Why it is time to review the role of private health insurance in Australia

TO THE EDITOR: Since its introduction on 1 January 1999, the 30% rebate has been the subject of much misleading comment by the opponents of the private health sector. A recent addition to these ranks was published in the first edition for 2004 of *Australian Health Review* (Segal 2004).

There is no real attempt at balance in the article. While Segal argues that the rebate has failed to take the pressure off public hospitals, we are not told, for example, that almost one-in-five extra patients admitted by public hospitals in the three years to 2002-03 were actually private patients!

Similarly, the article is littered with generalisations and, in some cases, misleading or completely incorrect statements, such as "Private hospitals do not offer a complete hospital service ..." Even a cursory examination of the available national data indicates that private hospitals provide services in all but 7 of the 654 diagnosis-related groups (DRGs) recorded. Private hospitals perform all the remaining 647 DRGs.

In 200 of these DRGs, private hospitals treat more than 38% of all patients, even though private hospitals account for only 34% of all hospital beds. For example, in 2002–03, private hospitals provided 42% of all coronary bypass operations, 46% of all cardiac valve procedures, 54% of major procedures for malignant breast conditions, 55% of hip replacements, and 71% of major wrist, hand and thumb procedures. All this from a sector that, according to Segal, " ... can choose to focus on the more profitable health services."

Segal tells us that " ... the private hospital system focuses on elective surgery, and within that, the more profitable area of day surgery." Again, a look at the independent national data from the Australian Institute of Health and Welfare actually shows a different picture. In 1998–99, private hospitals provided 28.3% of total overnight separations and 37.4% of same day separations. In 2002–03, the private hospitals sector provided 32% of total overnight separations and 44.0% of same day separations. Since 1999–00, overnight admissions to public hospitals have fallen by 15 000. Over the same period, overnight admissions to private hospitals increased by 97 000!

Finally, we have the good old standby of " ... most of the oldest, poorest and sickest patients will be cared for publicly ..." Again, the data shows that this is simply untrue. For example, in 2002–

03, patients aged 65 years and older comprised 34.3% of all patients treated in private hospitals, and comprised 34% of patients treated in public hospitals. Clearly, public and private hospitals are dealing with a commensurate proportion of the health needs of older Australians.

The only way forward for Australia is via a balanced health care system, in which the 30% rebate is a crucial element. Who knows, one day you might even run a balanced article on the 30% rebate.

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IN REPLY: We are pleased to see the call for a balanced public debate by Roff, Executive Director of the Australian Private Hospitals Association. This is precisely the reason for undertaking an objective academic analysis of the private health insurance (PHI) rebate and subjecting it to peer and editorial review before publication in *Australian Health Review*.

Unfortunately, the letter by Roff does little to further the debate and fails to address the central arguments of my article concerning the efficiency and equity of the PHI rebate and other policies to support PHI. While Roff contends that a number of statements concerning private hospitals are incorrect, the evidence produced tends to be immaterial to the point being made.

For instance, in relation to completeness of the service offered by private hospitals, we are told that private hospitals cover most DRGs. This does not mean the service mix is similar, nor does it address the other activities of public hospitals (eg, providing emergency care, seeing non-admitted patients, training health professionals) which are almost entirely delivered by public hospitals. For instance in 2000–01, 96% of non-admitted occasions of service (which include visits to emergency departments) were delivered through public hospitals and only 12% of emergency admissions occurred in private hospitals — making up less than 9% of private hospital admissions, but over 42% of public hospital admissions (Australian Institute of Health and Welfare 2004). Roff comments that public hospitals are admitting more private patients. This would seem to confirm a crowding out of public patients rather than a freeing up of beds for public patients. The small increase in public hospital overnight separations between 2000–01 to 2001–02, given the large increase in PHI membership and when considered against a fall in overnight separations each year from 1997–98 to 2000–01, hardly suggests a large redirection of demand to private hospitals. No information is provided by Roff concerning the focus of private hospital activity in relation to profitability. But the increasing activity in day procedures — up 29% in the 2 years to 2000–01 in the highly profitable free standing day hospitals, with a mean net operating margin of 17% per annum in the 5 years to 2000–01 — would seem to support the proposition (Australian Bureau of Statistics 2002).

We concur that the community deserves an informed debate on the PHI rebate and other policies relating to health insurance.

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