

# Private health insurance: the problem child faces adulthood

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## Abstract

*Since its election to office in 1996, reform of Private Health Insurance (PHI) has been the most obvious health policy focus of the Howard Government.*

*The reform process has focussed on price, product, promotion, legislation and regulation. It has resulted in one of the largest new Commonwealth health outlays in recent memory. Health insurance funds have emerged as active purchasers of care, not just passive reimbursers of costs. PHI fund reserves have moved from precarious liquidity to healthy surplus. Private hospitals are busier than ever before, but margins are slim. Anecdotally, public hospitals report little benefit to date. Waiting lists have not been reduced, and their budgets are unchanged as a result of the \$2 Bn allocated under the 30% Rebate scheme.*

*The paper begins by describing the origins of the PHI reform. Its objectives, policy initiatives, results to date and criticisms are analysed. Criticisms include the actual and opportunity costs. Specific concerns remain as to its effectiveness to date in reducing pressure on public hospitals, and perceived lack of equity for certain client groups. The most significant result is that much of the reform package is here to stay including the expensive and much criticised 30% rebate. Like Medicare before it, the PHI reforms have achieved bipartisan support. The paper concludes by describing future implications for Government, industry, consumers and the medical profession.*

## The private health insurance problem in 1996

In reviewing the PHI reforms, it is useful to describe the problems that they sought to solve. The first of these was the declining number of persons holding private health insurance. Private Health Insurance Administration Council (PHIAC) figures showed that the proportion of the eligible population covered for hospital insurance in 1996 was 33.6%, trending down from 41.0% in 1992 (PHIAC 2001a). PHIAC (2001b) revealed that the decline in coverage was almost exclusively in the under 65 year age group, with no discernible decline in the number of persons aged 65 or over with PHI.

The impacts of the falling PHI membership have not been entirely predictable and depend on the respective interests of the stakeholder. For the consumer, who prefers to pay for their choice to access the private system, the shortcomings of the 1996 PHI arrangements were significant. Many were simply priced out of the market, or saw little value in the product.

For the public hospital sector, the relationship between the percentage of the population covered for private health insurance and their fortunes was less clear. It had been assumed that there was a clear inverse relationship between the overall level of PHI coverage and the workload (pressure) of hospitals. This assumption was formalised into the 1993-1998 Medicare Agreement between the Commonwealth and the States to the extent that a decline in coverage would trigger a review of funding to the States (Australian Government Solicitor 1993).

Subsequently the Australian Healthcare Agreement 1998-2003 (Department of Health & Aged Care 1999a) included a similar clause that more accurately defined upward and downward movements in PHI coverage.

These were set as trigger points for either a clawback (should coverage exceed the agreed level) or an increase (should coverage fall). The agreement also included a commitment to explore the relationship between movements in overall PHI coverage and the pattern of utilisation changes that might result.

At the time of signing of both agreements there seemed to be little upside risk for the States as PHI rates continued to proceed in a determined southerly direction. The prevailing orthodoxy was that falling PHI rates equalled increased “pressure” on the public hospital system, notwithstanding lack of clarity on the dynamics of the relationship between the two. Therefore, should not increasing PHI rates mean reduced pressure on the public hospital system?

“Pressure” may be defined in a number of ways. This could be lengthy waiting times as more people opt for public hospital care. As any hospital with a waiting list is likely to be operating at the limit of its available resources, increasing the waiting list arguably creates more pressure for *clients* than it does for hospitals.

Hospitals may define pressure in terms of resource availability and consumption. Reducing the waiting list may not necessarily result in a significant reduction in pressure, expressed as a freeing up of resources.

By this definition, the major pressure for the public hospitals had resulted from falling revenues earned from private patients. Australian Institute of Health and Welfare (AIHW) data indicates that in the period from 1990 through to 1996 the proportion of public hospital bed-days occupied by private patients declined from 23.6% to 14% (AIHW 1998). This decline appears to have had less to do with falling levels of PHI in the population than with other supply side factors in the private sector. Its impact on the revenues of public hospitals was exacerbated by the policy of some State Governments that transferred the risk of falling private patient revenue to individual public hospitals.

The decline in PHI had been a less obvious problem for the private sector, or segments of it at least. Throughout this period (and beyond), the drop in private patient activity in the public sector had been taken up by the private sector as it competed more aggressively for its share of the overall hospital activity market. This was achieved mainly through expanding supply and increasing the range of services available in the sector. Much of this was in the free-standing day surgery segment. Co-locations, and a range of public-private collaboration experiments also contributed.

Australian Bureau of Statistics (ABS) data shows that in the period from 1991/92 to 1996/97 the following trends emerged (ABS 2001).

- Overall private acute and psychiatric hospital activity (separations) increased by 33%. This was the result of a 2.1% increase in overnight separations, and a 117% increase in day only separations.
- Activity in free-standing day hospitals increased by 83.4%.
- Private acute and psychiatric hospital margins declined from 10.2% to 8.5%.
- Free-standing day hospital margins also declined from 22.3% to 20.4%.

The second problem was the attractiveness of the PHI product for consumers. The marketing concept of the “Four Ps” (McCarthy 1960) is useful in analysing the problem child that was PHI. The Four Ps are Price, Product, Place (distribution) and Promotion.

*Price* was an obvious problem, with a history of premium increases that were as predictable as they were unwelcome. PHI was becoming unaffordable. Those sticking with it had higher risk profiles, and many of them were the less well off.

The *product* was unattractive. PHI did not behave like other insurance products. It did not sufficiently cover the costs associated with the event that it was insuring due to the existence of large “gaps” or co-payments. The previous Labor Government had already recognised this product defect and introduced contractual agreements between PHI funds and private hospitals. Over time this effectively eliminated one element of the gap problem – hospital charges. However, the medical gap problem persisted.

Under community rating, individuals’ claims history and risk were not taken into account. A common criticism levelled by the prevailing “user pays” school of thought was that the healthy were subsidising the unhealthy.

PHI offered quicker access to hospital care, but this care was not as comprehensive as that available in the free public system, albeit with some waiting periods.

The product was also complicated to use. It had exclusions that were not always clear to the user. Processes for checking eligibility of an individual episode were cumbersome. This left many people uninsured for some episodes. Some learned of this after the event. Even after a completed and insured episode, the recovering individual was hit with a volley of bills. Some of these arrived several months after the event had taken place, and were not always easily traceable to the hospital episode.

A final product issue was that it could be used selectively. It could be used as a means of quickly accessing health care in the private sector, or to secure doctor of choice in either public or private sector. It did not *have* to be used for this purpose. In fact, by not using it, the insured person was financially rewarded by avoiding gap payments.

The place (*distribution*) aspect of PHI was less obvious, and probably less problematic. The problem of distribution is more to do with the location of private hospital facilities, and the range of services on offer in the one place. If you lived outside the metropolitan areas, local access to comprehensive private hospital care diminished significantly. Choice of doctor remained the key attraction, but not much of an attraction when there is a limited choice locally. There was also a strong likelihood of being admitted as a public patient under your choice of doctor anyway.

*Promotion* of PHI was made difficult against a backdrop of the product and price defects. It was, in effect, a *dog*. Not surprisingly, the obvious promotional strategy was to portray its alternative (no insurance) as a *bigger dog*. Advertising promoted images of the insured as smart (fast lane access to better care) and responsible (looking after themselves, while not troubling the good, but stretched public system). However the product defects remained largely unresponsive to such promotion.

The third problem was the precarious state of the PHI funds' cash reserves. The combined effect of declining levels of insurance, the high-risk profile of the remaining insured persons and the progressive transfer of private activity from the lower cost public system to the expanding private system was predictable. It pushed many PHI funds closer to and, in some cases, beyond their minimum statutory liquidity levels. Increasingly, the PHI funds were running deficits.

The Productivity Commission's report into Private Health Insurance (Productivity Commission 1997) identified six funds operating with reserves below the statutory 2 months, and a further six with reserves below the alternative minimum of \$1m. The inquiry also reported the combined operating loss of the funds to be \$81.3m in 1995-6. The reserve to benefits ratio had declined to 0.32, from 0.41 some ten years earlier.

Politically, this was the most pressing problem for the new government. Almost all of the PHI funds were non-profit organisations, though not immediately obvious due to the increasingly slick public image of the larger funds. The non-profit funds existed for the purpose of enabling their members to access services. Their surpluses (and deficits) were not distributed to profit-oriented shareholders. In fact many of the smaller funds were established from the mutual efforts of unions, industry groups and community owned entities. While there may have been less public sympathy for misfortunes befalling for-profit PHI entities such as National Mutual Health Insurance (now AXA), the same could not be said for the non-profit groups. In any event, the consequences of a collapse of the PHI funds would have been substantial. While the recent collapse of HIH Insurance is not directly comparable, it is illustrative of the widespread fallout of insurance company collapses.

In summary, the problem was one of little incentive for individuals to choose the private health care system and contribute their own resources. The benefits to themselves and the broader benefits to the public system were therefore not being realised. *Supporting Choice through Private Health* was the program developed by the Howard Government in response to the identified problems.

## Policy response between 1996 and 2001

Government policy initiatives may be summarised under eleven headings, as follows. The first group of initiatives was directed at price and affordability of PHI.

1. *Private Health Insurance Incentive Scheme*. This scheme, introduced in 1997 and scrapped in 1999, offered a subsidy towards the cost of PHI premiums for the less well off.

2. *30 % PHI Rebate.* A non-means-tested rebate was made available for all approved PHI policies in January 1999. This also applied to ancillary cover taken out as part of an approved hospital cover policy.
3. *Medicare Surcharge.* An additional 1% Medicare levy was imposed on high-income earners who did not take out an approved PHI policy (Department of Health & Aged Care 2001a).

The second group of policy initiatives was directed at PHI product deficiencies, and included the following.

4. *Gap Cover - No Gap and Known Gap Policies.* Independent Senator Brian Harradine held the balance of power in the Senate at the time of the passing of the legislative amendment that gave rise to the 30% rebate (Private Health Insurance Incentives Bill 1998, Private Health Insurance Incentives Amendment Bill 1998 & Taxation Laws Amendment [Private Health Insurance] Bill 1998). His agreement to the legislation was conditional on an amendment that required all PHI funds to offer a No Gap and Known Gap Policy option by July 2000. Lobbying by the medical profession ensured that the new No Gap arrangements remained totally at the discretion of the medical practitioner, rather than formally contracted by the PHI funds. This was described in Health Legislation Amendment (Gap Cover Schemes) Act 2000.

Health Legislation Amendment Act (No 2) 1998 facilitated the first No Gap medical contract between a PHI fund and medical practitioners, introduced by National Mutual Health Insurance. These changes built on legislation introduced by the former Labor Government that encouraged contractual arrangements between PHI funds and hospitals, and thus facilitated the progressive elimination of hospital gaps.

5. *Simplified Billing.* Health Legislation Amendment Act (No. 2) 1998 also sought to simplify the process of billing through contractual arrangements between hospitals and medical practitioners (Department of Health and Aged Care 1999b). Patients could assign their Medicare payments to approved billing agents to simplify the process.
6. *Informed Financial Consent.* Health Legislation Amendment (Gap Cover Schemes) Act 2000, which took effect in August 2000, introduced into legislation the notion of informed financial consent. This required medical practitioners, when operating under a gap cover scheme or other negotiated agreement, to provide the patient with a quote on costs before the procedure was undertaken (Department of Health and Aged Care 2001b).
7. *Discounted premiums.* Health Legislation Amendment Act (No. 2) 1999 clarified the arrangements and rules pertaining to premium discount practices. This legislation sought to limit the practice of excessive discounting on bases other than administrative savings.
8. *New services available under PHI.* Health Legislation Amendment Act (No.1) 2001 provided for the coverage of approved outreach services. These followed successful private sector early discharge (Department of Health & Aged Care 2000) and hospital-in-the-home program trials. Amendments moved by the Opposition limited medical service coverage under these schemes to those MBS items which otherwise would only be available to hospital inpatients.

The third group of policy initiatives introduced by the Government is as follows.

9. *Lifetime Health Cover (LHC).* LHC came into effect in July 2000 following the passage of National Health Amendment (Lifetime Health Cover) Bill 1999. It replaced the former community rating system that applied to PHI fund premiums. All those who were enrolled in an approved PHI scheme as at July 2000 would be eligible for the base premium rate applicable after that date to persons aged 30 years or below, or 65 years and over. Failure to join by July 2000 resulted in a loading on the base premium of 2% for every year of age in excess of 30 years at the age of joining, up to a maximum of 70% (Department of Health & Aged Care. 2001c).
10. *Reinsurance.* All registered health benefit funds participated in a reinsurance arrangement whereby the risk of adverse selection was spread across all of the funds, rather than borne individually. A review of the model was completed in 1999. It recommended a shift to a risk-based capitation model, rather than one based on actual service use. This has yet to be implemented.

11. *Private Rehabilitation Payment Methodology.* As part of the of an overall move towards episodic payments, a trial of a blended episode based payment model for approved private rehabilitation programs was introduced (Eagar, Green & Gordon 1999). This is based on the AN-SNAP classification system. It is the first time that a non per-diem based payment model has been used by the PHI funds outside the acute care environment.

## Results of government policy initiatives

The results of the reform and recent changes in the hospital industry can be looked at in a number of ways. Some results were obviously attributable to the PHI reforms. Others were responses by the PHI, private hospital and public hospital industries. A third group comprised other underlying industry factors that have existed for some time. They will be probably be further affected by the PHI reforms.

### Level of insurance coverage

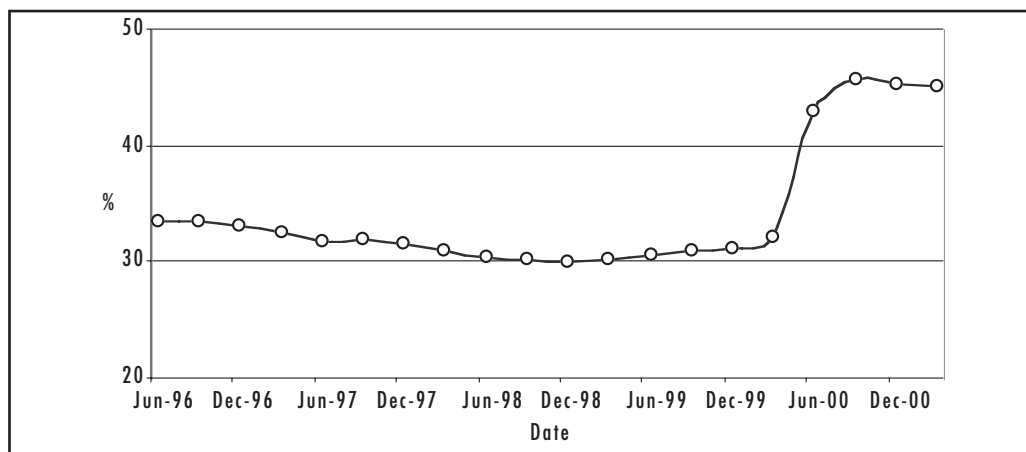
Figure 1 shows the percentage of persons covered for hospital insurance throughout the reform period. Earlier policy initiatives such as the incentives and the 30% rebate (January 1999) at best showed some arrest in the decline that had been occurring for several years.

The largest effect occurred with the introduction of Lifetime Health Cover (LHC) on 1 July 2000, and further extended by two weeks. The jump that took place in the June 2000 quarter (32.2% to 43%) was followed by a further increase to 45.8% in the September quarter reflecting the extension of the deadline for LHC in July 2000. This has subsequently declined to 45.1%. LHC was clearly the principal trigger for the increase. It precipitated a 43% overall increase in percentage of the population covered by hospital PHI.

Most of the new PHI members were younger and lower risk. In fact 81.5% of them were aged less than 50. The increased size of the insured pool, coupled with lowering the risk profile, had obvious benefits for the PHI funds after decades of decline on both measures. In September 2000, 89% of all persons covered were aged less than 65 years (PHIAC 2000).

The range of PHI products purchased by member also has an impact on the risk borne by the PHI funds. Front-end deductible (FED) products create a disincentive for the member to use their insurance. They are also required to make a co-payment towards their care in return for a lower premium. Exclusionary products similarly share risk with the insured. In September 2000, 52.3% of persons covered for PHI had a FED and/or exclusionary policy (PHIAC 2000).

**Figure 1: Proportion of population covered for hospital insurance.**



Source: PHIAC Quarterly Statistics, March 2001

## Financial state of the private health insurance industry

The Productivity Commission Inquiry into Private Health Insurance (Productivity Commission 1997) painted a gloomy picture of the financial health of the industry. It had reported a combined industry-wide operating loss of \$ 81.3m in 1996. By 1999, this had been turned around to a surplus of \$126m, and \$343m in 2000 (PHIAC 1999, PHIAC 2000).

PHI reserves were approximately \$1.3Bn in 1999, up from less than \$1.2Bn in 1998. By 2000 this had further increased to more than \$1.6Bn. In 1998 there were four organisations (of a total of 44) holding less than the statutory two months contribution income as reserves. This declined to two in 1999 and none in 2000. At the other end of the spectrum, the number of funds holding more than 5 months contribution income as reserves increased from five in 1998, to twelve in 1999, and fifteen in 2000.

Contribution revenues received by the PHI funds increased from \$4.962Bn in 1999 to \$5.462Bn in 2000. Benefits paid increased from \$4.254Bn in 1999 to \$4.514Bn in 2000.

## Medical gaps

PHIAC began compiling consistent medical gap payment data in September 2000 (PHIAC 2001b). The results to date are expressed in Figure 2 and show an increase in the percentage of service claims with no medical gap. However, there has been an increase in the average payment for services where a gap is paid.

**Figure 2: Gap payments for in-hospital medical services**

	Proportion of services with no medical gap	Average payment made by patients across all services	Average payment by patients where a gap was paid
June Quarter 2000 (est)	51%	N/A	N/A
September 2000	60%	\$ 21.49	\$ 54.20
December 2000	65%	\$ 18.18	\$ 51.56
March 2001	69%	\$ 20.29	\$ 64.28

Source: PHIAC Medical Gap for Insured In-Hospital Services, March 2001

## Simplified billing

This practice involves the use of billing agents to co-ordinate the large number of medical bills associated with a hospital admission. PHIAC data (PHIAC 1999) indicated in the first year of operation (1998/99) that 33 applications for registration as a billing agent were approved. This increased to 43 in 1999/00 (PHIAC 2000b).

By comparing the total number of Medicare claims submitted and the total number of claims submitted to patients, PHIAC estimated that there had been a five-fold reduction in the number of accounts that patients received directly as a result of the use of billing agents in 1998/99.

## Affordability

The introduction of the 30% rebate in 1999 had the immediate effect of reducing the cost of PHI. This could be taken as a tax rebate or price reduction. Most elected to take a price reduction. In 2001, PHI premium increases were minimal or absent altogether.

## Commonwealth financial outlays

The major cost for the Commonwealth has been the 30% rebate. Department of Health & Aged Care (1999b) estimates presented in July 1999 to a Senate Community Affairs Legislation Committee foreshadowed a gross cost of \$1.385Bn in 1999/00 associated with the 30 % rebate, rising to \$1.531Bn in 2000/2001. This was offset by savings associated with the abolition of the previous PHI incentives scheme. Estimates were based on achieving a 35% PHI coverage rate. Additional costs included provision for an extra \$80m per year associated with higher Medicare (MBS) benefits paid to medical practitioners, based on a projected increase in privately insured hospital episodes.

The level of PHI coverage exceeded the 1999 estimates. The 2001/2002 Federal Budget revised the estimate to \$1.896Bn in 2000/2001, rising to \$1.924Bn in 2001/2002.

### Impact on the hospital sector

The impact of the 43% increase in the number of insured persons in the period coinciding with the LHC deadline is far less clear. It is difficult to isolate which variable from a range of pre-existing trends, emerging industry conditions and the increase in PHI coverage will contribute to any long-term impact on the sector. Some of these have nothing to do with PHI, some have everything to do with PHI, and some are a combination of factors.

First, there is the obvious one. The Australian Health Care Agreement (AHCA) provides for a reduction in the amount of funding (clawback) for public hospital services to the States by the Commonwealth should the percentage of each State's population covered by PHI reach an agreed threshold level. All States exceeded their respective threshold by a country mile in June 2000. As part of their agreement to passage of the LHC legislation the Democrats secured a commitment that the clawback would not be invoked. This was agreed in an exchange of letters, not in legislation.

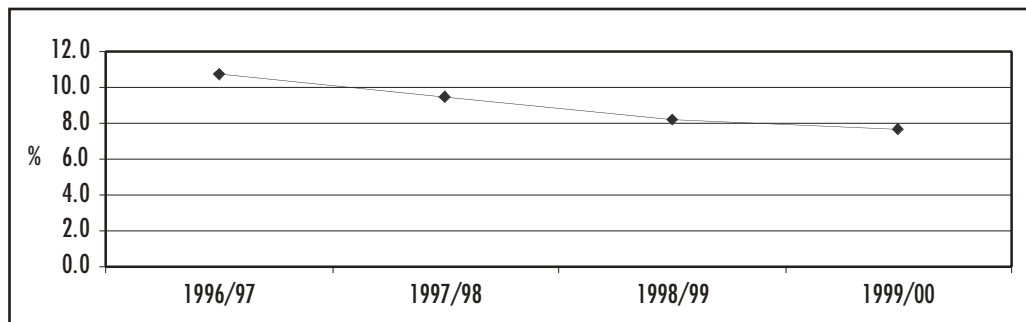
This commitment was subsequently reaffirmed by the Minister for Health and quantified in the 2001 Federal Budget. Had the clawback been invoked, the result would have been an annualised reduction of \$990m in Commonwealth payments to State and Territory health budgets.

To put this figure in perspective, \$990m would have purchased 362,903 casemix-adjusted hospital separations, based on the latest hospital national average cost of \$2728 per separation (AIHW 2001). On 1999/00 data this translates to approximately 9.5% of the total number of acute public hospital separations nationally.

Second, there is the less obvious factor that declining private patient activity in public hospitals was well entrenched before the PHI reforms. It was brought about by the transfer of privately insured patient activity to the private hospital sector. Figure 3 illustrates this trend over the preceding four-year period. Not shown is the fact that it has fallen from 23% in 1990/91.

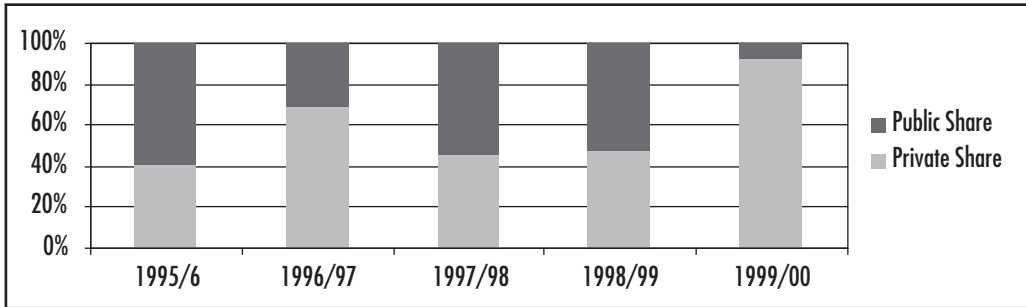
With PHI increasing, public hospitals might hope to reverse this trend in the future. However a look at the previous 5-year trend may not be so reassuring. This decline has less to do with the absolute number of insured than with the expansion of private hospital activity.

**Figure 3. Private patients proportion of public hospital activity**



Source: AIHW Hospital Statistics 1999/00

The split in overall activity across the two sectors has shifted from 70:30 (public: private) to 65:35 across the five-year period from 1995/96 to 1999/00. Figure 4 shows the distribution of annual growth in total hospital activity across the public and private sectors in consecutive years. This has been flowing strongly towards the private sector, including 92% of overall activity growth in 1999/00.

**Figure 4.: Allocation of annual growth in hospital separations to sector**

Source: AIHW Australian Hospital Statistics 1995/96 – 1999/00

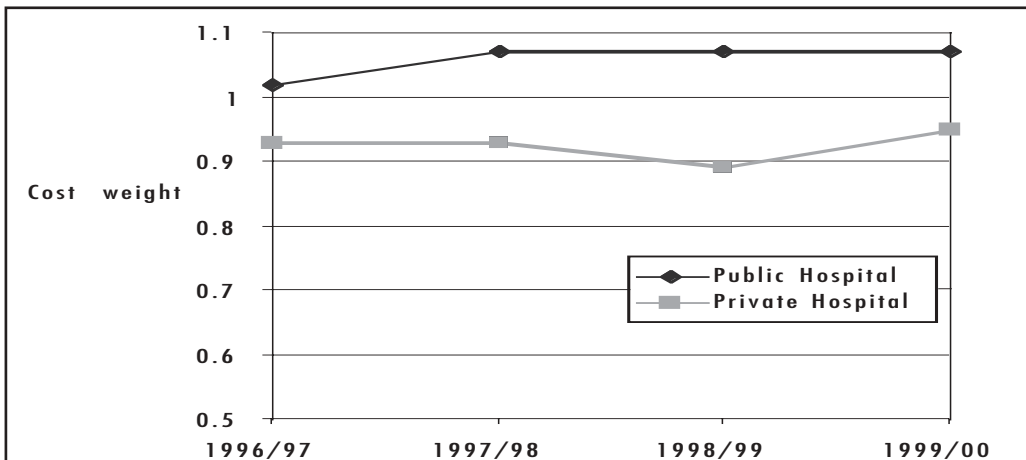
Annual growth in the total number of *private patients* across both sectors in 1997/98 and 1998/99 was flat at 1.6% and 0.5% p.a. respectively. In 1999/00 it increased to 6.1%. The allocation of this annual growth in private patient activity across the two sectors mirrors that of total activity that is displayed in Figure 4.

Waiting and exclusionary periods for the new members dampened the potential impact of the big increases in overall PHI coverage. These periods have now passed and the impact of higher PHI coverage will begin to emerge in the 2000/2001 figures. However, as most of the newly insured are young and low risk, this may take several years.

Anecdotal information suggests no significant reduction in public hospital waiting lists, yet private hospitals across Australia are reporting significantly elevated activity. Some of this could be a transfer of waiting list activity, while some would also be latent demand not reflected in waiting lists. Overall, the 1999/00 hospital data suggests a significant increase in the private sector activity, and a below average increase in public hospital activity.

A final view on the public hospital impacts is that of casemix. Differences in casemix relate directly to the cost of care borne by the hospital. The public sector has traditionally had a higher average cost weight than the private sector. In 1996/97 this was 1.02 (Public sector) and 0.94 (Private Sector). The difference narrowed considerably in 1999/00. Average cost weight is now 0.99 (Public sector) and 0.98 (Private sector).

However a comparison of eligible private patients (excludes compensable, Veterans Affairs and public contract patients) in private hospitals with those that remained in the public system indicates a significant casemix difference (Figure 5). Eligible private patients in public hospitals (the object of PHI reforms) are more costly and complex than those in the private sector.

**Figure 5: Average cost weight of private patient separations**

Source: AIHW Hospital Statistics 1999/00

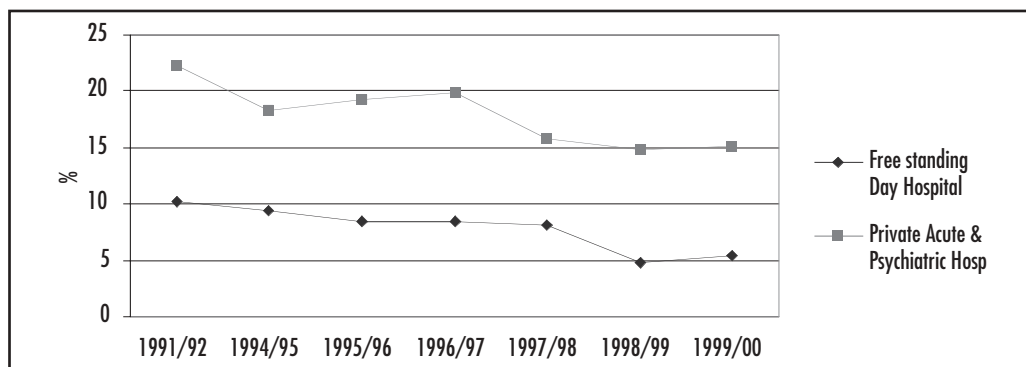


## Private hospital changes

It is important to state at the outset that much of the private hospital changes described below are not necessarily directly related to levels of PHI coverage. Like the public sector, the effects of the increase in PHI coverage on the private sector are yet to be fully realised.

The industry has been experiencing a progressive decline in operating margins. Based on ABS figures (ABS 2001), margins decreased between 1991/92 and 1999/00 from 10.2% to 5.4% for private hospitals, and from 22.3% to 15.2% for free standing day surgery centres. This downward trend, depicted in Figure 6, was arrested somewhat in 1999/00.

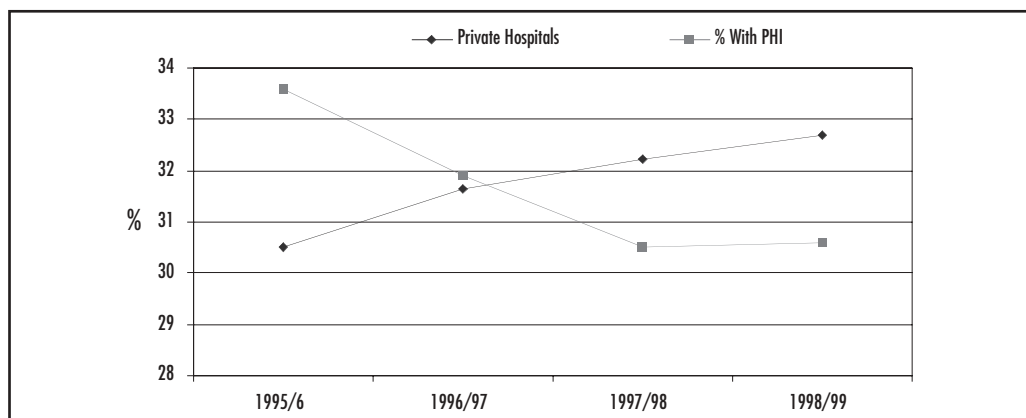
**Figure 6: Operating margins for private hospitals**



Source: ABS Private Hospitals 1999/00

Figure 7 describes the relationship between private hospital sector share of overall hospital activity and the level of PHI coverage in the population, based on AIHW and PHIAC data. The private hospital sector's response to falling PHI has been to increase its share of overall hospital activity. The percentage of private hospital activity derived from insured patients declined from 82% in 1994/95 to 74% in 1999/00 (ABS 2001). Day Hospital percentages are largely unchanged from 55% to 57%. This has been supplemented by revenue from sources including Veterans, public contracts, compensable patients and self-insured.

**Figure 7: Private hospital percentage share of overall hospital activity and percentage of population with PHI**



Source: AIHW Hospital Statistics 1999/2000 & PHIAC 2001a

Private hospitals have been subject to more aggressive contracting processes with the PHI funds. Contracts have progressively incorporated a shift to episode-based payment methods with an associated shift in risk to the provider. Some of the contract negotiation processes have been associated with a degree of acrimony, with the hospitals increasingly ending up as price takers in the process. This has impacted significantly on margins. The Australian Competition and Consumer Commission (ACCC) has been active in ensuring that the contracting process has been free of collusion in price setting across the private hospital sector. This has had a more significant impact on the smaller independent hospital operators that lack market power.

Restructuring and mergers have been a feature of the sector. Mayne Health has acquired Australian Hospital Care, and is aggressively pursuing a process of vertical integration. The Ramsay group is also involved in mergers and consolidation. Amalgamations and mergers have also taken place in the religious and charitable sector. In addition, this group has lost significant taxation benefits as a result of the Federal Government's new taxation system.

Shares of four major listed private hospital groups as at 13 July 2001 were trading at levels between 74% and 380% above their preceding 52-week low points.

## **Consumer impacts**

Price, simplified billing and gap effects have been described above. Again, the ACCC has been active in policing claims of misleading advertising by the health funds, in some cases resulting in orders being issued.

Guidelines for Informed Financial Consent have been drafted (Department of Health & Aged Care 2001b). These cover the practices required by doctors, practitioners, funds, consumers and regulatory mechanisms.

Industry actions include a Code of Conduct, websites providing information about practitioners who provide No Gap services and, in one case, access to a consumer version of the Cochrane Collaboration website. Formats for the provision of pre-admission quotes for Known Gap episodes have been developed.

## **Criticisms of the PHI reforms**

### **Efficiency, cost and opportunity cost**

The 30 % rebate has been consistently criticised on the basis of overall cost and efficiency. Duckett & Jackson (2000), based on an analysis of costs of public and private hospitals, argued that the government funding associated with the rebate would have been better allocated directly to the public hospital sector. They concluded that the program's estimated cost of \$2.19Bn could not be justified on the basis of efficiency. The authors state that allocation of the funding directly to the public hospital sector would have purchased 58% of the current total private sector demand.

Segal (2000) similarly calculated that the program would, at best, save \$1.38Bn in public hospital activity for an estimated outlay of \$2.75Bn. An economic analysis of the rebate undertaken by Vaithianathan (2001) also concludes that the cost of the rebate will exceed the savings it generates. This is due to failure to target the scheme towards high users of hospital services.

Clarke (1999) explored the PHI purchasing intentions of Australian in response to the 30% rebate. He estimated that the rebate alone would at best achieve population coverage for PHI of 34.3% by May 2000. The key point here was that this study was published without reference to the impact of the then unknown Lifetime Health Cover (LHC) policy initiative. Analysis of the PHIAC data for this period supports Clarke's estimate. It was not until the period immediately preceding the deadline for LHC (July 2000) that the percentage level of PHI coverage surged above its stable pattern in the low 30s.

Hindle (2000) described the likely impact of the 30% rebate on levels of PHI coverage in the population. Specifically, he modeled the potential impact of this in terms of resulting bed-days saved by the public hospital sector. Simply on the basis of estimating transferred costs, annual "savings" of between \$117m (worst case) and \$483m (best case) may result. However, when well established factors such as annual utilisation growth and unmet demand were considered "... even in the best case scenario, there could not possibly be any significant reduction in public hospital activity levels." (Hindle 2000, p 8).

The activation of the clawback provision in the AHCA would have offset the annual cost of the program by approximately \$990m. While this would have been politically impossible for Government, as well as disastrous for the public sector, it was the only significant financial offset identifiable in the program. The total funding package must now be assessed more directly on the basis of its opportunity cost as Duckett & Jackson (2000), Segal (2000), Clarke (1999), Hindle (2000) and Vaithianathan (2001) suggest.

An additional criticism is that the Lifetime Health Cover initiative, which appeared to have the biggest impact on PHI uptake, costs very little and has minimal impact on future Commonwealth financial outlays. Conversely, the most expensive policy initiative (the 30% Rebate) appeared to have minimal impact on the uptake of PHI and will result in approximately \$2Bn in annual Commonwealth outlays.

Hindle (1999) reports that the risk profile of the PHI funds is reduced by an influx of young, healthy members. However assuming that overall level of care requirements for the community is unchanged then “..the reduced utilisation experienced by the private insurance sector will be balanced by increased utilisation in the public insurance sector.” (Hindle 1999; pp158). Risk transfer is clearly a two way street, and Hindle argues that this transfer has been of greater benefit to the PHI funds than it has to the public sector. The above-mentioned return to profitability for the health insurance sector supports this position.

### Impact on public hospitals

The absence of timely national data on hospital activity and waiting lists limits the ability to make a prompt assessment of impact. However any potential for a positive impact on public hospital activity is likely to be offset by the following factors.

- Low risk profile of new members (81.5% aged < 50 years).
- High percentage (52.3%) of members with front-end deductible products, a disincentive for the use of PHI.
- Selective use of PHI. All persons have the right to choose to be admitted as public patients on an episode by episode basis.
- Casemix effects. Use of public hospitals for urgent, high cost and low-profit episodes is unlikely to be affected by changes in PHI. Most of the growth in private hospital services has been in less complex, day only procedures.
- Lengthy waiting lists and unmet demand are likely to mask impacts.
- Annual utilisation growth above population growth. The AHCA allows for an annual growth factor of 2.1% in utilisation.

### Equity

Concerns have been raised about the equity of some of the PHI reforms, and especially the non-means-tested 30% rebate. Smith (2000) concluded that around half of the value of health insurance concessions was directed to the most well off third of taxpayers, while less than 20% went to the third of individuals in the lowest income group.

The inclusion of ancillary cover in the calculation of the 30% rebate is problematic from an equity viewpoint. Dental benefits paid to persons with PHI amounted to \$603m in 1999, and \$635m in 2000 (PHIAC 2000b). The rebate effectively underwrites this expenditure to the extent of 30% of total benefits payable, and is equivalent to a Commonwealth subsidy for private dental services of \$180.9m and \$190m respectively over the period.

The Commonwealth Dental Program, which provided funding exclusively for the financially disadvantaged, was discontinued prior to the introduction of the 30% rebate. Concerns persist about equity of subsidising access to dental care for the privately insured while cutting access to the same services for the most disadvantaged.

Sullivan (2001) argues for more direct government intervention in private health care, beyond insurance aspects. He concludes that the increased funding to the sector via the insurance mechanism is encouraging commercial and profit motives to take precedence over the health service requirements of specifically needy groups such as the aged and those with chronic health conditions. Such persons have legitimate expectations that the private sector should be able to provide services to them consistent with their needs and insurance status. Sullivan argues that insurance policy alone is insufficient. A more direct purchasing role, as illustrated by Veterans' health care, may be more effective in meeting health needs of older persons and those with chronic health conditions.

## Future implications

The PHI reforms have achieved a several of the government's objectives while others (reducing public hospital pressure) will take longer to assess. The major achievement is that, despite the criticism directed towards the reforms, they are likely to remain in place having gained bipartisan political acceptance. The implications of this for the industry, Government and the community are significant.

*The private hospital sector* has demonstrated a capacity to survive and grow despite falling levels of PHI. It has secured other sources of revenue to make up for the shortfall, and has withstood considerable margin squeeze. The industry has consolidated, restructured and integrated. Its excess capacity has been absorbed and its negotiating position with purchasers is stronger than before. Some operators have been prepared to walk away when the price offered is unacceptable. The likelihood of increased PHI payments per hospital episode is high given a long period of margin decline.

The private hospital industry holds the productive capacity to deliver on the Government's \$2Bn promise of choice through private health. On the basis of activity growth demonstrated during periods of PHI revenue decline, it is likely that this growth will continue and increase. With occupancy levels at an all time high, the limitation on future growth will be capital stock and skilled staff, not revenue sources.

*The private health insurers*, with fully replenished reserves, have been the major beneficiaries to date. New products, new members and high expectations will keep the pressure on the funds to deliver for Government and the taxpayer. Key priorities will be to keep premium increases to a minimum, deliver on elimination of gap payments, and trim their costs. They have lost their dominant negotiating position with the hospitals, and with it the capacity to suppress payments. Effective relationships with public and private providers and the medical profession are more critical than ever. Empowering their members to exercise choice based on information about their hospital care, its cost and the comparative performance of providers is a major strategy in delivering quality, gap-free services.

*Medical practitioners* and their billing behaviour are critical to consumer satisfaction with private care. The increased availability of information about their billing behaviour is empowering consumers to shop around. The ACCC will be vigilant in policing of any price setting behaviour that may emerge. Public statements by medical groups that price should not be a factor in the consumer's choice of specialist will be viewed sceptically until such time as there is evidence to support the implicit proposition that higher prices equate with better care.

The current review of the Medicare Benefits Schedule provides the profession with the opportunity to try to trade increased delivery of No Gap episodes in return for selective MBS increases. In their role as primary determinants of the success of No Gap products, their influence on future premium increases, client satisfaction with PHI and cost to government is highly significant.

*Public hospitals* seem to be benefiting much less from the reform process at present. Private patient revenue is unlikely to return to the previous levels. The sector's role in private patient activity will largely be confined to providing choice of doctor for those patients who are not profitable as private patients for the private sector.

The decline in PHI revenue can be partially arrested through better marketing of the benefits of private care in public hospitals, improving the billing processes for remaining private patients, and also through capitalising on the sector's comparative advantage as a provider of hospital-in-the-home programs, now covered by PHI.

The benefits of reduction in activity in the public sector are yet to be demonstrated. The 1999/00 AIHW data show an increase in public hospital separations of less than 0.4%, its lowest annual increase in recent years. The full impact of increased PHI on public hospital activity will take more than one year to emerge. The benefits of this reduction to clients will be lost if State governments respond with reductions in purchasing of public hospital or other health care. With the removal of the AHCA clawback provisions, there is no external financial pressure on them to do so. However, should each State's overall utilisation fall significantly, other provisions in the AHCA permit the Commonwealth to reduce its funding.

State governments have implicitly endorsed the continued transfer of lower cost, lower complexity elective work to the private sector. Their approval of co-locations and public contract work to the private sector is evidence of this. If this strategy has delivered social, health and economic benefits to the community, then these should be demonstrable and made explicit. If there are benefits then this strategy needs to be more formally planned and managed. If there are limited or no benefits then should this process continue in an unplanned fashion?

*Consumers'* benefits have been described earlier. The key implications relate to sustainability of gains thus far. If a visit to a private hospital continues to result in gap payments, then the gains derived for them through their forced choice or encouragement to join PHI may be short lived. Similarly, if payments to private hospitals from the PHI funds increase (total and per episode), coupled with an increased level of No Gap claims and new products, then pressure on current premium levels will increase.

Increased access to information about health care and its costs should improve consumers' ability to choose providers on factors other than their GP's recommendation. The activity of the ACCC is also likely to influence both the advertising practices of funds, and the competitive behaviour of the wider industry. However, increased scrutiny and regulation could have happened in the absence of the package of PHI reforms.

For the current and future Federal Governments, the PHI reforms will provide significant challenges. If the level of PHI coverage is maintained, the transfer of activity to the private sector continues, and the current rebate program is retained, the Government has inherited new financial risk, with no immediate offsets. Available evidence (Duckett & Jackson, 2000) indicates that when casemix effects are taken into account the public sector has a lower cost structure than the private sector. The 30% rebate now effectively underwrites part of the cost of annual utilisation growth in the more expensive private sector, with no immediate or politically feasible offsets in the public sector.

Continuation of Commonwealth funding for private dental and other ancillary services of more dubious benefit will become increasingly difficult to justify.

The next Australian Health Care Agreement will need to more explicitly deal with the changed dynamic between the public and private healthcare services, and the impacts of PHI. Hindsight, informed by such major increases in PHI coverage, causes one to question the wisdom of this aspect of current Commonwealth and State hospital funding agreements.

The relationship between levels of PHI and demand for public hospital services (and private hospitals for that matter) has proven to be more complex than both levels of government had believed it was. It is incomprehensible to imagine any Federal Government attempting to extract almost \$1Bn per year from the States on the basis of its achievements in PHI. Yet that is what their agreement suggested should happen.

Conversely, is it economically responsible, or in the interests of long-term planning of health services, for any government to commit to \$ 2Bn worth of additional annual expenditure to private hospital care, without any offsets, effective controls on utilisation, targets for access or indicators of health outcomes?

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