Submission on Private Health Insurance Incentives Amendment Bill 2004

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Executive Summary

The cost of the private health insurance rebate is now approaching $3 billion. While there has been an increase in private health insurance uptake from 30% in 1998 to a high of 46% in September 2000, the increase was due to the introduction of Lifetime health cover and not the private health insurance subsidy.

Despite this increase in private health insurance uptake, the reforms have had little impact on public hospitals and public hospital use actually increased following their introduction.

The changes have serious equity implications, with high-income earners benefiting at the expense of low-income earners and people living outside capital cities. In addition, the reforms do not improve either technical or allocative efficiency so they cannot be justified on economic grounds.

Extending the private health insurance reforms to people aged over 65 years cannot be justified because the rebate is inequitable, inefficient and has not achieved its primary objective of "taking pressure off public hospitals".

On the grounds of effectiveness, efficiency and equity, the private health insurance rebate should not be extended to people aged over 65 years.

Effectiveness

The cost of the 30% private health insurance rebate is now approaching $3 billion. If one includes the $1.1 billion in taxation revenue forgone through exemption of the additional 1% Medicare levy surcharge, approximately $400m in extra Medicare payments for medical and pharmaceutical services associated with private hospital use and the cost of a tax-payer funded advertising campaign to promote private health insurance uptake the cost to taxpayers is over $4 billion. To place this in a broader context, the subsidy to

the private health insurance industry is larger than subsidies for the mining, manufacturing and primary agricultural production industries combined [1].

The rationale for these reforms was to decrease the pressure on public hospitals [1] however this ignored existing evidence that the decline in private health insurance coverage during the 1990s was not having a significant impact on private hospital use. Not surprisingly, the increase in the uptake of private health insurance has had little impact on public hospitals and during the period from March 1999 to September 2001, there was actually an increase of 23% in the number of patients admitted to the major metropolitan public hospitals [2].

Even if we accept that an increase in private health insurance uptake is desirable, the 30% subsidy was not a major factor in the increased uptake. In December 1998, one month before the introduction of the 30% rebate, only 30.1% of the population were privately insured. By September 1999, this figure had risen to only 31% of the population. However the impact of Lifetime Health Cover was significant with 43% of the population taking out insurance by June 2000, 15 days before the cut-off for Lifetime Health Cover.

Equity

A positive association exists between private health insurance and income, with low-income earners and the elderly having the lowest levels of private insurance and wealthy households having the highest. As a result, approximately half of the taxpayer-funded rebate for private health insurance goes to the top 20 per cent of society and nearly three-quarters goes to the top 40 per cent [3]. The private health insurance rebate is therefore a regressive subsidy because it redirects taxpayer funds away from low-income earners to high-income earners. These differential levels of private health insurance mean that any reforms that subsidise private health insurance have serious equity implications.

The equity effects of the rebate on the public health system also need to be considered. For example the private health insurance subsidy in 2002 meant that Australian taxpayers indirectly paid for ancillary cover worth $578 million to those with private health insurance. Of this, $290 million went into the support of private dental care, far exceeding the $70 million Commonwealth contribution to public dental services in 1999-00 [4].

People living outside capital cities also have significantly lower levels of private health insurance than those living in capital cities, largely because people in rural areas are not serviced well by the private health sector. As a result of this differential in private health insurance uptake, it is estimated that approximately $100 million is being diverted away from the regional health system, further exacerbating regional health disadvantage [5].

Efficiency

The implementation of the private health reforms should be supported by evidence of economic benefit, irrespective of political factors. Using data from both the private and public hospital sector, Duckett compares the differences in costs by diagnosis-related group (DRG). He shows that while the average cost per weighted separation in public hospitals is about 11% higher than private hospital costs, this does not take into account discrepancies in the way costs are met in these institutions. The most notable of these relate to medical, pharmaceutical and depreciation expenses such as pathology testing, imaging and pharmaceutical costs. When all of these costs are taken into account, public hospitals are seen to be less costly than private hospitals per standardised unit of output [1]. Based on this evidence, the private health insurance subsidy should be redirected into the public sector because it has greater technical efficiency.

While there is less data to compare the differences between the public and private sectors in terms of the broader question of allocative efficiency, it is likely that the public sector is also more efficient in this area. Treatment within the private sector has been shown to result in higher rates of interventions without any demonstrated health benefit [6] [1]. Payment rates for medical practitioners within the private sector are substantially higher than within the public sector so public hospitals must compete with the private sector to attract doctors, resulting in an increase in wages within the public sector.

Conclusion

On the grounds of effectiveness, efficiency and equity, the private health insurance rebate should not be extended to people aged over 65 years.

References

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