Health Spending in the Bush

An analysis of the geographic distribution of the private health insurance rebate

Richard Denniss

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Introduction

Shortages of medical services in rural and regional Australia are well documented. Major problems include access to adequate GP, specialist and allied health services, access to conveniently located public and private hospitals and the availability of advanced diagnostic and treatment equipment.

Since coming to office the Coalition Government has promoted the private financing of health services to meet the needs of Australian citizens in preference to publicly funded medical services and hospitals. An important part of this policy is the uncapped and non-means tested 30 per cent private health insurance rebate which is estimated to cost the Government $2.5 billion per year (Howard, 2002). The rebate is designed to increase the uptake of private hospital cover in order to reduce the pressure on the public hospital system (Elliot, 2003).

The indirect nature of the private health insurance rebate means that the Government is unable to influence the regional distribution of private health services. This paper considers the geographic distribution of the benefits of the 30 per cent private health insurance rebate. Using unpublished ABS data, it shows that people living outside capital cities have substantially lower private health insurance coverage than those living in capital cities. As a result, proportionally more Government expenditure is directed to capital cities than to rural and regional Australia, despite the greater health needs of the latter.

Due to their lower rate of private health insurance coverage, rural and regional areas receive an estimated $100 million dollars less of the Government's private health insurance rebate than they would if funds were allocated on a per capita basis. People living in rural and regional areas are missing out on both public and private health services. The private health insurance rebate exacerbates the health inequalities between metropolitan and regional Australia.

The crisis in rural and regional health services

The health status of rural and remote Australians is inferior to that of their counterparts in urban areas. They have a lower life expectancy. For example, in metropolitan areas males and females are expected to outlive their counterparts in remote areas by three years (AIHW, 2002b p. 218). Various factors are responsible for this difference, but the lower access to health services in these areas is likely to exacerbate the poorer health status of regional Australia.

Lack of convenient, affordable and timely access to GPs is a major problem in rural and regional Australia. In addition to the financial and time costs to individuals associated with inadequate numbers of rural doctors, the social costs of medical treatment are likely to be increased when early diagnosis and intervention is prevented.

A study commissioned by the Australian Medical Association (AMA, 2002) revealed that, proportionately, the number of GPs in regional areas is low compared to capital cities and that there is an increasing shortage in rural, remote and outer suburban Australia. The study estimated a shortage of rural doctors of 16-18 per cent compared to 3.7- 6.7 per cent in urban areas.

Compounding this shortage of rural and remote practitioners is the lower rate of bulk billing in these areas when compared to urban areas. In 1997-98 bulk billing rates for out-of-hospital services ranged from 80 per cent in capital cities to 62 per cent in remote areas (NRHA, 2003). Because the rate of bulk billing is generally lower in rural and remote areas, proportionally more people face out-of-pocket costs in those areas than in urban areas. The National Rural Health Alliance estimates that, due to the higher average rate of out-of-pocket expenses, rural and remote Australians pay $43 million more in out-of-pocket costs on a proportional basis for their health services than their urban counterparts (NRHA, 2003 p. 10). As the NRHA has said:

> This is particularly a concern because of the overall low socio-economic status of many country areas. Average incomes, both per person and per household, are generally lower in non-metropolitan areas than in metropolitan areas. Thirty-three of the poorest electorates in Australia are rural electorates, with the average weekly earnings of families and individuals in these areas considerably lower than the national average. (NRHA, 2003 p. 9)

Government intervention to protect rural health

Increasing access to health care facilities and allied health professionals in regional areas is critical to improving the health outcomes of people in rural and remote areas compared to those in metropolitan areas. In this regard, public hospitals in regional areas play an important role in addressing the inequitable distribution of health resources by providing access to advanced diagnosis and treatment facilities.

People living in rural areas have to travel relatively long distances (at their own expense) to receive care in regional public hospitals. For some forms of specialist care, they must travel even further to capital cities.

Such travel results in a broad role for acute care hospitals in rural and remote regions of Australia. As the AIHW notes, 'people with chronic conditions such as diabetes and asthma may be hospitalised more frequently in rural and remote zones if they are required to travel long distances for follow-up treatment' (Strong *et al*., 1998 p. 77). Thus regional hospitals have traditionally supported GPs and substituted for specialist care in regional areas. The Federal Government has recognised the regional health services gap and has responded with some special programs for rural general practice such as scholarships and retention payments (Paterson 2002). However, the shortage of GPs persists. While some measures have been announced to try to address the regional shortage of medical practitioners, the Government's response to the erosion

of rural and remote hospitals has been limited. In launching the Regional Health Strategy in 2000, the Government recognised the importance of rural and remote hospitals. The strategy paper stated: 'The closure of a hospital in a rural location is a catastrophic event for any community' (DoHA 2000a, p. 21). In the same document Prime Minister Howard stated that 'many struggling country hospitals will be given help to restructure and continue providing reliable services to their surrounding communities' (DoHA 2000a, p1). The additional funds allocated to provide direct support to regional hospitals under these initiatives (Bush Nursing, Small Community and Regional Private Hospitals initiative) were only $4.6 million for 2001-2002 (DoHA, 2000b).

In contrast, the private health insurance rebate is estimated to cost the Government $2.5 billion per year (Howard 2002). However, a general subsidy to private health decisions neglects to recognise an important market failure apparent in private health care systems, namely that private hospitals motivated by profit have no reason to consider the availability of health care services to all Australians. As regional Australia has already discovered in the case of commercial banks, market forces ensure that private firms locate in areas of highest potential profit rather than areas with the greatest need for additional services.

Location decisions for public hospitals are based primarily on relative need, while private hospitals make location decisions primarily on financial criteria. This is evident from examining the ratio of public to private hospital beds in regional areas. Private hospital beds account for 34 percent of total hospital beds in capital cities. In contrast they account for 17 per cent in small regional centres and only 6 per cent in other rural and remote areas (Strong *et al*. 1998, p. 78). In some non-metropolitan areas, only residents willing and able to travel considerable distances have the potential to derive any benefits from their private health insurance.

According to the Department of Health, 'generally, large for-profit private hospitals are located in suburbs in capital cities and areas which have high rates of private health insurance (that is, areas with higher average incomes). Overall, 67 per cent of private overnight facilities and 74 per cent of available private hospital beds are located in capital cities which contain 64 per cent of the population' (DoHA. 1999 p. 17).

As was recently pointed out by Kay Hull, the National Party Member for the Federal seat of Riverina, there are 'only three private hospitals outside metropolitan areas in New South Wales offering obstetric services…' (Hull 2002). Such shortfalls in the provision of health services are unlikely to be addressed through the private health insurance rebate.

Participation in private health insurance

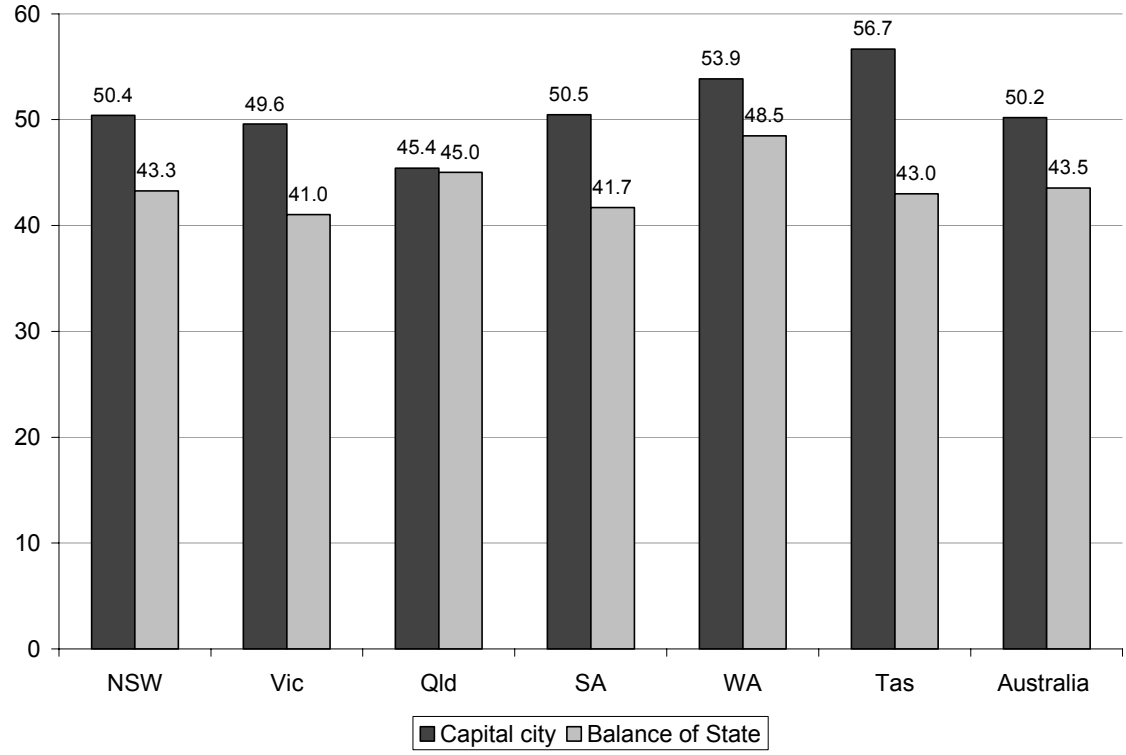
Private health insurance membership rose sharply following the introduction of the lifetime health cover policy and, to a lesser extent, the 30 per cent private health insurance rebate. Although debate continues as to which of these policies had the greatest impact on membership, it is clear that the trend away from membership has re-emerged, particularly for the younger, healthy members that the policies were designed to encourage (PHIAC, 2003).

While the 'carrot' of the 30 per cent rebate costs the Government an estimated $2.5 billion per year (Howard, 2002), the 'stick' of the lifetime health cover policy, which raises the cost of private health insurance premiums for every year past the age of 30 that individuals delay joining, imposes costs on individuals. Several authors have argued that it was the Lifetime Health Cover Policy rather than the expensive 30 per cent rebate that had the biggest impact on private health insurance membership (see for example Butler, 2001; Duckett and Jackson, 2000).

People living outside regional areas are more likely to suffer the costs of the 'stick' approach without having the capacity to enjoy any of the benefits. That is, people living outside capital cities who have decided that there is little or no benefit in taking out private health insurance due to the absence of conveniently located private hospitals or ancillary services, will still be required to pay higher health insurance premiums in later life should they decide to take out private health insurance.

For the purposes of this study, the ABS was commissioned to supply previously unpublished data on the percentages of people with private health insurance within and outside capital cities in each state. As shown in Figure 1, private health insurance membership is 6.7 per cent lower for people living outside capital cities than for those living within them. The disparity is greatest in Tasmania (13.7 per cent) and lowest in Queensland (.4 per cent).

Figure 1 Private health insurance coverage by state, and region, 2002 (%)



Source: unpublished ABS statistics derived from the National Health Survey (ABS 2002). Health insurance membership refers to those with hospital cover, including those with hospital cover only and those with hospital and ancillary cover.

There are two likely reasons for the disparity depicted in Figure 1. First, one of the main benefits of private health insurance cover is to have access to private hospitals.

However, given that private hospitals are concentrated in city areas, as discussed above, the benefits of taking out private health insurance are lower for people living outside capital cities.

The second factor is income. Even after taking into account the 30 per cent rebate, private health insurance remains an expense that many people cannot afford. As Davoren (2001) concluded:

> It is well recognised that those people with chronic illnesses are more likely to be elderly and/or of low income compared with the general population, and people with limited income are more likely to suffer ill health. The very people who rely most on our public hospitals are those that are least likely to be able to afford private health insurance. In addition, even if they could, they can't afford the significant gap fees that come with private health care (Davoren, 2001).

As incomes in capital cities are generally higher than incomes outside capital cities, the percentage of residents in rural and regional areas who cannot afford private health insurance is likely to be high. It has been estimated that more than 50 per cent of the benefits of the private health insurance rebate accrue to those earning the top 20 per cent of incomes (Smith, 2001).

Problems with private health insurance

The 30 per cent private health insurance rebate is a blunt instrument for improving the quality of the Australian health system. Despite forgoing an estimated $2.5 billion in revenue each year the Government has no direct control over how the health funds are spent. That is, having increased the membership of private health insurance, it is now up to the private health insurers, private hospital owners, and other private companies to make decisions about the kinds of new services that should be provided, as well as the location of those services. Unless it is profitable to do so, new hospitals and expanded medical services will not be provided to the rural and regional areas that need them most.

In this respect, there are a number of specific problems in the Australian healthcare system:

- A shortage of doctors and other health professionals in rural and remote areas.
- Lack of subsidised access to dental care for low-income and elderly patients.
- Indigenous health outcomes are consistently poorer than in the non-indigenous community. Average life expectancy for the indigenous community is 20 years shorter than the national average (Ruddock, 2001).

The 30 per cent private health insurance rebate is uncapped, meaning that the Government is committed to providing additional funding whenever membership increases or premiums rise. On 1 April 2003, the Government authorised an average increase in private health insurance premiums of more than seven per cent (Patterson, 2003). As a result the cost of the rebate to the Government increased automatically by more than $170 million per year.

The cost to regional Australia of the private health insurance rebate

As shown in Figure 1, private health insurance membership is substantially lower outside capital cities. This is true for all states except for Queensland, where a large percentage of the population resides in sizeable metropolitan centres such as Townsville, the Sunshine Coast and Rockhampton.

The most significant differential occurs in Tasmania where private health insurance membership is more than 13.7 per cent higher in Hobart than in the rest of the state. The lowest level of coverage, however, is in non-metropolitan Victoria. Outside of Melbourne only 41 per cent of the population is covered by private health insurance.

Across Australia, 50.2 per cent of people living in capital cities are covered by private health insurance compared to 43.5 percent outside of capital cities. This gap of more than 6.5 per cent equates to a shortfall of 350,875 people.

Data on average private health insurance premiums are difficult to obtain due to the wide range of factors that have an impact on pricing such as the number of people covered by each policy, the existence of an 'excess' and the range of ancillaries that are covered. However, some data are available from the Private Health Insurance Administration Council (PHIAC). According to PHIAC (2002, Table 5), the average level of contribution was $834.64 per member in 2001-02. Given that premiums rose by an average 7.4 percent in April 2003 (Patterson, 2003) average premiums, per person covered would therefore now be equal to $896.40.

If 350,875 people from outside capital cities were to take out private health insurance at an average cost of $896.40 per person covered then the additional cost to the Commonwealth of its 30 per cent private health insurance rebate would be $94.4 million per annum.[1] This figure is likely to be an underestimate as the average price of health insurance is dragged down by people who take out 'ancillary only' health insurance policies, such as ambulance cover. Such policies are substantially cheaper than hospital cover and do not attract the Government's 30 per cent private health insurance rebate. The actual cost to regional Australia of the Government's reliance on the private health insurance rebate to distribute resources is therefore likely to exceed $100 million per year.

Conclusions

People living outside capital cities have significantly lower membership of private health insurance funds than those living within capital cities. This disparity results in several inequities within the health system.

First, the Government's $2.5 billion expenditure on the private health insurance rebate flows disproportionately to those living in capital cities. This policy results in approximately $100 million dollars being diverted away from the regional health system. Secondly, despite evidence of existing shortfalls in regional health services, the current reliance on private provision of health services is unlikely to address the problem as private hospital owners will build new hospitals where they will be most profitable, not where they are most needed.

[1] Assuming the mix of hospital only and hospital plus ancillary policies remained constant.

Finally, people who choose not to take out private health insurance because they live in regional areas that are poorly serviced by the private health industry will be punished if they choose to become privately insured in later life.

The private health insurance rebate is an ineffective and inequitable policy for providing health care to Australians. Given the significant disparities in health status and health care seen in regional areas, public policy should alleviate rather than exacerbate the regional health disadvantage.

Richard Denniss

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