CHAPTER 5

IMPACT OF THE PRIVATE HEALTH INSURANCE REBATE

Introduction

5.1 The Committee's terms of reference require it to report on the impact of the private health insurance rebate on demand for public hospital services. The impact of the rebate must be seen in the overall context of private health insurance and as part of a package of measures undertaken by the Government to address issues in the private health insurance sector. This chapter provides a brief overview of the private health insurance sector and recent Government policy initiatives in this area as well as discussing the impact of the rebate.

Background

5.2 Health insurance funds operated by organisations registered under the *National Health Act 1953* have offer benefits to members for approved hospital services. Services may be provided in both public and private hospitals. Funds also offer members benefits through ancillary tables for a wide range of non-hospital and health-related services.

5.3 In 1998-99, the health funds received $3,872 million in contributions from members and $1,055 million in direct payments and tax subsidies from the Government. This compares to $4,404 million in contributions from members in 1996-97, the year before the introduction of the Private Health Insurance Incentives Scheme.[1]

5.4 Excluding the Government subsidies, in 1998-99 the health funds paid out $3,785 million in benefits of which $2,200 or 58 per cent went on hospital services, $198 million on in-hospital medical services and the balance of $1,387 million on ancillary health care, ambulance services and administration. The share of total health spending met by private health insurance from private contributions dropped from 9.99 per cent in 1996-97 to 7.5 per cent in 1998-99.[2]

5.5 The downward trend in spending on private patients in public hospitals also continued over this period. Only 10.2 per cent of the spending on health insurance

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1 1998-99 is the latest year for which detailed figures are available. The direct payments and subsidies relate to the means tested Private Health Insurance Incentives Scheme which was introduced in 1997 and was available during the first half of the financial year and the 30% rebate on premiums which applied to the second half of the year. See paras 5.13, 5.19 for a description of these schemes. Australian Institute of Health and Welfare, *Australia's Health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare*. Canberra, AIHW, p.253.

2 1998-99 figure based on AIHW preliminary estimate for 1998-99 of total health expenditure of $50,335 million. AIHW, *Australia's Health 2000*, p.233.

subsidies in 1998-99 went to public hospitals. Private hospital care represented 89.7 per cent of all total hospital-related benefits paid. Hospital bed days in private hospitals accounted for 84.1 per cent of all hospital bed days for which hospital benefits were paid in 1998-99.[3]

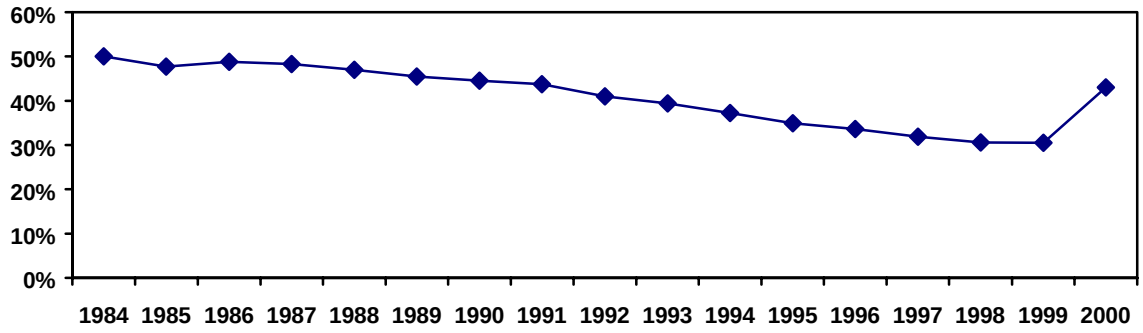
Table 5.1: Private health insurance fund spending on hospital services

	1996-97 ($M)	1998-99 ($M)		
		Privately funded	Subsidy	Total
Public hospitals	360	226	63	289
Private hospitals	2437	1974	550	2524
Total	2797	2200	613	2813

Source: AIHW, Australia's Health 2000, p.253.

5.6 While total benefits paid by funds have increased steadily, membership of private health insurance diminished and has done so since the introduction of Medicare (at least until recently). Between June 1984 and December 1998, the proportion of the Australian population covered by private health insurance fell from 50.2 per cent to a low of 30.1 per cent. As will be discussed later in this chapter, the effect of various incentives has significantly increased participation since December 1998 with levels now back to where they were in the early 1990's.

Figure 5.1: Proportion of the Population with Private Hospital Cover



Source: Private Health Insurance Council (PHIAC), http://www.phiac.gov.au.

5.7 The age group distribution of those covered by private health insurance also changed between 1983 and 1998. The AIHW reported that in all age groups below 60 years, the level of coverage by hospital insurance fell markedly. Excluding the age groups 60 years and over, coverage ranged from 54.6 per cent (age group 15-24 years)

3 AIHW, *Australia's Health 2000*, p.252.

to 75.6 per cent (age group 35 to 49 years) in 1983. In 1998, coverage in those age groups had fallen to 16.3 per cent and 32.0 per cent respectively. In the case of contributor units headed by persons aged 60 years and over, the decline was less dramatic. Coverage of contributor units headed by persons aged 60-69 years fell from 45.3 per cent to 39.6 per cent, while there was little change in the 70 years and over range which remained relatively constant at around 36 per cent.[4]

5.8 The fall in membership coincided with a rapid rise in the cost of premiums. The premiums of health insurers with the largest memberships in each State increased, in real terms, between 58 per cent and 173 per cent from 1984 to 1996.[5] The Industry Commission, in its 1997 report on private health insurance, stated that the average price of private health insurance had risen at a rate of 3.5 times CPI inflation since 1990. The Commission found that the major contributions to the rise in premiums included a substantial rise in the proportion of fund members using private hospitals; an increase in private hospital admission charges, due to changes in technology and clinical practice; and an increase in average hospital admissions by private patients.[6] The rise in the cost of premiums resulted in a decline in affordability, particularly among the lowest income groups.[7]

5.9 The Industry Commission also noted that unpredictable 'out-of-pocket' expenses following episodes of hospitalisation and the difficulties faced by consumers in comparing the products offered had diminished the attractiveness of private health insurance by various funds.[8]

Response to the fall in coverage

5.10 A number of incentives have been introduced to address the continued fall in membership of funds. In the late 1980s the 'front-end deductible' (FED) was introduced. Funds may offer cover for that part of hospital charges that exceed a given amount in a year. Between 1995-96 and 1998-99, coverage by FEDs grew by 0.8 million and coverage by non-FED tables fell by 1 million. In 1995, exclusionary and non-exclusionary tables were introduced. Funds were able to offer tables which excluded coverage of certain types of treatment such as obstetrics.[9]

5.11 In 1995, the Health Legislation (Private Health Insurance Reform) Amendment Act, in part, facilitated contracting between private health insurance funds and hospitals (Hospital Purchaser Provider Agreements), private health

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4 AIHW, *Australia's Health 2000*, p.256.

5 AIHW, *Australia's Health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare*, Canberra, 1997, p.178.

6 Industry Commission, *Private Health Insurance*, Report No 57, Canberra, the Commission, 1997, pp.xxxi, xxxv-xxxvi.

7 Australian Institute of Health and Welfare, *Australia's Health 1998*, p.178.

8 Industry Commission, pp.xxxi-xxxii.

9 *Australia's Health 2000*, p.253.

insurance funds and doctors (Medical Purchaser Provider Agreements) and hospitals and doctors (Practitioner Agreements).

5.12 In May 1996, the Minister for Health and Family Services, Dr Michael Wooldridge, stated that 'the continuing decline in the number of Australians with private health insurance is perhaps the single most serious threat to the viability of our entire health system' and announced that the Government would introduce incentives to 'encourage people into private cover and to help retain those who still have private insurance'.[10] Initially, these incentives were the Private Health Insurance Incentives Scheme (PHIIS) and a Medicare levy surcharge. A number of other measures have subsequently been introduced by the Government to address the issue of declining health insurance coverage.

5.13 The PHIIS provided, from 1 July 1997, an income-tested benefit for those holding private health insurance. The benefit was provided by way of either reduced premiums or tax offset. The incentive amount was dependent upon the type of policy held. The incentive was aimed at making private health insurance more affordable for lower and middle-income earners. The Government's funding estimates were based the assumption that coverage of private health insurance would increase from 32 per cent of the population (expected at 1 July 1997) to 34 per cent in 1997-98.[11]

5.14 The Medicare levy surcharge was introduced, with effect from 1 July 1997, to provide a disincentive for higher income earners to rely on the Medicare system and not take out private health insurance. Where individuals, with gross taxable incomes exceeding $50 000, and families, with combined gross taxable incomes exceeding $100 000, did not hold private health insurance providing hospital cover, an additional Medicare levy of one per cent applied.

5.15 In introducing the PHIIS, the Minister for Health and Family Services stated:

> The private health insurance incentive scheme…is the centrepiece of the Government's strategy to assist Medicare from collapsing under the weight of demand for publicly funded hospital and medical services…The private health insurance incentive scheme, and the addition to the Medicare levy…are essential measures designed to arrest the catastrophic decline in the level of participation in private health insurance.[12]

5.16 In 1997 the Government introduced legislation aimed at making contracting between funds, hospitals and doctors more attractive and to reduce some of the cost pressures on health insurance premiums. For the first time, funds were allowed to pay medical benefits above the MBS to doctors who have practitioner agreements with private hospitals. These agreements are permitted only where the hospital also has a

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10 Minister for Health and Aged Care, 'United Effort Needed to Address Health Insurance Crisis', *Media Release*, 24 May 1996.

11 Health and Family Services Portfolio, *Portfolio Budgets Statements 1996-97*, p.145.

12 House of Representatives, *Debates*, 13.12.96, pp.8573-74.

fixed cost (HPPA) contract with the fund. The effect of the reforms were to either 'exclude out-of-pocket costs altogether or to allow for a predetermined amount of such costs known by the person in advance'.[13] Other reforms were aimed at removing unnecessary costs on funds, improving the regulatory environment and making refinements to the legislation to improve the operation of the industry.

5.17 The Government's 1998 tax reform package, *Tax Reform: not a new tax, a new tax system*, contained measures to assist families and individuals with the cost of private health insurance through the introduction of a 30 per cent tax rebate. The Minister for Health and Aged Care, in introducing the legislation for the scheme, stated:

> This is an important Bill for it proposes a measure that will prove to be of enduring benefit to the Australian health system, and to the Australian public, namely to cut the cost of private health insurance by 30 per cent through a rebate outlined in this Bill…This is one of the simplest, most effective and most important changes that could be made to restore the balance in our health system by working to slow the drop-out from private health insurance. The proposed cut in the cost of private health insurance will help the private sector, take pressure off public hospitals and help restore much needed balance to our health care system.[14]

5.18 The Minister noted that the PHIIS had achieved a slowing down of the drop-out rate but the continuing decline in coverage was 'proof of the need for further action'.[15]

5.19 The new scheme, known as 'the rebate', replaced the PHIIS from 1 January 1999. The rebate scheme provided for a non-income tested financial incentive for individuals and families who take out or maintain private health insurance. It is provided by a 30 per cent reimbursement of premiums paid or a 30 per cent premium reduction. The incentive is generally available to an individual who pays for appropriate private health insurance cover with a fund registered under the *National Health Act 1953* and who is eligible for Medicare.

5.20 Under the rebate scheme all health insurance funds which offered the rebate as a premium reduction were required to establish no/known gap products by 1 July 2000.

5.21 The Commonwealth's original estimate of the cost to revenue of the rebate was $1.09 billion in 1999-2000 (the first full year of operation); $1.8 billion in 2000-01; $1.27 billion in 2001-02 and $1.36 billion in 2002-03.[16] Additional information provided to the Community Affairs Legislation Committee indicated that these

13 House of Representatives, *Debates*, 27.11.97, p.11436.

14 House of Representative, *Debates*, 12.11.98, p.263.

15 House of Representatives, *Debates*, 12.11.98, p.264.

16 Explanatory Memorandum, Private Health Insurance Incentives Bill 1998, p.58.

estimates were 'a cash estimate, which does not take account of accrued expenses (ie, year-on-year liabilities). These figures represent the net cash cost of the Rebate.'[17] The Department provided the following full combined cost estimate of the rebate which 'are the result of further refinement of the original estimates using the hard data that was not available when the Budget estimates were developed'. The Committee was also provided a split between outlays and revenue:

Table 5.2: The Additional Estimates for the Total Cost of the 30% Rebate

Year	Outlays ($M)	Revenue ($M)	Total ($M)
1998-99	545[a,b]	not available	not available
1999-00	1394	223[b]	1617
2000-01	1516	400	1916
2001-02	1623	428	2051
2002-03	1735	458	2193

[a] Figure reported in 1999-00 Portfolio Additional Estimates Statement.
[b] Half year effect only.

Note: the cost of the 30% Rebate is split between outlays, administered by the Department of Health and Aged Care, and revenue, administered by the Australian Taxation Office. Outlays consist of claims made via premium reductions and direct payments. Revenue is made up of claims made through the tax system.

Source: Senate Community Affairs Legislation Committee, Answer to Question on Notice, No.59, Additional Estimates, February 2000.

5.22 Expenditure of $1.6 billion on the rebate in 1999-00 represents 6.7 per cent of the Commonwealth's appropriation for the Health and Aged Care Portfolio in the 1999-00 Budget.[18] The November 2000 Mid Year Economic and Fiscal Outlook report indicates that the above Budget estimates of outlays will increase by a further $390 million in 2000-01 as a result of higher membership. No figure has been provided for the increase in cost of the tax rebate.

5.23 The Community Affairs Legislation Committee was provided with the following updated information at a supplementary estimates hearing on 22 November 2000 for the 2000-01 Budget.

17 Senate Community Affairs Legislation Committee, DHAC Answer to Question on Notice No.58, Additional Estimates 1999-2000, February 2000.

18 Health and Aged Care Portfolio, *Portfolio Budget Statements 1999-2000*, p.18. Total appropriation for the Health and Aged Care Portfolio was $23,844 million in 1999-2000.

Table 5.3: Variation from the 2000-01 Budget for 2000-01 Additional Estimates due to increases in Private Health Insurance Participation Rates

Year	2000-01 Budget Estimates ($M)	2000-01 Additional Estimates ($M)	Variation ($M)	2000-01 AEs increase in MBS* ($M)	Total Variation ($M)
1999-00	1567	1533	-34	na	na
2000-01	1882	2214	332	130	462
2001-02	2021	2358	337	185	522
2002-03	2155	2435	280	245	525
2003-04	2296	2527	231	240	471

* These are temporary figures which are due for review, as such they have not been identified separately in Additional Estimates.

Source: Community Affairs Legislation Committee, Supplementary Estimates, November 2000, Tabled Paper, Department of Health and Aged Care.

5.24 The estimate now for 2000-01 is $2.2 billion – nearly twice the Government's original estimate. There will also be a flow on cost of $130 million in costs for the MBS which pays 75 per cent of the cost of 'in-hospital' medical expenses for private patients.[19]

5.25 In the 1999-2000 Budget the Government announced that it would introduce 'Lifetime Health Cover' from 1 July 2000. Under this arrangement funds are required to set different premiums depending upon the age at which a member first takes out hospital cover with a registered health fund. People who join early in life will be charged lower premiums throughout their life compared to people who join later. Existing fund members are protected and pay the base rate (set at 30 years of age) for the rest of their lives, provided they stay insured. The starting date of 1 July was adopted to allow for a 12 month period during which people who did not have private hospital cover could join a health fund and pay the 30 year old rate.

5.26 The Government's aim was to discourage 'hit and run' behaviour thereby contributing to the stability of the private health insurance industry and restraining pressures for increases in premiums.

5.27 In June 2000, the *Health Insurance Amendment (Gap Cover Schemes) Act 2000* was passed. It provides for gap cover schemes to enable registered health

19 Joint Statement by the Treasurer and Minister for Finance and Administration, *Mid-Year Economic and Fiscal Outlook 2000-01*, November 2000, p.41.

benefits organisations to provide no gap and/or known gap private health insurance without the need for contracts.

5.28 The 'gap' is the difference, paid by the health fund member, between fees charged by doctors for in-hospital medical services and the combined health insurance benefit and Medicare benefit.[20] The cost of medical gaps for in-hospital medical services provided to people with private health insurance was around $200 million in 1997-98. The average medical gap for an episode for a private patient in a private hospital was $151 and for a private patient in public hospital was $69, though for some procedures the gap payment can be much higher.[21] The presence of gaps has been shown to be a major contributor to consumer perception that private health insurance does not offer value for money. It remains a major cause of consumer complaint about private health insurance.

5.29 Previous legislation allowed the gap to be covered in circumstances where the service is rendered by, or on behalf of, a medical practitioner:

- with whom the registered health fund has a medical purchaser-provider agreement (MPPA); or
- who has a practitioner agreement (PA) that applies to the professional service provided, with the hospital where treatment occurred, and that hospital has a hospital purchaser-provider agreement (HPPA) with the registered fund.

5.30 While many health insurance funds had successfully negotiated HPPAs with hospitals, most medical practitioners were opposed to the agreements as a means of limiting out-of-pocket costs for health fund members. Their opposition was based on a perception that the arrangements would permit health insurance funds to interfere in the doctor-patient relationship, thereby leading to 'US-style managed care'. As a result, very few MPPAs had been negotiated. The gap cover schemes in the new legislation are entirely voluntary and provide an alternative mechanism through which the medical gap may be covered by funds, without the need for formal contracts between doctors and funds.

Impact of the rebate on participation rates in private hospital insurance

5.31 The Government expected that access to the rebate would 'lead to a significant increase in private health insurance membership'.[22] Private Health Insurance Administration Council (PHIAC) data shows that by the September 2000 quarter, coverage had increased to 45.8 per cent of the Australian population having private health insurance.

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20 Where health funds have reached agreements with individual doctors and signed Medical Purchaser Provider Agreements, health fund contributors with the appropriate level of cover are eligible for reimbursement of fees charged above the schedule fee.

21 Community Affairs Legislation Committee, *Report on the Health Insurance Amendment (Gap Cover Schemes) Bill 2000*, p.1.

22 Commonwealth Government, *Tax reform, not a new tax system*, AGPS, 1998, p.49.

Table 5.4: Coverage of Hospital Insurance Tables Offered by Registered Health Benefits Organisations by State

Persons and Percentage of Population

Quarter ended		NSW	VIC	QLD	SA	NT	WA	TAS	AUST
30 Sept 2000	Coverage '000 **P**	3,190	2,167	1,521	697	73	930	211	8,789
	% Population **P**	47.0%	45.3%	42.5%	46.5%	37.1%	49.2%	44.8%	45.8%
30 June 2000	Coverage '000**R**	3,035	2,009	1,436	651	68	833	204	8,236
	% Population **PR**	44.8%	42.1%	40.3%	43.5%	34.9%	44.2%	43.4%	43.0%
31 Mar 2000	Coverage '000	2,211	1,478	1,077	492	49	688	162	6,157
	% Population **R**	32.7%	31.1%	30.3%	32.9%	25.3%	36.6%	34.5%	32.2%
31 Dec 1999	Coverage '000	2,140	1,440	1,037	477	47	670	159	5,970
	% Population **R**	31.6%	30.4%	29.3%	31.9%	24.1%	35.7%	33.8%	31.3%
30 Sep 1999	Coverage '000	2,113	1,416	1,023	472	46	661	158	5,890
	% Population	31.4%	30.0%	29.0%	31.6%	24.0%	35.4%	33.6%	31.0%
30 Jun 1999	Coverage '000	2,070	1,398	1,006	465	46	651	157	5,793
	% Population	30.8%	29.7%	28.7%	31.2%	23.8%	35.0%	33.4%	30.5%
31 Mar 1999	Coverage '000	2,048	1,382	996	459	46	645	156	5,733
	% Population	30.5%	29.4%	28.5%	30.8%	23.7%	34.8%	33.2%	30.3%
31 Dec 1998	Coverage '000	2,021	1,374	986	459	45	634	156	5,676
	% Population	30.2%	29.3%	28.3%	30.8%	23.6%	34.3%	33.2%	30.1%
30 Sep 1998	Coverage '000	2,027	1,378	989	461	45	641	158	5,699
	% Population	30.4%	29.5%	28.5%	31.0%	23.6%	34.8%	33.4%	30.3%
30 Jun 1998	Coverage '000	2,050	1,381	996	465	45	634	157	5,728
	% Population	30.8%	29.6%	28.8%	31.3%	23.7%	34.6%	33.3%	30.5%
31 Mar 1998	Coverage '000	2,084	1,399	1,014	472	46	639	161	5,814
	% Population	31.4%	30.1%	29.4%	31.8%	24.2%	35.0%	34.1%	31.1%
31 Dec 1997	Coverage '000	2,107	1,428	1,022	479	46	639	164	5,885
	% Population	31.9%	30.9%	29.8%	32.3%	24.4%	35.3%	34.7%	31.6%

R = Revision P = Preliminary

Source: Private Health Insurance Administration Council, <http://www.phiac.gov.au/phiac/stats/MEMCov/hos_quar.htm>

For the period 1 July 1997 to 1 January 1999 when both the PHIIS and Medicare levy surcharge both operated, coverage of hospital insurance tables generally continued to decline (there was a small rise in the quarter ended 30 September 1997). During 1999, there was a small rise of some 300 000 members attracted by the 30% rebate over the first year of its life followed by a sharp increase of 2.26 million new members in the weeks prior to the cut off date for Lifetime Health Cover (15 July 2000). The Government argues that both polices complemented each other. However, it is evident that the stick of penalties under Lifetime Health Cover was much more effective in achieving the Government's aim than the incentive of a rebate.

Private health insurance participation and the demand for hospital services

5.32 A range of views on the impact of the rebate on demand for public hospital services was submitted to the Committee. It was considered by some that the introduction of the Rebate would reduce demand on public hospital services[23] while others were supportive of the Rebate but did not know if demand would be reduced.[24] Many submissions argued that there would be little or no fall in demand.[25] Others stated that it was too early to tell if there will be an impact in the public sector or if other initiatives are also affecting demand.[26]

5.33 DHAC stated that while the Commonwealth is increasing real spending on the public hospital system 'the Government realises that this additional funding for public hospitals will not be enough to maintain the integrity of the Australian health care system if the viability of the private health care sector is not supported'. This is because insured people cost the Commonwealth less for health services than the uninsured who do not make any direct contribution to the costs of their health care; and 80 per cent of private hospitals services are provided to privately insured persons, hence a decline in membership 'runs the genuine risk of not properly utilising the major capital stock base of private hospitals'.

5.34 DHAC went on to state that 'declines in private health insurance coverage lead to more people becoming entirely reliant on the public system for their health care, increasing the cost pressures on public hospitals'.[27] Further, that 'it is expected that people with private health insurance have a greater opportunity to use the private hospital system because they have got a system of financing behind them, so the expectation is that that will relieve some of the pressure on the public hospital

23 *Committee Hansard*, 18.8.00, p.669 (AMA).

24 Submission No.60, p.22 (SA Government); Submission No.61, p.17 (Australian Physiotherapy Association).

25 Submission No.11, p.3 (DRS (WA)); Submission No.16, p.10 (QNU); Submission No.17, p.8 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.41, p.26 (Qld Government).

26 Submission No.40, p.4 (Committee of Presidents of Medical Colleges); Submission No.45, p.24 (RACP, ACA & Health Issues Centre); Submission No.61, p.17 (Australian Physiotherapy Association).

27 Submission No.38, p.31 (DHAC).

system'.[28] DHAC also stated that the impact of the rebate on the demand for public hospital services could only be assessed in the long term and that even preliminary data for 1998-99 would not be available for some considerable time.[29]

5.35 In answering a question on notice on 14 August 2000, the Minister for Health and Aged Care, stated that DHAC had estimated, 'on the basis of very conservative assumptions about utilisation rates' that over the next two to three years the increase in participation in private health insurance 'will mean an extra 400 000 treatments will occur for people who are privately insured, a majority of them in the private system, thus taking some of the pressure of demand off the public hospital system'.[30]

5.36 The Australian Health Insurance Association (AIHA) estimated that had the pre-incentive trend continued 'the pressures this would have placed on Medicare would have been unsustainable. Government action to halt such freefall, or deal with its effects, would have placed enormous strain on the taxation base.'[31]

5.37 The Review of NSW Health noted that reductions in private health insurance coverage 'increases the stress on the public systems' but the notion that the public health system would collapse if the level of coverage fell below a specified point 'is an exaggeration and unproven'.[32] The South Australian Government supported the reforms being implemented by the Commonwealth but stated that although these were expected to halt the decline in coverage rates, 'it is much more difficult to say whether they will have any significant impact on the demand for public hospital services'.[33] The Queensland Government stated that the rebate 'will do little to reduce demand on the public hospital system' and that the issue of demand for public hospital services 'is complex and it is overly simplistic to assume that the demand on the public system is directly related to the level of private health insurance'.[34] The Tasmanian Government stated that 'the only impact of the private health insurance rebate has been the stabilisation in the numbers insured…there has been no observable impact on workload in public hospitals, nor is one expected in the near future'.[35]

5.38 A number of submissions supported the States' view. Evidence was provided pointing to the complexity of the relationship between private health insurance coverage and the demand for public hospital services and the difficulties of making a

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28 *Committee Hansard*, 11.11.99, pp.32-33 (DHAC).

29 Submission No.38, p.32 (DHAC).

30 House of Representatives, *Debates*, 14.8.00, p.18844.

31 Submission No.55, p.8 (AIHA).

32 Independent Pricing and Regulatory Tribunal of New South Wales, *A Review of NSW Health*, 1998, p.43.

33 Submission No.60, p.22 (SA Government).

34 Submission No.41, p.26 (Qld Government); See also *Committee Hansard*, 11.11.99, p.58 (Queensland Health).

35 Submission No.67, p.10 (Tasmanian Government).

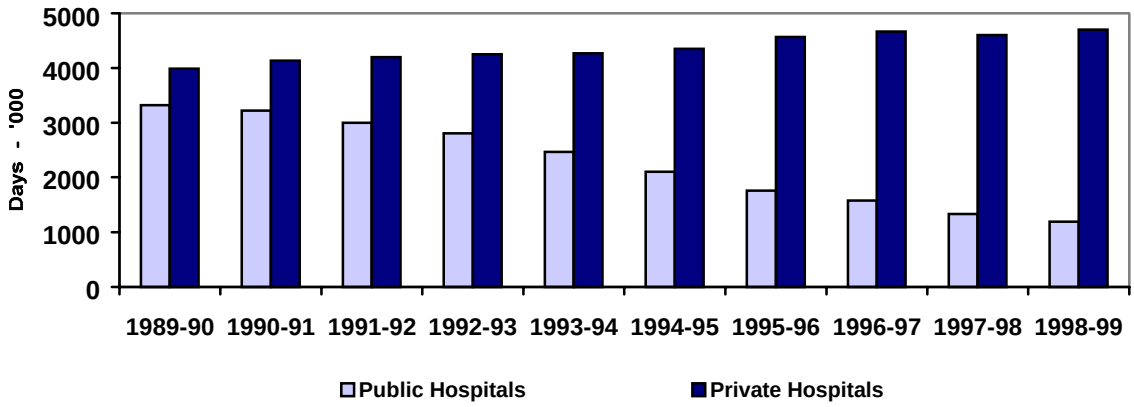
direct link between the decline in private health insurance and pressures on public hospitals.[36]

5.39 For example, it was pointed out that private hospital utilisation has been steadily increasing during the period private insurance coverage was decreasing.[37] Between 1993-94 and 1997-98 there was a 10 per cent increase in separations from public acute hospitals and a 28 per cent increase in separations from private hospitals. There was a decrease of 5 per cent in patient-days for public hospitals over this period but an increase of 14 per cent for private hospitals.[38]

5.40 Other indicators also point to increased utilisation of the private sector. Private hospitals in 1996-97 accounted for 22.1 per cent of all hospital expenditure, up from 15.6 per cent in 1989-90. Expenditure on public hospitals increased by an average of 3.2 per cent per annum over the period 1989-90 to 1996-97 while expenditure on private hospitals has increased by 8.4 per cent per annum over the same period.[39]

5.41 Since 1994-95 the proportion of public hospital patient days attributable to private patients fell from 14 per cent to 10 per cent.[40] In 1989-90, 45 per cent of total private hospital days were in public hospitals. This reduced to 20 per cent in 1998-99.[41] Average lengths of stay have been falling in each sector. Thus the bed-day changes do not simply reflect longer stays in the private hospital sector.

Figure 5.2: Privately Insured Hospital Days by Type of Hospital 1989 to 1999



Source: PHIAC, Operations of the Registered Health Benefits Organisation Annual Report 1998-99, Figure 36B.

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36 See for example, Submission No.45, p.24 (RACP, ACA, HIC); Submission No.46, p.12 (CHPE).

37 Submission No.17, p.7 (PHH & MAQ); Submission No.46, p.12 (CHPE); Submission No.65, p.12 (ANF (SA)); *Committee Hansard*, 11.11.99, p.58 (Queensland Health) and 22.3.00, p.429 (QNU).

38 AIHW, *Australia's Health 2000*, p.272.

39 Submission No.46, Additional Information, p.9 (CHPE).

40 AIHW, *Australian Hospital Statistics, 1998-99*, AIHW cat.no. HSE 11, Canberra, p.53.

41 PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 1998-99*, p.47.

5.42 The Centre for Health Program Evaluation (CHPE) indicated that the total demand (public plus private) for public hospitals has not increased sharply while private hospital insurance membership has declined. In 1982-83 it was 75.1 per cent of total hospital admissions and in 1996-97 it was 75.6 per cent.[42]

5.43 CHPE argued that the increased use of private hospitals was due to the fact that those holding basic insurance dropped out, while the membership level of those with supplementary insurance–upon which private hospitals depend–had declined significantly less. The proportion of the population holding supplementary insurance in 1984 (29.6 per cent) was almost the same as in 1999.[43] CHPE concluded 'it is not possible to argue that the demand pressure on the public hospital sector is due to a shift in demand from the private hospital sector'.[44] This view was supported by other submissions.[45]

5.44 CHERE, in its review of issues for the Committee, noted that the relationship between private insurance participation and the demand for public hospital services is also complicated by the fact that the demand for public hospital services comes from both public patients and private patients. While the number of private patients in public hospitals has declined, 20.3 per cent of total private health insured days in the year ending 30 June 1999 were in public hospitals. This was due, in part, to the lower premiums paid for hospital cover that is limited to private treatment in public hospitals. CHERE concluded that 'this form of demand on public hospitals is unlikely to be dampened by the rebate and may in fact increase'.[46]

5.45 A further factor to be noted is that the coverage has fallen significantly in the under 24 year age group (see para 5.7) – a group that is healthy and therefore would not be expected to place a high demand on public hospital services.

5.46 Another matter impacting on the complexity of the relationship between demand for public hospitals and health insurance levels is that privately insured persons can elect to be public patients in a public hospital. It is difficult to be precise about the proportion of those holding health insurance exercising their right not to declare their status on admission to a public facility. However, some evidence is available which would indicate that a significant proportion of privately insured persons do not declare their status on admission to a public hospital.

5.47 The June 1998 health insurance survey carried out by the Australian Bureau of Statistics indicated that 15.4 per cent of Medicare patients in public hospitals had private health insurance.[47] An analysis of patient status was provided in the *Final*

42 Submission No.46, p.13 (CHPE).

43 Submission No.46, p.12 (CHPE).

44 Submission No.46, Additional Information, p.9 (CHPE).

45 See also Submission No.17, p.7 (Public Hospitals, Health & Medicare Alliance of Queensland).

46 CHERE, Discussion Paper 3, p.6.

47 Australian Bureau of Statistics, *Health Insurance Survey, June 1998,* p.24.

Report Hospital Data Analysis Consultancy provided to the Committee by the NSW Government. The consultancy matched 956 010 separations taking place in private and public hospitals with members of five major health funds. The analysis indicated that of this sample of 956 010 matched separations taking place in both public and private hospitals, 25.9 per cent were treated as public patients. Of the 403 707 matched separations which took place in public hospitals 39 per cent used their private health insurance status. The remaining 61 per cent did not declare their private health insurance status and were admitted as public patients.[48]

5.48 Submissions indicated a range of reasons for people taking out private health insurance and then not using it.[49] These factors include:

- large and unknown gap payments;
- the Medicare surcharge for individual incomes over $50 000 or couples earning over $100 000; and
- the availability of products with high front end deductibles (FEDs) or co-payments, which therefore have relatively, low premiums.

5.49 The increased use of FEDs and exclusionary health insurance policies was seen as having a significant impact on the trend not to declare health insurance status. PHIAC reported that in 1998-99 nearly 50 per cent of the insured population in some States had some form of FED. Australia wide, 38.4 per cent of persons covered have FED tables.[50] This was a growth of approximately 75 per cent from July 1997 to July 1999. Over the same period exclusionary policies increased by 67 per cent.[51] It was argued that this trend would result in high income earners avoiding payment of the Medicare levy, while still using the public health system rather than the private where the person would be faced with an up-front excess payment.[52] The Queensland Government noted that some FEDs have excesses of $1 000. This amount is more than the charge for an average length of stay (3.5 days) in a Queensland hospital and would act to discourage a person from using their insurance in a public hospital. The Queensland Government also argued that exclusionary policies generally exclude

48 *Committee Hansard,* 21.3.00, p.341 (NSW Health Department).

49 Submission No.16, p.10 (ANF(SA)); Submission No.41, p.26 (Queensland Government); Submission No.60, p.23 (SA Government); Submission No.67, p.10 (Tasmanian Government); *Committee Hansard,* 23.3.00, pp.509,517 (Victorian Minister for Health); *Committee Hansard,* 25.2.00, p.274 (Health Department WA); *Committee Hansard,* 21.3.00, p.358 (NSW Health Department); *Committee Hansard,* 11.4.00, p.646 (ACT Minister for Health and Community Care).

50 PHIAC, p.2.

51 Submission No.41, p.26 (Queensland Government).

52 Submission No.16, p. 10 (QNU). See also Submission No.41, pp. 26-7 (Queensland Government); Submission No.60, p.23 (SA Government); Submission No.17, p.9 (Public Hospitals, Health & Medicare Alliance of Qld).

more complex care, and that the policy holder would use public hospitals for their complex needs not covered by their private health insurance.[53]

5.50 The Commonwealth has partially recognised the problem of the use of cheaper FED policies to avoid the Medicare levy surcharge. From 25 May 2000 the exemption from the surcharge is no longer available to singles who take out a new policy after that date with a FED of $500 or more a year or to families or couples with a FED of $1 000 or more.

5.51 The AHIA did not support the view that people were buying cover and not intending to use it:

> there have been some suggestions that, because of the surcharge or other reasons, people may buy very cheap cover and then not use it. That is unlikely. Our experience has been that people who buy health insurance cover are very selective about the cover they use, and whenever they have the opportunity to do so they make a very rational judgment based on their own state of health. So the people who are buying cheap products are buying products which, in their own assessment, they are probably not going to use because they are pretty healthy. They just want it as a backup in case something goes wrong.
>
> However, by having people who otherwise would not have bought those products buy those products, there is money going into the pool.[54]

5.52 It was also argued that a number of other factors influence demand for hospital services including changes in technology, the ageing population, increases in the size of the population and changes in the type of private health insurance policy.[55] The Queensland Government, for example, stated that demand in Queensland public hospitals has grown at a consistent rate of approximately three times that of the average population growth in Queensland.[56] The South Australian Government also noted that many factors contributed to demand for hospital services and it was difficult to determine the relative impact of each of these factors on demand.[57]

5.53 Submissions pointed out the public and private sectors have different roles in the provision of health care. It was argued that private hospitals frequently provided high volume, comparatively low cost procedures as these are more profitable. More expensive procedures such as paediatric and intensive care services are infrequently provided in private hospitals. Similarly, emergency care is more frequently provided by public hospitals as is the management of complex, chronic conditions. As a result, public hospital workloads contain a larger proportion of higher cost, longer stay and

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53 Submission No.41, pp.26-27 (Queensland Government).

54 *Committee Hansard,* 11.11.99 p.142 (AHIA).

55 See for example *Committee Hansard,* 22.3.00, p.402 (DRS).

56 Submission No.41, p.26 (Queensland Government).

57 Submission No.60, pp.22-3 (SA Government).

more intensive work. It was argued that because of the different roles of the public and private sectors, the impact of the demand for public services is unclear. However, the AHA, WHA and AAPTC argued that the end result might be that per bed day costs of public hospitals might increase due to changes in the casemix.[58]

5.54 Evidence was received that there was now a significant proportion of those in private hospitals who self-funded their care. Estimates of self-funding ranged from 10 to 15 per cent of private patient admissions.[59] The Australian Private Hospitals Association (APHA) stated that 13 per cent of patients treated in private hospitals in 1997-98 self-funded. The proportion in day surgeries (33 per cent) was far higher than in acute and psychiatric hospitals (9 per cent).[60] DHAC indicated that a TQA survey had found that 12 per cent of private hospital admissions were by people who were self-funded. This was about 215 000 people. DHAC estimated that with an average treatment cost of $2 500, self-funders saved the public hospital system some $540 million per year.[61]

5.55 The Public Hospitals, Health and Medicare Alliance of Queensland concluded:

> there are a number of people who do not have private health insurance and are able to fund their own. So the crisis that the government paints as a reduction in private health insurance may not be a crisis or of as great a magnitude as what we are led to believe in the public arena…But there is no doubt that, although private health insurance was reducing, the usage was not reducing at the same rate. So the perception that has been painted out there is, 'We have a crisis. Private health insurance is going down.'…What we are saying is that it may not be quite that way because this group of people are not being taken into account in the equation and they should be.[62]

Estimates of the impact of the Rebate

5.56 Submissions to the Committee argued that it was too early to tell whether the rebate had had an impact on the demand for hospital services. However, some witnesses did provide the Committee with some analysis of the impact.

5.57 CPHE argued that 'the net effect of the PHI subsidy upon the hospital sector, at least in the short run, will almost certainly be less than the effect upon the hospital sector of a direct subsidy of equal magnitude to public hospitals'. CPHE stated that the greater part of a rebate will be received by existing fund members and will result in increased expenditure on existing goods and services by the already insured and

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58 Submission No.45, p.25 (RACP, ACA, HIC); Submission No.63, p.29 (AHA, WHA, AAPTC).

59 Submission No.16, p.9 (QNU).

60 Submission No.18, p.6 (APHA).

61 *Committee Hansard*, 11.11.99, p.32 (DHAC).

62 *Committee Hansard*, 22.3.00, pp.459-60 (Public Hospitals, Health & Medicare Alliance of Queensland).

therefore will not alter the overall level of insurance or funds available for hospitals.[63] It was estimated that the 'break even' point where the subsidy had the same impact on hospital expenditures as direct payment would occur when the subsidy increased the insured by 12.5 percentage points. CPHE concluded that 'in the short run this is very unlikely to occur and consequently, the direct payment to the public hospital would achieve a greater impact on hospital spending'.[64]

5.58 Professor Don Hindle noted that while there was some freeing up of beds in public hospitals, it was a relatively small proportion, and that between one per cent and four per cent of public hospital costs would be transferred to private hospitals (between $117 and $483 million per year). This estimate was based on an upper and lower estimate in October 1999 of the expected membership levels in May 2000 with a lower estimate of 30.5 per cent and an upper estimate of 34.3 per cent. Professor Hindle concluded:

> although up to four per cent of patients had moved out and vacated beds in the public hospitals, there are other patients out there who are waiting to get in. In other words, there is an unmet need and an unmet demand for public hospital services so that, as soon as you free that bed, some other patient who would not otherwise have got in is now admitted to hospital…the statistics that I have been able to obtain around Australia, comparing calendar year 1998 with calendar year 1999, suggest that the change in the hospital admission rates in the public hospitals is negligible…overall, as far as I can see, the change has been negligible for the reason that patients come in.[65]

5.59 In its comments, CHERE stated that since Professor Hindle had undertaken his analysis two sets of figures had become available which would suggest that the rebate would have an even smaller effect than estimated by Professor Hindle. The first figure is that at 31 March 2000, private health insurance membership was 32.2 per cent of the population. Secondly, the report of the hospital data analysis consultancy indicated that 25.9 per cent of those patients in the sample with private insurance had been treated as public patients. CHERE argued that if this figure is reflective of the entire population, 'then this indicates that 25.9 per cent of the additional people taking out private health insurance will still choose to be treated as public patients. Both figures indicate that the upper [band] of the percentage of public cost likely to be transferred to private hospitals is in fact an over estimate.'[66]

5.60 The Australian Hospitals Association (AHA), Women's Hospitals Australia (WHA) and the Australian Association of Paediatric Teaching Centres (AAPTC) commented that it had reviewed Dr Hindle's estimate of four per cent and suggested

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63 Submission No.46, p.12 (CHPE).

64 Submission No.46, Additional Information p.9 (CHPE).

65 *Committee Hansard*, 21.3.00, p.323. See also Submission No.20, p.14 (DRS).

66 CHERE, Discussion Paper 3, p.7.

that it was overstated as it did not take into account casemix effects and the waiting list effects were understated.[67] AHA, WHA and AAPTC also argued that while there may be a reduction in waiting lists through the transfer of patients to the private system, this will in itself not reduce demand in the public system – it simply shortens the time that patients have to wait.[68]

5.61 The Queensland Government commented on the impact of the rebate on public hospital admissions:

> it is Queensland's view that the rebate arrangements do not appear to be delivering a tangible benefit to the public hospital system, that our demand continues to grow, that our private patient numbers continue to decline while the new rebate arrangements are in place–either the current scheme or the previous one…It is not as if the total number of patients are declining correspondingly. People are coming in as public patients when historically they might have come in as private patients. So we find ourselves with an increasing aggregate workload and a declining revenue stream from private patients when it is our understanding at least that there was some expectation that the new arrangements would be encouraging patients, as the number of privately insured people grows, to access the private hospital system, in which case we would get the benefit that you have implied. But that does not appear to be happening for us at all.[69]

5.62 As noted by the Queensland Government, public hospitals have experienced a fall in revenue from private patients. Payments by health insurance funds accounted for 6.0 per cent of expenditure on public non-psychiatric hospitals in 1989-90 and fell to 3.0 per cent in 1996-97.[70] The NSW Government stated that revenue from private patients in NSW hospitals had declined by about $180 million since 1990-91. Private bed days in public hospitals fell from 1 410 320 in 1990-91 to 537 634 in 1998-99. Private patient revenue now accounts for only $133 million.[71] The South Australian Government noted that between 1984-85 and 1997-98 private patient revenue in the State's public hospitals had fallen from 11.3 per cent of the cost to 5.1 per cent.[72]

5.63 CHPE and other witnesses argued that the fall in revenue from private patients at a time when State governments were capping hospital budgets was a significant problem for public hospitals and not the excessive demand for their services. CHPE concluded that the fall in revenue contributed to a reduction in public hospital capacity to *supply* hospital services without first effecting significant internal reform.[73]

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67 Submission No.63, p.30 (AHA, WHA, AAPTC).

68 Submission No.63, p.29 (AHA, WHA, AAPTC).

69 *Committee Hansard,* 11.11.99, p.60 (Qld Government).

70 AIHW, *Health expenditure bulletin, No.15: Australia's health services expenditure to 1997-98,* p.12.

71 Submission No.79, p.20 (NSW Government).

72 *Committee Hansard,* 23.2.00, p.155 (South Australian Minister for Human Services).

73 Submission No.46, p.13 (CHPE). See also Submission No.63, p.30 (AHA, WHA, AAPTC).

5.64 The NSW Government and other witnesses also noted that the charging system for private patients in public hospitals contributed to revenue problems. The NSW Government argued that the gap between the costs of services provided to private patients in public hospitals and the benefits paid has widened significantly in recent year. The benefits paid by private health insurance funds for private patients in public hospitals – the default rate – is set by the Commonwealth. This rate, according to the NSW Government, represents just over one third of the real costs of providing these services. It has calculated the subsidy to private patients at $286 per day for NSW and ACT hospitals. While the NSW Government acknowledged that it could set a higher rate, 'to do so would provide a major incentive for privately insured patients to elect for public patient status'.[74]

Cost and equity considerations

5.65 A number of witnesses questioned the economic justification of the rebate and pointed to some possible additional costs of increased use of private health insurance and equity implications of the rebate.

5.66 CHPE argued that the rebate may lead to higher health care costs. Research in the area of acute myocardial infarction has suggested that private hospitals are more likely to employ costly procedures and that the unit cost of such procedures are significantly greater in the private sector.[75] Therefore, it argued if an increased use of private hospitals leads to an increase in the number of medical services per patient, then the impact of the rebate would be 'less favourable from a global perspective. That is, Medicare spending on private medical services will be disproportionately increased.'[76] During the second Roundtable, Professor Barclay also noted that research shows that there is a greater likelihood of privately insured women not having a normal birth and that 'the costs of post-natal care [for privately insured women]…are very much higher than they are in the public sector. So there are long-term spin-off effects of a change in private insurer.'[77] The CHPE study is discussed further in Chapter 6 (see paras 6.41-47).

5.67 AHA, WHA and AAPTC also supported CHPE's argument. They concluded that the greater use of the private sector as a percentage of total hospital care, the greater the overall cost. AHA, WHA & AAPTC noted that the larger pool of privately insured patients might result in increased per capita utilisation because private hospital patients receive higher volumes of services. There may thus be no positive impact other than higher income for private care providers and higher overall costs to the community.[78]

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74 Submission No.79, pp.21-22 (NSW Government).

75 Submission No.46, p.18 (CHPE).

76 Submission No.46, Additional information, p.9 (CHPE).

77 *Committee Hansard*, 20.1.00, pp.750-51 (Professor Barclay).

78 Submission No.63, pp.29-30 (AHA, WHA, AAPTC).

5.68 At the second Roundtable, Mr Mark Cormack of the Australian Healthcare Association also cautioned:

> The private health insurance arrangements as they now stand do not contain any real checks, balances and incentives to look at per capita utilisation. There is already good evidence around that the privately insured have higher levels of utilisation for certain service types, and we need to look very carefully at this to see that the increase in funding available through private health insurance does not simply lead to an overall increase in acute hospital utilisation rather than some sort of release of pressure off the public system.[79]

5.69 Professor Hindle noted that his estimate of the reduction of public hospital costs by $483 million as a result of the rebate, 'is more than counterbalanced by the higher costs of providing the transferred patients with care in private hospitals. We estimate that private hospital care for privately insured patients is 27% higher.'[80] Professor Hindle stated that the average cost of a public patient is about $2 400 while the average cost of a private patient in a private hospital is about $2 850.[81]

5.70 In a recent study, Professor S Duckett and Dr T Jackson commented that the rebate is 'effectively a subsidy to the health insurance industry and is larger than budgetary assistance for the mining, manufacturing and primary agricultural production industries combined'. Duckett and Jackson went on to argue that the economic justification for subsidising the private sector should demonstrate improvement in one or more of three economic criteria: technical, allocative and/or dynamic efficiency. They concluded that the private health sector preforms worse than the public health sector on all three criteria and therefore the subsidy is not justified on efficiency grounds.[82]

5.71 Some witnesses also pointed to the impact of higher costs of private hospital episodes on health insurance premiums. For example, increases in premiums may result from the movement from the public to the private sectors as higher benefits are paid to private hospitals when compared with private care in public hospitals.[83] For example, it was estimated that health insurance funds had faced added costs of $400 million in extra benefits payable due to the shift from private beds in public hospitals to private hospital that occurred between 1989-90 and 1997-98.[84] However, the

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79 *Committee Hansard*, 20.11.00, p.755 (Australian Healthcare Association).

80 Submission No.22, p.8 (Professor Hindle).

81 *Committee Hansard*, 21.3.00, p.323 (Professor Hindle).

82 Duckett, SJ and Jackson, TJ, 'The new health insurance rebate: an inefficient way of assisting public hospitals', *The Medical Journal of Australia*, 172, pp. 439-42.

83 Submission No.63, p.30 (AHA, WHA, AAPTC).

84 Messenger, A, 'Rebate reprieve for private hospitals', *Australian Medicine*, 4-18 January 1999, p.14.

Minister for Health and Aged Care stated that the higher levels of participation would 'give the industry stability and encourage funds to lower their premiums'.[85]

5.72 The AHIA noted that pressure on premiums would continue because funds had to meet costs and the costs of increasing private hospital utilisation. As well, more complex procedures were being undertaken in the private sector. AHIA stated:

> Ten years ago we were paying for very minor surgical procedures. Today we are paying for very high–tech ones and they are growing and growing. The simple example...is the [heart] stent…It is a very complex, high-tech operation. The stent itself costs us $2,700. The operation can cost $12,000 to $15,000 or maybe even $20,000…About five years ago we paid for none and this year we will pay for 5,000. Next year I would expect 7,000 and the year after that probably 10,000 or 20,000.[86]

5.73 Concerns were also expressed that public hospitals could face difficulties in retaining and attracting professional medical staff as they may be attracted to the private sector. The public sector would then be forced to pay premium rates of pay in specialist areas to compete with the private sector.[87]

5.74 Witnesses argued against the rebate on equity grounds and noted that many people in rural and remote Australia could not access private health care.[88] CHERE argued that the rebate is not means tested and is accessible to those who choose to purchase health insurance for either ancillary tables, hospital tables or both. While some lower income families do have private health insurance, the ABS Health Insurance Survey found that 'the likelihood of having private health insurance increased as the income of the contributor unit increased, from 20% of people in units with an annual income of less than $20 000 to 76% in units with income of $100 000 or more per annum'.[89] CHERE concluded that:

> This would suggest that this policy provides a subsidy to middle and upper class Australia who, in general, are not the sector of society government usually aims to assist financially. The opportunity cost in terms of equity is that those on lower incomes are less likely to receive this subsidy since even with the rebate, private health insurance may still be out of reach for many Australians.[90]

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85 *The Sydney Morning Herald*, 28.8.00.

86 *Committee Hansard*, 11.11.99, p.131 (AHIA).

87 Submission No.16, p.10 (QNU); Submission No.20, p.15 (DRS); Submission No.63, p.30 (AHA, WHA, AAPTC).

88 Submission No.41, p.27 (Queensland Government); Submission No.66, p.27 (National Rural Health Alliance).

89 Australian Bureau of Statistics, 1998, *Health Insurance Survey*, p.6.

90 CHERE, Discussion Paper 3: Key Issues, p.8.

This view was supported in other submissions.[91]

5.75 It was also argued rural and remote areas with poor health services and indigenous health sectors will not benefit from the rebate as traditionally these areas have low health insurance levels. Private services in rural and remote Australia are few. The Northern Territory, for example, has only one private hospital located in Darwin. There would be little impact on demand for public hospital services in these areas.[92] However, evidence was provided that even though there are few private facilities, people in rural and remote areas are joining private health insurance funds in order to minimise costs. The AMA (NT) state that:

> There is a general feeling, particularly since the introduction of Lifetime Community Cover Ratings, that residents of the Territory are being punished by the Commonwealth by attempts to force them to expend money on an insurance that in essence a significant proportion of residents cannot access.[93]

Other options for the funding

5.76 Much evidence to the Committee asserted that the rebate represented poor value for money and that it would have been of greater benefit to have the Commonwealth's expenditure on the rebate paid directly into the public hospital system.[94] The Committee was provided with a number of estimates of the impact on health services if this had occurred.

5.77 CPHE argued that had the $1.5 billion private health insurance subsidy in 1996-97 been allocated to public hospitals, 'their capacity would have increased at least 14 per cent[95] (which significantly exceeds the likely affect of the subsidy – at least in the short run – upon PHI and the indirect effect upon public hospitalisation'.[96]

5.78 Professor D Hindle argued that his analysis indicated that 3 to 12 times more health care could have been provided from the original estimate of $1.7 billion per

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91 See for example Submission No.20, p.16 (DRS); Submission No.63, p.31 (AHA, WHA, AAPTC).

92 Submission No.17, p.8 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.41, p.27 (Queensland Government); Submission No.89, p.10 (AMA (NT)); *Committee Hansard,* 11.11.99, p.122 (National Rural Health Alliance).

93 Submission No.89, p.10 (AMA (NT). See also *Committee Hansard*, 22.3.00, p.474 (Queensland Minister for Health).

94 Submission No.17, p.8 (Public Hospitals, Health & Medicare Alliance of Qld); Submission No.26, p.2 (Medical Consumers Association of NSW);. Submission No.39, p.7 (ANF); Submission No.65, p.12 (ANF(SA)).

95 This figure represents the percentage increase in the public hospital budget that would have occurred. As the marginal cost of hospital care is significantly less than the average cost, the increase in capacity would have significantly exceeded 14 per cent.

96 Submission No.46, pp.13-14 (CHPE).

year in rebate expenditure if it had been allocated instead directly to public hospitals or made available for competitive tendering by both public and private hospitals.[97]

5.79 The Victorian Minister for Health stated:

> For the $500 million [Victoria's share], the public hospital system could treat thousands more patients more efficiently and increase quality, infection control and other issues facing our hospitals now…with that $2 billion Victoria could treat an additional 150,000 patients, could increase throughput by 25 per cent and could dramatically reduce waiting lists.[98]

5.80 The Doctors Reform Society (DRS) stated that for $1.5 billion a year, 'no more than 100 000 people are covered by private health insurance. The government could have bought 1.5 million individual memberships each year with the same money or opened an extra dozen 500 bed public hospitals.'[99]

The Rebate and the Australian Health Care Agreements

5.81 Under the Australian Health Care Agreements (AHCAs), provision was made for fluctuations in the private health insurance participation rate. Should the participation rate decline in 1999-2000 and later years, thereby placing greater demands on public hospitals, Commonwealth funding under the Agreements would increase at around $82 million per percentage point change. Should the participation rate increase above certain levels, funding would decrease at the same rate of $82 million per percentage change. As a consequence, the risk of fluctuations was 'explicitly shared between the Commonwealth and the States as one part of the risk sharing structure that improves on the previous arrangements'.[100]

5.82 In his second reading speech for the Private Health Insurance Incentives Bill 1998, the Minister for Health and Aged Care stated that if the drop-out rate of private health insurance continued to follow the long term trend of two per cent per year, by July 2001 the Commonwealth would have to provide $500 million per year to the States in additional funding.[101]

5.83 Witnesses, including State governments, expressed concern that the arrangements under the AHCA was based on the assumption that rising levels of private health insurance will automatically result in comparable reductions in demand for public hospitals services.[102] Dr Filby of Queensland Health stated:

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97 Submission No.22, p.4 (Professor Hindle).

98 *Committee Hansard*, 23.3.00, pp.509-10 (Victorian Minister for Health).

99 Submission No.20, p.14 (DRS).

100 Submission No.38, p.31 (DHAC).

101 House of Representatives, *Debates*, 12.11.98, p.265.

102 See for example, Submission No.20, p.15 (DRS); Submission No.45, p.24 (RACP); Submission No.63, p.31 (AHA, WHA, AAPTC).

> The difficulty for us is that the Health Care Agreement implies a relatively straight line relationship between the proportion of people insured and the use of public hospital systems. It implies that in the funding arrangement, albeit with a benchmark or a level upon which the finances will continue to flow, that straight line relationship does not appear to us to be operating. Therefore we find ourselves in circumstances where the demand for our service continues to rise without us getting the benefit.[103]

5.84 The South Australian Government was 'strongly of the view', that given the uncertainty of the relationship between demand for public hospitals services and private hospital insurance rates, 'that Commonwealth funding should not be reduced just because health insurance levels rise above the target rate'.[104] Other witnesses supported the need for more detailed study of the relationship between private health insurance and hospital utilisation.[105]

5.85 The Committee notes that during the passage of the National Health Amendment (Lifetime Health Cover) Bill 1999 through the Senate, the Government agreed to address the concerns of the States. It was announced that the Commonwealth would guarantee that the States would not be worse off as a result of any increase in private health insurance participation rates. In the event that participation rates rise above the level where Commonwealth grants would be reduced, 'revenue from privately insured patients and veterans will be compared to revenue received from those patients during 1997-98. If the increase in revenue from these patients does not match or exceed any loss in revenue under the agreements, the Commonwealth will waive the additional reduction. For example, if Commonwealth funding to a state would otherwise be reduced by $7 million and the increase in revenue in that state was $5 million more than in 1997-98, the Commonwealth will waive $2 million.'[106]

Conclusions

5.86 The Committee considers that it is difficult to come to a conclusion that the rebate has been a substantial factor in influencing people to take out private health insurance. The Committee has considered two matters: first, the rebate is only one of a package of government measures, including the Medicare levy surcharge and Lifetime Health Cover, aimed at improving coverage by private health insurance. These measures have acted in concert to influence decisions to either retain private health insurance or to take out private health insurance.

5.87 Secondly, while it would be extremely difficult to identify the change in participation in private health insurance attributable to any one particular measure, it

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103 *Committee Hansard,* 11.11.99, p.61 (Queensland Health).

104 Submission No.60, p.24 (SA Government).

105 Submission No.63, p.31 (AHA, WHA, AAPTC).

106 Senate, *Debates,* 27.9.99, p.8939.

is possible to identify general trends because of the staggered introduction of the measures. During the period of operation of the PHIIS and Medicare levy surcharge (from 1 July 1997) the decline in coverage continued. During 1999, when the rebate replaced the PHIIS (from 1 January 1999) and the Medicare levy surcharge continued, participation rates rose only 1.2 per cent. However, in the first half of 2000 as the deadline approached for the introduction of Lifetime Health Cover (initially 30 June and subsequently extended to 15 July), participation rates jumped significantly: from 31.3 per cent at 31 December 1999 to 43.0 per cent at 30 June 2000 and 45.8 per cent at 30 September 2000. This increase has seen another 2.8 million people covered by private health insurance.

5.88 The Committee is persuaded by the evidence to conclude that the impact of the rebate on health insurance participation rates has been much less significant than the impact of the Lifetime Health Cover.

5.89 The Committee is concerned about claims that there is a direct link between private health insurance participation rates and the demand for public hospital services. It was argued that higher levels of participation would result in a fall in demand for public hospital beds as patients move into the private system. However, evidence to the Committee indicated that the relationship between health insurance participation and public hospital demand is highly complex and that a number of factors mitigate against rising participation leading to a fall in public hospital demand.

5.90 A recent analysis of patient status found that only 39 per cent of people with private health insurance in the public hospital system actually elected to declare it and be treated as private patients in a public hospital. It was suggested that there were a range of reasons for people to continue to enter hospital as public patients including high, unknown ‘gap’ payments and the availability of insurance products with front end deductibles or co-payments.

5.91 A further issued raised was that there is continuing unmet demand for public hospital services, so that even if the rebate resulted in a move to the private system, people would continue to be admitted to the public system and so no fall in demand would occur.

5.92 The Committee concludes that these factors undermine the argument that there is a direct relationship between an increase in participation rates and a fall in public hospital demand. There is serious risk that public hospitals will be worse off due to changes in the pattern of usage and the threat that funds may be withdrawn.

5.93 The Committee is also concerned that, as new members of health funds reach the end of their waiting periods and start to utilise their insurance for more frequent or more expensive health care than they would have previously sought, the total cost of health care will rise. This will drain limited health resources and increase waiting times at both public and private hospitals and produce further upward pressure on health insurance premiums.

Recommendation 20: That the Federal Government confirm its statement that no funds will be withdrawn from public hospitals through use of the 'clawback arrangements' in the Australian Health Care Agreements.

Recommendation 21: That the health insurance industry take urgent steps to adequately inform their new members about the features of the polices they have sold. There is currently a high level of confusion in the community about the extent of coverage, waiting periods, the rules on pre-existing ailments and the limitations on cover for many products.

Recommendation 22: That the health insurance industry take urgent steps in relation to providing wider availability of gap free products so that a large proportion of their members can access medical services on this basis.