Preserving Choice: A Defence of Public Support for Private Health Care Funding in Australia[1]

April 2003

Executive Summary

The Howard Government has recently introduced three reforms to private health insurance (PHI) with the aim of increasing the demand for private health insurance cover:

- 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
- lifetime health cover.

Those Australians who take up private health insurance or who pay directly for private hospital treatment pay *twice* for health care. They contribute through income taxes to the cost of the public health system as well as paying separately 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.

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.

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[1] The involvement of Joshua Gans and Stephen King of CoRE Research Pty Ltd in developing the arguments in this report is gratefully acknowledged. The report was commissioned by Medibank Private Limited—however, the ideas and views expressed are those of the author and should not be attributed to Medibank Private Limited, its shareholder or employees.

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.

This is the reasoning behind the Government's decision to support private health insurance.

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 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.

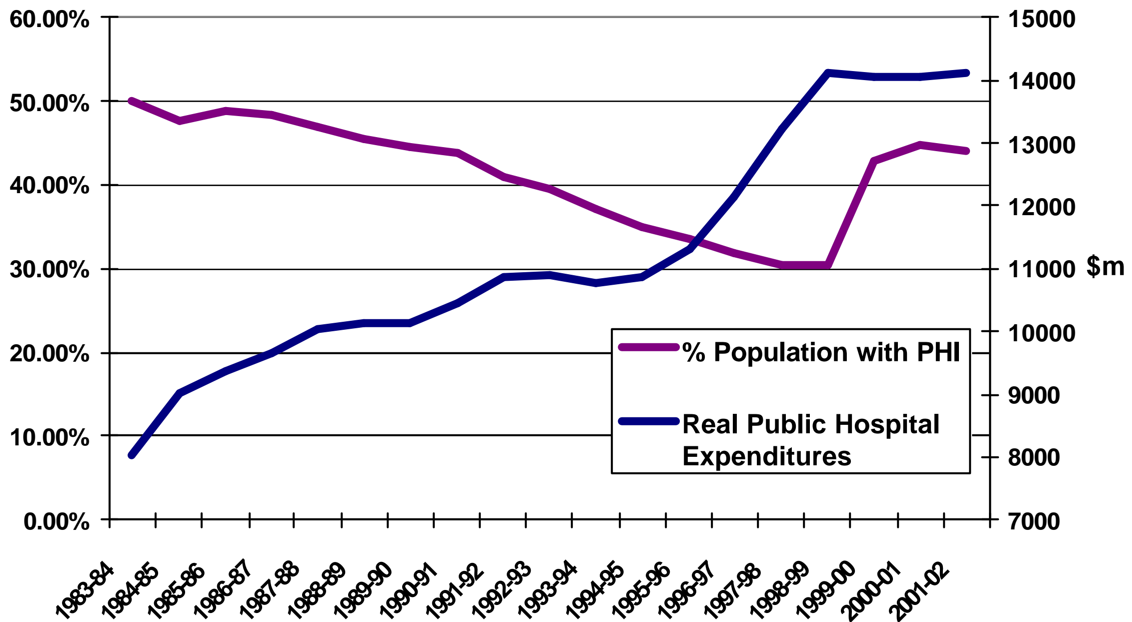
For instance, in 2000-01 alone, private hospitals in Australia performed procedures which it would have cost the public hospital system around $4.3 billion to perform.

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. 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.

Figure 1[2]

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



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.

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. 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'.

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 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 Howard Government has helped to shore up the principle of community rating by encouraging more people to take up PHI.

In a properly functioning health insurance system, those with good health cross-subsidise those with poor health.

Prior to the 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 (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.

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