

Tax expenditures and public health financing in Australia

Julie Smith

Number 33
September 2000

THE AUSTRALIA INSTITUTE

Tax expenditures and public health financing in Australia

Julie Smith

Discussion Paper Number 33
September 2000

ISSN 1322-5421

Acknowledgements

The historical data series used in this study was originally compiled in collaboration with Dr James Butler (Senior Research Fellow, National Centre for Epidemiology and Population Health, Australian National University) and funded by the Australian Tax Research Foundation.

I am also grateful to Ian McAuley (Lecturer in public finance at the University of Canberra) for helpful discussion and comments on drafts and data sources. Final responsibility for the paper rests with the author.

Table of Contents	
Acknowledgements	ii
List of Tables	iv
List of Figures	iv
Executive Summary	vi
1. Introduction	1
2. What does ‘tax expenditure’ mean?	2
2.1 The concept	2
2.1 The data	6
3. Tax concessions for private health-related expenses	8
3.1 Tax concession for health insurance fund membership – the Medicare levy surcharge exemption	8
3.2 Tax rebates and deductions for health-related expenses	8
4. Tax expenditures on health – the level and distribution	10
5. Private health insurance and public funding	15
6. Conclusion and policy implications	19
References	23
Appendix	25

List of Tables

Table 1 Tax concessions for health-related expenditures, 1960-61 to 1998-99	9
Table 2 Tax expenditures on health, 1980-81 to 2001-02 (\$ 000, current prices)	11
Table 3 Taxpayer distribution of total tax expenditures on health, selected years	14
Table 4 Distribution of tax expenditures on health, net medical expenses	14
Table 5 Distribution of tax expenditures on health, contributions to health insurance funds	14
Table 6 Source of funds for health service expenditures, unadjusted for tax expenditures	17
Table 7 Adjustments for tax expenditures and PHIIS or private health insurance rebate	18
Appendix Table A Distribution of total tax expenditures by decile	25
Appendix Table B Distribution of tax expenditures on net medical expenses by decile	25
Appendix Table C Distribution of tax expenditures on private health insurance by decile	25

List of Figures

Figure 1 Tax expenditures on health-related expenses, 1960-61 to 2001-02	12
Figure 2 Distribution of tax expenditures on private health insurance by taxable income group, 1997-98 income year	13
Figure 3 Private health insurance coverage 1984 to 2000	16
Figure 4 Health services expenditure, source of funds adjusted for tax expenditures	18

© The Australia Institute.

This work is copyright. It may be reproduced in whole or in part for study or training purposes only with the written permission of the Australia Institute. Such use must not be for the purposes of sale or commercial exploitation. Subject to the Copyright Act 1968, reproduction, storage in a retrieval system or transmission in any form by any means of any part of the work other than for the purposes above is not permitted without written permission. Requests and inquiries should be directed to the Australia Institute.

Executive Summary

At various times in Australia's recent history, the Commonwealth government has used the tax system to support its public health policy goals. Tax concessions cost the same as direct, budget subsidies but are less transparent and less scrutinised. This study breaks new ground by examining how the benefits of tax concessions for health expenditures, such as the rebate for private health insurance, have been distributed among taxpayer income groups in the four decades since 1960. It also shows for the first time the value of the tax relief arising from the Medicare levy surcharge for those with private health insurance.

Taxation reform over the last decade has emphasized removing special concessions from the tax system in order to improve equity, economic efficiency and transparency. The use of the tax system since 1997-98 to provide subsidies to the health insurance industry directly contradicts the thrust of the Government's tax reform agenda. The private health insurance industry now receives more budgetary assistance than provided to the mining, manufacturing and primary agricultural production industries combined.

One of the basic strengths of Australia's public health system is that universal access to free public hospitals and cover against specified medical costs have been financed substantially through progressive taxation. The present extent of public assistance to the health insurance industry significantly distorts this progressive pattern of health care financing. The current rebate for private health insurance has a direct annual cost that is likely to be around \$2 billion or more. Based on taxation statistics, this study shows that tax concessions for health remain heavily skewed towards the affluent. For 1997-98, the latest year for which taxation statistics are available:

- around a half of the value of tax concessions for private health insurance went to the most well off third of taxpayers; and,
- less than a fifth of these concessions go to the one third of individuals in the lowest taxable income group.

According to taxation statistics, the income-tested rebate for health insurance was at least as regressive as the universal rebate existing in the early 1980s. The removal of the income test from January 1999 makes the current rebate even more inequitable. It is likely that well over a billion dollars of public money is underwriting the health care of Australia's richest individuals and families. Around a quarter of the tax subsidy may be spent on ancillary rather than hospital insurance.

This skewed distribution of incentives for private health insurance contrasts sharply with a wide range of evidence on the progressive distribution of direct public spending on health.

This study also shows that assistance to the health insurance industry through the tax system has been severely understated. On conventional definitions of 'tax expenditures', the exemption from the 1 per cent Medicare levy surcharge that is allowed for the

privately insured should be included in official published estimates of tax expenditures. This study shows the exemption represents a tax expenditure of around \$1.1 billion annually. This is a substantial additional tax prop to the private health insurance industry that has attracted virtually no comment because of its lack of transparency and its omission from the Treasury's annual *Tax Expenditures Statement*. The use of Commonwealth taxation powers to impose a discriminatory tax on individuals choosing not to purchase a commercial product is questionable, and sets a precedent for imposing discriminatory income taxes according to other dubious criteria.

One rationale put forward for the present policy of encouraging high-income earners to take out private health insurance is that they can afford to pay more for health care. The most effective and equitable way to increase the contribution of the rich to health care costs would be to abolish the exemption from the Medicare levy surcharge and channel the revenues into the public health system.

While encouraging private health insurance membership is said to take pressure off public hospitals, there is compelling evidence that the cost of the private health insurance rebate far exceeds any financial gains to public hospitals.

Public assistance for the private health insurance industry is at the expense of public health care. Public sector cutbacks over the last decade have produced queues in public hospitals and axing of public dental care services. 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. Through the 30 per cent rebate for ancillary insurance the Commonwealth is now spending around \$180 million each year funding dental services mainly for the affluent. As well as undermining the progressive financing of universal health care, the scheme is an ineffective and wasteful way of funding health care.

Current financial incentives for middle and high-income earners to take out private health insurance and abandon Medicare are a drain on the public purse and threaten the progressive principle underpinning Australia's public health care financing system. The private health insurance rebate should be abolished, particularly for ancillary insurance. By doing so, at least \$2 billion of additional funding could be earmarked for improving access to medically-necessary hospital services, and public dental and allied health programs.

The Medicare levy surcharge is an untapped opportunity for expanding a progressive funding base for health care. Extending the Medicare levy surcharge to all high-income earners would further expand available revenues system for the public health care by around \$1 billion, and whilst also enhancing the progressivity of health care financing.

Existing incentives for private health insurance also lack transparency about public support for private health funds. The above measures would also serve to bring the reality of the tax system into line with the rhetoric of tax reform, and improve accountability of government.

1. Introduction

At various times in Australia's recent history, the Commonwealth government has used the tax system to support its public health policy goals. Tax concessions to particular industries or groups of taxpayers cost the government the same as direct subsidies. However, the income distribution of these tax 'carrots' and 'sticks' has not previously been analysed. This study breaks new ground by examining how the benefits of tax concessions for health expenditures were distributed among taxpayer income groups in the four decades since 1960, and how this affects the progressivity of Australia's system of funding health care.

From July 1997, the Coalition Government introduced an income-tested tax rebate for private health insurance premiums. At the same time, middle- and high-income individuals or families who chose to self-insure or rely on Medicare were penalized through a 1 per cent Medicare levy surcharge. Soon after, this income-tested rebate was scrapped in favour of a 30 per cent rebate on private health insurance from January 1999. This was similar in character to the rebate in existence for around two years in the early 1980s, although unlike the earlier rebate, benefits can also be claimed directly through private health insurance funds.

Like the tax rebate for private health insurance operating briefly in 1981-82 and 1982-83, the latest scheme is very costly to public revenue. When introduced, the scheme was costed at \$1.09 billion in 1999-2000 (the first full year of its operation), rising to \$1.36 billion by 2002-03 (Senate Community Affairs Legislation Committee 1998). With population coverage reportedly rising sharply to around 40 per of the population (around 7.9 million members) in June 2000, the cost of the rebate has been substantially revised (Senate Community Affairs Legislation Committee 2000). While the Government's latest estimate is \$1.9 billion, and that by Duckett and Jackson (2000) \$2.2 billion, some estimate the cost could reach \$2.4 billion a year (Segal 2000). This is more budgetary assistance than received by the mining, manufacturing and primary agricultural production industries combined (Duckett and Jackson 2000). The exemption from the Medicare levy surcharge for those with insurance also represents tax assistance for the industry. The \$0.9 billion Medicare benefit payments for private patients in public hospitals is a further public subsidy of the private health sector.

At the end of a decade in which fiscal constraints produced unprecedented 'queuing' at public hospitals (Deeble 1999), and saw various public health programs abolished (Duckett and Agius 2000), who benefits from this public largesse warrants careful scrutiny.

Evidence from surveys suggests that those purchasing health insurance are likely to be earning high incomes (Wilson 1999) (Schofield 1997). For example, in 1995, those with incomes above \$50,000 p.a. were three times more likely to have private health insurance than those earning less than \$20,000 (McAuley 1998). Around two-thirds of this high-income group were private health fund members.

However, to date, because of the limited data available on the income characteristics of the insured population, there has been no systematic analysis of how the benefit of tax concessions for private health-related expenses are distributed across income groups.

Taxation statistics, despite their limitations, are one way of assessing the likely distributional effects and implications of the Government's assistance policy for the private health insurance industry. Data on how tax concessions are distributed across income groups, and how much such concessions cost in lost revenue, is available back to 1960-61. It can show both the pattern and trends in how benefits of tax concessions for health-related expenditures are distributed.

The tax expenditure concept needs first to be explained, and some related issues reviewed. In Section 2 the conceptual and practical issues surrounding estimates of tax expenditures are discussed and their implications analysed. Section 3 describes tax concessions for private hospital insurance and medical expenses over the last four decades, while the following section presents summary estimates of the distribution of tax rebates and deductions, for the lower, middle and upper third of taxpayers by income group between 1960-61 and 1997-98. Section 5 places this distributional analysis in the wider context of health system funding in Australia and discusses the efficacy and the equity of subsidizing private health insurance in order to inject new funds and produce savings for the public health system. The final section sets out the policy implications of the study findings.

2. What does 'tax expenditure' mean?

2.1 The concept

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).

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. Tax expenditure estimates are also of interest because the pattern of distribution of tax expenditures may be quite different from that of direct expenditures. Unlike direct subsidies, tax expenditures have also 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 analyzing tax reform.

Tax reform in Australia in recent years has emphasized widening the tax base. Tax expenditures are viewed as economically inefficient because they narrow the tax base, thus requiring higher tax rates on the remaining base to replace the revenues forgone. A billion of revenue forgone through tax concessions such as for private health insurance raises the annual bill for each personal income taxpayer by around \$100.

The benchmark tax structure

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.¹ The norm, or benchmark, may differ between countries and over time. Such differences in the benchmark for measuring tax expenditures include:

- how the tax base and tax-paying unit is defined;
- whether it is adjusted for inflation;
- what degree of integration between the corporate and individual taxation is considered desirable;
- which accounting period is appropriate;
- whether a realisation or accruals basis is used for assessment; and
- how tax penalties and negative tax expenditures are assessed.

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 (Commonwealth Treasury 1999).

There are also different approaches to measuring tax expenditures:

- the 'revenue gain';
- the 'outlay-equivalent'; or
- the 'revenue-forgone' approach.

These different approaches reflect different assumptions about taxpayer behaviour and the scope of the estimates, rather than differences in the underlying concept being measured (Butler and Smith 1992). Of particular importance is that estimates using the revenue gain approach conventionally incorporate the effects of price and behavioural

¹ The main conceptual issues arising in estimating tax expenditures are discussed more fully in Butler and Smith (1992, pp. 43-58).

changes due to the tax concession, whereas those using the revenue forgone approach do not.

Behavioural responses

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 (1992) and is used for the Commonwealth Treasury’s Tax Expenditures Statement (Commonwealth Treasury).

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.

This means for example, that if a tax concession makes private health insurance cheaper, and this significantly affects taxpayers’ claims for net medical expenses, the total revenue cost of the concession may be either over- or under-stated. The direction of bias depends on whether private health insurance is a substitute for, or a complement to, net medical expenses:

- If private health insurance membership goes with lower net medical expenses claims by taxpayers, thereby lowering the revenue cost of the tax concession for net medical expenses, the revenue cost of the private health insurance concession is overstated.
- If net medical expenses rise substantially when private health insurance becomes cheaper, that is, private health insurance and higher net medical spending claims are ‘complements’, then the revenue cost of having a tax concession for insurance will be understated, as will the revenue saving from abolishing the concession.

For this reason, adding together the cost of various tax expenditures, such as for net medical rebates and private health insurance, may also result in inaccurate totals.

Likewise there may be price effects and consequential resource shifts arising from increasing funds to a particular area if key resources are in fixed supply.² For example, if certain health specialists are in short supply, increasing funding available for private health services will enable the private providers to pay more attractive packages, and thus

² Where a tax expenditure is large in relation to the budget and the wider economy, it may also have broader feedback effects into estimates of its revenue cost. For example, how a large tax expenditure is financed, whether through higher other taxes, through an increased public borrowing requirement, or lower budget surplus, or through monetary measures, may affect relative prices, interest rates or incomes. This in turn has implications for the true revenue cost of the tax concession.

draw specialists away from public health services or facilities. Privately insured patients then get better access to medical care than those without insurance, even if their medical needs are the same. At the same time, higher price paid for specialist services contribute to cost inflation in the health services sector.

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.

Tax penalties

Another key issue in the present context is the treatment of tax penalties, such as the 1 per cent Medicare levy surcharge on uninsured high-income taxpayers. One approach is to treat all 'tax penalties' as a 'negative' tax expenditure, which can make the concept of tax expenditures somewhat absurd. For example, the penalty excise on leaded petrol was treated as a negative tax expenditure, of -\$120 million in the 1997-98 Tax Expenditures Statement (Commonwealth Treasury 1999). Following this approach, the Medicare levy surcharge would be viewed simply as a negative tax expenditure on taxpayers without health insurance, with a 'cost' equal to minus the revenue raised, that is -\$72 million.

However, a more meaningful and consistent approach would be to define the Medicare levy surcharge on the uninsured as part of the benchmark income tax system. This is consistent with "the principle criterion of benchmark design [which] is that it should represent neutral taxation treatment of similarly placed activities or classes of taxpayers" (Commonwealth Treasury 1999, Appendix A). According to Treasury, a criterion used to identify tax expenditures in other OECD countries is that 'it provides assistance to a distinct class of taxpayer and could be replaced by a direct outlay'.

Exemption from the 1 per cent levy surcharge 'provides assistance to a distinct class of taxpayers' – that is, those with private health insurance. It clearly could be a substitute for a direct outlay. The surcharge should be included as part of the income tax benchmark so as to properly reflect the tax benefit to insured taxpayers that is afforded by exemption from the surcharge.

This approach would also ensure the tax concession granted high-income earners with health insurance – exemption from the Medicare levy surcharge – is treated consistently with the Medicare levy exemption for low-income earners and other groups, which Treasury does count as a tax expenditure.³

³ Exemptions for health care card-holders, repatriation beneficiaries, foreign government representatives and non-residents are also treated as tax expenditures in Australia (OECD 1996).

This study estimates the value of the tax relief afforded by the exemption by calculating the per capita Medicare levy surcharge applying for those paying the surcharge in each taxable income group above \$50,000 p.a. It is then assumed that the number of insured taxpayers benefiting from this tax relief is measured by the difference between the number of those paying the Medicare levy in each income group, and those already paying the surcharge in each income group (ATO (1999)).

The value of the tax expenditure is the sum of the per capita surcharge for each income group multiplied by the number of individuals paying the Medicare levy but not the surcharge in each income group above \$50,000.

Tax incidence

The 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 for the same amount, as has occurred in recent years.

Fiscal efficiency - 'targeting' tax subsidies

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). In some cases, this may be a useful design feature of the concession, for example to target high income earners for donations to charity (see Freebairn 1994). In other cases it simply reflects the exercise of political influence and has little to do with efficiency in the use of public resources (Chesterman 1999).

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 permit an increase in the cost of private health fund premiums, the economic benefit is effectively captured by the funds and/or health service providers rather than fund members.

2.2 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 (Commonwealth Treasury 1999). Treasury estimates provide the basis for estimates of

tax expenditures on health published by the Australian Institute of Health and Welfare (AIHW 2000).⁴ 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.⁵

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. The AIHW estimates are used in this study for the period 1989-90 to 1998-99. However, they are attributed to the financial year after the expenditure was made for comparability with the TES presentation.

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.
- The estimates of the value of tax expenditures are based on data for 'taxable individuals', 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. (Prior to that date, taxation statistics provide insufficient detail to assess effects of excluding non-taxable incomes.) Estimates based on data for taxable individuals could thus be expected to provide an accurate picture of trends for the total individual taxpayers for at least the last two decades.
- 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. Advice from the ATO is that threshold adjustments for taxpayers with several dependent children may allow access to the rebate by some

⁴ Revised estimates for 1996-97 and 1997-98 in Table 1 compared to AIHW published data were advised by AIHW on 4/7/00.

⁵ The latest publication is for income year 1997-98.

high-income taxpayers with large families. Later auditing may also alter the statistics as originally published. Further research and comparison with 1998-99 taxation statistics is necessary to explain this surprising feature of official data.

3. Tax concessions for private health-related expenses

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; and
- 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
- 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 recently introduced *exemption from the Medicare levy surcharge* for private health insurance fund members represents the most recent type of substantial tax concession for private health insurance.

3.1 Tax concession for health insurance – the Medicare levy surcharge exemption

The exemption from the 1 per cent Medicare levy surcharge which applies to individual taxpayers with taxable incomes above \$50,000 p.a. (couples \$100,000 p.a.) represents a tax concession benefiting private health insurance funds and/or their members. This tax benefit has not so far been included in the official estimates of tax expenditures in Australia (Commonwealth Treasury 1999). As discussed earlier, it is possible to estimate the value of this concession using 1997-98 income year tax statistics.

This study estimates the value of this concession for members of health insurance funds having taxable incomes above \$50,000 to be around \$1.1 billion in 1997-98. For more recent years, this amount will rise commensurate with any expansion of private health insurance fund membership since that time.

Taxation statistics for the 1998-99 income year will be published in November 2000. However, the tax concessions for private health insurance will expand substantially in 1999-2000 because of the jump in fund membership in June 2000.

3.2 Tax rebates and deductions for health-related expenses

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

Changes from deductions to concessional rebates and the abolition of tax concessions for private health insurance were associated with broader tax reforms during the early 1970s and with the introduction of Medibank in 1975. Likewise, changes during the 1980s were associated with the introduction of Medicare in 1984, and with reforms to the income tax structure.

Table 1 Tax concessions for health-related expenditures, 1960-61 to 1998-99

Year	Medical expenses	Health insurance fund contributions
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	Separate rebate at 30.67 cents in the dollar of eligible expenditure for basic hospital and/or medical insurance only
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	Not allowable

Year	Medical expenses	Health insurance fund contributions
	excess of \$1000	
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 1 July 1997 to 31 December 1998, income-tested rebate of up to \$150 for a single individual, \$250 for a couple, and \$450 with a dependent child. ⁶ Exemption from 1 per cent Medicare levy surcharge for those with private health insurance
1998-99	Net medical expenses rebate at 20 cents in the dollar for eligible expenditure in excess of \$1250	From January 1999 to the present, a non income tested 30 per cent rebate for private health insurance. Exemption from 1 per cent Medicare levy surcharge for those with private health insurance.

Sources: AIHW 2000; Butler and Smith 1992.

4. Tax expenditures on health – the level and distribution

No previous study has analysed the distribution of these tax expenditures across taxpayer income groups, and no previous study has examined long-term trends in the equity of these tax concessions. Yet as is evident in Table 2 below, the amounts involved are substantial.

⁶ Announced in 1996-97 Budget.

Table 2 Tax expenditures on health, 1980-81 to 2001-02 (\$000, current prices)

<u>Year</u>	<u>Net medical rebates</u>	<u>Health insurance rebates</u>	<u>Total tax expenditures on health</u>
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	44,000		44,000
1990-91	61,000		61,000
1991-92	85,000		85,000
1992-93	82,000		82,000
1993-94	91,000		91,000
1994-95	95,000		95,000
1995-96	91,000		91,000
1996-97	122,000		12,2000
1997-98	103,000		103,000
1998-99	124,000	207,000 ^(a)	331,000
1999-00	142,000	273,000 ^(a)	415,000
2000-01 ^(f)	157,000	294,000 ^(a)	451,000
2001-02 ^(f)	158,000	309,000 ^(a)	467,000

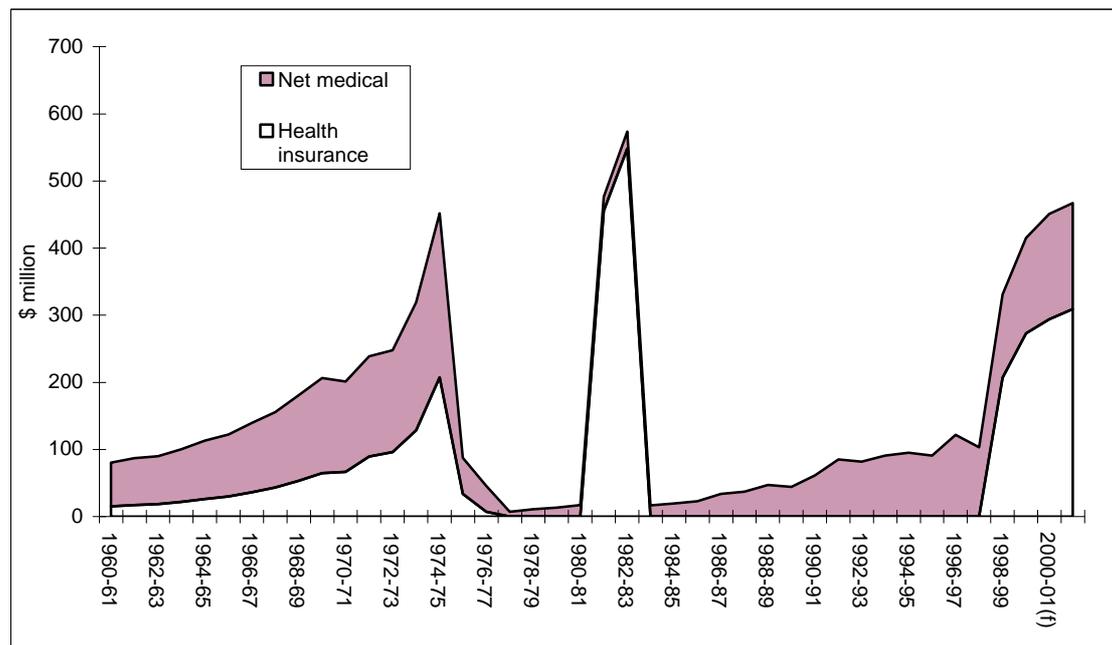
(a) excludes amounts paid out as direct subsidies to health insurance funds and counted as direct expenditures (having an approximate cost to the Budget of \$252 million in 1997-98, and \$782 million in 1998-99).

(f) Treasury forecast, (Commonwealth Treasury 1999).

Sources: For the period to 1988-89, see Butler and Smith (1992, p. 49). For 1989-90 onwards, see AIHW (2000) and Commonwealth Treasury (1999).

The total cost of the private health insurance rebate also depends on any associated increases or decreases in tax expenditures for net medical expenses, and vice versa. As is evident from Figure 1, the historical pattern has been for the revenue cost of tax concessions for net medical expenses rises with the cost of concessions for private health insurance. This suggests health fund membership is a complement to, rather than a substitute for, high net medical expenses. This implies that the revenue cost of the tax concession for private health insurance is understated if these relationships are not taken into account.

Figure 1 Tax expenditures on health-related expenses, 1960-61 to 2001-02



Source: see Table 2

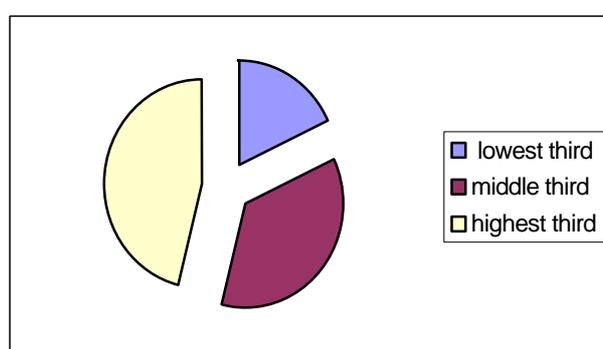
Bearing in mind the caveats about aggregating the value of tax expenditures for medical expenses and those for private health insurance (discussed in Section 2 above) the distribution of tax expenditures across taxpayer income groups is set out in Tables 3-5, and Figure 2.⁷

Appendix Tables A-C provide the same data organized into taxpayer deciles.

⁷ See Appendix for more detailed tables of the distribution by taxpayer deciles.

It is evident from Figure 2 and Table 3 that the distribution of tax concessions for private health related spending of individuals is heavily skewed towards those with high incomes. Half of the value of tax expenditures on health-related private spending benefits taxpayers in the group with the highest third of taxable incomes. This high income earner share has increased since the early 1980s, after shrinking in the 1970s.

Figure 2 Distribution of tax expenditures on private health insurance by taxable income group, 1997-98 income year



The combined effect of the tax rebate for net medical expenses and the private health insurance tax rebate was to provide those with annual taxable incomes above \$35,000 with tax subsidies of at least \$126 million in 1998-99, arising from their 1997-98 tax assessment. Projected to 1999-2000, this distribution implies around \$207 of tax subsidies for health related spending went to the most affluent third of taxpayers, with this amount rising even further to \$234 by 2001-02 on Treasury's 1999 forecasts for these tax expenditures.

The distributional patterns are similar for net medical expenses and private health insurance:

- A minimum \$95 million (46 per cent) of the \$207 million tax rebate for private health insurance premiums for 1997-98 (impacting on the budget in 1998-99) went to around 250,000 high-income individuals with taxable incomes exceeding \$35,000 pa;
- Around 56 per cent of the value of the rebate for net medical expenses accrued to the highest income third.

Just 18 per cent of the value of tax expenditures (\$37 million) subsidised the private health fund membership of the bottom third taxable income group. These individuals had taxable incomes of less than around \$20,000 pa.

Table 3 Taxpayer distribution of total tax expenditures on health, selected years

Year	lowest third	middle third	highest third
1962-63	6	28	66
1968-69	8	27	65
1974-75	7	29	64
1982-83	18	33	48
1988-89	20	24	56
1997-98	18	32	50

Table 4 Distribution of tax expenditures on health, net medical expenses

Year	lowest third	middle third	highest third
1962-63	7	27	66
1968-69	8	27	65
1974-75	7	29	64
1982-83	n.a.	n.a.	n.a.
1988-89	20	24	56
1997-98	17	27	56

Table 5 Distribution of tax expenditures on health, contributions to health insurance funds

Year	lowest third	middle third	highest third
1962-63	6	29	66
1968-69	7	27	65
1974-75	7	30	63
1982-83	18	33	48
1988-89	0	0	0
1997-98	18	36	46

These estimates will probably underestimate the share of these tax expenditures accruing to the highest income earners because they exclude the \$252 million rebate paid directly through health funds in the 1997-98 income year (\$782 million in the 1998-99 income year), and are based on outdated Treasury forecasts predating the rise in fund membership in 2000. Direct payments would also disproportionately benefit high-income earners.⁸ With current estimates of the total subsidy from the rebate for private health insurance ranging up to \$2.4 billion (Segal 2000), it would be expected based on tax rebate statistics that as much as \$1.1 billion might accrue to those in the top third of taxable incomes. Around \$280 million of this would subsidise the purchase of ancillaries insurance by this income group.

Estimates based on 1997-98 income year tax statistics also understates the proportion of the current private health insurance rebate claimed by high-income earners because the rebate was no longer subject to an income-test from January 1999. While there are some concerns at the validity of the data, the official taxation statistics for 1997-98 suggest that in 1998-99 and subsequent years, the higher-income earner share of the rebate will be greater than 46 per cent because the rebate was not income tested from December 1998.

It is also noteworthy in Tables 3 to 5 that the tax deductions in the 1960s and early 1970s were even more skewed in favour of higher-income groups than the tax rebates allowed for health insurance and net medical expenses in the last two decades. For example, in 1982-83, around \$263 million of the value of the tax rebate for private health insurance premiums (48 per cent) was paid annually to taxpayers with the top third of taxable incomes, compared to around 63-66 per cent during the 1960s and early 1970s. This is because deductions are of greatest value to those with the highest marginal tax rates, and during those decades, marginal income tax rates were around 66 per cent for high income earners.

5. Private health insurance and public funding

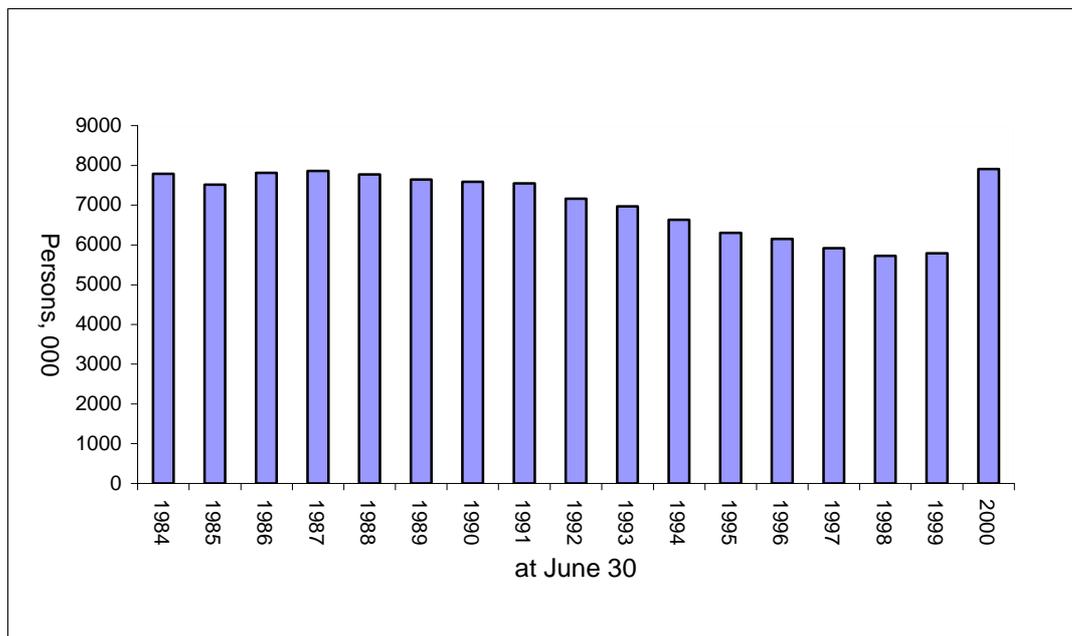
The package of reforms to encourage private health fund membership introduced by the Federal government in 1996 purportedly aimed to increase private funding of health care, reduce pressure on the public hospital system, and increase consumer choice. The Australian Health Insurance Association told a Senate inquiry the rich would subsidise the poor as a result of the new incentive scheme for private health insurance because the

⁸ It is not known whether or not the direct rebate for private health insurance has a significantly different distribution to that shown above for the tax rebate. It is possible that lower income earners will have a higher representation among those receiving the rebate directly via health funds than among taxpayers receiving the rebate. If this were the case, the estimates of the distribution of the tax rebate for private health insurance will be more skewed towards higher income earners than the direct rebate. Nevertheless, with private health insurance being disproportionately held by the affluent, the overall picture of regressive distribution of public funds is unlikely to change substantially, and is likely to be comparable with that for the tax rebate.

new system was about 'ensuring the rich add to health financing moneys' (Senate Community Affairs Legislation Committee, 1998).

There has been a steady decline in fund membership since the early 1990s, with a slight recovery when the PHIIS and private health insurance rebate was introduced, and a strong rise associated with the deadline for the Life Time Health Cover Scheme from July 2000 (Figure 3).

Figure 3 Private health insurance coverage 1984 to 2000



Source: PHIAC (2000)

However, available data on funding to mid-1999 shows tax and other incentives for health fund membership may reduce rather than increase the private share of national health services funding because of the increased government contribution through tax concessions.

Health services in Australia have historically been funded by a combination of the Commonwealth, State/local, and non-government sectors. On the face of it, the non-profit sector was a major player in financing health expenditures until recent years, when its predominant position was taken over by the Federal Government (Table 6). For example, in the early 1970s, before the introduction of Medibank, the non-government sector appears as the major player in financing health services expenditures. Likewise, in 1982-83 the non-government sector apparently financed just over 40 per cent of spending on health services in Australia.

Table 6: Source of funds for health service expenditures, unadjusted for tax expenditures

Year	Commonwealth health services expenditure, current prices	State/local	Government sector	Non government sector, unadjusted for tax expenditures
1974-75	30.2	31.2	61.4	38.6
1975-76	49.0	22.6	71.6	28.4
1982-83	27.4	32.3	59.7	40.3
1987-88	38.0	32.0	70.0	30.0
1988-89	42.4	26.0	68.4	31.6
1997-98	44.6	23.6	68.2	31.8
1998-99	45.0	22.	68.0	32.0

Source: AIHW (2000); Butler and Smith (1992)

However, the presentation in Table 6 treats tax concessions granted by the Federal government as if they were ‘non-government’ financing of health services. This is misleading. In reality, these tax concessions represent government funding of health services.

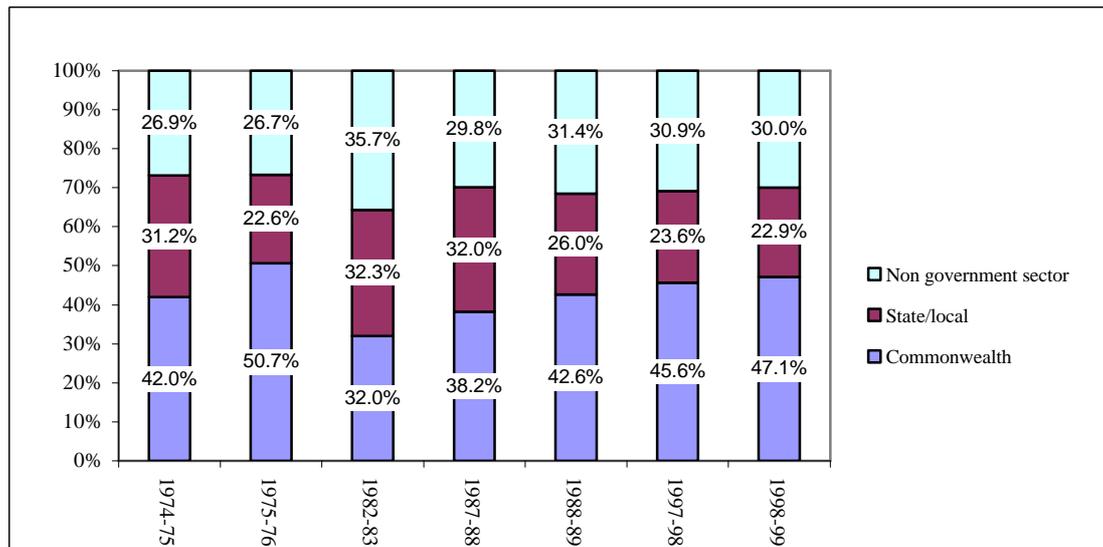
The government/non-government pattern of funding of health services changes considerably if these tax expenditures are taken into account. Abolition of tax concessions for private health insurance when Medibank and Medicare were introduced helped offset the budgetary cost of those public health financing systems (Table 7 and Figure 4). In 1974-75, just before the introduction of Medibank, tax concessions for health-related private spending accounted for around 12 per cent of the total health services funding. By the time Medicare was introduced in 1984, tax expenditures represented around 5 per cent of health services funding.

This suggests the funding role of the non-profit sector is significantly less than apparent from unadjusted data such as that in Table 6. The growth of Commonwealth funding due to the introduction of Medibank and Medicare is much less dramatic than it would seem from unadjusted data. For example, if the non-government and Commonwealth government share is adjusted to account for funding provided as tax concessions, the private sector share remains at around one third or less of total funding for the period since 1974-75 (Figure 4).

Table 7: Adjustments for tax expenditures and PHIIS or private health insurance rebate

Year	Taxation expenditures as per cent of total health services expenditures	(including PHIIS or private health insurance rebate)
1974-75	11.8	11.8
1975-76	1.7	1.7
1982-83	4.6	4.6
1987-88	0.2	0.2
1988-89	0.2	0.2
1997-98	0.7	1.0
1998-99	0.8	2.1

Sources: AIHW (2000) (Butler and Smith 1992)

Figure 4 Health services expenditure, source of funds adjusted for tax expenditures

Sources: see Table 7

It remains to be seen whether the recent rise in private health insurance coverage significantly changes the overall funding balance. Between 1997-98 and 1998-99, the non-government share of funding for health services did not increase but rather declined from 30.9 per cent to 30.0 per cent as a result of the Federal government's substantial tax subsidies for private health insurance.

Similarly, while the lifetime rating system and greater publicity of the tax concessions increased health fund membership, the net effect on the non-government share of funding of health services depends on the fiscal impact of the associated tax concessions for fund membership. As noted early, the tax subsidy associated with fund membership of around 8 million is likely to be well above original Treasury forecasts.

6. Conclusion and policy implications

Taxation reform over the last decade has emphasized removing special concessions from the tax system in order to improve equity, economic efficiency, and transparency. The use of the tax system since 1997-98 to provide subsidies to the health insurance industry directly contradicts the thrust of the Government's tax reform agenda, as well as undermining the progressivity and effectiveness of the national health care financing system. The private health insurance industry now receives more budgetary assistance than provided to the mining, manufacturing and primary agricultural production industries combined (Duckett 1999). The effect of this industry assistance scheme on the efficient allocation of resources requires urgent review.

This study is the first to examine the distribution of tax expenditures on health-related spending including the private health insurance rebate. One of the basic strengths of Australia's public health system is that universal access to free public hospitals and cover against specified medical costs has been financed substantially through progressive taxation. The present extent of public assistance to the health insurance industry including through tax concessions significantly distorts this progressive pattern of health care financing in Australia because it has an 'upside-down' distributional effect. The current rebate for private health insurance has a direct annual cost that is likely to be around \$2 billion or more. This study shows based on taxation statistics that tax concessions for health remain heavily skewed towards the affluent. For 1997-98, the latest year for which taxation statistics are available:

- around a half of the value of tax concessions for private health insurance went to the most well off third of taxpayers; and
- less than a fifth of these concessions go to the third of individuals in the lowest taxable income group.

According to taxation statistics, the income-tested PHIIS rebate for health insurance was at least as regressive as the universal rebate existing in the early 1980s. The removal of the income test from January 1999 makes the current rebate even more inequitable. It is likely that well over a billion dollars of public money is underwriting the health care of Australia's richest individuals and families. Around a quarter of the tax subsidy may be spent on ancillary rather than hospital insurance.

This skewed distribution of incentives for private health insurance contrasts sharply with a wide range of evidence on the progressive distribution of direct public spending on health (Harding et al. 2000; Schofield 1998; Withers, Throsby and Johnston 1994).

This study also shows that assistance to the health insurance industry through the tax system has been severely understated. On conventional definitions of 'tax expenditures', the exemption from the 1 per cent Medicare levy surcharge for the insured should be included in official published estimates of tax expenditures. This study has shown that the exemption represents a tax expenditure of around \$1.1 billion annually, a substantial additional tax prop to the health insurance industry that has attracted virtually no comment because of its lack of transparency and its omission from the Treasury's annual *Tax Expenditures Statement*. The use of Commonwealth taxation powers to impose a discriminatory tax on individuals choosing not to purchase a commercial product is questionable, setting a disturbing precedent for governments to impose discriminatory income taxes according to other dubious criteria.

Furthermore, based on past experience, the cost of the tax rebate for net medical expenses is likely to expand along with the rebate for private health insurance. On available statistics, subsidising private health insurance has little, if any benefit in the form of increasing non-government funds for health services.

One rationale put forward for the present policy of encouraging high-income earners to take out private health insurance is that they can afford to pay more for health care. Yet far from being a 'Robin Hood' policy, tax incentives for private health insurance feudalise public financing of health services by eroding the progressivity of taxation. Exempting the insured from the Medicare penalty and subsidizing their insurance premiums effectively absolves high-income earners, most of who are insured, from contributing appropriately to the community's health care costs. A more effective and equitable way to increase the contribution of the rich to health care costs would be to abolish the exemption from the Medicare levy surcharge and channel the revenues into the public health system.

While encouraging private health insurance membership is said to take pressure off public hospitals, there is compelling evidence that the cost of the private health insurance rebate far exceeds any financial gains to public hospitals (Segal 2000). Shifting demand to the private hospital sector would save less than \$1.3 billion annually, ignoring continued use of public hospitals by the privately insured. The research by Segal confirms previous work concluding that the private health insurance rebate is a very inefficient way of meeting the demand for hospital services (Duckett and Jackson 2000).

Public assistance for the private health insurance industry is at the expense of public health care. Each year, the private health insurance rebate alone is drawing over \$2 billion of government funding away from public health care provision.⁹ 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

⁹ The Medicare benefit payment for private in-hospital medical services, costing at least \$0.9 billion annually is a further direct public subsidy to the private health sector (Duckett and Jackson 2000).

jump hospital queues, obtain cosmetic surgery and dental care, and pay for their gym club membership. For example, through the 30 per cent rebate for ancillary insurance the Commonwealth is now spending around \$180 million pa funding dental services mainly for the affluent (Duckett and Agius 2000).

As well as undermining the progressive financing of universal health care, the scheme is an ineffective and wasteful way of funding health care:

- It discriminates against those who choose to self insure. While private health insurance adds \$4.4 billion annually of non government funding for health care, around \$7.6 billion of funding is contributed annually by individuals though self insurance (AIHW 2000, Tables A2 to A16).
- The administrative costs of private health insurance funds account for around 12 per cent of the value of premiums. This means that of every billion dollars of public subsidy, over \$100 million is wasted on administration. By comparison, average income tax collection costs are around 1 per cent of revenues (Collins et al. 1988).
- Recent research shows demand for health insurance is relatively unresponsive to price (Butler 2000). The price elasticity of demand for private health insurance is around – 0.5 per cent, while demand for ancillary cover is even less price elastic. This suggests increasing membership through public subsidy of membership premiums is likely to be high cost and/or ineffective because it is not perceived as value for money.
- Most of the rebate is also paid to those with existing private health insurance rather than to new members. For example, if 60 per cent of high income earners are already health fund members, even a 20 per cent increase in membership due to the rebate still means around four fifths of the subsidy is a windfall to those who are already members (Richardson 1998).

Current financial incentives for middle and high-income earners to take out private health insurance and abandon Medicare are thus a drain on the public purse and threaten the progressive principle underpinning Australia's public health care system.

The private health insurance rebate should be abolished, particularly for ancillary insurance. By doing so, at least \$2 billion of additional funding could be earmarked for improving access to medically-necessary hospital services, public dental and allied health programs.

Existing incentives for private health insurance also lack transparency because the extent and distribution of public assistance to the private health insurance industry and its clients is not properly documented in the Commonwealth government's financial publications.

The Medicare levy surcharge is an untapped opportunity for expanding a progressive funding base for health care. Extending the Medicare levy surcharge to all high-income earners would further expand available revenues system for the public health care by

around \$1 billion, and would at the same time enhance the progressivity of health care financing.

Existing incentives for private health insurance also lack transparency about public support for private health funds. The above measures would also serve to bring the reality of the tax system into line with the rhetoric of tax reform, and improve accountability of government.

The Commonwealth Government has repeatedly affirmed its stated commitment to Medicare. However, its actions in support of the private health insurance industry belie its claims. While its objective is stated to be to preserve choice for health consumers, the Commonwealth government has effectively removed the option for middle and high-income earners to commit to the public health care system.

This will have profound long-term consequences. Medicare and public hospital care will increasingly become the preserve of the poor, akin to the manifestly inadequate United States' Medicaid system for that country's welfare recipients. It also opens the way for advocating the United States' system of employment-based health insurance, which is costly, provides patchy coverage, and is unfair to many ineligible unpaid, low paid and casual workers.

The evidence in this study on tax concessions for private health related spending shows there is a need for renewed public debate on 'choice' in Australian public health financing - on whether we should resource and improve an equitable and cost-restraining public health care system with its single national insurer through a progressive financing arrangement, *or* whether we should exploit the coercive powers of the public revenue system to support a wasteful and heavily subsidized private insurance system for financing health care that has been abandoned in nearly every developed country because of its rising costs and gross inequity.

References

- AIHW (Australian Institute of Health and Welfare) 2000, *Health expenditure bulletin*, Australian Institute of Health and Welfare, Canberra.
- ATO (Australian Taxation Office) 1999, *Taxation statistics*, Commonwealth of Australia, Canberra
- Butler, J. and Smith J. 1992, 'Tax expenditures on health in Australia: 1960-61 to 1988-9', *Australian Economic Review*, no. 3, pp. 43-58.
- Butler, J. 2000, *Estimating elasticities of demand for private health insurance*, Working Paper No 43, National Centre for Epidemiology and Population Health, ANU.
- Chesterman, M. 1999, 'Foundations of charity law in the New Welfare State.' *The Modern Law Review* vol.62, no. 3, pp. 333-49.
- Collins, D., Hunt P., et al. 1988, *Review of the state tax system; tax reform and NSW economic development*, Sydney, New South Wales Tax Task Force.
- Commonwealth Treasury 1999, *Tax Expenditures Statement*, Canberra: AGPS.
- Deeble, J. 1999, 'Medicare: Where have we been? Where are we going?' *Australian and New Zealand Journal of Public Health*, vol.23, no. 6, pp. 563-70.
- Duckett, S. and Jackson, T. 2000, 'The new health insurance rebate: an inefficient way of assisting public hospitals', *Medical Journal of Australia* vol.172, no. 439-42.
- Duckett, S.J. and Agius, P. 2000, The health system's role in reducing health inequalities, presented at the "The social origins of health and well-being: from the planetary to the molecular" Conference, Canberra, July 2000.
- Freebairn, J. 1994, 'Income taxation of charities: some economic considerations.' *Economic Papers* vol.13, no. 3, pp. 10-22.
- Harding, A., Percival, R. et al. 2000, *Lifetime distributional impact of government health outlays*, Discussion Paper no. 47, NATSEM, University of Canberra.
- McAuley, I. 1998, 'Coalition's proposed rebates for private health insurance', unpublished.
- 1998 'Private health insurance - redefining the issues.' *The Australian Rationalist* vol.47, no. Spring, pp. 8-15.

— 1999, 'Saving private health insurance', Submission to Senate inquiry into the 1998 private health insurance rebates.

OECD Organisation for Economic Cooperation and Development 1984, *Tax expenditures: a review of the issues and country practices* OECD Paris.

— 1996, *Tax expenditures: recent experiences*, Paris, OECD.

Richardson, J. 1998, 'The health care financing debate', in G. Mooney and Scotton, R. (eds), *Economics and Australian health policy*, Allen & Unwin, St Leonards, NSW.

Schofield, D. 1997, *The distribution and determinants of private health insurance in Australia*, Discussion Paper no. 17, NATSEM, University of Canberra.

Segal, L. 2000, *Submission to Senate Community Affairs References Committee re First Report - Public Hospital Funding and Options for Reform*, Health Economics Unit, Centre for Health Program Evaluation, Monash University.

Senate Community Affairs Legislation Committee 1998, 'Private Health Insurance Incentives Bill 1998 Private Health Insurance Incentives Amendment Bill 1998 Taxation Laws Amendment (Private Health Insurance) Bill 1998.'

http://www.aph.gov.au/senate/committee/clac_ctte/Ptehealth/index.htm. December.

— 2000, 'Hansard' pp. CA77, *Senate Community Affairs Legislation Committee*, Canberra.

Surrey, S., and McDaniel, S. 1985, *Tax expenditures*, Cambridge MA: Harvard University Press.

Wilson, J. 1999, *An analysis of private health insurance fund membership in Australia, 1995*, Discussion Paper no. 46, NATSEM, University of Canberra.

Withers, G., Throsby, D., and Johnston, K. 1994, *Public Expenditure in Australia*, Commission Paper No 3, EPAC, Canberra.

Appendix

Appendix Table A Distribution of total tax expenditures by decile

	Lowest income decile	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Highest Income Decile
1962-63	0	2	3	5	7	10	11	15	20	27
1968-69	1	2	3	5	7	9	12	15	18	28
1974-75	1	1	4	5	7	10	13	16	18	25
1982-83	3	6	7	8	9	11	12	13	15	16
1988-89	1	5	11	7	7	8	7	10	14	30
1997-98	2	5	8	8	9	10	11	13	16	18

Appendix Table B Distribution of tax expenditures on net medical expenses by decile

	Lowest income decile	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Highest Income Decile
1962-63	0	2	3	5	7	10	11	15	19	28
1968-69	1	1	4	5	7	9	12	14	18	29
1974-75	1	2	3	5	7	10	12	16	18	26
1982-83	na	na	na	na	na	na	na	na	na	na
1988-89	1	5	11	7	7	8	7	10	14	30
1997-98	2	5	8	8	7	8	9	11	14	28

Appendix Table C Distribution of tax expenditures on private health insurance by decile

	Lowest income decile	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Highest Income Decile
1962-63	0	2	2	5	8	9	13	16	20	25
1968-69	1	1	4	4	7	10	13	16	19	25
1974-75	0	2	4	5	7	10	14	16	19	23
1982-83	3	6	7	8	9	11	12	13	15	16
1988-89	0	0	0	0	0	0	0	0	0	0
1997-98	3	5	7	8	10	12	13	14	17	10



The Australia Institute promotes a more just, sustainable and peaceful society through research, publication and vigorous participation in public debate.

The Institute is an independent non-profit public policy research centre. It carries out research and policy analysis and participates in public debates on economic, social and environmental issues. It undertakes research commissioned and paid for by philanthropic trusts, governments, business, unions and community organisations.

The Institute is wholly independent and not affiliated with any other organisation. As an Approved Research Institute, donations to its Research Fund are tax deductible for the donor.

Philosophy

The Institute was established in 1994 by a number of individuals from various sections of the community. They share a deep concern about the impact on Australian society of the priority given to a narrow definition of economic efficiency over community, environmental and ethical considerations in public and private decision making. A better balance is urgently needed.

The Directors, while sharing a broad set of values, do not have a fixed view of the policies that the Institute should advocate. Unconstrained by ideologies of the past, the purpose of the Institute is to help create a vision of a more just, sustainable and peaceful Australian society and to develop and promote that vision in a pragmatic and effective way.

Membership

Membership is a valuable means of contributing to the objectives of the Institute. The annual fee is \$80 (with a discount for low-income earners). Members receive the *Newsletter*, published four times a year, and are entitled to Institute papers free of charge on request. They also receive discounted admission to some Institute functions.

If you would like to purchase our publications or support The Australia Institute through membership or donation please contact us at:

Garden Wing, University House, ANU, ACT 0200
Tel: (02) 6249 6221 Fax: (02) 6249 6448
Email: mail@tai.org.au
Website: www.tai.org.au

Discussion papers available from the Australia Institute

32. Kinnear, P., *Mutual Obligation: Ethical and social implications* August 2000
31. Denniss, R., *Taxing Concern? The Performance of the Green Power Scheme in Australia* August 2000
30. Toyne, P. and Farley, R., *The Decade of Landcare: Looking Backward – Looking Forward* July 2000
29. Chapman, B. and Kapuscinski, C., *Avoiding Recessions and Australian Long Term Unemployment* June 2000
28. *Indicators of a Sustainable Community: Improving quality of life in Newcastle* May 2000
27. Smith, J., *The Implications of the GST for Charities* February 2000
26. Turton, H. & Hamilton, C., *Population Growth and Greenhouse Gas Emissions* December 1999
25. Wensing, E., *Comparing Native Title and Anglo-Australian Land Law* November 1999
24. Neutze, M., Sanders, W., Jones, G., *Public Expenditure on Services for Indigenous People* September 1999
23. Eckersley, R., *Quality of Life in Australia: An analysis of public perceptions* September 1999
22. Hamilton, C. & Turton, H., *Business Tax Reform and the Environment: Emissions trading as a tax reform option* August 1999
21. Nevile, A., *Competing Interests: Competition policy in the welfare sector* June 1999
20. Quiggin, J., Saddler, H., Neutze, M., Hamilton, C., Turton, H., *The Privatisation of ACTEW: The fiscal, efficiency and service quality implications of the proposed sale of ACT Electricity and Water* December 1998
19. Turton, H. and Hamilton, C., *The GST Package and Air Pollution: The impact of proposed indirect tax changes on atmospheric emissions* September 1998
18. Disney, J., Nevile, J., Quiggin, J. and Smith, J., *Perspectives on the GST Package* September 1998
17. Sheehan, J. and Wensing, E., *Indigenous Property Rights: New developments for planning and valuation* March 1998
16. Smith, J., *Gambling Taxation in Australia* March 1998
15. Hamilton, C. and Quiggin, J., *Economic Analysis of Greenhouse Policy: A layperson's guide to the perils of economic modelling* December 1997
14. Hamilton, C. and Saddler, H., *The Genuine Progress Indicator: A new index of changes in well-being for Australia* October 1997
13. Hundloe, T. and Hamilton, C., *Koalas & Tourism: An economic evaluation* July 1997
12. Hamilton, C. and Saddler, H., *The Genuine Progress Indicator for Australia* (summary version) July 1997
11. Wensing, E. and Sheehan, J., *Native Title: Implications for land management* April 1997
10. Hamilton, C., Hundloe, T. and Quiggin, J., *Ecological Tax Reform in Australia*, April 1997