The private health insurance rebate

Report to State and Territory Health Ministers

John Deeble

National Centre for Epidemiology and Population Health
The Australian National University

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Executive summary

On both economic and health service criteria, the rebate has failed to produce the results claimed for it. It has not increased the flow of private funds into the health care system. As a proportion of all health service funding, these have actually fallen. The net contribution of private insurance to health service funding (ie, excluding the rebate subsidy and its own administrative costs) is now about 26% lower than it was before the rebate began. The Commonwealth has simply replaced private funding with over $2 billion of its own.

That was because, despite the claims of its advocates, private insurance membership is relatively insensitive to price. Its post-Medicare decline was more related to perceptions of poor value for money, growing confidence in Medicare's stability and an increasing number of people with no history of using it. The rebate itself played almost no role in the large increase in private insurance membership in June-July 2000, nor can the introduction of 'lifetime health cover' alone explain it. Almost all of the increase came from the fear campaign associated with its implementation.

Only about 40% of the increase in private insurance benefits post-1998-99 has gone to supporting health services which had some possible offset on the public side. The remainder went to higher ancillary benefits, the upgrading of existing insurance coverage, the elimination of hospital 'gaps' and the extension of medical gap insurance over schedule fees. These simply reduced the out of pocket expenses of insured people. They produced no additional care.

Up to 2000-2001, a maximum of about 7.7% of public patients may have shifted to private status. The maximum notional reduction in public patient outlays nationally was about $ 700 million per year, less at marginal costs. That would equate to only 4.5% of all public hospital expenditures and less than 30% of the rebate's cost. It gives no ground for any reduction in Commonwealth hospital grants, which would be illogical anyway. Also, all the figures are probably overstated because most any shift appears to have been in relatively low cost same-day procedures. Waiting times did not change.

Australia already has a hospitalisation rate much higher than in comparable countries. However if more hospital care was the main objective, it would have been both more efficient and more equitable to have transferred the same gross funding to the public system. That would have avoided leakages of over 60%. One estimate is that for additional grants equal to the rebate cost, the public hospitals could treat almost 60 % of **all** the patients now treated in the private system, although the demand for unsubsidised insurance would be unlikely to ever fall that far.

Although the Commonwealth seems locked in to its present policy, a number of changes could and should be made. Structurally, ancillary insurance should be excluded from the rebate's scope, with its main subsidy component – dentistry – transferred to a restored scheme for aged and disadvantaged people. Measures designed simply to reduce the insurance system's out-of-pocket costs should also be excluded, particularly medical gap insurance over schedule fees, which is of doubtful efficacy and has inflationary implications for the public system as well. However both of these changes would need Commonwealth support and because all of the

savings would accrue to it, it not clear that any of them would be transferred to the States.

Operationally, the two measures most canvassed have been full cost charging for private patients in public hospitals and charging people who hold private insurance whether they elect to be treated privately or not. These would effectively tap in to both the rebate and the flow of private funds. The first may be defensible. Patients would not notice it, although their private insurance advocates would. The second is based on the observation that a high proportion of privately insured patients do not disclose it to public hospitals, anecdotally to avoid the front-end deductibles which their insurance policies require. But charging on insurance status alone would not only be complex (would patients facing deductibles be treated as insured or not) but would also conflict with the basic Medicare principle of universal access to public services to which everyone contributes. In the long run, it would strengthen the case for even more private sector subsidy than is contemplated now.

However there are several regulatory measures which would have substantial longer run benefits. There are currently no conditions on the services eligible for insurance subsidy but taxpayers are entitled to know that it is used efficiently. $2.1 billion is a large amount of money. The Commonwealth could and should require that all the service providers covered by it establish transparent and independent utilisation review. That is no more than the public hospitals must do now. And regulation should be extended to mandatory participation in public - private sector planning with, ideally, to better arrangements for the treatment of public patients in private hospitals as well. The underlying cause of all the current activity has been the almost complete separation of the public and private sectors. These changes would reduce it. They would require Commonwealth action but that should have public support and they would cost the government no money.

Introduction

The Terms of Reference of this paper were to report on;

* The effectiveness of recent policy on private health insurance in Australia.

- The impact of the Commonwealth's private health insurance policy on the provision of health services, particularly in the public health system.

- Suggestions as to how the current Commonwealth private health insurance subsidies may be more effectively targeted to improve the Australian community's access to public health services.

All of these issues clearly require some policy framework. It is otherwise impossible to say what 'effectiveness' might mean. That requires some agreement on the role which private insurance is expected to play. But there is no consensus on it. Private insurance is only a small part of the Australian financing system. By itself, it now raises only about 7% of the total funds and less than one sixth of the cost of public and private hospitals. However it is the major funder of private hospitals, a significant support for the incomes of medical specialists, particularly procedural specialists, and the centre of most of the ideological debate over health care financing in this country. In the design of Medicare (and its predecessor) it was seen as a practical way of allowing better-off people and those with a strong preference for private treatment to 'opt-up' without 'opting out' of the universal scheme to which they all contributed. Private insurance could fund their extra demands – and those of their doctors - but in a regulated way. It was not subsidised but subsidising insurance is not the only way of supporting private care. Until 1986-87, subsidies were paid direct to private hospitals which reduced both their charges and the cost of insurance to cover them.

Private sector subsidies thus have a precedent. In their last full year of operation they amounted to about 12.5% of all private hospital costs. Their removal was a crucial decision. It saved some public money but it started the price growth in private insurance premiums and, more importantly, effectively divorced the private sector, and private insurance, from the whole structure of Medicare. Over time, that separation has developed to the point where private insurance is now viewed by the press, politicians, some bureaucrats and the public as an alternative to Medicare, in competition with it, rather than a useful supplement. For many of its proponents, it is the way in which the majority of people would be expected to finance their health care.

The government has never taken that position publicly. However all of its policy measures since 1996 have been designed to strengthen private insurance as a parallel financing system and there are precedents for that support as well. The Fraser government's first change to the original Medibank encouraged people with private insurance to opt out of both the newly-introduced Medicare levy and all government benefits. About 50% of the population did so and the structure of the present levy surcharge and the exemptions from it directly parallel that system. From 1982, when the original scheme had been almost entirely dismantled, the same government (in

which the present Prime Minister was Treasurer) allowed a 30.7% tax deduction on all insurance premiums for private medical insurance and hospital insurance at the basic level. And in August 2000 the bill allowing private gap insurance without contracts also extended it to all specialist fees, a provision later withdrawn because of opposition by GP groups in the AMA.

These are the origins of the present structure and Ministers will have views on the broader issues. This paper is written on the assumption that, in affirming their commitment to Medicare, they see private insurance as supplementary rather than an alternative to be maximised *per se*. It concentrates on the effects of the 30% private health insurance rebate although there are some other policies (such as the Medicare levy surcharge and the conditions of exemption from it) which cannot be divorced from the subsidy system. Its criteria are those of maximising the health of the Australian people through adequate and equitable access to hospital treatment in a system which retains some elements of choice in how it is delivered. The issues relate to the Commonwealth's stated justifications for the rebate policy, namely that;

- falling private insurance membership had reduced the flow of private funds into the heath care system and increased the demand for public hospital care. Its continuation would threaten Commonwealth and State budgets.

- cost was the most important determinant of private health insurance membership,

- the most effective and efficient remedy was therefore to increase the flow of private funding by subsidising insurance premiums. That would increase membership, shift demand from the public hospitals to private providers and in the process, improve the availability of public hospital care for disadvantaged people.

The discussion which follows assesses experience in the light of those objectives.

I Effects on total funding

Pre-rebate

The contention that private insurance funding had fallen dramatically post-Medicare is wrong. In fact, its net contribution to total health expenditures (eg, excluding administrative costs) was almost identical in 1996-97 – the year before any rebates began – to that in 1984-85, which was the first year of Medicare. The 1984-85 proportion was 10.8%. In 1996-97 it was 10.0%. That was despite a fall in membership. The insurance share peaked between 1986 and 1988 but only to 11.8% and the subsequent decline was slow.

The distribution of this funding changed however. More went to benefits for ancillary services, medical fees – and in the later years – some gap insurance; and to funding a very large shift of patients from private treatment in public hospitals to the private hospitals where charges were much higher than in the public system. The private hospital share of all hospital admissions rose from 26% to 33%, equivalent to a 90% rise in their admissions per 1000 population, as compared with a 35% increase in

public hospital separations. The private hospital sector was therefore well supported. Funding problems were related more to the very large rise in hospital admissions generally than to any decline in private financing.

Post rebate

The universal 30% premium rebate began in January 1999. In its first full year, (1999-2000) $1,580 million was paid in rebates In 2000-2001, the cost was $2.13 billion and the 2001-2002 figure was almost identical. But the revenue raised by the reduced premiums did not increase enough. In 1999-2000 the net health service contribution from private health insurance itself was $1 billion less than it was in 1996-97, before any rebates began and in 2000-2001 the difference was only marginally lower. The net contribution had fallen to only 6% of total health expenditures and as the relevant AIHW report pointed out, the absolute contribution from private insurance was actually 10% less than had been ten years earlier. The decline was not as extreme in 2001-2002 when insurance benefits rose by 16% and the funds incurred a loss. However their share of total health expenditures was still only 7.4% at most. Details are in Appendix Table 1.

That was an extraordinary result. Instead of the leveraged increase which it projected, the Commonwealth had simply replaced private funding with over $2 billion of its own, with almost no net gain to the health care system. That was despite a spectacular rise in health insurance membership. And the position will not improve. Much has been made of the 16% increase in insurance benefits last year but the insurers are already seeking premium rises to cover them and the Commonwealth will meet 30% of that.

There were two main reasons for this outcome. The first was a mistaken view of the responsiveness of private insurance membership to price; the second was the inclusion of ancillary insurance, administrative costs and gap insurance cover in the rebate net, none of which had any cost offsets on the public side; and the third, an apparent oblivion to the way in which both the public and the insurance industry would use these undirected subsidies. The following sections discuss the issues.

II Effects on membership

In the first two years of its operation, the 30% insurance rebate achieved very little. Hospital insurance coverage stabilised but did not rise However the ‘run for cover’ campaign associated with 'lifetime health insurance' had a dramatic effect. Its basic message was that the government could not provide universal access to an adequate standard of hospital care through Medicare and that the only way to ensure personal coverage was to take private insurance now. That would not only advantage new members, who would otherwise pay more in the future, but also benefit those who could not afford to be insured.

It was an aggressive campaign and in terms of membership growth alone, a very successful one. Hospital insurance membership rose by 50%.(Appendix Table 2) Concern for others is unlikely to have much influenced the result and while the premium rebate may have been useful in public relations, the ‘fear factor’ appears to have been by far the most important influence. The whole campaign created a

perception of crises in the public system and a climate of uncertainty about both the quality and the continued availability of Medicare coverage to which private insurance was the obvious answer. Many less informed people believed that they now had to insure.

All of this was quite predictable because the demand for health insurance, although quite responsive to income (more high-income people hold it than the poor, though it is less essential for them) is not sensitive to price. That has been known for years, confirmed by experience and formally demonstrated in many studies. The consensus is that its 'price elasticity', or responsiveness to price, is about -.0.3 to - 0.4 which means that a 10% change in price would produce a 3-4% change in membership. That is because demand does not depend on price alone. As for any good or service, it also reflects the perceived quality and availability of any alternatives, which in Australia means Medicare. It was always in the insurance industry's interest to portray price as the dominant reason for falling membership but the decline was equally concerned with a perceived lack of value (uncovered gaps etc.), a growing acceptance of Medicare's stability and the progress of a cohort of people with no history of private health cover.

One would therefore expect that the effects of even a 30% reduction in premiums would be quite small. That was what Clarke (1998) found from national survey of buying intentions six months before the rebate took effect. It suggested that, at the most, the population coverage of hospital insurance would rise by 4% and that of ancillary cover by 5.6%. However no change was almost equally possible. The implied price elasticity was only about -0.15.

That was almost exactly what happened. PHIAC data show that as a proportion of the population, hospital membership did not change at all in the first eighteen months of the rebate when it and the levy surcharge were the only policies used (see Appendix data). In the light of the previously declining trend it was entirely consistent with the Clarke survey's maximum prediction. As Butler (2002) has pointed out, that would mean that most of the very large outlays on the rebate have actually been wasted. All of the increased membership coincided with the introduction of 'lifetime health cover' (which cost the government nothing) and the campaign associated with it. He has pointed to the incentives built into the new system and the change in insurance prices at different joining ages as possible explanations.

This conclusion as to the rebate's direct effect is clearly correct and was both predicted and predictable. The price structure of 'lifetime health cover' may have had some influence but as a total explanation of the result it is even less plausible than the rebate. If an immediate reduction of 30% in premiums only increased membership by 4% how could the prospect of a 2% per annum price rise over 15 years (which in present value would be much lower) create a 50% increase in membership now? The implied price sensitivity would be ridiculously high. The only plausible explanation is that it was the 'fear factor' which dominated. The resulting structure is now relatively insensitive to price again - premium increases last year had little effect on membership. Some people will see insurance as less value for money but while the perceptions generated several years ago remain, small price rises will be absorbed. However demand may not be quite as inelastic as before if the number of 'reluctant' members is as high an anecdote suggests.

Responses

These conclusions have of course been challenged by the insurance and private hospital industries. For obvious reasons, their contention has always been that cost is the main driver of membership and that without the rebate it would have continued to decline. The Access Economics report for the Australian Private Hospitals Association rejects the Butler data out of hand (Access Economics,2002). It purports to measure the relationship between the 'affordability' of private insurance (as expressed by the inverse of the ratio of private health insurance premiums to household disposable income since 1984-85) and the proportion of the population covered. The results are translated into an estimate that the 30% premium rebate would alone have produced an 11% increase in the proportion of the population insured, three quarters of the 15% rise which actually occurred. Affordability is thus seen as the dominant driving force. That is the key to the paper's whole argument. Declining affordability is claimed to explain over 90% of the fall in private insurance coverage, a result reportedly based on an econometric analysis. Given the importance attached to it, the standing of the consultants and the appearance of technical expertise which it conveys, it is important to examine how valid these conclusions are.

In fact, all of them are wrong. At the technical level, the paper claims a highly significant statistical relationship between affordability and coverage but even a simple inspection of the data shows otherwise. Apart from the coverage data being wrong, there was an 18% reduction in the 'affordability index' between 1984-85 and 1988-99 but no change in the proportion of the population privately insured. Conversely, there was almost no change in the index between 1992-93 and 1998-99 but a 25% reduction in the proportion of the population covered. That leaves only 5 years in which some association might be found and there the results were random.

There is a clear explanation for this error. The claimed relationship is actually based on a regression which is spurious for a simple methodological reason (serial correlation) for which there is a well-known remedy (regression of annual changes). If the correct technique is used the association almost completely disappears. Secondly, even if the claimed association did exist, the translated result would be wrong because the right base for calculation is the number of people previously insured, not the proportion of the population covered. On that basis, the reported figures imply a 33% rise in membership for a 30% reduction in price. That would be about three times the level of price sensitivity ever demonstrated for health insurance anywhere and one which would apply to very few goods or services in a developed economy.

But all of these difficulties pale before the way in which 'affordability' was measured. Changes in average premiums included everything – the upgrading from public to private hospital cover which accounted for much of the price increases in the late 1980s and 1990s, the growing uptake of ancillary cover, increasing utilisation, higher technology, the introduction of both hospital and medical gap cover etc. Some of these changes resulted from consumer choice, some were promoted by the insurance funds themselves and some came from outside. It would be impossible not to find declining affordability for a product which had expanded so much, quite apart from the broader effects of both higher hospital use and health care prices rising more

rapidly than incomes. But household incomes were still increasing and as the Access Economics report points out, health insurance is a good on which people spend more as income rises. Given all of the uncertainties above, there is no good evidence that price changes alone had anything like the effects upon demand which have been claimed.

III Responses to subsidy

Between 1998-99 and 2001-2002, the non-investment income of private insurance rose by over $2000 million to $7,266 million, or 47%. That was somewhat less than the growth in membership, largely because the number of members with front end deductible insurance increased from less than 40% to over 56%. A high proportion of 'post-lifetime health cover ' members took such policies. The rebate component rose by $1,042 million.

Benefits rose by 52% to $6,558 million, leaving an operating deficit in 2001-2002. However a substantial surplus in the preceding year meant that the industry's overall position had improved.

But only part of the increase went to hospital care. Over the three years to 2001-2002,

- excluding implanted prostheses (which are really part of hospital costs) ancillary benefits grew by 65% to $1.47 billion. About half of this was dental.

- hospital benefits rose by 37% to $3,861 million, but the number of hospital days, including those for same day procedures, grew by only 9%. Benefits per day thus rose by 26%. That was three times the average growth in hospital costs as measured by the ABS, although private hospital costs may have risen somewhat more than in the public system. Nevertheless, about half of the increase came from existing members upgrading to higher benefit tables and from the funds eliminating hospital gaps.

- medical gap benefits more than doubled, from $253 million to $598 million. However the number of medical services grew by only 38% and gap payments up to the schedule fee accounted for less than one third of the increase. About $235 million was for gap insurance over the schedule fee.

Together these factors accounted for about $1.32 billion in additional benefits - $580 million in ancillaries, about $505 million in upgraded private hospital insurance and $235 million in gap insurance over the schedule fee. That was nearly 60% of the $2.25 billion rise in benefit payments overall. Over half of it simply reduced the out – of- pocket expenses of insured people.

Again, this was an entirely predictable result. Many existing members used the rebate to upgrade their benefit cover and purchase ancillaries, gap insurance etc; and the health funds used it to improve their products. Lowering out-of-pocket costs improves marketability and the insurers have publicised it vigorously. But that had nothing to do with health, produced no more health services and had no offsets on the public side.

Summary

A basic principle of public finance is that taxes are most effective when levied on items with a low responsiveness to price, and subsidies work best when applied to those with a high price sensitivity. The PHI rebate does exactly the opposite. Though useful from a public relations viewpoint, it played almost no role in the increase in private insurance membership. Uncertainty, perceptions of a public sector crisis and the 'fear factor' associated with doubts over the quality, and even the continued availability of Medicare coverage were much more important influences.

Overall, the rebate has not increased the flow of private funds into the health care system. As a proportion of the total, the flow has actually fallen by about 26%, which is the very similar to the rebate. Commonwealth funds have simply replaced private funding with almost no net gain. Only about 40% of the $2.13 billion subsidy went to supporting service use for which there might be some long run offsets on the public side. The remainder went to ancillary services and the reduction of both premiums and out-of-pocket costs for insured people.

IV Effects on public hospital use

The public benefit argument for the rebate is that by reducing the demand for public patient care, it will improve availability for disadvantaged people. Many people question this assertion on the ground that the public and private sectors provide different services, treat different types of patient and that nearly all emergencies and most of the oldest, poorest and sickest patients will still be cared for publicly. The two approaches reflect quite different views about how the system works. The first assumes that the demand for hospital care is fixed, in which case any increase in one sector must logically produce a reduction in the other. The second holds that demand is not fixed, that availability creates its own market and that any increase in private sector activity would simply be an addition to the total. The latter is what history suggests.

The only analysis to date was recently published in the Australian Health Review (Deeble, 2002). It used the most recent national data on hospital activity to estimate the underlying shift from public to private patient status and what that implied for any notional reduction in public in-patient costs over the two years from 1998-99 to 2000-2001. The results showed;

- a 7% rise in hospital separations overall. That was the same as the average for the preceding ten years. However public patient separations increased by only 1%. Private patients rose by 16% (19% in private hospitals).

- three quarters of the increase in private patient separations was in same day procedures.

- per 1000 people, private patient separations rose by 11.3%. That rate was identical across the country.

- based on New South Wales data (where there was no increase in per capita utilisation overall), the maximum shift from public to private patient status was about 7.7%.

- at average costs (and an average casemix) that equated to a notional reduction of about $700 million in public patient expenditure, less at marginal cost. It represented only 4.5% of gross public hospital outlays nationally and less than 30% of the private health insurance rebate's cost. However both figures are probably overstated because much of the transfer appears to have been in same-day procedures.

These results suggest that while the private health insurance changes have produced some effects, they are small relative to all public hospital activity and they give no justification for any clawback of Commonwealth funding in the next Heath Care Agreements. If improved access for public patients is really an objective, it would be entirely illogical to do so. .

Because official data for 2001-2002 will not be available until after the Health Care Agreement negotiations are over, the same article reported on activity in a national, stratified sample of 30 hospitals over the two four-monthly periods of April-July 2001 and 2002. Compared with 2000-2001, when total public hospital separations actually fell, it showed a 1.6% increase in separations overall, with a 1.8% growth in public patient work. That was somewhat lower than the average annual increase but it is consistent with experience elsewhere. Financing changes can cause a temporary pause in growth but they do not alter long-term trends. About two years' growth in public patient admissions may thus have been deferred but that is likely to be all. The States will, of course, have both better and later information than this

V Waiting lists/waiting times

As is well known, these are very difficult to measure. One study of Victorian elective surgery waiting lists has estimated that about 11% of elective surgery cases shifted from public to private patient status (and private hospital admission) between 1998-99 and 2000-2001 (Hanning, 2002). That was rather higher than the estimated shift in overall admissions nationally but it is consistent with the type of work which private hospitals do most and with the large increase in same day separations from those hospitals. Some estimates of waiting list effects were also presented but they were much more speculative.

The official indicators compiled by AIHW relate to waiting times, not waiting lists. They show no changes over the same period. Nationally, there were 551,000 admissions from waiting lists in 2001-2002 which at a constant level of hospital throughput implies a list of similar magnitude. Most people are admitted promptly and any small changes in timing might not be evident for years.

Summary

The hospital separations data for the two years to 2000-2001 suggest that, at the maximum, about 7.7% of public patients shifted to private patient status, with an

emphasis on elective surgery and same day procedures. There is as yet no evidence of any reduction in public hospital waiting times. The notional reduction in public patient expenditures was, at most, about $700 million annually, which was only 4.5% of total public hospital outlays and only about 27% of the rebate's cost. On these data, there is no justification for any clawback of Commonwealth funding under the new Health Care Agreements. Any notional savings are already being spent. Outpatient demand, which is particularly sensitive to the level of GP bulk billing, has grown significantly.

VI Efficiency

Efficiency has several dimensions. The first relates to the allocation of funds relative to health care needs and the second to utilisation, costs and prices. Any insurance system, public or private, needs some control over the latter because of 'moral hazard'. That was the main concern of the recent IMF review of Australia's economic performance, which while conceding that the PHI rebate had' greatly improved the coverage of the Australian people', pointed to its particular susceptibility to moral hazard; and urged that consideration be given to excluding ancillary services from its scope (although moral hazard was not necessarily the major issue in that case). Despite its associations, it is not a judgemental term. It simply means that risks may change with insurance against them. People will be more inclined to seek health services and doctors will be more inclined to recommend them when all costs are covered. Moreover, both parties will be more willing to accept cost increases, particularly when those costs are also the incomes of providers. Patient demand is not the only issue, as industry documents like the Access Economics report infer. Patients do not admit themselves to hospital, doctors do and very few patients would reject their doctor's advice on economic grounds alone. Medicare handles these problems by fixing budgets and establishing, at least in principle, medical need as the prime criterion for treatment. But it is much harder to do that in private insurance whose major selling point is unrestricted access.

If more hospitalisation was the main objective – and given Australia's very high hospitalisation rate, that is not self-evidently necessary – the rebate has clearly been the most inefficient way of funding it. About 12% of it has been absorbed in administrative costs and of the remainder only 40% has gone to supporting hospital and medical services *per se*. Over two thirds of that may have been associated with existing patients shifting from public to insured patient status, leaving only a small real increase. Most of that increase was in same day procedures. In 2001-2002, same day separations for endoscopic and arthroscopic procedures were nearly 10% of all separations in private hospitals, compared with less than 3% in the public system. But diagnostic work has not been the public system's greatest need. Surgical resources and facilities have been and there is evidence that, contrary to the popular view, that need could be better met through the public system than in the private one. Duckett and Jackson (2000) have calculated that, for a similar casemix, overall costs (including medical and pharmaceutical costs paid by the Commonwealth) are about 10% higher in private hospitals than public ones. On that basis, they showed that, for additional grants equal to the levy's cost, the public hospitals could not only eliminate undue waiting, but also treat nearly 60% of <u>all</u> the patients now in the private system. Insurance would not be subsidised but given all that has been said about its price

sensitivity, it is highly unlikely that unsubsidised private insurance would ever fall that far.

That is quite obviously true. Quite apart from any cost differences, all of the funding would be used directly on public sector services and not 'leaked' into administration, ancillaries and measures which simply improved the insurance industry's products. Because admission would then depend on medical need rather insurance status, it would also be more equitable. It could not be achieved without significant resource transfers but the same applies to any stimulated private sector growth. It is one area where in the short run at least, a zero-sum game applies. As a Canadian observer of the Australian scene has commented, "You can have two systems but there is only one medical profession".

That is where moral hazard issues arise. A health-maximising policy would concentrate on specific service needs, but the rebate is unconditional, undirected and uncapped. There is no reason to believe that a purely demand-driven system will always deliver the most effective services but every reason to believe that ultimately both overall utilisation and service costs would rise. As O'Loughlin (2002) has pointed out in the context of private hospital 'cherry picking' of surgical patients, there are inherent conflicts of interest amongst the major private sector partners – doctors, hospitals and insurers. The first two gain from more activity of a familiar kind and in the private hospital case from higher profitability, particularly when corporately owned. On the other hand, the insurers need some protection against growth in both utilisation and costs. But they are in a poor position to achieve it. They are in a symbiotic relationship with the other parties and their discretion is limited as long as the commitment to unrestricted access and full cost coverage remains. The alternative of 'managed care' has been effectively killed by both the government and the AMA. These are the aspects of moral hazard to which the IMF strictures really refer. The Commonwealth response has simply been to say that it is still too early to judge the rebate's effects.

VII How might the present arrangements be improved?

All of the analysis above shows that on any health service criteria, the rebate policy has failed to produce the claimed results. It has not generated any extra private funding or any demonstrated service growth in crucial areas and its effects on public hospital demand and outlays have been small. Extra public hospital funding would have been a less wasteful, more efficient and more equitable solution, but if private sector subsidies are to be paid on both pragmatic and 'equity' grounds (that people who do not use public services deserve support) it would be much more effective to pay them directly to providers.

The federal government is unlikely to be swayed by these arguments, although it would now be hard pressed to justify any clawback of public hospital funding. Its over riding objective has been to foster private insurance and it is locked into that policy by both political credibility and the commitments it has made to supportive groups. So much has been invested in promoting the present system that no radical reforms seem open to it. There are nevertheless a number of changes in both structure and operation which could and should be made.

Structure

The most obvious change would be to exclude ancillary insurance from the rebate's scope. Nearly $500 million is involved. Apart from dentistry, the services it covers are poor candidates for subsidy and there are no clear offsets on the public side. In dentistry, the offset was effectively taken by the cancellation of the Commonwealth dental program in 1996 but an undirected subsidy of even cosmetic dentistry at over twice the cost in rebate is demonstrably less effective and less equitable than the specific program for the aged and disadvantaged people which it replaced. Ancillary insurance has been traditionally used by the health funds to cross-subsidise their hospital operations but that is unlikely to be true now.

Secondly, outlays designed simply to improve insurance saleability should be excluded. Medical gap insurance is the clearest example. Though popular and much used by both sides of politics, it produces no extra services and has inflationary implications for the whole system. The mandatory insurance coverage of charges up to the full schedule fee and its subsequent extension to 25% of the fee made no difference to patient gaps. Ten years later these were exactly the same as before but they were then over schedule fee levels. There is no reason to believe that the long run outcome will be any different. It makes no sense for the Commonwealth to subsidise by 30% charges above what its own fee schedule deems to be fair and reasonable. How can any of its schedule then be justified ? Gap insurance (of both kinds) now attracts nearly $200 million a year in insurance rebates and it can be shown that reverting to the standard Medicare practice would save almost half of that.

Finally, the rebate could be either capped (at a fixed sum per insured person) or means tested, or both. Equity would be improved and a greater pressure put on cost containment. However neither would be currently acceptable to the Commonwealth. Furthermore, none of these measures would necessarily benefit the constituencies which the Ministers represent without a commitment that the funds saved would go to them. That is uncertain.

Operation

The two internal changes which have been canvassed in the public system are, firstly, the charging of full cost recovery fees for private patient treatment in public hospitals and secondly, a requirement that privately insured people be compelled to reveal their status to a public hospital. Their health fund would then be charged hospital fees at rates agreed with the insurance funds, whether their medical services were provided privately or not. These are logical changes which are consistent with other proposals for altering the way in which hospitals are paid for public patients (Duckett, 2002) In the insurance context, they have been highlighted by the observation that up to 55% of insured people presenting to public hospitals do not declare it and choose to be treated as public patients, largely to avoid the out of pocket payments which their front-end-deductible insurance policies require (Thwaites, 2002).

However both changes would need Commonwealth legislative support and even if that were given it is not clear how large the real gains might be. Since they would raise insurance premiums the Commonwealth could claim to have met 30% of them and the remaining net revenue might well be further offset by reductions in grants

under the Health Care Agreements. Moreover they would further promote the notion of parallel and independent funding systems. Charging full fees might be superficially defensible. Most patients would not know the difference although their advocates would question whether that really represented the costs of treating private patients in overwhelmingly public institutions. However charging people who did not elect to be private would be a different matter. Medicare has been built on a universal right to use public services for which everyone contributes. Charging patients on insurance membership alone would not only be complex (would people facing deductibles be treated as insured or not?) but it would also strengthen the case for even more private sector assistance than is contemplated now.

Integrative options

All of the measures above are simply variations on the historical theme of separated public and private activity which has bedevilled Australian health care policy for years. They would do nothing to reduce it. However $2.1 billion is a large enough sum to force some integration and it should be used as such. Despite the rebate's deficiencies there **is** a case for certain private sector subsidies but the community is entitled to see that they are used efficiently, costs are controlled and that the most effective services are provided. That is currently doubtful because there are no conditions on the services entitled to the insurance rebate. The Commonwealth would have every right to impose them and to require that all eligible services be covered by transparent and independent utilisation review processes. That would be no more than the public hospitals are now forced to do. It would certainly not be too much to ask of the major corporates like Mayne Health, Ramsey Heath Care or Nova.

And the relationship between public and private hospitals could just as easily be strengthened. Private hospitals have always been entitled to Medicare funding for accepting public patients through contracts with the States but only 3% of public patients are currently treated in that way, largely because of doctor opposition. However at the least, eligibility for insurance subsidy could be linked to participation in joint public-private sector planning and that could be extended to improved arrangements for public patient treatment as well. Those are quite minimal requirements for such substantial assistance. They would have the very desirable result of blurring the black and white distinctions which exist at present. Both changes would also require Commonwealth action. However they should have public support and they would cost the government no money.

29-1-2003

Appendix

Table 1 Gross and net funding of health services through private insurance, 1997-98 to 2001-2002

Expenditures on:	1996-97	1998-99	1999-2000	2000-2001	2001-2002
	($mill	($ mill)	($ mill)	($ mill)	($ mill)
(a) Benefits					
Gross	4,178	4,252	4,469	5,348	6,558
Rebates	-	840	1,358	1,827	1,967
Net	4,178	3,412	3,111	3,521	4,591
% all health exp.	10.0	7.1	6.0	6.2	7.4
(b) Administration					
Gross	530	591	717	843	804
Rebates	-	117	217	288	252
Net	530	474	500	555	552

Note. Rebate growth lags behind the growth in contributions and benefits because of delays in the submission and processing of claims. Sources; AIHW, Health Expenditure Bulletin , 2000-2001; Health Insurance Commission, Annual Report, 2001-2002; PHIAC, Report on the Operations of the Registered Health Benefit Organisations, 200)-2001 and 2001-2002. The total health expenditure figure for 2001-2002 was estimated.

Table 2 Persons covered by hospital insurance, total and as a percentage of the population, 1996-97 to 2001-2002

At 30 June	Persons covered	% population
	(Mill)	(%)
1996-97	5.916	31.9
1997-98	5.728	30.5
1998-99	5.793	30.5
1999-00	8.236	42.8
2000-01	8.712	44.7
2001-02	8,705	44.1
% increase 1998- 99 to 2001-02	50.3	13.6

Source; PHIAC, Annual reports.

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