Health Finance: Cutback or Redistribution?

Keith Tarlo

> The most alarming thing about the changes in hospital financing and medical insurance arrangements announced by the Government yesterday is that the Australian Medical Association approved of the changes.
>
> (Editorial, Australian Financial Review, 30/4/81).

INTRODUCTION

On 29th April, 1981, the Commonwealth Minister for Health announced major changes to the arrangements for financing health services in Australia. In doing so, he spoke about efficiency, the cost to the individual and the community, the States having responsibility for the provision of health services, the user-pays principle, the need for individuals to take responsibility for their health care needs, and the desirability of supporting the private sector in health services. This article shows that much of this is rhetoric, and that the changes can only be understood in terms of:

(a) a redistribution of both private income and access to services (i.e. social wage) from the poor to the rich;

(b) giving the appearance of increasing private sector financing of health services in the cause of "smaller government";

(c) a redistribution of service provision from the public to the private sector;

(d) further distancing the private medical profession from Government finance through private health insurance; and

(e) the offloading of responsibilities onto the States.

First, the changes are briefly described. Secondly, the inequitable impact of the changes is discussed. Thirdly, other effects of the changes are examined in the light of the rhetoric used by the Government to justify the changes. This leads to an understanding of the underlying forces and ideologies behind the changes.

THE CHANGES

(i) Commonwealth Funding of Public Hospitals etc.

Until the end of 1980/81, the Commonwealth and the States shared the agreed net operating cost of public hospitals and the cost of some community health services and the school dental scheme by means of separate specific purpose grants from the Commonwealth to the States. The Commonwealth has now combined the funding of these three services, and absorbed them into the general revenue grants to the States. This does not apply to S.A. and Tasmania, whose cost-sharing agreements last until 1985.

The Commonwealth has also decided to force the States to limit eligibility for free public hospital treatment to Commonwealth-defined categories of people, and to impose charges on or increase the level of charges to everyone else. The Commonwealth has enforced this by cutting each State's allocation for health services by the Commonwealth's estimate of the extra revenue each State is expected to raise through the new charges. The States do have the option of making up the difference by some other means (e.g. a State income tax or health levy, a resources tax, or a redistribution from other areas of expenditure), but it seems unlikely that any States will do this, at least in the short term.

(ii) Health Insurance

The changes to health insurance are of two basic types:

* changes designed to force people into insurance by making it too financially risky to be uninsured; and
* changes designed to encourage people to insure.

(a) Forcing People to Insure

Firstly, Commonwealth Medical Benefits are now paid only to insured people; that is, an end to universal Commonwealth benefits. This means that uninsured people other than certain pensioners and disadvantaged people (discussed below) face the full cost of medical services, where previously they paid only the first $20 for each service.

Secondly, uninsured people are no longer eligible for public hospital and outpatient treatment at no charge, again with the exception of certain pensioners and disadvantaged people, and with the added exception of Queensland. This means an end to universal access to free public hospital treatment. Uninsured people now face the risk of large hospital bills if they are hospitalised.

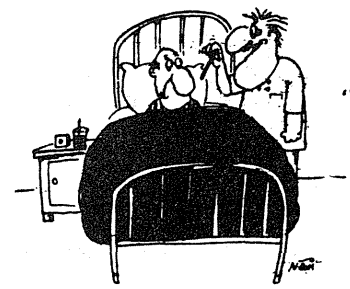
Thirdly, not only will uninsured people now face hospital charges, but the charges themselves have risen steeply. In most States, the charge for an insured person in a shared ward has risen from $50 to $80 per day (an increase of 60%). For an uninsured person, it has risen from $0 to $80

per day (except in Queensland). Other rises are from $75 to $110 per day for a private room (46.7%); from $25 to $45 per day for the professional services charge for treatment by salaried hospital doctors (80%); and from zero to $15 for each outpatient service.[1]

(b) Encouraging People to Insure

The measures designed to encourage people to insure are either aimed at reducing the price of insurance, mostly via subsidies, or at improving benefits.

The Commonwealth Medical Benefit considerably reduces the price of health insurance below what it would otherwise be. However, the new benefit (30% of the Schedule Fee) represents only a marginally increased overall subsidy compared with the former benefit (everything over $20), which was equivalent to about 29% of the total cost of services rendered to members of health insurance funds.[2]



'You misunderstood—I said, "Stick out your wallet."'

An income tax rebate of 32c for each dollar spent on basic health insurance premium has been introduced. This rebate is separate from the concessional expenditure rebate for which expendiutre exceeding $1590 is required.

The Commonwealth is now paying nursing home benefits to all nursing home patients whether they are insured or not. Previously, the funds had to pay nursing home benefits for insured nursing home patients. Although this means that the Commonwealth has now accepted financial responsibility for all nursing home patients, it also means that the funds are relieved of about $120 billion worth of expenses.

The Commonwealth will pay $100 million per year into the Reinsurance Pool which spreads the cost of long stay patients (principally aged people and people with chronic illnesses) between the funds and the Commonwealth.[3] Although this is a decrease of $25 million compared with the subsidy paid in 1980/81, it is effectively an increase because of the removal of $120 million worth of nursing home benefits from the pool.

Basic medical benefits have been increased from 75% to 85%, with a maximum "gap" of $10. Although this will increase premiums, it also means that the amount the patient has to pay directly is reduced.

Cut rate optional schemes offered by the registered non-profit health funds have been abolished. These allowed the funds to offer lower premiums for less benefits (e.g. 50% benefit instead of 75%; or patient liability for the first $200 of health expenditure). These tended to attract young, healthy and single people. This left the main insurance pool with a higher proportion of people who use many services, leading to higher premiums.

However, the government has not moved against similar schemes offered by commercial insurers. These are only available to healthy people, and in

some cases, premiums vary with age. Although there is no tax rebate for commercial health insurance premiums, these schemes are likely to continue to undermine the registered funds.

Forcing and encouraging people into health insurance increases the size of the health insurance pool. Many of the people who have left insurance are low users of health services (young, healthy or single). If they return, there will be more healthy people to subsidise the sick (under the community rating principle), so premiums will tend to fall. Despite these measures, premiums have risen mainly because of the increased hospital charges. Basic hospital plus medical insurance premiums for a family have risen from between $7 and $9 per week, to around $10 per week. After the tax rebate, the net price of insurance in most States is lower than before September 1981 (N.S.W., Victoria, S.A., W.A.). In the other States, the net price will be similar to the price before September 1981, as they previously had lower premiums.

(iii) Private Hospitals

The private hospital subsidy of $16 per patient per day will rise to $28 for patients having surgical procedures.

(iv) Pensioners and the Poor

Because Commonwealth Medical Benefits and free public hospital treatment are no longer available to uninsured people, it was necessary to define categories of people who would have access to free medical and hospital services. These categories are:

* pensioners eligible for income-tested Pensioner Health Benefits Cards;
* migrants in their first six months (issued on application to the Department of Social Security);
* people receiving Unemployment Benefits and Special Benefits, on an income test (issued every two weeks separately from cheques); and
* people passing an income test of:

  $160 per week for married couples, plus $20 for each dependant child;

  $160 per week for single parents with one dependant child, plus $20 for each extra dependant child;

  $96 per week for single people.

This last group must apply to the Department of Social Security for a Health Care Card, which will last for six months.

The people in all these categories will be eligible for public hospital inpatient and outpatient treatment without charge, and bulk billing of the Commonwealth by their doctors for medical services. The categories do not apply to Queensland hospitals which continue to offer the choice of free public treatment to all patients. N.S.W. and Victoria have widened the categories for free hospital treatment to include all uninsured pensioners and beneficiaries (NSW), and to patients using certain services such as

sexually transmitted disease clinics, preventive services, and outpatient services for chronically ill people. The Commonwealth's categories apply in all States for medical services.

EQUITY

> The overriding aim of the Government's health policy is that all Australians should have access to high quality health care ... The system must be equitable, paying particular attention to the capacity of individuals to contribute towards their health costs.
>
> Mr. McKellar, 29/4/81[4]

In this section, it is shown that the changes are grossly inequitable, in relation to both the contributions individuals make towards their health costs, and their access to services.

From Each According to ....

Because the changes are mainly to how health services are financed, rather than to how they are provided, they have a number of redistributive effects.

Insurance premiums are regressive. They are a flat money rate for everyone, so that an individually rich person pays a smaller proportion of his or her income than a poor person, for the same level of benefits. The tax rebate does nothing to improve this (though it is better than a tax deduction which would favour the rich even more). The 1974/75 Household Expenditure Survey showed that a declining proportion of income was spent on health insurance as income rose, even though poor people are less likely to have any insurance, and if they are insured, likely to have lower levels of insurance than rich people . (See Table 1).[5]

To the extent that a higher proportion of the total health bill will now be financed via regressive insurance premiums and tax rebates instead of progressive taxation, the redistribution from the poor to the rich is increasing. The size of redistribution that will occur within the insured population in 1981/82 was estimated by comparing premium payments for basic health insurance with what different income groups would have under an income proportional health levy. A levy of 2.05% on all tax payers on taxable income above the tax free limit would raise the same amount of money as basic hospital and medical insurance will raise in 1981/82 (around $1800

million). The calculation assumes that people with incomes below the income test for free health care will not insure.

TABLE 1: Expenditure on Health Insurance by Family Income 1974-75

(Household) Family Income per week $	Mean Expenditure per week on Insurance $	Percentage of Income spent on Health Insurance $
Less than $80	0.81	1.71
$80 - 140	2.03	1.78
$140 - 200	2.63	1.56
$200 - 260	2.92	1.29
$260 - 340	3.38	1.15
More than $340	4.01	0.87
All households	2.58	1.25

Source: Australian Bureau of Statistics: Household Expenditure Survey, 1974-75, unpublished tables; quoted in Duckett, S.J., "Promoting Inequity: The Jamison Report Proposals on Health Insurance", Australian Journal of Social Issues, 16, 2, 1981.

On this basis, a total of $270 million is being redistributed from 2.4 million insured contributor units (families or single people) above the income test limits and below the levy-premium breakeven point, towards 1.7 million contributor units above the breakeven point. This is an average of $114 for each contributor unit below the breakeven point. As can be seen from Table 2, about $46 million will be redistributed away from married couples with dependant children with family incomes between $251 and $300 per week towards wealthier contributor units.[6]

There will also be redistributive effects between the insured and the uninsured populations. All people with taxable incomes above the tax-free limit pay tax, but only insured people will receive the health insurance rebate. As the proportion of people insured increases with income (see Table 3), there is a redistribution from the unsured tax paying poor to the insured rich.

In addition, it appears that the health insurance tax rebate (which will cost the government about $600 million in lost revenue in 1-82/83) is being paid for by the abandonment of half tax indexation (which will gain the government about $550 million extra in 1982/83). The extra income tax collected will be entirely redistributed to insured people who are disproportionately rich.

To Each According To ...

The most blatant inequity is that uninsured people will be excluded from receiving the tax-financed Commonwealth Medical Benefit, even though they still have to pay full taxes. Thus not only will poor uninsured people have to deny themselves medical care or face large bills with no help from the Commonwealth, but they will have to subsidise the use of services by insured people through the Commonwealth tax system. The Commonwealth Medical Benefit is thus no longer a means of increasing financial accessibility to medical care (by being universal and having a maximum patient payment), but a means to channelling tax-subsidised services towards the rich.

Only slightly less blatant is the denial of free public hospital treatment to all except certain pensioners and categories of disadvantaged people. Although in theory, an uninsured person can still obtain Commonwealth-State subsidised hospital treatment by paying the hospital charges, in practice these charges are so high that they are a strong deterrent to using hospitals when needed.

Within the insured population, there is now evidence that the use of services bears little relationship with need. A study of the medical and hospital use of the members of a health fund in South Australia showed that, contrary to medical expectation, the middle aged used more medical services than aged people, and those living in wealthy suburbs used more services, and had more spent on them, than those living in poor suburbs (the research did not include data on individual income or wealth). Thus support for private health insurance funds is effectively support for an inappropriate and inequitable pattern of use of medical services.[7]

Access for Poor People

The Commonwealth has deemed that certain categories of people will be exempt from health insurance premiums, hospital charges and medical fees. This categorization is unavoidable in a system which provides access on the basis of ability to pay. The categories were detailed above.

In some respects, these arrangements are an improvement over the previous demeaning arrangement whereby poor people had to ask their doctor to classify them as disadvantaged in order to be exempt from payment for medical treatment. Also, the Commonwealth has avoided a means test at the point of service by making it possible to obtain a Health Card either before or after receiving treatment. However, although it is obviously more equitable that these people (estimated to total three million) have access to services than having no access at all, in most respects these arrangements are a deterioration. Most of the problems derive from the selectivity of access.

Selective eligibility for categories of people inevitably stigmatizes these people. The connotations of charity about such services discourages people from taking up their rights to use them. The ever-present danger is of developing two standards of service: one for the poor, and one for the rich. In addition, the existence of a scheme of selective access does not mean that everyone knows about it, or is able to make use of it. For example, under the Subsidised Health Benifits Plan operating from 1970 to 1975 in which selective groups of people had their health insurance premiums partly or wholly paid by the Commonwealth, the take up was only about 40 per cent of those eligible.[8]

TABLE 2: Redistribution of Income: A Comparison of Insurance Premiums with A Proportional Tax 1981-82

Gross Weekly Income of Contributor Unit [1,2]	Average Deficit of Premium over Tax Per Contributor per year[3]	Number of Contributor Units ('000)	Total Redistributive Effect[5]
$	$		$m
	HEAD ONLY		
0 - 100[6]	-	-	-
101 - 150	127.79	273.6	35.0
151 - 200	74.55	298.6	22.3
201 - 250	21.30	313.9	6.7
251 or more	Credit[7]	461.8	-
Total	-	1347.9	63.9
	HEAD WITH DEPENDENT CHILDREN		
0 - 150	-	-	-
151 - 200	249.55	18.8	4.7
201 - 250	196.30	22.5	4.4
251 - 300	143.05	19.9	2.9
301 - 377	74.89	14.6	1.1
378 or more	Credit[7]	23.3	-
Total	-	99.2	13.1
	MARRIED COUPLE[8] WITH NO DEPENDANT CHILDREN		
0 - 150[6]	-	-	-
151 - 200	249.55	93.2	23.3
201 - 250	196.30	129.3	25.4
251 - 300	143.05	152.2	21.8
301 - 377	74.89	168.2	12.6
378 or more	Credit[7]	490.6	-
Total		1033.5	83.1
	MARRIED COUPLE[8] WITH DEPENDANT CHILDREN		
0 - 200[6]	-	-	-
201 - 250	196.30	193.0	37.9
251 - 300	143.05	320.6	45.9
301 - 377	74.89	360.1	27.0
378 or more	Credit[7]	769.7	-
Total	-	1643.4	110.8
Grand Total	-	4123.9[9]	270.7

Notes:

1. Contributor units are the basis for paying health insurance premiums. A contributor unit is either a single person, or a family (which may be a single parent with dependant children, a couple, or a couple with dependant children.)
2. Gross weekly income groups used in ABS (1980), indexed by estimated change in Average Weekly Earnings, March 1980 to December 1981 (26%).
3. Premiums (net of tax rebate) of $350 per year (family) or $175 per year (single) based on rates in September 1981. Tax calculated as 2.05% of income above $4,195 per year (the tax free unit). One tax free unit per family assumed. Average income for group assumed to be mid-point of group.
4. Based on number in category at March 1980, increased by 22.1%. This is based on a net increase of 5.6% in the number of people with insurance (see Note 8). Because it is assumed that all those who are below the income test limits will drop out of insurance, this increase is concentrated amongst those who are above the limits. It is also assumed that those who did not know their income are distributed over all income groups within each type of contributor unit.
5. Average deficit per contributor unit in income group multiplied by number in group.
6. Approximation to income-test units. Single parents assumed to have one dependant child; married couples with dependant children assumed to have two.
7. Tax would exceed premium.
8. Includes de facto relationships.
9. This figure based on the following estimates:

Contributor Units

	('000)	%	Source
Insured	4121.0	61.8	*Derived figure
Pensioners, Veretans etc.	993.8	14.9	*ABS Health Insurance Survey March 1981, Preliminary, p.4.
Disadvantaged	553.6	8.3	*Government estimate of one million people, converted to contributor units
Uninsured	1000.3	15.0	*Estimate based on percentage uninsured before Medibank.
Total	6668.7	100	Total contributor units, March 1981 Health Insurance Survey.

Source: derived from date in:

Australian Bureau of Statistics: Health Insurance Survey, March 1980, No. 4335.0, ABS, Canberra, 1980, p. 12.
_____: Health Insurance Survey, March, 1981 (Preliminary), No. 4341.0, ABS, Canberra, 1981, p.4.
_____: Persons Covered by Hospital and Medical Expenditure Assistance Schemes, August 1972, No. 1710, ABS, Canberra,1974.
_____ : Average Weekly Earnings, June Quarter, 1981, No. 6362, ABS
Australia, Dept. of the Treasury: Income Tax Statistics,1981/82 Budget Paper No. 11, p.4.

Equally important is the plight of those who fall outside the eligible categories for free treatment and remain insured. Under any voluntary system, it is inevitable that many people will remain uninsured and face the risk of large hospital and medical bills. Some of these will have chosen to take the risk, but most will be uninsured because they cannot afford to insure, or because of a lack of information about or understanding of the system.[9] Prior to the introduction of Medibank in 1975, some 13.5 per cent of people were neither insured nor covered by a scheme giving them free health care (pensioners etc.).[10] The prospect is for a return to bad debts for hospitals, and bankruptcy for the people who cannot pay the bad debts. In 1974, prior to the introduction of universal access to hospitals, hospital and medical bills were the major single cause of bankruptcy in South Australia.[11] It is not yet clear whether hospitals will pursue their bad debts as thoroughly in 1981.

A problem of marginal equity also exists because the income test limits are not tapered. Thus, someone just above the income limit will be worse off than someone just below the limit, because the first person will either have to pay health insurance premiums or pay hospital and medical bills directly.

TABLE 3: Health Insurance Coverage by Gross Weekly Income, March 1980

Gross Weekly Income ($)	Has some form of Private Insurance	No Private Insurance	Total	% Insured
Less than $10	39.0	70.5	109.5	35.6
$10 - 79	272.6	800.6	1073.2	25.4
$80 - 119	322.0	529.1	852.0	37.9
$130 - 159	375.7	297.8	673.6	55.8
$160 - 199	500.0	273.5	773.5	64.6
$200 - 239	539.8	211.9	743.6	71.5
$240 - 200	515.9	145.1	661.0	78.1
$300 or more	1049.9	222.2	1272.1	82.5
Don't know	294.6	117.6	412.2	71.5

Notes: 1: A contributor unit is the unit for purchasing health insurance. It is either a single person, or a family.

Source: Australian Bureau of Statistics, Health Insurance Survey, Australia, March 1980, ABS, Canberra, 1980: p.12.

> It is not an exaggeration to state that the health care delivery system could become a bottomless pit down which an ever increasing proportion of the gross domestic product could be poured without any real increase in the health standards of Australia. All of us, whether we be providers or recipients of health care, should be conscious of the cost of health services.
>
> Mr. MacKellar, 29/4/81.[12]

This concern has been expressed by this Government on many occasions since it came to power in 1975, and it is shared by the governments of many other advanced industrial nations. It is apparently concerned with the overall cost of health care services, rather than with who pays for them, or who provides them. However, it is usually not explained why it is a problem that a high or increasing proportion of GDP is spent on health services. Presumably it is based on the conception of health services as being non-productive activities which are a drain on the surplus value produced in "productive" industries. This ignores the roles of health services, on the one hand picking up the tab of ill health generated by the private economy (both directly in the workplace, and indirectly through the environment and the consumption of products), and on the other hand as a consumer of health care products produced in the private sector.

The only change purporting to aim at overall cost constraint is the extension of the so-called "user pays" principle. The rationale given for this is that if people make a contribution towards the cost of each service they use, they will reduce their utilization of services. This strategy is unlikely to have any effect on overall costs for a number of reasons.

Firstly, the imposition of a price on health services has been shown to have little effect on overall utilization. In a major comparative study in Ontario, Canada, user charges were found to have little effect on the overall utilization or cost of health services, and no effect on the utilization of the most expensive service, hospitals. However, the study did find that the user charges redistributed the use of services away from the poor, the disadvantaged and the elderly, towards the rich.[13]

Secondly, the "user-pays" principle is not being applied to the majority of people who are covered either by health insurance or the provisions for pensioners and poor people. The government could have partly overcome this weakness in its user-pays policy by eliminating so-called "gap" insurance (insurance for 100 per cent of the Schedule Fee). The government did not do this, despite a recommendation to do so by the Jamison Commission.[14] In fact, making the user pay (i.e. making the sick pay) goes against the government's own policy of supporting community rates health insurance as a means of sharing health costs between the sick and the healthy. Insurance in conjunction with a private system of service provision really means the "payer uses" rather than the "user pays", because those who can afford insurance can use services, whereas those who cannot afford insurance are restricted in their use.

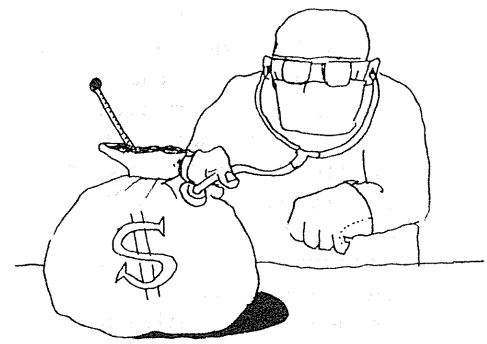
Thirdly, making the user pay as a means of reducing utilization is aimed at the wrong target - the patient. This is like blaming the victim. Apart

from the intial contact with a general practitioner or hospital casuality department, the majority of decisions (and the most expensive ones) are made by doctors. The decision to order diagnostic tests, surgical procedures, hospitals admissions etc. are usually not made by patients.[15] Under a private fee-for-service system, there are incentives to maximise the number of services provided, and to provide the more expensive service when there is a choice between two equally effective services.[16] There is increasing evidence that these incentives result in overservicing and especially in the provision of unnecessary surgery.[17] User payments do nothing to change this situation. Any measures to constrain overall cost must be aimed at:

(a) influencing doctor behaviour; through different methods of payment (e.g. salary; health and maintenance organization), or through administrative review of doctors' utilization patterns; and/or

(b) constraining the supply of inputs such as doctors, hospital beds, technological equipment, etc., and/or

(c) constraining the price of inputs such as medical fees, and hospital supplies etc.[18]



Given the unlikelihood of any effect on overall cost, why has the Government proceeded with this extension of the "user pays" principle? There are three main reasons.

Firstly, the alternative means of constraining cost listed above all effect in some way the income, professional autonomy and power of the medical profession. The fact that the Commonwealth is unwilling to use any of these methods, even though several State governments are trying to use some of then, indicates both the hollowness of the Commonwealth's concern about overall cost, and the power of the organized medical profession.

Secondly, there is an ideological commitment to making people contribute towards the cost of services they use, other than through the taxation system.

Thirdly, the "user pays" principle is a pretext for appearing to shift a significant proportion of health service finance from the public to the private sector, giving the impression of "smaller government". The major application of user charges is in hospitals, where the increased charges and their widened application will result in about an extra $570 million revenue being collected, and an equivalent reduction in direct Commonwealth hospital funding. Simultaneously, the government introduced the tax rebate on basic health insurance costs (worth about $600 million). The net effect of these measures is to reduce both Commonwealth revenue collection and expenditure outlays by about $600 million, and shift the apparent source of this expenditure towards the private sector, Looked at in another way, however, the net effect is a shift, not from the public to private expenditure,

but from direct Commonwealth expenditure to indirect expenditure by the Commonwealth. Indirect expenditure is revenue foregone through taxation concessions, principally the rebate on basic health insurance premiums. This was a major source of health finance prior to 1975/6. The 1981 changes will increase indirect Commonwealth expenditure from 1% to 7% of total health expenditure in a full year (see Table 4). As a result, the proportion of total health expenditure borne by the Commonwealth will actually increase slightly from an estimated 37% in 1979/80 to a predicted 38% in 1982/83, despite the cutback in direct funding of health services. Ironically, another effect of the tax rebate will probably be a slight reduction in the proportion of total health expenditure funded from private sources, because the amount coming from the tax rebate will exceed the increase in health insurance contributions due to increased premiums and increased numbers of insured people.

TABLE 4: Current Health Expenditure by Source, 1979-80 to 1982-83 (Per Cent)

Year	GOVERNMENT					PRIVATE			TOTAL
	Commonwealth			State	All Government	Insurance	Individuals	Total Private	
	Direct expenditure[1]	Indirect Expenditure[2]	Total						
1979/80[3]	36	1	37	23	60	22	18	40	100
1982/83[4]	31	7	38	24	62	21	17	38	100

Notes:

1. Direct Commonwealth expenditure is money allocated to services, programs or grants, including the "identified health grants" included in general revenue grants to the States from 1981/82 onwards.

2. Indirect Commonwealth expenditure is revenue foregone through taxation concessions, principally the income tax rebate on basic health insurance premiums, but also including concessions for medical and hosptial expenses not recouped through health insurance.

3. Estimated from figures for 1978/79 in Deeble (1981).

4. Predicted, assuming no further major policy changes. 1982/83 is the first year in which the full effect the 1981 changes will be felt. Transition arrangements will apply in 1981/82. See Table 5 for a detailed breakdown of the effects of the changes on Commonwealth revenue and expenditure.

Reference: Deeble, J.S., Financing Health Care in a Static Economy, paper presented to the Seventh International Conference on Social Science and Medicine, Leeuwenhorst, Netherlands, June 1981, pp. 15, 16 and 22.

COST TO THE INDIVIDUAL AND THE TAX REBATE

By "cost to the individual", the government generally means the cost of health insurance. Thus, "The Government believes that health insurance should be available to all Australians at a reasonable cost and should have a wide coverage of the population in order to support the community rating principle."[19] The cost to currently uninsured people will, of course, rise enormously. If they insure, their costs will rise from zero to about $350 for a family, making a mockery of the so-called "incentive" to insure, i.e. the tax rebate. To those who remain uninsured, there will either be the risk of enormous debts, or the time and degradation involved in obtaining a health care card.

The main measure to reduce the cost of health insurance is the tax rebate. However, the price-reducing effect of the rebate has been partially offset by the increases in premiums, due mainly to the increases in hospital charges.[20] The main effect of the rebate is not so much to reduce the price of insurance, as to restructure the sources of finance as discussed above. Further weight is added to this explanation when one considers the other ways the government could have reduced the cost of health insurance. The most obvious way would be to pay the $600 million in direct subsidies to the health insurance funds, instead of paying it indirectly via tax rebates. This would be administratively more efficient. Also it would make it easier for low income earners to pay for health insurance because they would have to pay $7 per week for basic hospital and medical insurance, instead of having to find $10 per week, and then get one-third back at the end of the year. (In March 1980, 54 per cent of contributor units which were neither insured nor covered by pension or disadvantaged schemes, gave cost as their reason for not insuring.)[21] However, direct payment of subsidies to health insurance funds would make the $600 million a direct Commonwealth expenditure and destroy the appearance of smaller government.

COMMONWEALTH EXPENDITURE EFFECTS

Despite the long standing Government rhetoric about reducing public expenditure, the net effect of the 1981 changes to health service financing will be an increase in the Commonwealth's outlays of about $130 million in 1982/83, the first year when the full effect of the changes will be felt (see Table 5). Again the real reason for these changes is not to cut public expenditures but to shift Commonwealth expenditure from direct to indirect (taxation) expenditure.

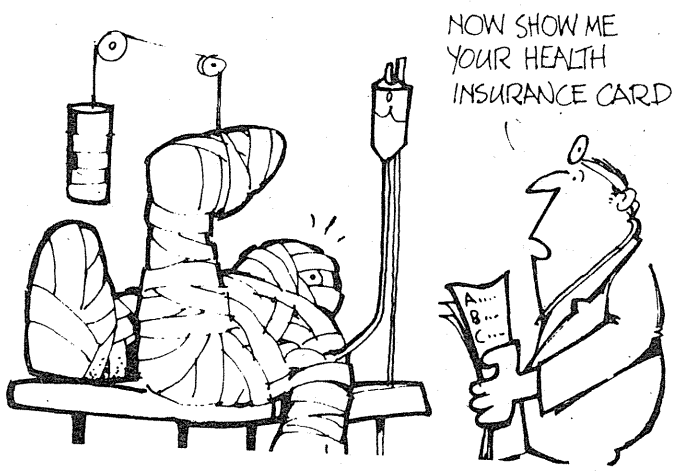
EFFICIENCY AND STAFF RESPONSIBILITY

> Clearly, if this level of quality is to be maintained, given priorities in other areas, every effort must be made to ensure that resources allocated to the healty area are used in an efficient and cost-effective way.
>
> Mr. MacKellar, 29/4/81.[22]

By efficiency, the Government usually means the internal efficiency of the public hospital system, that is, the cost per patient treated in the system. There is little evidence to support the Government's concern with inefficiency in the public hospital system. Although it frequently uses the report of the Jamison inquiry into hospital efficiency to justify its concern, the report itself states that "real resources for each patient for Australia

have risen by only 3 per cent from 1970/71 to 1978/79 in recognised hospitals."[23] This figure was obtained by deflating current price expenditures by a hospital price index. This is a remarkable result considering the labour intensity of hospitals, the increasing specialisation of medicine, the increasing technological sophistication and the number of new and upgraded hosptials - factors which are supposed to have led to real increases in costs.[24]

If there is a problem of inefficiency, it is more likely to be a problem of allocative inefficiency between institutional and non-institutional services, than a problem of internal efficiency in the public hospitals. It is possible (and in many cases desirable on health grounds) to substitute cheaper non-institutional services for some institutional services. Thus, some inpatients and outpatients in hosptials and nursing homes could be equally effectively cared for outside of institutions by community or domiciliary healty services.[25] More fundamentally, occupational, environmental, public and preventive health services are more likely to have an effect on people's health than additional curative medicine. Both Commonwealth and State expenditure programs reinforce the dominance of institutional services at the expense of non-institutional services. For example, the Commonwealth has constructed the community health program since 1976, and has now abandoned responsibility for it, while until 1981, it had kept the number of domiciliary nurses it subsidised constant for five years. In total, community, domiciliary, occupational, environmental, public and preventive health services used only 3 per cent of Australia's health expenditure in 1977/78, compared to 56.5 per cent used by institutional care. Also the proportion used by institutional care continues to increase. In 1974/75 it was 54.7 per cent.[26]



However, upgrading non-institutional services would involve extra public expenditure, at least initially. More fundamentally it threatens the medical profession where power lies in curative medicine, especially in hospitals, and the manufacturers of pharmaceuticals and hospital equipment. (Non-institutional services are generally less oriented to curative medicine, and to technology.)

Even if the internal efficiency of public hospitals is regarded as a problem, what has the government done about it? In 1979, the government had appointed a Royal Commission with broad terms of reference to inquire into the efficiency and administration of hospitals. This Commission (the Jamison Commission) identified the Hospitals Cost-Sharing Agreements, which divided responsibility for hospital funding between the Commonwealth and the States, as one factor in hospital inefficiency. It recommended the replacement of the cost-sharing agreements by block grants. It also recommended a wide range of specific measures aimed at directly improving hospital efficiency.[27]

In its 1981 announcement on health financing, which was effectively the government's response to the Commission's report, the government placed most of the blame for hospital inefficiencies on the Cost Sharing Agreements, and the divided financial responsibility.[28] Instead of the Commonwealth using its share of responsibility to initiate measures to improve hospital efficiency such as those recommended by Jamison, it has abandoned this responsibility by absorbing hospital, community health and school dental funding into general revenue grants to the States, so that "States fully accept their constitutional responsibilities for the provision of health services and determine their own priorities as to how funds are to be allocated to the different parts of the health system."[29] Ironically, Mr. MacKellar also said that "failure by the Commonwealth to ensure that efficiencies are effected would mean that it would be abrogating its proper responsibilities."[30]

This move is unlikely to have any effect on efficiency. Firstly, there is no reason to believe that non-involvement by the Commonwealth will "ensure that efficiencies are effected." Secondly, although the Commonwealth's hospital funds have been included in general revenue grants, the remaining State finance for hospitals is not affected by the changes (see Table 4). Thus the States may have to determine their priorities alone, but their financial responsibility has not been increased. Thirdly, although the Commonwealth has abandoned financial responsibility, it has certainly not abandoned power over the hospital system. This is clearly demonstrated by the Commonwealth's power to force increased charges on hospitals, and to impose an income test on free public hospital treatment. Thus the concept of the States having individual power over their hospitals is illusory. Fourthly, if inefficiency is due to divided responsibility, then divided responsibility remains, with the Commonwealth responsible for hospital insurance and the States responsible for the provision and funding of hospital services.

In addition, the absorption of the community health program and the school dental scheme into general revenue funding will not help allocative efficiency in most States. Community health and school dental services will inevitably lose funds without their own specific purpose grants. Hospitals have far greater political power in the competition for resources at the State level. Also they were originally Commonwealth initiatives, and several States remain antagonistic towards them.

As this move will not affect efficiency, the only reason for it is an ideological commitment to handling activities over to the States. However, this is tokenism because of the power the Commonwealth still has over the State public hospital systems.

THE PRIVATE SECTOR

> The Government fully recognises the valuable role played by the private sector of the health care delivery system. It believes that a strong health insurance industry underpins the continued viability of the private sector.
>
> Mr. MacKellar, 29/4/81.[31]

The government's aim here is to encourage people into health insurance as a means of encouraging people to use private doctors and hospitals. This is consistent with its ideology of shifting activities into the private sector. While it is true that health insurance enables people to use private doctors and hospitals, it does not force them to. People with hospital insurance are

TABLE 5: Full Year Effect in 1982/83 on Commonwealth Revenue of the 1981 Changes to Health Financing at 1981 Prices

Change	Increase to Revenue (Decreased Expenditure) $m	Decrease to Revenue (Increased Expenditure or Decreased Taxation) $m
Tax Rebate for Basic Health Insurance		600
Nursery Home Benefits for insured people (formerly paid by funds)		120
Increased subsidy for surgical patients in private hosptials ($28/day instead of $16/day)		28.5
Decrease in Reinsurance Pool contribution	25	
Restriction of definition of disadvantaged patients, and increase in payments to doctors from 75 per cent to 85 per cent of Schedule Fee	9	
Change from Commonwealth payment of excess over $20 for medical bills for all patients to 30 per cent of all medical bills for insured patients only	11	
Proposed reduction in payments to States for hospitals[1]	572	
TOTAL	617	748.5
Net decrease to revenue		131.5

Notes:

1. Proposed reduction in 1981/82 is $258 million. This is 60 per cent of the revenue expected to be raised in the last nine months of 1981/82 through increased and extended charging for hospital accommodation (429m).

Sources: Klugman, R.E.; Speech in House of Representatives Daily Hansard, 5 May 1981, pp. 1963-64.

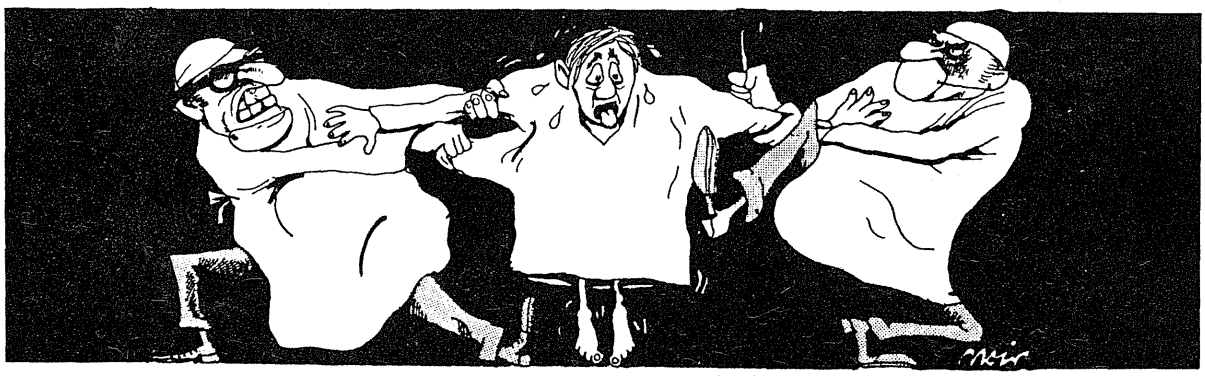
Treasury Department: 1981-82 Budget Papers, Nos. 1 and 7, AGPS, Canberra, 1981.

covered for treatment by salaried hospital doctors on both an inpatient and an outpatient basis (if they have access to a hospital with these services) as well as for their hospital accommodation. Hospital-only insurance is much cheaper than hospital and medical insurance. In a clear attempt to minimise the number of people taking this option, neither the Commonwealth nor the funds have mentioned it in their advertising.[32] In contrast, the N.S.W. and Victorian Governments publicised this option.

The Commonwealth's support for private health insurance as a means of encouraging the private provision of health services is a little harder to explain. The funds are non-profit organizations which are so tightly regulated and so heavily subsidised that they are little more than semi-government health tax collection agents. Furthermore, a universal, equitably-financed public health insurance scheme would also support private service provision, if there was not a corresponding build-up in public health services. So why the emphasis on private health insurance? There are a number of reasons.

Firstly, the Australian Medical Association lobbied the government in early 1981 to introduce a scheme very similar to one implemented by the government.[33] Although the private medical profession depends on government subsidies to maintain their incomes, they fear that this funding is the first step towards a nationalised health service. The medical profession wants to keep government funding at a distance to retain their autonomy. The private health insurance funds achieve this by acting as a third party channel for government subsidies.[34]

Secondly, although the funds are non-profit, they identify closely with private enterprise, and with the private medical profession. Thirdly, although they do not accumulate capital in the usual sense of the word, they have large reserves, much of which is invested in private capital. In 1979 the Funds had a total of $533 million invested, $391 million of which was privately invested.[35] Thus the funds channel money collected to pay fo health services into private investment.



CONCLUSION

The 1981 changes to health financing should be seen not so much as a cut in health expenditure but as a redistribution and restructuring of that expenditure. The main effects are:

a) a massive redistribution of private income and social wage from the poor to the rich;

b) a strengthening of the basis of private medicine and private hospitals;

c) a restructuring of the sources of health financing, mainly from direct Commonwealth expenditure to indirect Commonwealth expenditure(via taxation concessions);

d) a nominal transfer of responsibility for hospitals to the States.

These changes are thus broadly consistent with both the Razor Gang's emphasis on shifting activities from the Commonwealth to the States and to the private sector, and the education funding emphasis on increasing assistance to private schools while decreasing assistance to public schools.

THE ALTERNATIVES

The alternatives, at the very least, would include a simple, universal equitably-financed, public health insurance scheme, with built-in constraints on overservicing by the medical profession. This alone would not solve many of the problems of private health care service provision .Some of these problems would be ameliorated by increasing the public provision of health services in conjunction with a shift in emphasis away from institutional care to non-institutional care. However, such changes deal only with the organisation of services to cure ill-health, rather than to prevent ill-health or maintain good health. More fundamental changes require a recognition that the causes of much ill-health are social, occupational and environmental[36], and that many of these causes originate in a system of production which releases products into the workplace, society and the environment without regard to their effects on human health. Action taken to change these causes, or the system of production from which they originate, will ultimately have more effect on people's health than improved access to curative services.

FOOTNOTES

1. There are some interstate differences in hospital charges:
   W.A. : $85 per day for shared wards
   S.A. : $85 per day for both shared and private wards
   $20 per outpatient service.

2. Commonwealth Department of Health: Director-General's Annual Report, 1979-80, AGPS, Canberra, 1980, pp. 250-251.

3. If a health fund contributor spends more than 35 days in hosptial in any one year, then his or her basic hospital benefits are paid out of the Reinsurance Pool. The deficit remaining in the Reinsurance Pool after the Commonwealth's subsidy is shared by all registered health funds in proportion to their membership. This arrangement helps to even out premiums between health fund, despite differences between funds in the proportion of contributors who are long stay patients. It also allows the Commonwealth to subsidise the care of the aged and the chronically ill. Participation in the Reinsurance Pool arrangements is a condition of registration for registered health funds.

4. MacKellar, M.J.R.: Health Care Services; Ministerial Statement, House of Representatives Daily Hansard, 29 April, 1981, p. 1720.

5. The 1974/75 Household Expenditure Survey was conducted at a time when the health scheme then operating was very similar to the scheme introduced in September 1981. All patients had to pay for hospital treatment, except those passing a means test. Uninsured patients did not receive Commonwealth Medical Benefits, and received lower Commonwealth Hosptial Benefits than insured patients. Under the Subsidised Health Benefits Plan, categories of migrants, unemployment and sickness beneficiaries,and low income earners, very similar to the new categories, were eligible for free or subsidised health insurance.

6. It is recognised that this calculation is based on a large number of assumptions, estimates and predictions, some of which are listed in the notes to Table 2. However, it provides an indication of the magnitude of redistribution.

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8. Deeble, J.S., personal communication.

9. Australian Bureau of Statistics: Health Insurance Survey, Australia, March 1980, No. 5335.0, ABS, Canberra, 1980, p. 14.

10. Australian Bureau of Statistics: Persons Covered by Hospital and Medical Expenditure Assistance Schemes, August 1972, No. 1710, ABS.

11. Australia, Commission of Inquiry into Poverty, Debt Recovery in Australia, Research Report, Law and Poverty Series by David St. L. Kelly, AGPS, 1977.

12. MacKellar, op.cit., p. 1715.

13. Badgley, R.F. and Smith, R.D.: User Charges for Health Services, Ontario Council of Health, Toronto, 1979.

14. Australia, Commission of Inquiry into the Efficiency and Administration of Hospitals: Report, Volume 1, December 1980, AGPS, Canberra, 1-81, p.9.

15. Roemer, M.I.: The Public Demand for Medical Care, in The Organization and Evaluation of Medical Care, University of Otago, 1970, pp. 41-49.

16. For more detailed discussion of this, see:
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17. Taylor, R., Medicine Out of Control, Sun Books, Melbourne, 1979, Chapter 6.

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18. Palmer, G.R., Cost Containment and Cost Escalation in the Australian Health Service, Current Affairs Bulletin, 55, 5, October 1978, pp. 15-13.

19. MacKellar, op.cit., p. 1719.

20. The family rate for basic hospital and medical insurance in September 1981 was around $10 per week in all states. After the tax rebate, the net price was $6.80. Before September 1981, rates varied from $7 to $9 in different states and different funds.

21. ABS: Health Insurance Survey, Australia, March 1980, No. 5335-0, ABS, Canberra, 1980, p. 14.

22. MacKellar, op.cit., p. 1715.

23. Australia, Commission of Inquiry into the Efficiency and Administration of Hospitals, Volume 2, op.cit., p.15.

24. Australia, Commission of Inquiry into the Efficiency and Adminsitration of Hospitals, Interim Report, June 80, AGPS, Canberra, 1980, pp. 29-24.

25. For more detailed discussion of this, see:
Bennett, C. and Wallace, R., Alternative Forms of Care for the Aged and handicapped, National Institute of Labour Studies Working Paper No. 39, Flinders University, June 1980; and

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26. Commonwealth Department of Health, Australian Health Expenditure, 1974-75 to 1977-78: An Analysis, AGPS, Canberra, 1980, pp. 45-49.

27. Australia. Commission of Inquiry into the Efficiency and Administration of Hospitals, Volume I, op.cit., pp. 10-19.

28. MacKellar, op.cit., p. 1717.

29. Ibid., p. 1716.

30. Ibid.

31. Ibid., p. 1720

32. Commonwealth Department of Health, In Sickness and in Health ... Better Value for your Dollar, AGPS, Canberra, July 1981, pamphlet; and

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