

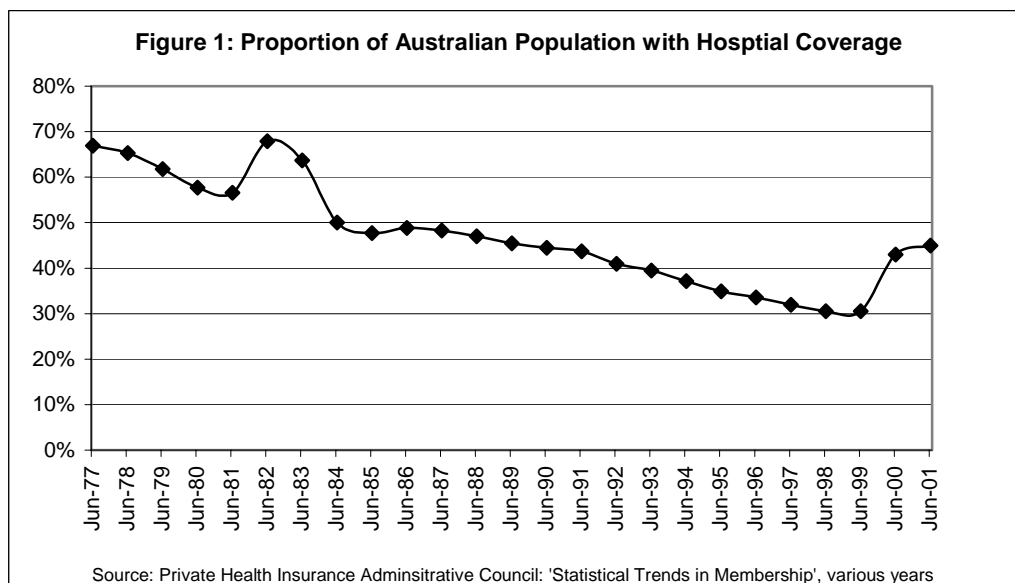
The 30% Rebate for Private Health Insurance: A Critical Review

Greg Ford

On 26 February 2002, the Commonwealth government announced private health insurance premiums would rise by an average of 6.9%, taking effect from 1 April 2002. While the rise in premiums is an increased burden for singles, couples and families with private health insurance, it is also an additional cost to the taxpayer via the government's 30% Rebate. With the cost of the 30% Rebate estimated to be \$2 billion per year, the 6.9% rise in premiums will add an additional \$150 million per annum to this figure. Despite its cost, the effectiveness of the 30% Rebate – as a measure to encourage the uptake of private health insurance – is questionable. By reviewing recent policy changes to encourage private health insurance this article highlights its shortcomings.

Over the past 20 years the proportion of the Australian population with private health insurance has fallen dramatically, as indicated by Figure 1. Peaking at 67.9% in June 1982 the numbers with private insurance reached an all-time low of 30.1% in December 1998 (Private Health Insurance Administration Council, 2002a).

While the cost of private health insurance premiums has increased over this 20 year period, the most plausible explanation for the decline in those with private health insurance is the success of Medicare, introduced in February 1984. As Health Issues Centre (1993, p. 1) has previously argued the decline in private health insurance "... reflects a rational choice by Australian consumers reflecting confidence in the publicly funded Medicare program".



Policy Initiatives to Encourage Private Health Coverage

From the time of assuming office in 1996, the Howard government has actively promoted the uptake of private health insurance by providing taxpayer subsidies for those with private health insurance and penalties for those who do not take out insurance. Since 1997, the Private Health Insurance Incentives Scheme (PHIIS), the 30% Rebate and Lifetime Health Cover have been three key measures introduced by the government to stem the decline in the numbers with private health insurance.

1. Private Health Insurance Incentives Scheme (PHIIS)

The first and most shorted-lived of these measures was the PHIIS, introduced in July 1997. In summary, the PHIIS sought to encourage more people to take out private health insurance by providing a subsidy to low-income earners who did, and a tax penalty to high-income earners who did not. Middle-income earners were not the target of this policy and as such they were neither eligible for the tax subsidy nor liable to incur a tax penalty regardless of their private health insurance status (Butler, 2000, p. 2).

2. The 30% Rebate

The second measure – and the focus of this article – was the introduction of a 30% Rebate for private health insurance in January 1999, an amendment to the PHIIS (Butler, 2001, p. 2). The 30% Rebate is essentially a taxpayer-funded subsidy for any individual or family with private health insurance. The 30% Rebate means that singles, couples and families who spend \$1000 on private health insurance will receive \$300 from the Commonwealth government. The rebate can be claimed via a reduced health insurance premium, through direct payments from Medicare or through a tax rebate (Commonwealth Department of Health and Ageing, 2002).

Unlike the PHIIS, individuals and families do not have to satisfy an income test to be eligible for the 30% Rebate. In other words, a person with an income of \$20,000 and a person with an income of \$200,000 are both eligible to receive the 30% Rebate. Despite this, high-income earners who do not take out private health insurance, or who take out private health insurance with high front-end deductibles, incur a 1% Medicare Levy Surcharge, introduced in July 1997. This is in addition to the 1.5% Medicare Levy for high-income earners (Private Health Insurance Administration Council, 2002b).

The cost of the 30% Rebate is substantial and growing. As a subsidy to the private health insurance industry, Duckett and Jackson (2000) argue the cost of the 30% Rebate is larger than the combined budgetary assistance to the mining, manufacturing and primary agricultural production industries. Budget figures estimate the 30% Rebate will cost \$1.93 billion in 2001-02 (Commonwealth Department of Health and Aged Care, 2001). This figure was calculated before the recent rise for private health insurance was announced, which is expected to cost \$150 million per year.

Demand for Public Hospitals

One argument used by the Commonwealth government to justify the cost of the 30% Rebate was it would bring a balance to the health system by reducing demand on public health system (Commonwealth Department of Health and Ageing, 2002). This is despite a 1997 Productivity Commission inquiry that advised the 30% Rebate “is unlikely to cost-effectively relieve pressure on the public [health] system” (Moynihan, 2002, p. 76).

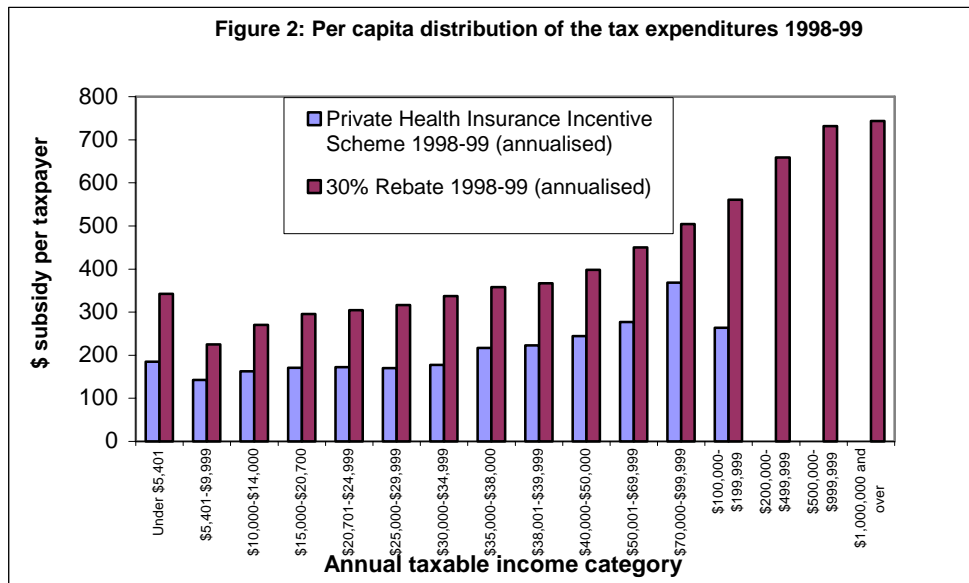
The pressure on the public system has continued to grow since the introduction of the 30% Rebate. Figures published in Victoria for example, show an increase of 23% in the number of patients admitted to the major metropolitan public hospitals during the period from March 1999 (two months after the introduction of the 30% Rebate) to September 2001 (Department of Human Services, 1999 and 2001).

Redistributing government subsidies from the private system to the public hospital system would have a dramatic impact on the capacity of public hospitals to manage demand. Duckett and Jackson (2000) estimate that if all government subsidies to the private health sector were withdrawn, \$3.4 billion per year could be redirected into the public system by 2002-03. (This figure includes the 30% Rebate estimated by Duckett and Jackson to cost \$1.5 billion per year in 2000), the Medicare benefit payment for private in hospital medical services totaling \$1.2 billion per year and the rebate for ancillary services costing \$0.7 billion per year). Using 2002-03 Victorian casemix figures,

Duckett and Jackson also estimate this is the equivalent of an additional \$1.5 million cases that could be treated in Australian public hospitals.

How is the 30% Rebate Distributed?

The 30% Rebate is not only a costly subsidy, but as some research suggests, favours high-income earners compared to low-income earners. A recent study by the Australia Institute (see Figure 2) examining the distribution of tax subsidies for health in Australia indicates the 30% Rebate, when compared to the Private Health Insurance Incentives Scheme (PHIS), has dramatically shifted tax subsidies for private health insurance in favour of high-income earners (Smith, 2001).



Source: Smith, J. (2001) p.17.

The distribution of the 30% Rebate in favour of high-income earners at the expense of low-income earners is further illustrated when we consider the example of dental care. For low-income earners, the axing of the Commonwealth Government Dental Health Program in 1996 withdrew the Commonwealth’s support to the provision of dental care to health care card holders. Despite ‘savings’ of \$100 million per year to the government, the withdrawal of this program has resulted in increased waiting lists, the introduction of co-payments and poorer oral health for low-income earners (Ziguras & Moore, 2001).

By comparison, the introduction of the 30% Rebate has resulted in the Commonwealth Government subsidising between \$316-\$345 million per year in dental rebates to those with private health insurance (Spencer, 2001, p. 39).

3. Lifetime Health Cover

The third measure introduced by the Commonwealth Government to increase the proportion of the population with private health insurance was the introduction of Lifetime Health Cover in July 2000. Lifetime Health ‘encourages’ people to take out private health insurance before they turn 30 and maintain their membership throughout their life. To be eligible for Lifetime Health Cover, people aged 30 and over were required to join a private health fund by the cut-off date on 15 July 2000 (Commonwealth Department of Health and Ageing, 2002).

Information about Lifetime Health Cover on the Commonwealth Department of Health and Ageing’s website argues:

“Lifetime Health Cover recognises the length of time that a person has had private health insurance and rewards that loyalty by offering lower premiums. People who take out

hospital cover early in life will be charged lower premiums throughout their life, relative to people who take out cover later. People who delay taking out hospital cover will pay a 2% loading on top of their premium for every year they are aged over 30 when they first take out hospital cover. For example, a person who delays joining until the age of 40 will pay 20% more than someone who joined at the age of 30" (Commonwealth Department of Health and Ageing, 2002).

Unlike the 30% Rebate, Lifetime Health Cover has succeeded in achieving the government's objectives of increasing the proportion of the population with private health insurance without incurring any direct cost to the government (Butler, 2001).

The impact of Lifetime Health Cover compared to the 30% Rebate is clearly illustrated in Table 1. In December 1998, one month before the introduction of the 30% Rebate, only 30.1% of the population were privately insured. By September 1999, this figure had risen to only 31% of the population (Private Health Insurance Administration Council, 2002a).

By comparison, the impact of Lifetime Health Cover, announced on 29 September 1999, was dramatic. By June 2000, 15 days before the cut-off for Lifetime Health Cover expired, 43% of the population had taken out private health insurance. (Private Health Insurance Administration Council, 2002a). The demand for Lifetime Health Cover was so strong that the cut-off date, originally set at 1 July 2000, was extended to 15 July 2000 due to extensive waiting times people experienced in lodging their claims (Butler, 2001, p. 5).

Table 1: Private Health Insurance: Key Dates Over the Past 20 Years

Date	Proportion of population with private health insurance
<p>June 1982</p> <p>The highest proportion of the Australian population with private health insurance over the past 20 years</p>	67.9%
<p>December 1983</p> <p>Two months before the introduction of Medicare (introduced from 1 February 1984)</p>	61.5%
<p>March 1984</p> <p>One month after the introduction of Medicare</p>	54.3%
<p>June 1997</p> <p>Introduction of Private Health Insurance Incentives Scheme (PHIIS) in July 1997</p>	31.9%
<p>December 1998</p> <p>The lowest proportion of the Australian population with private health insurance over the past 20 years – one month before the introduction of the 30% Rebate for private health insurance (introduced on 1 January 1999)</p>	30.1%
<p>September 1999</p> <p>Lifetime Health Cover announced on 29 September 1999</p>	31%
<p>June 2000</p> <p>15 days before the cut-off date for Lifetime Health Cover</p>	43.0%
<p>June 2001</p> <p>The first year of Lifetime Health Cover</p>	44.9%

Source: Private Health Insurance Administration Council – Membership and Coverage, various years

Conclusion

Since 1997, the Commonwealth government has introduced a range of measures to increase the proportion of the population with private health insurance. As research presented in this article has shown, the impact of the \$2 billion, 30% Rebate in achieving this aim is questionable when compared to the impact of Lifetime Health Cover.

At a time when the government is facing pressure to maintain its budget surplus, the cost of the 30% Rebate continues to rise. Organisations such as Health Issues Centre are concerned that this cost will place pressure on other publicly funded health care

initiatives. For this reason a coalition of groups called the *National Medicare Alliance* (including Health Issues Centre, the Public Health Association of Australia, ACOSS, the Doctors Reform Society, Australian Consumers' Association and the Australian Nursing Federation) have called for a public review of the 30% Rebate. A Senate or Productivity Commission inquiry should be convened to clearly establish where the 30% Rebate is being spent and to determine whether this is the fairest and most effective expenditure of public funds.

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