

A comment on the response from Graham Wright

In the short space of a response to Mr Wright's letter, it is impossible to do justice to the raft of issues that he raises. At the outset, his opening remarks give cause for concern. He appears to believe that all analysts start from a position of either opposition to, or support for, private health insurance subsidies. I would describe such positions as end points rather than starting points, with constructive debate concentrating upon the differences in value judgements and empirical evidence that lead to these different end points.

Moving on, one could take issue with numerous arguments put forward in this letter. I will attempt to address four of them. First, the analogy between subsidies for private health insurance and private schooling is mistaken. Individuals and families who purchase private health insurance do not forego any entitlements under public health insurance. Those with private health insurance continue to have access to zero-priced public hospital treatment on the same terms and conditions as those without private health insurance. The extent to which they take advantage of this is not known with any accuracy since declaration of private health insurance status is not required upon admission to a public hospital. The situation would be quite different, of course, if the subsidies attached to private hospital treatment rather than private health insurance – this would be a much closer analogy with subsidies for private schooling.

Second, on the effect of the private health insurance rebates on the uptake of private health insurance, Mr Wright argues that the “core finding” in my AHR paper of only a modest effect “has been contradicted by a recent research paper” (Access Economics 2002). My “core finding” in the AHR paper was based upon an analysis of the temporal behaviour of private health insurance coverage over the period when various policies were implemented. My findings accord with those of other analysts (Frech, Hopkins and MacDonald 2002) and with my own earlier work on the price-elasticity of demand for private health insurance in Australia based on multivariate analyses of a large range of factors likely to affect the demand for private health insurance (Butler 1999). The Access Economics study is very simplistic in that it included only one explanatory variable in the analysis of demand for private health insurance, viz. affordability, which is presumably a proxy for prices and income.

But this will likely have little impact on Mr Wright's thinking, given his position on the “lack of balance displayed by many academic commentators” and their “poorly informed sniping at the health insurance rebate”. Unfortunately, his position on the effect of the rebate disagrees not only with that of many “academic commentators” but also with the Commonwealth Government! In response to a question in Parliament regarding the estimated effect of the rebate, the Prime Minister indicated that coverage was expected to increase to 33 per cent (Commonwealth of Australia 1998, p.624). This is in line with the projections based upon estimated price-elasticities and supports the argument that the introduction of lifetime community rating accounted for most of the increase in private health insurance coverage in Australia over the years 1999 and 2000.

A third argument concerns the effect of the increase in private health insurance coverage in reducing demand on the public hospital system, whatever the cause of that increase in coverage. Mr Wright's belief in the mistaken analogy discussed above apparently leads him to believe that, once privately insured, a person will seek all their inpatient treatment from a private hospital. This is not necessarily the case, of course. To the extent that those with private health insurance continue to avail themselves of zero-priced treatment as a public patient in a public hospital, the reduction in demand for public hospital treatment consequent to the large uptake in private health insurance is less than it otherwise would be. The reason that analysts are concerned about the utilisation of public hospitals by privately insured patients, and are also concerned about our inability to measure such utilisation with acceptable accuracy, is that it compromises one of the objectives of subsidising private health insurance in the first place. Yet Mr Wright is dismissive of these concerns, saying they are “... conditioned by perspective. An alternative view is that all Australians are entitled to free (sic) public hospital care. Why then should any Australian be required to pay for a basic public hospital bed?”. In other words, his

position can be characterised as saying “One hopes the mistaken analogy is correct, but if not there’s no problem because people are only doing what they’re entitled to do anyway”. Is this really a sound basis on which to appraise public policy?

Finally, Mr Wright claims that my *AHR* paper contains “egregious errors in the cost of the health insurance rebate”. The sources of my estimates, clearly documented in the paper, are figures released by the Commonwealth Treasury and the Health Insurance Commission (HIC). Mr Wright attempts to discredit these by taking 30% of the premium revenue of private funds in a year as the cost of the subsidies, and showing that his estimated cost is less than mine. This difference is primarily attributable to the methods used by Treasury to calculate tax expenditures on private health insurance subsidies. Unlike many social security benefits in Australia, the private health insurance subsidy is not taxable in the hands of the recipient. The Treasury includes an estimate of the tax revenue foregone on account of this in its tax expenditure estimates.

References

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