Jeromey Temple
PhD Candidate & Research Assistant
Demography & Sociology Program
Research School of Social Sciences
H C Coombs Building, #9
Canberra ACT 0200 AUSTRALIA

THE AUSTRALIAN NATIONAL UNIVERSITY

Phone: +61 2 6125 2295
Facsimile: +61 2 6125 3031
E-mail: Jeromey.Temple@anu.edu.au
http://demography.anu.edu.au/

Mr. Elton Humphery
Committee Secretary
Community Affairs
Legislation Committee
Parliament House
CANBERRA ACT 2600

Monday 6th December, 2004

Dear Mr. Humphery,

Thank you for the invitation to comment on the **Private Health Insurance Incentives Amendment Bill 2004**.

Consistent with the issues designated by the Selection of Bills Committee, the following paper seeks to examine:

(1) Whether the proposed reform will increase the affordability of PHI for older Australians who currently hold health insurance;
(2) Whether the proposed reform will increase the affordability of PHI for older Australians who do not currently hold health insurance; and
(3) Inequity issues arising from the application of the proposed Bill.

This paper argues that the effectiveness of the proposed reform is reduced considerably by the **Lifetime Health cover policy**. I suggest that the rules inherent in the Lifetime Health Cover legislation render ineffective the proposed rebate from the perspective of the uninsured elderly who are aged 71 years and under in 2005. From a life course perspective, future cohorts of the uninsured elderly regardless of age, will not benefit from the suggested reform. Furthermore, any effect of the proposed rebate on the insured elderly will be somewhat diminished by the combined effect of (i) health price inflation and (ii) price targeting by health insurance companies. Finally, due to differences in the socio-demographic profile of the insured versus the uninsured, the proposed reform will not solve the problem of inequality in access to health care for older Australians.

The analysis herein is a condensed version of the detail provided in several papers that I have written on the private health insurance coverage of the elderly (Temple, 2004a 2004b 2004c 2004d 2005). For detail on data sources, methods and broader policy issues please consult these sources.

Yours sincerely

Jeromey Temple

Submission to the Australian Senate Legislation Committee – Private Health Insurance Incentives Amendment Bill 2004.

Jeromey B. Temple
Demography and Sociology Program
Research School of Social Sciences
The Institute of Advanced Studies
The Australian National University

Jeromey.Temple@anu.edu.au
+61 2 6125 2295

1.0 Introduction

Between 1997 and 2001, the Australian health insurance market underwent three key policy reforms: the Private Health Insurance Incentives Scheme, the Private Health Insurance Incentives Act and Lifetime Health Cover. The current Bill before the Legislation Committee seeks to amend the second of these reforms, the Private Health Insurance Incentives Act. To improve the affordability of private health insurance (PHI), the government has proposed an increase in the private health insurance rebate from 30% to 35% for persons aged 65-69 and to 40% for persons aged 70 and over.

In order to examine the effectiveness of the proposed reform, it is important to understand potential interactions with the Lifetime Health Cover policy. Lifetime Health Cover, introduced in July 2000 deregulated the age component of community rating in the Australian health insurance market. All persons aged over 30 who remained uninsured after July 2000 had their future insurance premiums subject to a 2% surcharge for each year of age that they remain uncovered. Between July 1999 and July 2000, a person of any age could join a health insurance fund and remain exempt from the surcharge, so long as they remain covered for the rest of their life. For example, a person aged 40 who purchased health insurance for the first time in 2004 is subject to a 20% surcharge on their current and future premiums ((40 – 30)*2%). If this same person delayed purchasing health insurance for a further 10 years, the surcharge would grow to 40% ((50-30)*2%) and so on. The Lifetime Health Cover surcharge is capped at a maximum loading of 70%. All persons born before July 1934 are exempt from Lifetime Health cover. It is important to note that once private health insurance is purchased, persons are entitled to a 24 month period of absence. For each 365 days after this 24 month period, the Lifetime Health cover surcharge increases by 2%.

This paper argues that the effectiveness of the proposed reform is reduced considerably by the Lifetime Health cover policy. The following analysis is structured as follows: firstly, the proposed reforms are evaluated from the perspective of an insured elderly person; secondly, from the perspective of an uninsured elderly person; and finally, the equity implications of the proposed reform are examined. This paper concludes by suggesting that the rules inherent in the **Lifetime Health Cover** legislation render ineffective the proposed rebate from the perspective of the uninsured elderly who are aged 71 years and under in 2005. From a life course perspective, future cohorts of the uninsured elderly regardless of age, will not benefit from the suggested reform. Furthermore, any effect of the proposed rebate on the insured elderly will be diminished by the combined effect of (i) health price inflation and (ii) price targeting by health insurance companies. Finally, due to differences in the socio-demographic profile of the insured versus the uninsured, the proposed reform will not solve the problem of inequality in access to health care for older Australians.

2.0 Will the Proposed Reform Increase the Affordability of Health Insurance for the Insured?

The first issue identified by the Legislation Committee is whether the proposed reform will increase the affordability of health insurance for the insured. The following section seeks to indirectly measure the effect of an increased rebate upon affordability by (1) examining the effect of the earlier 30% rebate upon the propensity of an elderly person to purchase health insurance, and (2) by simulating changes in insurance premiums under the proposed system.

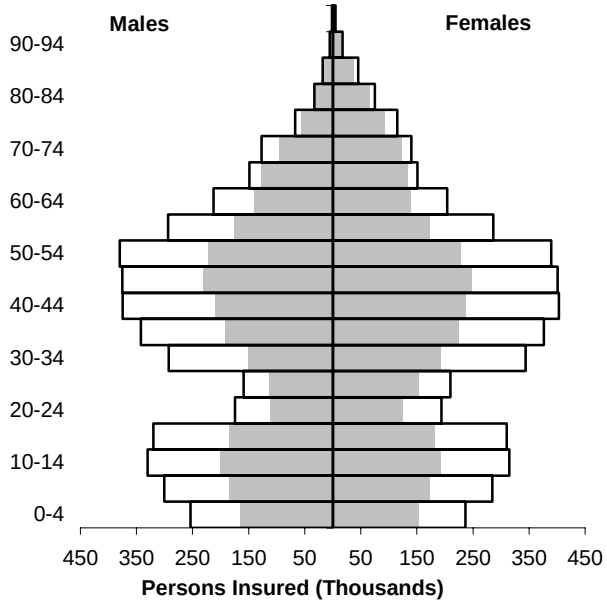
2.1 Did the Original 30% Rebate and Lifetime Health Cover rules increase the health insurance coverage of the elderly?

A growing body of literature has examined the effectiveness of the Private Health Insurance Incentives Act, the Private Health Insurance Incentives Scheme (30% rebate) and Lifetime Health Cover on the health insurance coverage of the Australian population. Butler has argued that the effect of the 30% rebate was small in comparison to the introduction of Lifetime Health Cover (Butler, 2003). Frech et al also point out that the 30% rebate did increase health insurance coverage, but the effect was small (Frech, Hopkins and Macdonald, 2002). Manners has suggested that the 30% rebate was not as successful as it could have been due to the lack of the financial attractiveness of private health insurance for low income earners, but does note that no gap insurance may have improved the operation of the 30% rebate (Manners, 2003). Quinn's study concludes, "even a generous rebate seems small compared to the effective prices faced by many Australians" (Quinn, 2003).

Research has shown that the uptake in health insurance due to the Private Health Insurance Incentives Scheme and the 30% rebate has not been uniform across the population. Using taxation data, Smith found that about half of the Australian Government's expenditure on the 30% rebate went to the highest 20% of income earners, and almost 75% of the federal funding for the 30% rebate goes to the top 40% of income earners (Smith, 2001). A possible explanation is the high level of self insurance in the population. Vaithianathan has shown that prior to the reforms in 1997, many wealthier families were opting out of private health insurance coverage and becoming self insured (paying the cost of surgery etc, out of-pocket). When the tax disincentive in the Private Health Insurance Incentives Scheme was introduced and then the subsequent Private Health Insurance Incentives Act 30% rebate, a large number of wealthier people switched from self-insurance to private health insurance (Vaithianathan, 2001). More generally, Wilcox argued that since income is highly associated with health insurance, it is not surprising that middle and upper income households benefited more from the 30% rebate than lower income households (Wilcox, 2001). Hall et al have pointed out that a large proportion of federal funds were simply directed to high income earners who already held insurance before the reforms (Hall, 1999).

To summarise, those on high and medium incomes were far more likely to benefit from the 30% private health insurance rebate, while the policy had little effect in inducing a large number of low income earners to purchase health insurance. These findings, however, apply to the Australian population of all ages. Results vary substantially by age.

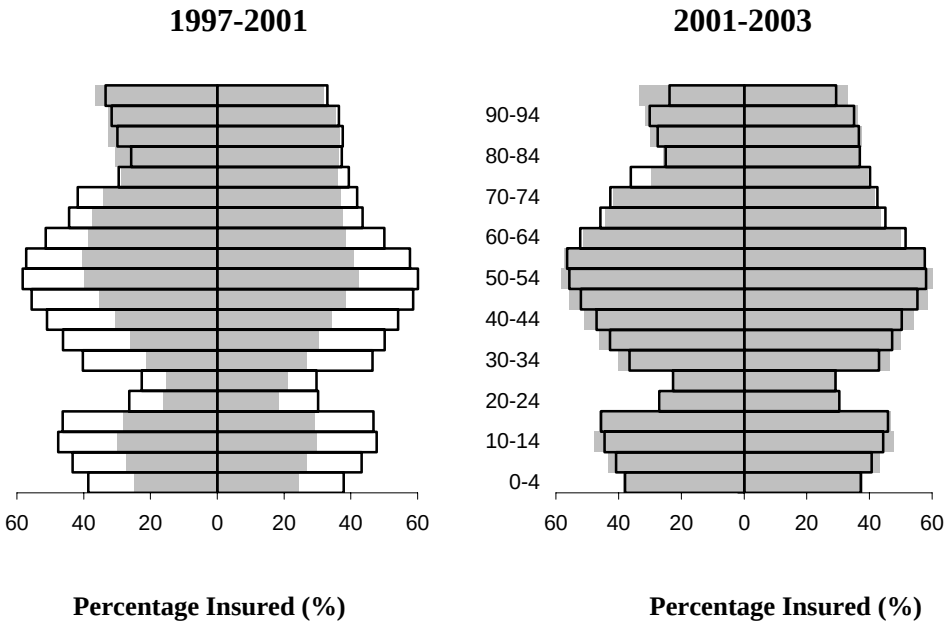
FIGURE 1 – Number of Persons (thousands) with Hospital Insurance, 1997 (shaded) and 2001.



SOURCE: Temple, 2004d. Private Health Insurance Administration Council, Statistical Trends – Membership and Benefits, 2004.

Figure 1 displays the shift in the insured age structure between 1997 and 2001. The number of persons covered by any type of hospital insurance increased dramatically, particularly between ages 30 and 55. Among older Australians, the increase in insurance purchase appears to decrease with age. For example, between 1997 and 2001, the number of 55-64 year old males with health insurance increased from 315, 458 to 505, 969, a growth of about 60%. In contrast, the number of 75 year olds and over increased by only 14%, from 109, 232 in 1997 to 125, 128 in 2001. The true uptake of insurance based on these data may be misleading due to the changes in the population age structure. To re-correct for compositional shifts over this period, the Private Health Insurance Administration Council (PHIAC) and ABS estimated resident population data were combined to estimate the proportion of the each age group covered by hospital insurance in 1997 and 2001, as shown in Figure 2.

FIGURE 2 – Percentage of Persons with Hospital Insurance, 1997 (shaded) to 2001 and 2001 (shaded) to 2003.



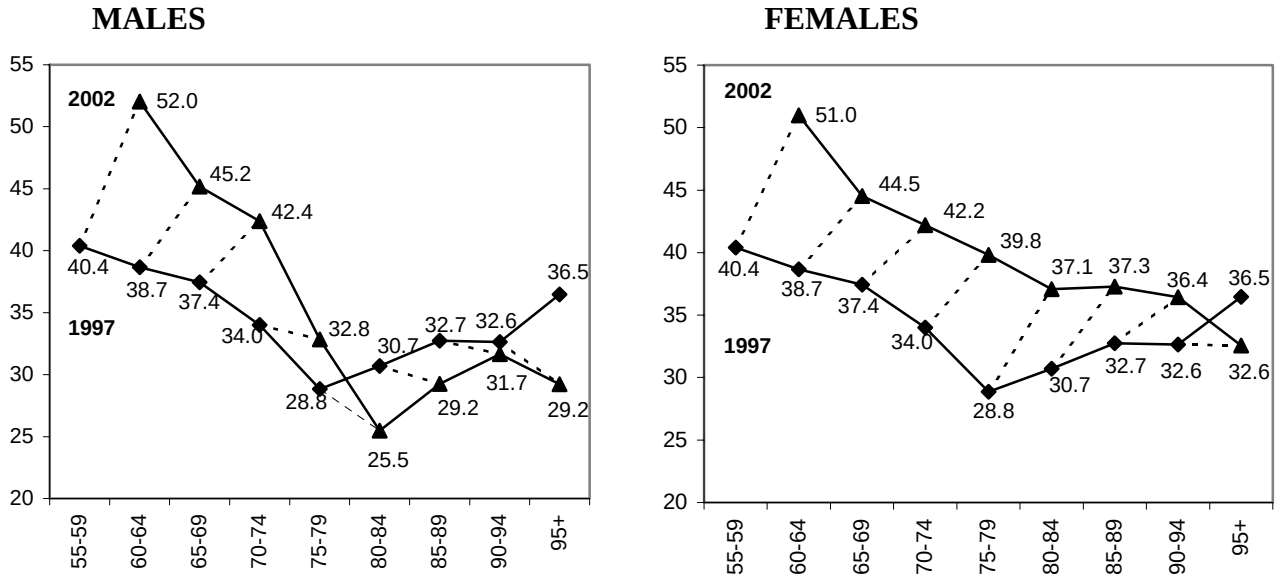
SOURCE: Temple, 2004d. Private Health Insurance Administration Council, Statistical Trends – Membership and Benefits, 2004 ; Australian Bureau of Statistics, Estimated Resident Population – Australia, 2004.

The proportion of the population with health insurance also increased dramatically over the period 1997-2001. This is particularly so for persons aged under 55 whose insurance coverage increased by about 16.6 percentage points over this period. For persons aged over 55, the percentage covered increased from 37.2% in 1997 to 45.6% in 2001, an increase of just over 8%.

However, among the elderly there is significant variation in this increase. The proportion covered between ages 55-59 is approximately the same as for the younger population, but decreases thereafter. Indeed from age 75 onward, little change occurred in the proportion of persons with insurance, and the proportion of males in this age range with health insurance actually decreased. For example, between the ages 55-64 the percentage insured grew by about 14 percentage points for both males and females. In contrast, between the ages of 65-74 the percentage insured grew by about 7 percentage points for males and 5 percentage points for females. For persons aged over 75, the percentage insured grew by only 1.41 percentage points for females, and actually declined by 2.23 percentage points for males.

These data provide some evidence that the effect of the reforms were not as persuasive for the older population. Although the insurance incentive certainly had some effect for those aged 55-65, the effect on the remainder of this population has been negligible. Figure 2 also shows that since 2001, the proportion of persons with health insurance has remained relatively stable.

FIGURE 3– Percentage With Hospital Insurance by Birth Cohort, Males and Females, 1997 to 2002.

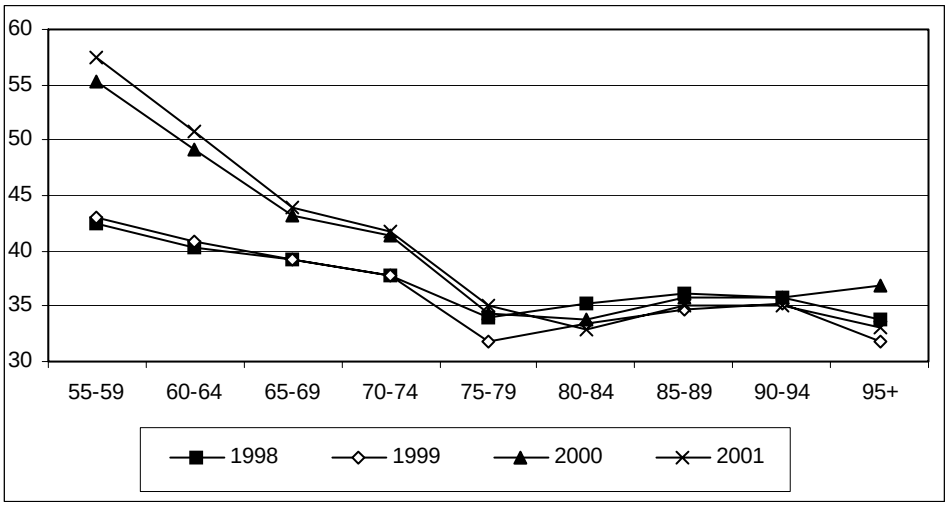


SOURCE: Temple, 2004d. Private Health Insurance Administration Council, Statistical Trends – Membership and Benefits, 2004 ; Australian Bureau of Statistics, Estimated Resident Population – Australia, 2004.

Apart from these cross-sectional comparisons, it is possible to analyse the age-cohort changes in health insurance purchase as shown in Figure 3. In 1997, 40.4% of males aged 55-59 were insured, while 5 years later when this cohort is aged between 60-64, approximately 52% of this cohort were insured. Similarly, approximately 40.4% of females aged 55-59 were insured in 1997. In 2002, 51% of this cohort were covered by insurance.

It is interesting that for each 5 year female age cohort, the difference between the percentages covered in 1997 and 2001 is positive except for the 90-94 cohort which experienced no change. For males, however, the situation is different. For age cohorts 55-59, 60-64 and 65-69 the increase in the percentage with health insurance is positive (52-40.4=11.6% ; 45.2-38.7=6.5% ; 42.4-37.4=5%). However, the remaining age cohorts experienced a slight decrease in the percentage insured over time. For example, 28.8% of the cohort aged 75-79 in 1997 had health insurance. Five years later, only 25.5% of this cohort remained covered. Further, from ages 80 and onwards the cross sectional profile is actually lower in 2002 than in 1997. For example, about 30.7% of persons aged 80-84 held health insurance in 1997, compared with just 25.5% of persons aged 80-84 in 2002.

FIGURE 4 – Percentage with Health Insurance by Age, 1998-2001.



SOURCE : Temple, 2004a; Private Health Insurance Administration Council, Statistical Trends – Membership and Benefits 2004 ; Australian Bureau of Statistics, Estimated Resident Population – Australia, 2004.

2.2 How Will the Proposed Rebate Affect Insurance Premiums for the Elderly already covered by Health Insurance?

The above summary points to the fact that the older population were less sensitive to the insurance reforms and associated reforms than the broader population. This effect is clearly conveyed in figure 4. More specifically, the effectiveness of the reforms decreased with age. Importantly, those born after July 1934 were reacting only to 30% rebate as they were exempt from Lifetime Health Cover. To what degree then will insurance premiums change under the proposed system and hence increase affordability?

Appendix 1 displays the change in annual insurance premiums under the current PHIIA system and the proposed rebate for insured persons for a broad range of policies. The health insurance policies and prices after the current 30% rebate are taken from the Australian Consumers Association (2004) 'Compare a Policy' Tool. The policies selected assume the person is not subject to a Lifetime Health Cover charge, and all policies enable the consumer to avoid either an excess or co-payment. Furthermore, the simulations are based upon purchasing health insurance in N.S.W, and the policies are separated according to (1) Premium- (2) Standard and (3) Basic Cover. Appendix 1 also separates the premium payable by whether the person is living alone or living in a couple household. Using the base premium prices, I calculate the savings to the 65-69 group and 70+ group under the proposed PHIIA changes. Table 1 presents a summary of the detail provided in the Appendix.

TABLE 1 Summary Statistics for Annual Savings ($) on Insurance Premiums by Insurance Policy Type under the Proposed Rebate System.

COUPLE POLICY

		Saving		Saving Per Capita	
Cover Type		**65-69**	**70 +**	**65-69**	**70+**
Premium	Mean	162	325	81	162
	Minimum	121	242	61	121
	Maximum	256	512	128	256
Standard	Mean	146	293	73	146
	Minimum	107	215	54	107
	Maximum	212	425	106	212
Budget	Mean	90	179	54	90
	Minimum	75	149	37	75
	Maximum	113	226	56	113

LONE PERSON POLICY

		Saving	
Cover Type		**65-69**	**70 +**
Premium	Mean	81	162
	Minimum	61	121
	Maximum	128	256
Standard	Mean	73	146
	Minimum	54	107
	Maximum	106	212
Budget	Mean	46	91
	Minimum	38	75
	Maximum	57	114

SOURCE: Summary of Appendix 1.

As shown in Table 1, the potential savings differ by policy type and age. Due to the greater cost, couples in the 65-69 age group holding a premium policy save on average $162 per annum, compared with just $90 per annum for those who have purchased a budget policy. The savings for the 70+ group are larger, approximately $325 and $293 for the former groups respectively.

Similarly, for lone persons, the 65-69 age group holding a premium policy can expect to save $81 per annum, compared with those with a budget policy who save just $46. The figures for the 70+ group are $162 and $91 respectively. These figures are in accordance with the government's expectation of savings up to $200 per annum on health insurance premiums for the elderly.

2.3 Who Will Yield the Greatest Saving?

Another method of measuring potential saving, is to examine what level of financial outlay on insurance is required to maximize savings. The government has proposed that elderly Australians will save up to and exceeding $200 per year on their health insurance premiums. So what premium is required to reap the maximum $200 per year saving?

Assuming, once more, that persons have maintained insurance since July 2000, and are therefore not subject to any Lifetime Health Cover surcharges:

Using simple algebra, let:

B_p	denote the base premium. i.e., the premium before the 30% rebate
P_p	denote the premium after the current 30% rebate
P_{p65-69}	denote the premium after the proposed rebate for 65-69 year olds
P_{p70}	denote the premium after the proposed rebate for 70 +
S_p	denote the saving after the proposed rebate

Following the rules set out in the Private Health Insurance Incentives Amendment Bill (2004), we can define the following:

$$P_p = 0.7 \times B_p \qquad [1]$$

$$P_{p65-69} = 0.65 \times B_p \qquad [2]$$

$$P_{p70} = 0.60 \times B_p \qquad [3]$$

For the 65-69 year old group, we can define:

$$S_p = P_p - P_{p65-69} \qquad [4]$$

Substituting [1] and [2] into [4] yields:

$$B_p = \frac{S_p}{0.05} \qquad [5]$$

Similarly, for the 70+ group:

$$S_p = P_p - P_{p70} \qquad [6]$$

Substituting [1] and [3] into [6] gives:

$$B_p = \frac{S_p}{0.10}$$

Tables 2 and 3 show the base premiums required for older persons to maximize their savings on health insurance premiums.

TABLE 2 Savings, Base Premium and Net Premiums for 70+ Group

Saving ($) S_p	Base Premium ($) B_p	Premium After 30% ($) P_p	Premium After 40% ($) P_{p70}
250	2500	1750	1500
200	2000	1400	1200
150	1500	1050	900
100	1000	700	600
50	500	350	300

SOURCE: Calculations by author.

TABLE 3 Savings, Base Premium and Net Premiums for 65-69 Group

Saving ($) S_p	Base Premium ($) B_p	Premium After 30% ($) P_p	Premium After 35% ($) P_{p65-69}
250	5000	3500	3250
200	4000	2800	2600
150	3000	2100	1950
100	2000	1400	1300
50	1000	700	650

SOURCE: Calculations by author.

Tables 2 and 3 clearly point out that elderly Australians who have the financial means to purchase more expensive comprehensive policies will benefit more than older Australians holding cheaper, hospital only policies. For example, a 65-69 year old who purchases a $2800 policy under the existing PHIIA rebate will save $200, compared with a saving of $50 for an elderly person purchasing a $700 policy.

The relationship between expected saving and initial investment is also interesting across both age groups. For those aged 70 and over, spending an additional $300 on insurance yields a $50 saving under the proposed rebate system. For a person aged 65-69 to yield a $50 saving, requires an additional investment of $650.

It appears, therefore, that greater savings will accrue to those older Australians with health insurance who have the financial means to purchase more expensive policies. This poses an important question: Is it predominantly wealthier people purchasing more expensive policies, or elderly people in need of care? The most recent data on expenditure on private health insurance is from the 1998 Household Expenditure Survey. Unfortunately, these data were collected before the implementation of Lifetime Health Cover and as such may not accurately reflect the current health care environment. In a separate paper using the 2001 National Health Survey, I modeled the effect of economic and demographic factors upon purchasing (1) no insurance (2) basic hospital insurance or (3) comprehensive hospital insurance. The finding from this paper was that after controlling for a range of health and demographic factors, the probability of purchasing either basic or comprehensive health insurance increased as income increased. Furthermore, I found that as income increased older Australians were more likely to purchase the more expensive comprehensive health insurance, over the cheaper basic hospital policy (Temple, 2004b, 2005).

At this point, it is important to note two very important assumptions inherent in the above calculations of Tables 1-3. First, it is assumed that health price inflation is held constant: a very unlikely scenario. And second, that health insurance companies are acting in accordance with the

concept of community rating. I.e., health insurance companies do not discern between younger healthier consumers, and older consumers more predisposed to require health care. As will be discussed in the conclusion, the combined effect of increasing health price inflation and price targeting by health insurance companies will greatly reduce the marginal savings offered by the proposed reform.

3.0 Will the Proposed Reform Increase the Affordability of Health Insurance for the Uninsured?

The second issue identified by the legislation committee was whether the proposed reform would increase the affordability of health insurance for elderly persons who are currently uninsured. Table 4 displays the change in annual insurance premiums under the current PHIIA system and the proposed rebate for both insured and uninsured persons. The base premiums are for a lone person purchasing hospital cover. The value $1300 is similar to a number of hospital insurance policies as shown above in Table 1 and 2.

TABLE 4 Annual Insurance Premiums under the Current and Proposed Rebate System, Insured and Uninsured.

Year Born	Age	Base Premium	Purchased Insurance		Base Premium	Premium After 30%	Premium After New
			Before July 2000 (Amnesty Period)	After July 2000 (After Amnesty)	Plus surcharge	Rebate	Rebate
1932	73	1300	n.a	n.a	1300.00	910.00	780.00
1933	72	1300	n.a	n.a	1300.00	910.00	780.00
1934	71	1300	n.a	n.a	1300.00	910.00	780.00
1935	70	1300	-	70% max	2210.00	1547.00	1326.00
1936	69	1300	no surcharge	-	1300.00	910.00	845.00
1937	68	1300	-	70% max	2210.00	1547.00	1436.50
1937	68	1300	no surcharge	-	1300.00	910.00	845.00
1950	55	1300	-	50%	1950.00	1365.00	1365.00
1950	55	1300	no surcharge	-	1300.00	910.00	910.00

SOURCE: Temple, 2004c

Viewing Table 4, the effect of the Lifetime Health Cover in reducing affordability is clear. Under the current system a person born in January 1934 purchasing insurance for the first time will pay $910 for this insurance policy after the 30% rebate. With the introduction of the 40% rebate, the premium drops to $780, a saving of $130.00.

Private health insurance is considerably more expensive for a person born one year later in 1935 who attempts to purchase health insurance for the first time. Aged 70 in the year 2005, they are subject to the maximum 70% Lifetime Health cover surcharge. The base premium for this person is increased from $1300 to $2210 after the surcharge. Under the current 30% rebate system, this person pays $1547.00 per annum for this hospital insurance policy. Under the new rebate system, the person pays $1436.50. To be clear, this 70 year old pays $656.50 more than the 71 year old for

exactly the same insurance policy due to the Lifetime Health cover exemption rule, even with the new rebate.

In contrast, a person born in 1937 who had purchased health insurance before July 2000 pays no Lifetime health cover surcharge. After the current 30% rebate this person pays $910. Under the proposed system, the person is entitled to a 35% rebate, decreasing the rebate by $65 to $845.00. A person of the same age attempting to purchase health insurance for the first time in 2005 will face a premium of $1436.50 for exactly the same insurance policy.

The key point is that older persons, who would like to purchase health insurance for the first time since July 2000, face a much higher premium than those older persons who already have health insurance. In fact, due to the Lifetime Health cover surcharge, any person born between 1935 and 1940 is subject to the maximum 70% surcharge in the year 2005. As such, an additional 5% or 10% rebate for the uninsured will only have a small effect at the margin for those older Australians with above average retirement incomes. This is important, as pointed out earlier, the majority of persons aged over 60 do not have private health insurance.

An important consideration is what rebate would enable an uninsured person to purchase the same health insurance policy at the same price as an insured person in 2005? That is, what rebate may increase affordability and encourage an uninsured person to buy health insurance?

We can define the rebate required (RR) at age i as;

$$RR_i = 1 - \frac{NP_i^{INS}}{SP_i^{UN}}$$

where:
NP is the Net Premium for an insured household of age i, that is the out-of-pocket premium paid by an insured household.
SP is the after Surcharge Premium for an uninsured household of age i. This is the base premium plus the Lifetime health cover surcharge, but before the rebate.

Table 5, shows the rebate required to allow people who do not have health insurance to purchase it at the same price as a person who had purchased insurance prior to July 2000. Instead of a rebate of 40%, a person aged 70 in 2005 requires a rebate of 64.7% to purchase health insurance at the same price as a person aged 70 who already holds it. A person aged 55 would require a rebate of 60% to buy health insurance at the same price as a person of the same age with insurance already. As this person qualifies for the 30% rebate, not the extended rebate, this represents a shortfall of 30 percentage points. To be clear, I am not proposing such a policy. However, this calculation points to the inequity faced by many Australians, both old and young, who desire to purchase health insurance. Although the Lifetime Health cover provided a 1 year grace period (July 1999 to July 2000) in which a person of any age could purchase health insurance and remain exempt from the surcharge, it is likely that a large number of people simply did not have the funds to purchase health insurance during this time frame. If the grace period had been extended over a longer period, it may have helped more people purchase health insurance, and avoid the 2% surcharge.

TABLE 5 Lifetime Health Cover surcharge, rebate offered and rebate required for uninsured persons to reduce costs to the level of those required to pay the surcharge, 2005.

Age in 2005	Lifetime Health Cover Surcharge	PHIIA Rebate	Proposed Rebate	Rebate Required	Shortfall	
					PHISS	New Rebate
73	na	30	40	n.a	n.a	n.a
72	na	30	40	n.a	n.a	n.a
71	na	30	40	n.a	n.a	n.a
70	70	30	40	64.7	34.7	24.7
69	70	30	35	64.7	34.7	29.7
68	70	30	35	64.7	34.7	29.7
67	70	30	35	64.7	34.7	29.7
66	70	30	35	64.7	34.7	29.7
65	70	30	35	64.7	34.7	29.7
64	68	30	30	64.3	34.3	34.3
63	66	30	30	63.9	33.9	33.9
62	64	30	30	63.4	33.4	33.4
61	62	30	30	63.0	33.0	33.0
60	60	30	30	62.5	32.5	32.5
59	58	30	30	62.0	32.0	32.0
58	56	30	30	61.5	31.5	31.5
57	54	30	30	61.0	31.0	31.0
56	52	30	30	60.5	30.5	30.5
55	50	30	30	60.0	30.0	30.0

SOURCE: Adapted from Temple, 2004a

4.0 What are the Equity Issues?

The final issue identified by the legislation committee was the identification of inequity issues in the proposed reform. The above simulations show that although the insured may benefit, at least in the short term from the proposed rebate, the reforms will do very little to increase the affordability of health insurance for elderly persons who have been uninsured since July 2000. Furthermore, it appears the policy will favor more strongly those older persons with comprehensive health insurance policies, rather than those on basic hospital insurance policies.

Following from this argument, I postulate that a measure of the 'equity' of the suggested policy reform is the differences in the socio-demographic and economic characteristics of the insured (comprehensive and basic hospital cover) and the uninsured elderly. This form of inequity, I refer to as a question of 'Intra-generational' equity. An additional concern is the compounded influence of the Lifetime health cover rules on the suggested reform for future cohorts of the aged, which I term 'Inter-generational' equity.

4.1 Intra-Generational Equity (Within the current cohort of the aged).

The Prime Minister has stated on several occasions that these reforms will assist a broad cross section of the elderly (Howard and Abbott, 2004). Although it is true that many older Australians with health insurance are on low incomes, results from my previous research using a non-linear

demand model show that lone females, lone males, those aged over 75, those who are born overseas or living in regional areas, and with low retirement incomes have a substantially lower probability of holding health insurance in old age (Temple 2004b). Furthermore, in separate research I have also shown how the reforms between 1997 and 2001 have not improved the relative position of these groups (Temple 2004b, 2005). That is the odds of purchasing health insurance for disadvantaged groups of the elderly have not increased.

The government's own Industry Commission inquiry into health insurance also hypothesized that in old age, those on low incomes and who are widowed are locked out of health insurance (Industry Commission, 1997). It is these groups of older Australians who will continue to be locked out of health insurance and who will not reap the benefits of the new reforms due to the Lifetime Health Cover surcharge. What is, therefore, the effect of older persons being unable to afford health insurance?

International studies have shown that older persons who lack appropriate insurance cover are at greater risk of disability, have insufficient access to necessary drugs, pay high out-of-pocket health care expenses and are less likely to seek health care services (Landerman, Fillenbaum et al, 1998 ; Federman, Adams et al, 2001 ; Rogowski, Lillard and Kington, 1997 ; Angel, Angel and Markides, 2002). In the Australian case the combination of Medicare and the PBS, limits the out-of pocket health care expenses of the elderly (Temple, 2005). However, one particularly relevant factor in Australia is access to timely surgical care.

A key justification made for the recent insurance reforms is that by improving health insurance coverage of the population, pressure will be taken off public hospitals and waiting times will decrease (Hurley, Vaithianathan, Crossley and Cobb-Clark, 2002). However, since the implementation of recent reforms, there is little evidence to suggest that waiting lists have been reduced. Drawing upon National and State level data, Hurley et al find waiting lists for public hospitals have remained relatively stable over the period 1995 to 2001 (Hurley, Vaithianathan, Crossley and Cobb-Clark, 2002). Birrell et al however find that for surgical procedures, there is actually a trend to increased, rather than decreased waiting times (Birrell, Hawthorne and Rapson, 2003). Supporting both the Hurley and Birrell et al observations, Deeble argues 'Some bottlenecks remain and they tend, unfortunately, to have most impact in a few specific services, mostly surgical, which are used by older people with the least ability to use private alternatives' (Deeble, 1999). Hurley et al have also argued 'Both theory and evidence indicate that creating a parallel private sector can actually increase wait times when providers can work simultaneously in both the public and private sectors' (Hurley, Vaithianathan, Crossley and Cobb-Clark, 2002).

This poses important equity questions for the Australian health care system – those with health insurance are able to jump the public sector queue and obtain timely care. Those without health insurance must queue. Although many of the 'elective' procedures are considered non life threatening, many uninsured people may have to continue with severe discomfort and pain until surgery becomes available on the public waiting list. The proposed reforms will do very little to solve this intra-generational equity issue.

4.2 Inter-Generational Equity (Future cohorts of the aged).

A separate equity issue of the reform is the effect upon future cohorts of the elderly. This inter-generational equity issue arises as a result of the interaction between the proposed reform and the Lifetime Health cover policy. As outlined earlier, the LHC surcharge does not apply to persons born

before 1934. That is, all persons aged 71 and over in 2005 are not subject to the maximum 70% surcharge that is locking elderly persons out of health insurance. Table 6 illustrates this issue. An uninsured person aged 71 (born 1934) in 2005 can purchase health insurance at the same price as a 71 year old who is insured. In five years time, a 71 year old (born 1939) would require a 64.7% rebate to purchase health insurance at the same price as an insured person. The rebate offered under the proposed system is 40%, i.e., there is a 24.7% shortfall.

This issue is important, as over a relatively short period of time, a larger number of the oldest-old Australians will fall under the LHC surcharge, rendering the proposed reform ineffective. In 2005, persons aged 65 to 71 (born after July 2004) are subject to the full 70% surcharge, whereas 5 years later, all persons aged between 65 and 76 who had not purchased health insurance during the amnesty period (July 2000) fall under the maximum LHC surcharge. In a recent paper, I find that about 60% of all uninsured people do not purchase health insurance because it is simply unaffordable (Temple, 2004d). The increasing cohort drift of more elderly people into the LHC maximum 70% surcharge years will aggravate affordability, and the new reform will not offset this. That is, although the 40% rebate seems overly generous, it will not counter the extremely high premiums faced by the elderly subject to the 70% surcharge.

The potential effectiveness of the proposed reform will decrease each year.

TABLE 6 Cohort Flow and the Adequacy of the Rebate for Older Australians, 2005, 2010 and 2015.

Year Born	Year = 2005				Year = 2010				Year = 2015			
	Age	LHC Surcharge	Proposed Rebate	Required Rebate	Age	LHC Surcharge	Proposed Rebate	Required Rebate	Age	LHC Surcharge	Proposed Rebate	Required Rebate
1932	**73**	**n.a**	**40**	**n.a**	78	n.a	40	n.a	83	n.a	40	n.a
1933	**72**	**n.a**	**40**	**n.a**	77	n.a	40	n.a	82	n.a	40	n.a
1934	**71**	**n.a**	**40**	**n.a**	76	n.a	40	n.a	81	n.a	40	n.a
1935	**70**	**70**	**40**	**64.7**	75	70	40	64.7	80	70	40	64.7
1936	**69**	**70**	**35**	**64.7**	74	70	40	64.7	79	70	40	64.7
1937	68	70	35	64.7	**73**	**70**	**40**	**64.7**	78	70	40	64.7
1938	67	70	35	64.7	**72**	**70**	**40**	**64.7**	77	70	40	64.7
1939	66	70	35	64.7	**71**	**70**	**40**	**64.7**	76	70	40	64.7
1940	65	70	35	64.7	**70**	**70**	**40**	**64.7**	75	70	40	64.7
1941	64	68	30	64.3	**69**	**70**	**35**	**64.7**	74	70	40	64.7
1942	63	66	30	63.9	68	70	35	64.7	**73**	**70**	**40**	**64.7**
1943	62	64	30	63.4	67	70	35	64.7	**72**	**70**	**40**	**64.7**
1944	61	62	30	63.0	66	70	35	64.7	**71**	**70**	**40**	**64.7**
1945	60	60	30	62.5	65	70	35	64.7	**70**	**70**	**40**	**64.7**
1946	59	58	30	62.0	64	68	30	64.3	**69**	**70**	**35**	**64.7**

SOURCE: Calculations by author.

5.0 Conclusion

For persons born after 1934, the suggested reforms will do very little to encourage health insurance purchase due to the heavy surcharge, of up to 70%, on older persons' insurance premiums. Persons born before 1934 were largely unresponsive to the recent health insurance reforms. Given that past research has shown that it is those on middle and higher incomes who benefited and were encouraged to take up health insurance by the 30% rebate, it is unlikely that an extra 5% or 10% rebate will encourage health insurance among those aged over 70, specifically those who are on restricted incomes. There may be some small effect at the margin for persons with well above average retirement incomes.

Nonetheless, an additional 5% rebate for persons aged 65-69 and 10% for those aged 70 and over will increase the affordability of health insurance for those older persons who currently hold health insurance, in the ***short term***. Whether savings of up to $200 per annum as cited by the government will enable older persons to maintain their health insurance requires further analysis. Furthermore, those older persons who may save in the short term are also more likely to be drawn from the more affluent. To reap a $200 per annum saving for an elderly person aged 65-69 requires an initial investment of $2800 per annum on health insurance, an outlay that is well beyond the reach of many elderly Australians.

A further issue to consider is the long run effectiveness of such a subsidy. As suggested earlier, increases in the price of health insurance undermine the effectiveness of insurance subsidies in improving affordability and stabilizing insurance membership. Further, recent research suggests that insurance companies themselves are creating insurance products to separate young healthy low risk consumers from higher risk elderly consumers, who must pay a higher premium (Vaithianathan, 2001). Clearly, this is against the concept of community rating and 'Lifetime health cover' more specifically and decreases the affordability of health insurance for all older persons. This combination of health price inflation and risk separation by insurance companies has the potential to substantially influence the effectiveness of the proposed reforms.

Finally, this paper has sought to examine the effectiveness of the proposed policy in terms of equity in access to care. Within the current cohort of the aged, this is a definite social gradient associated with the purchase of health insurance. The result of this effect is that many older Australians without health insurance who are drawn from the ranks of less affluent (lone persons, low education, lower income) are forced to queue in the public sector for surgical care. Due to the Lifetime Health Cover rules, the proposed reforms will do very little to address this problem. Over time too, the effect of Lifetime Health cover on the effectiveness of the proposed reforms will increase as more people an the older age groups (over 70) become subject to the maximum 70% surcharge. This will lead to the continuation of the current situation in which the uninsured must queue in the public sector, and the insured are able to skip the queue and obtain adequate, timely care.

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APPENDIX 1 Annual Insurance Premiums Under the Current and Proposed Rebate System.

Household: Single Person
Cover: Premium Cover

Company	Policy	Base Premium	Premium after 30%	Premium after 35%	Premium after 40%	Saving* 65-69	Saving* 70 +
Health Partners	Gold Hospital	1364	955	887	819	68	136
NRMA	Hospital Super Plus	1569	1098	1020	941	78	157
HBA	Ultimate Hospital Cover	2557	1790	1662	1534	128	256
GEHF**	Hospital Cover	1474	1032	958	885	74	147
GEHF	Hospital Cover & Select Ancillary	1909	1336	1241	1145	95	191
HCF	Top Plus Cover	1364	955	887	819	68	136
MBF	Premium Hospital	1507	1055	980	904	75	151
NIB	Top Private Hospital	1210	847	787	726	61	121
NIB	Gold with Ancillary	1657	1160	1077	994	83	166

Household: Single Person
Cover: Standard Cover

Company	Policy	Base Premium	Premium after 30%	Premium after 35%	Premium after 40%	Saving 65-69	Saving 70 +
Medibank Private	Blue Ribbon Hospital	1237	866	804	742	62	124
St Lukes Health	Access Hospital Platinum	1374	962	893	825	69	137
St Lukes Health	EziPlan Platinum	2090	1463	1359	1254	105	209
Medibank Private	Premium Plus	2124	1487	1381	1275	106	212
HBA	Top Hospital Cover	1301	911	846	781	65	130
Latrobe	Top Hospital	1347	943	876	808	67	135
GMHBA	Great Hospital Cover	1073	751	697	644	54	107
Australian Unity	Comprehensive Hospital Cover	1170	819	761	702	59	117

Household: Single Person
Cover: Budget Cover

Company	Policy	Base Premium	Premium after 30%	Premium after 35%	Premium after 40%	Saving 65-69	Saving 70 +
HCF	Hospital Savings Option	1090	763	709	654	55	109
HCF	Hospital Advanced Savings	761	533	495	457	38	76
Latrobe	Basic Hospital Cover	754	528	490	453	38	75
Latrobe	Health Start	831	582	540	499	42	83
HBA	Singles Choice Saver	897	628	583	538	45	90
NIB	Public Hospital Cover & Quality Extras	1140	798	741	684	57	114

Household: Couple
Cover: Premium Cover

Company	Policy	Base Premium	Premium after 30%	Premium after 35%	Premium after 40%	Saving 65-69	Saving 70 +	Saving Per Capita 65-69	Saving Per Capita 70 +
Health Partners	Gold Hospital	2730	1911	1775	1638	137	273	68	137
NRMA	Hospital Super Plus	3136	2195	2038	1881	157	314	78	157
HBA	Ultimate Health Cover	5116	3581	3325	3069	256	512	128	256
GEHF*	Hospital Cover	2947	2063	1916	1768	147	295	74	147
GEHF	Hospital Cover and Select Ancillary	3816	2671	2480	2289	191	382	95	191
HCF	Top Plus Cover	2730	1911	1775	1638	137	273	68	137
MBF	Premium Hospital	3014	2110	1959	1809	151	301	75	151
NIB	Top Private Hospital Cover	2420	1694	1573	1452	121	242	61	121
NIB	Gold with ancillary	3314	2320	2154	1989	166	331	83	166

APPENDIX 1 – Cont'd

Household: Couple
Cover: Standard Cover

Company	**Policy**	Base Premium	Premium after 30%	Premium after 35%	Premium after 40%	Saving 65-69	Saving 70 +	Saving Per Capita 65-69	Saving Per Capita 70 +
Medibank Private	Blue Ribbon Hospital	2473	1731	1607	1484	124	247	62	124
St Lukes Health	Access Hospital Platinum	2750	1925	1788	1650	138	275	69	138
St Lukes Health	EziPlan Platinum	4180	2926	2717	2508	209	418	105	209
Medibank Private	Premier Plus	4249	2974	2762	2549	212	425	106	212
HBA	Top Hospital Cover	2601	1821	1691	1561	130	260	65	130
Latrobe	Top Hospital	2696	1887	1752	1617	135	270	67	135
GMHBA	Great Hospital Cover	2146	1502	1395	1287	107	215	54	107
Australian Unity	Comprehensive Hospital Cover	2341	1639	1522	1405	117	234	59	117

Household: Couple
Cover: Budget Cover

Company	**Policy**	Base Premium	Premium after 30%	Premium after 35%	Premium after 40%	Saving 65-69	Saving 70 +	Saving Per Capita 65-69	Saving Per Capita 70 +
HCF	Hospital Savings Option	2179	1525	1416	1307	109	218	54	109
HCF	Hospital Advanced Savings Option	1524	1067	991	915	76	152	38	76
Latrobe	Basic Hospital Cover	1507	1055	980	904	75	151	38	75
HBA	Family Essentials Hospital Cover	1491	1044	969	895	75	149	37	75
NIB	Public Hospital Cover & Quality Extras	2256	1579	1466	1353	113	226	56	113

NOTES: * This is the difference between the current 30% rebate and the proposed rebate for each age group ** Government Employees Health Fund
SOURCE: Premium after 30% rebate and policies from Australian Consumers Association, 2004. All other calculations by author.