CHAPTER 11

Private health insurance rebate

Introduction

11.1 Term of Reference (d)(ii) requires the Committee to examine:

> The implications of reallocating expenditure from changes to the private health insurance rebate.

11.2 The Commonwealth government's 30 per cent rebate on private health insurance (PHI) came into effect on 1 January 1999,[1] and aimed to:

> … restore the balance in our health care system. A balanced system will ease the burden on Medicare and the public health system and give more Australians greater choice and access to private hospitals. The Commonwealth 30% Rebate makes private heath insurance more affordable. This will help encourage more Australians to take up private health insurance, which will ensure Australia's unique mix of public and private health care continues to be viable.[2]

11.3 The rebate means that, for every dollar spent on a private health insurance premium, the Federal Government reimburses thirty cents. The rebate is available to all Australians who are eligible for Medicare, and who are either members of a registered health fund, or are paying the premium for another person. The rebate is available irrespective of family type or income, and is available on hospital cover, ancillary cover or combined cover.

11.4 The rebate can be claimed via reduced premiums, direct payment from Medicare offices, or a tax rebate in the annual tax return.

11.5 Under the Lifetime Health Cover policy, health funds are able to charge different premiums based on the age at which each member first takes out hospital cover with a registered health fund.

11.6 People who delay taking out hospital cover pay a two per cent loading on their premium for every year they are aged over 30 when they first take out hospital cover. The maximum loading a person can be required to pay is 70 per cent, payable by people who first take out hospital cover at age 65 or older.

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1 Department of Health and Ageing website, http://www.health.gov.au/privatehealth/rebatefaq/whenavail.htm

2 Department of Health and Ageing website, http://www.health.gov.au/privatehealth/rebate/consumers/rebate.htm

11.7 The Commonwealth has estimated it will spend $2.26 billion on the PHI rebate for the year 2003-04.[3] However, the Committee notes that some commentators have estimated the real costs to be higher. Dr Costa from the Doctors Reform Society claimed:

> Leonie Segal from Monash University did a study on this $2.5 billion rebate and it is actually $3.7 billion when you take away the Medicare levy foregone and the added cost.[4]

11.8 This chapter examines some perceived problems with the rebate, including concerns relating to social equity, access to private services in rural areas, and the efficiency and effectiveness of the rebate in achieving objectives. The possibility of reallocating the funds to alternate public health measures is canvassed, followed by an analysis of the effect of such a change on both the private health insurance industry and the wider health system.

Criticisms of the PHI rebate

11.9 Critics of the PHI rebate dispute the use of public funds to subsidise private health insurance, arguing that it is inequitable, inefficient and ineffective. More specifically, they consider that it is neither the best nor fairest way to achieve public policy objectives, and has not in fact achieved these objectives.

Social equity

11.10 A common view of the current rebate arrangements is that it directs a large amount of public money to wealthier parts of society which can already afford private health insurance. Professor Sainsbury commented that the individual's right to choose should not be subsidised by others:

> People should be allowed to choose private health care if they so wish. But, again, the question becomes: if you want to choose private health care, why should the rest of society subsidise your choice to have it? By all means have the choice but do not subsidise it.[5]

11.11 The Western Australian Government levelled a similar criticism at the policy:

> Assessed against equity criteria, a high proportion of expenditure … is contributing toward meeting the cost of insurance policies for people on middle and higher incomes.[6]

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3 Department of Health and Ageing, Portfolio Budget Statements 2003-2004, p. 217

4 Dr Costa, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 56

5 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 85

6 WA Government, Submission 177, p. 14

11.12 While supporters of the PHI rebate argue that over one million Australians earning less than $20,000 per year benefit from the rebate,[7] Dr Woodruff suggested that this figure may be somewhat misleading:

> If we were to analyse that group of one million, I am quite sure we would find – and you probably have the figures, even – that almost every one of them owns their own home and does not have to pay a significant proportion of their weekly income in rent, which really takes away a huge group of those people.[8]

11.13 The WA Government also questioned the validity of that claim:

> Many of the people on low incomes who access private health insurance do so at the very basic hospital rate to meet the lifetime guarantee and those sorts of things that encourage people to take out private health insurance… The issue of who has private health insurance cover needs to be considered in the context of who has what private health insurance, what that covers, [and] whether there are large gaps … .[9]

11.14 The alternative perspective was put by the Australian Private Hospitals Association (APHA), who reiterate the importance of choice, which they argue means access to affordable private health insurance in Australia's mixed private and public system:[10]

> The public system must prioritise and ration … and as society's resources are not infinite, ultimately someone must be denied access or made to wait for services which in the view of the health professional's assessment of resources and priorities, are of lower priority than others.
>
> But individuals may, and often do, have differing priorities, especially when their own health or that of their family is concerned, and what may seem to be a reasonable prioritisation for one health professional (though not necessarily for another) may not be reasonable for the individual. So private systems allow choices.[11]

11.15 This view concludes that the rebate achieves social equity by reducing the cost of exercising choice by 30 per cent.

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7 AHIA, Submission 105, p. 9. See also the discussion by Senator Knowles, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 83

8 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 53

9 Ms Prudence Ford, *Proof Committee Hansard*, Perth, 29 July 2003, p. 17

10 APHA, Submission 99, p. 2

11 AHIA, Submission 99, p. 2

Access to private health insurance benefits in rural areas

11.16 A related issue is the widely varying degree of access to private health insurance infrastructure between the metropolitan and rural insured. All tax paying Australians are both subject to the tax penalty and Lifetime Health Cover provisions, and beneficiaries of the rebate. However, this equal treatment does not take into account the discrepancies in the availability of private health infrastructure in rural and remote communities.

11.17 The National Rural Health Alliance argued that 'the Commonwealth should recognise that its private health insurance rebate is of little value to rural and remote areas residents',[12] with Mr Gregory suggesting that on average seven percent fewer people take out PHI in rural areas than in cities:

> Again, this is another one of those deficit arguments about how rural areas are missing out on the rebate, compared with the situation that would apply if it were distributed on a per head basis.[13]

11.18 The Australian Health Insurance Association (AHIA) partly acknowledged the discrepancy:

> [P]rivate health insurance numbers in rural areas are lower if there is no private facility. In those areas where there is a private hospital or a private facility of some sort, participation rates are actually quite high.[14]

11.19 Such remarks highlight one aspect of the inequity: that people who live in rural areas where private facilities are unavailable have less choice about the type of care they access.

11.20 Moreover, people living in areas where there are no private facilities can find themselves obliged (through the tax system) to obtain PHI, even though they have no opportunity to utilise it. This contrasts with the situation of those in metropolitan areas, and represents a demonstrable structural inequity.

11.21 Patients with PHI who have no access to private medical facilities still require care, and evidence presented to the Committee suggested that some patients in rural areas are opting to take out private cover to avoid penalties while continuing to use the public health facilities they can access. Patients in this situation effectively subsidise the PHI industry at the expense of their local public health services and of other taxpayers.

11.22 The West Australian Government provided a useful example. Outside of the Perth metropolitan area, there are only two private hospitals, therefore:

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12 NRHA, Submission 87, Position paper, p. 15

13 Mr Gregory, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 83

14 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 83

> People in these areas gain little from having health insurance because they do not have access to services for which insurance is relevant. People on higher incomes in rural and remote areas are subject to a tax penalty if they do not have insurance. Under the Lifetime Health Cover they are also subject to having to pay increased premiums if they delay purchasing insurance … .[15]

11.23 The Queensland Minister for Health told the Committee the potential for utilising private cover was minimal in many areas of Queensland:

> Perhaps the most anger I have received about private health insurance has been from rural areas where there is no access to private health facilities. The only access to health facilities is in the public sector, with our rural hospitals or GPs, so they are being forced in many instances – or they believe they are being forced – into taking out private health cover or paying higher tax penalties et cetera when they do not really have any option of using private health cover.[16]

11.24 Similar issues emerged from the Northern Territory:

> Figures for the NT population indicate that the number of people with health insurance is around 8 to 10 per cent below the national average. There is only one private hospital in the NT so options for utilisation of private hospital insurance are limited.[17]

An inefficient path to public health objectives?

11.25 There are conflicting views on the efficiency of the PHI rebate as a mechanism to achieve the purposes outlined above.[18]

11.26 Supporters of the rebate assert that the rebate is a sound investment on the basis that the 30 per cent contributed by the government leverages more than double that amount from the private health insurance holder. The argument follows that the subsidy operates to swell the overall health funds pool by encouraging people to contribute to their own health care costs. The AHIA highlighted the benefits of relatively young and healthy people bolstering the total insurance pool:

> [O]ne of the things that tends to be overlooked in discussion of the private health insurance rebate is the very significant effect of community rating in the Australian health care system ... Community rating means that everyone, regardless of their means, age, sex or state of health, is entitled to the same benefit at the same price. What it does, in effect, is bring in a large pool of people who are healthy, whose contributions to the pool subsidise those of

15 WA Government, Submission 177, p. 14

16 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 18

17 NT Government, Submission 82, p. 6

18 see paragraph 11.2

> the sick. That instantly leverages a lot of money from people who would otherwise spend it on other things, I suppose, and certainly would not spend it on their own health care because, by definition, they do not need very much. ...
>
> We tend to overlook that when we talk about the rebate, because what the rebate actually does is produce even more leverage for the financial impact of community rating. Every 30c that the government puts into the private health insurance system via the rebate turns into a dollar to be spent on the health care system. You cannot get that sort of leverage from taxation … .[19]

11.27 The AMA also emphasised the impact of government funds in leveraging private sector funds:

> If you distributed that $32.5 billion to the public hospital system it would probably not allow that many services to take place. It is great value for money for the government because, although the 30 per cent is paid by the taxpayer, 70 per cent is paid out of post-tax dollars for everybody else. That represents pretty good value for money for the government and for the people of Australia.[20]

11.28 In his analysis, Professor Harper from the Melbourne Business School, regarded this as a de facto subsidy by those who are privately insured, who in effect pay twice for health care:

> They contribute through income and other taxes to the cost of the public health system as well as paying for the right to access private health care.
>
> In effect, they pay for the option of using either the public or the private system whenever they need (or elect to have) hospital treatment. These additional resources help to keep the average cost of health care down in both the public and the private systems.[21]

11.29 Thus, 'as people abandon private health insurance, the cost of providing public health care and the cost of PHI both rise, reflecting the loss of the implicit subsidy paid by those who take out PHI in addition to paying taxes to fund public health treatment.' Professor Harper concluded that, although expensive in public revenue terms:

> [S]o long as the cost incurred is outweighed by the value of the implicit subsidy, the net impact is positive.[22]

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19 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 80

20 Dr Haikerwal, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 40

21 Prof Harper, Submission 127, pp. 4-5

22 Prof Harper, Submission 127, pp. 4-5

11.30 In dollar figures he calculated it would be cost effective for the government to pay up to $4.3 billion per annum into the private health system to keep it going.[23]

11.31 However, the Committee also heard considerable evidence that diverting public funding through the private health system represented an inefficient means of achieving public policy objectives. As a percentage of GDP, the contribution of the private health funds to overall health expenditure has remained largely constant over the period 1984-85 to 2000-01, and this fact casts doubt on the leverage argument.[24] The point was taken up by Professor Sainsbury:

> The private health insurance rebate did not increase the dollars that the public directly invested in private health insurance. This can be quite easily demonstrated arithmetically. If we say that the uptake rate was 30 per cent before the rebate and that it was 45 per cent after the rebate was introduced, and if premiums stayed the same, that was a 50 per cent increase in the amount of money that went into the funds. … But 30 per cent of the total amount is now provided by the government, which is just about the same amount as the extra money invested by the public directly.[25]

11.32 The Committee also notes that Professor Deeble, in his report to the state and territory health ministers on the operation of the PHI rebate, argued that:

> 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.[26]

11.33 In more general terms, Professor Jeff Richardson described the Australian PHI policy arrangements as 'strange but true', explaining that:

> Because of the levy that we put on the wealthy, for a family with an income of over $100,000 – or rather less than that – the price that a family pays for its private health insurance is negative. At the end of the year you have more money in your pocket if you buy private insurance than if you do not buy the insurance. I know of no other product in the world that has a negative price. But there is a degree of equity, because if you use your private health insurance then you will be out of pocket financially in a way that you will

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23 Prof Harper, Submission 127, p. 20

24 DHA, Submission 138, p. 11; see also discussion at *Proof Committee Hansard*, Canberra, 28 August 2003, p. 88

25 Prof Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 85

26 Prof Deeble, *The Private Health Insurance Rebate*, Report to the state and territory health ministers, p. 11

> not be if you do not have insurance. So you are paid to have insurance but you are penalised if you use it.[27]

11.34 The Committee was told that the private system delivers less public health per dollar than the public system. Dr Woodruff from the Doctors' Reform Society noted administrative inefficiency and the profit motive inherent in the private health system:

> Why go over to a private system where 15 per cent is spent on administration and 25 per cent on profits for shareholders, leaving 60 per cent of the health dollar for health, when Medicare administration costs are only three per cent?[28]

11.35 Many respondents urged that the most efficient way to reduce the pressure on public hospitals is through direct funding. The National Rural Health Alliance considered that:

> If one wants to do something for the public hospital system – if that is what it is about – then it would be much more effective, all things being equal, to divert the money directly to public hospitals.[29]

11.36 Professor Duckett argued in his submission:

> The Health Minister has recently cited a 245,000 increase in separations from private hospitals in 2000/01 and a 5,000 reduction in separations from public hospitals as evidence of the success of the policy. Although later figures don't bear out the magnitude of the shift, even these figures call into question the efficacy of the rebate.
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> Given the rebate costs around $2.5 billion per annum, the government is paying over $10,000 per additional patient treated through private hospitals. This is over three times the average cost per patient treated in a public hospital. Eighty per cent of the private hospital increase is in same day admissions.
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> Direct support for public hospitals is clearly a more efficient way of assisting public hospitals than an indirect policy such as the rebate.[30]

11.37 A further concern raised with the Committee is that the policy ties the Commonwealth into uncapped expenditure of a private health system that is becoming

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27 Professor Richardson, *Proof Committee Hansard,* Melbourne, 24 July 2003, p. 90

28 Dr Woodruff, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 50; a view shared by National Medicare Alliance, Fact Sheet 4: Equity, Efficiency and health care, www.nma.org.au accessed 10 June 03

29 Mr Gregory, *Proof Committee Hansard,* Canberra, 21 July 2003, p. 83

30 Prof Duckett, Submission 93, p. 4; see also Mr Goddard, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 66; and Prof Deeble, *The Private Health Insurance Rebate*, Report to the state and territory health ministers, p. 11

steadily more expensive. The higher premiums rise, the greater the amount of money the government needs to return to policy holders. Articulating this concern, Sharryn Jackson MP stated that:

> I worry for the future about this 30 per cent of an unknown figure, which the government has to commit each year.[31]

11.38 As table 11.1 illustrates, PHI premiums have demonstrated significant growth rates, and since 1996-97, have averaged a rise of 10.6% each year in real terms.

Table 11.1 Contributions income by Registered Health Benefits Funds, Australia, constant prices 1984-85 to 2000-01 ($ million)

Year	Contributions income	Annual growth Rate (%)
1984-85	2,494	..
1985-86	2,701	8.3
1986-87	3,094	14.5
1987-88	3,379	9.2
1988-89	3,396	0.5
1989-90	3,502	3.1
1990-91	3,833	9.5
1991-92	4,308	12.4
1992-93	4,496	4.4
1993-94	4,535	0.9
1994-95	4,458	-1.7
1995-96	4,449	-0.2
1996-97	4,559	2.5
1997-98	4,814	5.6
1998-99	5,027	4.4
1999-00	5,462	8.7
2000-01	6,825	24.9
Average annual growth rates		
1984-85 to 2000-01		6.5
1984-85 to 1988-89		8.0
1989-90 to 2000-01		6.3
1996-97 to 2000-01		10.6

11.39 In 2003 alone, the top five private health insurance funds, controlling over 70 per cent of the market, all had premium increases well above the CPI benchmark,

31 Ms Jackson, *Proof Committee Hansard*, Perth, 29 July 2003, p. 61. These concerns are also reflected in Catholic Health Australia, Submission 96A, p. 3

with the weighted average increase of 7.4 per cent as against a 3.2 per cent CPI benchmark.[32]

Ineffective at meeting its objectives

11.40 As outlined at the beginning of this chapter, the objectives of the PHI Rebate were to increase membership of private health funds; reduce the load on public hospitals; and make the choice of private health insurance more affordable to all in the community.

11.41 Critics suggest that despite the significant costs involved, the policy has not succeeded in meeting these objectives.

Raising numbers in the insurance pool

11.42 In outright terms, it is evident that the objective of increasing private health insurance membership has been met. Since the rebate's introduction in 1999, the proportion of the Australian population covered by PHI has increased from 30% to around 45%.[33]

11.43 However, the PHI Rebate was introduced about 18 months prior to the Lifetime Health Cover initiative, encouraging younger people to take out private cover by providing disincentives to doing so later in life, and introducing a 1% surcharge in the Medicare levy for high-income earners not covered by private health insurance.[34] The impact of these disincentives must be measured in any valid assessment of the effectiveness of the rebate in increasing membership of private health funds.

11.44 The Australian Institute of Health and Welfare, among others, argued that it is the effect of these latter two initiatives, and not the PHI rebate, that has been the primary cause of the membership increase:

> The greatest immediate influence on the level of coverage was the lifetime health cover provision. Coverage increased from 32.3% [of the population] at the end of March 2000, to 45.8% at 30 September 2000, reflecting the full implementation of the Commonwealth Government's lifetime health cover arrangements during the September quarter.[35]

11.45 The effect of the Lifetime Health Cover was heightened by the 'run for cover' media campaign. Mr Greg Ford commented:

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32 Amanda Elliott, *Regulation of private health insurance premiums*, Research Note, Department of the Parliamentary Library, June 2003, p. 2

33 Professor Harper, Submission 127, p. 12

34 Department of Health and Ageing, Submission 138, p. 6

35 Australian Institute of Health and Welfare, *Australia's Health 2002*, Canberra, p. 266

> People might remember the ads at the time, with the umbrellas – the 'run for cover' ads. Such was the rush for people to join private health insurance companies that the deadline was extended from the end of June until mid-July because insurers were overwhelmed by numbers joining. The argument is that it was lifetime health cover at no cost, which got people into private health insurance, not the 30 per cent rebate.[36]

11.46 As Professor Deeble argued in his report to state and territory health ministers:

> Its basic message was that the government could not provide universal access to an adequate standard of hospital care through Medicare and the only way to ensure personal coverage was to take private insurance now.[37]

11.47 The Department of Health and Ageing insisted that it is impossible to establish a causal link between increased membership of private funds, Lifetime Health Cover, and the rebate:

> [T]his is, essentially, an evidence-free zone. We cannot separate the two. We introduced lifetime health cover in a world where there was a 30 per cent rebate. We have not conducted a controlled trial, so it is impossible to say what the impact of lifetime health cover would have been had there not been a 30 per cent rebate in place. I would suggest that that is ultimately an arid topic for debate. The reality is that we went into the sequence of rebate and lifetime health cover, and it is methodologically impossible to untangle the impact of the two.[38]

11.48 Mr Schneider of the AHIA adopted a more optimistic approach to the impact of the rebate:

> I do not believe … that it would have been possible to have got that sort of participation rate at the prices that would have prevailed at that time without the rebate. Around 1997 or 1998 an organisation called TQA Research … determined that the attrition that was taking place would require a minimum 30 per cent reduction in the price of health insurance to be stopped or turned around.
>
> The moment the 30 per cent rebate was introduced, the erosion stopped and turned around. I would draw your attention to the fact that, several quarters before the 30 per cent rebate was introduced, the government did experiment with a means tested rebate, but it failed – it increased participation rates for one quarter only. After that, the trend resumed its downward path. The rebate instantly turned things around. … Indeed, one wonders whether any government would have been willing to introduce

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36 Mr Ford, *Proof Committee Hansard*, Canberra, 21 July 2003, pp. 78-79

37 Professor Deeble, Submission 85, p. 5

38 Mr Davies, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 84

> lifetime health cover without the attraction of the 30 per cent reduction in the price achieved by the rebate.[39]

11.49 As Mr Schneider and others have noted, community rating (ie the take up of insurance products across all demographics) is important to the sustainability of the sector. If these trends were to continue the long term sustainability of the industry could be in question.

11.50 In considering the rising membership base of the private health insurers, it is necessary to look deeper into the age profiles of members. In research prepared for the Australian Consumers' Association, Martyn Goddard and Ian McAuley point out that between September 2000 (the first quarter after Lifetime Health Cover was introduced) and June 2003, 384,000 fund members aged below 55 gave up their private health cover, replaced by 234,000 people aged 55 or more. Although the net decrease of 150,000 seems insignificant in a total membership of 8.5 million, they note that in the June 2003 quarter alone 67,894 people aged 0-54 dropped out, while 9356 aged 55 and over joined.[40]

11.51 These figures have significant financial implications for the health funds:

> Someone under 55 brings an average of about $570 a year in gross profits to the funds (they claim $570 a year less than they pay) and someone of 55 or over costs the funds about $500). On the basis of those figures, the younger people dropping out over the most recent quarter will cost the industry $38.7 million a year and the older people joining will cost $4.7 million. In all, the industry will be about 43.4 million every year worse off as a result of the demographic shift in just that three months.[41]

Easing the burden on public hospitals

11.52 The rebate has also been criticised on the basis that it has failed to meet its original aim to reduce the burden on the public hospital system.

11.53 Supporters of the rebate, in particular AHIA and APHA, produced evidence to demonstrate the increasing role that private hospitals, funded by private health insurers, are playing in Australia's overall health system. According to the AHIA, once the rebate was introduced private hospital episodes increased and are still increasing from a low of 1.5 million to an expected 2.2 million this year. These episodes are likely to include:

- 168,000 orthopaedic operations, including hip replacements, knee reconstructions, etc.;

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39 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 81. See also Prof Harper, Submission 127, p. 12

40 Martyn Goddard and Ian McAuley, *Beyond the private health rebate*, ACA, 2003, p. 6

41 Martyn Goddard and Ian McAuley, *Beyond the private health rebate*, ACA, 2003, p. 6

- more than 60,000 cataract operations or other eye disease treatments;
- 130,000 cancer treatments;
- 135,000 patients receiving cardiac treatment or heart surgery; and
- 43,000 patients receiving plastic and reconstructive surgery (not including cosmetic surgery).[42]

11.54 The AHIA submission also pointed out that private hospitals provide fifty per cent or more of overall treatments in a number of significant categories, including:

- Chemotherapy 50%
- Cardiac valve procedures 56%
- Mental health treatment (sameday) 65%
- Knee procedures 75%[43]

11.55 Overall, the average increase in hospital separations from 1997-98 to 2001-02 has been 3.5% per annum, with public hospitals handling a 1.3% rise per annum. Private free-standing day hospital facilities saw an increase of 11.0% per annum since 1997-98, while private hospitals overall increased by 7.9% over the same period.[44] APHA state:

> In 1998-99, the private hospitals sector provided 28.3 per cent of total overnight separations and 37.4 per cent of same day separations. In 2001-02, the private hospitals sector provided 32 per cent of total overnight separations and 43.5 per cent of same day separations. That is, the proportion of both overnight and same day separations has increased in the private hospitals sector since 1998-99 … .[45]

11.56 AHIA also pointed to the increasing numbers of people over 65 benefitting from PHI:

> In March 2003 health funds paid more than $2 billion in hospital benefits to people aged more than 65 [which is] almost equivalent to the total cost of the 30 percent rebate. Insured patients aged more than 65 occupied almost 3 million bed days.[46]

11.57 Critics suggested that these positive statistics mask a more complex reality, and have not translated into any real reductions in public hospital workloads.

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42 AHIA, Submission 105, p. 7

43 AHIA, Submission 105, p. 8

44 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2001-02*, p. 16

45 APHA, Submission 99A, p. 1

46 AHIA, Submission 105, p. 9

Professor John Deeble submitted that the rebate has not flowed through to the hospital system in the way it was intended:

> Only about half of the rebate's cost went to additional hospital treatment. The remainder went to more ancillary services (mainly dentistry); to more and higher gap insurance for in-hospital medical fees; to higher levels of insurance cover, higher administrative cost and to reducing the premiums of people who were already insured. It had increased admissions to private hospitals considerably, but the overall cost per additional admission was over twice the public hospital average and the effect on public hospitals had been small.[47]

11.58 Others commented that the rebate has merely generated extra demand for private hospital services without effectively reducing demand for the public system. The Tasmanian government for example had seen:

> … no significant reductions in waiting lists for elective surgery and the pressure on public hospitals continues to grow. While demand has increased in the private sector, there has been no reduction in demand on the public sector. The effect of the increased uptake in private health insurance has therefore been to stimulate additional demand for private hospital services.[48]

11.59 In contrast, the AHIA dismissed the suggestion that people would seek medical treatment for reasons other than need:

> Unless people are being admitted by doctors to hospitals when they do not need to go and are going into hospitals voluntarily to be put under anaesthetic and be cut open for the fun of it, by definition we almost certainly have to believe that they would otherwise be going into public hospitals or be on public hospital waiting lists.[49]

11.60 Nonetheless, most evidence presented to the Committee indicated little impact had been made on public hospital demand. The Queensland Government stated that the rebate had been ineffectual:

> [T]he activity in Queensland public hospital emergency departments has grown from 674,000 to 747,000 patients over a couple of years. That is 10.94 per cent growth. That is way ahead of any population growth and is totally unsustainable. … We keep hearing how the private health system with the private health insurance subsidy has taken pressure off the public hospital system. We simply cannot find that in any of our data. We have

47 Professor Deeble, Submission 85, p. 10

48 Tasmanian Government, Submission 147, p. 6; a similar view was put by the NT Government, Submission 82, p. 6

49 Mr Russell Schneider, *Proof Committee Hansard*, Canberra, 28 August 2003, p 45

> seen that, yes, it plateaued for a small period and now it is going up again ahead of population growth. [50]

11.61 The NSW Government aired a similar criticism:

> We do hear from time to time that in fact the public hospital system is not as busy as it used to be because of the reforms in the private health care arrangements and the private sector. This claim is simply not correct. A recent analysis by NSW Health of our activity and also of private hospital activity has shown that we have had a two per cent increase in activity overall. We provided 22.6 million services to inpatients and the data put together suggests a preliminary increase of 5.8 per cent in activity in New South Wales alone.[51]

11.62 ACT Minister for Health, Mr Simon Corbell noted that:

> We are seeing an increasing pressure on our public hospital system even though we have one of the highest level of take-up of private health insurance in the country. Our private hospitals are simply not delivering the complexity of services that people are expecting, and the burden is still falling very heavily on our public system. [52]

11.63 The imperatives of the private system also came under scrutiny in the context of working towards achieving the best outcomes for the neediest patients. It was alleged that private hospitals are inclined to choose patients and procedures selectively on the basis of profitability rather than clinical need.

11.64 The WA Government questioned whether increased admissions levels actually represent addressing urgent health care priorities:

> [U]nlike public hospitals, private hospitals do not necessarily work on the basis of clinical need. There is uncertainty about the extent to which increased health insurance membership is leading, via increased private hospital activity, to the nation better meeting the most urgent cases that should be dealt with by hospitals. [53]

11.65 One effect of the Lifetime Health Cover policy has been to drive many people into getting the minimum possible private cover, in order to avoid the penalty provisions. In this context, Queensland Minister for Health, the Hon Wendy Edmond, highlighted the issue of 'front end deductibles'. Queensland currently has 62.4 per cent of front-end deductibles compared to an average of 59.2 per cent across Australia:

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50 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 34

51 Associate Professor Picone, *Proof Committee Hansard*, Sydney, 22 July 2003, p. 80

52 Mr Simon Corbell, *Proof Committee Hansard*, Canberra, 28 August 2003, p. 16

53 WA Government, Submission 177, p. 14

> [W]e have the highest rate of front-end deductibles, which means that most people go in to get the cheapest private health insurance they can, with the intention that they will never use it. In fact, we have shown statistically that people joined private health insurance not because of the rebate in the system but because of the penalties involved with higher taxation levels et cetera and the lifetime cover. As a result many of them took front-end deductibles and still use our public health system totally; they do not use their private health cover.[54]

Increased affordability

11.66 The final consideration is whether the PHI Rebate has made private health insurance more affordable for people across all socio-economic levels.

11.67 As noted previously, supporters of the rebate pointed to the outright increase in numbers of people with private health insurance, and in particular to the fact that these numbers include over one million Australians with annual incomes of less than $35,000, and over 600,000 in the $35,000 - $50,000 income bracket.[55] Similarly, in an Access Economics analysis commissioned by the Australian Private Hospitals Association, it is concluded that the rebate has restored PHI affordability to a level equivalent to the late 1980's.[56]

11.68 However, Professor Deeble criticised the methodology of the Access Economics Report, arguing:

> 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.[57]

11.69 The Committee also notes that the rapid and sustained rises in the PHI premiums over the past four years (see table 11.1 above), have occurred regardless of both the rebate and the increased numbers in private health insurance schemes.

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54 The Hon Ms Edmond, *Proof Committee Hansard*, Brisbane, 26 August 2003, p. 18

55 AHIA, Submission 105, p. 9

56 Access Economics, *Striking A Balance*, p. 9, attachment to APHA, Submission 99

57 Professor Deeble, Submission 85, Attachment: The private health insurance rebate, p. 7

Reallocation of rebate to public health

11.70 A significant number of submissions and witnesses to the Inquiry continued to oppose the PHI rebate and advocate its abolition with reallocation of the funds to other public health priorities.[58]

11.71 This suggestion raised two questions:

- What would be the likely effects of removing the rebate?; and
- What are the alternative uses of the funds?

Effects of removing the rebate

11.72 The Committee considered the effect the removal of the rebate would have on the viability of the PHI industry; the numbers of people who would retain private health insurance; the cost of premiums, and the wider implications for the overall balance of the health system.

11.73 The immediate effects of abolishing the subsidy for private health insurance are difficult to predict. Mr Schneider of AHIA indicated that without the subsidy premiums would rise considerably:

> I think it goes without saying that it would instantly increase the price of health insurance, and not by 30 per cent. If you do the maths, it would actually be in excess of 42 per cent, simply because of the oddity of mathematics. It would be a very savage percentage increase. [59]

11.74 This would mean additional costs of $230 on average for family cover and up to $400 a year for others.[60] The inevitable outcome of rising premiums would be an attrition in membership, as Mr Greg Ford commented:

> [T]here are a number of young, healthy people who have the cheapest private health policy because that costs less than the penalties through lifetime health cover. So I would imagine that people would drop out if we got rid of lifetime health cover as well.[61]

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58 see for example: Council of Social Service of NSW, Submission 84, p. 5; Australian Greens, Submission 100, p. 8; Mr Nilsson, Submission 119, p. 2; Australian Nursing Federation, Submission 159, p. 6; Public Interest Advocacy Centre, Submission 170, p. 2; Women's Action Alliance, Submission 183, p. 4; Mr Goddard (Australian Consumers Association), *Proof Committee Hansard*, Canberra, 21 July 2003, p. 66

59 Mr Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 81

60 AHIA, Submission 105, p. 16

61 Mr Ford, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 82

11.75 The decrease in numbers of people in lower risk categories with private health insurance drives what is described as an 'adverse selection spiral',[62] as Mr Schneider explained:

> The inevitable assumption must be that the first to go would be the best risks. They would make the logical decision that, given that they are healthy, they do not need to be paying for it, and they would carry their own risk. Therefore, the actual impact on price is more likely to be something like 50 per cent. The inevitable impact of that, of course, would be that those on the lowest incomes would be the least able to maintain their insurance. Almost by definition, those people are retired. Most of them are over 65 and many are over 70.[63]

11.76 AHIA concluded this would transfer between 313,000 – 417,000 episodes from the private to the public sector, which would cost between $704 - $939 million, or waiting lists would increase by 400,000 people.[64]

11.77 The AHIA also tabled a document containing the statements of several hundred people, outlining the importance of the PHI rebate to them, and the implications of its removal. The following comments provide an example typical of these sentiments:

> If the rebate is taken away I will no longer be able to afford private health fund [membership] and will pull out. I am a pensioner and $139 a month is a big cost each month to me out of my pension. If the 30% rebate is taken away I will drop out of the private health fund and let the government look after me.[65]

11.78 The Association of Independent Retirees made their views similarly clear:

> AIR strongly supports the 30% rebate for private health insurance, carried by over half its members, and will oppose any attempt by any party to remove or reduce this subsidy.[66]

11.79 Removal of the rebate could also be expected to have a significant impact on allied health professionals, many of whom opposed abolition of the rebate unless the funds were reallocated to their services. For example, the Australian Physiotherapy Association told the Committee:

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62 Professor Harper, Submission 127, p. 6

63 Mr Russell Schneider, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 81

64 AHIA, Submission 105, p. 18

65 Mr Richard Thorne, NSW, extracted from *Health fund contributors and their 30% rebate*, AHIA, tabled document, Canberra, 28 August 2003

66 AIR, Submission 97, p. 10

> We have certainly aired concerns that, if the 30 per cent private health insurance component that covers physiotherapy services is touched in any way, it must be put somewhere else into the system. Therefore we are totally opposed to those submissions and proposals from groups that suggest it be put into GP services and nursing services.[67]

11.80 According to the AHIA, the removal of the rebate on ancillary cover alone would cause around 46% of the 8.2 million people who currently have ancillary insurance to opt out.[68]

Alternative uses for the funds

11.81 If the 30 per cent PHI Rebate were to be abolished and the funds reallocated, a second question is how to redistribute the funds most efficiently and equitably. Several commentators consider that putting the money directly into the public hospital system would be more cost effective than indirect support via the rebate. Similarly, the Western Australian government stated that:

> Based on a 2000/01 AIHW estimate that the national average cost per casemix-adjusted separation was $2,834, the $2.5 billion per year now spent on the rebate could alternatively fund around 900,000 additional in-patient services in public hospitals.[69]

11.82 An alternative suggestion, that the funds in part be used to support bulk-billing by increased MBS rebate levels and other community health initiatives, was made in several submissions. The SA Divisions of General Practice observed that:

> The Divisions network has achieved substantial success in delivering integrated patient care though a number of initiatives including the More Allied Health Services Program. Funding from the private health insurance rebate could be redirected to expand this program so that patients in both rural and urban areas have better access to coordinated general practice and allied health services.[70]

11.83 The Doctors' Reform Society offered the Committee the most detailed alternative, targeting a variety of health sectors:

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67 Ms Katie Mickel, *Proof Committee Hansard*, Melbourne, 24 July 2003, pp. 5-6

68 AHIA, Submission 105, p. 16

69 WA Government, Submission 177, p. 15

70 SA Divisions of General Practice, Submission 33, p. 4; see also ADGP, Submission 37, p. 7; Australian Greens, Submission 100, p. 13

Table 11.2 Alternative allocation of Private Health Insurance Rebate funds[71]

Supporting General Practice through a $5 increase per GP consultation, made up by addition of $140 m from current Gov proposals)	$280m
Package for GPs who bulk-bill everyone (yearly bonus, practice nurse, support for capital infrastructure, medical indemnity)	$80
Additional funding to community based primary care, aged care, mental health and hospitals.	$860
Dental Health Scheme	$800
Saving the PBS: Education Program for Doctors Prescribing Drugs (to reduce pressure on PBS from pharmaceutical industry)	$160
Aboriginal Health (increase by 10%)	$120
TOTAL	**$2,300**

Alternatives to abolishing the rebate

11.84 Abolition of the private health insurance rebate is not, however, the only alternative: there are a range of other options by which the rebate could be retained but its application refined to ensure the optimum public policy results. As Professor Deeble commented, the current rebate arrangements are 'unconditional, undirected and uncapped.'[72] There are four principal options.

11.85 Firstly, expenditure on the rebate could be capped. As discussed above, there are already concerns that the Commonwealth has committed itself to funding rebates amounting to thirty percent of an amount that continues to grow rapidly, with no sign of slowing. It may, therefore, be necessary to limit the extent of the public commitment to the scheme by imposing a maximum level of subsidy, which would provide budgetary certainty and allow additional funding to be allocated to other public health priorities.

11.86 A second option is to remove the rebate for private health insurance ancillary cover. As Professor Deeble pointed out:

> 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

71 Doctors Reform Society, Submission 25, p. 5

72 Professor Deeble, Submission 85, Attachment 1, p. 12

> 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.[73]

11.87 It is acknowledged that removal of ancillary cover would be likely to have some impact on access to the services of allied professionals such as psychologists, physiotherapists, chiropractors, and nutritionists. There is evidence showing that expenditure on allied professionals does result in improved health outcomes, but more definitive work needs to be done.

11.88 Thirdly, it has been argued that a more efficient way to use private hospitals, and thereby reduce the pressure on the public hospital system, is by means of direct funding. This would effectively involve by-passing the private health insurers. Mr Goddard of the Australian Consumers Association argued:

> A more appropriate scheme would involve fee-for-service payment in accord with AR-DRGs,[74] augmented with block funding to recognise the total cost of running a hospital, including infrastructure and return on investment. … As with Medicare, a schedule fee would be set for each item, with the benefit being paid to the patient with the capacity to assign that benefit to the provider if the provider elects to bulk-bill.[75]

11.89 He noted that a cheaper and more cost effective version could be created by funding only those services which public hospitals could not adequately deliver.

11.90 This method retains the advantages of private hospitals, while utilising the economies of scale, efficiency and public control of Medicare as the universal health funding agency.

11.91 A final option is to change the arrangements for providing funding to increase the transparency of the use of public funds and the public health policy outcomes from those funds. This would involve the imposition of a greater range of conditions on private health insurers and private hospitals to ensure that funds are spent on public health priorities and also that public funds are not used in the private system to duplicate or undermine the public system. According to Professor Deeble:

> $2.1 billion is a large enough sum to force some integration and it should be used as such. Despite the rebates' 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.[76]

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73 Professor Deeble, Submission 85, Attachment 1, p. 13

74 'Australian Defined Diagnosis Related Groups' – referring to patient case-mix management techniques.

75 Martyn Goddard, *Beyond the private health rebate*, ACA, 2003, p. 9

76 Professor Deeble, Submission 85, Attachment 1, p. 14

11.92 The Commonwealth would have every right to:

> … require transparent and independent utilisation review processes. That would be not more than the public hospitals are now forced to do.[77]

11.93 The Committee was made aware of the need to refine the relationship between public and private hospitals so that they are working as a single, complementary system, rather than as competitors. In this context, the Committee notes the comments of Mr Goddard of the ACA who stressed the necessity to:

> … create complementarity between the public and private hospital systems, rather than continuing today's wasteful duplication. … the nation cannot afford two competing hospital systems, we need one system, adequately and fairly funded, of which private hospitals are an integrated part.[78]

11.94 As Professor Deeble advocated, one means of achieving this complementarity is to link the receipt of public insurance subsidies to participation in joint public-private sector planning.[79]

11.95 The relationship between the public and private insurance systems and the private and public hospital systems is complex and interrelated, and changes to any part of the system must be carefully considered for its wider effects. Nevertheless, the amounts of public funds currently invested through the private health insurance rebate are enormous, and the public have every right to expect that these funds are spent in a transparent way, with a clearly defined and measurable outcome.

11.96 The Committee is not convinced that this is currently the case, and concludes that the options discussed above deserve detailed consideration.

Conclusion

11.97 To determine definitively whether the expenditure on the rebate is equitable and has met its objectives is a complex task. The Committee is concerned that the argument has been diverted into a debate about the relative effectiveness of the public and private sectors rather than the broader question of resources. In the interests of best use of funds, and with an understanding of the historical context of our hospital system, more attention should be applied to seeking collaboration between the two sectors. The Committee also considers it a priority that confidence in the public health system must be restored. To this end, the Committee recommends that further inquiry into the effectiveness of the rebate is required.

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77 Professor Deeble, Submission 85, Attachment 1, p. 14

78 Martyn Goddard, *Beyond the private health rebate*, ACA, 2003, p. 9

79 Professor Deeble, Submission 85, Attachment 1, p. 14

11.98 Such a view was expressed by the West Australian government:

> Given the differing views and the present lack of clarity about the implications for the health insurance rebate, a rigorous independent assessment should be undertaken.[80]

11.99 Since the rebate only came into force in January 1999 and Lifetime Health Cover in July 2000, the limited data on both the equity of the measures and their effectiveness makes it difficult to make unequivocal determinations.

11.100 Nevertheless, the Committee considers that sufficient evidence has already been presented to cast doubt on the overall effectiveness of the PHI rebate in contributing to the improvement of Australia's health system. In the light of the large amount of money involved in the subsidy, and the alternate uses to which it could be put, these criticisms must be taken seriously.

11.101 The Committee considers it premature to form any conclusions on alternative allocation of the resources, but the options outlined in this report will remain as future assessments of the PHI rebate policy are made. Professor Sainsbury framed the question of the allocation of the rebate in this way:

> The issue is: how can we most effectively spend taxpayers' money to protect and promote the health of the poorest in society – and the middle and the richest? Is subsidising those people who earn under $20,000 a year to allow them to purchase private health insurance the most cost-effective way of improving their health and treating them when they are sick?[81]

11.102 Total removal of the rebate would probably have immediate and adverse implications for the take-up of private health insurance. Any removal or alteration to the allocation of the rebate must not occur without a commensurate reallocation of the resources to ensure that at the very least, equitable access to the health system is maintained.

11.103 The advice of the ACA is this respect is sound: at no time during the transition phase must the overall health system become less efficient or effective; and the people's confidence in the capacity of publicly funded health system, particularly of publicly purchased hospital services, must be restored.[82]

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80 WA Government, Submission 177, p. 15

81 Professor Sainsbury, *Proof Committee Hansard*, Canberra, 21 July 2003, p. 85

82 ACA, Submission 72, p. 12

Recommendation 11.1

The Committee recommends that an independent inquiry be established to assess the equity and effectiveness of the 30% private health insurance rebate, and the integral Lifetime Health Cover policy.