

Why it is time to review the role of private health insurance in Australia

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Abstract

The role of private health insurance (PHI) within the Australian health-care system is urgently in need of comprehensive review. Two decades of universal health cover under Medicare have meant a change in the function of PHI, which is not reflected in policies to support PHI nor in the public debate around PHI. There is increasing evidence that the series of policy adjustments introduced to support PHI have served to undermine rather than promote the efficiency and equity of Australia's health care system. While support for PHI has been justified to 'take pressure off the public hospital system' and to 'facilitate choice of insurer and private provider', and the incentives have indeed increased PHI membership, this increase comes at a high cost relative to benefits achieved. The redirection of hospital admissions from the public to private hospitals is small, with a value considerably less than 25% of the cost of the policies. The Commonwealth share of the health care budget has increased and the relative contribution from private health insurance is lower in 2001-02, despite an increase in PHI membership to nearly 45% of the population, compared with the 30% coverage in 1998. The policies have largely directed subsidies to those on higher incomes who are more likely to take out PHI, and to private insurance companies, private hospitals and medical specialists. Ad hoc policy adjustments need to be replaced by a coherent policy towards PHI, one that recognises the fundamental change in its role and significance in the context of universal health coverage.

Background

The private health insurance system in Australia is unusual and possibly unique. It is neither a self-contained system, as in much of the US where managed care organisations have responsibility for all 'core' health care services for members. Nor is it purely supplemental like the Canadian system where private health insurance is confined to 'non-core' health care services, those not covered by the universal health scheme. Rather, in Australia, private insurance is both supplemental to and a substitute for universal cover – with individuals able to opt in and out of the publicly funded system, whenever they choose. Also unique is the level of government support for private health insurance, alongside publicly funded universal health cover.

The role of PHI has not been comprehensively reassessed since the introduction of universal health cover gave Australians free access to public hospitals and free or subsidised access to medical and pharmaceutical services. Universal cover was available temporarily under Medibank (1975), and reintroduced in 1984 under Medicare, resulting ultimately in bipartisan support for universal health cover, in recognition of widespread community support. The role of private health insurance is undoubtedly different in the context of universal health cover compared with the situation in which free access to a hospital bed is restricted to eligible low-income individuals, as was the case prior to 1984 (except briefly under Medibank). Prior to 1984, in the absence of universal cover, a range of policies were introduced to improve affordability of PHI and private hospitals. These have included subsidies on private hospital bed-days, community rating of private health insurance, government subsidy to a reinsurance pool for high-risk claims (and the elderly) and a 32% tax rebate on public hospital ('basic') cover.

In recent years new policies have been introduced to support PHI, in response to falling PHI membership, despite this fall being a logical consequence of universal cover. These policies can be judged in terms of their capacity to achieve their purported objectives and for their impact on the efficiency and equity of the Australian Health care system. This paper presents an analysis of the evidence which suggests that the recent policies have served to undermine rather than promote the efficiency and equity of Australia's health care system.

Policies to promote PHI

Current policies to promote PHI are described fully elsewhere (see Butler 2002, Willcox 2001). In short they consist of:

- i) an open-ended 30% rebate on private health insurance premiums for hospital and ancillary cover introduced December 31 1998 (replacing a means-tested dollar-limited rebate introduced on July 1 1997).
- ii) exemption from the 1% Medicare surcharge on high income earners (which applies to single tax-payers with taxable incomes of \$50,000 or more, and families/couples with a taxable income of >\$100,000) for those who purchase 'eligible' private health insurance, introduced in December 1998. (The effect of this policy is that high-income households can be financially worse if they do not take up PHI, a substantial incentive for enrolment by this group.)
- iii) an adjustment to community rating of PHI premiums, imposing a penalty on those who take out insurance after they reach 30 years of age, at the rate of 2% pa to a maximum loading of 40%, applicable to those joining after July 1 2000 (known as 'life-time rating').
- iv) an aggressive publicly-funded publicity campaign promoting PHI membership, coinciding with the change to community rating (Deeble 2003).

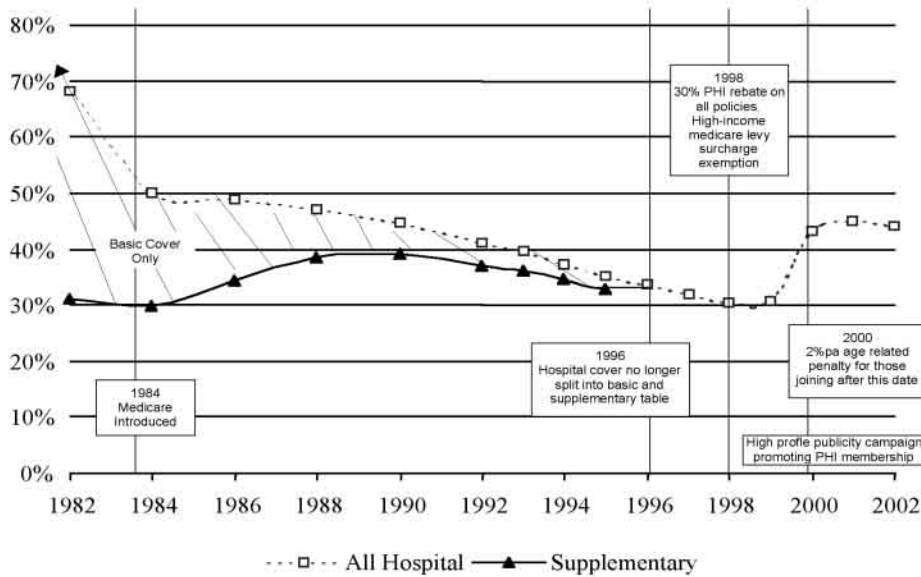
Impact of policies on PHI membership

Statistics published by the Private Health Insurance Administration Council (www.PHIAC.gov.au) demonstrate that the combined effect of these initiatives has been a large increase in PHI membership. The pattern of membership is reported in Table 1 and illustrated in Figure 1. A modest increase in membership occurred in response to the extension of the PHI rebate and exemption from the Medicare levy surcharge – from 5.68 million persons at Dec 31 1998 (30.1% of the population) to 6.12 million persons by March 31 2000 (32.3% of the population). This was followed by a much larger increase in membership to 8.71 million persons (44.9% of the population) with the change in life-time rating and the aggressive publicity campaign promoting PHI membership. (For a more detailed analysis of the pattern of PHI membership, and the key influences, see Butler 2002.)

In seeking to understand the longer-term changes in PHI membership it is necessary to distinguish two types of cover available prior to 1996, namely the 'Supplementary' and 'Basic' tables. The Basic table was designed primarily to meet the costs of a *public* hospital admission, while the Supplementary table provided insurance against a *private* hospital admission. In 1982, pre Medicare, when public hospital services were free of charge only to designated low income groups, 67.5% of the population had hospital insurance, but 36.2% (over half) had cover under the Basic table only, while 31.3% of the population also had cover under the Supplementary table. Understandably membership under the Basic table plummeted after 1984, given free access to public hospitals under Medicare. (This mirrored an earlier fall in PHI with the introduction of Medibank in 1975, which was in part reversed with the removal of universal cover by the incoming Liberal Government. See Industry Commission 1997, Figure 6.1). Despite the post-1984 fall in total hospital cover, membership of supplementary tables initially rose, peaking at 39% of the population in 1990 before falling to 30.2 % in 1998. Current levels of cover for *private* hospital care are virtually unprecedented.

Over the entire period, due to increases in premiums and population growth, the dollar value of private health insurance premiums and hospital benefits paid by funds continued to increase. This is why, despite what appears as a massive fall in private health insurance cover over several decades, the use of private hospitals has continued to grow, and often at a faster rate than public hospitals.

Figure 1: Private Health Insurance Cover 1982 to 2002. All Hospital & Supplementary Table (for private hospital cover) % population



Source: PHIAC Quarterly Statistics

Table 1: Membership of PHI Hospital tables: Supplementary, Basic (1982 to 1996) and All hospital (1981 to 2002). Number and percentage of population

Year (at 30 June)	Supplementary table ¹		Only Basic Table ¹		All hospital ¹	
	million persons	% popn	% popn	% popn	% popn	% popn
1978						65.3
1982	4,750	31.3		36.6		67.9
1984	4,606	29.6		20.4		50.0
1986	5,476	34.2		14.6		48.8
1988	6,365	38.5		8.5		47.0
1990	6,655	39.0		5.5		44.5
1992	6,465	36.9		4.1		41.0
1994	6,136	34.4		2.8		37.2
All hospital¹						
	million persons	% popn				
1996	6,149	33.6				
1998	5,728	30.3				
1998 (December)	5,680	30.1				
19992	5,793	30.5				
20003	8,236	42.8				
2001	8,712	44.9				
2002	8,705	44.2				

Source: PHIAC Quarterly Statistics

Notes:

1. Until 1996, Hospital Cover was separated into Supplementary Table designed primarily for private hospital admission and Basic Table, primarily to cover a public hospital admission. With the introduction of Medicare, cover under the Basic Table rapidly declined to <2% by 1995, at which time it was no longer offered. From 1996 Supplementary cover is equivalent to 'all hospital cover'.
2. General PHI rebate introduced December 31 1998.
3. Change to life-time community rating for those joining after July 1 2000 plus aggressive publicity campaign.

Cost of policies to promote PHI membership

The large increase in private health insurance membership has been at high cost to the tax-payer.

The estimated cost of the policies to support PHI was approximately \$2,500 million in 2001-02, without including any allowance for the effect of the exemption from the Medicare tax surcharge. This is made up of:

- \$2,110 million in funding the 30% rebate in 2001-02 as reported by the AIHW (2003, Table 17, prelim estimate).
- \$410 million in extra Medicare payments to cover additional medical and pharmaceutical services associated with higher private hospital use. This is equivalent to 3.5% of Commonwealth expenditure on medical and pharmaceutical services (Dr John Deeble NCEPH, unpublished research).

The impact of the exemption from the Medicare surcharge is estimated at between \$760 million to \$1,100 million in taxation revenue forgone (Butler 2002, Smith 2000). This amount has not been included above in line with the stated intention of the surcharge, which was to provide an incentive for high income earners to join PHI, rather than to raise revenue through collecting the surcharge (Wooldridge 1996). Other analysts (eg Butler 2002, Smith 2000) have taken the alternative view, and treated it as a legitimate component of a progressive tax system.

This level of public subsidy for private health insurance, and indirectly to private hospitals and private medical and other health professional service providers, represents a massive industry subsidy. The net operating margin of private hospitals has directly benefited, with a turn-around of declining margins (ABS 2002b). Based on a notional allocation of the 30% rebate to reflect benefit payments and other expenses of the health insurance funds (which must ultimately be translated into premiums), some 60% of the rebate, or around \$1,260 million, supported hospital services (~30% of \$4,380 million, see Table 2) and some \$555 million supported services covered under ancillary tables, (~30% of \$1,925 million, see table 4). An estimated \$255 million was contributed to management costs and profit of the private health insurance funds (at ~13% of contribution income) (PHIAC 2003b). Furthermore, of the estimated \$1,250 million subsidy on hospital services, some \$150 million went to support medical incomes, with nearly half of this on payments above the schedule fee (see Table 2). (Numbers are approximate and have been adjusted to equal the estimated subsidy).

The cost of the subsidy at over \$2,500 million is also high relative to Commonwealth funding of public hospitals, which in 2000-01 was \$7,125 million (AIHW 2002b, Table 25). The various incentives to support PHI are equivalent to 35% of the Commonwealth contribution to public hospitals, or 50% if the imputed revenue foregone through the tax surcharge is included.

While these policies have been successful in increasing private health insurance membership, it has not been demonstrated that this has generated a net community benefit. On the contrary, several studies suggest it to be wasteful, inefficient and inequitable (Duckett and Jackson 2000, Hall et al 1999, Deeble 2003, Wilcox 2001, Smith 2001, Butler 2002). In the remainder of this paper much of this evidence is drawn together and with new material is used to assess the overall performance of the policies.

Benefits of Private Health Insurance

Government assistance for private health insurance reflects concern about affordability and membership levels. The community interest underlying this concern is not self evident, but is generally expressed in terms of i) 'taking pressure off public hospitals' (by diverting demand from public to private hospitals); ii) 'providing citizens/patients with choice of insurer', 'ensuring a viable private health industry' and iii) 'reversing the withdrawal of private funds from the health system to curtail the increasing and unsustainable burden on the public purse'. These ideas are expressed in various public documents and speeches. For example Dr Wooldridge, Minister for Health commented that 'for the first time in 13 years there is a Federal Government that understands that the long-term viability of Medicare depends on a stronger private health insurance industry and having more people covered for private hospital treatment' (Wooldridge 1997). (See also DHAC 1999, Schneider 2000, PHI Branch DHA 2004)

These claims are now explored.

I. Impact on demand for public hospital services

The evidence concerning the impact of private health insurance membership on public hospital demand is still being gathered. The limited evidence (see for instance Hanning 2002, Cromwell 2002, Deeble 2002, 2003), suggests that the policies have been largely ineffective and inefficient as a means of taking pressure off the public hospital system. The size of the possible redirection of demand can be observed most directly in the data on benefits paid by health insurance funds for acute care, as reported by PHIAC (2003a and 2003b) - see Table 2 below. The increase in benefits paid for hospital care, adjusted for trend growth in benefit payments, inflation and transfer payments, provides an indication of the possible size of any demand shift from the public to private hospitals associated with the growth in PHI membership.

Table 2: Private Health Insurance Hospital Benefits Paid: 1998 to 2002;
million dollars

Calendar year	Total Acute patients – all claims	Nursing home type	Medical		Prosthesis	All hospital benefits paid
			Up to schedule fee	Above sched. fee		
1998	2,535.6	17.1	237.7	6.9	222.1	3,020
1999	2,539.9	15.4	248.2	16.8	249.6	3,070
2000	2,737.0	12.3	272.3	76.9	274.6	3,373
2001	3,270.9	11.6	287.9	151.0	367.0	4,089
2001/02	-	-	309.8	214.6	-	4,381
2002	3,507.4	11.3	365.2	306.6	470.3	4,660

Source: PHIAC (2003a and 2003b)

Comparing the year 1998 and 2001, immediately pre and post the large growth in PHI membership, 'All hospital benefits' paid under hospital tables increased by \$1,069 million (from \$3,020 million in 1998 to \$4,089 million in 2001 (current dollars). Excluding the increase of \$134 million in medical payments above the schedule fee - a pure transfer payment (not associated with any additional service), the increase in benefits paid for hospital services was \$935 million. (Net of the Commonwealth contribution, private health insurers paid out an extra \$655 million in hospital benefits.) The mean annual increase that would have applied without the new policies can be estimated by projecting the mean annual increase in hospital benefits of 3.4% p.a. (5 years to 1997-98, PHIAC 1999 Figure 32a) forward to 2001. Using this method, hospital benefits would have grown by ~\$430 million between 1998 and 2001, incorporating cost inflation of 8.8% (AIHW 2002b, Table 5), plus an increase in services per member. Netting out these components, the effect of the increase in PHI membership was an additional \$505 million on hospital services in 2001 and \$650 million in 2002. The latter might be considered the full effect, as it is beyond a waiting period when new members may have been ineligible for treatment.

This latter estimate is not dissimilar to that derived by Deeble (2002) of \$700 million as an upper estimate of the possible reduction in public hospital in-patient costs. At \$650 million in 2002, this is equal to 3.9% of public hospital expenditure (\$16,154 million in 2001-02, AIHW 2003), and 25% of the cost of the rebate, (or 16% if revenue forgone from the Medicare levy surcharge is included). This means at best a 'saving' of \$1 from the public hospital system for each \$4 spent on the rebate. The estimate is not inconsistent with research by Hanning (2002), who estimated a potential reduction in elective surgery cases from public hospitals (relative to a 1989-90 baseline) of 7.6%, given that elective surgery is where the greatest redirection is expected.

But even this will overstate the possible reduction in demand from public hospitals, as it is necessary to adjust for increased levels of servicing with PHI membership, due to supplier-induced demand and moral hazard, phenomena observed under fee-for-service payment systems in the context of 3rd party payment. The likely impact may be large, based on a study by Robertson and Richardson (2000), who report procedure rates after heart attack at 2 to 3 times higher for privately insured patients, compared with public patients. This means that any increase in funding and use of private hospital services will not equate with a reduction in the use of public hospital facilities.

In short, the available evidence, while limited, suggests that the large increase in PHI membership has been associated with only a small redirection in demand from public to private hospital services. This is not surprising:

- Firstly, many privately insured patients will continue to use public hospitals, as they are entitled to under Medicare. Private hospitals do not offer a complete hospital service, and even where equivalent services are available, persons with private health insurance have an incentive to use public hospitals, not divulging their insurance status, to avoid out-of-pocket costs. By June 2000, 50% of persons covered by private hospital insurance had policies with front-end deductibles compared with 5% in 1989 (PHIAC 2000 Figure 25), and there has been a further increase to 59% by June 03. This is a logical response to the set of policies used to promote private health insurance. High-income earners have an incentive to purchase the cheapest (approved) private health insurance policy, typically carrying a high excess, to avoid the 1% tax surcharge, even if they have no intention of using the private hospital system. Researchers at the Australia Institute (Hamilton and Denniss 2002) estimate that 735,000 people have taken out PHI simply, or primarily, to avoid paying the tax surcharge. Regardless of income levels, insured persons may choose to use public hospitals, or may need to use public hospitals, for clinical or preference reasons as well as to avoid out-of-pocket costs.
- Secondly, most of the new members recruited in response to the package of PHI incentives were young. Comparing PHI membership at June 2000 with June 1998, there were an extra 2.45 million persons under 65 years of age, but only 60,000 additional members aged 65 or older. Persons under 65 tend not to be large users of public hospital services, at 0.6 mean bed days per head (in 1997-8), compared with 3.8 mean bed days per head for persons 65+ (AIHW 2002A, Tables S32, A1). Encouraging young people to take out PHI cannot be expected to take pressure off the public hospital sector, as they are not big users of public hospitals.

The continuing rise in public hospital expenditure also suggests the policy has been ineffective at redirecting demand from public to private hospitals. Between 1998-99 and 2000-01, the use of private hospitals increased by \$490 million (constant prices) from \$4,049 million to \$4,539 million (AIHW 2002b), while over the same period public hospital expenditure increased by \$740 million (constant prices), from \$14,114 to \$14,854 million. The growth rate in public hospital expenditure, at 2.6%/annum, was similar to that for the decade 1990-91 to 2000-01 at 2.9%/annum. (Later data suggests there may have been a one off slow down in the rate of growth in public hospital expenditure, but with a return by 2001-02 to previous levels, AIHW 2003, Table 15).

Furthermore, any increase in demand for private hospital services will mean greater competition for medical specialists and experienced nursing staff, which in the context of a tight labour market may reduce the capacity of public hospitals to meet the needs of public patients. Private hospitals also have an incentive to seek the more profitable cases potentially increasing the complexity of cases left in the public hospitals. In this way an increase in the level of private insurance may increase rather than reduce the pressure on public hospitals.

2. Choice of insurer/choice of health service

The second principal argument used to justify government support for private health insurance is to provide citizens with choice of insurer and support 'a viable private health industry to improve choice of health services for Australians' (This objective is enunciated in the Budget Papers 2002, Health and Ageing Portfolio statement of mission and outcomes, Commonwealth of Australia, 2002). There are several elements to this argument: firstly, that consumers value choice of insurer, or that choice of insurer is central to choice of provider which they do value; secondly that the policies have improved affordability (worsening affordability at least partly reflected a worsening risk profile, as young people dropped out of, or did not take up, PHI), and finally that there are net social gains from the policy, not merely a gain to those who take out PHI, equivalent to the cost to the general taxpayer. This is a complex argument, two components of which are briefly considered below.

In relation to a healthy private sector, it can be noted that private health care is funded through a combination of public and private monies. Private medical practice is almost entirely underpinned by public funds. Private hospitals can also be funded through the public purse, through contracts for the provision of health services under Medicare, through privatisation of public hospitals, and directly through payments for services by Veterans Affairs. AIHW (2003) reports average real annual growth in private hospitals over the period 1992/93 to 1997/98 of 2.5% per annum, equivalent to the growth in public hospital expenditure for that period, but with negative growth for 1996-97 and 1997-98. If the worsening profitability of private hospitals is accepted as a legitimate cause for intervention, it would still need to be established that policies to support PHI are an efficient way to ensure a healthy private hospital sector (and that the particular policies adopted are an efficient means to promote PHI). As there is no unique relationship between ownership of service delivery and funding, private hospitals do not have to be underpinned by increasing PHI. In 1997-8, 21% of expenditure on private hospitals was from public sources, increasing to 35% in 2001-02, (AIHW 2003, Table 13 & 14).

Finally, with respect to affordability, despite the major change in the age profile of PHI membership, through a large influx of young members, the promised fall in premiums has not occurred. Rather premiums continue to rise, invoking an ever-increasing government subsidy. .

3. Commonwealth and private contribution to health care costs

The third argument for supporting private health insurance concerns the size of the Commonwealth government funding commitment under Medicare, and a perceived need to bring additional private monies into the health system.

The evidence shows two things. Firstly, that between 1991-2 and 1996-7, despite the fall in PHI membership, the Commonwealth and total government share of health expenditure changed relatively little, and could not be depicted as an out of control upward spiral (see Table 3). Secondly, while the PHI contribution to total health care expenditure was falling over this period, from 11.5% in 1991-92 to 10.4% in 1996-7, the policies seem to be a disproportionate response to the drop of 1.1% point.. Contrary to the stated objective, the introduction of the limited rebate on PHI membership in 1997 and its extension to all memberships from Dec 31 1998 resulted in a further fall in PHI as a source of funding of health services (net of the Commonwealth contribution), to 6.5% in 1999-2000. It has since recovered somewhat, with the large increase in PHI membership, to 7.6% of health expenditure in 2001-02. At the same time, the Commonwealth share of the health budget has increased following the PHI initiatives, to over 46% in each year between 1998-99 and 2001-02, levels seen only once in the preceding 40 years (AIHW 2000, Table 5.2, p235). The policies to support PHI have not brought additional private monies into the health sector, but have had the opposite effect, placing greater demands on the Commonwealth. If the system was not sustainable before, in terms of the level of government contribution, the current policies have made it worse in this regard, not better.

Table 3: Source of funds: Commonwealth and State government, PHI and other private funds as a percent of total recurrent expenditure financial year 1991–92 to 2001–02

	Commonwealth government	State government (+ local)	PHI ¹	Other non-government
1991-2	42.8	24.6	11.5	21.2
1992-3	43.6	23.4	11.4	21.7
1993-4	45.1	21.3	11.0	22.6
1994-5	44.8	21.6	10.7	23.0
1995-6	45.1	22.0	10.5	22.4
1996-7	43.7	22.9	10.4	22.9
1997-8	44.7	23.8	8.9	22.6
1998-9	46.1	22.9	7.5	23.5
1999-2000	46.9	23.0	6.5	23.6
2000-01	46.8	22.6	7.1	23.5
2001-02	46.1	22.3	7.6	24.0

Source AIHW (2003) Table 12 and table 18;

Note 1: Net of Commonwealth subsidy.

Efficiency of the current policies as a means to promote PHI

Regardless of the arguments about the social benefit of increasing PHI membership, it is unequivocally the case that if PHI is to be promoted by government, it should be done in the most efficient manner.

The major component of cost, the unlimited non-means-tested 30% rebate on all PHI policies did not stimulate a large increase in PHI membership, which rather occurred in response to the change in lifetime rating and the publicity campaign promoting PHI membership. An estimated \$1,500 million of the rebate was paid to the 5.7 million members who already had PHI, in relation to whom the only possible impact is an improvement in membership retention. The pattern of benefit payments suggests that only 54% of the rebate goes towards additional hospital services, with some 26% on extras and, 14% for management expenses and the like. See Table 4.

Table 4: Pattern of benefit payments 2002–03 \$million (% of contribution income)

Category of payment		
	Additional hospital services	Transfer payment or non-hospital service
Hospital benefits		
- private hospital benefits	3,166	
- public hospital benefits	307	
- day hospital	136	
- medical up to schedule fee	369	
- medical above schedule fee		330
Listed prosthesis*	273	273
<i>Subtotal hospital benefits</i>	<i>4,251 (53.9%)</i>	<i>603 (7.6%)</i>
Ancillary		2,043 (25.9%)
Management expenses		828 (10.5%)
State levies		102 (1.3%)
Surplus (before tax)		195 (2.5%)
Contribution income	7,885.0#	

Source: PHIAC 2003b Figure 12, Table 2

Notes:

* the major increase in prosthesis payments has been due to price increases, (nominally 50% of prosthesis payments allocated as a transfer payment)

numbers do not balance due to other income and changes in equity

Equity

The various incentives to promote private health insurance provide disproportionate benefit to those on higher incomes. Persons on high incomes are more likely to take out PHI and thus receive the rebate on the cost of PHI. The most recent ABS survey of PHI in 1998 estimated that 76% of persons with an income above \$100,000 had private health insurance, while only 20% of persons with an income of < \$ 20,000 had insurance, with a gradient across the entire income range (ABS 1998). The situation is likely to have become more extreme since, with the combination of the Medicare levy surcharge and the rebate increasing the financial incentive for high income earners to take out PHI. Research by Smith also demonstrates the regressive nature of the PHI rebate. She reports that an estimated 50% of the subsidy would accrue to those in the top quintile in 1998-99 compared with 4% in the bottom quintile. She also shows the policy is considerably more regressive than the means-tested dollar-limited rebate it replaced (Smith 2001).

Persons with PHI, disproportionately those on higher incomes, get taxpayer support for access to private hospitals and a range of community-based services. In 2002–03, the Commonwealth contributed \$711 million towards the latter through the PHI rebate on ancillary cover (30% of contribution income received by private insurers is for Ancillary cover, PHIAC 2003b, Table 2). The largest categories of benefit payments in 2002–03 were for dental at \$977 million, optical \$312 million, physiotherapy \$144million, chiropractic services \$139 million, pharmacy \$75 million, fitness and lifestyle equipment \$66 million and podiatry at \$50 million (see Table 5). Through the 30% rebate, the taxpayer in effect contributes 30% of the cost of these services.

While a subsidy on some community-based health services might be desirable, to tie that subsidy to the purchase of private health insurance, rather than to relevant clinical or health economic criteria is questionable on both efficiency and equity grounds. It is interesting to note that some service types, central to clinical care, such as speech therapy, occupational therapy and dietetics attracted less than \$5million subsidy (total across all 3 areas) in 2002–03, while ‘natural therapies’ in effect received a taxpayer subsidy of \$10 million (see Table 5).

The inequity of current arrangements is well illustrated by the Commonwealth government subsidy on dental services. Through the rebate on ancillary cover, the Commonwealth in effect contributed in 2002-03 \$293 million (30% of \$977 million) to private dental services, largely for those on higher incomes. At the same time Commonwealth financial support has been withdrawn from the public dental scheme, which offers dental care to low income Australians, arguing that dental care is not a Commonwealth responsibility.

In short, the policies to support PHI use taxation revenue to assist those predominantly on higher incomes to gain priority access to elective surgery and other health services. There is no mechanism to ensure that the subsidy is directed to those with the greatest clinical need. This is inefficient as well as inequitable (Smith 2000, 2001, Willcox 2001, Deeble 2003) and at odds with one of the stated government goals of 'improved life expectancy and infant mortality for low income Australians, so that they are comparable with the general population' (Commonwealth of Australia, 2002). Hall and colleagues (1999) conclude that the Australian system of subsidies and penalties to promote private health insurance 'leads to greater inequity in access to health care,' (p 659).

**Table 5: Benefits paid for services under ancillary tables.
Implied Commonwealth contribution. 2002–03 Million dollars**

Service type	Benefits paid \$ million	Implied Commonwealth subsidy at 30% benefit \$ million
Dental	977.4	293.2
Optical	312.3	93.7
Physiotherapy	143.9	43.2
Chiropractic	138.9	41.6
Fitness and life-style	65.6	19.7
Pharmacy	74.6	22.4
Podiatry/chiroprody	50.4	15.1
Ambulance	30.6	9.2
Natural therapies	30.4	9.1
Psychology/group therapy	19.6	5.7
Acupuncture	18.7	5.6
Prostheses aids and appliances	18.5	5.6
Hearing aids and audiology	10.6	3.2
Speech therapy	9.1	2.7
Occupational therapy	4.4	1.3
Dietetics	3.9	1.2
Other	58.8	
Total*	1968.6	590.6

Source: <http://www.phiac.gov.au>

Notes* Total non-contractual ~94% of all payments including contractual.

Health system costs

Promotion of private health insurance is likely to increase health system costs, through increased demand (driven by a combination of consumers wanting to 'use' their insurance – the phenomenon of moral hazard and providers recommending a higher level of servicing – the phenomenon of supplier induced demand). But in addition, systems with a high private insurance component tend to exhibit higher cost/price structures. The increase in the unit cost of prostheses and of medical payments above the schedule fee, and the acceleration in the rate of increase in health expenditure as a percent of GDP in Australia (which has accompanied the increase in PHI membership), suggest reasons for concern. Anderson and colleagues (2003), in an analysis of

health care spending in 30 OECD countries, which seeks to explain the reason for higher health care spending in the USA, conclude that it is essentially due to higher prices (including fees) and costs. The higher costs they argue are due at least in part to a fragmented health care system in which providers wield market power, compared with other countries in which government funders and purchasers dominate and are able to exercise greater control over costs and prices.

The fact that health systems with a high proportion of private funding tend to be more expensive, with no evidence of improved health outcomes, is not coincidental, but reflective of certain cost-inflating aspects of private funding. Duckett and Jackson (2000) in their analysis of the health insurance rebate, estimate that public hospitals are 10% more efficient than private hospitals, given an appropriate adjustment for differential case mix. In the right regulatory environment, a single insurer is the most efficient way of providing insurance, due to the capacity to spread risk and minimise administrative and management costs. The costs of management under Medicare are estimated at 3.2% of recurrent health care expenditure compared with 13.8% for the Private Health Funds (AIHW 2002b, Table A9). In addition, many private health funds must achieve a profit.

While one of the arguments for supporting private health insurance was to contain costs, or at least the Commonwealth contribution to health care, we find that both total health care expenditures and the Commonwealth share of funding have risen with increasing PHI membership. By 2001-02 health expenditure was 9.3% of GDP following a rise of 0.6% points over the 3 years post 1998-99, twice the increase of the previous 3 years (of 0.3% points). Commonwealth health care spending has risen from 3.7% of GDP in 1996-97 to 4.3% of GDP in 2001-02. The continuing increase in PHI premiums, in the face of a vastly improved risk profile of health insurance funds, is further evidence of the cost inflating effect of PHI.

The perverse incentives of a partial system

The current PHI policies also support the perverse incentives contained in a partial (that is non-comprehensive) health insurance model. There is no requirement on the private health system to offer a fully self-contained health service. In fact the opposite is the case. As insured persons retain full entitlements under Medicare, private insurers and private providers need not cover the full range of health care needs, but can choose to focus on the more profitable health services. As noted by Deeble 2003, 'nearly all emergencies and most of the oldest, poorest and sickest patients will be cared for publicly' (p9), while the private hospital system focuses on elective surgery, and within that, the more profitable area of day surgery¹. In 2001-02, private hospitals in Victoria accounted for 53% of all elective surgery cases, but 24% of all hospital expenditure (Hanning 2002). Furthermore, with more intensive care beds and employment of full time medical staff, public hospitals are likely to attract more complex cases, both as elective admissions and through emergency transfer from private hospitals following a serious adverse event.

Policy Implications

This paper has drawn on a wide range of evidence which, when taken together provides a compelling case for a total overhaul of policies relating to private health insurance. Current arrangements are seen to undermine the efficiency and equity of the Australian health care system, and increase the overall cost of health care and cost to the Commonwealth, while reducing the contribution by the overall private health insurance industry. It has provided greatest subsidies to those on higher incomes and improved their access to private hospital and other health services, in a way that is unrelated to clinical need.

Universal coverage is now the accepted standard across the 'developed' world, with 'the US the only major industrialised nation not to provide health coverage for all' (Davis and Cooper 2003 p3).

¹ Over the 5 years to 2000-01 the net operating margin for Day hospitals averaged 17%, compared with 6% on private acute and psychiatric hospitals (ABS 2002).

The existence of universal coverage changes radically the function of private health insurance, however, this change is not yet reflected in policy. Rather, a set of policies exist to support PHI, that seem to have more relevance to a two health tiered system in which public health care is not for all, but targeted at 'disadvantaged groups'. The evidence is clear that current policies to promote PHI, which are offered alongside a universal health insurance system, make the health care market less rather than more efficient and less rather than more equitable. The open-ended funding support for private health insurance through the 30% rebate means that the distortions are not only costly, but are not self-limiting and have the potential to reduce funds available in other areas, such as public hospitals.

A review of the role of PHI is required as a matter of urgency, consistent with Recommendation 22 of the Industry Commission Report into Private Health Insurance (1997), which calls for 'a broad public inquiry into Australia's health system'. In the interim, given the poor performance of the private health insurance rebate subsidy, it should be capped, or withdrawn, and the savings redirected to the public hospital system and cost-effective primary and secondary care services.

In the context of universal health cover, PHI could be seen as a product of no special significance, with government intervention in the play of market forces a matter to be argued not presumed.

References

- ABS 2002. Private Hospitals, Bulletin no 4390.0, Australian Bureau of Statistics, Canberra.
- ABS 1998. Health Insurance Survey, Australia, cat no 4335.0 www.abs.gov.au/Ausstats/
- AIHW 2003. Health Expenditure Australia 2001-02, Australian Institute of Health and Welfare, Canberra, Sept 2003, cat no HWE 24.
- AIHW 2002a. *Australia's Health 2002*, Australia's Health No. 8, Australian Institute of Health and Welfare, <http://www.aihw.gov.au/publications/index>. accessed March 2003.
- AIHW 2002b. *Health Expenditure Australia*, 2000-01, Australian Institute of Health and Welfare, Canberra, Sept 2002, cat no HWE 20.
- AIHW 2000. Australia's Health, Australian Institute of Health and Welfare, aiwh cat no 19 Canberra.
- AIHW 1999. *Australian Hospital Statistics*, 1997-98, Australian Institute of Health and Welfare, Canberra.
- Anderson G, Reinhardt U, Hssey P, Petrosyan V 2003. 'It's the prices stupid: Why the United States is so different from other countries' *Health Affairs* vol 22(1) pp 89-105.
- Butler J 2002. 'Policy change and private health insurance: did the cheapest policy do the trick', *Australian Health Review*, vol 25, no 6, pp 33-41.
- Cromwell D 2002. 'The lore about private health insurance and pressure on public hospitals', *Australian Health Review*, vol 25, no 6, pp 72-74.
- Commonwealth of Australia 2002. Budget Papers 2002, <http://www.fed.gov.au> accessed March 2003.
- Davis K, Cooper BS 2003. American Health Care: Why so costly? Invited Testimony, Senate Appropriations Committee, The Commonwealth Fund NY, www.cmf.org
- Department of Health and Aged Care 1999. *Occasional papers: new series no 4, Private Health Insurance*, Commonwealth Department of Health and Aged Care Canberra.
- Deeble J 2002. 'Funding the essentials: the Australian Healthcare Agreements', 2003-2008, *Australian Health Review*, vol 25, no 6, pp 1-7.

- Deeble J 2003. *The private health insurance rebate. Report to State and Territory Health Ministers*, NCEPH, ANU, Canberra.
- Duckett S & Jackson T 2000. 'The new health insurance rebate: an inefficient way of assisting public hospitals' MJA, vol 172, pp 439-442.
- Hall J, De Abrea Lourenco R & Viney R 1999. 'Carrots and sticks – the fall and fall of private health insurance in Australia,' *Health Economics*, vol 8, pp 653-660.
- Hamilton C & Denniss R 2002. *Health Insurance Tax Rort*, Discussion Paper, The Australia Institute, Canberra.
- Hanning B 2002. 'Has the increase in private health insurance uptake affected the Victorian public hospitals surgical waiting list' *Australian Health Review* vol 25, no 6, pp 64-71.
- Industry Commission 1997. *Private Health Insurance*. Report No 57, <http://www.pc.gov.au/ic/inquiry/57privatehealth/finalreport/index.html>, accessed March 2003.
- PHIAC 2003a. *Quarterly Statistics*, Private Health Insurance Administration Council, <http://www.phiac.gov.au> accessed 2003.
- PHIAC 2003b. *Operations of the Registered health benefits Organisations Annual Report 2002-03*, www.phiac.gov.au
- PHIAC 1999. *Operations of the Registered Health Benefits Organisations, Annual Report 1998-1999*, Private Health Insurance Administration Council, Canberra.
- PHIAC 2000. *Operations of the Registered Health Benefits Organisations, Annual Report 1999-2000*, Private Health Insurance Administration Council, Canberra.
- Private Health Insurance Branch, Department of Health and Ageing 2004. 'Private Health Consumer information 30% rebate', www.health.gov.au
- Robertson I & Richardson J 2000. 'The effect of funding upon hospital treatment: the case of coronary angiography and coronary artery revascularisation procedures following acute myocardial infarction', MJA, vol 173, pp 291-295.
- Segal L, Donato R, Richardson J & Peacock S 2002. 'Strengths and limitation of competitive versus non-competitive models of integrated capitated fundholding', *J Health Serv Res Policy*, vol 7, suppl 1, pp S56-64.
- Smith J 2000. *Tax expenditures and public health funding in Australia*, Discussion Paper no 33, Australia Institute, Canberra.
- Smith J 2001. *How Fair is health spending?* Discussion Paper No 43, Australia Institute, Canberra.
- Willcox S 2001. 'Promoting Private Health Insurance in Australia', *Health Affairs*, vol 20, no 3, pp 152-161.
- Wooldridge M 1996. Private Health Insurance Incentives Bill 1996, Second Reading 13 December 1996 House Hansard pg 8573.
- Wooldridge M 1997. 'Government to maintain community rating as keystone of a strengthened private health insurance system', Media release 10th April 1997, MW27/97, <http://www.health.gov.au/archive/mediare/1997/mw2797.htm> accessed March 2003.