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Preserving Choice

A Defence of Public Support for Private Health Care Funding in Australia

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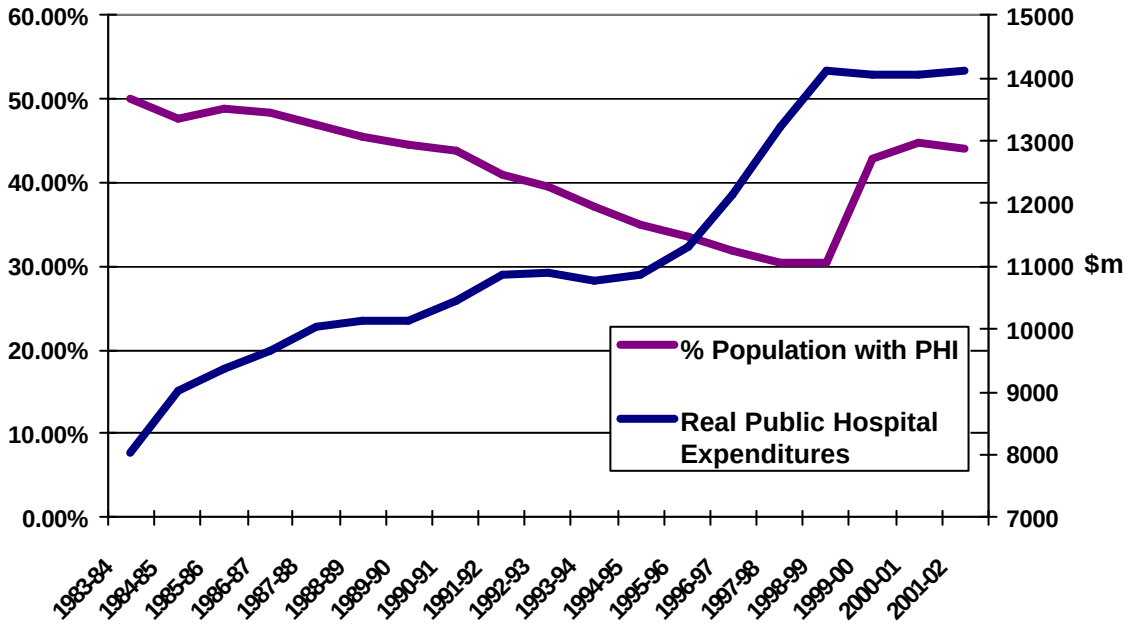
1 Overview

The Australian health insurance system has been the focus of considerable policy attention over the past three decades. Since the mid-1970s, the industry has been through five major reforms involving the introduction of a universal public health insurance scheme (on two occasions) and numerous policies aimed at stimulating demand for private health insurance (PHI), including taxation relief, the direct subsidy of insurance premiums and the introduction of lifetime community rating.

The effect of these policies on the take-up of private health insurance has been mixed—although the proportion of the population with private health cover ceased its historic decline and then rose dramatically following the introduction of the 30 per cent PHI rebate and lifetime community rating. By comparison, public expenditure on hospital treatment has risen more or less consistently in real terms since the mid 1980s but levelled off markedly soon after the introduction of the 30 per cent rebate in 1999 (see **Figure 1**).

Figure 1[1]



[1] Sources: PHIAC, Australian Institute of Health and Welfare.

Three themes resonate through recent government policy initiatives:[2]

- *Universal Access*—the principle that all Australians should have access to good quality health care at an affordable price;
- *Community Rating*—the principle that premiums paid for health insurance (explicitly in the case of private insurance or implicitly through income taxes in the case of the public health system) should not depend upon a person's actual or perceived health status (or that of his or her dependants); and
- *Government Cost Containment*—the general goal of keeping government outlays on health care to a manageable level.

The goal of community rating is difficult to sustain in a mixed public-private health insurance system like Australia's. Community rating requires low-risk individuals to cross-subsidise high-risk individuals by paying higher premiums than their health risk status warrants on actuarial grounds.

In order to be viable, private health insurers must attract low risk (healthy) members prepared to pay the higher premiums. When the option of using a non-means-tested, high quality public health system exists alongside the private system, healthier people are inclined to abandon private insurance rather than pay the higher premiums. This raises the premiums required of those who remain in private health insurance, reflecting their lower average health status and higher claims experience.

To achieve community rating in both the public and private parts of a mixed health insurance system, low risk individuals must be encouraged to remain privately insured. This normally requires some form of government intervention.

In a world where health consumption is a normal economic good (i.e., consumer demand for health care rises with income) and health supply is subject to technological change making new and improved treatments available to consumers, the goals of achieving community rated coverage and containing public health care costs often conflict (Cutler, 2002).

The end result is a policy mix that attempts to maintain universal access and community rating while encouraging as large a private contribution to the cost of health care provision as possible.

[2] Cutler (2002) provides a review of health care policies in OECD countries over the past century and identifies these as common goals of policy change in the health arena.

In Australia, private health expenditure is usually related to private health insurance. Not everyone who uses a private health facility draws on private health insurance, however—some pay for the services directly.

The Federal government has recently introduced three reforms to private health insurance with the aim of increasing the demand for private health insurance cover (and thereby increasing the private contribution to total health care expenditure):

- an additional tax penalty on high-income earners who do not have private health insurance;
- a 30 per cent rebate on private health insurance premiums; and
- a form of lifetime community rating.[3]

Public health insurance is not means-tested in Australia and private health insurance 'overlaps' with public insurance. In other words, an individual or family with private health insurance may nevertheless access public health facilities on the same basis as those publicly insured. However, public patients may not access private health facilities without private insurance or meeting the direct costs from their own pockets.

Those who take up private health insurance or who pay directly for private treatment 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.

If a privately insured patient uses the private system, his or her taxes pay for a place in the public system that can be re-allocated to someone else. On the other hand, if a privately insured patient uses the public system, the unspent portion of his or her PHI premiums lowers the cost of private health cover for others.

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

[3] For an attempt to separately identify the effects on the take-up of PHI of each of these policy initiatives, see Frech, et.al., (2003).

extent that people abandon private health insurance, the subsidy is reduced.

If people choose instead to be treated exclusively in the public system, they consume the services their taxes have funded, leaving (on average) nothing to be allocated to other public patients. There is also no unused premium helping to subsidise the cost of PHI.

Should they choose to pay for private treatment directly rather than through PHI, their taxes help to subsidise the public system, which they do not use. But in this case there is no risk-sharing with other private patients, leading to higher PHI premiums on average.

In summary, 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.

This is the reasoning behind the Government's decision to support PHI.

Even though it might be at some cost to the public revenue (the 30 per cent PHI rebate cost taxpayers around $2.2 billion in 2001-02), so long as the cost incurred is outweighed by the value of the implicit subsidy, the net impact is positive.

In fact, it would cost the government more to allow PHI to dwindle than to continue to support it.

As PHI dwindles, more people access the public health system, raising its costs. This is starkly evident in **Figure 1** which shows the increasing cost burden imposed on public hospitals by the gradual decline in private insurance coverage.

Even those who choose to pay directly for private health treatment potentially raise the cost to 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.

There is evidence that the gradual decline in the proportion of the population with PHI has produced an 'adverse selection spiral' in the pool of privately insured health risks. Barrett and Conlon (2002) remark that:

> "… there is unequivocal evidence that over the 1989-95 period those individuals and families who represented better insurance risks (from the point of

> view of the insurers) … were most likely to quit the pool of the insured" (p.17).

As this has occurred, the health profile of the privately insured has steadily become less robust. This is mainly reflected in the higher average age of the privately insured.

In other words, it has been the young and the healthy who have opted out of PHI (or chosen not to join) and decided instead to access the public system or to 'self-insure', i.e., take the chance that they will need treatment and pay for it directly through the private system should the need arise.

With a deteriorating health profile of the privately insured, the subsidy to the health care system implicit in PHI takes on an additional flavour. Those taking out PHI and subsidising the public system (if they use private facilities for treatment) or PHI premiums (if they use public facilities for treatment) are increasingly the older and less healthy members of the community.

This flies directly in the face of the principle of community rating, one of the benchmark goals of Australia's mixed health care system.

Community rating requires that the healthy subsidise the sick, not the other way around. The gradual decline of PHI in our system prior to 1998-99 reversed the principle so that, increasingly, the older and sicker subscribers to PHI contributed additional resources to the health system—with the result that younger and healthier Australians could access free public health care more easily.

Support for PHI in the three forms introduced by the Government has helped to shore up the principle of community rating by encouraging more people to take up PHI.[4]

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[4] Some have argued that the principle of community rating can only be applied fully in an exclusively public system where health risks are shared through the tax system. The demise of PHI is viewed in these quarters as a move towards *greater* community rating.

While it is true that a fully public system, in which PHI is not only non-existent but *prohibited*, would abide by the principle of community rating, it would also be extremely expensive to the public revenue. For example, in 2000-01, Australia's private hospitals performed procedures which would have cost the public system an additional $4.3 billion to undertake (estimated using published national 'casemix' cost weights). In other words, had the private sector not existed, public hospital expenditure would have been around 30 per cent higher in a single year.

The Government's aim in supporting Australia's mixed public and private system has been to achieve community rating at lower overall cost to the public revenue.

As more of the young and healthy return to the pool of privately insured risks, the implicit subsidy from PHI users to the system at large looks more like a subsidy from the healthy to the sick, as required by community rating.

The health status of the privately insured as a group improves relative to those in the public system, and there are more young and healthy members of the PHI pool, enabling older and sicker members to pay lower premiums for PHI.

2 Some Features of Australia's Health Insurance System

2.1 Public versus Private Health Insurance

Australia's health insurance system operates with a mixture of public and private elements. All Australians enjoy public health insurance, in the sense that anyone can access treatment for illness in a public hospital at no cost. The cost of providing such treatment is met from general taxation revenue, to which all Australians contribute according to their means. By the same token, public health insurance is mandatory in that people cannot claim a rebate of tax paid should they choose to be treated in a private rather than a public hospital (or to be treated as a private patient in a public hospital).

Because publicly provided health care is funded through the tax system rather than explicit premiums, changes to the public health insurance system have fiscal implications for the government. If the government wished to improve the level of coverage and services provided by the public health system, this would involve raising additional taxation revenue, lowering expenditure on other government programs and/or increasing the level of public debt. In such circumstances, it is unsurprising that the debate on public health insurance has often been diverted into a debate about funding and fiscal priorities rather than addressing the fundamental issues of the nature and coverage of the Australian health insurance system.

In Australia, private health insurance is generally provided by not-for-profit institutions, including a government-owned health insurance company, Medibank Private Limited. The policy benefits and premiums charged by these institutions are regulated by the Federal government. Private health insurance provides an individual (and his or her dependants) with a variety of benefits, some of which substitute for those available in the public system and some of which are additional or ancillary. The particular benefits depend on the exact nature of the insurance policy purchased.

A privately insured patient can access the services of private hospitals with zero or reduced out-of-pocket expenses compared to someone without private insurance cover. In particular, a privately insured patient can choose to be treated in either a public or a private facility

and also exercise some choice over the specialist medical staff involved.

A privately insured individual can often receive more timely care by avoiding the waiting lists associated with treatment as a public patient in a public hospital. This is true of anyone who opts to pay for private treatment, whether or not they are privately insured. The element of insurance creates options that would otherwise be contingent upon a patient's financial circumstances at the time. Insurance also replaces uncertainty surrounding a person's financial outlays on private health care with relative certainty, something many people value.

Private health insurance is more comprehensive in its coverage than public insurance but also overlaps with the public insurance system. Apart from the additional choice available to privately insured patients, they may also access a range of services, including dental and optical services, which are available only on a limited basis in public facilities. But the two systems also overlap in that many procedures undertaken by private hospitals are identical to those available in public hospitals (or may even be exactly the same if the insured person is treated as a private patient in a public hospital).

When a privately insured patient opts for treatment in a private hospital for a procedure that would otherwise have been performed at public expense in a public hospital, there is no rebate of taxes paid by the private patient. The private patient simply pays twice for hospital treatment—once through taxes paid to support the public system and once again to access private treatment. This is true even if the privately insured patient chooses to be treated in a public hospital and fails to declare his or her status as privately insured. In this case, the premiums paid to secure a place in a private hospital are not rebated and the patient effectively pays twice for the procedure.

2.2 The Decision to Purchase Private Health Insurance

The benefits to the individual from taking out (basic) private health insurance include:

- choice of medical practitioner, regardless of whether the treatment is undertaken in a public or a private hospital;

- cover for the 25 per cent gap between the scheduled fee and the Medicare rebate for in-hospital medical treatment as a private patient[5];
- cover for accommodation expenses in hospital; and
- cover for allied expenses associated with hospitalisation, including theatre fees, intensive care, dressings, prostheses (surgically implanted), diagnostic tests and most pharmaceuticals.

The (net) costs of private insurance include:

- the private health insurance premiums;
- less the 30 percent PHI rebate on those premiums; and
- less 1 per cent of taxable income for high income households (avoiding the Medicare Levy Surcharge where applicable).

A decision to take out basic PHI is a decision to preserve choice in the event of an adverse or elective health episode. An individual opts to pay for the right to access private hospital treatment when his or her taxes have already secured a place in the public hospital system. Those who value choice in health care, and take out PHI, supply additional resources to the health system. If they choose treatment in a private facility (or as a private patient in a public facility), their taxes fund additional treatment in the public system. Even if they choose treatment in the public system without declaring their privately insured status, private insurance claims and premiums for other users are reduced.

Private insurance cover can also be obtained for ancillary services such as dental treatment, ambulance, chiropractic treatment, home nursing, podiatry, physiotherapy, occupational, speech and eye therapy, glasses and contact lenses, prostheses and the like. Such services are not covered by Medicare and hence there is no overlap between public and private insurance. The decision to take out PHI for ancillaries is not about choice, since there is no public alternative, but about the desire to lay off the risk of unforeseen expense. Those without PHI for ancillaries choose to self-insure, either because they are less risk averse than the privately insured or because they cannot afford to pay an insurer to bear the risk on their behalf.

[5] Some policies cover the additional gap between the scheduled fee and the actual fee charged by the medical practitioner.

Private health insurers offer ancillary cover to attract the young and healthy into private health insurance, those for whom the option of private hospital treatment does not by itself rank highly. Any device which draws the young and healthy into the privately insured risk pool promotes the goal of community rating in private health insurance.

2.3 Income Redistribution and Health Insurance

Some commentators appear to view the health insurance system as a legitimate and useful means of redistributing income. They consider it unexceptionable that someone who takes out private health insurance should pay twice for health cover. According to this argument, those who can afford private health insurance should be allowed to pay twice as a disguised means of transferring income in favour of those who can only afford to use the public hospital system.

There are at least two objections to this reasoning. First, while income redistribution is a laudable objective, it is far from clear that such redistribution should occur through the health insurance system. Basic economic analysis shows that income redistribution should occur through clear, well-defined taxation and social security systems. Disguising income redistribution in the form of public health insurance is very likely to be inefficient as well as poorly targeted.

Secondly, as argued in greater detail below, those Australians with private health insurance (at least prior to the recent policy reforms) are on average less healthy and older than those who rely solely on the public health system. Redistributing income away from those with PHI is therefore tantamount to redistributing income away from older, sicker Australians in favour of the young and healthy.

Even if the older, sicker subscribers to PHI are wealthier on average than the younger and healthier users of the public health system, such a redistribution would still strike most people as regressive—health being at least as important as income in most people's minds as a determinant of overall well-being.

The aim of achieving socially desirable income redistribution through the taxation and social security systems should be kept quite separate from the aim of constructing a socially desirable health insurance system. They are two quite separate welfare issues.

3 The Fall and Rise of Private Health Insurance

Figure 1 shows clearly the trend decline in the take-up of PHI from the mid 1980s until late 1999. The trend decline was driven by:

- the impact of free universal health care available through Medicare (i.e., "free" public health insurance);
- regulations setting minimum benefit levels for private health funds and obliging them to cover good and bad health risks alike; and
- inevitable increases in PHI premiums as better health risks abandoned private insurance in favour of the public alternative.

Figure 1 also shows the trend increase in real public hospital expenditure that accompanied the decline in PHI. As people abandoned private health insurance, they fell back onto the public hospital system, increasing its cost to the public revenue.

Beginning in 1997, the Federal government introduced a series of reforms designed to reverse the decline in PHI and relieve the pressure on public hospital outlays. These included:

- an income tax surcharge of 1 per cent on high-income earners who do not have private health insurance—effective from July 1997;
- a non-means-tested 30 per cent rebate on private health insurance premiums—effective from January 1999; and
- a form of lifetime community rating—effective from July 2000—which imposes higher premiums on those who join a private health fund after the age of 30 (or, for those already over 30 years of age, who join after 30 June 2000).

The combined effect of these changes was to produce a dramatic reversal of the trend decline in PHI, beginning in late 1999. Since that time, the proportion of the Australian population covered by PHI has increased from 30 per cent to around 45 per cent. Much of the increase occurred around the implementation date for lifetime health cover (although Access Economics (2002) regards the general 'price' of PHI as the primary driver of the amount demanded). Frech et. al. (2003) attribute the response primarily to the second and third of the policy changes, noting that a high proportion of high-income earners already subscribed to PHI when the 1 per cent surcharge was introduced.

There is emerging evidence that the recent reforms have relieved pressure on the public hospital system. Outlays on public hospital

treatment have stabilised at around $14 billion per annum in real terms since the introduction of the reform initiatives. Had the trend rate of increase in public hospital outlays prior to that time continued, annual expenditure would today be in excess of $17 billion in real terms.

Public expenditure on hospitals is but a share of total health expenditure by the public sector but, given the nature of PHI in Australia, involves services most likely to be relieved by an increased take-up of private health insurance. While the 30 per cent rebate costs the Federal government around $2 billion per annum, had previous trends in public hospital outlays alone continued, the increase in that expenditure (around $3 billion in 2001-02) would easily have outweighed the annual cost of the rebate.

In addition, Access Economics (2002) report that:

- in the past five years, private hospitals have expanded their bed stock by 32 per cent;
- while, in 1995-96, private hospitals treated less than a third of all patients, this had risen to 38 per cent by 2000-2001;
- in 2000-2001, the absolute number of patients treated in public hospitals actually fell from the previous year—moreover, since 1995-96, the number has risen by only 8 per cent compared with a 44 per cent increase in private hospital separations; and
- employment in private hospitals has increased by 17 per cent in the last five years while public hospital employment has remained essentially static.

The increasing take-up of PHI since 1999 would appear to be changing the mix of hospital service provision between the private and public sectors.

3.1 Encouraging PHI Helps to Sustain Public Health

It is unsurprising that the trend decline in PHI was accompanied by a trend increase in public hospital outlays. 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 hospital treatment.

This is the reasoning behind the government's decision to support PHI. Even though it might be at some cost to the public revenue, so long as the cost incurred is outweighed by the value of the implicit

subsidy, the net impact is positive. It would cost the government more to allow PHI to dwindle than to continue to support it.

As PHI dwindles, more people access the public hospital system, raising its costs—had the government not intervened to support PHI, public hospital outlays would, arguably, now be $3 billion per annum higher in real terms. Even those who choose to pay directly for private hospital treatment (rather than take out PHI) potentially raise the cost to 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 hospital system.

This conclusion stands in contrast to those of other commentators who have argued that government support of PHI is uneconomic (Hurley et.al., 2002), ineffective (Vaithianathan, 2002) or misplaced entirely on the grounds that private insurance should be allowed to wither on the vine (Duckett and Jackson, 2000). Such views ignore the implicit subsidy to public hospital costs which arises from the willingness of PHI subscribers to pay twice to keep their options open in hospital care. The willingness of such people to cross-subsidise the public hospital system can only be ignored at the expense of higher costs and longer waiting times in Australia's public hospitals.

4 Achieving Community Rating

Everyone faces uncertainty regarding episodes of illness and how complete recovery from illness might be (Arrow, 1963). Related to these risks is uncertainty regarding the costs associated with treatment and recovery at the time illness occurs. Health insurance covers individual uncertainty regarding the costs of medical treatment rather than losses associated with poor health *per se*. As uncertainty regarding health care expenditures (both over time and at any given point in time) is not perfectly correlated amongst individuals, there is a gain to risk-sharing via insurance. Ultimately, insurance involves those individuals with a greater incidence of illness (high medical expenditures) being compensated by those with lower incidence.

4.1 The Social Value of Insurance

There is a social value to the provision of insurance. The optimal allocation of risk-bearing in society will involve some mechanism by which risks are pooled. At issue, however, is whether a market system on its own could achieve that optimum.

Owing to the presence of both adverse selection and moral hazard, economists since Arrow (1963) have believed that a market system left to its own devices will not provide an optimal degree of health insurance. This is because the very imposition of insurance either changes individual behaviour (increasing health care costs) or leads to 'sorting' effects which mean that insurance premiums do not reflect fair actuarial values.

The inefficiency of a pure market-based means of providing health insurance has motivated government intervention in this area. Intervention has taken various forms—from regulation of the operation of private health insurers to public provision of insurance. While, in principle, the latter can merely be a government-owned insurance provider, it also can involve government guarantees of health care payments or government provision of health care itself. Whether health care is provided directly by government is not at issue when it comes to health insurance and achieving universal community rating. That is a question of the net benefits of public versus private ownership and, as such, is a separate public policy issue.[6]

[6] See King and Pitchford (1998) for a discussion of privatisation issues.

4.2 Supporting PHI Enhances Community Rating

There is evidence that the gradual decline in the proportion of the population with PHI has produced an 'adverse selection spiral' in the pool of privately insured health risks. Barrett and Conlon (2002) remark that:

> "… there is unequivocal evidence that over the 1989-95 period those individuals and families who represented better insurance risks (from the point of view of the insurers) … were most likely to quit the pool of the insured" (p.17).

As this has occurred, the health profile of the privately insured has steadily become less robust. This is mainly reflected in the higher average age of the privately insured. In other words, it has been the young and the healthy who have opted out of PHI and chosen instead to access the public system or to 'self-insure', i.e., take the chance that they will need treatment and pay for it directly through the private system should the need arise.

With a deteriorating health profile of the privately insured, the subsidy to the health care system implicit in PHI takes on an additional flavour. Those taking out PHI and subsidising the public system (if they use private facilities for treatment) or the PHI premiums (if they use public facilities for treatment) are increasingly the older and less healthy members of the community. This flies directly in the face of the principle of community rating, one of the benchmark goals of Australia's mixed health care system.

Community rating requires that the healthy subsidise the sick, not the other way around. The gradual decline of PHI reversed the principle so that, increasingly, the older and sicker subscribers to PHI contributed additional resources to the health system with the result that younger and healthier Australians could access free public health care more easily.

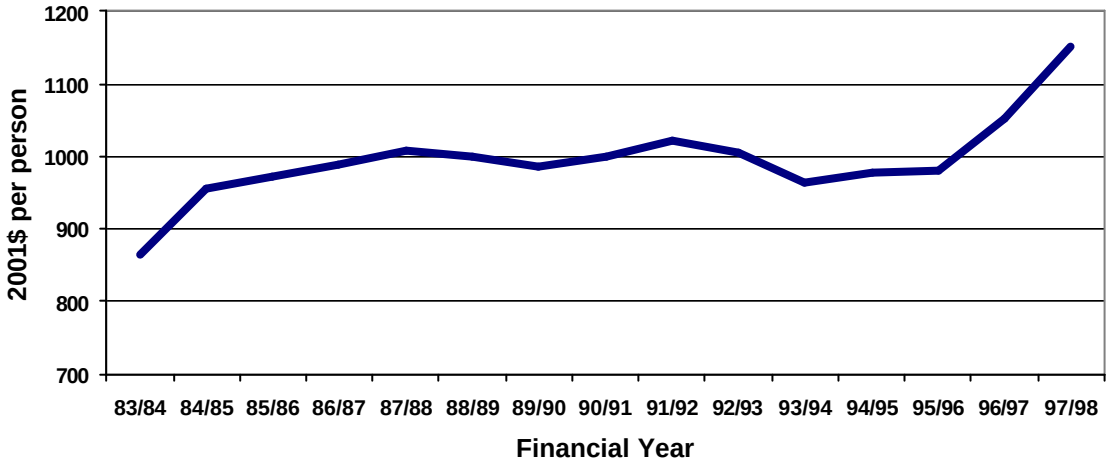
It is possible to estimate the extent of cross-subsidy by measuring the contribution of privately insured individuals to the costs of running the public hospital system. **Figure 2** plots the average contribution in real terms from privately insured individuals to the public hospital system from 1983-84 to 1997-98.[7] This number is calculated by

[7] Sources: Australian Institute of Health and Welfare, Commonwealth Department of Health, PHIAC, ABS. Public hospital outlays include all expenditures by Federal, State and Local governments on services in non-psychiatric public hospitals.

dividing total public outlays on public hospitals by the number of taxpayers (since PHI subscribers, as taxpayers, bear an equal share with other taxpayers of the costs of running the public hospitals).

The calculation *overestimates* the cross-subsidy to the extent that PHI subscribers access public hospital treatment without disclosing their PHI status. On the other hand, the calculation *underestimates* the cross-subsidy to the extent that PHI subscribers are in the higher income tax brackets and accordingly contribute disproportionately to public revenue. The calculation also ignores those who self-insure, i.e., who pay directly for private hospital treatment on an 'as needs' basis.[8] They also cross-subsidise the public hospital system by paying taxes and not using public hospitals.

Figure 2: Privately Insured Contributions to Public Hospital Expenditure (1983/84 to 1997/98)



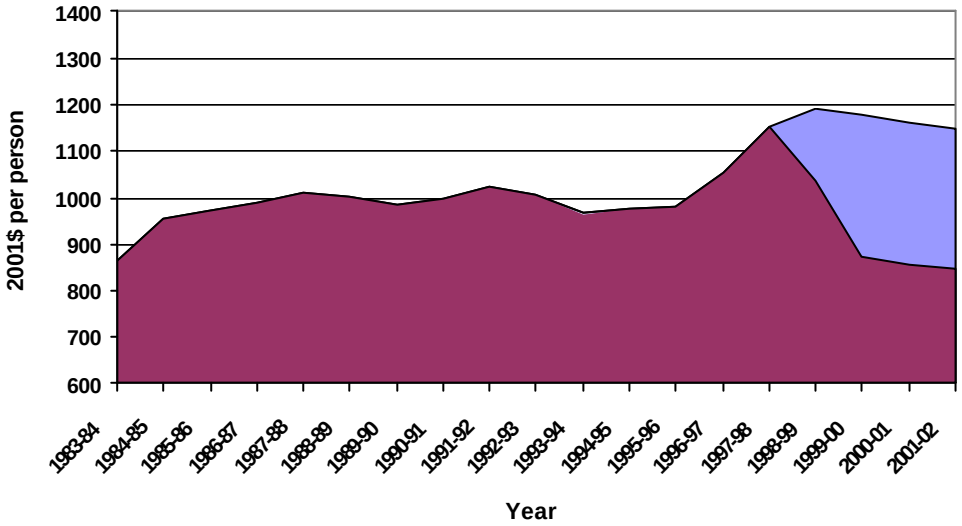
The chart shows the cross-subsidy steadily increasing over the years from the mid 1980s, reaching $1,150 per privately insured taxpayer (in constant 2001 dollars) by 1997-98, when the first of the government's policy initiatives came into force. The faster rate of increase since 1995-96 reflects the continuing fall in numbers of people taking out PHI against the faster growth of public hospital costs.

[8] Data on numbers of such persons are not available. However, according to the Industry Commission (1997), nine per cent of private hospital admissions are self-pay.

Support for PHI in the three forms introduced by the Federal government has helped to shore up the principle of community rating by encouraging more people to take up PHI. As more of the young and healthy return to the pool of privately insured risks, the implicit subsidy from PHI users to the system at large looks less like a subsidy from the sick to the healthy and the cross-subsidy itself is smaller, bringing the system more into line with community rating. The health status of the privately insured as a group improves relative to those in the public system, and there are more young and healthy members of the PHI pool, enabling older and sicker members to pay lower premiums for PHI.

In addition, the younger, healthier subscribers to PHI begin to cross-subsidise the public system (albeit at lower levels that before the 30 per cent rebate). Their taxes pay for hospital treatment for the old and sick in the public system; their premiums pay for hospital treatment for the old and sick in the private system; and they, being young and healthy, tend to use neither. On all counts, the principle of community rating is well served.

Figure 3: Public Contribution by Privately Insured Individuals (1983/84 to 2001/02)



The effect of recent policy initiatives on the extent of cross-subsidy between PHI subscribers and the public hospital system is illustrated in **Figure 3**. The chart shows the value of the cross-subsidy in the absence of the policy initiatives implemented since 1997 as the upper of the two lines diverging post-1997-98. Note that the cross-subsidy levels off, reflecting the levelling off of public hospital costs over this period as well as the higher numbers of PHI subscribers.

Including the impact of the 30 per cent rebate reduces the per capita cross-subsidy to the lower of the two lines—the reduction is shown as the blue-shaded area.

Three points should be noted:

- without the 30 per cent PHI rebate, the cross-subsidy would still have been around $1,150 in 2001-02, having peaked at $1,190 per privately insured taxpayer in 1998-99—notwithstanding the infusion of younger and healthier subscribers to PHI since 1999, a cross-subsidy at this level would have continued the transfer from those already in private health funds (who were predominantly older and less healthy) to the public hospital system, continuing to compromise community rating across Australia's mixed system;
- with the 30 per cent rebate in place, the per capita cross-subsidy fell to around $850 in 2001-02, similar to its level in 1983-84—at this level, there is some chance that the proportion of the population with PHI cover will remain at current levels, which are also similar to those last experienced in the mid 1980s; and
- the combination of more younger and healthier people taking out PHI and the lower per capita cross-subsidy from private insured taxpayers to the public hospital system has brought the whole system closer to the ideal of community rating—in which the well cross-subsidise the sick, not the other way around.

5 Conclusion

Recent debate over policy initiatives designed to encourage the use of private health insurance (PHI) has focused on the effects of reform on public health care outlays. On the one hand, supporters of the recent initiatives (especially the 30 per cent rebate on private health insurance premiums) point to the increased use of private alternatives to public hospital care. Opponents claim that this substitution is socially wasteful, as public provision is more efficient than private provision of hospital care.

This report focuses instead on the implicit cross-subsidy between subscribers to PHI and the public hospital system. The fact that some people are willing to pay twice for hospital treatment—once through their income taxes and once again through PHI premiums—provides additional resources to Australia's mixed public and private hospital system. If private health insurance were to disappear, 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.

The willingness of PHI subscribers to cross-subsidise public health helps to keep the cost of the public hospital system within manageable limits. For this reason, the government has instituted three policy changes designed to preserve PHI and the cross-subsidy it offers. 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.

Another way to think about this conclusion is to note that it is worth the government paying anything up to $4.3 billion per annum into the private health system in order to keep it going. The 30 per cent PHI rebate cost the government $2.1 billion in 2000-01.

More importantly, the report considers the impact of the rebate on the provision of *genuine* health insurance in the Australian 'mixed' system of public and private hospital care. In a properly functioning system of health

insurance, those with good health cross-subsidise those with poor health. The report demonstrates how the 30 per cent PHI rebate moves the Australian system closer to this goal by mitigating an existing tendency to produce precisely the opposite outcome.

Prior to recent reforms, those with private health insurance (increasingly older and less healthy members of the community) cross-subsidised those without insurance (predominantly younger and healthier people) at the rate of about $1,150 per privately insured taxpayer per annum. Today that rate is about $850 per privately insured taxpayer per annum, closer to levels of 20 years ago when PHI membership was nearer 50 per cent of the Australian population.

The lower 'tax' on private insurance has also induced more people to take out PHI cover (infusing younger and healthier risks into the privately insured pool), as has the encouragement provided by lifetime health cover. Taken together, recent reforms to PHI have helped to redress the topsy-turvy nature of the Australian health insurance system—bringing it more into line with the principle of community rating—by making it more likely that the healthy compensate the sick, rather than the other way around.

6 References

Access Economics (2002) *Striking a balance: choice, access and affordability in Australian Health Care*, October, Canberra.

Arrow, K.J. (1963), "Uncertainty and the Welfare Economics of Health Care," *American Economic Review*, 53, 941-973.

Barrett, G. and R. Conlon (2002), "Adverse Selection and the Decline in Private Health Insurance Coverage in Australia: 1989-1995," *mimeo.*, UNSW.

Cutler, D.M. (2002), "Equality, Efficiency, and Market Fundamentals: The Dynamics of International Medical-Care Reform," *Journal of Economic Literature*, 60, 881-906.

Duckett, S. and T. Jackson (2000), "The New Health Insurance Rebate: An Inefficient Way of Assisting Public Hospitals," *Medical Journal of Australia*, 72, 439-442.

Frech III, H.E., S. Hopkins and G. Macdonald (2003), "The Australian Private Health Insurance Boom: Was It Subsidies or Liberalised Regulation?", *Economic Papers*, 22, 58-64.

Gans, J.S. and S.P. King (2003), "Anti-insurance: Analysing the Health Insurance System in Australia," *mimeo.*, Melbourne Business School (available at www.core-research.com.au).

Hurley, J., R. Vaithianathan, T.F. Crossley and D. Cobb-Clark (2002), "Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada," *Discussion Paper*, No.48, CEPR/ANU.

Industry Commission (1997), *Private Health Insurance*, Report No.57, Canberra: AGPS.

King, S.P. and R. Pitchford (1998), "Privatization in Australia: understanding the incentives in public and private firms," *Australian Economic Review*, 31, 313-328

Vaithianathan, R. (2002), "Will Subsidising Private Health Insurance Help the Public System?" *Economic Record*, 78 (242), 277-283.