Senate Economics Legislation Committee

Inquiry into the Fairer Private Health Insurance Incentives Bills

Dr John Deeble

Thank you for the invitation to attend the hearings of this Committee. Because of the short time frame and the complexity of some issues I have not made a written submission in advance, but I am happy to provide this text of my comments.

In relation to the specific legislation under review, my position is as follows. I have had and continue to have many concerns about the structure of the Private Health Insurance Rebate. I think it has been wasteful, ineffective in raising more private money for health (private health insurance *per se* now raises a lower proportion of total health expenditure than it did ten years ago), inequitable in the way that the Medicare Levy Surcharge reacts with it and divisive in the way in which it separates the public and private hospital systems, rather than integrating them. However it is what we have and the Government has promised to maintain it. In that context, I would strongly support the proposed legislation as going some way towards a more equitable and financially sustainable system. I also believe that, on the basis of all the Australian and international evidence, that it will have almost no effect on the underlying structure of the health care industry. In that respect, I agree entirely with the Treasury's calculations. People concerned about maintaining the status quo can rest easy.

To support this position, I will reverse the order in which these matters are generally viewed and look not at the way in which the private sector and the Private Health Insurance Rebate work but at Medicare's funding and the nature of the basic Medicare levy first. The levy goes back over 40 years to the first proposals for universal

insurance and their implementation in the Medibank system of 1975. In the confrontational politics of the day, it was introduced to fund the extra medical benefits that the Commonwealth would take over from the private health funds, not the hospital costs which had always been funded from tax. And to avoid allegations of income transfer, it was introduced as a simple charge proportional to income, not the progressive structure embodied in the income tax. A surcharge on tax paid would have been fairer but that was unacceptable politically. The same arrangements were re-introduced in the Medicare of 1984. The levy was never intended to represent the cost of hospital treatment or to be used as a device for manipulating the net cost of private health insurance.

But it has been so used and for that purpose the present levy is inequitable. Richer people pay too little and poorer people pay too much. And the relationship has been complicated by the levy surcharge which raises, in one step, the levy on richer people who do not take private insurance but which, as I pointed out in my submission to the Economics Committee last year, is unique amongst income-related charges in having an extraordinarily high marginal tax rate at and about the income at which the surcharge cuts in. The proposed changes will not remove that problem but when the new surcharges are included, they will make the Medicare levy structure more progressive and much more like the income tax. It follows logically, then, that in putting people who take private health insurance in the same net position as those who rely upon the public system, both the Private Health Insurance Rebate and the Medicare levy have to be taken into account. A little thought will show that, to achieve this, the PHI rebate has to be phased out as income rises. That is a much more equitable and defensible position than the present arrangements which take the PHI rebate as given and try to manipulate all the other factors to get the same result, which is, in effect, a preservation of the private insurance market.

I have no argument with the income thresholds proposed. Like all means-tested arrangements, the system will be more complex to administer than at present and the marginal problems associated with the levy surcharge thresholds will still exist. It will not be entirely equitable because the PHI rebate applies to a range of ancillary services

(dental, etc) which Medicare does not provide and to other functions (medical gap insurance, for example) in which in Medicare's protection is less complete but also much less inflationary. And it will not bring the public and private systems any closer together because there will still be no conditions on how the proceeds of the rebate are used. However it should be better than at present.

The effects on private health insurance membership issue are much easier to address. The characteristics of private insurance are very well known, here and overseas. It is sensitive to income. Richer people are much more likely to hold it than poorer ones and changes in income have a significant effect on membership. But it is not sensitive to price – the estimates included in the Treasury's calculations may even be a little high. I have attached a table derived from the Private Health Insurance Administration Council's reports which demonstrate this clearly. It shows the proportion of the population covered by private insurance from 1997 to 2008. There were no general subsidies in 1997 and 1998. A 30% PHI rebate and the Medicare levy surcharge were both introduced in early 1999, but without the 'Lifetime Health Cover" changes introduced in July 2001 and the government–funded publicity campaign which accompanied them, As can be seen, the rebate and the levy surcharge alone had almost no effect in the two years following their introduction – coverage rose by only 2%. But it jumped by nearly 15% with the 2001 changes. Many people, including some economists who ought to know better, attributed this to the threat of premiums rising if people did not join immediately but elementary theory says that it could not have accounted for all of the rise – people are generally believed to discount future costs and benefits at about 5% a year, over twice the 2% annual penalty under 'Lifetime Health Cover'. The main factor was the major advertising campaign and the very clear message that it contained. People needed private insurance because Medicare might not cover them in future.

And I can confirm all this from personal experience. As a member of the old Health Insurance Commission for 16 years to early 2000 who was also a Director of Medibank Private with a special responsibility for premium setting, I can assure Senators that price, as such, was not the major element in competition. Within quite wide limits, we

could vary our premiums without any discernable effect on membership and there could be significant differences between us and the other funds without any noticeable change in market share. Competition was mainly in constructing packages which would appeal to certain types of customer and I am sure that this is still the main consideration. It is, in fact, almost impossible for people to understand all of the various products that the health insurers offer and decide whether they represent value for money. That is not to say that price would never be important, only that people buy private health insurance for a variety of reasons, including custom, amenity, perceptions of social position and concerns about the availability and quality of the public alternative. Both the statistical evidence and practical experience suggest that cost is rarely the dominant factor and that, for the highest income groups, even quite large variations are irrelevant.

John Deeble

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Table 1

Proportion of the Australian population holding private health insurance, 1997 to 2008

Year	Percent population covered.
1997	31.6
1998	30.2
1999	31.4
2000	32.2
2001	45.0
2002	44.6
2003	43.4
2004	43.0
2005	42.9
2006	43.2
2007	44.3
2008	44.8

Source. **Private Health Administration Council,** Part A Report, March quarter 2009 Figures are for December quarters