Working in Partnership: Health Funds and Medicare

Australian Health Insurance Association

Submission to Senate Select Committee on Medicare June 2003

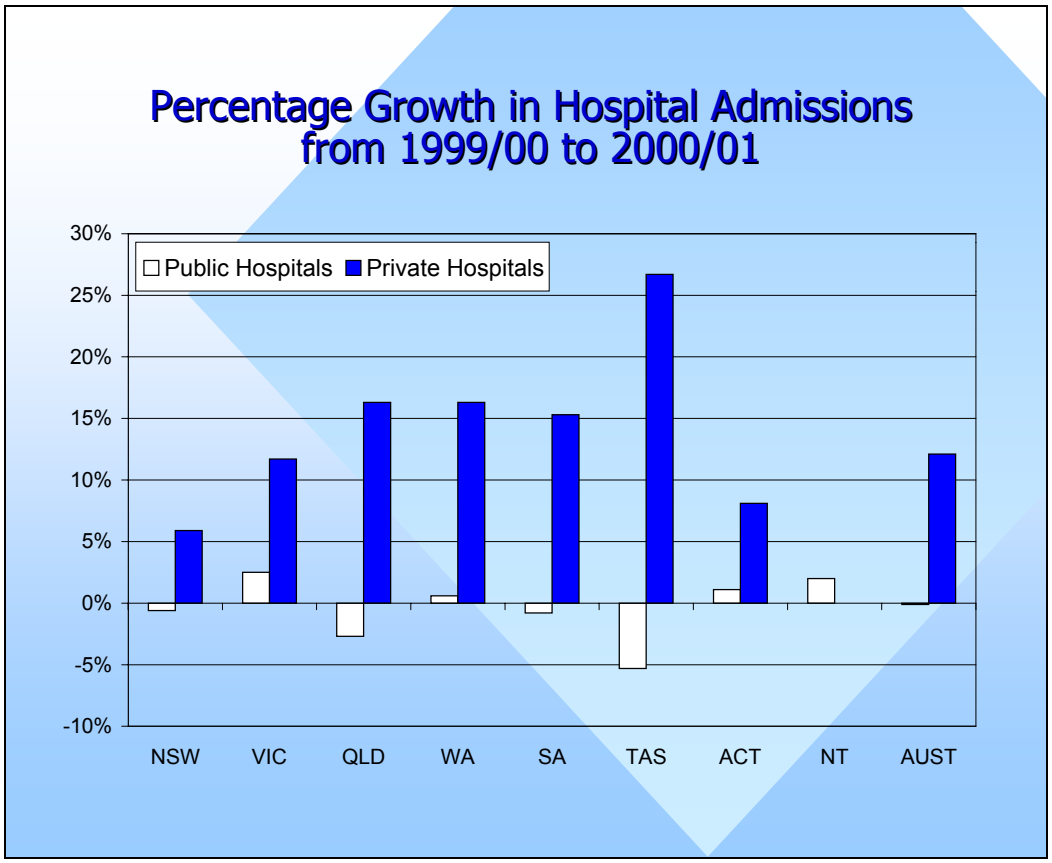
AHIA Submission to Senate Select Committee on Medicare June 2003

EXECUTIVE SUMMARY

i. This year health funds will provide more than $7 billion in health care benefits to members and provide cover for more than 2.2 million admissions to private and public hospitals (paragraph 3).

ii. The growing number of private hospital admissions, in many cases for complex procedures, must reduce demand in the public system. Each privately-insured patient who uses their health insurance in a private hospital must by definition open up space in a public hospital (paragraph 3).

iii. In 2000-01 total public hospital admissions fell by 4,591 while private hospital admissions rose by 245,129. This shows the current Federal policies are working to relieve pressure on the public sector.



Data Source: Australian Institute of Health and Welfare. (These are the latest figures available. The debate on health policy issues is not assisted by the considerable lags in publication of public sector data compared with that available from health funds which show ongoing increases in private admissions).

iv. Australia's public-private partnership provides the nation with a much greater capacity to maximise the dollars available to health care and allow Australians to meet their collective and individual needs and priorities (paragraph 1).

v. There are very important inter-relationships between public and private health care delivery and funding because the health - or ill-health - of one inevitably affects the other, usually in adverse ways (paragraph 4).

vi. Public health systems must prioritise and ration. But individuals want choices which private systems allow, releasing pressure on the public sector and this is assisted by the 30-percent rebate (paras 6-9).

vii. Means tested incentives do not work (paras 10-12).

viii. The increase in privately-insured numbers has led to a significant shift in payment responsibilities with health funds paying a greater share of health costs (paragraph 15).

ix. The rebate has helped more and more people over 65 and those on lower incomes to take out or keep their private cover. As a result demand for extensive and often complex treatments of this age group can and is being provided in private hospitals (paragraph 19-20).

x. The increase in the insured population has, in fact, made way for greater supply of public facilities to the uninsured population (paragraph 22).

xi. Even with the rebate, Governments pay far less per person for hospital services to the insured than the uninsured (paragraph 23).

xii. Increased utilisation and costs are now at record levels. In these circumstances health funds have done extremely well in keeping premiums overall below CPI for the last three years (paras 25-26).

Proposed Medicare Reforms

xiii. The Government's proposed Medicare reform package represents a significant improvement on the existing arrangements (paras 28-29).

xiv. It is patently unfair that current arrangements deny families the opportunity to cover themselves against heavy costs for medical treatment outside hospital (paragraph 30).

xv. In the last few years medical technology and treatment options have changed significantly, and in many cases appropriate treatment can be provided outside the hospital environment but such care may be expensive (paragraph 31).

xvi. The current system provides perverse incentives which can make it more financially attractive - for both provider and patient - for treatment to be provided in hospital rather than what may be more appropriate non-hospital settings (paragraph 32).

xvii. The new arrangements will be a positive contribution to the attractiveness of insurance for those already covered, or considering coverage, while allowing those who wish to cover themselves only for treatment of catastrophic illness outside hospital the opportunity to do so. It would be wrong to deny these people the opportunity to receive insurance coverage if they wish to obtain it (paragraph 33).

xviii. Extending Medicare to cover allied health professional services currently covered by ancillary insurance would require Australians to pay an additional 2 percent of taxable income (paragraph 36).

xix. Removal of the rebate would lead to a significant drop in the insured population. It would mean families, many of them on low incomes, would be confronted with an increase of up to $1200 per year, or more than $20 a week for top cover simply as a result of the withdrawal of the rebate (paragraph 37).

xx. Means testing of the rebate would undoubtedly lead to better risks opting out of the insurance system and driving up prices as the vicious cycle resumed. This would create massive distortion in the public sector itself (paragraph 38).

xxi. **Removal of the rebate on ancillaries would cost an extra $230 on average family cover, and up to $400 per year (paragraph 42), and many would drop both ancillary and hospital cover.**

xxii. **Withdrawal of the rebate from ancillaries would cost the Government more in hospital services than its retention! (Not counting the impact on allied health professionals. Benefits paid to allied health professionals would drop by $911 million)** (paragraph 44).

xxiii. Five years after the rebate was introduced the average cost of family cover is still less than it was in 1998. This is a very positive policy achievement which benefits the entire health care system, relieving pressure on the public sector and maintaining a balanced partnership (paragraph 46).

End of Executive Summary

Australian Health Insurance Association Limited
4 Campion Street, Deakin ACT 2600

SUBMISSION FROM THE AUSTRALIAN HEALTH INSURANCE ASSOCIATION TO THE SENATE SELECT COMMITTEE ON MEDICARE 2003.

(This submission deals with terms of reference 1 (c) (iv) and (d). Although the other terms of reference represent significant questions, AHIA considers it should confine its comments to those matters directly related to private health insurance activities).

1. Australia has a unique health care system, which combines high levels of clinical care with overall social equity. It is virtually the only country in the world which provides a genuine mixed public- private funding and delivery health care system which combines the benefits of universal coverage with a highly competitive private sector. This public private combination - this partnership - provides the nation with a much greater capacity to maximise the dollars available to health care and allow Australians to meet their collective and individual needs and priorities.

2. The Australian Health Insurance Association therefore welcomes this opportunity to provide a submission to the Senate Select Committee in the hope it will assist its general inquiry and assist in a better understanding of the inter relationship between the public and private sectors. AHIA represents 30 registered health benefits organisations (RHBO's) more commonly known as health funds. Together AHIA funds provide health cover for 94 percent of the insured community, or more than 8 million Australians.

3. This year the health insurance system will provide more than $7 billion in health care benefits to members, and provide cover for more than 2.2 million admissions to private and public hospitals. This is of itself a significant contribution to the overall pool of funds available for health care. The growing number of private hospital admissions, in many cases for complex and resource intensive procedures must reduce demand for such services in the public system. Each privately insured patient who uses their health insurance in a private hospital must, by definition, open up a space in a public hospital.

4. In this submission AHIA would seek to help the Committee understand the very important inter-relationships between public and private health care delivery and funding because the health - or ill-health - of one inevitably affects the other, usually in adverse ways.

5. Discussions about health funding in general, and Medicare in particular, rarely address the fundamental question of the roles of the public and private health care sectors in a philosophical, as distinct from an ideological sense. AHIA believes that public health has a role and a duty to ensure (though not necessarily itself provide) an adequate health and safety framework for all Australians, and this includes everything from proper sanitation and clean water through to prevention and management of epidemics, accident and emergency services, workforce teaching arrangements, primary care and hospital facilities..

6. But by its very nature this system must prioritise and ration. It has a duty to provide care to those in most need, whether that be with respect to health status or geographical location or financial circumstances. Priorities in public health systems are determined by what health professionals think is best for individuals within budgetary constraints determined by a range of factors that are not directly, or even indirectly, affected by health policies. And as society's resources are not infinite, ultimately someone must be denied access or made wait for services which, in the view of the health professional's assessment of resources and priorities, are of lower priority than others.

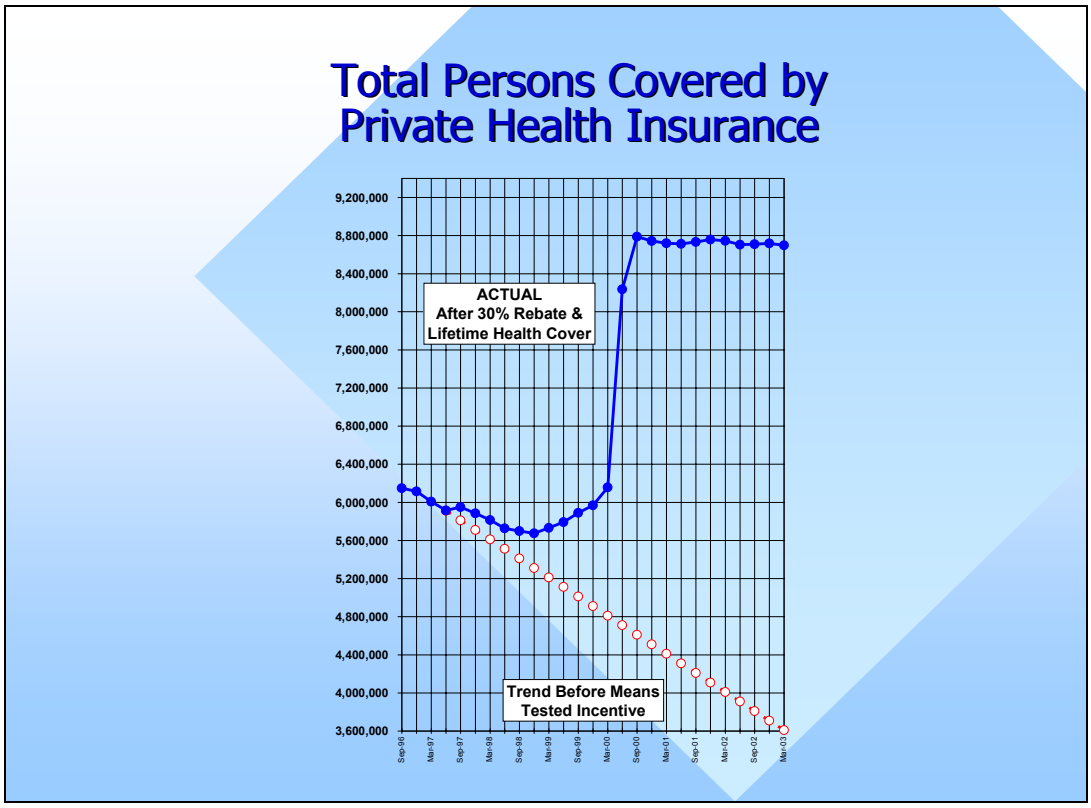
7. But individuals may, and often do, have differing priorities, especially when their own health or that of their family is concerned, and what may seem to be a reasonable prioritisation for one health professional (though not necessarily for another) may not be reasonable for the individual. So private systems allow choices.

8. Taken to extremes totally public systems can, in fact, be counter productive. Imposition of rationing, such as occurs in the UK, denies individuals the care they believe they need when they believe they need it (and when health care professionals may themselves believe they need it). Successive UK Governments have tried to introduce elements of market economies and competition into their National Health Service with little success. Nor have progressively increased funding commitments had any appreciably beneficial effect. (Nor is the ultimate in socialised health care, the Canadian system, without major problems. As the Canadian Senate's Standing Committee on Social Affairs, Science and Technology said in its recent report on The Health of Canadians

> *"rising costs strongly indicate that Canada's publicly funded health care system, at is it currently organized and operated, is not fiscally sustainable given current funding levels…the system does not currently have sufficient resources to respond to all the demands that are placed upon it. In particularly timely access to quality health services is increasingly not the norm. The Committee is aware that no system providing services that are perceived to be "free" can ever fully meet the demands placed on it…" (page 9, October 22, 2002).* (The Committee did not point to the incident several years ago in which a Provincial Minister opted for treatment for a potentially life threatening heart ailment in the much maligned United States. So much for socialised medicine representing a "single tier" healthcare!)

9. AHIA strongly believes the best system is a mixed system, provided funding arrangements allow individuals a choice of the best of both. Current funding arrangements, particularly the 30 percent rebate on private health insurance contributions, make it possible for those Australians who wish to exercise choice to do so, and in doing so makes it possible for the public sector to better meet the demands placed on it. As Professor Ian Harper, Professorial Fellow in the Melbourne Business School at the University of Melbourne, said:

> *In a mixed health insurance system like Australia's, the existence of private health insurance allows those who value keeping their options open in health care to subsidise overall health care capacity. To the extent that people abandon private health insurance, the subsidy is reduced.*
>
> *If 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.*
>
> *In fact, it would cost the Federal Government more to allow PHI to dwindle than to continue to support it.*
>
> *If private health insurance were to disappear entirely, the cost of providing public hospital treatment to all who were not prepared to pay directly for private hospital treatment (predominantly those in a financial position to self-insure) would escalate dramatically.*
>
> *For instance, in 2000-01 alone, private hospitals in Australia performed procedures which it would have cost the public hospital system around $4.3 billion to perform.*
>
> *In other words, had the private sector not carried its share of the hospital load in Australia in that year, public hospital outlays would have been around one third higher in real terms. Even if PHI does not disappear altogether, fewer people taking up PHI means more people accessing the public health system, raising its costs.*
>
> *Even those who choose to pay directly for private health treatment potentially raise the cost to the Federal Government, as the higher PHI premiums which follow their departure from the privately insured pool drive sicker, less wealthy patients out of the private into the public health system.*
>
> *(Ian R Harper, Preserving Choice, April 2003)*



Data Source: AHIA Estimates, PHIAC Quarterly Reports

10. The above graph shows the impact of the Federal Government's incentives program on health fund membership, starting with the first means tested incentive in 1997. As a result of that intervention membership increased for one quarter, but then started its downhill slide once again. This was understandable. A means tested incentive means that people on low incomes - who are on average in poorer health than the rest of the population - find it easier to remain insured (or take it out when illness strikes).

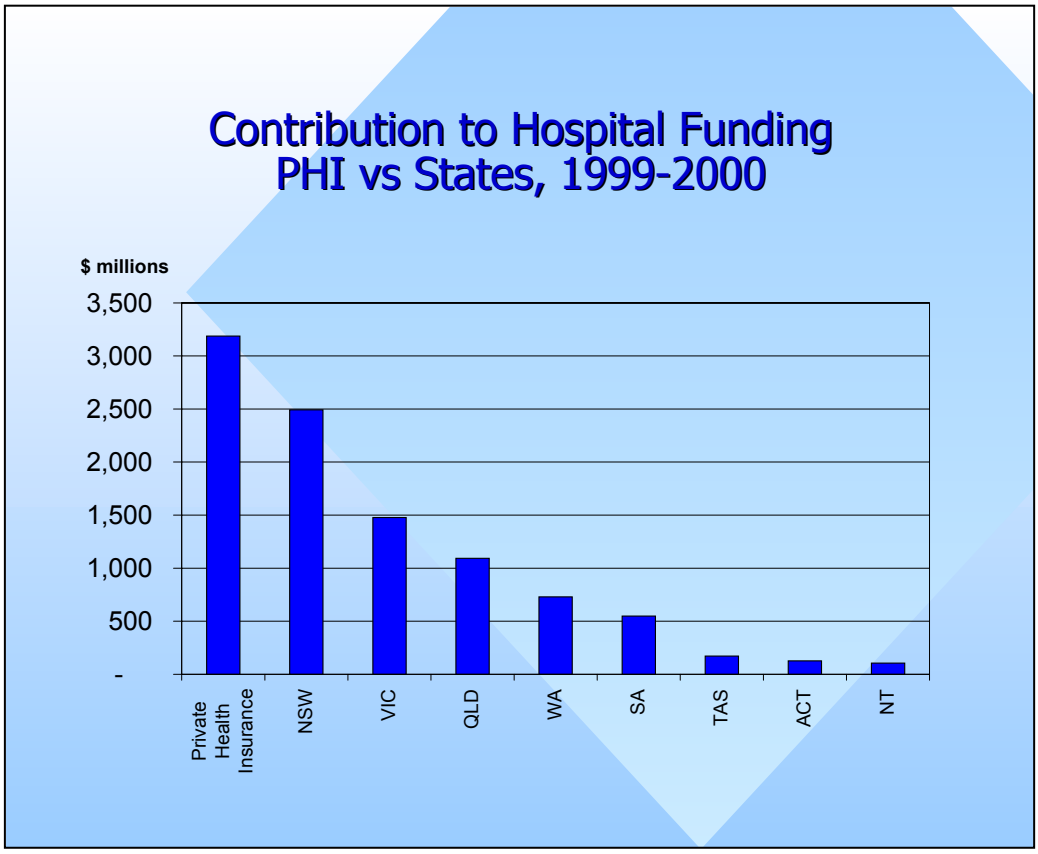
11. People on higher incomes, however, receive no incentive and make a logical financial decision, especially if they are convinced their own health is unlikely to require hospitalisation - and if it does occur, they feel they have sufficient funds to deal with the issue (or can take advantage of their Medicare entitlement, possibly ahead of someone on a lower income). So in some respects it is as important, if not more important, to provide encouragement to all people regardless of income to be insured. (Indeed, market research by TQA in 1997 pointed out there were as many high income earners who would respond positively to a 30 percent drop in the price of health insurance as in low income groups - TQA Syndicated Survey Health Care and Insurance-Australia 1997, p.260).

12. After the rebate was introduced without means test sustainable membership growth occurred, leading up to the introduction of Lifetime Health Cover, and this saw a dramatic increase. AHIA does not believe LHC would have had this effect without the rebate. This is confirmed by market research at the time which indicated membership growth was unlikely unless the then price level was 30 percent lower. (e.g., TQA Research "Health Care and Insurance Australia 1997 reported that *"..at current prices interest in the product has been decimated….those currently without private hospital cover need a quite dramatic fall in the price of private hospital cover-around 30%-before there would be any appreciable demand"*). The rebate achieved this reduction.

13. The graph also shows what would have happened to the insured population if health fund coverage had not increased. Today less than 20 percent of the population would be insured had the pre-rebate trend continued. Indeed more likely the figure would have been much lower because of the vicious cycle that would have taken place, with higher premiums driving out better risks, leading to increases in price etc. The likelihood is the private health insurance system would have collapsed, and with it private hospitals and, of course, private providers and suppliers would have faced a sharp downturn in demand.

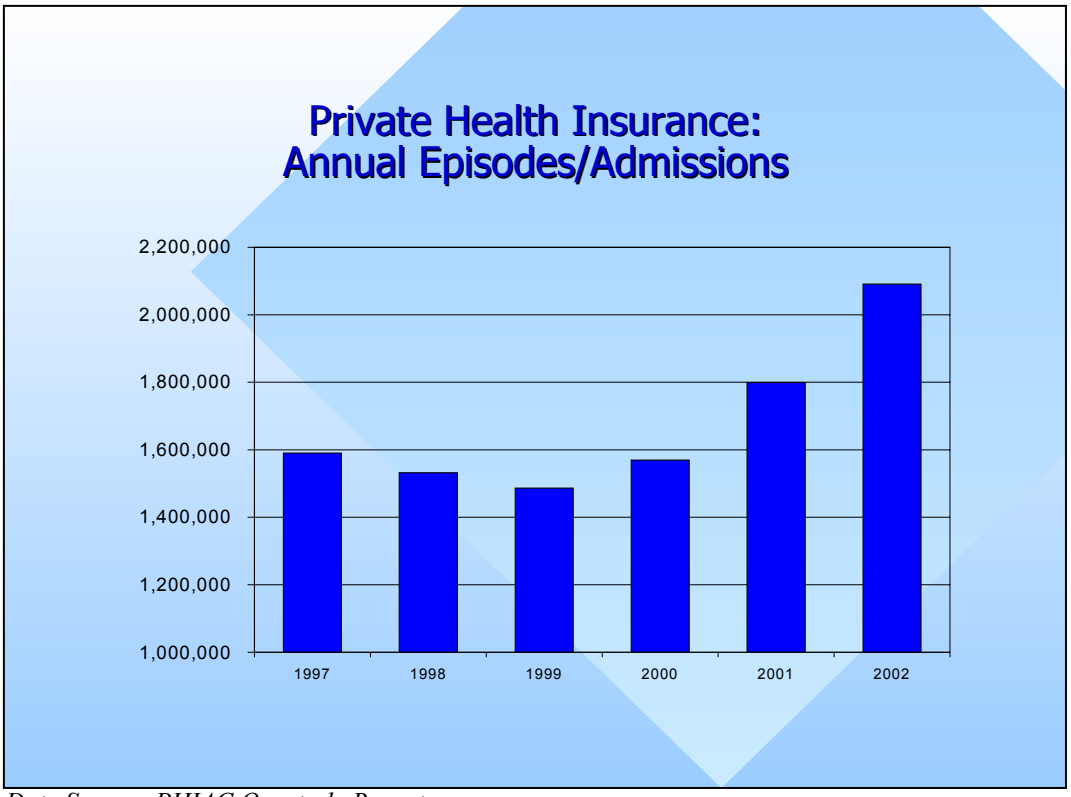
14. Is the rebate working? The facts answer unequivocally, YES. As Professor Ian Harper concluded:

> "*The willingness of PHI subscribers to cross-subsidise public health helps to keep the cost of the public hospital system within manageable limits…. It is worth the government paying money to PHI subscribers - as it does through the 30 per cent PHI premium rebate - to encourage more into the private system. So long as the cost of the rebate remains below the value of the implicit subsidy - as it does on current estimates by a considerable margin (around $850 per privately insured taxpayer per annum) - the government is ahead. The 30 per cent PHI rebate is cost effective.*" (Preserving Choice, Ian R. Harper, March 2003)



Data Source: Australian Institute of Health and Welfare Health Expenditure Bulletin 2000-01, PHIAC Quarterly Reports

15. The increase in privately insured numbers has led to a significant shift in payment responsibilities. We now have a situation where the increase in the numbers insured, and being treated as private patients, means that health funds pay more for hospital services in Australia than any single State Government! Contrary to those who would dismiss private insurance as irrelevant, this shows that the private health fund system is a significant component of our overall health funding arrangements.



Data Source: PHIAC Quarterly Reports

16. Before the rebate was introduced, private episodes were on the decline, as even those with illnesses were forced to drop their cover. Once the rebate was introduced episodes increased and are still increasing…from a low of 1.5 million to 2.2 million this year. This is obviously a very significant contribution to reducing pressure on the public sector. Indeed, a demographic analysis by AHIA shows that the 2.2 million expected admissions to be covered by private health insurance would include:

    - 168,000 people would have orthopaedic operations, including hip replacements, knee reconstructions, and ankle, shoulders and similar surgery.
    - More than 60,000 members would have cataract operations or be treated for various other eye diseases and disorders.
    - 130,000 cancer treatments would be provided
    - 135,000 patients would need cardiac treatment or heart surgery.
    - 43,000 patients would receive plastic and reconstructive surgery for burns, after mastectomies and other unfortunate incidents (health funds do NOT pay for cosmetic surgery).

Contribution of Private Hospitals

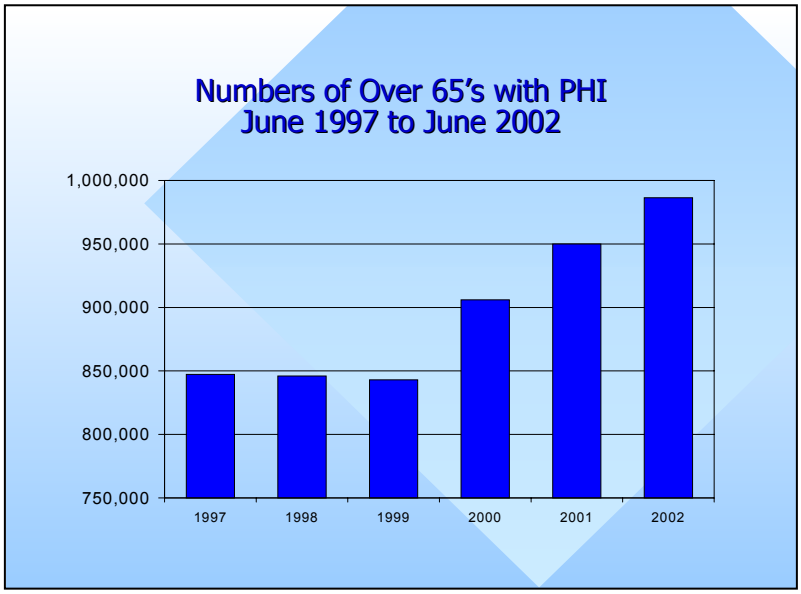
Proportion of selected episodes performed in private hospitals

Chemotherapy	50%
Major procedures for malignant breast conditions	53%
Cardiac valve procedures	56%
Other major joint replacement & limb reattachment	60%
Mental health treatment, sameday	65%
Major lens procedures	70%
Major wrist,hand & thumb procedures	70%
Knee procedures	75%

Data Source: Australian Institute of Health and Welfare

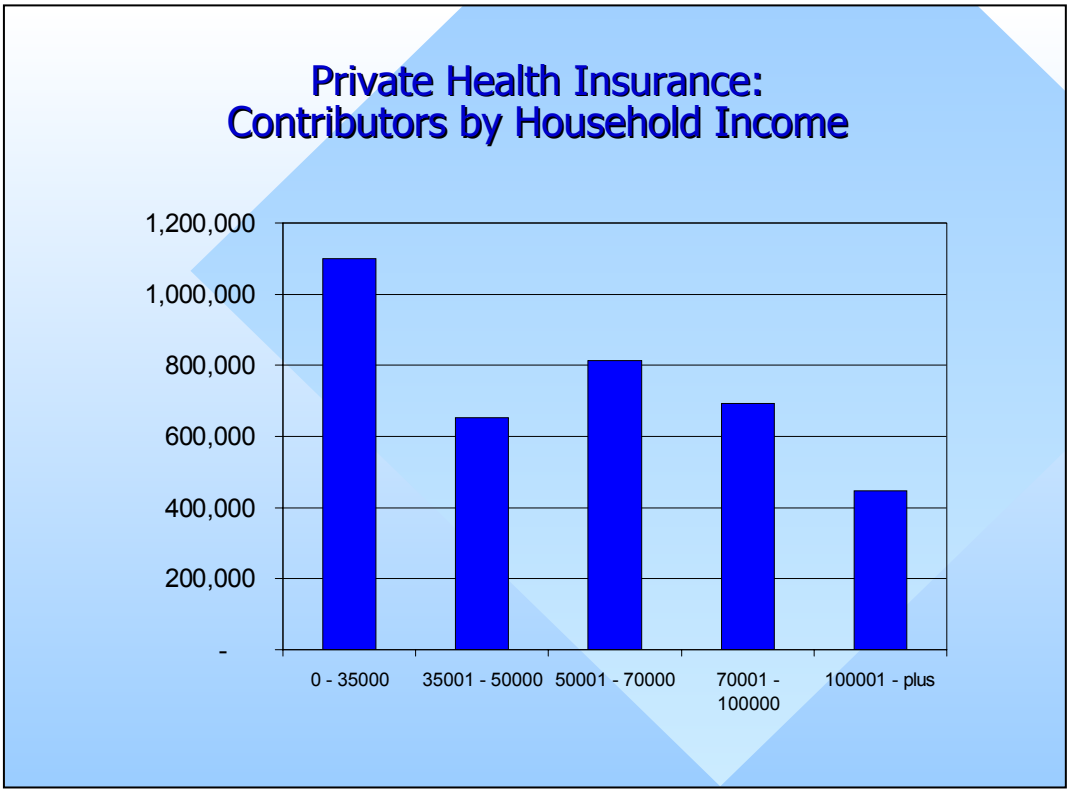
17. As a result of the expansion of private health insurance, private hospitals are now playing a very significant part in the overall health care system - restoring balance. The above table is just a selection of those procedures where private hospitals perform more than 50 percent of total treatment.

18. Nor are these trivial procedures. Many are resource intensive, complex and costly procedures, and although they may be described as "elective" make substantial improvements in the quality of life - and in many cases save lives. Helping people to see, walk, and manage debilitating illnesses are hardly minor issues.



Data Source: PHIAC Quarterly Reports

19. The over 65 population are the highest users of health care, in either public or private systems. And the rebate has helped more and more people over 65, most of whom are on fixed and relatively lower incomes, take out or keep their private cover. As a result demand for extensive and often complex treatments of this age group can and is being provided in private hospitals. In the year ended March 2003 health funds paid more than $2 billion in hospital benefits to people aged more than 65…almost equivalent to the total cost of the 30 percent rebate. Insured patients aged more than 65 occupied almost 3 million bed-days during that period. In the absence of private insurance these people would have needed public hospital treatment, and this would have adversely affected either public sector costs or waiting lists, or both.

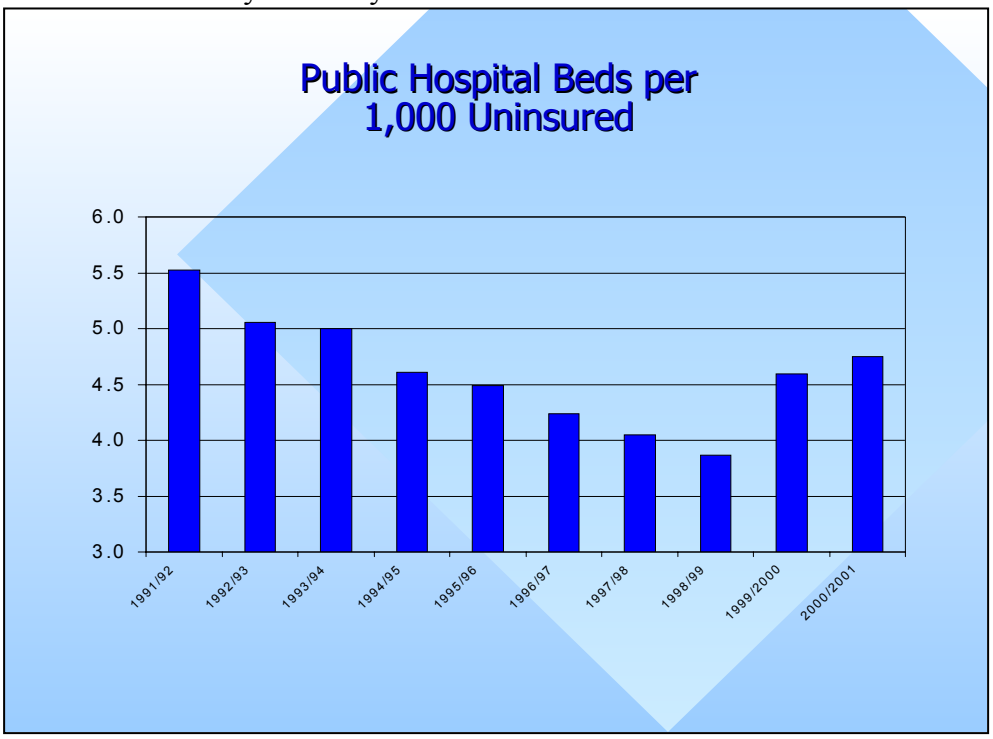


Data Source: Australian Bureau of Statistics

20. Contrary to popular folklore, a significant number of privately insured people are on very low incomes. The rebate has made it possible for these people to remain insured.

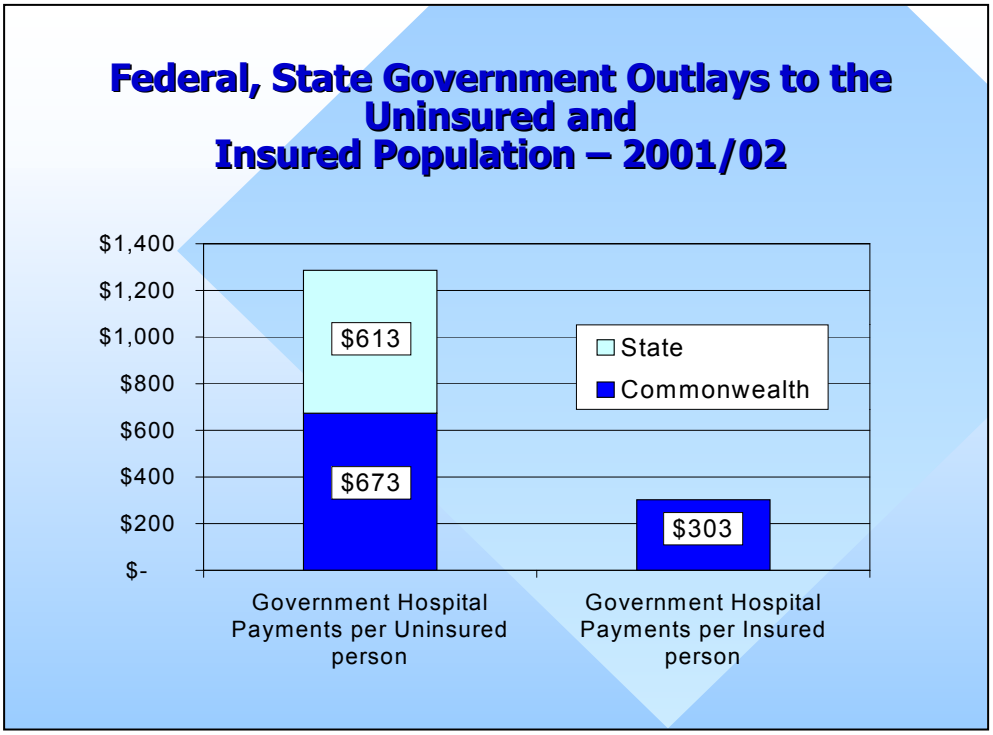
21. By far the greatest majority of bills are for hospital services. Hospitals this year will receive almost $1 billion more in accommodation and theatre benefits than before the rebate was introduced, and much more than they would have received if the pre rebate trend in the insured population had continued. In addition funds provide more than $500 million in prostheses benefits and $691 million in medical gap payments. While medical gap payments are now built into contribution rates it should be remembered that these were previously paid by those members unfortunate enough to

need treatment in hospital, and were as much a cost of insurance before gap cover was introduced as they are today.



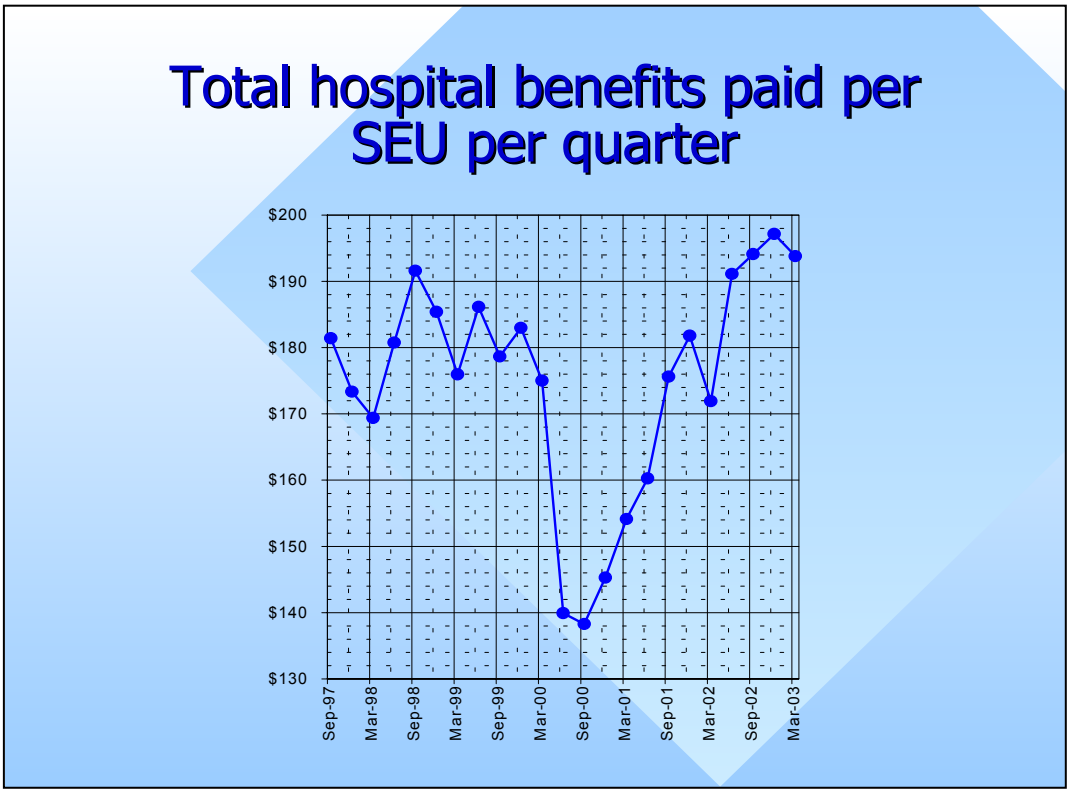
Data Source: AHIA Estimates, Australian Institute of Health and Welfare

22. But there have been significant system benefits as well. The increase in the insured population has, in fact, made way for greater supply of public facilities to the uninsured population. Whether State Governments are managing that change adequately is a matter for them.



Data Source: AHIA Estimates, Australian Institute of Health and Welfare, PHIAC Quarterly Reports

23. The simple fact is that even with the rebate, Governments pay far less per person for hospital services to the insured than the uninsured.

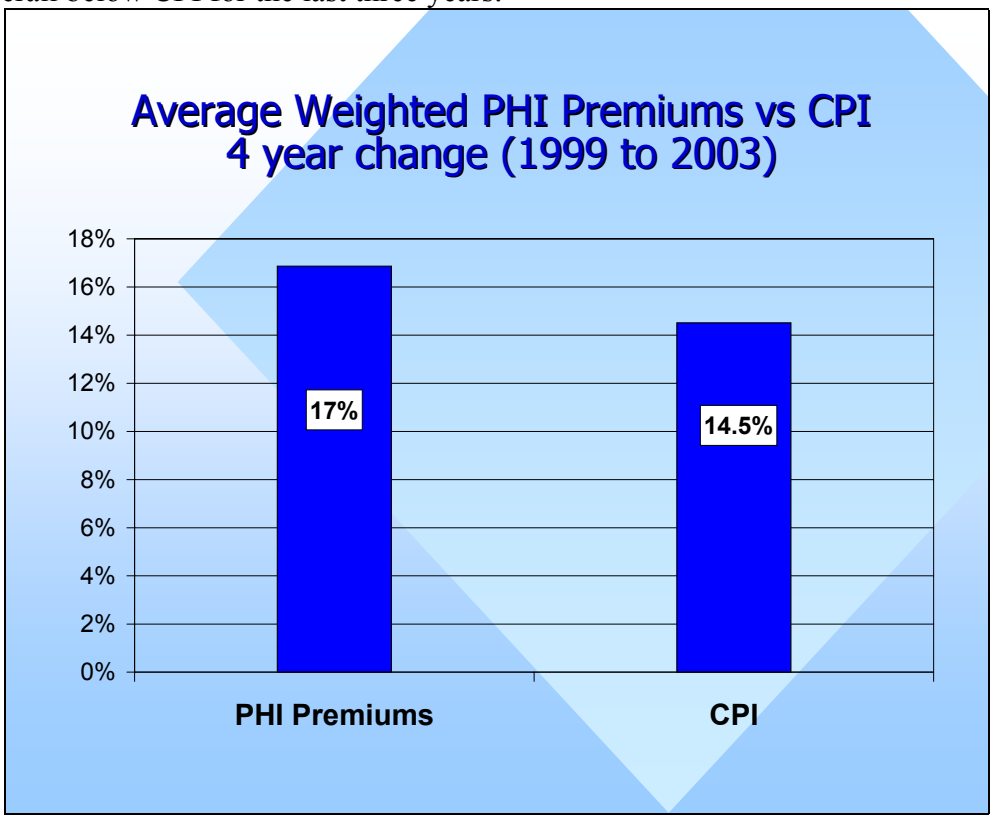


24.

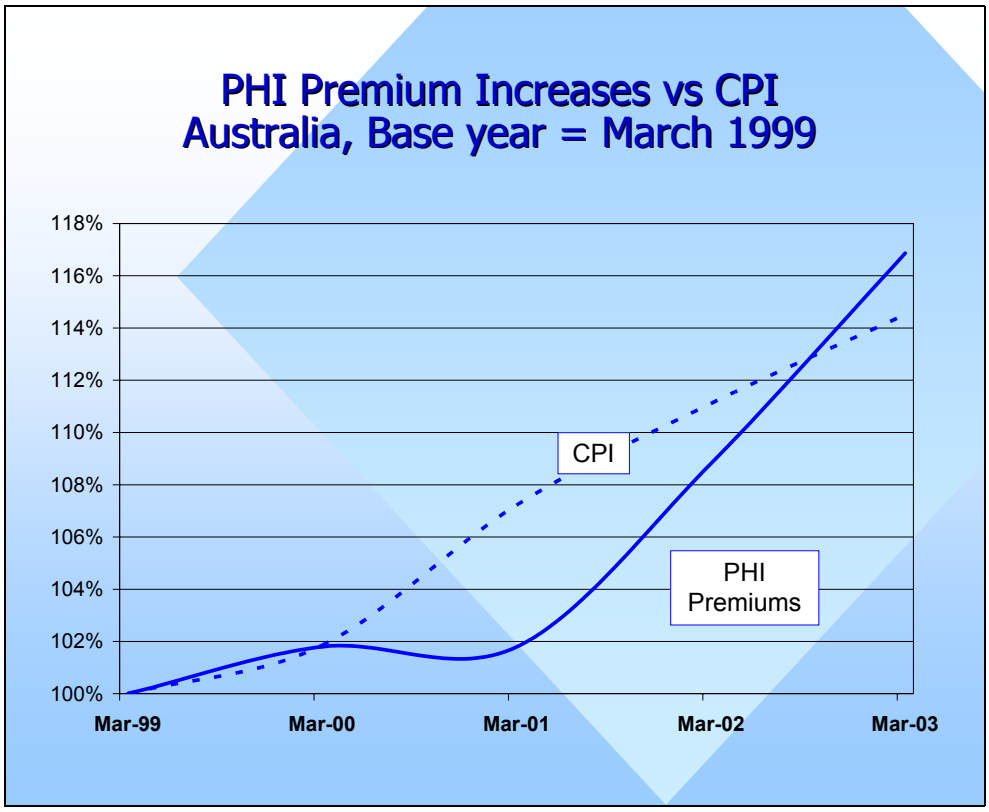
Data Source: PHIAC Quarterly Reports

25. Nevertheless, increased utilisation and increased costs are having their effect. The cost of hospital benefits per single equivalent unit - that roughly equates to each adult member - is now at record levels. Despite the influx of new risks following the introduction of the rebate and Lifetime Health Cover, the cost per individual adult is now greater than it was prior to the incentives. This has come about for a number of reasons, including the impact of higher nursing costs flowing on from State Government agreements in the public sector, the cost of new technology, ageing of the population and the general increase in complexity in private hospitals. Indeed, the increase costs of care make the retention of the rebate all the more essential.

26. In these circumstances health funds have done extremely well in keeping premiums overall below CPI for the last three years.



Data Source: Senate Hansard Tabled Reports, Australian Bureau of Statistics



Data Source: Senate Hansard Tabled Reports, Australian Bureau of Statistics

27. **Medicare Reform Package**

28. AHIA believes the Government's proposed Medicare reform package represents a significant improvement on the existing system both in relation to encouraging bulk billing, streamlining payment arrangements and allowing individuals to insure for catastrophic illnesses which may involve very high costs incurred outside of hospital. These people are currently exposed to financial problems as well as health problems, with no capacity to protect themselves from potentially heavy financial exposure.

29. The most significant component of the package in relation to health insurance is the provision that would allow Australians to secure coverage for non-hospital medical expenses exceeding $1,000 above Medicare rebates. At the moment individuals and families have no capacity to cover themselves for these costs, even though they may be privately insured for hospital and ancillary services. As a result people suffering catastrophic illnesses which may require extensive treatment outside hospital must meet the cost from their own resources rather than the insurance system.

30. AHIA believes it is patently unfair that current arrangements deny families the opportunity to cover themselves against such costs.

31. In the last few years medical technology and treatment options have changed significantly, and in many cases appropriate treatment can be provided outside the hospital environment. It is expected that this shift will be even more pronounced in the future. Such care may, however, be expensive and in some cases beyond the

capacity of families to pay without major sacrifice as it would involve substantial out of pocket costs at a time when they can least afford it

32. The current system also provides perverse incentives which can make it more financially attractive - for both provider and patient - for treatment to be provided in hospital rather than what may be more appropriate non-hospital settings. A patient treated in hospital will receive "gap-cover" benefits which they are currently denied for non-hospital treatment for the same condition. In addition, however, their fund must pay for the hospital accommodation which is ultimately reflected in higher contribution rates.

33. Under the new arrangements individuals will be able to purchase this cover with or without hospital/ancillary packages. AHIA believes this will be a positive contribution to the attractiveness of insurance for those already covered, or considering coverage, while allowing those who wish to cover themselves only for treatment of catastrophic illness outside hospital the opportunity to do so. This will improve affordability of care for those unfortunate individuals who may suffer unexpected illnesses involving extensive and expensive treatment. It would be wrong to deny these people the opportunity to receive insurance coverage if they wish to obtain it.

Term of Reference (d). alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care, in particular:

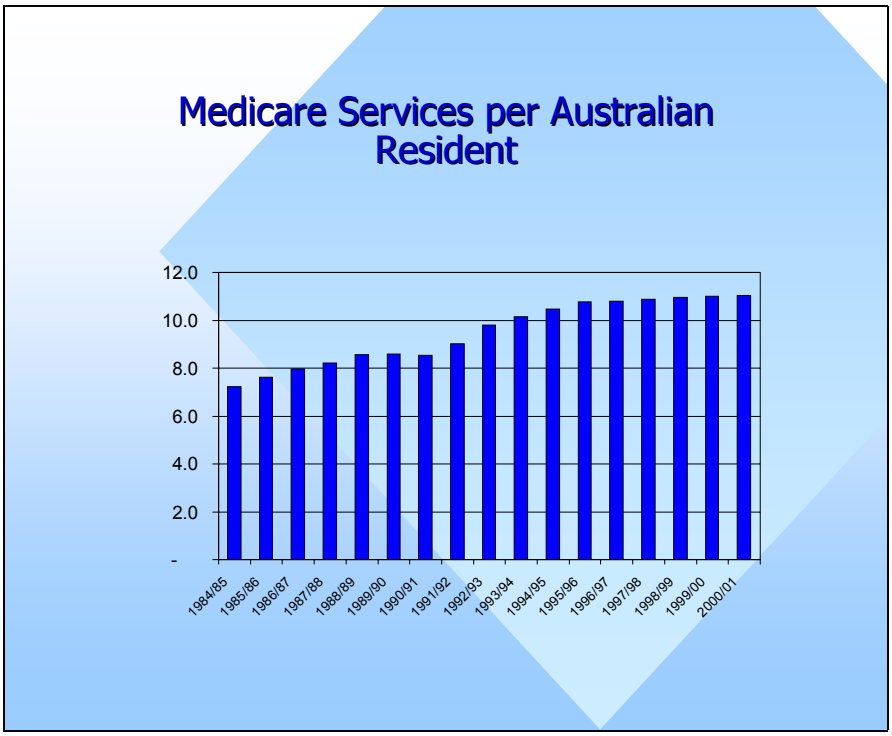
(i)whether the extension of federal funding to allied and dental health services could provide a more cost-effective health care system.

34. These terms of reference, if they suggest federal funding taking the place of health insurance for these services, could be construed as a deliberate attack on the existence of private health insurance in Australia.

35. At the moment approximately 41.4 percent of the Australian population have cover for allied and dental health services. In the year ended March 2003 health funds paid $2 billion in benefits for these services. Total fees charged were $3.7 billion (The overwhelming majority of treatments covered were for dental, chiropractic, physiotherapy, optical, and pharmacy services. Other services included dietetics, prostheses, ambulance, podiatry, home nursing, diabetic education, blood glucose monitors, weight management programs etc).

36. It is unlikely providers would be willing to reduce their fees under a nationalised system. If coverage was to be extended on the same basis as Medicare, i.e., 85 percent of total fees, and universal access regardless of means, taxes would have to rise by $6.9 billion. This would require more funding than is currently raised by the Medicare levy of approximately $5 billion. In effect, it would require Australians to pay an additional 2 percent of taxable income. And if the Medicare experience is to

be repeated, one could expect a very significant increase in services once a nationalised system was introduced.



Data Source: Health Insurance Commission Annual Reports, Australian Bureau of Statistics

Term of Reference D (ii): Reallocation of expenditure from changes to the private health insurance rebate.

37. AHIA has already pointed out that removal of the rebate would lead to a significant drop in the insured population, similar to that which occurred after the introduction of Medicare when Government support for the privately insured was withdrawn. It would mean families, many of them on low incomes, would be confronted with an increase of up to $1200 per year, or more than $20 a week for top cover simply as a result of the withdrawal of the rebate.

38. AHIA has already pointed out that a means tested rebate failed to reverse the decline in privately insured numbers that had been taking place during the nineties. The available evidence shows that means testing does not recruit or retain membership. Means testing of the rebate would undoubtedly lead to better risks opting out of the insurance system undermining the fundamental principles of community rating and driving up prices as the vicious cycle resumed. These price rises, over and above those inevitably brought about by natural increases in health costs, would drive more good risks out of the system until it resumed the downward trend that occurred before the rebate was introduced with all that involves for public sector demand.

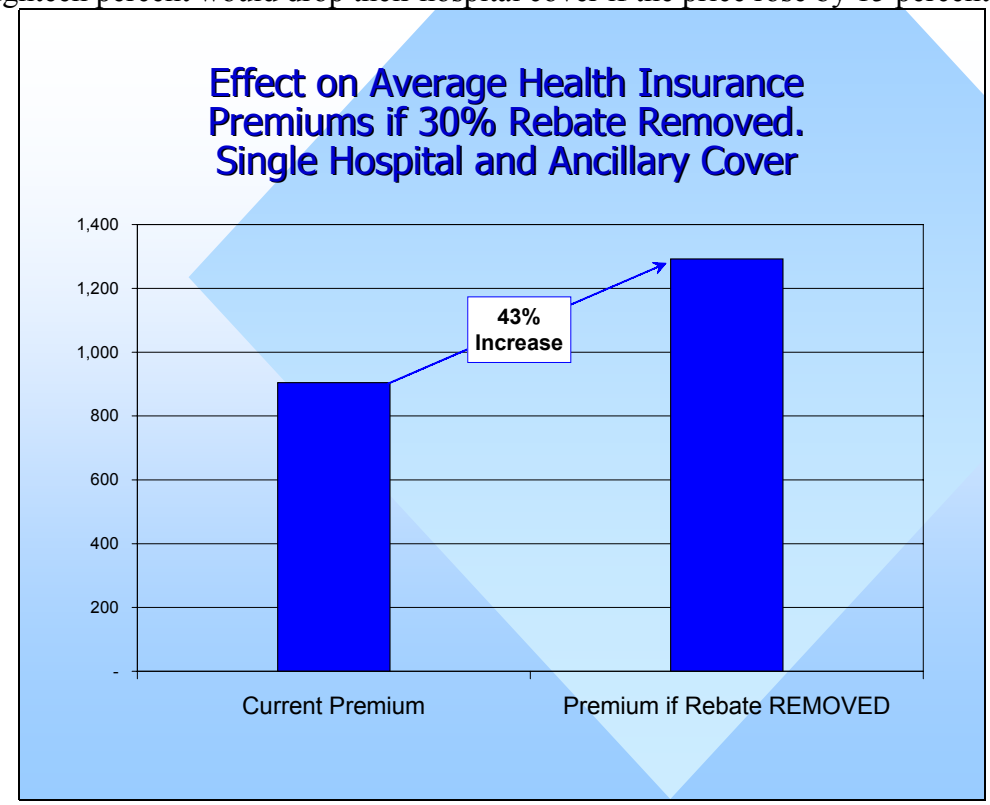
39. This would in fact create massive distortion in the public sector itself. Assuming treatment on the basis of health need remained a public sector priority, many of those currently being treated in private hospitals paid for by private health insurance,

would, when priced out of the health fund system, be entitled to priority in the public sector. This would simply mean those uninsured people who would otherwise be treated without significant delay under the current system would be forced to wait. Any existing dissatisfaction with public hospital services would be exacerbated and understandable given the inequitable nature of this forced realignment of priorities.

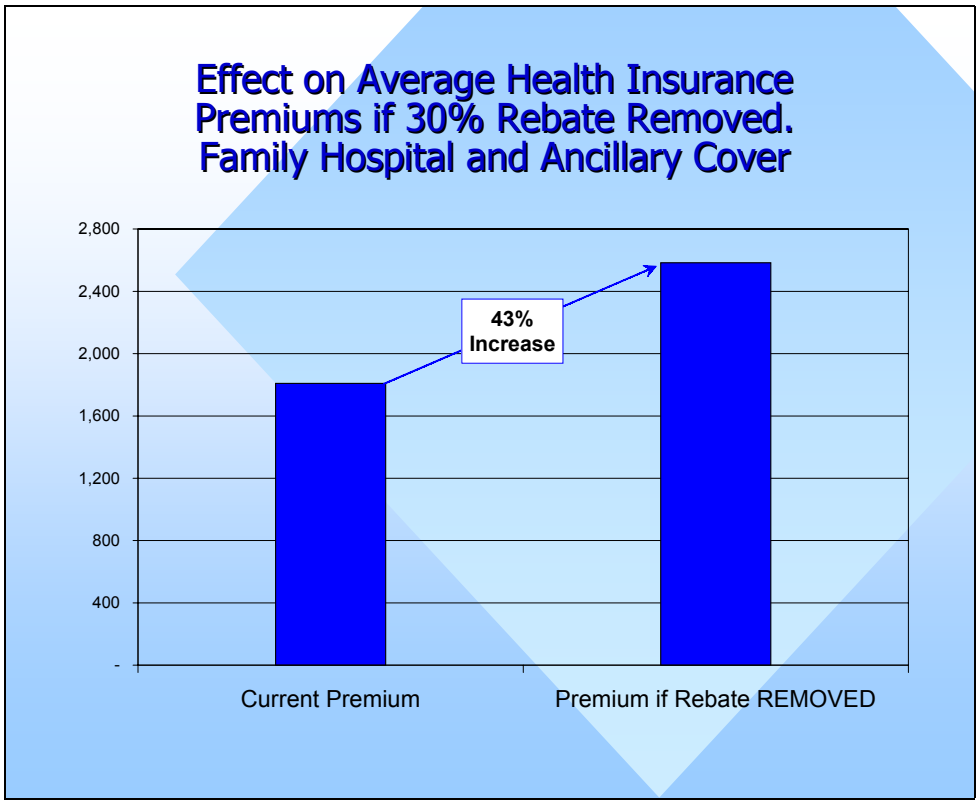
40. AHIA notes suggestions that the rebate should be removed from ancillary cover. Such a move would have a devastating impact not just on ancillary coverage but overall insurance levels as well.

41. As at December 2002, 8.2 million people had ancillary cover. Of these seven million had combined ancillary and hospital cover and 1.2 million people had ancillary only cover. Total 2002 benefits paid to allied health professionals from ancillary table were $1.9 billion .Average premium income for ancillary cover per family is $800. However some policies are above $1200.

42. **Removal of the rebate on ancillaries would cost an extra $230 on average family cover, and up to $400 per year.** (this is in addition to any premium increases brought about by higher benefits, etc)**.** In October 2001 Research Firm TQA reported (Health Care and Insurance, Australia 2001) that 46 percent of people with ancillary cover would drop it if premiums increased by 30 percent. TQA also reported that 31 percent of people with hospital cover would drop it if the price rose by 30 percent. Eighteen percent would drop their hospital cover if the price rose by 15 percent.



Data Source: PHIAC Annual Reports, PHIAC Quarterly Reports



Data Source: PHIAC Annual Reports, PHIAC Quarterly Reports

43. Removal of the rebate would in fact represent a 43 percent increase in price. TQA said its research indicated hospital price elasticity was quite linear, and that once people pass the 15 percent mark a 1% increase in price leads to 1% of members dropping their cover. *This suggests 43 percent of people with hospital cover would drop it if the hospital rebate was removed, and 20 percent would drop it if the rebate was halved.* These estimates are conservative in that they do not take into account relativities between tables: i.e., some people may have lower cost hospital tables with FED's or exclusions and full cover ancillaries, and vice versa. For most people hospital and ancillary cover appear as combined rather than separate covers, and therefore any increase in the price of the ancillary component of a package will flow on to hospital cover)

44. On this basis AHIA believes that removal of the 30 percent rebate on ancillaries would result in:
    - 46 percent of those with ancillary only cover - 558,000 people - would drop it - i.e., from 1.2 million covered to 655,000 covered.
    - 46 percent of those with combined tables would drop their ancillary cover - i.e. 2.6 million people
    - **A total 3.8 million Australians would no longer be covered for allied health services.**
    - The increase in price of ancillary cover would flow through to combined tables. AHIA believes between 15-20 percent of people on combined cover would drop their insurance …i.e., an immediate drop in hospital coverage of between 1 million people and 1.4 million.

- Based on average utilization, this would transfer 313,000 (15 percent decline) and 417,000 (20 percent decline) episodes from the private to the public sector.
- Private sector benefits (revenue to private hospitals) would drop by between $704 million and $939 million.
- Treating these patients in the public sector would cost between $704 and $939 million.(or waiting lists would increase by more than 300,000 - 400,000 people) In other words withdrawal of the rebate from ancillaries would cost the Government more in hospital services than its retention!(not counting the impact on allied health).

- In addition, withdrawal of the rebate would see a very significant reduction in the numbers covered for ancillary benefits, with a consequent reduction in allied health services in the private sector. If the number insured for ancillary cover dropped by 3.8 million people to only 4.4 million the number of services receiving rebates would drop from 47. 8 million to 25.8 million - less than before the rebate was introduced. **Allied health professional incomes from health fund benefits would drop by $911 million**

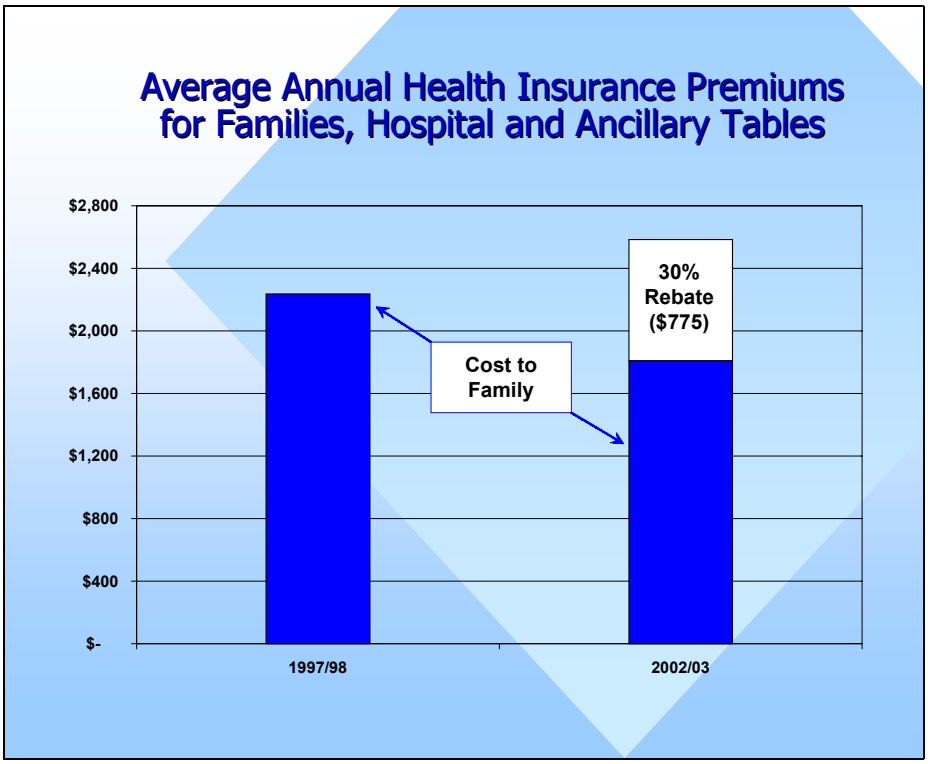
- Major service areas affected are shown below:

30 percent rebate withdrawn

Allied Health Service Type	Services Today	Benefits Paid	**Service Reduction**	**Benefit Reduction**
Dental	21,490,297	$965,563,251	9,885,537	$444,159,095
Optical	4,837,719	$304,666,171	2,225,351	$140,146,439
Physiotherapy	5,604,264	$143,018,676	2,577,961	$65,788,591
Chiropractic	6,254,454	$136,558,575	2,877,049	$62,816,945
Pharmacy	2,545,040	$74,233,600	1,170,718	$34,147,456

45. People with private health insurance voluntarily contribute a total $7.3 billion to the Australian health care system. Even when 30 percent of this contribution is given back to them via their rebate, they still provide $5.1 billion in addition to their taxes and Medicare levies. Removal of the rebate would force them to pay an additional $2.2 billion to the cost - an average of $388 per single person and up to $1200 per annum for families on top cover. This would be a severe disincentive for them to make provision for their own health care and many would drop out.

46. If removal of the rebate led to these people dropping their cover, and the total collapse of the private health insurance system, taxpayers - including the uninsured - would have to pay $5 billion more to provide services already covered by the insured community.



Data Source: PHIAC Annual Reports, PHIAC Quarterly Reports

Five years after the rebate was introduced the average cost of family cover is still less than it was in 1998. As a result it has led to very high private health fund retention rates and significantly increased necessary activity in the private sector. This is a very positive policy achievement which benefits the entire health care system, relieving pressure on the public sector and maintaining a balanced partnership.

AHIA June 2003