

Tax expenditures and public health financing in Australia

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Abstract

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. It is found that around half of the \$2 billion tax subsidy for private health insurance accrues to the taxpayer group with the highest third of incomes.

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. 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

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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, it was costed at \$1.09 billion in 1999-2000 (the first full year of its operation), rising to \$1.36 billion by 2002-03. In 1999-00, its actual cost according to the Australian Institute of Health and Welfare (AIHW) was \$1.6 billion (AIHW 2001), and some estimate the cost could reach \$2.4 billion a year (Segal 2000). With insurance coverage rising sharply to around 40 per of the population in June/July 2000, costs are likely to rise further.

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 (Schofield 1997; Wilson 1999). 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. Section 4 places the 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. Section 5 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. The final section sets out the policy implications of the study findings.

2. What does 'tax expenditure' mean?

2.1 The concept of tax expenditure

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, p. 7) 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* (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 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*.

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 or nursing staff are in short supply, increasing funding available for private health services will enable the private providers to pay more attractive packages, and thus draw resources 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, the higher prices paid for these 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 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.

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

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). Whether this is a useful design feature of the concession, for example to target the behaviour of more price elastic high income earners, is contentious (Steinberg 1997). The regressive incidence of tax expenditures may simply reflect the exercise of political influence or ideology with little to do with efficiency in the use of public resources (Chesterman 1999) (Surrey and McDaniel 1985).

In this context, it is useful to again draw the distinction between the apparent and actual beneficiary of the tax concession, because the legal incidence may not be the same as the actual economic incidence. While the legal beneficiary of the health insurance rebate is the individual taxpayer or fund member, the government has promoted the health insurance rebate on the basis of helping the health insurance industry and organizations. Should the package of financial incentives for private health insurance 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 Taxation Statistics

Since 1986, the Commonwealth Treasury has produced an annual set of estimates of tax expenditures of the federal government published in its Tax Expenditures Statement (Treasury 1999). Treasury estimates provide the basis for estimates of tax expenditures on health published by the AIHW (2000). 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 (ATO), derived from tax administrative processes.

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. AIHW estimates for net medical expenses are more accurate, as they remove other unrelated small rebates included in the Tax Expenditures Statement.

Some features of the data warrant mention.

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

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):

Table 1. Tax concessions for health-related expenditures, 1961–2001

Year	Medical expenses	Health 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	As above at 30.67 cents in the dollar
1983-84 and 1984-85	Concessional expenditure rebate at 30 cents in the dollar for eligible expenditure in excess of \$2000	Not allowable
1985-86	Net medical expenses rebate at 30 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable
1986-87 and 1987-88	Net medical expenses rebate at 29.42 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable
1988-89	Net medical expenses rebate at 29 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable
1989-90 to 1996-97	Net medical expenses rebate at 29 cents in the dollar for eligible expenditure in excess of \$1000	Not allowable
1997-98	Net medical expenses rebate at 20 cents in the dollar for eligible expenditure in excess of \$1250	From July 1997, income-tested rebate up to \$150 (\$250 for a couple; \$450 with dependent child). Medicare levy surcharge exemption for private hospital fund members
1998-99 and onwards	Net medical expenses rebate at 20 cents in the dollar for eligible expenditure in excess of \$1250	From January 1999, 30 per cent rebate for private health insurance. Medicare levy surcharge exemption as above

Sources: AIHW 2000; Butler and Smith 1992

- *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 major tax provision for private health insurance, although it was not initially reported as a tax expenditure (Treasury 1999). The appropriate treatment of the Medicare levy surcharge arrangements in the *Tax Expenditures Statement* remains contentious; while the surcharge might be viewed as a 'tax penalty', an alternative view is that the surcharge exemption should be reported a tax relief for certain taxpayers, and hence as a 'tax subsidy' (Smith 2001).³

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

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

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

The more recent shift towards funding health expenditures through tax subsidies is evident in the rising trend in tax expenditures for health related spending since 1997-98 (Table 2). This was associated with changes in health care financing policies introduced in 1997 following the Industry Commission (IC) inquiry into private health insurance ((IC) 1997).

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

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

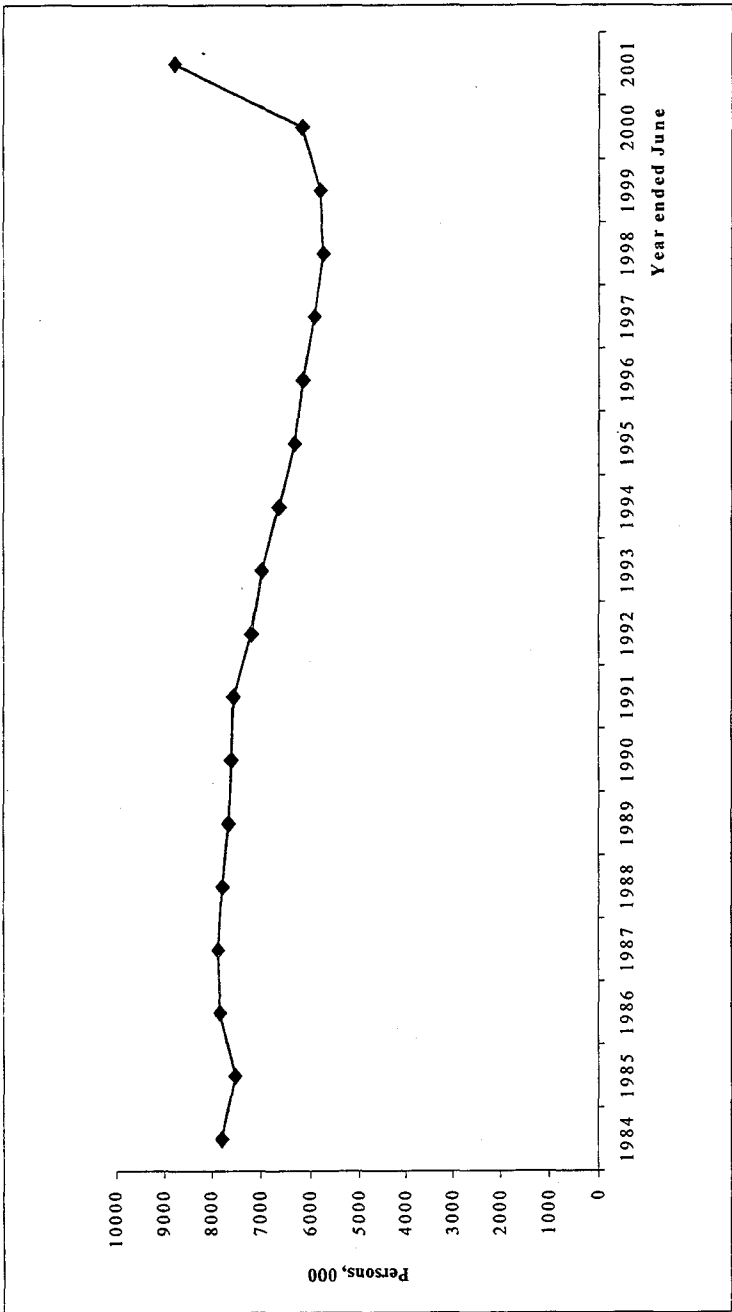
(f) Treasury forecasts in Tax Expenditures Statement (TES) 2001. Note that TES forecasts relate to the year in which the claim is assumed to affect the Budget, that is, to the year after the income year for which the tax rebate claim is made. The AIHW 2001 attributes tax expenditures to the same year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

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

4. Private health insurance and public funding

A package of reforms to encourage private health fund membership introduced by the Federal government in 1997 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, known as the Private Health Insurance Incentive Scheme (PHIIS), because the new

Figure 1. Private health insurance coverage 1984 to 2000



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 PHIS and the 30 per cent private health insurance rebate was introduced, and a strong rise associated with the deadline for the Life Time Health Cover Scheme from June-July 2000 (Figure 1).

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

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

This highlights the importance of a comprehensive framework for evaluating the source of funds for health care expenditures, a problem addressed from the early 1990s when the AIHW began producing annual estimates of health funding sources which adjusted for tax expenditures. Table 3 sets out figures derived from AIHW data showing tax expenditures as a share of total funding for health services, and as a share of Commonwealth health services expenditures from 1974-75 to 1999-00.

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

and fell to less than one per cent after the associated elimination of the tax rebate for private health insurance.

Table 3. Tax expenditures^(a) share of health services expenditures

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

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

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

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

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

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

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

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

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

Despite the recent policy emphasis on increasing the financing role of the private health insurance funds, AIHW data shows a fall in the non-government share of health services funding from 32.8 per cent to 28.6 per cent between 1996-97 and 1999-00. More specifically, the share of health care financing costs borne by private health insurance funds has fallen to 7 per cent in 1999-00 from around 10-12 per cent during the last two decades, and from 17-22 per cent during the period of the Fraser government (AIHW 2001).

Meanwhile, the out of pocket' contribution by individuals has risen to 16 per cent of total health funding in 1999-00, a level that is nevertheless below the 33 per cent share of the financing burden carried by individuals during the 1960s before introduction of Medibank (Butler 1998). To the extent that these rising out of pocket medical expenses are reflected in increased taxpayer claims for the net medical expenses tax rebate, there are also further implications for the Commonwealth budgetary costs.

Thus it remains to be seen whether the recent rise in private health insurance coverage significantly changes the overall funding balance, but the evidence so far is for a reduced non-government contribution to health funding resulting from fiscal incentives for private health insurance.

5. Tax expenditures on health – the level and distribution

The previous section has shown the nature and extent of tax expenditures for health related spending, and their place in the overall financing system for health care services in Australia. Despite the significance of tax expenditures, no previous study has analysed their distribution across taxpayer income groups, or considered the implications of long-term trends. The

following examines the level and distribution of tax expenditures on health related expenses for selected years during the 1960s to the present.

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 for 1997-98 is set out in Table 7, with a detailed breakdown for net medical expenses and private health insurance in Tables 5 and 6.

Table 5. Distribution of tax expenditures on health, net medical expenses

Year	lowest third	middle third	highest third
1962-63	7	28	66
1970-71	8	27	66
1974-75	7	29	64
1982-83	n.a.	n.a.	n.a.
1988-89	20	24	56
1996-97	18	27	55
1997-98	17	27	56
1998-99	17	27	56

Table 6. Distribution of tax expenditures on health, contributions to health insurance funds

Year	lowest third	middle third	highest third
1962-63	6	29	66
1970-71	7	28	65
1974-75	7	30	63
1982-83	18	33	48
1988-89	0	0	0
1996-97	0	0	0
1997-98	18	36	46
1998-99	12	27	61

Table 7. Distribution of tax expenditures on health, total

Year	lowest third	middle third	highest third
1962-63	6	28	66
1970-71	7	27	66
1974-75	7	29	64
1982-83	18	33	48
1988-89	20	24	56
1996-97	18	27	55
1997-98	18	32	50
1998-99	14	27	59

It can be seen that the distribution of tax concessions for private health related spending of individuals is heavily skewed towards those with taxable incomes at the top end of the income distribution. More than half of the value of tax expenditures on health-related private spending benefits those with the highest third of taxable incomes. The share of the top third of the income distribution has increased since the early 1980s, after shrinking in the 1970s.

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 \$146 million in 1997-98 and \$192 in 1998-99 (Table 2 and Table 7).

For most of the period, the distributional patterns are similar for net medical expenses and private health insurance (Tables 5 and 6):

- However, in 1997-98 means testing of the PHIIS rebate meant it was less regressively distributed than net medical expenses, while the move to the 30 per cent rebate reversed this in 1998-99.
- A minimum \$74 million (46 per cent) of the \$160 million PHIIS tax rebate for private health insurance premiums for 1997-98 went to around 250,000 individuals in the top third of the income distribution, 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 (\$29 million) subsidised the private health fund membership of the bottom third taxable income group in 1997-98 (Table 6). These individuals had taxable incomes of less than around \$20,000 pa. In 1998-99, when the 30 per cent rebate was in operation for 6 months of the income year, this proportion fell to 12 per cent.

These estimates 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 do not reflect the cost impact of the rise in fund membership from June-July 2000. It is not clear to what extent higher income earners are over represented, and lower income earners underrepresented, in the taxation statistics. However, these direct payments through the HIC would also disproportionately benefit high-income earners, and tax statistics provide some indication of the income distributive effects of the financial incentives for private health insurance introduced from 1997.⁴ With current estimates of the total subsidy from the rebate for private health insurance ranging up to \$2.4 billion (Segal 2000), tax rebate statistics

suggest that at least \$1.5 billion might accrue to those in the top third of taxable incomes.

Based on recent AIHW data, at least a quarter, that is, \$280 million of this subsidy for private health insurance by the top third of taxpayers will be directed to providing ancillary insurance (covering mainly dental, optometrist and allied health services) (AIHW 2001, Figure 7).

Estimates based on both the 1997-98 and 1998-99 income year tax statistics considerably understate the proportion of the current private health insurance rebate claimed by high income earners because the income-test was abolished from January 1999. The new rebate is also an *ad valorem*, or open ended rebate, rather than fixed in amount (see Table 1). The share of tax subsidies for private health insurance accruing to the top third of the taxpayer income distribution in 1998-99 was 61 per cent; this will increase in 1999-00 to around 70 per cent based on disaggregation of the 1998-99 data.

Also noteworthy in Tables 5 to 7 is that the tax deductions in the 1960s and early 1970s were generally more skewed in favour of higher-income groups than the tax rebates allowed for health insurance and net medical expenses in the 1980s and early 1990s. 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 were 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. However, the effect of a half-year of the 30 per cent rebate in 1998-99 was to bring the tax expenditure share of the top third of the income distribution to similar levels as in the period of tax deductibility before Medibank was introduced in 1976.

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 and Jackson 2000). The effect of this industry assistance scheme on the efficient allocation of resources requires urgent and broad ranging 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 financial incentives for private health insurance cost \$1.6 billion in 1999-00, and may exceed \$3 billion p.a. extrapolating from Treasury forecasts of the private health insurance rebates claimed through the tax system.

This study shows based on taxation statistics that tax concessions for health are increasingly heavily skewed towards the affluent. For 1997-98, when the rebate for private health insurance was subject to a means test;

- 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 went to the third of individuals in the lowest taxable income group.

According to taxation statistics, the income-tested PHIS 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. Furthermore, around a quarter of the tax subsidy is directed to ancillary rather than hospital insurance.

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

Furthermore, it can be argued that assistance for private health insurance through the tax system has been severely understated, with an additional expenditure on account of the Medicare levy surcharge arrangements of up to \$750 million (Smith 2001), and a possibility that the cost of the tax rebate

for net medical expenses may expand along with increased private health insurance coverage.

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.

Another argument for the substantial public subsidy of private health insurance is that it is unfair for the insured to pay twice for their hospitalisation (Richardson 1998). Some consider that those able to afford it should use private health insurance, and it has been argued that expanded private health insurance permits better targeting of public health funds to those in need because of the additional private funds injected into the system (IC 1997; Owens 1998).

However, this view of 'equity', akin to the argument that those choosing private education for their children should receive a public subsidy equal to any cost savings to the public system, reflects a view of the role of the state that is based on the 19th century 'charity' law model for provision of health, welfare and education services and is contrary to the underlying principles of the modern welfare state (Chesterman 1999). It also assumes that private health insurance membership does produce substantial and measurable public cost savings when this is not at all clear from available evidence.

On available statistics, subsidising private health insurance has little, if any benefit in the form of increasing non-government funds for health services. 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).

With budget constraints on Commonwealth funding for health care, subsidies for private health insurance will tend to displace other public health funding priorities. With the financial incentives for private insurance now accounting for around 7 per cent of Commonwealth health funding, Commonwealth subsidies for private insurance are likely to be at the expense of additional funding for Medicare. Each year, the private health insurance rebate alone is drawing some \$2 billion of government funding away from public health care provision, and the Medicare benefit payment for private in-hospital medical services adds at least \$0.9 billion annually to this subsidy to the private system (Duckett and Jackson 2000).

Public sector cutbacks over the last decade have produced queues in public hospitals (Deeble 1999) and axing of public dental care services such as the Commonwealth Dental Health Program (Duckett and Agius 2000). Yet through the rebate for private health insurance, the Federal government now provides a large public subsidy for high-income earners to jump hospital queues, obtain cosmetic surgery and dental care, and pay for their gym club membership. 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 through self insurance (AIHW 2000, Tables A2 to A16).
- The administrative costs of private health insurance funds account for around 12-14 per cent of the value of premiums (AIHW 2000, 2001). This means that of every billion dollars of public subsidy, some \$120-140 million is spent on fund administration, mainly marketing costs (Owens 1998). 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 as well as threatening 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, 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 substantially expand available revenues system for the public health care, and would at the same time enhance the progressivity of health care financing.

Existing incentives for private health insurance lack transparency about public support for private health funds. The above measures would 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. It is indirectly subsidizing though private health insurance markets many services not funded under Medicare or public programs, and removed community-rating requirements for private health funds premiums from September 1999. The Commonwealth has thus moved decisively away from the model put forward as providing wide and uniform access to private health care as an alternative choice to public provision (Owens 1998).

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. Furthermore, the Australian public will massively subsidise the private health insurance industry.

This policy is contrary to either of the defensible models for government policy regarding the Australian health insurance industry (see Owens 1998). It amounts to a 'privatisation' of the most profitable part of the private health care financing 'market', accompanied by an expanded public subsidy underwriting the profitability of an increasingly 'deregulated' private health insurance industry. Such a trend, evident in other countries and other sectors, has profound implications for the future role of the public sector in its relations with corporations and private markets in health, education and welfare (Whitfield 2001).

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.

Notes

- 1 The main conceptual issues arising in estimating tax expenditures are discussed more fully in Butler and Smith, 1992.
- 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.
- 3 Treating the arrangements as a tax relief for taxpayers with private hospital insurance, who are exempted from the additional Medicare levy, the revenue forgone would be up to around \$750 million on 1997-98 statistics Smith, 2001. Viewed on the other hand as a 'tax penalty' the arrangements are a 'negative' tax expenditure, yielding revenue of \$105 million for the 1997-98 income year Treasury, 2001.

- 4 Lower income earners may have a higher representation among those receiving the cash rebate through the HIC and 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 cash rebate.

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