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Australia's private health insurance industry: structure, competition, regulation and role in a less than 'ideal world'

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Abstract. Australia's private health insurance funds have been prominent participants in the nation's health system for 60 years. Yet there is relatively little public awareness of the distinctive origins of the health funds, the uncharacteristic organisational nature of these commercial enterprises and the peculiarly regulated nature of their industry. The conventional corporate responsibility to shareholders was, until recently, completely irrelevant, and remains marginal to the sector. However, their purported answerability to contributors, styled as 'members', was always doubtful for most health funds. After a long period of remarkable stability in the sector, despite significant shifts in health funding policy, recent years have brought notable changes, with mergers, acquisitions and exits from the industry. The research is based on the detailed study of the private health funds, covering their history, organisational character and industry structure. It argues that the funds have always been divorced from the disciplines of the competitive market and generally have operated complacently within a system of comprehensive regulation and generous subsidy. The prospect of the private health funds enjoying an expanded role under a form of 'social insurance', as suggested by the National Health and Hospitals Reform Commission, is not supported.

What is known about the topic? Government policies promoting private health insurance have long been the subject of public debate and have received considerable academic analysis. The health funds have a high profile in the media and with the public, reflecting the extent of private health insurance coverage.
What does this paper add? There is relatively little awareness of the unique nature of the private health insurance industry. This paper highlights the distinctive organisational origins of the health funds, the recent changes to the structure of the sector which have complicated their corporate identities and the complex role they play in an extraordinarily regulated private health insurance industry.
What are the implications for practitioners? Awareness of the nature of the sector should take us beyond perennial concerns about premium rises and the level of private health insurance coverage to better appreciate the diverse nature of the industry, the constraints under which the funds operate and the potential they may have to deliver 'social insurance'.

One of the strongest and most consistent policy themes of the conservative Coalition government, led by Prime Minister John Howard (1996–2007), was its support for the private health insurance (PHI) system. The traditional Liberal moral preference for the 'self-reliance' associated with PHI has not diminished in the party, now in opposition. Of the multitude of contentious policies announced in the May 2009 Commonwealth budget, the proposed means-testing of the PHI rebate was the only measure that the Coalition vowed to oppose unreservedly. Opposition leader Malcolm Turnbull upheld the perennial Liberal position, declaring that: 'in an ideal world, every Australian would have private health insurance. That would be the best, that would be the best outcome'.[1]

Although the 'ideal world' envisaged by the Liberal party has always had a place reserved for the private health funds, that place is a long way removed from the competitive market ideal. The PHI system created, nurtured, defended and revived by Liberal governments has never been distinguished by profit-driven firms competing whole-heartedly in a dynamic, free market. For most of the history of government-sponsored PHI in Australia, the health funds have been exclusively not-for-profit associations, and the sector remains essentially of this character, although this is complicated by recent acquisitions and demutualisations. The former head of the organisation established to oversee the health insurers, the Private Health Insurance Administration Council (PHIAC), portrayed the traditionally non-profit character of 'an unusual industry' in a favourable light: 'a commercial industry whose suppliers, almost exclusively, exist to provide mutual benefit to their respective members rather than to return dividends to external shareholder investors'.[2] This perspective overlooks the entrenched institutional vested interest that has developed in the health funds since their inception, and also the role they play in underpinning the profitability of the private healthcare sector. The funds have long had a high public profile, being enthusiastic advertisers and sponsors, and most Australians are, or have been, their contributors, but there is little awareness of the peculiar

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organisational character of the health funds and the nature of their uniquely regulated industry.

The health insurance organisations have essentially existed as licenced agents of the Commonwealth, initially registered under the *National Health Act (1953)*, which imposed rigorous and comprehensive regulation on their constitutions, health benefits rules and business activities. Conformity of product and price, rather than competition, was the result. Above all, Commonwealth guarantee of a portion of the health benefits (or a portion of the premiums in the case of the more recent Howard scheme) insulated the health funds from the conventional business imperatives to satisfy customers and contain costs in the industry, and inflated their significance in the funding of healthcare in Australia. Richardson and Scotton suggested that the health insurers have functioned 'basically as a passive conduit of funds from consumers to service providers. The chief difference from a conduit is that they had deducted on average 15% in management expenses'.[3]

The persistence of the notion of 'managed competition', most recently advocated as a 'social insurance' model dubbed 'Medicare Select' by the National Hospitals and Health Reform Commission (NHHRC), promises the private health insurers the main, though not exclusive, intermediary role in the health system. Managed competition originated from the proposals of Alain Enthoven,[4] and featured in the abortive Clinton healthcare plan,[5] before being substantially adopted by the Dutch health system.[6] In Australia, managed competition has been associated with Richard Scotton, one of the architects of Medibank (the predecessor to Medicare), and focuses on health funds functioning as 'cost-conscious budget holders at arm's length from the providers'.[7] The Scotton model envisages the funds taking responsibility for publicly funded Medicare Select members while still offering exclusive private hospital access to contributors who pay additional premiums.[8] Managed competition has periodically been raised in health reform discussions in Australia since appearing as Option 3 in the report of the Keating government's National Health Strategy.[9] It operates on questionable assumptions. These concern the desirability of delineation between the funders, the purchasers and the providers of healthcare and takes for granted that, if purchasing authorities compete among themselves for custom, they will be driven to bargain effectively with service providers while being responsive to the various healthcare needs of their contributors (see pp. 202–204).[10] This article does not engage with the general propositions of managed competition, but argues that Australia's private health insurers are not suited by the structure of their industry, nor equipped by their historic role, to operate as effective agents in a universal health scheme. They have never been keen participants in a competitive market nor are they, notwithstanding their mutual origins and the customary designation of insurance contributors as 'members', responsive philanthropic organisations.

The private health funds in the politics of private health insurance

Health funding policy has been exceptionally divisive in Australia, exceeded in this regard only by the US experience. Every election between 1969 and 1996 has seen the contending parties at loggerheads over the issue of health insurance, with Labor supporting national health insurance (NHI) and the Liberal and National Coalition favouring a system primarily based on private (or 'voluntary' as it was formerly styled) health insurance. During the Howard era, the Coalition pragmatically adopted a formal commitment to Medicare while introducing measures to promote PHI through the subsidisation of premiums and the penalisation of non-enrolment. For its part, the ALP, although continuing to uphold Medicare as its priority, eventually accepted the Liberals' PHI policy reforms. Kay argues that, 'after 50 years of conflicting policy frames, these reforms mark the agreement by both parties that Australia would operate a parallel system in healthcare financing', and that this finally represented 'a bipartisan policy paradigm on healthcare financing in Australia' (see pp. 588–590).[11] Kay underestimates the ideological unease within both parties on this accommodation (see pp. 139–141),[12] which has been starkly revealed in the parliamentary confrontation over the Rudd government's revisions to PHI announced in the 2008 and 2009 budgets. Although the private insurers like to portray the two health insurance systems in the Medicare era as 'complementary', the systems experience significant rivalry over funding and healthcare resources as well as being in ideological tension.

The funding of healthcare in Australia has been the subject of extensive research in the social sciences since the 1960s. This is understandable, considering the intensity of the debate over NHI, which has been driven by differences between the political parties and the mobilisation of highly motivated health sector interests.[13] Research evaluating Commonwealth policies dealing with health financing could not avoid taking sides in this passionate ideological and interest-based debate.

The principles of 'equity' and 'efficiency' are central to the host of economic analyses of the PHI system that have been published. Both the advocates of NHI and the defenders of PHI have employed these concepts, although the latter have also emphasised the merits of 'choice'. Most of the published academic work on PHI has concentrated on Commonwealth policies and expenditure in terms of the national *v.* private health funding debate or else has examined specific policy initiatives, such as the Howard government's rebates and 'Lifetime Cover' reforms[14–18] (see pp. 303–306[16]). Little attention has been given to the PHI organisations themselves, despite the importance and idiosyncratic nature of the industry. Although their role in the health system was profoundly altered by the establishment of Medicare, they have continued to be treated as the agents of the state. Notwithstanding revisions to the system of regulation, and even putative rounds of 'deregulation', the PHI market remains heavily constrained by government legislation and bureaucratic oversight.

The groundbreaking research conducted by Scotton and Deeble in the mid–late 1960s,[19,20] which inspired the ALP's National Health Insurance Scheme,[21] provoked two parallel inquiries into health insurance that garnered a wealth of information on the industry, revealing tensions within the sector and the incestuous relationships between the funds and the suppliers of healthcare. The Senate Select Committee on Medical and Hospital Costs published many submissions from the health funds and other interested organisations along with hundreds of pages of transcripts of evidence verbally presented to it.[22] The report of Commonwealth Committee of Enquiry chaired by

Justice Nimmo sparked a reform of the Coalition government's health insurance policy that had essentially beneficial implications for the private health funds, especially after the government dispensed with Nimmo's suggested rationalisation of the sector.[23] Systematic reporting by the private health funds to the Commonwealth Department of Health was mandated in 1970, and since then an annual report on their operations has been tabled in Parliament. This task was transferred to PHIAC when it was established in 1989.[24]

In the 1990s, with the private health funds facing an uncertain future as Medicare entrenched itself, two more inquiries provided detailed information on the organisations and the state of their industry. The Senate Select Committee on Health Legislation and Health Insurance produced over 2000 pages of submissions and transcripts of evidence on the PHI system in examining 'the effectiveness of the current health insurance industry structure'.[25,26] The Howard government, after reintroducing incentives for contributors to PHI, initiated an Industry Commission review of the industry, which reported in 1997.[27] The Industry Commission inquiry also attracted a multitude of submissions from interested parties, and the health funds again demonstrated their energetic lobbying activities (Submissions to the Industry Commission, see www.pc.gov.au/ic/inquiry/57privatehealth). Finally, the Rudd government's Hospitals and Health Reform Commission, chaired by the chief medical officer of the largest non-government health insurer, provided another focus for examination of the industry and submissions from participants.[28]

The private health insurance industry and the health funds

The organisations responsible for the provision of health insurance are a diverse group. Until recently, they had in common some form of mutual character and non-profit status. The 37 registered health funds enjoyed a combined premium income in 2008–09 of over AU$13 billion, 31% of which came from the Commonwealth rebate, and total assets of almost AU$9 billion. At 30 June 2009, 44.5% of the population were covered for hospital benefits and, with ancillaries policies included, 51% held some form of PHI coverage.[29]

The current industry structure can be traced back to the implementation of the Page 'Voluntary Health Insurance' (VHI) scheme introduced in 1952–53 by federal Health Minister Earle Page. The policy of the Menzies government was 'to base its scheme on the established voluntary health insurance agencies which existed in the community and which had provided such insurance for their members even before the introduction of the Commonwealth scheme'.[30] Most of the health insurers predated the Page scheme but their registration as agents for VHI and the subsidisation of their operations through the payment of Commonwealth benefits, tax deductibility for contributions and Commonwealth underwriting of the claims of the chronically ill served to entrench them. The uncompetitive character of the industry, underpinned by comprehensive regulation, protected funds against depredations from new entrants and more ambitious rivals, even during the less supportive Medicare era. Hence, most of the organisations operating in the first decade of this century had survived from the inception of VHI, though their names may have changed for marketing reasons. There has, nonetheless, been an attrition of the friendly society health funds, which had pioneered coverage against the costs of medical care in colonial Australia.[31]

In the late 1960s and early 1970s there was a round of rationalisation as several regional hospital organisations (mainly those associated with Victorian bush nursing hospitals), some small friendly societies and employment-based funds ceased business. Again, in 2008–09 merger and acquisition activity intensified, with BUPA's takeover of MBF, producing the most dramatic consolidation the industry has ever seen.[32] The PHI business was opened to for-profit companies after the introduction of Medicare, but there have been few commercial entrants, and they did not persist in this highly regulated industry. The industry is still predominantly under non-profit ownership (on the basis that Medibank Private remains in public hands despite the privatisation ambitions of the Howard government, and BUPA, established as the British United Provident Association, is a mutual organisation, notwithstanding the scale of its transnational corporate activities). However, the two largest funds in all states except for Western Australia, Medibank Private and the BUPA funds (MBF, HBA and Mutual Community), are registered as 'for profit', as is Australian Unity's health fund and some small funds recently acquired by larger competitors, so that 71% of the market is classified as 'for profit' (up from 8% just 3 years earlier).[29]

Apart from distinguishing between them according to the size of their operations, the private health insurers may be classified in terms of the nature of their memberships, their organisational origins and their peak interest group identification. The simplest distinction is between the 'open' and 'closed' funds. The former accept anyone who seeks to be a contributor, the latter restrict their membership to defined groups, usually to the employees of a specific company or industry, and are classed as 'restricted membership organisations' (RMOs). The RMOs collectively withstood competition from Medibank Private and then Medicare more successfully than their open fund rivals, but they were not positioned to capitalise on the expansion of PHI membership sponsored by the Howard government's rebate and Lifetime Cover policies. They have been assisted by employers through the provision of free or subsidised facilities, equipment and staff and the promotion of enrolment among employees. The RMOs are also advantaged by membership profiles that have a bias towards the relatively healthy. Unlike the open funds, they have little need to maintain networks of branches and agencies to recruit and service contributors. This enabled the RMOs to contain management expenses and to boast better benefits at cheaper rates, but they have seen their advantages eroded by measures implemented to extend the reach of community rating.

Although the character of the closed health funds is by no means uniform, the open funds have been an especially diverse group. They may be classified in terms of their organisational character. We can distinguish between friendly societies, 'Blue Cross' type funds, regional hospital funds, commercial for-profit funds and the government fund (Medibank Private). The open funds in these categories, with the exception of Medibank Private, which was constitutionally excluded, have been represented by the Australian Health Insurance Association (formerly

the Voluntary Health Insurance Association of Australia), the major industry peak body.

The entry of Medibank Private in the late 1970s and its capture of substantial numbers of contributors, mainly at the expense of the major established funds, especially HBA in Victoria, was noteworthy. In terms of the national market, at 30 June 2009 Medibank Private was the largest insurer, covering 31.7% of national hospital membership taking into account its takeover of AHM. Its competitors have lacked Medibank's nationwide scale of operations, though MBF, long established in three states, held ~20% of the market and, following its acquisition by BUPA, the funds owned by this British mutual health conglomerate came to account for 27.3% of total membership at 30 June 2009. The concentration of the health insurance industry is demonstrated by the fact that the five largest fund groups (Medibank Private, BUPA/MBF, HCF, NIB, HBF) hold 84.5% of the PHI market between them.[29]

The relevance of many of the small open health insurers must be called into question. Many regional hospital funds, which originated as vehicles for access to the local public hospital, have folded since the late 1960s. The survivors have mainly been sustained by parochial loyalties, but a few have extended their reach. NIB (formerly Newcastle Industrial Benefits) has been notably successful over the past 30 years in expanding its operations. It became the first established private health insurer to list on the stock exchange after gaining member approval for a demutualisation in November 2007.[33]

The number of friendly societies involved in health insurance has declined markedly as societies collapsed, merged or withdrew from the commercial field of health insurance to concentrate on their traditional 'fraternal' functions. Since shortly after the implementation of the Page scheme of subsidised health insurance, the overwhelming majority of contributors to friendly society health funds have had no connection to the friendly society lodges. By the same token, some friendly societies transformed themselves into savings and investment vehicles in the 1970s–80s, most notably IOOF, which took them well beyond their traditional fraternal base and exposed them to financial risk. Although there were 33 friendly societies operating open health funds in 1971, there were only 13 societies remaining in the field in 1990, and just one (Australian Unity) in 2009.

The friendly society health insurers were, since the inception of the Menzies' government's health scheme, overshadowed in every state by the 'Blue Cross' funds. These funds were distinguished by their size, their founding links to healthcare providers and, most obviously, albeit superficially, their membership of the Blue Cross Association of Australia in the heyday of the Page scheme. With the exception of New South Wales, where MBF and HCF had complementary operations, the Blue Cross Association represented the single largest fund in each state. In 1965 the combined membership of these funds constituted 68% of total PHI hospital benefits membership. In June 2009, with MBF being acquired by BUPA, which had already taken over HBA and Mutual Community in 2002, only Western Australia's HBF and the New South Wales–centred HCF remained as independent entities, but the combined memberships of the funds in this group remained at 43%.[29] The Blue Cross funds have been the most influential forces in the voluntary health insurance sector. Their managers comprised the most authoritative voices in the industry. The honorary directors of these organisations tended to be men of property and prestige, notably senior physicians, whose participation lent weight to the lobbying activities of the Blue Cross funds.

HCF, HBA and HBF were founded upon the public hospitals, associated charities and the medical profession, whose representatives became the constituent members of these funds. Mutual Hospital was somewhat different in composition, being based on 100 'leaders of the community' in South Australia, who were invited to each hold a nominal 1 share in the company. The board of directors was then elected by and from the shareholders. Shares were transferrable upon the death of the subscriber, perpetuating the elite in control of the organisation.[34] MBF is the youngest of the organisations in this group. It was established in 1947 by members of the New South Wales medical profession, drawing upon 10 subscriptions from 1000 doctors to provide the initial capital, with membership of the organisation thereafter being restricted to registered medical practitioners. Branches of MBF opened in Queensland in 1950 and Tasmania in 1952. It offered indemnity insurance for fee-for-service medical care in conjunction with the hospital benefits provided by HCF. A falling out between the managements of the two funds in 1963 saw each develop their own hospital and medical benefits policies.[35]

The historical and organisational links between the providers of healthcare and the Blue Cross funds has been the source of concern. The funds were constituted in ways that denied real contributor representation on their boards of management. Those directors who were nominally 'contributor representatives' were actually appointed by the board or by the governing council based on the constituent health provider members. Allegations that the funds were the pawns of the providers, whose representatives controlled their boards of management, were frequently made, especially in the late 1960s and early 1970s. The cost control problems besetting VHI were, to some extent, attributed to the alleged unwillingness of the Blue Cross funds to challenge the interests of their constituents, the hospitals and doctors, over charges and rates of servicing.[36] With BUPA now owning three of the major funds, the traditional provider interests have been supplanted by parent company domination, with no gesture towards the representation of contributors, whom BUPA is comfortable to class as 'customers'. The UK parent company is founded upon '100 distinguished Association members' who apply 'the oversight normally provided by shareholders', a governance model that seems to parallel the elite model established in the 1930s by South Australia's Mutual Hospital.[37] PHIAC suggests that the independence of board members and the low rate of turnover among directors remains a concern throughout the PHI sector.[38]

Medibank Private is a relatively recent entrant to the VHI field, being created in 1976. By 1982 it had become the largest health fund in the country, and it remains so today. Its immediate establishment in all six states, a scale of operation not matched by any other health fund, allowed it to boast the largest national membership, despite being the largest fund in only one state. Its competitors argued that Medibank Private was unfairly advantaged in the market by the linkage of its operations to Medicare, which was administered by the same government authority, the Health Insurance Commission. Medibank Private was seen to be in a position to share the heavy infrastructure costs of operating a

PHI fund with its NHI partner. It also appeared that Medibank Private gained a valuable marketing advantage in operating from shopfront offices shared with Medicare. Moreover, as a recently established fund, Medibank Private soon found itself with a younger contributor profile than the other funds, and its rivals would continue to allege that it sought to compound this natural advantage by targeting their better-risk members with the offer of cut-price premiums.[39] By the time the Coalition regained office it was committed to removing Medibank Private's perceived advantages. It was separated from the Health Insurance Commission, re-established under its own board and in its own premises. The Howard government also sought the privatisation of the corporation, but lacked the legislative authority to pursue this until its final term. Legislation to sell off Medibank Private, either by a float or, more contentiously, a trade sale was eventually passed but the sale had not been implemented when the Coalition lost office. The Rudd government has reconstituted Medibank Private as a 'for-profit' entity subject to company tax and capable of remitting its surpluses to the Treasury.[40] Medibank Private has taken the lead among the private health funds in raising the bold idea of the insurers as active managers of their members' healthcare under a system of compulsory 'social' health insurance, undoubtedly being influential in the NHHRC's adoption of this idea.[41]

The regulation of private health insurance

The company structure of the PHI sector has always been markedly different from typical commercial industries. An extraordinarily comprehensive framework of Commonwealth regulation has been closely associated with this. The regulatory regime was designed to ensure that PHI, heavily subsidised from the public purse, was accessible to all, irrespective of their health status, that contributors were treated fairly and that the organisations were prudentially managed. Competition between funds on price and product innovation and differentiation has been deliberately stifled in order to realise these objectives. When the private health funds were the financial linchpins of the Commonwealth's national health scheme, as they were under the Page scheme before the introduction of Medibank and Medicare, such regulation seemed justified, but its rationale became questionable after Labor turned to Medicare and withdrew subsidies from PHI.

New entrants, in the form of commercial health insurers, were explicitly barred until after the introduction of Medicare in the 1980s. Even since then, the compulsory pooling of poor health risks, the maintenance of a rigid system of regulation that authorises the government to clamp down on premiums while constraining aggressive marketing and the development of cut-price products did not make PHI an attractive business venture. A few commercial insurers gained registration in the 1980s–90s, but soon departed and others, who sought to offer quasi-health insurance (such as trauma and income-replacement policies) outside the bounds of the regulated industry were prosecuted by the Commonwealth at the urging of the registered health funds.[42]

When the Page scheme commenced, organisations seeking to participate in order to gain access for their contributors to Commonwealth medical and hospital benefits were required to register with the Commonwealth Department of Health, submitting their constitutions and full details of their health insurance policies. The Department's registration committee had the power to refuse registration or to deregister organisations whose rules did not meet the Commonwealth's requirements. Thereafter, the registered insurers had to notify the Department in advance of any proposed rule changes, including amendments to premiums and benefits, which the Department could disallow.[43] Greater uniformity of rules between funds in regard to benefits, premiums and treatment of the newly enrolled and chronically ill developed. The regulator became increasingly prescriptive, defining the essential elements of all policies, and the relationship between 'basic' and higher levels of indemnification. The funds still face mandated limitations on waiting periods for new contributors and exclusions for 'pre-existing ailments', whereas their contributors are guaranteed full 'portability' of benefits entitlements. In the 1990s greater variety of policies began to be permitted, involving options with deductibles, (limited) exclusions and new categories of membership beyond the original single or family. Nevertheless, all policies must comply with a comprehensive array of government rules under the *Private Health Insurance Act 2007*, and the funds face intensive scrutiny from PHIAC. Regulations are constantly being extended and refined by the Private Health Insurance Branch of the Commonwealth Department of Health and Ageing.[44]

Despite the avowed commitment of all registered insurers to the principle of community rating, the Commonwealth found itself repeatedly called on to extend its regulations to uphold the principle. In 1958 it established a system of 'Special Accounts' to counter the tendency of the funds to employ pre-existing ailment, minimum waiting period and maximum benefits rules to withhold payments to claimants. Under the Special Accounts system the Commonwealth covered the entire insured benefits paid to contributors who would otherwise have been denied payment under fund rules.[45] In 1976, reinsurance replaced the special accounts; the main difference was that it involved a capped Commonwealth contribution to a high claims pool, the remainder of which was borne by the health funds. Reinsurance saw funds with relatively large numbers of high claims contributors (defined as more than 35 days of hospital treatment in 1 year) being subsidised by both the Commonwealth and by their fellow insurers. After the Hawke government added all contributors over the age of 64 years to the reinsurance pool, this expanded to cover over half of all PHI benefits paid.[46] This meant that, despite the appearance of competition between the health funds, they combined the bulk of their claims experience and socialised their losses. The modification of the reinsurance system in 2007 to take into account average increases in age-related claims from the age of 55 years and the creation of a separate 'high costs' pool has only modestly reduced the intensity of the pooling of risks.[47]

Although this compulsory industry pooling of risks mutes the incentive to pursue the relatively young and healthy, many funds have adopted strategies to do so. They have devised lower-cost policies with allowable exclusions or benefits restrictions and, before this was forbidden by regulation, 'lifestyle' attractions such as gym memberships, camping equipment and sports shoes designed to appeal to younger Australians. These policies, which under community rating have to be offered to all applicants, have been marketed as if only 'young singles' were eligible. Funds have also keenly sought to provide PHI packages to employment

and corporate groups, on the basis that such contributors are of above-community-average health status. They have pushed the boundaries of community rating by discounting the prices of the premiums for these groups. Regulations limit discounting to 12% of the value of the premium, and the discounts are supposed to be justified only in terms of the cost savings associated with payroll and direct debit deductions rather than the desirable health risks concerned. Any person is eligible for coverage in any policy, although the funds understandably do not promote this fact. Policies that have secured favourable risk groups may even be closed to new entrants.[48]

Framed by the over-arching principle of community rating, regulatory constraints on product differentiation and the effective collectivisation of their claims experience mean that price competition is only 'marginally effective' and, according to PHIAC, 'unsustainable'.[29] The funds are now required to provide 'Standard Information Statements' for their policies, which the Commonwealth publishes on a webpage allowing users to call up, albeit one at a time, the prices of comparable health insurance packages (see www.privatehealth.gov.au, accessed 16 January 2011). This is intended to encourage consumers to 'shop around' but the bewildering array of conditional products, many of which are closed to new entrants, and the apparent similarities in prices of readily comparable policies, undermines the point of the exercise. PHIAC acknowledges 'relatively low numbers of members 'switching' insurers, notwithstanding 'portability' provisions', but it claims that this 'demonstrates' the 'very competitive' nature of the PHI market.[29]

The funds have always had their premiums subjected to departmental scrutiny, and potential ministerial veto. Repeated premium rises in the mid–late 1990s, just as the Howard government was seeking to promote PHI, prompted it to transfer the vetting of applications for premium increases from the Department to the Minister, acting in consultation with the Prime Minister and Treasurer. This decisive move backfired politically when it became clear that not even these authorities could prevent unpalatable premium increases when benefits costs were rising significantly. To reject proposed premium increases may threaten the financial viability of the organisations, which itself is a vital objective of regulation of the industry. The arrangement has shifted to fund notification of annual premium changes, which are scheduled to be announced in March. The Minister for Health retains the authority to veto proposed increases, but only to protect an unspecified 'public interest', and PHIAC is no longer committed to 'minimising the level of health insurance premiums'.[49] At least the industry does not still embrace the 'uniformity' which prevailed in the 1960s as government-approved policy for the 'avoidance of unhealthy competition'. Uniformity meant that the major funds in each state levied the same contributions, and all open funds charged at least a minimum rate of contribution and did not pay benefits above a set ceiling. It safeguarded vulnerable funds from price competition while boosting the surpluses of already secure health insurance businesses.[30]

Although the private health funds have been criticised for inefficient and even extravagant management and administration practices, which have inflated premiums, the fundamental reason for the cost of PHI relates to the expensive, uncapped medical and hospital services its indemnity insurance system finances. Under the Page system, the health funds were not responsible for containing healthcare costs, but only for paying the bills of their contributors through a combination of insurance and Commonwealth benefits, allowing for a mandatory patient copayment. With Commonwealth benefits and associated tax deductions making PHI membership almost irresistible, the funds were not pressured to contain provider costs. As we have seen, the major funds evolved to financially underpin the healthcare providers, not to challenge their financial prerogatives. The manager of HCF declared 'the matter of charges is one between the patient and doctor ... It is not our business to advise contributors that they are being overcharged'.[22] The private health funds, of all types, enjoyed an assured existence as long as the Commonwealth's national health scheme revolved around subsidised PHI, with no public alternative, other than a residual scheme for pensioners.

The introduction of Medicare meant that the private health funds no longer seemed indispensable. Deprived of Commonwealth subsidies and forced to coexist with a free public alternative, they could no longer blithely regard the costs of healthcare as a matter for doctors and hospitals. HBA in Victoria led the way in the late 1980s in negotiating 'preferred provider' agreements with private hospitals to limit their bed and associated charges. The Keating government pressed the insurers to take contracting further, encompassing doctors as well, with the objective of policies that promised contributors 'no gaps' – no patient copayments, unless they held the deductibles policies that were slowly gaining a share of the market – or, at least, 'known gaps' – predictable gaps foreshadowed by the private healthcare providers.[50] Labor's reforms, sponsored first by Health Minister Graham Richardson, and then by his successor, Carmen Lawrence, caused unaccustomed ructions between the insurers and the medical profession and the private hospitals. The providers feared that the funds would hold the upper hand in negotiations, threatening to selectively contract with them. They alleged that the funds would clamp down on the care patients needed, overriding medical judgements in the name of financial stringency. The 'managed care' experience in the US was alleged to be the fate facing Australian private patients.[51]

This resistance seemed to treat the funds as potentially hard bargainers, despite their history of compliance with provider demands. It also overlooked the constraints on their negotiations: the funds could not afford to restrict the provision of healthcare to their contributors because this was the main attraction they had over Medicare. To seriously address the costliness of privately provided healthcare demands rigorously selective contracting with providers and, even more radically, the rationing of care to focus on clinically necessary treatment. This approach is alien to the Australian PHI funds and is at odds with their *raison d'etre* under Medicare.[52] Their negotiating power is limited, rather than enhanced, by competition; that is, by the existence of rivals who may be prepared to offer more generous terms to secure contracts with providers. A fund cannot afford to exclude too many hospitals and doctors from its list of preferred providers and the funds, both individually and collectively, cannot afford to alienate contributors, who still have Medicare as an option, by rationing care and delaying access to treatment.

Hospital purchaser–provider agreements burgeoned in the late 1990s, but the resistance of the medical profession slowed the progress of similar medical agreements. The profession won the right to have non-contractual agreements with funds that allowed them to vary the terms of treatment on a case-by-case basis. The Howard government made concessions to the providers, notably in expanding 'default' hospital benefits for hospitals without fund contracts, but showed impatience with doctors over their tardiness in adopting 'no gap', single billing and informed financial consent practices[53] (see pp. 41–43[54]). The escalation of private healthcare costs and, consequently, PHI premiums, has not abated significantly since the funds have moved into the field of contracting healthcare for their contributors. The funds claim to be actively involved in health promotion and chronic disease management, successfully lobbying to gain coverage of 'hospital substitute treatment' under the Broader Health Cover reforms of 2007.[55] To the extent that this has expanded their funding role, it is not expected to reduce their expenses in the foreseeable future. Similarly, the extension of policies to cover most in-hospital 'gaps', although perhaps allaying contributor disgruntlement with hospital and medical bills, has compounded the costliness of the system.

Reflecting on PHI internationally in 1990, Canadian economist Richard Evans suggested that cost control will be a compelling concern for insurers only if 'given levels of receipts' are assumed. If the insurers expect premium income to increase as healthcare charges rise, as has generally been the case for the Australian health funds, they may be quite complacent about costs. Moreover, Evans argued, insurers will find that their services acquire greater importance to contributors as healthcare becomes more expensive, and that such inflation produces burgeoning turnover, which enhances the margins set aside for administrative expenses (see p. 102).[56] The Australian experience is that premium rises do not significantly deter membership. Demand for health insurance has always been marked by relative price inelasticity.[27,57] Risk aversion, associated with a lack of confidence in access to public hospitals under Medicare, has long underpinned the appeal of PHI, and is quite immune to price. On the other hand, PHI exhibits a pronounced income elasticity of demand,[58] and this was reinforced after the 1% income tax surcharge was applied to the uninsured on middle–upper incomes in 1997. The Rudd government's plan to increase the surcharge on a graduated income scale will only intensify this effect.[59]

With their contributor bases assured by Commonwealth 'carrot and stick' policies, and competition constrained by regulation and consumer habit, the health insurers do not face the imperative to substantially reform their operations. Through most of their histories the funds have been exclusively not-for-profit enterprises operated by mutual organisations presided over by self-perpetuating boards aligned with senior management. This often resulted in their domination by long-serving professional managers who were more intent on maintaining the stability of the organisation than in expanding it. Operating surpluses, rather than profits, were valued as a means of bolstering security through accumulation of reserves and providing commodious employment conditions for management and staff. As we have seen, the bulk of health insurance business is now conducted by funds classed as 'for-profit' but, apart from the isolated case of NIB, the 'profit motive' and 'returns to shareholders' are not part of their corporate equations and managerial dominance may have even been strengthened.

Conclusion

Since being incorporated into Australia's national health scheme almost 60 years ago, the private health funds have been significant components of the health system. Even in their doldrums in the 1990s under unsympathetic Labor governments they covered a third of the population against the costs of healthcare, primarily related to treatment as a private hospital patient. The Liberals remain committed to PHI as the preferred vehicle for gaining access to hospitals and ancillary care but their 'ideal world' of universal PHI is unrealisable. Federal Labor has grudgingly come to endorse government subsidisation of PHI and the corollary of financial penalisation of non-membership, albeit seeking to apply this at different income levels to those established by its Coalition predecessor.

The private health funds are wedded to a highly regulated and subsidised system that assures their existence while they deliver expensive insurance packages to a segment of the Australian population covering a select portion of healthcare services. If the Commonwealth wishes to preserve a system of private hospital treatment employing user charges as an alternative to its own hospital Medicare, it should consider redirecting its subsidies to the hospitals themselves. PHI could then be reconfigured as an *option* for accessing private hospitals rather than the privileged mechanism for doing so. A deregulated industry, utilising insurance principles of risk-rating and allowing competition between firms would emerge, and it may attract a more diverse contributor demographic, which would consist of more demanding and price-sensitive customers.

Although the Rudd government has not adopted the 'Medicare Select' proposal of the NHHRC, it is worth reflecting on the implications of that model for the private health funds. If offered the unfamiliar role of budget-holders for the comprehensive healthcare needs of contributors in a system of universal health insurance, the funds would enjoy expansion. They may thereby become obliged to bargain more effectively with healthcare providers and could expect greater power to do so. They would need to engage in effective 'managed care' in order to ensure that the services purchased did not exceed the predetermined public funding allocation or, at least, to minimise the copayments required of Medicare contributors accustomed to free public hospital services and bulk-billing. However, managed competition, as constituted in Medicare Select, would bring an inefficient and inequitable 'dual economy' of healthcare into the health funds. They would not be bargaining with the private hospitals for treatment of price-controlled Medicare patients. Instead, the private hospital system would continue to be reserved for privately insured patients (and the self-insured) and thus would continue to function as an alternative, unrestricted pathway for healthcare. The NHHRC missed the opportunity to propose a truly national hospital system, in which the resources of public and private sectors could be pooled under Medicare.

Competing interests

The author declares that no conflicts of interest exist.

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