

# **How fair is health spending?**

**The distribution of tax subsidies  
for health in Australia**

Julie Smith

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## Executive Summary

Private health insurance incentives will cost Australian taxpayers \$3 billion a year in less than eighteen months if the Federal Government's 30 per cent rebate for private health insurance rises at the rate presently forecast by the Treasury.

While the costs of the new concessions for private health insurance have escalated, the rebate has failed spectacularly to reduce public sector health spending or increase membership of private health funds. It has also contributed to a burgeoning Commonwealth Government health care bill exceeding 48 per cent of Australia's health care costs.

In addition the private health insurance concessions strongly favour wealthy households. Previous analysis by The Australia Institute exposed the inequity of the superseded income-tested incentive scheme. Using new Taxation Office data on the 30 per cent rebate scheme, this study shows a substantial worsening of the inequity. The latest data shows that approximately half of the present open-ended subsidy for private health insurance goes to the top 20 per cent of taxpayers and nearly three-quarters goes to the top 40 per cent.

The rising Commonwealth share of health costs and declining role of private health funds have been at the centre of health financing policy debate in recent years. Seeking to encourage greater private provision for health, the Howard Government introduced the 30 per cent rebate for the costs of private health insurance in 1999. This replaced the failed income-tested incentive for private health insurance introduced from June 1997.

The 30 per cent rebate has proved very expensive. The cost to the budget of private health insurance was around \$1.6 billion in 1999-2000, and will increase further following the large jump in health insurance coverage from mid-2000. The sharp increase in coverage was not due to cash incentives for fund membership. The increase resulted from deregulation of health funds and the introduction of life-time health cover rules.

### Equity effects

This paper shows that instead of encouraging private provision, concessions for private health insurance have been a financial windfall for wealthy households. Since the 1960s, the benefits of tax concessions for private health insurance have been enjoyed disproportionately by the wealthiest households. This regressive pattern was interrupted by the replacement of tax deductions with rebates from the 1970s. The introduction of the 30 per cent rebate in 1999 reversed the improvements in equity in the previous two and a half decades. Current tax relief for private health insurance provides an annual per capita payment of around \$744 for taxpayers earning \$1,000,000 per annum in 1998-99. This is about twice the \$388 received by the average taxpayer.

The 30 per cent rebate for private health insurance is even more concentrated in the wealthiest households than tax deductions were in previous decades. Half the revenue forgone by the concession accrues to those in the top 20 per cent of taxpayers, compared to 26 per cent under the previous means-tested scheme.

The Commonwealth Government's subsidy of private health insurance means that Australian taxpayers have indirectly paid for around \$360 million of private dental care, and around \$430 million of private health fund administration costs during the period June 1997-June 2000.

Some affluent Australians may believe they are improving the fairness of the system and helping Medicare by taking out private insurance, but the extent of the public subsidy and its unequal distribution exposed in this study means they are being misled.

### **Public health cutbacks**

The cost of providing subsidies for private health insurance is placing pressures on the Commonwealth health budget and draining funds from public hospitals and other public health priorities.

While public sector cutbacks over the last decade have resulted in queues in public hospitals and the axing of public dental care services, the Federal Government now provides a large public subsidy through the private health insurance rebate for high-income earners to jump hospital queues, obtain cosmetic surgery and dental care, and pay for their gym club membership.

As financial incentives for private insurance now account for around 7 per cent of Commonwealth health funding, and are growing rapidly, subsidies for private insurance must be at the expense of additional funding for Medicare. Each year, the private health insurance rebate alone is drawing around \$2 billion of government funding away from public health care provision.

Current health policy directs an increasing portion of scarce Commonwealth health funds towards the top end of the income stream regardless of demonstrated health needs and public health priorities. While more than half of the current tax rebate for private health insurance goes to the wealthiest 20 per cent of households, the number of public hospital beds has declined by 3 per cent a year since 1996-97.

Present deregulatory trends point to an emerging policy of allowing private health insurance funds to cream off the most profitable part of the Australia's health insurance market, while leaving an underfunded public hospital system to provide care for the bulk of those with urgent or chronic health care needs.

### **Reforms needed**

The existing cash incentives and tax rebates for private health insurance are in urgent need of reform so that they are less costly, less inequitable, and more likely to substitute for public funding of hospital care. Likewise, the existing tax rebate for net medical expenses should be revamped to provide more equitable access for lower income groups, while limiting its costs to the public purse. These necessary reforms include:

removing health insurance cover for ancillaries from the 30 per cent health insurance rebate so that the Commonwealth contributes less to the elective health care expenditures of the well-off;

replacing the present open-ended rebate for private health insurance with a fixed rebate to limit the extent of subsidy and make the subsidy fairer; and

making payments under the 30 per cent rebate for private health insurance taxable, to make it more equitable and bring it into line with other government cash payments and transfers that are taxable (like social security benefits).



## 1. Introduction

Since 1997-98, there has been rapid growth in the magnitude of health related tax expenditures, with the introduction of first the income tested rebate for private health insurance (referred to as the Private Health Insurance Incentive Scheme or PHIIS), and in January 1999, the 30 per cent rebate for private health fund insurance. Budget incentives for private health insurance cost around \$1.6 billion in 1999-00, and will increase further following the large jump in health insurance coverage from June/July 2000.

The total budgetary cost of tax rebates and cash payments for private health insurance and net medical expenses may exceed \$3 billion p.a. within 18 months if direct payments for the 30 per cent rebate rise at the rate forecast by Treasury for the tax expenditure component.

The cost-effectiveness and efficiency aspects of recent policy changes are examined in Butler (2001). The question asked by this paper is how policy changes have altered the equity effects of the main tax subsidies for health related expenditures including in particular the 30 per cent rebate for private health insurance.

There was a substantial rise in private health fund membership in mid 2000 (Figure 1). Much of the increase, occurring in June-July of that year, was associated with the introduction of the lifetime rating scheme between September 1999 and June 2000 (Butler 2001). The full-year effects of this membership rise is not yet reflected in the most recent health financing data from the Australian Institute of Health and Welfare (AIHW) or from annual taxation statistics.

Tax statistics have limitations in measuring the distributional impact of the recent PHIIS and 30 per cent rebate. Comprehensive analysis of the 30 per cent rebate awaits detailed data from the five-yearly Household Expenditure Survey by the Australian Bureau of Statistics, which is not due for publication until 2004.

Nevertheless, public finance experts consider that subsidies provided indirectly through tax concessions should be scrutinized in the same way as direct spending programs are for their effectiveness, efficiency and distributional effects (Surrey and McDaniel 1985). Tax expenditure analysis is important in its own right to ensure proper evaluation of public spending policies. The latest available taxation statistics also permit analysis of the likely distributional effects of the 30 per cent rebate. This was in operation for the second half of the 1998-99 income year, and can be compared directly with the means-tested PHIIS available in the first half of the income year. There is currently no other official data on the income distribution effects of this health care financing policy tool.

The distribution of the tax subsidy for net medical expenses is also of interest in its own right and may in addition provide some useful information on trends and patterns of individuals' self-funding of 'out of pocket' health expenses.

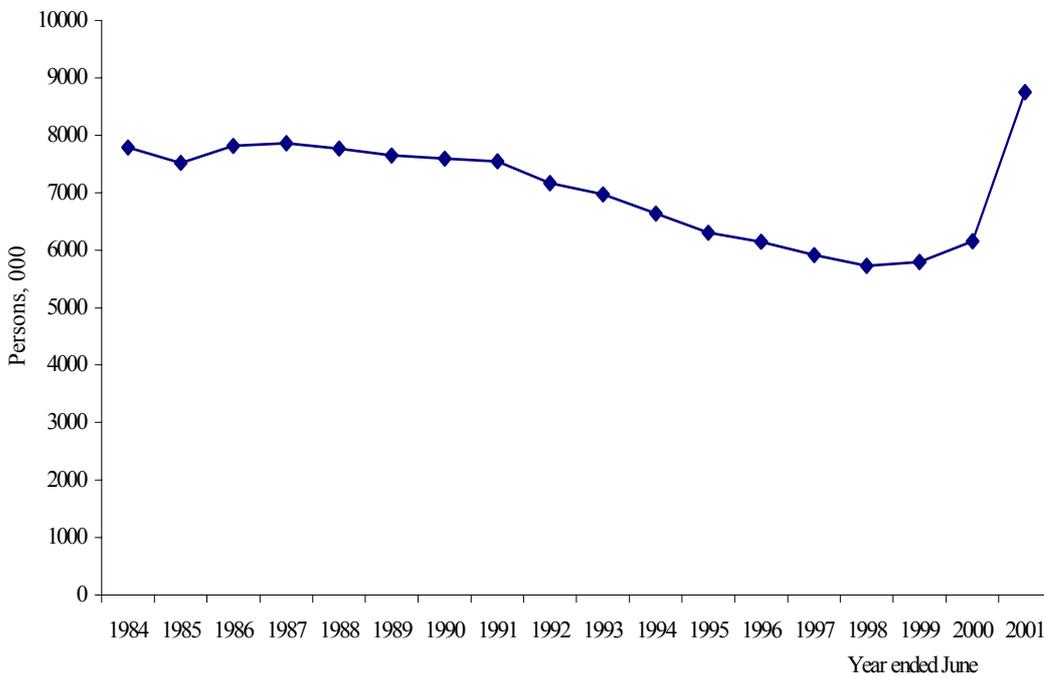
This paper uses tax statistics to analyse the distributional implications of tax expenditures for net medical expenses and private health fund contributions for selected years since 1962-63, and to assess the likely implications of the health financing policy changes since 1997.

The next part of the paper briefly reviews the concept of tax expenditures, and some issues regarding tax expenditure estimates. Section 3 examines long-term trends in tax expenditures in Australia, while Section 4 looks at trends in sources of funding for health services.

Section 5 presents estimates of the income distribution of tax concessions for health related private spending including for private health insurance for selected years since 1962-63. They are based on estimates of aggregate tax expenditures by Butler and Smith (1992) updated to 1998-99 from official taxation statistics.

The results are discussed and some conclusions drawn in Sections 6 and 7.

**Figure 1 Private health insurance coverage 1984 to 2001**



Source: PHIAC (2001)

## 2. What is a ‘tax expenditure’?

### 2.1. Purpose and definitions

Tax expenditure reporting began in the late 1960s and was adopted in most industrialized countries during the 1980s (OECD 1996). A tax expenditure is a departure from the generally accepted tax structure, which produces a favourable treatment of particular types of activities or taxpayers (OECD 1984). In Australia, a tax expenditure is defined as ‘relief’s or concessions in the tax system (not being a basic component of the taxation structure) which reduce tax liabilities and have effect (*sic*) on the Government’s budget similar to direct expenditures’ (Commonwealth of Australia 1985, p. xiii).

Tax expenditure estimates shed light on public policy because subsidies provided through tax concessions (such as for health insurance contributions and private medical expenditures) substitute for direct budget expenditures. U.S. pioneers of tax expenditures reporting Surrey and McDaniel argue that:

A tax expenditure is a spending program and must therefore be analysed in spending terms (Surrey and McDaniel, 1985, p.81).

Unlike direct subsidies, tax expenditures have traditionally been subject to little scrutiny. As the OECD (1996) recently pointed out:

The concept of a tax expenditure was developed because accounting for the costs and benefits of tax measures is often less rigorous than for direct expenditures, despite the fact that a tax system can be used to achieve similar goals as those of public spending programmes. As governments increasingly broaden tax bases and lower tax rates, tax expenditure accounts have become an important tool in analysing tax reform.

The Commonwealth *Charter of Budget Honesty Act 1998* now requires publication of detailed information on Commonwealth tax expenditures. According to Treasury (2001), the primary purpose of the Tax Expenditures Statement (TES) is ‘to provide estimates of the value of concessions received by individuals and businesses as a result of tax expenditures’, thereby permitting review and scrutiny as to ‘whether objectives are met at reasonable cost’ comparable with that for direct expenditures. The estimates are also to:

- provide a more comprehensive assessment of Commonwealth government activity than direct expenditures; and
- allow comparison of assistance provided by the Commonwealth government to different sectors.

Tax expenditure estimates are also of interest because the pattern of distribution of tax expenditures may be markedly different from that of direct expenditures (Surrey and McDaniel 1985).

## 2.2. Conceptual and measurement issues

A number of conceptual issues arise from the problem of identifying what is a tax expenditure as distinct from a part of the benchmark tax structure. The norm, or benchmark, may differ between countries and over time. The benchmark adopted by the Commonwealth Treasury for estimating Australia income tax expenditures is discussed in detail in Appendix A to its annual Tax Expenditure Statements (Treasury 1999). There are also different approaches to measuring tax expenditures:

- the ‘revenue gain’;
- the ‘outlay-equivalent’; or
- the ‘revenue-forgone’ approach.<sup>1</sup>

These different approaches reflect different assumptions about taxpayer behaviour and the scope of the estimates, rather than differences in the underlying concept being measured. Most studies of tax expenditures in Australia use the ‘revenue forgone’ approach. For example, this is the approach taken in the historical series produced by Butler and Smith (Butler and Smith 1992) and is used for the Commonwealth Treasury’s Tax Expenditures Statement (Treasury 1999).<sup>2</sup>

Such estimates gauge the magnitude of tax expenditures arising from a particular tax concession by reference only to the market for the particular commodity or activity in isolation. That is, they use what economists call a ‘partial equilibrium’ framework, which assumes a zero ‘cross price elasticity of demand’ between a commodity such as private health insurance and any other commodity (such as net medical expenses). It also ignores any product/factor market interactions or macroeconomic implications.

The implications are that each tax expenditure item should be examined separately, unless these interactions can be measured and accounted for. Complex secondary price and resource allocative effects may influence the revenue cost of a tax expenditure, and interpretation of individual tax expenditure estimates should allow for significant complementarities or substitution effects with other tax privileged items.

A further issue of relevance here is that under a progressive tax structure, the elimination of a tax deduction may decrease an individual’s taxable income sufficiently to move them into the next tax bracket. This results in underestimating the increase in revenue from eliminating a tax preference. Estimates of the distribution of tax expenditures may thus understate the extent to which tax expenditures are concentrated on higher income taxpayers.

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<sup>1</sup> The main issues arising in estimating tax expenditures are discussed more fully in Butler and Smith (1992).

<sup>2</sup> It is nonetheless worth noting that the latest TES moves towards an ‘outlay equivalent’ basis by including as a tax expenditure the foregone revenue on account of exempting the 30 per cent rebate for private health insurance from income tax.

A key issue in analysing the distribution of taxes and subsidies is how to allocate the burden and benefits. A reduction in tax liability accrues in the first instance to consumers of the subsidized commodity. However, the ultimate economic incidence of tax concessions will depend on the elasticities of supply and demand for the tax-preferred commodities. For example, a tax concession for private health insurance may simply allow funds to increase their premiums or increase their surplus or profit.

While recognising that the question of who finally bears the tax burden (or tax relief) may be unresolved, the OECD observes that this problem arises similarly in allocating direct subsidies. Most OECD countries allocate tax expenditures 'by allocating to subsidies to the taxpayer who immediately and directly benefits from them' even if there is a duality of beneficiaries (OECD 1984, p. 22).

Because tax expenditure programs are typically subject to less public scrutiny and fewer evaluation processes than Budget appropriations, distribution of their benefits is less transparent.

Tax deductions and rebates are often of least benefit to those on low incomes, producing an 'upside-down' distributional effect (Surrey and McDaniel 1985). Whether this is a useful design feature of the concession, for example to target the behaviour of more price elastic high income earners, is contentious (Steinberg 1997). The regressive incidence of tax expenditures may simply reflect the exercise of political influence or ideology with little to do with efficiency in the use of public resources (Chesterman 1999; Surrey and McDaniel 1985).

In this context, it is useful to again draw the distinction between the apparent and actual beneficiary of the tax concession, because the legal incidence may not be the same as the actual economic incidence. While the legal beneficiary of the health insurance rebate is the individual taxpayer or fund member, the government has promoted the health insurance rebate on the basis of helping the health insurance industry and organizations. Should the package of financial incentives for private health insurance flow through into fund profits, the economic benefit is effectively captured by the funds and/or health service providers rather than fund members.

### **2.3. The data**

Since 1986, the Commonwealth Treasury has produced an annual set of estimates of tax expenditures of the federal government published in its Tax Expenditures Statement (Treasury 2001). Treasury estimates provide the basis for estimates of tax expenditures on health published by the Australian Institute of Health and Welfare (AIHW 2001). Official estimates of tax expenditures can be integrated with those by Butler and Smith (1992) for the period 1960-61 to 1988-89. All estimates are based on data from taxation statistics published annually by the Australian Taxation Office, derived from tax administrative processes (ATO, various years).

The AIHW attributes funding for health services expenditures to the income year in which the qualifying expenditure was made, while the Tax Expenditures Statement attributes the cost of tax expenditures to the year in which the Budget revenue cost was incurred (on a 'cash' basis). AIHW estimates for net medical expenses are more accurate, as they remove other unrelated small rebates included in the Tax Expenditures Statement.

Some features of the data warrant mention.

- The unit of income taxation in Australia is the individual, which is the unit presented in taxation statistics. However, the more usual unit for distributional analysis is the household.
- The coverage of taxation statistics can also vary over time with changes in the tax structure and exemption levels. Taxation statistics exclude income earners who are not required to lodge income tax returns. This is unlikely to have implications for the present analysis because all individuals benefiting from tax rebates are included in taxation statistics. However it does complicate comparisons of trends based on the distribution of household or family incomes.

Historical estimates of the value of tax expenditures are based on data for ‘taxable individuals’ (Butler and Smith 1992), and thus exclude the value of rebates accruing to ‘non-taxable’ individuals. ‘Non-taxable’ individuals represent 5-6 per cent of the total taxpayers over the last two decades, and account for a similar, stable proportion of the value of rebates allowed in 1982-83 and 1997-98. For consistency over time, non-taxable individuals, who accounted for 1-5 per cent of the value of the PHIIS rebate and 3 per cent of the 30 per cent rebate, are excluded from this analysis.

There are some peculiarities in the 1997-98 data for high income earners claiming the means-tested PHIIS rebate which is considered more fully below (See ‘5.1 The distribution of tax subsidies for private health insurance’).<sup>3</sup>

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<sup>3</sup> A significant number of high income earning individuals in the 1997-98 taxation statistics are recorded as receiving the income tested rebate that was in effect for the 1997-98 income year. One individual was reported as receiving the rebate despite a taxable income between \$500,000 and \$999,999 p.a. Advice from the ATO was that threshold adjustments for taxpayers with several dependent children may allow access to the rebate by some high-income taxpayers with large families. Later auditing might also alter the statistics as originally published.

### 3. Long-term trends in tax expenditures on health

Income tax concessions for health related expenditures have taken three major forms in Australia (Butler and Smith 1992):

- *deductions* from taxable income, allowed until 1974-75 for net spending on medical services and expenditure on health insurance taken out with registered medical benefit funds;
- tax relief allowed under the *general concessional rebate*, as occurred for 1975-76 and 1976-77, and the *concessional expenditure rebate* operating from 1977-78 to 1984-85; and
- tax concessions provided by way of a universal or income tested *separate tax rebate*, such as the private health insurance rebate in 1981-82, 1982-83, and the private health insurance rebates from 1997-98 to the present.

The *exemption from the Medicare levy surcharge* for private health insurance fund members, introduced from July 1997 represents a new type of substantial tax expenditure in Australia, although whether these arrangements are appropriately classified as a 'tax penalty' (Treasury 2001), or as a tax relief for privately insured taxpayers, remains debatable (Smith 2001). Treasury estimates the revenue benefit from the surcharge at \$105 million for the income year 1997-98, \$140 million for 1998-99 and \$110 million for 1999-00. This is forecast to fall to \$25 million in future years because of the rise in private hospital insurance coverage from June 2000.<sup>4</sup>

In the latest TES Treasury also provides a tax expenditure estimate for the exemption of the private health insurance rebate from income tax, 'including expense equivalent'. It attributes an additional tax expenditure of \$380 million for 1998-99 and \$690 million for 1999-00 for this item, with the amount rising to \$760-800 million in the future forecasting period.<sup>5</sup>

Details of the main tax rebates and deductions applying to private health related expenditures since the early 1960s are set out in Table 1 below.

Butler and Smith (1992) provide the main consistent estimates for tax expenditures on health for the years 1961-62 to 1988-1989. Since the late 1980s, the AIHW has provided official annual data, based on Treasury estimates.

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<sup>4</sup> The alternative interpretation of these arrangements, as a tax relief for those private hospital insurance would result in estimated revenue forgone of up to \$750 million in 1998-99 and rising, as a result of the exemption of high income taxpayers with private hospital insurance from the Medicare levy surcharge.

<sup>5</sup> See note f) to Table 2 regarding the attribution of these TES estimates of tax expenditures to income years in this paper.

**Table 1 Tax concessions for health-related expenditures, 1961 to 2001**

<b>Year</b>	<b>Medical expenses</b>	<b>Health insurance fund contributions</b>
1960-61	Deductible to limit of \$150	Fully deductible
1963-64 to 1974-75	Fully deductible	Fully deductible
1975-76	General rebate of \$540 plus 40 cents in the dollar for eligible expenditure above \$1350	As for medical expenses
1976-77	General rebate of \$610 plus 40 cents in the dollar for eligible expenditure above \$1525	Not allowable after October 1976
1977-78	Concessional expenditure rebate at 32 cents in the dollar for eligible expenditure in excess of \$1590	Not allowable
1978-79	Concessional expenditure rebate at 33.5 cents in the dollar for eligible expenditure in excess of \$1590	Not allowable
1979-80	Concessional expenditure rebate at 33.07 cents in the dollar for eligible expenditure in excess of \$1590	Not allowable
1980-81	Concessional expenditure rebate at 32 cents in the dollar for eligible expenditure in excess of \$1590	Not allowable
1981-82	Concessional expenditure rebate at 32 cents in the dollar for eligible expenditure in excess of \$1590	Separate rebate at 32 cents in the dollar of eligible expenditure for basic hospital and/or medical insurance only
1982-83	Concessional expenditure rebate at 30.67 cents in the dollar for eligible expenditure in excess of \$1590	As above at 30.67 cents in the dollar
1983-84 and 1984-85	Concessional expenditure rebate at 30 cents in the dollar for eligible expenditure in excess of \$2000	Not allowable
1985-86	Net medical expenses rebate at 30 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable

<b>Year</b>	<b>Medical expenses</b>	<b>Health insurance fund contributions</b>
1986-87 and 1987-88	Net medical expenses rebate at 29.42 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable
1988-89	Net medical expenses rebate at 29 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable
1989-90 to 1996-97	Net medical expenses rebate at 29 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable
1997-98	Net medical expenses rebate at 20 cents in the dollar for eligible expenditure in excess of \$1250	From July 1997, income-tested rebate of up to \$150 (\$250 for a couple; \$450 with dependent child). Medicare levy surcharge exemption for private hospital fund members
1998-99 and onwards	Net medical expenses rebate at 20 cents in the dollar for eligible expenditure in excess of \$1250	From January 1999, 30 per cent rebate for private health insurance. Medicare levy surcharge exemption as above

Sources: AIHW 2000; Butler and Smith 1992

There have been important changes in the nature of public funding of health expenditures over the last four decades. There was a shift from deductions to concessional rebates and abolition of tax concessions for private health insurance, which were associated with tax reforms during the early 1970s, and with the introduction of Medibank in 1975. Likewise, changes during the 1980s were associated with introduction of Medicare in 1984, and with reforms to income tax concessions from 1985.

The more recent shift towards funding health expenditures through tax subsidies is evident in the rising trend in tax expenditures for health related spending since 1997-98 - see Table 2.

**Table 2 Tax expenditures on health, 1980-81 to 2002-03 (\$000, current prices)**

<b>Year</b>	<b>Net medical</b>	<b>Health insurance</b>	<b>Total</b>
1980-81	17,211		17,211
1981-82	21,107	455,479	476,586
1982-83	25,350	548,264	573,614
1983-84	16,747		16,747
1984-85	19,660		19,660
1985-86	22,875		22,875
1986-87	33,878		33,878
1987-88	37,000		37,000
1988-89	47,000		47,000
1989-90	61,000		61,000
1990-91	85,000		85,000
1991-92	82,000		82,000
1992-93	91,000		91,000
1993-94	95,000		95,000
1994-95	91,000		91,000
1995-96	105,000		105,000
1996-97	125,000		125,000
1997-98	130,000	160,000	290,000
1998-99	145,000	180,000	325,000
1999-00	125,000	220,000	345,000
2000-01 <sup>(f)</sup>	150,000	310,000	460,000
2001-02 <sup>(f)</sup>	160,000	320,000	480,000
2002-03 <sup>(f)</sup>	165,000	330,000	495,000

(f) Treasury forecasts in Tax Expenditures Statement (TES) (2001). Note that TES forecasts relate to the year in which the claim is assumed to affect the Budget, that is, to the year after the income year for which the tax rebate claim is made. The AIHW (2001) attributes tax expenditures to the same year for which the claim is made, as do Taxation Statistics (ATO)(2000) and Butler and Smith (1992). In this table, the estimates are attributed to years on the same basis as for Butler and Smith, AIHW, and the taxation statistics; TES estimates and forecasts are therefore attributed to the year prior to that reported in TES.

Source: Butler and Smith (1992, p. 49) to 1988-89; AIHW (2001) Table 13; Commonwealth Treasury (2001), Table 5.1 for 2000-03.

#### 4. Sources of health care funding

Health spending in Australia has historically been funded by a combination of the Commonwealth, State/local, and non-government sectors. The non-government sector includes private health funds and individuals as well as other non-government organisations. Historical trends in sources of funds for health expenditures are presented and discussed in Butler (1998).

Tax expenditures played an important role in financing health care financing from the early 1960s to the mid 1970s (Butler and Smith 1992). This reflects the heavy reliance on tax deductions for medical expenses and private health insurance over the period 1960-61 to 1974-75. An implication is that health expenditure data that excluded tax expenditures understated the extent of public sector financing in health care prior to the introduction of Medibank. Furthermore the growth in public sector financing due to introduction of Medibank and later Medicare is overstated because to a significant degree, the abolition of concession for health-related private expenditures helped off set the budgetary cost of introducing a public health insurance scheme.

This problem has been recognised since at least the early 1990s when the AIHW began producing official estimates of health funding sources which adjusted for tax expenditures.

Table 3 sets out figures derived from AIHW data showing tax expenditures as a share of total funding for health services, and as a share of Commonwealth health services expenditures from 1974-75 to 1999-00.

It can be seen that in 1974-75, just before introduction of Medibank, tax concessions for health-related private spending accounted for around 12 per cent of the total health services funding and represented on third of the Commonwealth's funding for health. Tax expenditures represented 4.6 per cent of health services funding before introduction of Medicare in 1984, and fell to less than one per cent after the associated elimination of the tax rebate for private health insurance.

**Table 3 Tax expenditures<sup>a</sup> share of health services expenditures**

Year	Taxation expenditures as per cent of total health services expenditures	Taxation expenditures as per cent of Commonwealth health services expenditures
1974-75	11.8	28.1
1975-76	1.7	3.4
1982-83	4.6	14.4
1987-88	0.2	0.4
1988-89	0.2	0.4
1997-98	0.6	1.3
1998-99	0.6	1.4
1999-00	0.6	1.3

a) excludes cash rebates for private health insurance paid by the HIC

Source: AIHW (2001); Butler (1992)

Despite the substantial growth in tax expenditures on private health insurance since 1997-98, tax expenditures have remained a small proportion, around 1.3 per cent, of Commonwealth health spending and less than one per cent of total health services expenditures. This reflects in part the growth in overall health services expenditures over the last decade. It is also because a large proportion of PHIIS expenditure and of the 30 per cent rebate for private health insurance premiums is paid out directly by the HIC as a cash rebate, and is therefore not recorded as a tax rebate.

For example, in 1999-00, the HIC paid \$1,414 million as direct subsidies for private insurance, alongside the \$220 million paid that year through tax rebates. In 1997-98 and 1998-99, the corresponding amounts were \$252 million and \$782 million respectively (Australian Institute of Health and Welfare 2001). If these payments of what may be characterized as 'refundable tax credits' are counted with tax expenditures, total tax expenditures rise to 3.3 per cent of total funding rather than 0.6 per cent in 1999-00. Likewise private health insurance subsidies account for nearly 7 per cent, rather than 1.3 per cent, of Commonwealth health care funding.

Looking at Table 4 and Figure 2, it can be seen that the rising Commonwealth share of health services funding since the early 1970s is as much a reflection of the declining State government funding role than a result of declining non-government funding. In fact, the non-government share of health financing in the last decade is slightly higher than it was in 1974-75.

However, despite the recent policy emphasis on bring more private money into health financing, the share of private health insurance funds has fallen from 31.9 per cent in 1996-97 to 24.7 per cent in 1999-00. As a result, there has been a fall in the non-government share of health services funding from 32.8 per cent to 28.6 per cent between 1996-97 and 1999-00.

Within the non-government sector, financing by private individuals rose markedly over this period, from 48.7 to 56.4 per cent (AIHW 2001, Table 15). This increasing role for 'self-insurance' has been evident from 1984-85, associated with a declining funding role for private health insurance (Butler 1998).

**Table 4 Source of funds for health service expenditures, adjusted for tax expenditures**

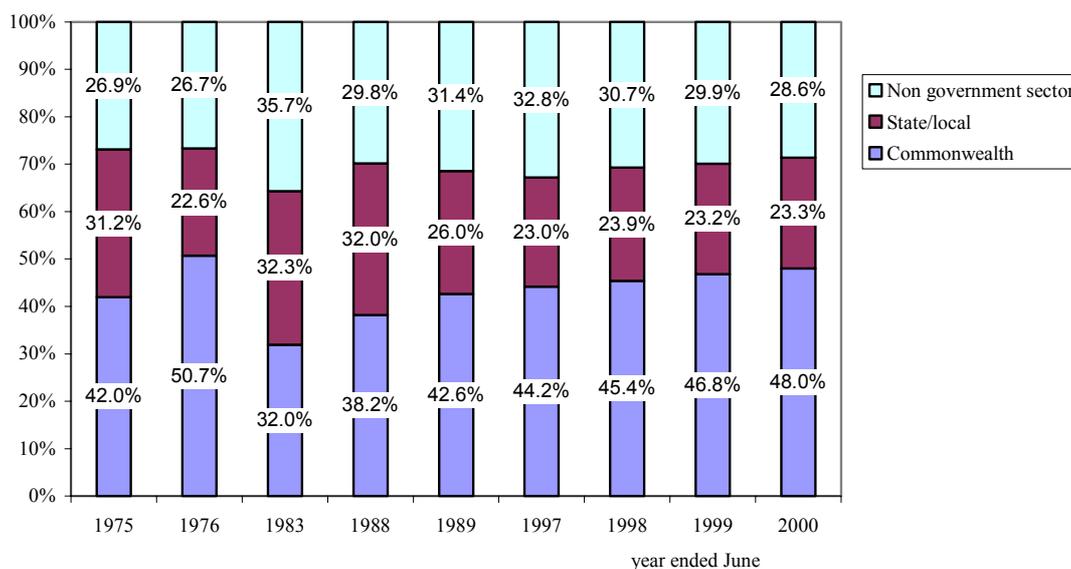
Year	Commonwealth health services expenditure, current prices	State/local	Government sector	Non-government sector
1974-75	42.0	31.2	73.1	26.9
1975-76	50.7	22.6	73.3	26.7
1982-83	32.0	32.3	64.3	35.7
1987-88	38.2	32.0	70.2	29.8
1988-89	42.6	26.0	68.6	31.4
1997-98	45.4	23.9	69.3	30.7
1998-99	46.8	23.2	70.1	29.9
1999-00	48.0	23.3	71.4	28.6

Source: AIHW (2001); Butler and Smith (1992)

The share of costs borne by private health insurance funds has fallen to 7 per cent in 1999-00 from around 10-12 per cent during the last two decades, and from 17-22 per cent during the period of the Fraser government (AIHW 2001, Table 15).

The out-of-pocket contribution by individuals has risen to 16 per cent of total health funding in 1999-00. This is nevertheless below the 33 per cent share of the financing burden carried by individuals during the 1960s before the introduction of Medibank (Butler 1998).

**Figure 2 Health services expenditure, source of funds adjusted for tax expenditures, selected years 1974-75 to 1999-00**



Source: Butler and Smith 1992, AIHW 2001

## 5. The distribution of tax subsidies for health-related spending

In the previous section we have seen how changes in public policies regarding the financing of health services affect the broad funding pattern. Here we examine the redistributive implications of this aspect of public funding for health care by looking more specifically at the distribution of these tax subsidies by taxable income category in order to evaluate its changing distribution over time.

### 5.1 The distribution of tax subsidies for private health insurance

Table 5 presents the distribution across taxpayers by taxable income category for tax subsidies for private health insurance for selected years since 1962-63.

This shows the different distributional pattern for tax concessions provided in the form of deductions compared to rebates, and for the means-tested rebate compared to concessions available to all income groups.

It can be seen that under a system of deductions during the 1960s and early 1970s, taxpayers in the lowest two quintiles received about 2-3 per cent and 7 per cent respectively of the value of the tax subsidy for private health insurance with nearly half the value of the deduction accruing to the 20 per cent of taxpayers with the highest taxable incomes.

The share of these lower income taxpayers rose with the change to tax rebates from the mid 1970s, so that the 40 per cent of taxpayers with the lowest taxable incomes received a total 24 per cent of the tax subsidy for the two years that this concession was allowed during the early 1980s.

The introduction of the means-tested PHIIS in the 1997-98 income year appears to have produced an income distribution for the tax subsidy which is not dissimilar to the fixed rebate for private health insurance contributions introduced by the Fraser government in 1981-82, then abolished with the introduction of Medicare – see Table 1.

The replacement of the means-tested PHIIS halfway through the 1998-99 income year means that the distributional implications were not fully felt in that year. Nevertheless, a striking feature of the result for 1998-99 is the increase in the share accruing to the highest 20 per cent of taxpayers, to 42 per cent – see Table 5. This is largely at the expense of the share to the middle quintile, and means that for 1998-99 the income tax concessions for private health insurance produced a distribution of the tax subsidy which was as regressive as the deductions for health fund contributions existing until 1975.

The full year effect of the 30 per cent rebate for private hospital insurance is evident in Table 6 which compares the distribution of the means-tested PHIIS that was available in the first half of the income year, with that of the 30 per cent rebate available in the second half year.

**Table 5 Distribution of tax expenditures for private health insurance, selected years 1963 to 1999**

Year ended June	Bottom quintile	Fourth quintile	Third quintile	Second quintile	Top quintile
1963	2	7	15	30	46
1971	3	7	17	29	44
1972	3	7	18	28	44
1975	3	7	18	32	40
1982	9	15	20	34	22
1983	9	15	20	25	31
1998	8	14	23	27	28
1999	6	11	15	26	42

Source: Derived from ATO (various years)

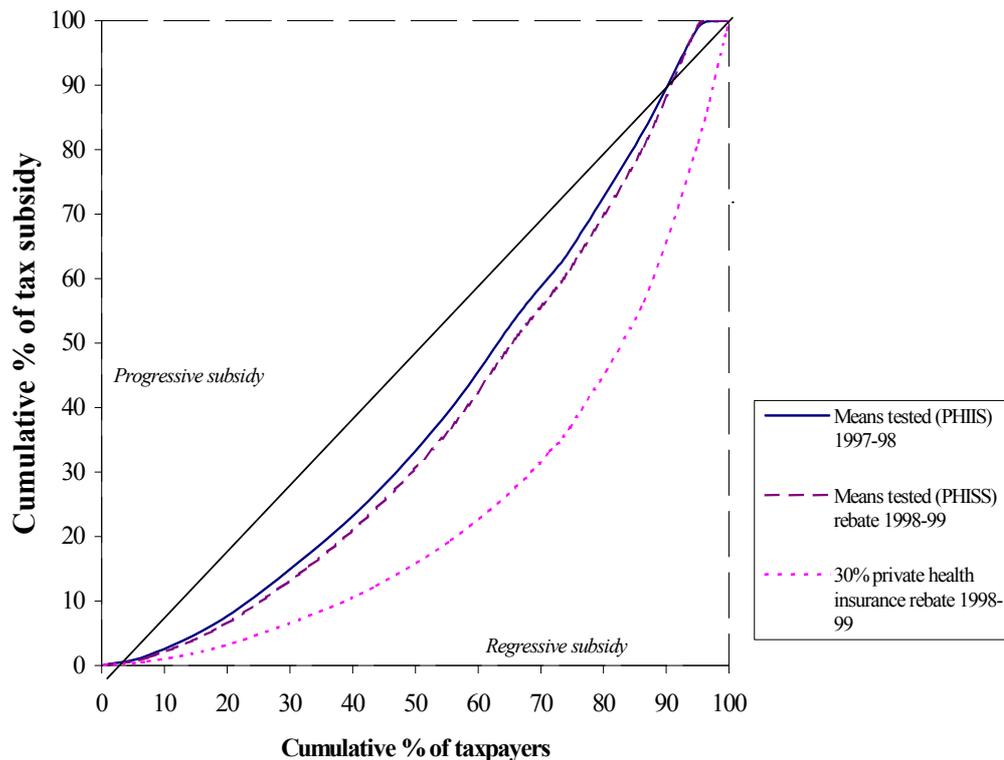
**Table 6 Comparison of distribution of PHIIS and 30 per cent rebate, 1998-99 income year**

	Bottom quintile	Fourth quintile	Third quintile	Second quintile	Top quintile
Means tested private health insurance incentive (PHIIS)	9	16	22	27	26
30% private health insurance rebate	4	9	12	25	50

Source: Derived from ATO (various years)

This provides an interesting comparison of the distributional effect of means testing of tax concessions for private health insurance. The PHIIS rebate is clearly less regressive than the present 30 per cent rebate, as is evident also in the Lorenz curves for the rebates - see Figure 3.

Furthermore it can be seen that the 30 per cent rebate for private health insurance is even more concentrated in the top quintiles of the income distribution than tax deductions were in previous decades. Half the revenue forgone by the concession accrues to those in the top quintile of taxpayers, compared to 26 per cent under the means-tested scheme, and 40-46 per cent under pre-1975 provisions for full tax deductibility.

**Figure 3 Lorenz curves for tax expenditures, private health insurance**

Source: Tables 5 and 6

Another perspective on the equity of current tax subsidies is to compare the average per capita level of payment for different income groups.<sup>6</sup>

Table 7 looks at how the per capita tax subsidy provided by tax concessions for health related expenses in selected years since 1962-63 varies for different income groups for the three years this data is available in taxation statistics.

This shows that the per capita average tax benefit for taxpayers qualifying for the concession for private insurance in 1997-98 was around \$190 p.a. Between June and December 1998, the PHIIS provide an average concession worth around \$200. On an annualised basis, benefits ranged from \$114 per taxpayer to \$450 pa in 1997-98, and from \$142 to \$369 per taxpayer in 1998-99. The highest benefits went to the highest income category of eligible taxpayers in both years. For example, in 1997-98, it appears around 28 taxpayers earning \$100,000-\$200,000 pa received an average per capita subsidy of \$332 from PHIIS, with one taxpayer in the \$500,000-999,999 income range receiving a \$450 rebate.

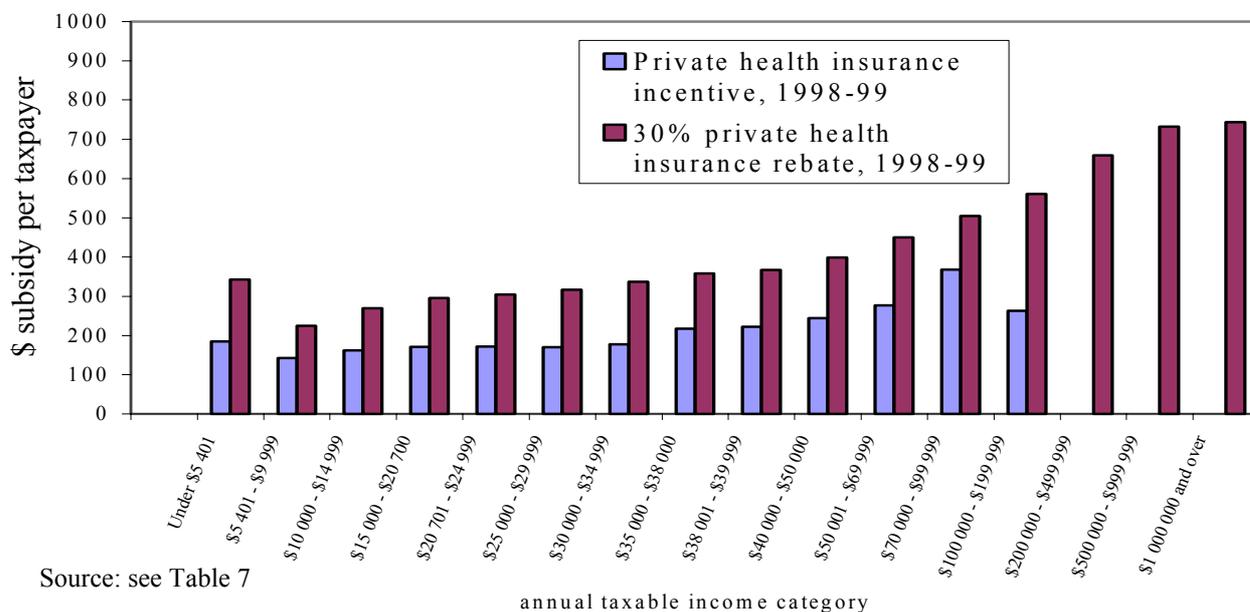
<sup>6</sup> Implicit in this analysis of the \$ value of the tax subsidy by income group is that the marginal utility of income does not diminish as income rises. It might be argued that equity effects should be assessed by reference to the utility significance of the tax subsidies. Under this argument, if there is a declining marginal utility of income, then higher per capita subsidies to higher income groups may nevertheless represent a lower utility gain to those groups compared with lower income groups.

**Table 7 Per capita distribution of tax expenditures**

Grades of taxable income	Net medical expenses 1996-97	Net medical expenses 1997-98	Private health insurance incentive 1997-98	Net medical expenses 1998-99	Private health insurance incentive 1998-99 (annualised)	30% private health insurance rebate 1998-99 (annualised)
Under \$5 401	263.62	501.65	151.86	191.71	184.85	342.79
\$5 401 - \$9999	165.09	177.00	114.06	147.01	142.28	224.80
\$10 000 - \$14 999	434.30	415.82	139.42	379.51	162.47	270.02
\$15 000 - \$20 700	503.33	506.69	154.53	523.24	170.94	295.55
\$20 701 - \$24 999	412.49	432.39	160.19	450.63	172.10	304.69
\$25 000 - \$29 999	370.54	386.46	163.43	417.55	169.87	316.49
\$30 000 - \$34 999	377.68	379.23	171.99	403.13	177.17	337.17
\$35 000 - \$38 000	357.81	386.97	223.69	408.65	217.15	358.09
\$38 001 - \$39 999	351.66	374.41	233.20	399.74	223.07	366.58
\$40 000 - \$50 000	345.04	371.90	256.06	398.63	244.15	398.38
\$50 001 - \$69 999	374.59	393.64	286.01	409.76	276.95	450.28
\$70 000 - \$99 999	443.15	458.56	329.02	474.36	368.59	504.70
\$100 000 - \$199 999	609.89	626.19	277.47	633.11	263.58	560.86
\$200 000 - \$499 999	944.98	949.57	332.75	913.02	-	658.95
\$500 000 - \$999 999	1,631.06	1,675.82	450.00	1,508.49	-	731.86
\$1 000 000 and over	2,538.69	2,082.33	-	1,483.07	-	743.91
Total taxable	407.43	425.02	193.13	444.03	202.60	392.98
Total non-taxable	758.55	734.74	150.19	712.11	153.73	274.21
Total taxpayers	428.18	442.83	190.59	462.67	201.96	388.44

Source: Derived from ATO (various years)

The following income year, 1998-99, a total of 2189 taxpayers in the taxable income range \$70,000-\$99,999 received an average annual subsidy equivalent of \$369 under the means-tested PHIIS, while a small number on incomes of \$100,000-\$200,000 received an average payment equivalent to \$263 p.a., presumably because they had more than one dependent child – see Figure 4.

**Figure 4 Comparison of distribution of per capita tax subsidy for PHIIS and 30 per cent rebate, 1998-99 (annualised)**

Source: see Table 7

A similar pattern of subsidy is evidenced for the uncapped and non-means-tested 30 per cent rebate available for the second half of the 1998-99 income year; a per capita benefit of around \$730 p.a. (annualised) accrued to the highest income taxpayer group earning above \$500,000 compared with that of \$390 p.a. paid on average to all eligible taxpayers.

## 5.2 The distribution of tax subsidies for net medical expenses

Tax allowances for net medical expenses are a longstanding and continuous feature of the Commonwealth income tax, being either deductible or partly rebateable on horizontal equity grounds since at least 1962-63. The distribution of the revenue loss associated with tax concessions for net medical expenses is presented in Table 8.

Again, there is a different distribution pattern for tax expenditures for years in which concessions were provided as a deduction compared to the more recent years when the concessions took the form of a 30 per cent rebate of eligible expenses.

The major features evident in Table 8 regarding net medical expenses are:

The change in the distribution of this tax subsidy associated with the move to rebates rather than deductions after 1974-75; and

The increase in the share of the highest quintile group in the 1997-9 and 1998-99 income years compared to 1996-97. The share increased from 18 per cent to 41-42 per cent mainly at the expense of the second highest quintile of taxable individuals. The medical expenses rebate provided a greater share of the total tax subsidy to lower income groups than the system of deductions especially before 1997-98.

Looking again at the per capita data on the tax concession for net medical expenses (Table 7), it can be seen that the average rebate has risen from \$407 in 1996-97 to \$444 in 1998-99, a 9 per cent increase. This reflects a rise in the level of claims for

**Table 8 Distribution of tax expenditures for net medical expenses, selected years 1963 to 1999**

Year ended June	Bottom quintile	Fourth quintile	Third quintile	Second quintile	Top quintile
1963	2	8	18	24	48
1971	3	8	16	26	47
1972	3	8	17	24	48
1975	3	9	16	27	45
1997	8	15	24	35	18
1998	8	14	16	20	42
1999	7	15	16	21	41

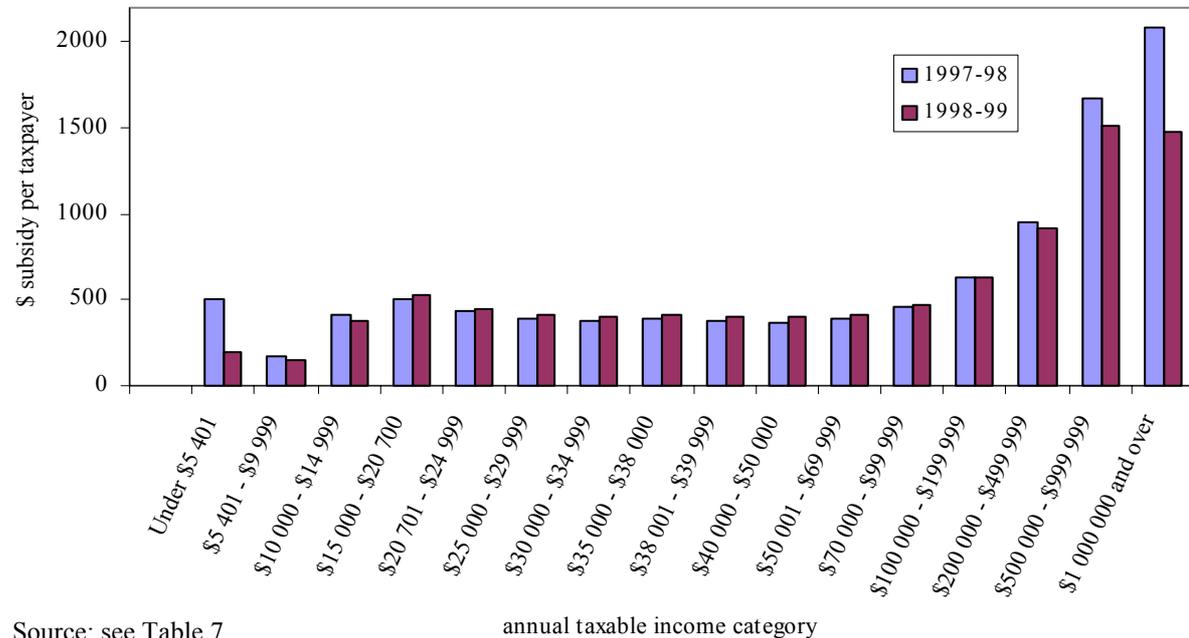
Source: Derived from ATO (various years)

net medical expenses by middle to higher income taxpayers; the per capita average rose for the \$15,000 to \$199,000 taxable income categories but fell sharply among the highest and lowest income groups.

Again from 1997-98 to 1998-99, (when the 30 per cent rebate for private health insurance came into effect), the average net medical expenses rebate per capita fell among low income taxpayers (up to \$15,000 p.a.), and especially among those earning below \$5,401 of taxable income (Table 7 and Figure 5). Net medical expense claims also fell sharply among taxpayers earning \$200,000 and over. However, net medical expense claims rose for taxpayers in all categories of income from \$15,000 to \$200,000 of taxable income p.a.<sup>7</sup>

The relation between trends in taxpayer claims for net medical expenses and private hospital funding is worthy of close examination. In principle, this might be either a relationship of complements or substitutes (Butler and Smith 1992). The pattern and timing of changes in the distribution and level of net medical expenses claims suggests medical expenses claims rise along with claims for the PHIS and 30 per cent rebates (ATO 1999, 2000). Between 1997-98 and 1998-99, for middle-income taxpayers (\$30,000 of taxable income or more) rising claims for net medical expenses were associated with rising claims for private health fund membership. The nature and extent of this relationship has implications for the cost of subsidising private fund membership because a policy of encouraging private health fund membership may have other costs to the budget that have not been accounted for.

**Figure 5 Per capita tax subsidy for net medical expenses, 1997-98 to 1998-99**



Source: see Table 7

<sup>7</sup> This strong rise in claims by middle-higher income taxpayers suggests a complementary rather than a substitute relationship between private health insurance and net medical expenses across the majority of taxpayers. With 69 per cent of all taxpayer and 87 per cent of those claiming the net medical expenses rebate coming from the \$15,000 to \$200,000 taxable income categories, this suggests considerable potential for additional budgetary costs associated with the expanded claims for the net medical expenses tax rebate.

## 6. Discussion

This paper has assessed trends in the level and distribution of tax concessions for health for selected years since the early 1960s. Overall, tax expenditures have become less important as a means of subsidizing health care costs in Australia over recent decades, as direct spending through public health insurance schemes (Medibank and Medicare) has expanded and replaced indirect fiscal subsidies for private provision. This is consistent with developments in European countries, which have found tax incentives to be expensive and regressive without stimulating demand (Mossialos and Thomson 2000), with a consensus forming in most European OECD countries around social insurance systems for funding health care (Owens 1998). However, the trend towards social insurance and reduced use of tax incentives for voluntary health insurance has been reversed in Australia since 1996-97.

Budget incentives to take out private health insurance cost the Commonwealth government around \$1.6 billion in 1999-00. Following the large jump in health insurance coverage from June/July 2000, their annual cost will rise further. The 30 per cent rebate will cost more than \$2 billion p.a. in 2000-01 rising to \$2.3 billion in 2001-02 if cash rebates paid through the HIC rise at the rate the Commonwealth Treasury forecasts for rebates paid via the tax system (Treasury 2001).<sup>8</sup>

As shown by Butler (2001), expenditure of more than \$3 billion of public money in the three years to June 2000 was spectacularly unsuccessful in increasing private health insurance fund membership, or reducing public sector health spending. Deregulation of health funds, not cash incentives for fund membership, produced the sharp increase in health insurance coverage in mid 2000.

As a result of the financial incentives for private health insurance, the Commonwealth government is meeting an ever-increasing share, now 48 per cent, of Australia's health care costs. The share of costs borne by private health insurance funds has fallen to just 7 per cent. Meanwhile, the 'out of pocket' contribution by individuals had risen to 16 per cent of total health spending by 1999-00.

With only a half of private health insurance fund payments paying for hospital care, and with evidence that consumer demand for private health insurance coverage is largely unresponsive to price subsidies (Butler 2000), there appears little likelihood that further subsidy of private insurance will make any significant contribution to sharing the health financing cost burden with Australian governments.

The Commonwealth government's subsidy for private health insurance means, however, that it has indirectly paid for around \$360 million of private dental care, and around \$430 million of private health fund administration costs over this period. More than half of the current tax rebate for private health insurance is directed at the top 20 per cent of the income distribution. Meanwhile, since 1996-97, the number of public hospital beds has declined by 3 per cent a year (AIHW 2001).

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<sup>8</sup> This excludes the effects of reducing Medicare levy surcharge revenues, and the tax expenditure of around \$760 million reported on account of the income tax exemption of the 30 per cent private health insurance rebate.

The rise in the Commonwealth's share of total health funding largely reflects a declining contribution from State governments since the early 1980s, pointing to the pressing need for reforms to address this structural problem in Australia's public health care financing system.

Throughout the period, tax concessions for private health insurance have been disproportionately concentrated on the highest income taxpayers. While this pattern of regressivity was lessened by the replacement of tax deductions with rebates from the 1970s, the introduction of the 30 per cent rebate in 1998-99 has reversed that equity-improving development. The evidence from taxation statistics is that approximately half of the present open ended subsidy of private health insurance premiums through the 30 per cent rebate goes to the top 20 per cent of taxpayers, and nearly three quarters to the top 40 per cent.

This is comparable with the highly inequitable tax deductions for private health insurance and net medical expenses that were abolished on expert advice of their inequity during the tax reforms of the 1970s and 1980s (Commission of Inquiry into Poverty in Australia 1975; Commonwealth of Australia 1985; Taxation Review Committee 1975).<sup>9</sup>

The per capita subsidies for private health insurance and net medical expenses claimed by higher income earners are substantial. The current tax relief for private health insurance provides an annual per capita payment of around \$744 for those earning \$1,000,000 p.a. or more in 1998-99. This is about twice as high as for the average taxpayer. It compares with the Commonwealth's average contribution to Australia's health care costs of around \$1313 per person (AIHW 2001, Tables 5 and 11). It seems likely that even the previous system of bed subsidies for private hospital care would be more equitably distributed among income groups and better targeted to those needing health care than subsidies for private health insurance.

Prior to 1997-98, where Commonwealth subsidies for private health insurance membership existed, they took the form of tax preferences. With the introduction of PHIIS, such subsidies are now available as cash rebates on premiums paid through the private insurance funds by the HIC. This arrangement reduces the inequity associated with tax deductions or credits because it widens access to the subsidy for lower income earners. However, for this reason, tax statistics regarding the income characteristics of claimants via the tax system may not necessarily provide a representative picture of expenditures on the rebate as a whole. On the other hand, tax statistics clearly demonstrate the highly skewed nature of at least \$220 million of the \$1.6 billion subsidy for private health insurance paid in 1999-00. Furthermore it is likely that this is broadly indicative of the regressive distributional implications of the shift from a means-tested to a universal subsidy scheme for private health insurance and from a fixed to an open-ended rebate.

The full year fiscal effects of the shift in health care financing policy will not be evident before data is released for the 2000-01 income year, and its distributional

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<sup>9</sup> Deductions were replaced during the tax reforms of the 1970s and 1980s because in a progressive marginal rate system, they provided the greatest benefit to those on highest marginal tax rates, and were thus vertically inequitable (Smith 1993, pp. 104-122).

consequences can only be fully assessed when the ABS releases next household income and expenditure survey in 2002. Until then, tax statistics provide the only timely, if imperfect, basis for assessing the distributional consequences of current health financing policy.

## 7. Conclusion and implications

A central concern of health financing policy over recent years has been the rising Commonwealth share of overall funding and the declining role of private health funds. The introduction of financial incentives for private health insurance membership since 1997-98 has been an attempt to respond to these structural problems by arresting the decline in private health insurance coverage and shifting public hospital demand to private hospitals. The introduction of lifetime rating for private health insurance between September 1999 and June/July 2000, was another means of reducing the problems of adverse selection caused for private health insurance funds by the community rating system.

Private health fund coverage has been declining since the introduction of Medibank during the 1970s. Private health funds now provide just 7 per cent of the total funds for Australia's health care system, compared to around 11 per cent in 1994-95. Since the late 1970s, public hospitals have received a diminishing share of national health funding.

The place of private health insurance in Australia's system of health care funding remains unresolved. The private health insurance industry was sustained until the introduction of Medibank by Commonwealth subsidies (Owens 1998). Until 1986, Medibank and its successor Medicare incorporated daily bed payments to private hospitals on the principle that private patients should be entitled to benefits comparable with those extended to public patients of public hospitals. For budgetary reasons unrelated to the health system, this bed subsidy, and the substantial subsidy to the reinsurance pool to offset the cost of community rating, were abolished. The private health funds have faced escalating financial problems since that time.

Present problems and the Commonwealth government's policy response reflects this underlying tension relating to the long-term role of private health funds in the Australian health care financing system. Although it was beyond the scope of the Industry Commission review of private health insurance (Industry Commission 1997), at issue is whether private health insurance should be seen as topping up public funding for optional extras (that is, a complement to Medicare) or replacing public funding (a substitute for, or alternative to, Medicare). The former, 'residual' role would see the funds deregulated and catering to a small market mainly occupied by the wealthy. The latter, more mainstream role would see private health funds as the vehicle for channelling public funds to a substantial private health care system available on similar terms to all and providing an alternative health care choice to the public system.

It has been pointed out that on the first view, there would be no need for public regulation of private health insurance funds, 'and even less justification for public subsidy' (Owens 1998, p. 187). Much regulation of private health insurance, including community rating and various restrictions on benefits offered by health funds, would be unnecessary as most carried over from the pre-Medibank era, 'when the government heavily subsidized the health funds as the agencies for delivery of national health benefits' (Owens 1998, p. 176). Present dilemmas arise because the reduced social agency role of private funds has been only partly reflected in government policy, while the prerequisite commitment to adequate funding of

Medicare, to provide adequate access to quality health care for the whole population, has not been forthcoming.

The view of private health insurance as an alternative financing system to Medicare, giving choice between private and public health care providers, implies a regulatory system incorporating community rating and substantial government subsidy.

At present, the Australian health care financing system appears to be an uneasy compromise of these views, leading to the worse aspects of each. There is a very costly and inequitable public subsidy for private health insurance. At the same time, the shift to lifetime community rating is a significant move towards a risk rating system permitting the health funds to use selection strategies which 'cream skim' the private health financing 'market' rather than providing uniform premiums and equitable access to a private health care system.

While one argument has been that expanded private health insurance injects additional funds into the system, and permits better targeting of scarce public health funds to those in most need (Industry Commission 1997, p. 303), subsidizing private health insurance is increasing rather than reducing the funding burden on Australian governments. Similarly, current policy directs an increasing portion of scarce Commonwealth health funds towards the top end of the income stream regardless of demonstrated health needs and public health priorities.

There is increasing evidence that the costly financial incentives for private health fund membership are both wasteful and ineffective in increasing health fund membership, and are unlikely to significantly ameliorate funding pressures on public hospitals. The price elasticity of demand for private health insurance has been found to be low (Butler 2000) and a high proportion of the benefit of the private health insurance rebate is a windfall to existing members rather than attracting new members (Richardson 1998). The substantial increase in fund membership in June/July 2000 appears to be due to the publicity given to the introduction of lifetime rating rather than to the financial incentives provided through the PHIIS or 30 per cent rebate scheme (Butler 2001). Despite the recommendation of the Industry Commission, the rebate covers ancillary expenses and thus provides a large and open-ended Commonwealth subsidy to health expenditures such as private dental care, rather than substituting private for public hospital expenditures (Duckett and Jackson 2000).

Approximately 14 per cent of the subsidy for private health insurance goes in administrative expenses, mainly marketing and promotion. Only half of the subsidy is likely to be spent on hospital care with around a quarter directed at non-institutional health care. For example, around 12 per cent of private health insurance funding is for dental services. Arguments that a subsidy for private fund membership is fair because people should not have to pay twice for their hospitalisation costs are difficult to sustain without firm evidence that private health fund membership actually substitute for public health programs and budget outlays.

The equity case for the current subsidy of private health insurance also rests on assumptions that a dollar spent on supporting private health insurance does not reduce funding for the public health system (Richardson 1998). The rise in fund membership will dramatically increase the public subsidy to private health insurance. This subsidy to private health insurance (and indirectly to the private health care system) will

inevitably reduce Australian governments' ability to address the problems facing public hospitals and the difficulties that low- and moderate-income earners face in accessing health services including dental care. With budget constraints on Commonwealth funding for health care, subsidies for private health insurance tend to displace other public health funding priorities. As financial incentives for private insurance now account for around 7 per cent of Commonwealth health funding, and are growing rapidly, subsidies for private insurance must be at the expense of additional funding for Medicare. Each year, the private health insurance rebate alone is drawing around \$2 billion of government funding away from public health care provision, and the Medicare benefit payment for private in-hospital medical services adds at least \$0.9 billion annually to this subsidy to the private system (Duckett and Jackson 2000).

Public sector cutbacks over the last decade have produced queues in public hospitals (Deeble 1999) and axing of public dental care services such as the Commonwealth Dental Health Program (Duckett and Agius 2000). Yet through the rebate for private health insurance, the Federal government now provides a large public subsidy for high-income earners to jump hospital queues, obtain cosmetic surgery and dental care, and pay for their gym club membership.

While some see it as equitable to require those who can afford private health insurance to use it, this view of equity is inconsistent with providing large tax-payer funded financial incentives to the well off for doing so. Furthermore, this view provides no justification for providing higher per capita subsidies of private health insurance for the rich than for the poor, yet that is the result of the design of the current scheme. On the other hand, exempting the insured from the Medicare penalty and subsidizing their insurance premiums effectively absolves many high-income earners from contributing according to their ability to the community's health care costs. A more effective and equitable way to increase the contribution of wealth households to health care costs would be to abolish the exemption for the insured from the Medicare levy surcharge and channel the revenues into the public health system.

The present policy of subsidising private health insurance also ignores the substantial and growing financing contribution by the 'self insured'.

In conclusion, the present system of financial incentives for private health insurance is symptomatic of deeper structural problems in health care financing. The declining share of funding going to public hospitals and States' reduced contribution to health funding since the late 1970s may reflect greater efficiency. However, it is more likely to reflect the Commonwealth government's lack of commitment to adequately funding Medicare so the public system can provide care for the whole population. It also reflects the Government's priority of providing substantial public funding for private health insurance even at the expense of the public system.

Present deregulatory trends point to an emerging policy of allowing private health insurance funds to 'cream skim' the most profitable part of the Australia's health insurance market, while leaving an underfunded public hospital system to provide care for the bulk of those with urgent or chronic health care needs.

Deregulating private health insurance ought to entail elimination not expansion of public subsidies to the industry.

As incentives for private health insurance have been largely irrelevant to increases in health fund membership, there are strong arguments for reassessing the eligibility criteria, level and structure of subsidies for private health insurance membership. The looming budgetary burden of these open-ended subsidies may in any case force a reconsideration. The existing cash incentives and tax rebates for private health insurance should be reformed and restructured so that they are less costly, less inequitable, and more focused on substituting for public funding of hospital care. Likewise, the existing tax rebate for net medical expenses should be revamped to provide more equitable access for lower income groups, while limiting its costs to the public purse. This might be achieved by:

- replacing the present open-ended rebate for private health insurance with a fixed rebate to limit the extent of subsidy and make the subsidy less regressive;
- removing health insurance cover for ancillaries from eligibility for the 30 per cent health insurance rebate so that the Commonwealth contributes less to the elective health care expenditures of the well off; and
- removing the income tax exemption for the 30 per cent rebate for private health insurance to make it more equitable and bring it into line with other cash payments and transfers like Centrelink payments which are taxable.

The Government might also contemplate changes to the net medical expenses rebate in order to strengthen its basis in both horizontal equity and vertical equity, and limit its cost. Reforms which would widen access while reducing costs include:

- lowering the threshold from its present high level while at the same time introducing an income test; and
- fixing the level of the rebate or,
- capping the annual levels of expenses that can be claimed per taxpayer.

The most urgent problem of health care financing is addressing the structural imbalances between Commonwealth and States in the health care financing area. Nevertheless, if the Commonwealth continues to heavily subsidise the private health industry, it follows that public money should be redirected to providing private hospital bed day subsidies, and maintaining community rating by private health insurance funds and expanding access to health care such as dental services.

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