Public Health Association
AUSTRALIA

Public Funding of Private Health Insurance

Policy Position Statement

Key messages:

Private health insurance (PHI) is an *inequitable* mechanism for the distribution of scarce health care resources, and therefore contributes to health inequity. It is also an *inefficient* mechanism for funding health care services compared with universal public health insurance.

In its current form, the PHI industry is financially unsustainable. The fundamentals that underpin the viability of the PHI industry are placing the industry into a 'death spiral' in which it cannot be sustained without large public subsidy.

Government funding for PHI via the premium rebate is a poor use of public finances that could produce better and more equitable health outcomes by directly funding health care and implementing healthy public policies.

The tendency for PHI-funded private providers to be promoted as the health care pathway of choice – for those who can afford it – implicitly casts the universal public services as a second class option, eroding social justice and equity and resulting in adverse outcomes in terms of the social determinants of health.

In addition, while PHI is promoted as reducing waiting times and alleviating pressures with the public health system, it actually increases pressures due to workforce sharing across the public and private healthcare systems, compounding current health workforce shortages in Australia.

Key policy positions:

1. The current public funding of private health insurance should be transferred to universal health care services.
2. Public awareness should be promoted regarding the inefficiency and inequity of government funding for the PHI industry, and of the potential for improved Australian population health and health equity through the abolition of the PHI rebate and the reallocation of those public funds.
3. Donations from the private health insurance sector to political parties should be prohibited.

Audience: Federal, State and Territory Governments, political parties and candidates, health consumer groups, other NGOs, policy makers and program managers.

Responsibility: PHAA Political Economy of Health Special Interest Group (PEH SIG)

Date adopted: September 2024

Contacts: Genevieve Coorey, gencoorey@gmail.com PEH SIG Co-Convenor

Citation: Public Funding of Private Health Insurance: Policy Position Statement [Internet]. Canberra: Public Health Association of Australia; 2015 (Sep 2024). Available from: URL

Public Funding of Private Health Insurance

Policy position statement

This statement should be read with the background paper: *Private Health Insurance or Public Health?*

PHAA affirms the following principles:

1. Health is a fundamental human right. Its prerequisites include social justice and equity.
2. Health inequity results from unjust social treatment by governments, organisations and people. Free market economic approaches to health care provision have been shown to widen socio-economic and health inequities.[(1)]
3. Quality health care should be universally available, promptly provided based on need, regardless of ability to pay, with no cost barrier at the point of delivery, and funded by progressive general taxation.
4. Public funding of health care should be managed to optimise both allocative and technical efficiency to deliver the maximum population health benefit per dollar spent.
5. Health care services should be organised to contribute to improving social justice, equity and cohesion, all which have been proven to be beneficial to population health, rather than to eroding them.

PHAA notes the following evidence:

6. Private health insurance (PHI) covers 44.9% of Australians for hospital treatment.[(2)]
7. PHI is subsidised by public funds including a means-tested rebate currently paid at an average of 27.8% of the cost of the premium. The public cost of the rebate rises with PHI premium rises. It is around $6.7 billion (or 8% of Commonwealth healthcare expenditure) in 2022-23.[(3)]
8. The current 35 PHI entities incur costs of competing in advertising and promotion. PHI entities operate with an average after tax gross margin (premium income over benefits paid) of 9.3%, management expenses average 8.9%, and net margins (profit) average 5.2% .[(4)] The entities do not have the economies of scale available to Medicare. The additional cost (borne by policy holders via premiums) above that of Medicare is around 10% or about $1.6 billion per annum.[(5)]
9. The inability of private insurers to control the costs imposed by health service providers reduces the efficient use of funds. Providers have a market advantage compared to a monopsony setting where a single public insurer is sole purchaser (and price-setter) and closely associated with the regulator.[(5)]
10. Organisation for Economic Co-operation and Development (OECD) national comparison statistics show that the greater the proportion of health care costs are met by PHI, the greater the overall costs of health care are to the economy, as private providers use their market position to extract greater yields.[(5)]
11. Fragmentation and weakening of the demand side, as embodied in the dominance and proliferation of multiple PHI purchasers competing in the health care services market, has been identified as an explanation for the USA spending so much more per capita than other countries.[(6)]
12. Competition between PHI entities purchasing health care services also puts cost pressure on the public sector.[(7)] Medical salaries in public hospitals need to compete with the private sector to retain staff.[(8)]
13. PHI exacerbates fragmentation of health care. The core role of private hospitals is providing nursing and accommodation infrastructure for procedural medical specialists. PHI policy holders comprise the majority of private hospital patients. Private hospitals tend to deal with (profitable) acute procedural matters rather than costly chronic conditions which largely remain within the public sector.

14. In addition, it has been found that in healthcare systems where a public single payer offers universal coverage, the presence of supplementary private insurance can contribute to creating incentives on the supply side and lead to practices and an allocation of resources that are not optimal from a social welfare perspective.[(9)]

15. There is more low- or no-value care in private hospitals than in public hospitals. This drives up the cost of private hospital care.[(5)]

16. Compared with the rest of the population, those with PHI are richer, better educated, more health conscious, and healthier. PHI use is highest among those with the least need for health care.[(10)] This further contributes to health inequity.

17. Health inequities are increasing in Australia.[(11,12)] PHI may have some role in this as it sends "an implicit message of social division: PHI and therefore private hospitals are for those who have the means; public hospitals are for the poor".[(5)]

18. Analysts argue that the private health insurance industry cannot remain viable in its current form.[10]

19. Duckett and Moran argue that radical reform is needed to make private hospitals as efficient as public hospitals, to reduce out of pocket costs for patients, stop egregious billing by some doctors, cut prices for prostheses and to reduce premiums.[(13)] Others have called for risk-based premiums and abolition of the rebate for people under 55, while those over 55 would all pay the same premium and would continue to get the rebate for hospital insurance.[(14)]Such policies could provide a transition pathway for the private hospital sector towards a self-sufficient model, with public resources then dedicated to the universal access public hospital system; this would require bi-partisan political commitment and far-sighted decisions by government.

20. Implementing this policy would contribute towards achievement of UN Sustainable Development Goal 3: Good Health and Well-being and Goal 10: Reduced Inequalities.

PHAA seeks the following actions:

21. The Government of Australia should:

    i. Abolish the publicly funded PHI premium rebate and the Medicare Levy Surcharge.
    ii. Redirect the funds saved from abolition of the rebate to public health care services.

22. Donations from the private health insurance sector to political parties should be prohibited.

PHAA resolves to:

23. Advocate for the above steps to be taken based on the principles in this position statement.

(Adopted 2015 and revised 2018, 2021 and 2024)

References

1. Public Health Association of Australia. Policy Position Paper. 2016 [cited 2024 Aug 9]. Health Equity . Available from: https://www.phaa.net.au/common/Uploaded%20files/SIG%20documents/PEH%20SIG/2022%20policy%20review%20-%20final%20-%20Health%20Equity.pdf
2. Australian Prudential Regulation Authority. STATISTICS: Quarterly private health insurance statistics [Internet]. Sydney; 2024 [cited 2024 Aug 9]. Available from: https://www.apra.gov.au/sites/default/files/2024-02/Quarterly%20Private%20Health%20Insurance%20Statistics%20December%202023_0.pdf

3. Commonwealth of Australia (Department of Health). Budget 2022-23: Portfolio Budget Statements 2022–23 Budget Related Paper No. 1.7 Health Portfolio [Internet]. Canberra; 2022 [cited 2024 Aug 9]. Available from: https://www.health.gov.au/sites/default/files/documents/2022/03/budget-2022-23-portfolio-budget-statements.pdf
4. Australian Prudential Regulation Authority. Operations of Private Health Insurers Annual Report [Internet]. Canberra; 2024 Feb [cited 2024 Jul 23]. Available from: https://www.apra.gov.au/operations-of-private-health-insurers-annual-report
5. Menadue J, McAuley I. Private health insurance: high in cost and low in equity [Internet]. Sydney; 2012 [cited 2024 Jul 23]. Available from: https://cpd.org.au/work/private-health-insurance/
6. Colombo F, Tapay N. Private Health Insurance in OECD Countries The Benefits and Costs for Individuals and Health Systems [Internet]. 2004 [cited 2024 Aug 9]. Available from: https://read.oecd-ilibrary.org/social-issues-migration-health/private-health-insurance-in-oecd-countries_527211067757#page2
7. Kettlewell N, Zhang Y. Age penalties and take-up of private health insurance. Health Econ. 2023 Dec 23;
8. Michael T, Filc D, Davidovitch N. What motivates physicians to propose private services in a mixed private-public healthcare system? A mixed methods study. BMC Health Serv Res. 2022 Dec 10;22(1):51.
9. Milcent C, Zbiri S. Supplementary private health insurance: The impact of physician financial incentives on medical practice. Health Econ. 2022 Jan 11;31(1):57–72.
10. Banks E, Jorm L, Lujic S, Rogers K. Health, ageing and private health insurance: baseline results from the 45 and Up Study cohort. Aust New Zealand Health Policy. 2009 Dec 13;6(1):16.
11. Katterl R. RESEARCH ROUNDup. 2011 [cited 2024 Aug 9]. Socioeconomic status and accessibility to health care services in Australia . Available from: https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=c133a7a1ffcded62471924dab3db74431a12f0bb
12. Whitehead M. The Concepts and Principles of Equity and Health. International Journal of Health Services [Internet]. 1992 Jul 1 [cited 2024 Aug 9];22(3):429–45. Available from: https://pubmed.ncbi.nlm.nih.gov/1644507/
13. Moran G, Duckett S. Stopping the death spiral: creating a future for private health [Internet]. 2021 May [cited 2024 Aug 9]. Available from: https://grattan.edu.au/report/stopping-the-death-spiral/
14. Duckett S. Saving private health 2: Making private health insurance viable [Internet]. 2019 Dec [cited 2024 Aug 9]. Available from: https://grattan.edu.au/report/saving-private-health-2/