverage, while maintaining the universal entitlements of Medicare. There were three parts to this strategy; first, rebates on premiums for low income earners and financial penalties for high-income earners without private health insurance, second, a universal 30 per cent rebate on all private health insurance, and third, lifetime health cover (these are explained in more detail below). By mid-2000, private health insurance had reached a new high, with over 40 per cent of the population covered, albeit at the cost of making private health insurance one of Australia's most heavily subsidised industries (Duckett and Jackson, 2000).

Fig 1: Percent with Private Health Insurance 1996 - 2000



Source PHIAC 2001

Health has been a major election issue since at least the 1970s and remains so (Hall and Viney, 1999). The role of private health insurance in the Australian health care

system remained the substantial difference in health policy between the two major political parties for much of that time. Until the 1996 Federal election, the Liberal Party remained committed to a repeal of Medicare as a universal program and a return to a much stronger role for private health insurance. In the run-up to that election, the Liberal platform instituted support for the continuation of Medicare, leading some observers to comment that the major health policy difference between the two major parties had been resolved (Swerrisen and Duckett, 1997).

How, then, was such a major policy change presented to the public? What was the process of public debate? Public policy, in the modern meaning given it in English usage, is the justification or rationale for government action – or inaction (Parsons, 1995). Public policy is a response to what is construed as a social problem. The media plays an important role in defining and constructing a problem (Henshel, 1990; Kosicki, 1993; Davis, 1985); indeed how an issue is described and framed sets the tone for its subsequent debate; for example, whether illicit drug use is seen as a law and order issue or a public health issue. In some cases, the media have been accused of manufacturing a social problem from a topic or minor event (Kosicki, 1993). The media can both shape the context in which policy responses take place, and influence public opinion both as to the seriousness of the issue and the adequacy of the policy response. Governments and political parties will seek legitimisation of their policy through media, both for problem definition and adequacy of response. Similarly those with vested interests in an issue seek to use the media to legitimise their construction of the problem and preferred policy response (Bernard, 1998; Powers, 1999).

In determining what is newsworthy the media also act as gatekeepers, including or excluding issues (Henshel, 1990). Matters of health policy and health financing are generally considered lacking in newsworthiness. The material is usually complex, the content is often judged by editors to be important but dull (Otten, 1992), and generally it does not lend itself to packaging into stories of an appropriate size. There is less media coverage of broad policy issues such as the economics of health insurance than of medical breakthroughs, personal triumphs and general advice on health and illness (Lupton, 1995). However, in 1996, private health insurance was the most frequently reported topic of those dealing with health policy (Haas et al, 1999).

Therefore, how the media describe and interpret developments in and issues surrounding private health insurance is worthy of investigation, to assess the information provided to the community, to see how the 'problem' is constructed and whether alternative 'solutions' are proposed and debated, and to identify the major spokespersons and groups who are framing the debate.

This paper reviews the coverage of private health insurance by the two major east coast broadsheet daily newspapers. Printed quality media are more likely to run the type of in-depth investigative pieces that can address the complexities of this topic. Therefore, if there is an in-depth commentary on this issue, it should be found in these media. Further, previous work has established that these are the media most widely read by senior health bureaucrats; and that the Sydney and Melbourne major dailies were more likely to report on health policy and financing than the print media in other States (Haas et al, 1999).

Section 1 of this paper describes the private health insurance issue from the perspective of health economics, and therefore identifies aspects that one would expect to find in an informed commentary. It is perhaps important to note that I approach this as an analyst, not as an advocate. In Section 3 I describe my research methods. Section 4 gives the results of the content analysis, with a more detailed commentary and interpretation in Sections 4.2 to 4.4. Finally, I contrast the economic analysis with the media analysis and offer some conclusions in Section 5.

1 The health economics analysis

Background

Medibank – universal publicly financed health insurance – was introduced under a Labor government in 1974. The scheme was gradually dismantled under the Liberal governments that followed, until Australian health care financing had returned to voluntary private health insurance. In 1984, a new Labor government established Medicare, a second scheme of national universal health insurance. Although, as previously noted, the role of private health insurance was the major health policy difference between the two parties from the 1970s to the late 1990s, under both the universal public schemes, private health insurance was allowed to continue to cover a range of services.

Within the Labor Party there remained differences of opinion surrounding the role of private health insurance. Some interpreted that policy under Medicare was to allow private health insurance to decline gradually until it reached its 'natural' level, ie the long-term equilibrium with universal health insurance which was expected to be around 30 per cent. This supposedly natural level was based on the Queensland experience, where public hospital care had long been provided free and private insurance cover remained around 30 per cent of the population. Others maintained that a 'strong' private insurance sector was necessary as a complement to national tax-financed insurance, with strong being interpreted at different times across the range of 30 per cent to 40 per cent (Hall et al, 1999).

Financial incentives to encourage private health insurance were proposed in the Liberal election policy, and affirmed once they attained office. There have been three stages in the implementation of this policy. The first stage, a rebate for the poor and a financial penalty for the rich, was introduced in July 1997. Singles earning less than $35 000 per annum, and couples earning less than $70 000 (plus $3000 for each dependent child) were eligible for a part rebate on private health insurance premiums up to $125. High-income earners were classified as singles earning more than $50 000 per annum and couples, more than $100 000. Those who did not take out private health insurance were charged an income tax surcharge of 1 per cent . The cost of this scheme to government was estimated at $600 million per annum, or 11.5 per cent of the Commonwealth government's outlays on public hospitals.

At the same time as this strategy was announced (1996), a new round of premium rises was announced (at the time only the Minister for Health could approve such increases). The private health insurance industry was referred to the (then) Industry Commission which reported early in 1997. There was a subsequent Federal election late in 1998 in which the Liberal government was returned. The second stage of private health insurance incentives came into effect in January 1999. This retained the tax surcharge for high-income earners and also provided a 30 per cent rebate on all health insurance premiums, including front-end deductible policies, not limited to hospital cover and without a means test. In addition, by July 2000 the funds were required to provide policies with known gaps or no gaps. This means that the out-of-pocket expenses of a

hospital admission must be specified in advance. The implication of this is that funds must contract with hospitals and doctors on price. Legislative arrangements had been introduced as early as 1995 to facilitate contracting and preferred provider arrangements. Progress was slow at first, with substantial opposition from the medical profession. The cost of stage two was estimated initially at $1.5 billion per annum (Coalition Health Policy, 1998) but revised to $2.19 billion. Most recent estimates place the cost to government at close to $3 billion per annum.

Stage three of the package, 'lifetime health cover', was announced in 1999 to take effect from July 2000. This is a departure from strict community rating. The base premium rate applies to anyone taking out insurance up until the age of 30. Those people continue to pay the base rate for the rest of their lives as long as they remain insured (with some exceptions for events such as time living overseas). For others, the premium increases by 2 per cent per annum at the time they take out insurance, with the rate then locked in to the joining rate. There is a ceiling at 70 per cent above the base rate, ie the maximum rate is payable at 65 years and above at entry.

2 Major features of private health insurance in Australia

Private health insurance accounts for less than 10 per cent of total health expenditure. This is roughly one-third of the total private spending on health care, with the difference due mainly to out-of-pocket payments. To set this in the international context, Australia has relatively high rates of both private insurance and private financing of health care. Unlike Canada, private insurance was not restricted to coverage of services not provided by Medicare.

Table 1: Private expenditure and private insurance

Country	Private expenditure as % total health expenditure	Out of pocket expenditure as % total
Australia	**28.8**	**16.6**
Canada	**28.0**	**17.0**
Denmark	**15.7**	**15.7**
France	**23.1**	**20.4**
Germany	**22.5**	**11.3**
New Zealand	**28.3**	**22.0**
Norway	**18.0**	**18.0**
UK	**3.1**	**3.1**
USA	**55.9**	**16.6**

Source: World Health Report 2000

By 1996, the 30 per cent of the population who were insured were predominantly the wealthy and the aged. In 1992-3, 70 per cent of high-income households held private insurance compared with 20 per cent of the low-income group; and by 1994 40 per cent of the population aged 65 and over were insured, compared with 34 per cent of the younger group (AIHW, 1996). Private health insurance faces a classic adverse selection problem, enforced by community rating (Hall and Viney, 2000). The young and healthy find the costs of the premiums high compared to their chance of using hospitals. In addition, their financial risk is obviated by the universality of Medicare. As they drop private insurance, the risk of the remaining insured group increases, therefore insurance payouts rise and consequently so do insurance premiums. This, in turn, induces more low risk members to bail out.

Although private insurance coverage had been declining, the use of private hospitals had been increasing. Admissions to private hospitals increased by 80 per cent over the ten years to 1995-6 compared to a growth of 45 per cent in public hospital admissions. The proportion of public hospital patients with private insurance had also declined,

from 27 per cent in 1991-2 to 17 per cent in 1995-6 (AIHW, 1998). One explanation for this is that those remaining privately insured have increasingly chosen admission to a private hospital over admission to a public hospital as a private patient. This has had the effect of reducing the revenue base for public hospitals.

These two factors, the ageing profile of the insured population and the increased use of private hospitals plus increasing costs in private hospitals, are the factors driving the costs of insurance (Industry Commission, 1997). Private health insurance premiums rose 9.8 per cent per annum between 1989-90 and 1995-6, outstripping both the CPI (2.9 per cent per annum) and per capita health spending (5.6 per cent per annum) (Industry Commission, 1997). In addition, private patients admitted to public hospitals received several bills, often for substantial amounts not covered by their insurance, for the same accommodation and medical and other treatment as their public patient counterparts who were billed nothing. It is worth noting that the Industry Commission did not find evidence of inefficiencies in the health insurance funds themselves. Their comments on the structure of the industry – there are 44 separate funds, some with small membership bases – are more cautious.

Just as declining insurance is not inexorably linked to private hospital use, the reverse is also true. Increasing insurance coverage will not necessarily reduce the use of or budgetary pressure on public hospitals. Privately insured individuals have the choice of admission to private or public hospitals, thus the relative use of the two sectors may not change, although private admissions in public hospitals generate revenue. More importantly, anyone, irrespective of insurance status, can choose admission to a public hospital as a public patient – in effect, not drawing on private insurance at all and not bearing any out of pocket expenses. Data provided to the recent Senate Inquiry into Public Hospital Funding showed that, of people with private health insurance admitted to public hospitals, 60 per cent were admitted as public patients (Senate 2000). There is an additional incentive for this, as the funds have marketed policies with front-end deductibles.

3 Methods

Two newspapers were selected, the *Sydney Morning Herald* (*SMH*: Sydney-based daily broadsheet), and the *Age* (Melbourne-based daily broadsheet). These are the

papers of choice for health bureaucrats and claim an educated and informed readership. Hence they are more likely to carry investigative and analytical articles.

The articles were identified using The *Sydney Morning Herald Quarterly* on CD-ROM and the *Age* and *Sunday Age Quarterly* on CD-ROM for the years 1996-99 inclusive, using the search terms 'health insurance or private health insurance'. All retrieved articles were read by the author and those not dealing with private health insurance or health financing were discarded (there were some articles dealing with public hospital crises only). Letters were also excluded.

The selected articles were then coded as follows

- publication name
- date
- page number(s)
- whether health insurance was the leading topic of the article
- personalisation (were individuals such as patients or consumers used as the principal 'hook' for the story, or as devices to illustrate the substance of the article?)
- whether an expert or stakeholder (other than politicians) was quoted, and if so, who
- type of article (ie news; feature; editorial etc).

News articles were also coded for whether experts were cited.

The articles were then read and the content was categorised according to:

- whether the content of the article was descriptive reporting, eg legislation passed in Parliament, a statement from the Minister, without any comment as to its value;
- whether there was some judgemental comment, either positive or negative, from either the reporter or an expert commentator, but with no opposing viewpoint;
- whether there was any sense that there could be a difference of opinion on the issue or action. This was interpreted widely to include what appeared to be seeking an alternative viewpoint, such as seeking comments from the

Opposition Shadow Minister for Health on a Government policy, as well as explicit disagreement or criticism.

The context and framing of stories was assessed, with particular attention to the wording and analogies used in headlines and opening sentences. The categories were determined after analysing the articles. The categories included:

- as 'politics' those stories which assessed the effect on government popularity or election prospects;
- 'policy' where new policy proposals and their effect on individuals were described; 'conflict' where the framing of the story was a clash between interest groups, or governments;
- 'policy criticism' where the article was a negative review of policy; and
- 'critique' where strengths and weaknesses, or winners and losers were analysed.

All editorials were similarly analysed to categorise:

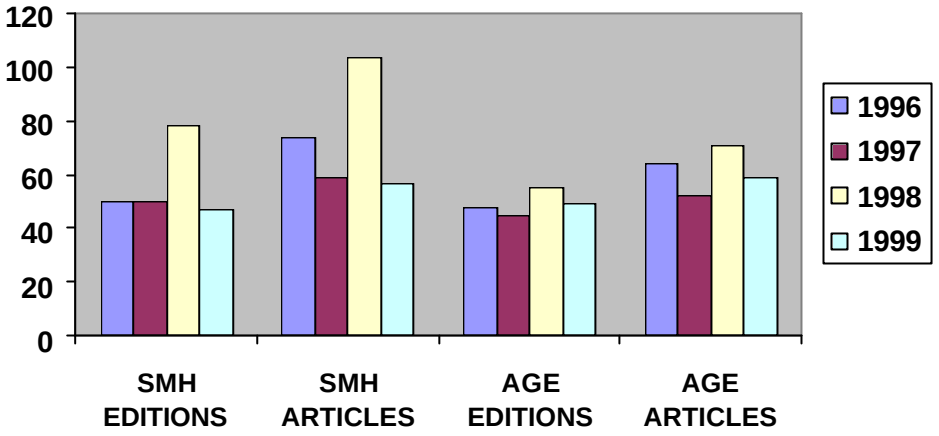
- the headline;
- editorial opinion, and
- the descriptive language used.

What was of interest here was the viewpoint taken by the editor and the way that the position was described and justified.

4 Results

There were 539 articles published over the five-year period, 293 in the *SMH* and 246 in the *Age*. One edition often included more than one article, so the total number of editions carrying health insurance articles was 471. The *SMH* printed 102 articles in 1998; otherwise the number of articles in both papers was similar (Figure 2). This is an average of nine articles per month.

Figure 2: newspaper coverage of private health insurance



The major events in the period were identified, as these would be triggers for news reporting.

Box 1: Major events in period

1996	
February	Federal election
August	Federal Budget
	Health insurance premium increases
	Productivity Commission inquiry announced
December	Industry/Productivity Commission draft report released
	Health insurance premium increases
1997	
March	Premiers Conference
April	Productivity Commission report released
May	New data on health insurance coverage
July	Support for private health insurance. Mark I, takes effect
August	New data on health insurance coverage
September	Health insurance premium increases
November	New data on health insurance coverage
1998	
January	Health Ministers' meeting
February	New data on health insurance coverage
March	Health insurance premium increases
May	Federal Budget
	New data on health insurance coverage
August	New data on health insurance coverage
September	Federal election
November	Health insurance legislation debated
	New data on health insurance coverage
1999	
January	Support for private health insurance, Mark II, takes effect
	New data on health insurance coverage
May	Federal Budget
June	Health insurance premium increases
	Health Ministers' meeting
August	Senate Committee of Inquiry into funding of public hospitals
September	Legislation for support for private health, Mark 3, debated
November	New data on private health insurance coverage

Figure 3: Timing of articles

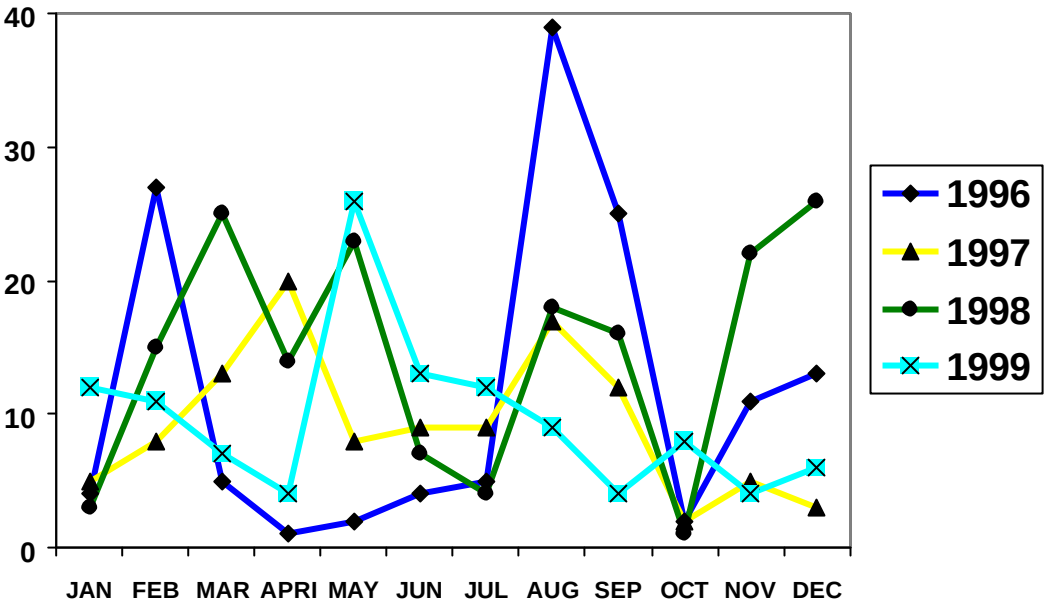
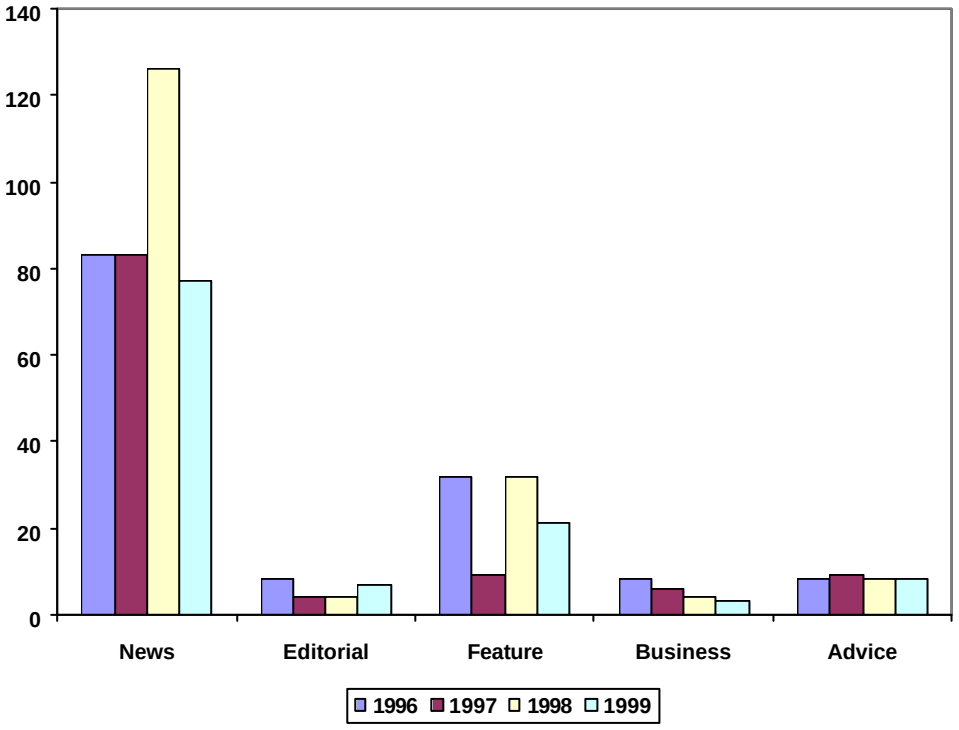


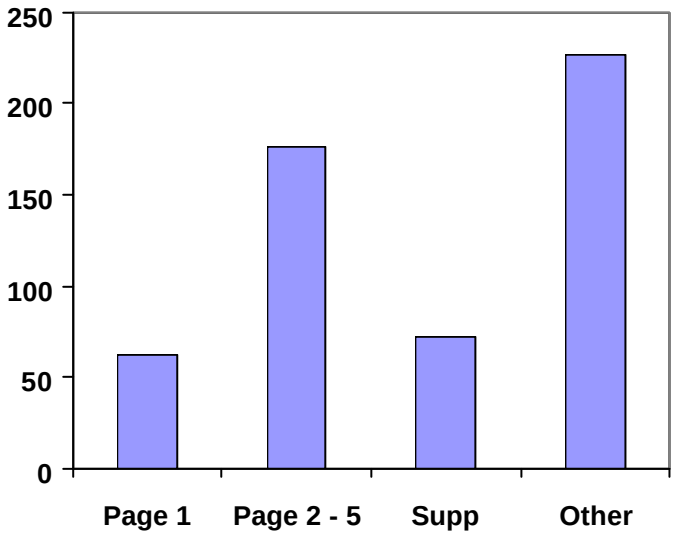
Figure 4: Types of articles by year



The timing of news interest coincided with Federal elections and Federal budgets (Figure 3), in particular, the 1996 election (February 1996), the Federal budget (May 1998 and May 1999). The 1996 budget (August 1996) was the vehicle for the introduction of the first stage of the incentives policy which coincided with the announcement of premium increases and led to the setting of the Productivity Commission Inquiry; not surprisingly this period had the greatest number of articles. The reason for the peak of March 1998 was not obvious; it was the second increase in premiums since the introduction of the first stage of incentives, and leading up to the Federal budget. The most frequent type of article was news stories, followed by feature articles (Figure 4). The *Age* was more likely to publish editorials on this subject than the *SMH*. The business pages published between two and three articles on health insurance each year; and advice sections (on managing your money) average between four and five articles each year. In 75 per cent of the stories, private health insurance was the leading issue.

Twelve per cent of stories were front-page news (Figure 5), with a further 33 per cent in the first five pages. Seventy-two articles, or 13 per cent, were carried in special supplements with most of these being supplements commenting on the Federal budget.

Figure 5: Placement of articles



Few stories, 3 per cent , used 'personalisation', that is, telling the story through the experience of a named individual.

Examples include:

> Campbelltown mother Cathy Micaleff is just one of the 2 million people who have opted out of private insurance since 1984, but her tale may be the perfect example of why the health funds are battling for survival as membership plummets.
> (*SMH*, 25 February 98)

> Grant Marshall from Carlton: Mr Marshall, 33, had not taken out private health insurance before he was diagnosed with leukaemia because he thought he'd never need the cover. 'I'd only been to the doctor three or four times in my life' he said.
> (*Age*, 15 May 96)

4.1 News articles

While feature articles or commentaries are often clearly written to present a particular point of view – to the extent that a number are authored by individuals associated with particular groups or viewpoints – news articles are presented as reporting events or describing issues. It is, therefore, interesting to consider how the news as such was presented (Table 2).

Table 2: Framing of news articles

SMH	**1996**	**1997**	**1998**	**1999**
Factual/descriptive	16	13	38	10
One viewpoint only	10	12	8	3
More than one view	16	22	31	21
Age				
Factual/descriptive	16	9	10	8
One viewpoint only	5	7	6	12
More than one view	20	20	33	23

The *SMH* was more likely to report news without commentary (39 per cent of stories), than the *Age* (26 per cent of stories). An example of factual reporting was the

description of the overhaul of insurance arrangements expected in the Federal budget, with no comment on the expected success or impact of the changes (*SMH*, 11 May 99*)*.

Around half of all the articles provided some indication of differing opinions or contention about the issues reported; (44 per cent of *SMH* and 56 per cent of the *Age* stories). This aspect was coded quite liberally so that a comment from the opposite side of politics was included as offering an alternative viewpoint. Frequently, the policy position of the Government was described, with supporting statements from interest groups; the Opposition spokesperson was quoted briefly in the final paragraph(s) of the article.

Quite a significant proportion of articles in both papers, 16-17 per cent, however, offered only one viewpoint or perspective on the issue in question. An example of reporting only one perspective was the story headed 'Push for US-style health insurance' (*SMH*, 16 February 98). The article quoted a leading consultancy firm advocating employer-paid health insurance. This stand was supported by the statement that the proposal was supported by a number of business groups. No alternative view was offered. Another example is 'AMA president accuses Canberra of getting it wrong' (*Age*, 21 August 96) where the article presented the AMA view only.

4.2 Use of experts

The term 'expert' is used here to denote individuals or organisations that are not members of a legislature or official representatives of political parties. These are people who are cited in newspaper stories, commenting on the events or issues being reported, with the implication that these are authorities on the topic. About half of all articles, and similarly half of news stories, used experts. In some articles, several experts would be cited. The total number of citations was 495. If comments from official organisations, such as AIHW, the Health Insurance Commission, Australian Health Technology Advisory Council, are excluded on the basis that they should have no particular view on the role of private health insurance, the total number of citations is 449.

Table 3: Summary of experts cited

Expert	No of citations
Academics	35
Australian Health Insurance Association	104
AMA	106
Health Insurance Fund managers	67
Private Hospitals Association	39
Catholic Health Care	12
Consultants & other insurance groups	16
Private hospital operators	8
Health lobby groups (pro public financing)	15
Royal Colleges and Societies	10
Health bodies, AIHW, AHTAC etc	8
Agencies representing the elderly	10
ACA/Choice	22

The groups and organisations most frequently cited are shown in Table 3. The AMA was the most often quoted, with the Australian Health Insurance Association appearing almost as often. However, in terms of individuals, Russell Schneider, the Association's Chief Executive Officer, was the most familiar name and quoted personally more often than the AMA President. Overall, groups representing private health insurers and private hospitals were cited 55 per cent of the time; the views of the established medical profession 26 per cent of the time; groups with established positions in favour of public sector financing of health care, 8 per cent, and academics and researchers 8 per cent. This is simply a count of the number of citations and does not reflect the relative amount of space given to differing viewpoints.

4.3 Context and framing of stories

Stories were categorised as 'conflict' when the opening described conflict, disputed issues, or deals being negotiated after dispute, when one group criticised a government or other stance. Examples are:

> The Australian Medical Association yesterday attacked a proposal by the major NSW health funds to force doctors to seek fund approval for prescribing certain drugs. The Federal President of the AMA, Dr Keith Woollard, condemned the plan as an attempt to interfere in clinical decisions about patient treatment and a step towards the 'torture' of the United States system.
>
> (*SMH,* 15 July 96)

> The war of words in the health debate escalated. The health insurance industry accused providers of 'hysterical' behaviour and manipulating the media.
> (*SMH,* 12 April 97)

> The Australian Medical Association yesterday urged doctors to stop bulk billing and making after-hours house calls, a protest against the Federal Government's treatment of general practice.
> (*Age*, 2 June 97)

Policy refers to those stories which provide a description of policy, in the period before the elections, in policy proposals being considered, or in new policy enacted such as the effect of changes announced in the Budget. In these stories, there is no initial assessment of whether the policy is sound or likely to be successful.

Stories were coded as 'politics' where the introduction placed the issue in the context of good or bad politics, its likely effect on electoral chances, or on government embarrassment.

> The Howard government's decision to increase the Medicare levy to force higher income earners into private health insurance is good economics but bad politics.
> (*Age*, 17 August 96)

> Cabinet gambles on abandoning Medicare election pledge but holding middle ground.
> (*SMH,* 17 August 96)

Also in this category were stories dealing with the passage of legislation such as whether the legislative changes enabling the introduction of lifetime health cover would be passed by the Senate, negotiations with the Democrats and Senator Harradine (Independent Senator for Tasmania).

As frequent as framing a story in terms of politics was setting the context in crisis or alarm. These stories called attention to the health system in crisis, or to some aspect of alarm in the system or new proposals. Examples include:

> It is no accident Medicare has come to resemble the people it serves – the only difference is our national health system is sicker than we are.
> (*SMH*, 7 February 96)

> The country's health system is in poor shape. Critics warn of its collapse within 10 years, and an average of 300 people opt out of private cover each day.
> (*Age*, 10 March 97)

In contrast, the *SMH* in 1999 printed one story with the banner that the health system was not in crisis.

> The health system is need of reform, but there is little evidence to support the argument that Medicare is unsustainable. …. The Australian system, without doubt, needs incremental reform to ensure that money is spent effectively and efficiently – but there is little evidence that reform needs to interfere with the fundamental principle of equity or that it should involve dismantling Medicare.
> (*SMH*, 15 January 99)

There was a second 'op-ed' piece, similarly headlined, written by a well-known advocate for the public system.

Thirty-six stories opened with a direct criticism of government policy, or equated the news – such as a fall in health insurance coverage – with policy failure. However, the difference between policy 'success' and 'failure' was small.

> The Federal Government's $1.7 billion gamble to stem the flood of Australians abandoning private health insurance may be paying off, at least in the short term.
> (*Age*, 21 April 99)

And the story went on to report rises in membership by big health insurance funds, with 2000 new members in one month for Medibank Private. One month later, the same paper and the same journalist wrote:

> The Federal Government's $1.7 billion health insurance rebate gamble has barely lifted the number of Australians with private cover.
> (*Age*, 21 May 99)

The number of new fund members was cited as 57 000 over three months for all funds. Medibank Private, being of the 'big three' insurance funds, accounts for around one-quarter (PHIAC, 1998-99); that would be over 14 000 new members –or over 4750 per month.

By August-September 1996, health insurance premium rises, and by 1997 the changing membership of private health insurance, had become stories in their own right. These were stories where the increase or proposed increase was not used to describe a crisis or a failure of government policy, but the increase itself was newsworthy.

However, the assumption that falling fund membership would add to pressure on public hospitals and pushthe health system further into crisis was rarely questioned.

> The decline of private health funds has been blamed for significantly increasing the pressure on public hospitals, with those leaving private funds joining public waiting lists.
> (*Age*, 23 September 98)

> There is a growing view that unless something is done about high premiums and out-of-pocket expenses, the Government's boldest efforts to encourage more private insurance will fail. And if they fail, the entire health system – including Medicare – is on the slippery slope.
> (*Age*, 7 September 96)

The most frequent context was 'conflict' (see Table 4).

Table 4: Context of article

Theme	**Number of articles**
Conflict	114
Policy	77
Politics	52
System crisis	51
Policy criticism	36
Policy critique	36
Premium increases	27
Membership changes	15

While the media was often used to announce policy changes or canvass reactions to possible shifts in policy direction, conflict and disputed views were the angle that most often provided the context for the story. The notion that the health system was in crisis was pervasive, both as an angle for particular stories and as an underlying theme to much of the reporting. The idea that private health insurance is linked to public hospital use/waiting lists also ran through most of the coverage, with few instances of explicit questioning. At some points, it read as though people who drop private health insurance move immediately onto public hospital waiting lists.

4.4 Editorial opinions

Age

The first 1996 editorial was set in the context of the Federal election, comparing the two parties' health policies. It was critical of the Liberal policy supporting private health insurance. The decline in private health insurance coverage was accepted as 'serious', but whether this was the cause of 'unsustainable pressure' on public hospitals was questioned. The second editorial continued with the theme of the seriousness of declining private health insurance, now described as 'troublesome'. It supported the introduction of the Medicare levy surcharge for those not purchasing private health insurance and argued that this does not represent a two-tier health system. The old two-tier system was graphically described

> Public hospitals were ghettoes in which the poor endured inferior treatment and high-handed arrogance from medical specialists who used them as guinea pigs for research and teaching purposes
> (*Age***,** 17 August 96)

In its third editorial, the *Age* echoed the cynicism that greeted the insurance rate increases which followed immediately on the new rebates. It restated the seriousness and urgency of the public hospital situation

> The core problem – shortening the queues at public hospitals – remains in urgent need of a solution.
> (*Age*, 30 August 96*)*

By November, the troublesome decline in private insurance coverage was now a

simple ‘fall in health fund membership’. And according to this editorial, it was the Government’s responsibility to ensure the private health funds keep premiums down, and by implication solve the private insurance problem. Finally, just before Christmas, the editorial issued a cry for fairness and inclusiveness as the values to underlie health insurance, rejecting any move away from community rating.

> Health care is more than an abstruse exercise in mathematics.
> (*Age*, 23 December 96)

In 1997, the *Age* continued to advocate Government responsibility for health care funding. Although the decline in the numbers of insured had now become an ‘exodus’, the first two editorials blamed lack of funds in public hospitals, not private health insurance, for the supposed crisis in health. Though one editorial also pointed out that people dropping private insurance to rely on public hospitals, patients queuing to get into hospitals, and school leavers competing for medical school entry, can all be read as signs of the success of Medicare. The *Age* continued to advocate the continuation of community rating, and to warn against ‘US-style managed care’.

Under the headline ‘Curing the health system’, the *Age* in 1998 turned to the need for creative policy. The decline in private health insurance was now a ‘haemorrhage’ and ‘one of the most crucial issues facing Australia’. Although still espousing access to medical care based on need regardless of income, Medicare was now described as a ‘safety net’. The second editorial for the year was headlined ‘Medicare has served us well’ – almost a valedictory tone. However, the editorial itself criticised the proposed voucher system which would let individuals opt out of Medicare and renewed the statement that the real problem lay in the lack of funding for public hospitals.

During 1999, the editorials focused on support for the principles of equity of access under Medicare and increased funding for public hospitals. At the same time, they saw the resolution of the private health insurance problem, described as ‘a trend’ by the end of the year, lying in removing gap payments and potentially ending community rating, leaving the Government to concentrate on maintaining Medicare.

Sydney Morning Herald

The *SMH* also accepted that the health system was in crisis, though their analysis was a 'chronic problem of uncontrolled costs'. Whilst no government could afford to dismantle Medicare, their 1996 editorials accepted the view that support for private insurance would take the pressure off public hospitals but called for fundamental reforms to tackle structural inefficiencies. Criticism was directed at Labor's health policy.

> Yet Medicare has long been in crisis, costing more and more and unamenable to the changes which would reduce costs and improve efficiency while still maintaining high standards of health care…There is little in the Labor health policy to suggest a commitment to tackling this problem. Instead, there has been a rather transparent bid to buy votes
> (*SMH*, 7 February 96)

In 1997, the one editorial dealt mostly with the omission of palliative care from private health insurance benefits. The themes of tackling systemic reform, waste and over-servicing, and the importance of arresting the decline in private insurance, continued.

By 1998, the *SMH* was also calling for 'creative thinking' in the area of health policy. The two editorials in 1998 were critical of the support for private health insurance, as an expensive strategy that has been ineffective. Further, they identified the problem of those privately insured choosing to use the public system

> The problem is persuading people who have insurance to use it when the occasion arises.
> (*SMH*, 15 August 98)

The SMH also considered the problems of community rating, and came out in support of 'community lifetime rating'.

In 1999, the Government was commended for its courage, boldness and imagination in introducing lifetime community rating.

> A radical policy measure to increase the flow of premiums to private health insurers is not for the insurers' benefit in isolation but because it is for the benefit of the system as a whole to have a strong private health insurance

component.
(*SMH*, 14 May 99*)*

But the Government was urged to take 'equally bold measures to rein in costs', by confronting doctors and tackling hospital payments.

> It is only by tackling these more complicated areas that the Government can complete the task it has just begun.
> (*SMH*, 14 May 99)

Both papers' editorials focused on Government responsibility, seeing the good of the country and/or the health system, going to the underlying problem, and the need for imaginative responses in doing so. However, while the *Age* began by criticising the Liberal policy, identified the core problem as inadequate public hospital funding and espoused equity and hence community rating, the *SMH* took a quite different stance. The *SMH* was critical of the Labor policy, identified the core problem as structural inefficiencies in the health system and welcomed the move away from community rating.

5 Conclusion and discussion

The topic of private health insurance often made the front page, and even new data on the coverage of private insurance warranted its reporting as a news item *per se*. There are a number of aspects of the news coverage that are noteworthy. First, the context of health policy, and private health insurance, was highly political and differences were cast in terms of political battlegrounds, either between or within the political parties, and between the States and the Commonwealth. Second, the construction of the problem – or issue – was that of a crisis, requiring urgent and major resolve. Third, Medicare was electorally popular and was not openly challenged by either side of politics. Fourth, the general public was sceptical about the role and motivation of private health funds. Fifth, policy changes were canvassed as proposals for consideration, often advocated by a particular interest group rather than government or opposition parties. Sixth, cooperation of doctors was important in implementing new schemes; however, such cooperation was not readily forthcoming, and even when deals appeared to be done, they could be undone. Finally, editors could not resist the temptation to use medical analogies in headlining their stories.

The role of private health insurance and the relationships between health funds, private hospitals, public hospital use and waiting lists, are complex issues and not the stuff of easy news 'bites'. Although these issues were explored in some of the features and more in-depth articles, there were few examples, and many feature articles were written by spokespersons for particular interests. Although the adverse selection problem was described and discussed, there was little recognition of the other aspects of the health insurance issue. The fall in private health insurance membership was portrayed as a crisis, but with no acknowledgment that coverage in Australia had remained, in international terms, high. There was frequently an implication that the rich were not paying their way. The assumed link between private insurance and less demand for public hospitals was not questioned. There was little recognition that the use of private hospitals was increasing, even though private insurance was falling. And there was no comment on the economic viability of 44 separate funds in such a small population.

Given the complexity of the issues, the story angle is important. Conflict between major stakeholders provided a readily communicated angle, so it is understandable that this context should provide a hook for so many articles. The result, though, was that the news on private health insurance became a game between different players, with only the few investigative features and the editorials considering any aspect of social welfare or 'what is good for the country'.

There are two consequences of this. The first is that the politics of health policy is a theme in itself. This is reinforced by the electoral popularity of Medicare, though what 'Medicare' means to the electorate is not clear. Political issues are reported in terms of winners and losers, good economics but bad politics, the political dealing around the passage of legislation in the Senate. There is a story here for students of politics and the political process. However, to a large extent this obscures the underlying and more complex issues of the topic itself.

The second consequence is the reliance on simple abstraction of the issues and the use of authority figures. So simple arguments are advanced, for example that more private health insurance means fewer people will use public hospitals, that paying for growing

numbers of old people is unsustainable. Reportage turns to authoritative 'experts' to give a precise view on the issues. The most frequently cited experts were clearly spokespersons or advocates for vested interests. However, those apparently independent individuals, such as consultants, actuaries, individual doctors, may have had some relationship with other players; consultants gain their income from advising someone. In other health news reporting, it is unusual for these relationships to be disclosed (Moynihan, 2000). In these stories, there was no disclosure. It is instructive to note that a significant proportion of stories presented only one viewpoint on the issue presented; and even where opposing views were presented, they frequently appeared in the last sentences of the article or were given much less exposure in terms of 'column inches'.

The media are used to disseminate policy, to describe new policies, to explain the details and to tell individuals what action they need to take. But it is also clear that the media are used to float issues and to prepare the ground for policy changes. So, for the introduction of lifetime health cover, first actuaries, as a particular authoritative group, aired the problems of community rating. Subsequent stories returned to the issue, with the idea of a departure from community rating gaining more acceptance from other players, until the Government was in a position to consider it seriously. The problem was framed as a conflict between the efficient running of the health insurance industry (for which risk-rating is a solution) on the one hand, and on the other, Australian social values of fairness and the electoral power of the elderly. The concept of lifetime community rating can thus be seen as the solution, combining actuarial responsibility with the goal of not disadvantaging the sick and the elderly.

For those concerned to see vigorous public debate on private health insurance, to promote information and evidence as a basis for policy, and to see community values inform health policy, there is little here to encourage.

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