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The hidden cost of private health insurance in Australia

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Abstract. The provision of health services in Australia currently is primarily financed by a unique interaction of public and private insurers. This commentary looks at a loophole in this framework, namely that private insurers have to date been able to avoid funding healthcare for some of their policy holders, as it is not a requirement to use private insurance when treatment occurs in Australian public hospitals.

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Introduction

The stated aims of the Australian healthcare system are 'to give all Australians, . . . access to healthcare at an affordable cost or at no cost, while allowing choice for individuals through substantial private sector involvement. . .'[1] The government currently allocates considerable funding to support the private health insurance (PHI) system through premium rebates and exemptions from the Medicare Levy surcharge. While this strategy has been politically popular, there is a loophole in the system that allows the insurance companies to act as 'free riders'. The term 'free riders' alludes to those who use public transportation without paying the fare, which typifies the situation where resources are consumed by those who do not pay.[2] In this article, we propose that this is inefficient in terms of resource allocation and offer our suggestions to improve the situation.

History of private health insurance

In response to waning PHI membership, the federal government introduced three schemes since 1997; the Private Health Insurance Incentive Scheme, the Private Health Insurance Incentives Act and the Lifetime Community Rating Scheme.[3] These incentives are essentially subsidies, allowing individuals who earn above a certain income threshold to purchase PHI to avoid paying an extra Medicare levy, a 30% rebate on the premium, and an age-based penalty scheme to encourage earlier adoption of PHI.

These schemes have been successful in expanding PHI coverage from 30% in December 1998 to 45% in 2010.[4] However this artificial support for PHI has come at a substantial cost –$3.59 billion to fund the rebate in 2009 and an estimate of $1.1 billion (in 1997–98) in lost taxation revenue through Medicare levy exemptions.[5,6] With revenues to PHI companies rising to the point of unprecedented profits ($1.42 billion before tax), there have been suggestions that the government should directly allocate these funds to public hospitals.[7,8] The subsidy of PHI could be acceptable if it was responsible for increasing PHI coverage and reducing the pressure on the public health system. However research suggests that it is the Lifetime Community Rating policy (allowing risk discrimination in premiums) – which has negligible costs to the government – that is largely responsible for the expansion in PHI coverage, rather than the other two major policies.[9,10]

In addition, when private patients are treated in public hospitals, the public hospital can only charge the fixed rate that is set by the federal government. This fixed rate is less than what private hospitals charge for the same services, and thus the government further subsidises the care of privately insured patients.[11] Such funding discrepancies are possible because all private hospitals are involved in contractual relationships with PHI companies.[12] It has been estimated that the insurers of private patients are charged only a third of the $1000 a day they would pay in private hospitals.[13]

Current implications and efficiency

Australia is one of many countries that has PHI acting as a duplicative or supplementary coverage to universal healthcare.[14] However it is one of only few that allows patients with PHI the option of being treated either publicly or privately in our public hospitals. Holders of PHI retain full access to Medicare coverage, which leads to a duplication of coverage.[15] A proportion of people

(12%) recognise this benefit and purchase not for the coverage benefits but to avoid the extra Medicare levy;[15] Twenty-four percent of Australians with PHI did not use their PHI in public hospitals in 2009.[16] There is also an equity consideration with the subsidies for PHI. Higher income earners are more likely to have PHI, demonstrating that the subsidy results in an unequal redistribution of benefits to more affluent Australians.[17] A recent study revealed that only 24% of households with an annual income below $25 000 have PHI.[18]

One reason that patients with PHI may elect not to use their insurance is that they may face out-of-pocket (OOP) costs when treated in public hospitals, whereas patients opting for treatment under Medicare are guaranteed no extra costs. As a consequence, PHI companies are able to collect insurance premiums from this subset of privately ensured patients while avoiding any financial responsibility for their treatment in public hospitals.

Current statistics indicate that private patients comprise ~10% of public hospital admissions, costing approximately $4695 per admission.[6] If one-quarter of the ~500 000 annual admissions to public hospitals with PHI did not use their PHI, this could cost the public $588 million annually.[19] By holding private insurers financially responsible, public hospitals would be directly funded for the private patients they treat. The key to improvement is to alter the system rather than putting the onus on individuals to elect to use their PHI.

Recommendations

This loophole in Australia's healthcare financing can be addressed in several ways. The first approach, which is already occurring at some public hospitals, would be to ensure that all patients are presented with the option of using their PHI. These hospitals employ private patient liaison officers who ask all admitted patients about their insurance status and inform patients about the benefits of using PHI, such as choice of physician or free daily newspapers.[20–22] One study performed previously has demonstrated that patients who are aware of the hospital initiatives to remove OOP expenses are more likely to use their PHI.[23] Many public hospitals are now also waiving OOP expenses to ensure that patients do not have gap fees. One difficulty with this proposal is that under the Australian Health Care Act, patients have the right not to disclose their insurance status and employees are not allowed to 'direct' patients to a particular choice.[23,24]

A second approach would be for the government to create a mandated PHI policyholder registry to allow public hospitals to identify patients with PHI. This registry will also detail the treatments covered by PHI, removing some of the information barriers that hinder the use of PHI in public hospitals.

A third possibility would borrow from a method used in the United States. When there is more than one payer (for instance, people older than 65 years have access to Medicare, but they may also have PHI), an established procedure for 'coordination of benefits' exists.[25] In the US, the PHI company is always the 'primary payer' and Medicare is the 'secondary payer'. In other words, if Australia implements a similar system, for patients with PHI admitted into a public hospital, the PHI would be the primary payer, paying the hospital bill first. Costs that are not covered by the PHI would be covered by Medicare.

The last alternative, as suggested by Paolucci and colleagues would be for individuals who purchase PHI to 'opt-out' of Medicare completely.[26] These individuals would still be able to use public services, but they would contribute only to private insurers and those insurers would be required to pay. This would direct funds to the hospitals and providers where they are used, reducing administrative duplication and cost shifting. A proportion of the funds saved from improving the efficiency of the system could be added to the subsidy and compensate for paying all the healthcare costs.

The option that we favour is for the government to create a national register of people with PHI and mandate the use of PHI in public hospitals if one has it. With this option it is important to guarantee that private patients will not be charged OOP costs. This can be achieved in two ways: either by prohibiting doctors from charging private patients in public hospitals in excess of the Medicare Benefits Schedule fee, or by requiring PHI to cover any potential gaps. We would also like to see an increase in the default rate that public hospitals can charge privately ensured patients, commensurate to that received in the private sector.

Potential barriers

The PHI industry is likely to argue that any changes to current regulations will breech privacy and freedom of choice, increase premiums and possibly lead to the collapse of the private health sector and put more pressure back on the struggling public system. The Australian Private Hospitals Association responded to Queensland hospitals attempting to tempt patients to use their PHI, with the statement 'people without insurance were being kept out of public hospital beds by patients who were being coerced to use their insurance'.[21] They may also point to the increased administrative burden of identifying PHI policy holders. While it is true that premiums may increase, the response of the public to the premium increase is less certain. If the increased costs were spread across all people with PHI, it would average out to be less than the annual premium rise approved by the Health Minister.[27] Nonetheless, regulatory oversight (such as the PHI Ombudsman) would need to be aware of this and ensure acceptable premiums and policy provision.[28] It must be remembered that in spite of the likely protestations of PHI companies, they accepted responsibility for paying any healthcare costs that their members may incur.

Conclusion

As Professor Jim Butler, the director of the Australian Centre for Economic Research on Health has pointed out, the 'utilisation of public hospitals by privately insured patients. . .. compromises one of the objectives of subsidising private health insurance in the first place'.[29] Our aim is to ensure that Australia's public healthcare system continues to provide high-quality care, by highlighting this financial loophole. While previous commentators have suggested abolishing the PHI rebates, this has not been embraced politically. We suggest that a positive start would be to address how PHI companies are free riding on the public healthcare system.[7,30] The Australian government can take measures to correct the current resource misallocations not only by improving administrative changes, but also by implementing new regulations.

Competing interests

The authors declare there are no competing interests.

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