Australian
Private Hospitals
Association

Mr Elton Humphery
Secretary
Senate Select Committee on Medicare
Parliament House
CANBERRA ACT 2600

Dear Elton

Thank you for your invitation to the Australian Private Hospitals Association (APHA) to lodge a submission to the inquiry by the Senate Select Committee on Medicare. On behalf of APHA, I have attached a submission addressing particular terms of reference of the inquiry. I have also attached a detailed analysis of the 30 per cent rebate commissioned by APHA from Access Economics.

Please contact me if APHA can assist further in this matter.

Yours sincerely

Michael Roff
Executive Director
23 June 2003

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SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE SENATE SELECT COMMITTEE ON MEDICARE

Background

In this submission, the Australian Private Hospitals Association (APHA) addresses primarily the Inquiry's term of reference (d)(ii): *the implications of reallocating expenditure from changes to the private health insurance rebate.*

In addition, brief comments are provided on term of reference (c)(iv): *private health insurance for out-of-hospital medical expenses.*

The Australian Private Hospitals Association (APHA) is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

Term of reference (d)(ii): *the implications of reallocating expenditure from changes to the private health insurance rebate.*

The inquiry's Term of Reference (d) reads as follows: *alternatives in the Australian context that could improve the Medicare principles of access and affordability, within an economically sustainable system of primary care…*

APHA argues that primary care cannot be isolated from the remainder of the health system. The consideration of alternatives and analysis of the implications of reallocating funding from the 30 per cent rebate for private health insurance must be examined in the light of their possible impact on other elements of the health system.

Role of the 30 per cent rebate

Despite its central role in restoring choice and balance to the Australian health care system, the 30 per cent rebate has been much criticised. However, it is important to consider that the cornerstones of Medicare, access and equity, can only be guaranteed within a balanced health care system. The way in which the rebate has restored balance to Australia's health system is starkly evident in the official data published by the Australian Institute of Health and Welfare which indicates that private hospitals treated an *extra* 245,000 patients in 2000-01, while public hospital admissions actually fell.

It is naive in the extreme to argue, as do some commentators, that the 30 per cent rebate should be scrapped and the funds diverted to State and Territory Governments which would apparently use the funds to support public hospitals. The record of successive governments at the State level is not encouraging in this regard and it is instructive to see

the reluctance of State and Territory Governments to agree to commit to particular public hospital funding targets as proposed by the Commonwealth as part of the negotiations for the next Australian Health Care Agreements. The Commonwealth Government Budget papers indicate that in 2000-01 public hospitals received an additional $362 million in funding, while the latest figures statistics published by the Australian Institute for Health and Welfare clearly show that in that same year public hospitals actually treated 5000 fewer patients than in 1999-00.

The crucial role of the rebate in enabling private hospitals to complement the role of public hospitals and the accompanying savings to the public purse, has been graphically illustrated in a recent analysis by Harper Associates. The report found that:

For instance, in 2000-01 alone, private hospitals in Australia performed procedures which it would have cost the public hospital system around $4.3 billion to perform.

In other words, had the private sector not carried its share of the hospital load in Australia in that year, public hospital outlays would have been around one third higher in real terms.[1]

The rebate has also restored choice to the Australian health system. Choice in health care is only possible if the alternative is affordable and increased affordability of private health insurance has been a central feature of the success of the rebate. This was demonstrated in a thorough analysis of the 30 per cent rebate by Access Economics, which found that *"affordability* [delivered via the rebate] *remains the most significant driver of coverage.*[2]

Role of private hospitals

The strength of Australia's health system is its virtually unparalleled mixture of private and public financing with services delivered by both the private and public sectors. This mixture has enabled Australia to avoid the chronic underfunding that has characterised the United Kingdom's National Health Service and the inequalities evident in the United States. Australia's private hospitals sector is providing an increasingly vital role, complementing that of the public hospital system. Recent Commonwealth Government initiatives, including the 30 per cent rebate and Lifetime Health Cover, have underpinned this key contribution of the private hospitals sector.

In 1995-96, private hospitals offered only 27 per cent of available hospital beds and treated less than one-third of all hospital patients. In five short years, private hospitals have expanded their bed-stock to nearly 32 per cent of all available beds and in 2000-01 treated 38 per cent of Australia's hospital patients. In so doing, private hospitals (including day hospital facilities) have enabled the demand on public hospitals to slow to such an extent that the number of patients treated in public hospitals actually fell by 5,000 in 2000-01, while patients treated in private hospitals increased by 245,000.

The number of patients treated in the private hospitals sector has increased by 42 per cent since 1995-96, from 1.66 million to 2.35 million in 2000-01. Over this same period, the

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[1] Harper Associates, *Preserving Choice: a defence of public support for private health care funding in Australia*, April 2003.

[2] Access Economics, *Striking a Balance: choice, access and affordability in Australian Health Care. A report prepared for the Australian Private Hospitals Association*, October 2002.

total number of patients treated in the private and public sectors has increased by only 19 per cent, from 5.17 million in 1995-96 to 6.14 million in 2000-01.

Critics of the private health insurance rebate argue that it has done little to reduce demand on public hospitals. It is important to note that these assertions are not supported by the facts. In the only comprehensive study to date that APHA is aware of, Dr Brian Hanning analysed data on Victorian surgical waiting lists and found that:

The total waiting list has varied little, reflecting significant decreases in both patients added to and removed. There was a marked increase in private sector elective surgery cases coinciding with the fall in additions to the public sector waiting list and in public sector elective surgery cases. The June 2001 Victorian surgical waiting list would have been 69,599 not 41,838 if the PHI uptake rate had continued to fall in line with pre-1999 trends, and that of June 2002 about 100,000 compared to 40,458 in March 2002. Limited data from other States suggests the Victorian trends are representative of Australia.[3]

Although its critics seek to dismiss private hospitals as places where only 'lumps and bumps' are treated, it is quite apparent that the sector has become increasingly sophisticated in the range and types of treatment available to patients. Interestingly enough, this has been recognised recently in a report prepared for Australia's Health Ministers, which noted that:

Over the last twenty years, there has also been growth in the capacity of the private sector, both in offering dedicated day procedure facilities and in offering a more complex range of services. With the exception of some super specialty services (such as transplantation), some large metropolitan private hospitals now offer comparable services to the major public teaching hospitals.[4]

Increasing sophistication is evident also in the number of specialised wards and units located in private hospitals. For example, the number of cardiac surgery units in private hospitals has increased by 200 per cent since 1995-96. In addition, over the period between 1995-96 and 2000-01, the number of neo-natal intensive care units has increased by 42 per cent, the number of neurological units has increased by 175 per cent and the number of oncology units has increased by 144 per cent.

While there remain some differences in the mix of patients treated in the public and private sectors, the private hospital sector now provides a much wider range of services for patients. For example, comparing 1999-00 and 2000-01, private hospitals provided 35 per cent more renal dialysis services, 23 per cent more chemotherapy services and 15 per cent more major lens procedures.

Indeed, there are several key areas where private hospitals now provide more than 50 per cent of patient separations. These include:

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[3] Hanning, B, "Has the increase in private health insurance uptake affected the Victorian public hospital surgical waiting list?", *Australian Health Review*, vol 25, no. 6, 2002, p.64.

[4] *Australian Health Care Agreements Reference Group Report*, "Interaction between hospital funding and private health insurance", 2002, p. 31.

Table 1 Percentage of selected episodes performed in private hospitals

Chemotherapy	50%
Major procedures for malignant breast conditions	53%
Other major joint replacement & limb reattachment	60%
Mental health treatment, sameday	60%
Major lens procedures	70%
Major wrist, hand and thumb procedures	70%
Knee procedures	75%
Sleep apnoea	81%

Source: calculated from Australian Institute of Health and Welfare, *Australian Hospital Statistics 2000-01*

It is often asserted that private hospitals mainly provide profitable services to people who aren't really all that ill, leaving public hospitals to pick up the *"poorest, oldest and sickest patients"*.[5] In fact, private hospitals more than pull their weight in both the treatment of older patients and in the variety and sophistication of the services offered to patients. For example:

- in 1995-96, patients aged 75 years and older comprised 14.6 per cent of total separations in private hospitals compared to 13.9 per cent in public hospitals;

- in 2000-01, patients aged 75 years and older comprised 19.2 per cent of total separations in private hospitals but only 16.7 per cent of total separations in public hospitals;

- between 1995-96 and 2000-01, there was an increase of 90 per cent in the number of separations for patients aged 75 years and older provided in private hospitals. The growth was much lower in public hospitals, at 30 per cent;

- in 1995-96, private hospitals provided 31.5 per cent of all separations for patients aged 75 years and older. In 2000-01, this proportion had grown to 40 per cent; and

- in 2000-01, 3.9 per cent of total private hospital separations were for patients aged 85 years and older. In public hospitals, 4.4 per cent of total separations were for patients in this age group.[6]

Concluding Comments

APHA argues that the main implication of reallocating expenditure from changes to the private health insurance rebate is the creation of a two-tier health system in Australia. The 30 per cent rebate has restored choice and balance to the Australian health care system by making private health insurance more affordable for a broader cross-section of the community. Any fundamental changes to the rebate will see private health insurance become affordable for only a small, select section of the Australian community. The 245,000 extra patients treated by the private hospitals sector will return to public hospital

[5] See, for example, Deeble, J "Funding the essentials: the Australian Health Care Agreements, 2003-2008", *Australian Health Review*, vol 26, no. 6, 2002, p.5.
[6] Australian Institute of Health and Welfare, *Australian Hospital Statistics*, various years.

waiting lists and the public hospital system will require a funding boost of some $4.3 billion annually.

Term of reference (c)(iv): *private health insurance for out-of-hospital medical expenses*

APHA is concerned to ensure that the proposal to permit private health insurance coverage in certain circumstances for out-of-hospital medical expenses proceeds only on the basis of actuarially sound premiums. In this regard, private health insurance funds do not have a distinguished track record. Premiums are set with virtually no considered input from providers, who actually incur the costs that the premium increases are supposed to meet. The dramatic blow out in the benefits paid for prostheses and medical gap insurance in recent years should have surprised no one, however the health funds appear to have badly misjudged the required premium adjustments to offset the impact of these products on benefits.

When the arrangements for medical gap products were introduced, most health funds provided these products to their members within hospital tables, at no additional cost. Similarly, when the prostheses arrangements were changed by the Department of Health and Ageing in 2001, at the express urging of health funds, no additional contribution was sought from health fund members. The financial impact of both measures was clearly underestimated by health funds in pricing their hospital table insurance products.

APHA is keen to ensure that with the possible introduction of a new health insurance product, that the mistakes of the past are not repeated. This must be a stand-alone product, with no cross-subsidisation from hospital tables.

Access Economics

Examining Australia's 30% private health insurance rebate

Striking a Balance:

Choice, Access and Affordability in Australian Health Care

A report prepared for the

Australian Private Hospitals Association

by

Access Economics

October 2002

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In mid-2002, the Australian Private Hospitals Association commissioned the nation's leading independent economic researchers, Access Economics, to conduct a series of reports into Australia's balanced public/private health care system.

The first in this series is a comprehensive analysis of the Federal Government's 30% private health insurance rebate.

Since its introduction in January 1999, the rebate has become a fundamental ingredient in the household budgeting of almost half of the Australian population. Yet, ideological – rather than practical or constructive – commentary on the effectiveness of the 30% rebate has clouded much of the health care landscape and made planning for the future a murky business.

For 30 years, the private health sector has struggled with an unstable policy framework characterised by partisan policies and wavering commitments. Australia now needs a more stable policy framework so that public and private hospitals can get on with the job of providing safe, high quality care.

This independent paper evaluates the extent to which the Australian health system benefits from the 30% rebate. It includes discussion of the extent to which the public hospital sector benefits from increased utilisation in the private hospital sector and highlights the significant contribution of private hospitals in the delivery of health care services.

Furthermore, this paper examines options for evolutionary policy change to ensure the maintenance of Australia's balanced health care system.

The Australian Private Hospitals Association believes Access Economics' research to be a seminal document, clearing the air of common misconceptions and providing the framework for a better informed, and more mature, debate on health policy reform.

Michael Roff
Executive Director
Australian Private Hospitals Association

28 October 2002

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This report is an independent assessment commissioned by the Australian Private Hospitals Association (APHA). It does not purport to represent and may not be construed as representing an APHA view.

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EXECUTIVE SUMMARY

- **For thirty years, private health insurance has been treated as a "fringe-dweller" around Medicare and has struggled with an unstable policy framework characterised by partisan policies and wavering commitment. This has cost Australia dearly;**

- **Australia has long had a "mixed" health system, with roles for both the public and private sectors in the financing and the provision of health care. The private hospital sector has matured and now plays a vital role, providing almost 40% of hospital services (as measured by separations). So that the private and public hospital systems can get on with the job of providing safe, high quality health care, and to ensure that there is continuing investment in private hospitals, Australia now needs a more stable policy framework with less "sovereign risk";**

- **The current policy framework—a mixture of incentives for membership (the 30% tax rebate) and disincentives for non-membership (Lifetime Health Cover, the Medicare levy surcharge)—has a good deal to recommend it if Governments wish to meet the expectations of the community about quality, choice, access and affordability of health care. Key points are:**

  - **It is better to empower patients by giving them financial power to negotiate markets than to pay subsidies directly to producers;**
  - **A tax rebate is a more efficient mechanism than a benefit payment system, and tax rebates are more equitable than tax deductions;**
  - **A non-means tested rebate is cheaper and simpler to administer than a means-tested rebate and, by keeping higher income earners "in the tent", protects the integrity of the tax system in regard to income transfers;**
  - **Lifetime Health Cover is an appropriate framework to address intergenerational equity issues;**

- **The affordability of private health insurance premiums is the dominant, but not the only, determinant of private health insurance coverage. The 30% rebate has made private health insurance once again affordable for a significant number of Australians. Keeping private health insurance affordable for a significant number of Australians ought to be a key policy aim;**

- **As real incomes rise, citizens seek greater choice. In health care, they seek choice in where they are treated, who treats them and when they are treated. They also wish to be consulted and informed about the nature of the treatment. The quid pro quo for greater choice is greater financial responsibility. But in accepting that greater financial responsibility, people still wish there to be an efficient mechanism through which they can share the financial risk of poor health. The 30% rebate responds to strong wishes within the community and it is therefore preferable for governments to support private hospital access indirectly—by supporting private health insurance—rather than to support private health care more directly. The level of the rebate currently strikes an appropriate balance between making private health insurance affordable to individuals, making the whole scheme affordable to taxpayers and eliciting an appropriate household contribution to the cost of health care;**

- **None of this suggests that the current policy framework is free of flaws or that it cannot be improved. With rising expectations of access to new health technologies and an ageing population, major challenges lie ahead for both the public and private health sectors. Of course, policy will have to adapt and evolve to meet changing circumstances. Indeed, given the challenges that lie ahead, it is now vitally important that Australia does not repeat the policy U-turns of the past thirty years;**

- **That means playing less politics with health financing. Australia needs to lock in on core policies that attract bipartisan political support and that fit in the political middle ground, and then develop them in a measured and consistent manner. These policies would encompass patient preferences for greater say on "who, when, where and what" without breaking the budget. They would recognise the contribution and build on the strengths of both the public and private hospital systems. The 30% rebate represents a good starting point;**

- **It is timely for governments to engage health consumers, producers and funders in a more fruitful dialogue regarding the changes that might be required in coming years. This report canvasses a number of such changes:**

  - **The Lifetime Health Cover framework imposes a relatively modest financial penalty (by means of a premium loading) on those who join a private health fund after the age of 30. This framework may need some fine-tuning;**

  - **There is much that can be done now to improve the efficiency of the private health insurance system. The system remains excessively regulated and too tightly focussed on being a benefit payment system instead of a risk-sharing system. Citizens will ultimately judge the private health insurance system by how well it supports them in times of health catastrophe;**

  - **In the longer term, the 30% rebate may have to evolve into a Transferable Medicare Entitlement (TME) in one form or another. There is a need for more consideration of the "chemistry" between Medicare and private health insurance. It may not be sustainable to continue to offer citizens full dual entitlements. The TME solution preserves the universality of the health insurance system but is potentially more efficient as it reduces transaction costs;**

  - **Also in the longer term, Australia should give consideration to developing health savings accounts as an adjunct to the SG (occupational superannuation) arrangements. There is no need to create a completely separate system (indeed, it would be foolish to do so). Health savings accounts would supplement and complement private health insurance, not replace it. Health savings accounts would help people better meet their lifetime out-of-pocket health costs, while health insurance would remain the mechanism for risk-sharing.**

INTRODUCTION

This paper examines Australia's 30% private health insurance rebate ("the rebate") from the perspective of health financing policy.

Part 1 describes the swings and roundabouts in policy, concentrating on the period since the commencement of Medicare in 1984-85.

Part 2 outlines a philosophical approach to private health insurance more generally and the rebate in particular.

Part 3 examines the structure & activity of the private hospital sector and the relationship between that sector and private health insurance.

Part 4 looks to the future, identifying the challenges that lie ahead and pointing to further policy changes that may be required.

Appendix A records a "policy timeline", listing the policy changes which have been most influential in originating change (and, from time to time, chaos) in private health insurance.

Appendix B presents technical information on an econometric analysis of the link between the affordability of private health insurance and its coverage of the population.

PART 1 PAST (AND PARTISAN) POLICIES

1.1 The Policy Pendulum

In the early 1970s, the Federal Government was a bit player in Australia's health care system. To this day, it remains a bit player in the ***provision*** of health care, but it has become the dominant player in ***health financing***, typically funding about half of national health spending.

Over a thirty-year period, we have observed a "policy pendulum" in health financing. Governments of alternative political persuasion have pushed the pendulum back and forth, sometimes emphasising private financing and sometimes emphasising public financing. Nowhere has this been more apparent than in private health insurance (PHI). The major changes are summarised in **Appendix A** (PHI Policy Timeline).

Until the early 1970s, Australia had a voluntary health insurance scheme with limited budget subsidies. While Labor shaped up on the opposition benches with policy development of a comprehensive national health plan, the Gorton Government was attempting to shore up the voluntary health insurance system with the adoption, in 1970, of a medical benefits schedule of the most common fees as part of a reformed "Health Benefits Plan" which commenced in July 1970.

At that time, the health system had a strong institutional focus, revolving around public hospitals operated and funded by State Governments. With a small number of exceptions, the private hospital industry was a small "cottage" industry, typically with small establishments and with limited capacity for surgical interventions.

1.1.1 The Whitlam years

The Whitlam Government brought in two major changes in health care financing. First, grants were made to the States for public hospitals, an initial small amount in 1973-74 and larger scale funding in 1974-75. Second, the taxpayer funded ***Medibank*** scheme commenced in July 1975. This scheme comprised both medical insurance and public hospital cost-sharing agreements with the States. The role for private health insurance declined.

1.1.2 The Fraser years

In a series of steps, the Fraser Government reverted towards, if not completely to, the voluntary health insurance model. First, Fraser introduced ***Medibank Mark II***, an "opt-out" model that applied from October 1976. Taxpayers above a preset income threshold could opt to pay a health insurance levy, or to take out private health insurance and enjoy a levy exemption. ***Medibank Private*** was created (and operated by the Health Insurance Commission) in competition with other private funds. In 1978, further changes were made. The original levels of benefits applied only to the disadvantaged and supplementary insurance played a larger role. The health insurance levy was dropped.

Further changes to the system failed to stabilise coverage and, from July 1981, the Fraser Government introduced a private health insurance rebate that applied only to premiums paid in respect of basic medical and hospital cover. This measure, which remained in

place for two years only, temporarily pulled coverage back up towards two thirds. By this stage, the Fraser Government had effectively subjugated the goal of universal coverage to other concerns.

1.1.3 The Hawke/Keating years

The Hawke Government lost no time in setting an agenda that was hostile to private health insurance. First, Fraser's PHI rebate was abolished and replaced temporarily with rebates for out-of-pocket health costs. Thus, the tax system rewarded those without cover, rather than rewarding those with cover. Second, the Hawke Government moved quickly in its first term of office to introduce ***Medicare***, a reincarnation of Medibank, as from the 1984-85 year. This swung the pendulum back towards public financing of health care. Medical insurance was nationalised, and the role of the private funds initially restricted to hospital insurance. The funds were quick, however, to move into the greenfield area of ancillary insurance, offering cover for dental care and a range of other paramedical services. Supplementary insurance, which covered private hospital accommodation costs, was promoted heavily and successfully.

Medicare quickly proved to be an expensive and fast growing program. The Hawke Government responded in part to the fiscal pressures, both before and after its introduction, by removing support from private health insurance:

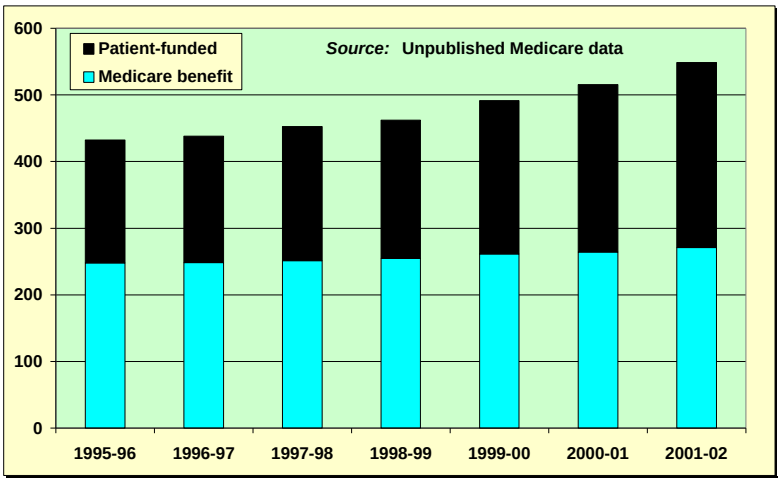
? One of those planks of support had been a subsidy to the private health funds through a contribution to the reinsurance pool (in the peak years of 1980-81 through 1982-83, this had been for amounts of $115.2m, $101.1m and $99.8m). This subsidy was reduced to $20.2m in 1983-84 and was phased out completely by 1987-88.

? Another had been the private hospital bed-day subsidy, which had run at a Budget cost of up to $140m p.a. This was discontinued in October 1986.

The Hawke Government also shifted costs onto private health insurance. In 1985, the private health funds were required to insure the gap between the Medicare rebate (85% of the schedule fee) and the schedule fee itself, thus funding 15% of each private in-hospital medical service. In 1987, the Hawke Government went further down this path, reducing the Medicare rebate for these services to 75% of the schedule fee and requiring the funds to cover 25%. In 1995, the Keating Government went another step in this direction with limited access to gap insurance above schedule fees in the context of agreements. By 2000, the Howard Government had gone further again with the gap cover schemes. Chart 1 illustrates the extent of this cost shift for a typical surgical procedure[7]. For this procedure, between 1995-96 and 2001-02, the average benefit paid increased by only 9.3% (less than the increase in the CPI over the period and much less than the increase in average earnings) while the patient funded component has increased by over 50%.

[7] Chart 1 illustrates the average benefit paid and the average patient-funded amount for MBS item 32508, the most common procedures for the treatment of varicose veins. The patient funded amount is the total of private fund rebates and out-of-pocket costs.

Chart 1: An example of cost shifting for a surgical procedure



The largest change of all is, however, in regard to hospital costs. When private patients receive care in public hospitals, private funds pay basic table (default rate) benefits only. In 1989-90, of all the privately insured patient days, 46% were provided by public hospitals. By 2000-01, this had fallen to just 19%. The factors that have driven this change include:

? Overt cost-shifting by the Federal and State Governments, in particular, the five-year Medicare Agreements applying from July 1993[8] provided significant incentives for public hospitals to increase their throughput of public patients and reduce throughput of private patients;

? New investment by the private hospital industry, increasing its capacity at the same time as the available beds in public hospitals have been reduced; and

? Patient preference, which is influenced by many factors including: perceptions of the quality and access offered by private hospitals, lower price barriers with the evolution of gap insurance, and the perceived increasing difficulty of getting access to public hospitals.

1.1.4 The Howard years

By the time of the 1996 Federal election, the collapse of private health insurance had become too large an issue to ignore. Both the Coalition and Labor Party election platforms promised support for private health insurance, the former offering more than the latter. The Howard Government's Private Health Insurance Incentives Scheme (PHIIS) took effect from July 1997, concurrently with the 1% Medicare levy surcharge for high-income earners who chose not to have private hospital insurance cover. The PHIIS was short lived. The modest subsidy offered appeared to have temporarily stabilised coverage, but it was not enough to entice any rebound.

The Howard Government was quick to go back to the drawing board. The 30% tax rebate for private health insurance took effect as from January 1999. To back the rebate and deal with issues of intergenerational equity, the Government introduced Lifetime Health Cover as from July 2000. These two initiatives together were sufficient to restore private hospital

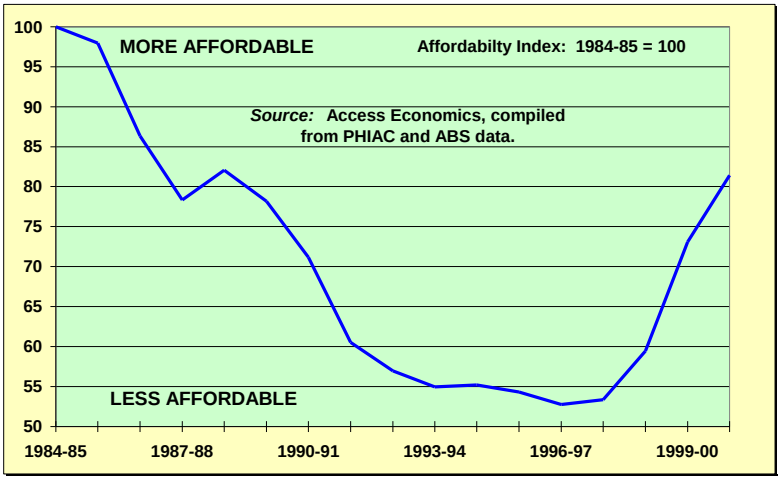
[8] Now known as ***Australian Health Care Agreements***.

insurance coverage almost to the 50% level applying immediately after the introduction of Medicare (see Chart 3).

1.2 Affordability and coverage

The post-Medicare strategies of shifting costs onto the funds and withdrawing subsidies had a telling effect on the affordability of private health insurance. As shown in Chart 2, the 30% rebate has restored affordability broadly to its level of the late 1980s.

Chart 2: Private health insurance affordability



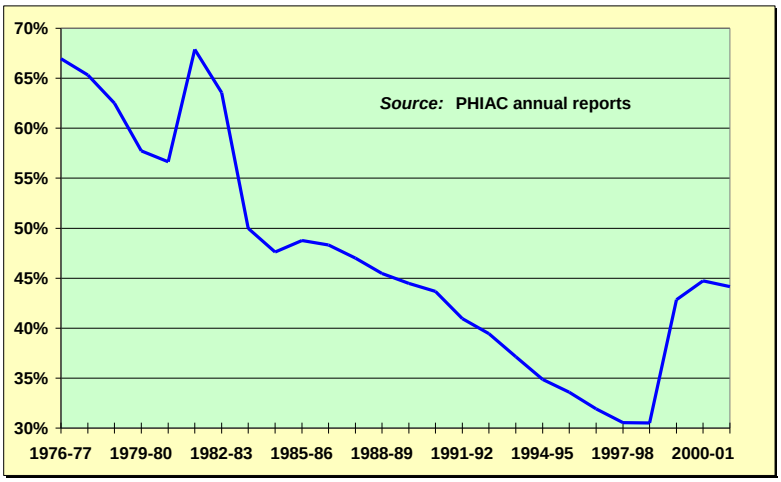
The measure of affordability shown above is not a perfect measure. Average premiums per person covered are used as a proxy measure of "price". However, premium changes also reflect quantity and quality changes. Part of the reason for increases in average premiums paid is that members have upgraded their cover. In the latter half of the 1980s, many fund members upgraded from basic cover only to basic and supplementary cover. Similarly in the 1990s, we have seen cover extended to address both hospital gaps and medical gaps (the latter with either "no gap" or "known gap" products). Finally, more members have taken out ancillary cover.

Were we able to get a better measure of "price", we might find that affordability has been restored to (or very close to) that applying at the time Medicare was introduced. As things stand, a true "price" index is not available for private health premiums in aggregate, let alone that part of the premiums that could be deemed to relate to hospital table benefits.

Chart 3 shows private hospital insurance coverage with time series data back to 1976-77. The Medicare Mark II arrangements failed to stabilise PHI coverage. There was a drift of people into publicly subsidised schemes. The Fraser Government responded with a PHI tax rebate, abolished two years later by the Hawke Government. The introduction of Medicare saw coverage drop sharply to around 50% of the population.

In the period since 1984-85, affordability and coverage have run almost hand in hand. The 30% rebate substantially improved the affordability of private health insurance and its impact on the rate of coverage, when combined with Lifetime Health Cover, is readily apparent.

Chart 3: Private hospital insurance coverage



1.3 What drives PHI coverage?

There is strong evidence that the affordability of private health insurance has a large impact on the willingness of the population to hold cover. But it is not the only factor. Other significant factors include:

A) **The "sticks"**—the negative financial incentives designed to modify the choices people make, comprising higher taxes (the 1% Medicare levy surcharge for high income earners without specified private hospital insurance cover) and higher premiums (the Lifetime Health Cover arrangements under which people joining or not maintaining continuous cover after the age of 30 pay a premium loading);

B) **The fear factor**—concern at lack of access, especially among those who are the most risk averse and also among those who may have less support otherwise (eg, widows). Perceptions of the state of the public hospitals come into play here. For example, industrial disputes in the public hospitals have at times had a discernible effect on private health insurance coverage;

C) **Access in time of need**—the desire patients may have to avoid the waiting times in the public hospital system which, for some kinds of elective surgery, can be five years or more;

D) **Satisfaction with health insurance products**—this can include many factors including whether there are uninsurable gaps, whether the cover is perceived by the patient as relevant to their needs (which may change over the life cycle), whether administrative systems are convenient, whether add-ons such as ancillary cover are attractive, whether the complexity of entitlements is a source of dissatisfaction.

E) **Intergenerational equity concerns**—throughout the 1985-1998 decline in coverage, it was very apparent that low-claiming younger members were tiring of cross-subsidising high-claiming older members and were ceasing to see private health insurance as offering value for money. The community rated system, in which everyone pays the same premium regardless of their age or health status, is built on the assumption that people would voluntarily cross-subsidise others. Either that, or that they would not be clever enough to work out that the optimal time to join a private fund was at the age of 50 to 60 when adverse health events start to increase. Lifetime Health Cover was, therefore, an important and constructive change in

policy, one that sought to address an ever-present source of instability in the arrangements; and

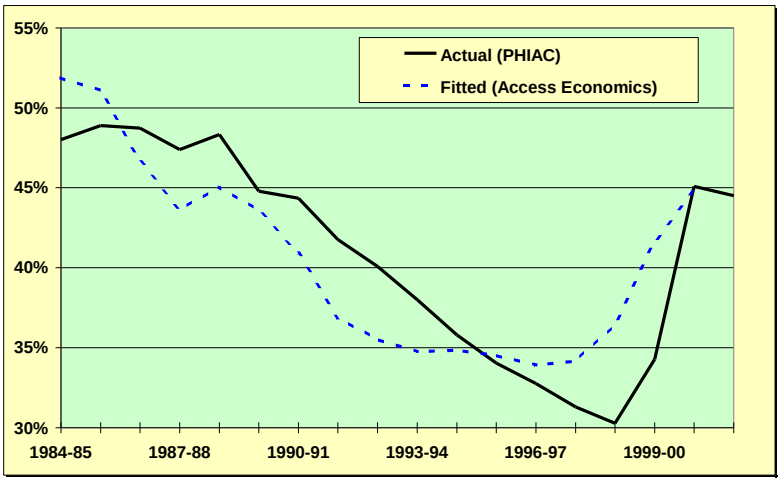
F) **Facilitating choice**—the desire among the population for choice of doctor, hospital and time is also a factor. As real incomes grow, people both want and expect to have more choice. This occurs in every part of the economy: housing and household equipment, cars, holidays, food, clothing—and health. In economic jargon, wider choice increases the "consumer surplus". It increases consumer satisfaction. Choice in health care can be increased through private health insurance and, in some cases, through direct out-of-pocket expenditure (in that case, without the scope for risk-sharing).

There are points in time where the influence of particular factors is quite readily discernible. But it is another matter to quantify their influence.

An econometric analysis shows that the affordability of private health insurance is, over time, the dominant factor determining the extent of coverage of the population. Broadly speaking, affordability explains over 90% of the variation in coverage, with the remaining variation attributable to the influence of other factors (addressed below). Technical details on the regression analysis can be found in **Appendix B**.

Chart 4 compares actual PHI coverage with the "fitted" (the rate of coverage predicted by the regression analysis).

Chart 4: Private hospital insurance coverage



Several points are worth noting:

? Private health insurance coverage proved "sticky" in the five years immediately following the introduction of Medicare. Some of this effect is attributable to NSW where PHI coverage rose quite sharply in the latter half of 1985 in response to the 1984 NSW doctors' dispute (the fear factor);

? A 1988-89 PHI price war induced a small rebound in coverage (in year-average terms) that year. This is one of several points in time where the price elasticity of demand for private health insurance is shown to be quite high;

? The sharp rise in PHI premiums following the price war kick-started the "vicious circle" that dogged private health insurance for much of the 1990s: premium hikes—

causing loss of younger members—leading to a deteriorating risk profile—occasioning further premium hikes—and around again;

? The decline in coverage in the mid-1990s was perhaps stronger than might have been expected, given that affordability was flattening out. By that time, private health insurance was decidedly unpopular especially with younger, lower claiming members, and the funds were finding it difficult to attract new members; and

? The rebound in coverage in the latter period was certainly stronger than would have been expected on the basis of improved affordability alone. The combination of the 30% rebate and Lifetime Health Cover does explain the observed rise. The two measures reinforced each other.

The lagged response of coverage to the introduction of the 30% rebate has attracted some comment. There have even been suggestions that the rebound in coverage was primarily a response to the introduction of Lifetime Health Cover rather than the rebate[9]. Our analysis indicates that affordability remains the most significant driver of coverage. The econometric analysis predicts that the improvement in affordability associated with the introduction of the rebate would have the effect of lifting coverage by some 11 percentage points. In fact, coverage lifted 15 percentage points. By itself, Lifetime Health Cover would not have proved an effective policy because the financial penalties (premium loadings) on those who join a fund after the age of 30 are relatively modest (this is addressed further in Part 4.2.1).

1.4 The cost of partisan policies

The nakedly partisan policies on private health insurance have been costly for Australians. As the pendulum swings to and fro between public and private financing options, there is a quite significant degree of disruption and dislocation of health services. The long term instability of public policy creates a "sovereign risk" with an adverse impact on both the private and public health sectors.

In the private sector, that acts as a deterrent to new investment in private hospitals. It also acts as a deterrent to new entrants into private health insurance, as a consequence giving Australia a private health insurance industry that is rather less competitive than would be ideal. Indeed, in most Australian States, there are only two or three private health funds with a market presence of any consequence.

In the public sector, the instability of PHI policy comes on top of significant budgetary and workload pressures. It is sometimes blithely assumed that the public and private hospital sectors are perfect substitutes for each other, but that is really not the case. It is true that the private system has expanded into areas once entirely, or almost entirely, the preserve of the public system. Yet the two sectors are in many respects complementary to each other with a different focus which becomes readily apparent when the casemix of the two sectors is compared. Some of these issues are explored further in Part 3.

Can Australia escape partisan policies on private health insurance? It is not clear. The major political parties have often felt it in their short term political interests to use this area to distinguish their own policies from the other. Meanwhile the minor parties, ever keen to

[9] JRG Butler, "Policy change and private health insurance: Did the cheapest policy do the trick?", NCEPH Working Paper Number 44, October 2001.

make some kind of impression, have tended to adopt policies further away from what might be regarded as the "middle ground". While the Coalition appears not to have lost its nerve with the 30% rebate despite the cost to the Budget, Labor's policies are under review. It is possible we will see some convergence towards the comfortable middle ground. But it is possible, also, that we will continue to see policy instability at a cost to the community. We can only expect that to change when the major parties start to perceive that the community is becoming fed up with the disruption that goes with the swinging pendulum.

PART 2 WHITHER THE REBATE?

The 30% private health insurance rebate has been a very successful initiative when measured in terms of its objectives, but still attracts a certain amount of criticism. This criticism is most trenchant from those who are fundamentally opposed to the underlying trend in health financing (which is to reduce the relative burden on taxpayers and to push more financial responsibility for health care back onto households). Apart from the support of private health insurance, other signs of that wider policy are the Federal Government's apparent willingness to allow rates of bulk-billing of medical services to decline and the proposed sharp increases in PBS co-payments.

This part looks at the 30% rebate and the associated policy elements (of which Lifetime Health Cover is the most significant). In Part 2.1, we note that some still try to conduct any debate about health financing within the constrict that the public hospital is still the epicentre of health care and Medicare is still the epicentre of health financing. This approach is dismissive of the vital role and growing importance of the private hospitals and equally dismissive of the role of private health funds. In Part 2.2, we canvass the prerequisites for achieving some policy stability in the health sector. Part 2.3 addresses moral hazard and adverse selection. Part 2.4 looks at the issues in empowering patients. Part 2.5 canvasses the options for delivering subsidies and concludes that best outcomes are achieved by ensuring that patients have the financial means to negotiate markets, rather than to pay subsidies directly to producers. Part 2.6 assesses the current policy settings (which have the 30% rebate and Lifetime Health Cover as core elements) and concludes that in addition to restoring affordability, the current policy mix scores well on a number of measures.

2.1 Epicentres

Health financing policy in Australia was a somewhat larger topic for debate in the 1970s and 1980s than it is now, and the debate was more polarised. In the meantime, the growing cost of health care has brought a sharper focus on budget implications. Both conservative and Labor Governments across the nation are worrying about how we are going to pay for it all. There is no abatement in their interest in shifting recurrent costs onto other levels of government, to other sources of finance (such as the private health funds) or to the household sector more directly. Nor is there any abatement in their interest in how new infrastructure can be put in place without adding (overtly at least) to public debt.

Despite these changes in the real politic, there are many still seeking to conduct the debate around the notion of epicentres. Thus, the public hospital is still held up as the epicentre of health care (despite the growing importance of private hospitals and the faster growth of community care as opposed to institutionally based care). Similarly, Medicare is held up as the epicentre of health financing despite the larger role now assumed by the private funds and the higher out-of-pocket costs imposed or proposed.

The epicentre approach condemns the private sector (whether in relation to the provision of health care or its financing) to fringe-dweller treatment. Is that a sensible way to tackle the issues? The answer is a resounding "no". Indeed, the fringe-dweller approach has arguably produced some unworkable policies on private health insurance.

Australia has long had a "mixed" system, with a role for both the public and private sectors in the provision and financing of health care. The swinging pendulum addressed in Part 1 of this paper may have changed the public/private mix in the financing of health care, but it has had rather less influence on the public/private mix in the provision of health care. Why is that so? Financing systems can be changed at relatively short notice—as we have seen—with many of the new initiatives having relatively short shelf life of a year or two. However, public and private hospitals cannot be thrown up or torn down in a short time frame of a year or two. Even if they could be, the waste of public and private money would be far too horrendous for any politician to contemplate. Moreover, while the public may have tolerated the turmoil in health financing, it is crystal clear that one thing they have liked about Medicare is its stability. And it is also crystal clear that they do not like to see and experience turmoil at the point of delivery of health care. Hence, every jurisdiction, be it public or private, seeks to manage change at a pace which the public will bear.

Over the past thirty years, Australia simply made too much of a meal of the extent to which the health system should be publicly or privately financed. It is time to move on, because with the forthcoming challenges of an ageing yet expectant population and potential stress from intergenerational equity issues, there are rather more important questions to be tackled. Since we have a hybrid (public/private) system, the focus of our efforts ought to be how we get the best we can from it. And that means getting the best from each sector (as they each have their strengths).

Following are examples of the sorts of issues that are arguably more important than the public/private financing mix. These are the issues that ought to be commanding the energies of policy makers:

? How can we improve the efficiency of the health sector while simultaneously lifting standards and improving patient safety? (Many people are working very hard to achieve these ends now, but there are also many impediments in place and ample evidence of pernicious inertia[10]);

? How can we address the large dysfunction in Commonwealth/State relations in the provision and financing of health care?

? How can we bring a stronger patient-centred focus to the provision of health care, instead of an inward-looking, institutional focus?

? How can we better integrate health care delivery to improve the chance that the patient is getting the most appropriate service in the most appropriate context at the most appropriate time (that includes tackling the silos within the institutions)?

? How do we deal with what is essentially discretionary health expenditure by the patient (that is, not medically indicated)? How do we define and identify it? And who pays?

Such questions transcend sectoral issues.

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[10] For example, private health insurance has long been over-regulated. An internal (to government) review recently completed produced an insignificant outcome. Clearly the bureaucracy prefers the status quo. The costs of that to the general public are largely hidden (and denied). Sadly, the resources put into that internal review, both by the bureaucracy and those outside bodies that put forward views, were poorly rewarded on this occasion.

2.2 Sectoral stability

What are the prerequisites for enough stability in the financing system so that the public and private health sectors can get on with the task of delivering high quality health care? First, stability is a means to an end, not an end in itself. It does not imply locking down sectoral shares according to some arbitrarily determined formula. There is no "magic number". The goal is not to guarantee either the public or private sector a place in the sun forever. The public and private sectors both have to earn their stripes. The goals are to deliver health care effectively and efficiently, to match community expectations about quality, choice, safety, access and affordability. The notion of affordability applies at both the macro level (what the whole community can afford) and at the micro level (what contribution individuals can afford to make to their own health care and through their taxes, to the health care of others less fortunate).

No community enjoys unrestricted access to health care. Health care resources are scarce and they have to be rationed, either by price, or by queues and other non-price restrictions on access, or by a combination of price and non-price measures. The necessity to ration services is fundamental to the design of any health financing system.

Health status is highly variable, and the need for acute care more variable again than the need for, say, general practitioner services. Accordingly, there is a strong desire within the community for the opportunity to share the financial risk of poor health. Health insurance systems, be they public or private, exist because the community wants them to exist.

In any community, there will be many who do not suffer socioeconomic disadvantage. This group is able and more or less willing to make a contribution to their own health care needs. There will be others who are heavily dependent upon taxpayer-funded health care, at least in some stages of their lives. Australians do regard access to health care as a "right", even if it means you have to pay for (some of) it. In Australia, there is perhaps no greater litmus test of the "fairness" or social equity of society than whether or not the disadvantaged have reasonable access to health care.

A key ingredient of any stable health financing system will be careful management of the tendency of patients, including the better-off patients, to "drift" towards taxpayer-funded health care. It is all in the way that a government strikes a bargain (a social contract if you like) with its better-off citizens to personally accept a larger share of the financial responsibility. That can be achieved with both incentives and disincentives.

Hitherto, the essence of the bargain is that people give up their right to fully subsidised care as public patients in return for more freedom to choose who (choice of doctor), when, where (choice of hospital) and what (some say in the procedure undertaken). And hitherto, Governments have attempted (and often failed) to combat the drift by changing the policy with respect to private health insurance (the fringe-dweller approach referred to in Part 1). But it has been a struggle because the "free" (taxpayer-funded) public system has that very powerful drawcard of no charge to the patient. Sooner or later, re-engineering of the system for stability will involve changes in Medicare as well. Australia will have to consider whether it can really afford to continue to offer its better-off citizens the right to enjoy fully subsidised care as public patients. In other words, can the cost of maintaining that right be reconciled with the willingness of the community to pay tax. There is a great

deal of "choice" in the notion of affordability. There are many things we could afford, but choose not to afford. Ultimately, the extent to which Australians can afford high quality health care will depend upon their willingness to trade off other spending priorities.

There is nothing radical about changing Medicare. Governments of both persuasions have been fiddling with Medicare all the way through, making all sorts of subtle changes in an endeavour to reconcile its cost with the willingness of taxpayers to pay taxes. There are, however, different ways to manage change. The surreptitious approach has the Health Minister standing with hand on heart denying that anything is changing. Under this approach, the public discover over time that not is all as it seems. The unguarded approach has the Health Minister declaring that things are changing and explaining why. Under this approach, the public get clear messages to change their own behaviour in response to the new policy. Part 4 looks at how we might achieve a stable health financing system in the future.

In the context of the Medicare promise of free care for public patients, some level of subsidy is necessary if we want people to voluntarily forego their public patient rights and to access care as a privately insured patient. The strong evidence from the past is that when that level of subsidisation is set too low, the pressures on the public health sector (both about the cost of Medicare and about public hospital workloads) become very difficult to manage, if not unmanageable.

2.3 Moral hazard and adverse selection

2.3.1 Moral Hazard

Moral hazard describes the tendency for people to over-consume health care because it is free, subsidised or cross-subsidised. Government uses different methods to try to moderate the effect of moral hazard in the different parts of the health system.

Evidence of moral hazard is found particularly among the ranks of the "worried well". However, the effect of moral hazard can be overstated very easily. Few people are breaking their necks to get into hospital. Operations and other procedures are not particularly enjoyable experiences. We would see a much larger moral hazard effect if we sought to finance restaurant meals or overseas vacations through a Medicare-style system. There are risks on the other side, risks of inappropriate under-utilisation of health care resulting in poorer health outcomes than could otherwise be achieved. The available evidence suggests that men are more likely to under-utilise health care than are women.

Under hospital Medicare, services to public patients are rationed by non-price queues. This is motivated by Budget pressures. Where there are no price signals, queues are necessary. Non-price queues involve administrative cost as the managers try to "hold the line" on expenditure while patients and doctors do what they can to get around the restriction and denial of service. Patients are not all equally able to negotiate the system and to act as their own advocates. But there is no objective way to measure whether or not there is over-consumption of services and whether or not some patients are getting "more than their share".

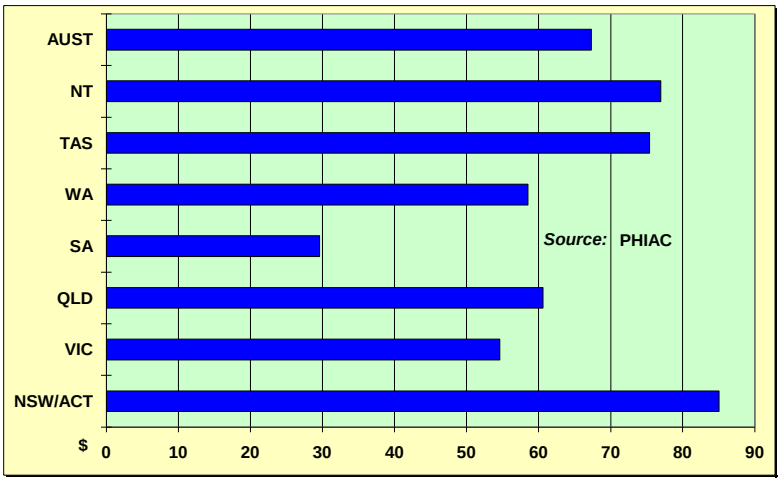
Under medical Medicare, the government relies mainly on price to ration access. Of course, medical Medicare is promoted as a benefit entitlement system and, since benefit

levels are subject to exactly the same Budget pressures as hospital spending, it is convenient to blame doctors for any out-of-pocket cost and to deny that services are being rationed through price barriers. There is a pretence that the MBS fee is a fair fee, even in cases where it is below the cost of producing the service. In relation to private in-hospital medical services, the task of managing moral hazard has been shifted to the private health funds.

There is anecdotal evidence that the "worried well" will pay for unsubsidised and uninsured services (such as full body scans) or that people will pay for higher quality services that public and private health insurance does not cover (such as MRI scans to ascertain the nature of sports injuries). It is important to understand that there is no moral hazard at play in those cases. Governments can step aside and allow markets to deal with such preferences.

A key issue is how we design the private health insurance system so that any distortion in demand due to moral hazard is minimised. It is contended here that we have not done a particularly good job of late. Insurance products that remove all medical gaps dampen already weak price signals and increase the risk of over-consumption. There is evidence that policy makers simply failed to understand the "problem", and therefore have adopted the wrong solution. The issue with medical gaps was always that they were very unevenly distributed. Not all patients encounter gaps and average gaps are very low, indeed under $100 in all jurisdictions in the year 2000-01 (see Chart 5 below). However, a small number of patients encountered very large gaps. Instead of dealing with that issue, governments went for a populist notion of trying to remove gaps for all. This has necessarily increased the cost of health insurance, and exacerbated perceptions that PHI was not affordable. We now have an unhealthy situation where there is pressure on the funds not to price the gap products correctly.

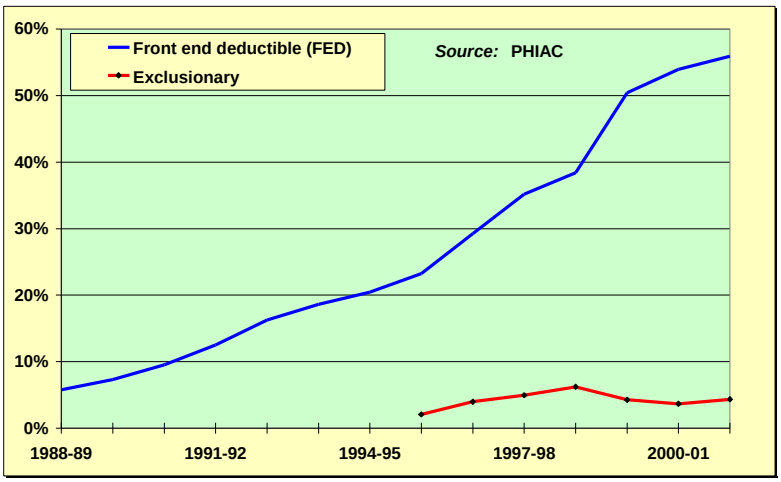
Chart 5: Average Gap Payment (where a gap was paid) 2000-01



For some years, the Government has been preoccupied with promoting gap insurance with the objective of removing or reducing gaps. These efforts may have been misplaced. Gaps themselves are not necessarily a problem. Large and unexpected gaps can be a significant problem, but they affect relatively few patients. Fund members have been expressing their own preferences, with more and more choosing front-end deductible (FED) policies. In short, the members are voting for "last dollar" insurance instead of "first dollar" insurance.

As Chart 6 shows, exclusionary policies (EX)[11] have not found a similar place in the sun. Instead, they have lost ground.

Chart 6: Proportion of Persons Covered by FED & exclusionary policies



The reasons for these trends are self-evident. FED products are familiar to everyone (car & house insurance operate that way). They help keep the premiums affordable. The amount the patient has to "kick in" is reasonably predictable, so people know more or less what they are up for and they can make an informed decision about whether or not an FED policy is value for money. Finally, FED products have administrative efficiency.

Exclusionary policies were developed in an attempt to appeal to the youth market. They made some small inroads after the introduction of the Medicare levy surcharge when they had some appeal to the "Claytons members" (those who purchased private health insurance primarily because that cost less than paying the surcharge). However, they did not ever achieve much popularity (peaking at 6.5% of the members in June 1999). Since then they have been in decline, partly because regulatory changes have reduced the scope to use an aggressive exclusionary policy to avoid the surcharge, and partly because the 30% rebate has made PHI more affordable. The attraction of exclusionary policies falls as members grow older and are perhaps more likely to need the excluded services.

The subsidies and cross-subsidies implicit in the public and private health insurance systems mean that moral hazard cannot be outlawed. But the effects of moral hazard on health system costs can be managed. In the private health insurance system, the best outcomes will be achieved where FED products apply. FED products do not avoid uninsurable gaps but are a little closer to "last dollar" insurance which is the conceptually the superior way to spread risk anyway (Medicare is "first dollar" insurance).

[11] Exclusionary policies do not pay private hospital benefits in respect of explicitly identified restricted services. These restricted services may include in-hospital psychiatric or rehabilitation treatment, cardio-thoracic procedures (including open heart and bypass surgery, and invasive cardiac investigations and procedures, such as angiograms), major eye surgery (cornea and sclera transplants and cataract surgery), hip and knee joint replacement surgery, Obstetrics related services, assisted reproductive services (such as IVF and GIFT). Benefits may still be payable limited to the Federal Government's Default Benefits, which means that members may be covered for treatment for items in the restricted list as a private patient in a public hospital. Note that all PHI policies are required by regulation to provide cover for psychiatric, rehabilitation and palliative care.

Exclusionary policies are not a particularly effective way to combat moral hazard given that they are most likely to be taken up by very low users of hospital services. That was not their intention. They were more a response to the intergenerational equity issues that were becoming more acute as the average age of fund members increased. Lifetime Health Cover is a rather more effective policy to deal with that issue.

2.3.2 Adverse Selection

Adverse selection is the tendency for a person's health status to determine their willingness to take out health cover. Those who are healthier (and, usually, younger) will be less inclined to take out cover. Those who are sicker (and, usually, older) will be more inclined to have cover. Overlaid on top is variation in risk averse behaviour. Some people are more inclined than others to take insurance not because they are ill, but because they are risk averse. Were we to assume that adverse selection is the main influence (and risk averse behaviour a minor influence), that raises the spectre that the ill are left sharing their risk with the ill, and the contribution (or, more explicitly, the cross-subsidy) from the healthy is missed[12].

The issues in adverse selection inevitably become intermingled with issues of intergenerational equity. Australia's private health insurance system is, in large part, a voluntary system. If the cross-subsidy required from the young and healthy is too large, they will tend to drop their cover. The old system of community rating meant that everyone paid the same premium regardless of age or health status. It had a veneer of fairness, and it was one aspect of private health insurance (perhaps the only one) that enjoyed bipartisan political support. But it allowed those joining private health funds later in life to enjoy lower lifetime health insurance costs at the expense of those joining at a younger age. It was built around two pretences, first that adverse selection did not exist and second that intergenerational equity was not a significant issue. Therefore, it was never sustainable in the long run in the context of a voluntary system.

Lifetime Health Cover (lifetime community rating) is primarily a response to issues of intergenerational equity. But it also mitigates the worst results that can be generated by adverse selection. For private health insurance to perform its role of sharing and spreading risk, there is a need for broad involvement by the community. That, in turn, requires an incentive structure to modify the behaviour of those who, in effect, sponge off the more risk averse members of the community. Lifetime Health Cover provides the incentive structure. The arrangements may need some fine tuning to ensure that the incentives remain appropriate. This is addressed further in Part 4.2.1.

2.4 Empowering patients

In Part 4.1, we predict that intergenerational pressures will heighten concerns about the burden on taxpayers from health costs and increase pressures for an expanded role for private financing of health care. At the same time, consumers will enjoy higher real incomes and be no less keen than they are now to enjoy the benefits of new health technologies. In exchange for greater freedom of choice as to the "who, when, where and what" of health care, consumers will have to expect to bear part, perhaps a larger part, of the cost of health care. Higher real incomes will mean that they also have the capacity.

[12] This is one of the arguments traditionally advanced in favour of compulsory contributions through taxes (Medicare) as opposed to a voluntary system.

This may mean that the core role for Governments will be to ensure that the less well-off in the community get access to health care on an equitable basis.

And if, as we speculate will be the case, the health system does evolve in the direction that patients assume a greater financial responsibility for health care in return for greater say on "who, when, where and what", it will be all the more important that patients are empowered to negotiate their way through health markets.

The ability to negotiate a way through health markets is not determined simply by whether on not the patient has buying power, but also whether or not they have good information. Private health insurance products can be very complex and confusing to consumers. There is a need for continued efforts to simplify the products and improve information to consumers. Some aspects of health care are also technically complex. An imbalance of information between producers and consumers does not prevent people accessing care, but it may make markets less efficient. Consumers may not understand how cars or computers work, but they still buy them. There is a need for some common sense. Consumers do not need to study for medical degrees in order to negotiate health markets. But more can be done to improve the quality of information[13], thus empowering consumers.

2.5 Effective subsidies

There are several broad means by which governments can support those who choose to access private health care:

> ***Subsidise producers directly***—the hope (or assumption) is that markets are sufficiently competitive so that any such subsidies are passed on to consumers in lower prices. In an economic framework, this option tends to be the least efficient way to provide a subsidy. The real cost of services is masked and depending upon where the subsidies are directed, the end result can be to distort patient choices towards the subsidised services.
>
> ***Subsidise the use of services through a benefit entitlement system*** (of one form or another)—an example is the private hospital bed-day subsidy that applied up until October 1986. Again, depending upon where the subsidies are directed, the end result can be to distort patient choices towards the subsidised service even though it may not be the most appropriate service. Furthermore, benefit entitlement systems tend by nature to be "first dollar" insurance systems and rarely meet the entire cost, leaving a trail of gaps to be picked up by the patient or by the private health insurance system.
>
> ***Pay subsidies to private health funds***—an example is the Government contribution to the PHI reinsurance pool that enjoyed its heyday from 1980-81 to 1982-83. Again, this is a sub-optimal solution as there is very little capacity to focus the subsidy on those who might need it most.
>
> ***Pay subsidies to PHI fund members***—examples are the current 30% rebate and the Fraser Government's PHI rebate that applied in 1981-82 and 1982-83. The essence of a PHI rebate is that it supports an insurance solution per se. Accordingly, it finds

[13] The current set of incentives for consumers fall well short of the best that we could achieve. We have ample evidence, for example, that tobacco smoking has very harmful health effects and that passive smoking effects can also harmful. Yet tobacco control is very significantly underfunded. Tobacco companies still appear to have considerable political clout to protect their business interests.

little favour with those who might prefer self-insurance (and therefore prefer to see subsidies attached to utilisation rather than insurance). That said, financing systems will inevitably respond to the wishes of the majority and the majority do want to be able to share the financial risk of poor health. Subsidies to PHI fund members are in several respects the most efficient way to provide support. They can be delivered relatively cheaply. They empower patients. They do not distort consumption patterns to the same degree as other options can do.

As noted in Section 2.2 and 2.4 above, there is an essential fairness in the notion that consumers accept more financial responsibility in return for greater freedom of choice about "who, where, when and what". In the context of the "free" (taxpayer funded) Medicare system, judicious subsidies to encourage the use of private care are a way to cement that bargain and to avoid intolerable pressures on the public system. But the various options for delivering subsidies are not all equal. Some are superior to others. In most cases, the best result is achieved by empowering the patient so that he or she is better placed to traverse the health marketplace, that is, providing the subsidy to consumers rather than to producers or funders. The 30% rebate fits the bill here. Consumer subsidies are more easily directed to those who need them most.

2.6 And the rebate?

The current subsidy arrangement is a 30% non-means tested tax rebate (which is mainly taken as a premium reduction) for private health insurance. There are a number of features of this system that score well:

Rebate versus deduction—since all cohorts of members pay the same premium under a community-rated (as per Lifetime Health Cover) system, a tax rebate (as opposed to a tax deduction) is strongly preferable. Since all within a cohort face the same price, there is no reason to provide greater assistance to those on the highest marginal rates of tax.

Universal versus means-tested—means testing adds far more to administrative costs than it does to fairness. Indeed, it can even reduce fairness. Means testing based on income alone is a gift to the asset rich/income poor (low income and poverty are quite different notions that do not always co-exist). Means testing based on both assets and income may encourage people to hide their assets and it runs into privacy problems. Means testing means arbitrary thresholds and poverty traps, and it increases the pressure for "opt out" models as those not eligible for the benefit are resistant to paying the tax. The best result comes from a universal benefit together with other measures to maintain the integrity of the tax system so that there continues to be appropriate transfers from the better off in the community to those less well off.

Administrative efficiency—the 30% private health insurance rebate is administratively efficient. By and large, the regular payments to some 40-odd private funds (where the rebate is taken as a reduction in the premium paid) deliver the subsidy to some 8.7 million Australians. There is scope to improve the efficiency. The option of claiming the rebate through a tax return adds needless cost. Recently, the Government announced that it plans to withdraw the premium reduction option from funds that do not meet performance standards. If pursued, this would punish the members for the failings of the funds. It is difficult to understand how such a silly proposal could have been adopted as policy.

Getting the level "right"—the PHIIS scheme (July 1997 to end 1998) failed to make any real impact because it was not a large enough subsidy to make PHI affordable. The 30% rebate has made PHI affordable and Lifetime Health Cover has provided an added incentive. The two policies together are an effective combination.

Some critics of the 30% rebate argue that it is too costly a way to make private health insurance affordable. It is of interest in this regard that the total cost of the rebate (estimated at $2.1 billion in 2000-01 and $2.2 billion in 2001-02) is very close to the amount the government would have been spending if it had kept in place the arrangements that pertained at the time Medicare was introduced. Table 1 provides estimates of those costs, based on indicators for 2001-02 (or 2000-01 where 2001-02 is not yet available).

Table 1: Estimated amounts of cost-shifting on private health funds

Item:	**$m**
Removal of the contribution to the reinsurance pool	**550**
Removal of the private hospital bed-day subsidy	**510**
Transfer of 25% of MBS fees for in-hospital medical services	**598**
Transfer from public to private hospitals	**590**
Total	**2,248**

None of this implies that the current policy strategy (the 30% rebate and Lifetime Health Cover) is free of flaws, or that the policy framework for private health insurance cannot be improved. On the contrary, the policy remains a "work-in-progress" with scope for much further refinement. These issues are discussed in Part 4. In summary, the rebate is a sensible way to support those who access private health care. There are some significant challenges ahead if Australia is to meet the needs and expectations of an ageing population. We've had thirty years of parochial policies as evidenced by the policy pendulum. Now it is timely to look for a model that ensures more stability, that fits the political middle ground, that finds ways to encompass patient preferences for greater say on "who, when, where and what" without breaking the budget, and that builds on the strengths of Australia's mixed public/private system. The 30% rebate represents a good start.

PART 3 THE CONTRIBUTION OF PRIVATE HOSPITALS

This part examines the structure and activity of the private hospital sector[14]. It assesses trends since 1995-96 and reports on the increasing contribution of the private hospital sector over this period to the care and treatment of patients. It is clear from the discussion below that the private hospital sector has become progressively more sophisticated in the range of services offered and is making an increasingly vital contribution to Australia's health system.

In 1995-96, private hospitals offered only 27 per cent of available hospital beds and treated less than one-third of all hospital patients. In five short years, private hospitals have expanded their bed-stock to nearly 32 per cent of all available beds and in 2000-01 treated 38 per cent of Australia's hospital patients. In 2000-01, the number of patients treated in public hospitals actually fell, while those treated in private hospitals increased by 245,000 (Chart 7).

Chart 7: Recent trends in hospital separations

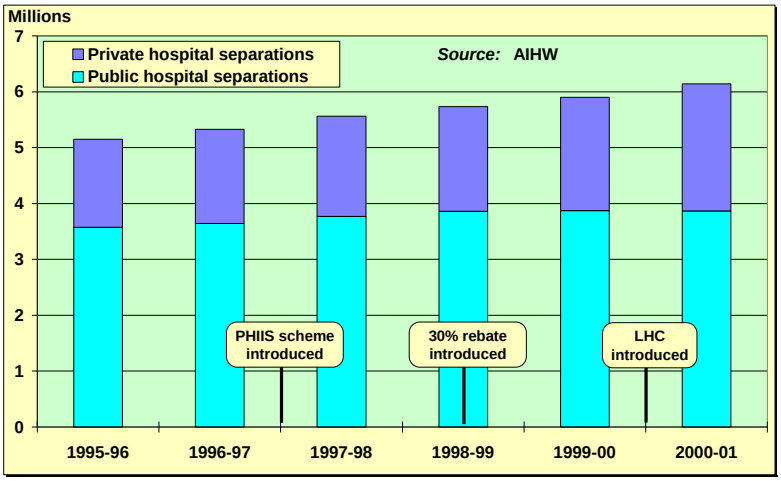
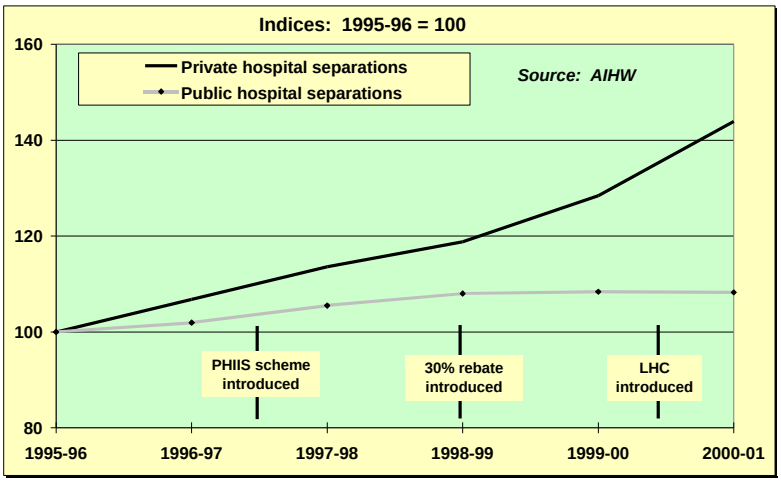


Chart 8 shows public and private hospital separations in index form.

[14] The private hospital sector includes private acute and psychiatric hospitals and private free-standing day hospital facilities.

Chart 8: Index of hospital separations



Public hospital separations in 2000-01 were only 8% higher than their level in 1995-96, while private hospital separations were 44% higher (as measured by AIHW). This remarkable turnaround has been the result of several factors, but the key initiative that began to turn the tide was the introduction in January 1999 of the 30 per cent rebate for private health insurance. It is now apparent just how much pressure has been taken off public hospitals as a consequence of the private health insurance incentives.

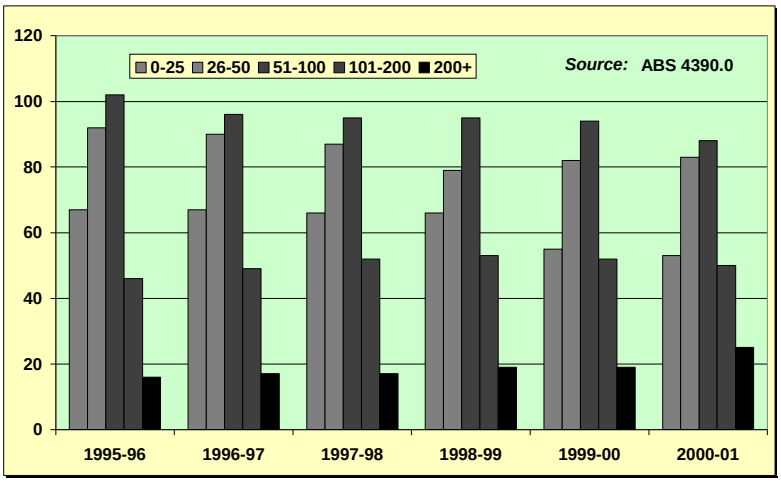
3.1 Structure and contribution of private hospitals

3.1.1 Hospitals and beds

In 1995-96, there were 323 private hospitals with some 22,757 beds. By 2000-01, the number of hospitals had fallen to 299 but the number of beds had increased by 7.5 per cent to 24,465. Over this same period, the number of public hospitals decreased slightly, from 756 in 1995-96 to 749 in 2000-01. However, the number of available beds in public hospitals fell by 12 per cent, from 59,720 in 1995-96 to 52,591 in 2000-01.

Chart 9 indicates the changes in the number of private hospitals of different sizes. Of note is the substantial decrease in the number of small hospitals (0-25 beds), which have declined by 21 per cent and the even more spectacular increase in the number of large hospitals (over 200 beds), which have increased by 56 per cent. A smaller, but still significant decline also occurred among private hospitals with 26-50 beds and 51-100 beds. There was a small increase over the period in the number of hospitals with 101-200 beds. This growth among larger hospitals has been a factor in the increased sophistication of services provided by the private hospital sector, which will be discussed in Part 3.3.

Chart 9: Number of Private Hospitals by Size, Australia

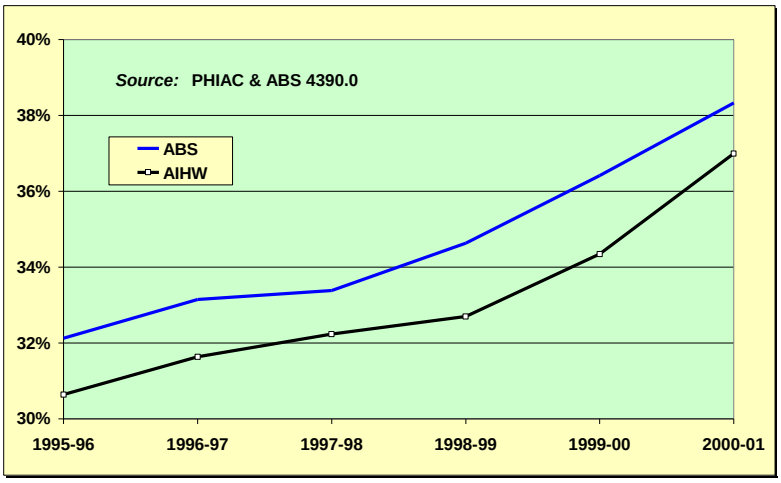


3.1.1 Patient Separations

The number of patients treated in private hospitals and private day hospital facilities has increased by 42 per cent since 1995-96 (as measured by the ABS), from 1.66 million to 2.35 million in 2000-01. Over this same period, the total number of patients treated in the private and public sectors has increased by only 19 per cent, from 5.17 million in 1995-96 to 6.14 million in 2000-01. The increased role of the private hospital sector in treating patients is even more evident in the period since the introduction of the 30 per cent rebate (introduced 1 January 1999). The number of patients treated in private hospitals has increased by 18.5 per cent in the period from 1998-99, compared to an increase of only 7 per cent in the total number of patients treated in both the private and public sector over this period. This has led to private hospitals increasing their share of total patients treated to almost 40 per cent.

Chart 10 indicates the increasing share of total patient separations that are provided in private hospitals and day hospital facilities.

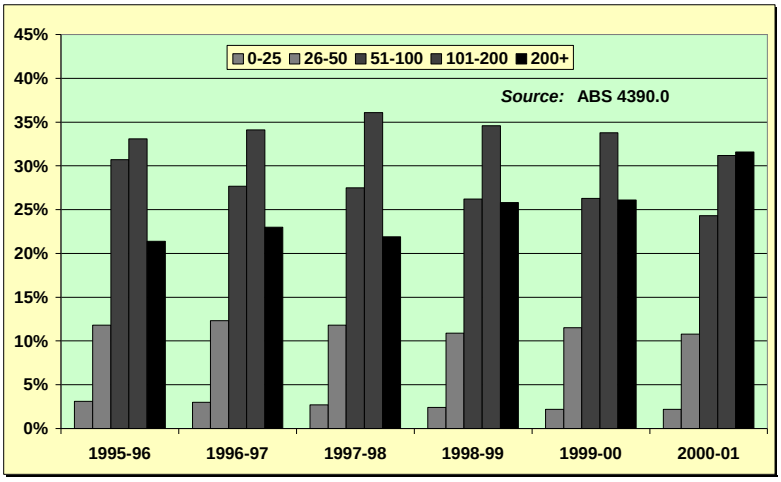
Chart 10: Private Hospital Share of Total Separations



The decline in the number of smaller private hospitals has been reflected in this segment of the market being responsible for a declining proportion of patient separations in the period

since 1995-96. Chart 11 indicates that the only hospitals that recorded an increase in the proportion of separations were those hospitals with more than 200 beds. These hospitals increased their share from a little over one-fifth of private hospital separations in 1995-96 (21.4 per cent) to almost one-third (31.6 per cent) in 2000-01, again reflecting the increasing sophistication of the private hospital sector over this period.

Chart 11: Separations by Hospital size (beds)—per cent of total



3.1.2 Changes in Hospital Classification

Allied to the increasing trend towards more larger hospitals, a feature of the period since 1995-96 has been an increasing trend towards group ownership. Although this has been a well-reported feature of the for-profit segment of the sector, it has also been apparent in the religious and charitable segment of the sector. As well as reflecting trends in other countries, this increased movement towards group ownership can be seen as a reaction to the funding environment for private hospitals, which changed significantly in 1995 with the passage through the Commonwealth Parliament of the "Lawrence reforms"[15].

In part, these reforms paved the way for the widespread use of contracts between private health insurance funds and private hospitals. A key and sustained effect of these reforms has been to enhance the power of private health insurance funds at the expense of hospitals, particularly small and independent private hospitals in negotiations over the level of benefits paid to hospitals for the treatment of health fund contributors. This is discussed in more detail later in Part 3.

The number of for-profit private hospitals has increased slightly, from 180 in 1995-96 to 182 in 2000-01 but the number of beds has increased by 16 per cent over the period, from 11,718 to 13,564. This represents 55.5 per cent of all private hospital beds, increasing from its 51.5 per cent share in 1995-96. At the same time, the number of hospitals in the not-for-profit sector has declined significantly, by more than 18 per cent, from 143 hospitals in 1995-96 to 117 in 2000-01. However, the number of beds in this segment of the private hospital sector has declined only slightly since 1995-96, from 11,039 to 10,901. This most likely reflects the fact that the charitable and religious segment operate the vast majority of large acute private hospitals.

[15] This term refers to the responsible Minister at the time, Dr Carmen Lawrence.

3.1.3 Staff employed in private hospitals

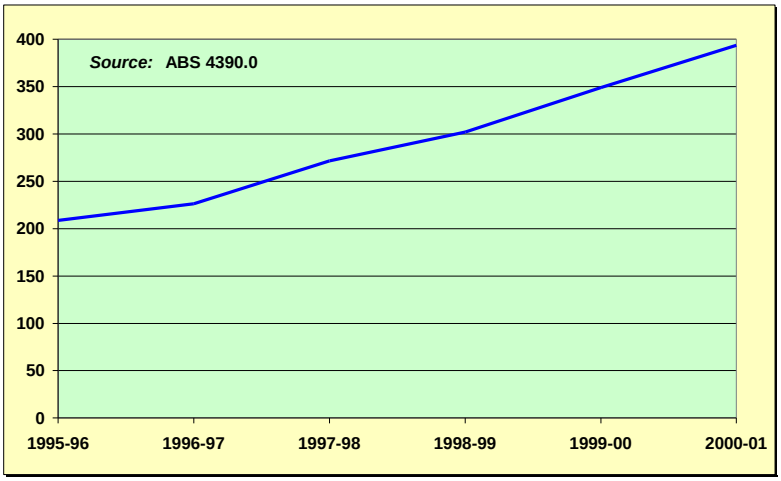
Total full-time equivalent (FTE) staff employed in private hospitals increased by more than 14 per cent, from 39,100 in 1995-96 to 44,720 in 2000-01. Despite difficulties in attracting and retaining nurses, the number of nurses actually increased by 17 per cent, from 19,545 in 1995-96 to 22,805 in 2000-01. Over the same period, total staff employed in public hospitals fell slightly, from 184,494 in 1995-96 to 182,995 in 2000-01. However, the number of nurses employed in public hospitals increased from 80,570 in 1995-96 to 82,476 in 2000-01.

3.2 Growth in free-standing day hospital facilities

The growth in free-standing day hospitals has been very significant over the period since 1995-96. The number of facilities has increased markedly, by some 55 per cent, from 140 facilities in 1995-96 to 217 in 2000-01. The number of FTE staff employed in free-standing day hospital facilities has increased by 79 per cent, from 889 in 1995-96 to 1,594 in 2000-01. When these staff numbers are combined with the number of staff employed in private hospitals, the private sector is now a very significant employer, accounting for more than 46,000 FTE staff.

The growth in the number of free-standing day hospital facilities has been reflected in an increase in the number of patients treated in the sector. Chart 12 indicates that the number of patient separations in free-standing day hospital facilities has almost doubled over this period, increasing from 209,000 in 1995-96 to 394,000 in 2000-01. Same day separations in other private acute and psychiatric hospitals have also increased strongly over the period (597,000 to 956,000), but the free-standing day hospital facilities have increased their share of the private same day workload (from 26% to 29%) over the period.

Chart 12: Free-standing Day Hospital Separations ('000)



3.3 Increased Sophistication of the Private Hospital Sector

Although its critics and ideologically driven sections of the media seek to dismiss private hospitals as places where only "lumps and bumps" are treated, it is quite apparent that the sector has become increasingly sophisticated in the range and types of treatment available to patients. This has been recognised recently in a report prepared for Australia's Health Ministers, which noted that:

> "*Over the last twenty years, there has also been growth in the capacity of the private sector, both in offering dedicated day procedure facilities and in offering a more complex range of services. With the exception of some super specialty services (such as transplantation), some large metropolitan private hospitals now offer comparable services to the major public teaching hospitals*."[16]

Increasing sophistication is evident also in the number of specialised wards and units located in private hospitals. For example, the number of cardiac surgery units in private hospitals has increased by 200 per cent since 1995-96. In addition, over the period between 1995-96 and 2000-01, the number of neo-natal intensive care units has increased by 42 per cent, the number of neurological units has increased by 175 per cent and the number of oncology units has increased by 144 per cent.

While there remain some differences in the mix of patients treated in the public and private sectors, the private hospital sector now provides a much wider range of services for patients. For example, comparing 1999-00 and 2000-01, private hospitals provided 35 per cent more renal dialysis services, 23 per cent more chemotherapy services and 15 per cent more major lens procedures.

Indeed, there are several key areas where private hospitals now provide more than 50 per cent of patient separations. These are listed in Table 2.

Table 2: Areas where private hospitals provide more than 50% of patient separations

Chemotherapy	50%
Major procedures for malignant breast conditions	53%
Cardiac valve procedures	56%
Other major joint replacement & limb reattachment	60%
Mental health treatment, sameday	65%
Major lens procedures	70%
Major wrist, hand & thumb procedures	70%
Knee procedures	75%
Sleep apnoea	81%

3.4 Benefits Paid for Private Hospital care

Private hospitals have only two sources of revenue:

? Benefits paid by third party funders (private health funds, compensation insurers, the Department of Veterans Affairs); and

? Charges levied directly on patients.

Since the passage of the "Lawrence reforms" in 1995, patient charges have been greatly reduced through the extensive use of contracts (Hospital Purchaser Provider Agreements)

[16] *Australian Health Care Agreements Reference Group Report*, "Interaction between hospital funding and private health insurance", 2002, p. 31.

between hospitals and health funds. Under these contracts, private hospitals generally agree to accept the health fund benefits as full payment for care and accommodation provided to patients with 100 per cent insurance cover.

Since the introduction of the 30% private health insurance rebate, PHI benefits for care and accommodation costs in private hospitals have fallen from 55% to under 50% of the total, while PHI benefits for care and accommodation costs in public hospitals have fallen from 5.9% to 4.6% of the total. This is due, in part, to productivity gains in hospitals (shorter average length of stay, more day surgery). But it is also due, in part, to what has happened with other benefits paid by private health insurance funds. Since 1995-96:

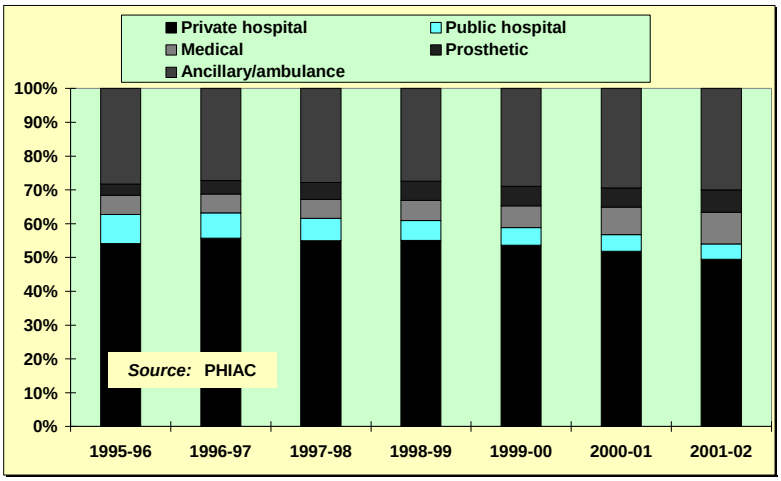
? benefits for ancillary services have increased to 30 per cent of benefits paid reflecting the efforts of the private health insurance industry to expand both the scope and the population coverage of ancillary cover;

? benefits for medical insurance have increased by two thirds reflecting the introduction of medical gap cover and the implicit transfer of the burden from Medicare to the private funds; and

? benefits for prosthetics have almost doubled their share of the total, reflecting among other things the increasing resort to private hospitals for elective procedures.

Chart 13 illustrates these changes in the share of total benefits over the period 1995-96 to 2001-02.

Chart 13: Selected Benefits as a Percentage of Total Benefits



Over the period since the introduction of the 30 per cent rebate, private hospitals and day hospital facilities have delivered resoundingly on the Commonwealth Government's stated objective of taking pressure off the public hospital sector. The private hospital sector has invested in new bed stock and equipment and now offers patients sophisticated and well-equipped hospitals capable of treating a wide range of conditions. Almost four out of every ten patients are treated in a private hospital and in many key areas the sector is treating more than 50 per cent of patients.

It will be of considerable concern if this increased effort by private hospitals is undermined by private health insurance funds directing their focus away from the central reason why many people contribute to private health insurance—so that when they require

hospitalisation, they can be treated in a hospital of their choice and by a doctor of their choice. Only private hospitals can offer this choice to patients.

PART 4 THE CHALLENGES AHEAD

Part 4.1 assesses the key developments that will shape health financing policy in the next decade or so. Part 4.2 discusses how policy with respect to private health insurance might evolve over that period.

4.1 Developments that will shape health financing

4.1.1 An Ageing Population

Any discussion of the impact of the ageing population sensibly starts with the issues raised in the Intergenerational Report (IGR) issued by the Federal Treasurer in the 2002-03 Federal Budget. The IGR is an important document. It seeks to kick start a debate about how we are going to meet the wants and expectations of an ageing population and still maintain a sustainable budget position. It raises issues without offering any solutions.

It is, in several respects, a flawed analysis of the "problem". To begin with, it assumes the task of assessing the impact of intergenerational pressures on the Federal Budget. If Australia is going to deal successfully with intergenerational pressures, then it is essential that we recognise that their impact is not limited to the Federal Budget. There are intergenerational issues also for State Governments and, importantly for this discussion, big issues for private health insurance. The recognition of intergenerational pressures was instrumental in the adoption of Lifetime Health Cover.

Secondly, the IGR is based on a number of rather controversial assumptions. These include what appear to be overly conservative approaches to the future growth of labour productivity and rates of workforce participation by older workers. The effect is some overstatement of the extent of future intergenerational pressures. This is perhaps a little unfortunate because even the more optimistic forecasters nonetheless foresee that some storm clouds are brewing. It would be better that Australia start to put in place some policies to handle intergenerational pressures than fritter all the time away arguing about whether we have to climb a large hill or a mountain. The sooner we start to adjust some settings, the less the long run pain.

Third, the IGR takes as a starting point an assumption that revenue is constant as a share of GDP. That is not our history. Much ado is made about the income tax cuts that are announced from time to time, but governments have been happy to allow fiscal drag to increase the tax burden over time.

Fourth, the IGR is built upon a very large number of assumptions, not all disclosed. One very important assumption is that new technology is a much stronger driver of growth in health care spending than the ageing of the population. That is a most difficult thing to predict. Health technologies can be very expensive and can increase costs because they also raise expectations. But in other cases, health technologies can be the source of very large savings in costs. What must be said here is that if health technologies offer patients more quality years of life, then the community's spending priorities will move that direction. Governments attempting to stand in the way of that (by tightly restricting access to new health technologies) run a risk of rapid relocation to the opposition benches.

In the years 2010 to 2025, the impact of an ageing population on health spending will be more acute. Australia will, of course, be a wealthier nation. That said, there may be relatively fewer taxpayers to shoulder the burdens of public spending programs. Ultimately, the level of taxation is a matter of choice determined at the ballot box. We can speculate, however, that the intergenerational pressures emerging in the years ahead will increase the pressures for a larger role for private financing of health care.

4.1.2 A Wealthier Population

The ABS household expenditure surveys show that as real wealth rises, consumers spend a higher proportion of their incomes on complex services—such as health, travel, other experiences—and a lower proportion on goods and chattels. A similar change in spending patterns is associated with age. There is a distinct drop-off in certain types of spending once people clear their fifties.

As Australia becomes wealthier, we can expect to see:

? more capacity for consumers to contribute to the overall cost of their health care;

? more willingness on their part to take financial responsibility for "discretionary" health spending; and

? a greater willingness to bear part of the cost of health care in exchange for greater freedom for the patient to choose the "who, when, where and what" of health care (and tertiary health care in particular).

In other words, there will be an increased appetite among better-off consumers for private financing of health care. This in turn will present governments with choices:

? they can continue to pursue the populist "middle class welfare" that is inherent in the current Medicare system; or

? they can concentrate more heavily on looking after the needs of those not able to afford private health insurance.

4.1.3 Quality and choice

In the perception of consumers, a fundamental aspect of quality in any market is to be offered choice. It is no less so in health care. There is food for thought here for the private health funds. If they seek to deal with cost pressures by restricting choice, they will reduce the value of their product in the eyes of consumers.

4.2 Policy evolution

4.2.1 Measured change

The current private health insurance policy framework (of which the 30% PHI rebate and Lifetime Health Cover are two important elements) has a great deal to recommend it in terms of delivering choice, industry stability, budget sustainability and equity. That does not imply, however, that there is no scope for improvement or that there will be no future need to adjust policy settings. No set of policies can stand still. There are always new challenges to be met. There will have to be continued improvement in private health insurance products if PHI is to play its role in helping the health system meet the

challenges of the future. What is needed now is measured change that is free of the pointless policy U-turns of the past thirty years.

To illustrate the scope for measured change, we will take Lifetime Health Cover as an example. We compare the situation of two mythical fund members, both with a lifetime expectancy of 80 years. Member A joins a fund at age 30, initially paying $2,000 p.a. We assume that fund premiums rise by 5% p.a. Member A has a lifetime premium cost of $441,631. Member B joins a fund at age 65, and pays 70% more than Member A for a lifetime premium cost of $443,683. At face value, the Lifetime Health Cover arrangements produce equivalent lifetime costs. However, when analysed in an economic context, the lifetime costs are very different. Economic analysis recognises that a dollar paid now is more costly than a dollar paid in the future, and dollar received now more valuable than a dollar received in the future, reflecting inflation and the investment potential of the dollar in the hand.

The two streams of payments can be reduced to a single common denominator, or a comparable figure, by applying a discount rate. Were we to use a modest discount rate of 10% p.a., the net present value of the lifetime premiums paid by Member A is $36,270, more than five times the net present value of the lifetime premiums paid by Member B of $7,007. Using a lower discount rate reduces the gap, but the essence of the issue remains that the premium penalty imposed on those who join a fund after the age of 30 is relatively modest. If the Government is keen to get younger people to join private health funds, then it may have to consider a larger "stick" in Lifetime Health Cover, one that goes closer to equalising lifetime premium costs in net present value terms.

In the case of the scenario above, the penalty required to equalise the lifetime premium costs in net present value terms is that premiums would need to increase by an extraordinary 22% for each year past age 30.

The following sections canvass some of the options for evolution in health financing policy in the future. Some of these are short-term options involving small change. Others are for the longer term.

4.2.2 Medicare entitlements

As noted in part 2.1, PHI has been treated often as a "fringe-dweller" on the outskirts of Medicare. But as PHI becomes a relatively more important part of the health financing system, there will be need for more consideration of the chemistry between PHI and Medicare.

That will inevitably involve questions as to whether Medicare entitlements in their current form are sustainable. In the current framework, consumers can "game" the system, using their private health cover when that suits and using their Medicare entitlement when that suits. That freedom to game the system may have to be traded off if consumers wish to see Governments continuing their support for PHI. In time, therefore, the current 30% rebate may have to evolve in steps into a transferable Medicare entitlement. This would preserve the universality of the health financing system, but would in time allow for a more rational system. This is an option for the long term.

4.2.3 Health Savings Accounts

Another option worth investigating for the long term is health savings accounts. These, it must be stressed, are not a complete alternative to private health insurance. On the contrary, they ought to be seen a complementary measure. Health savings accounts help patients better meet their lifetime out-of-pocket health costs. They do not perform a risk-sharing role.

The notion of private saving to ease intergenerational pressures is not new. The SG (or superannuation guarantee) arrangements introduced in the early 1990s were in response to expected pressure on Budgets from aged pensions. At the time the SG was introduced, little thought was given to health care.

With relative ease, the current occupational superannuation accounts could become health and superannuation accounts. There is no need to duplicate the structures or the administration.

4.2.4 Straddle Strategies

The lessons from the past are that once having put subsidy structures in place, Governments are then tempted to follow cost-cutting strategies that eventually result in the systems ceasing to achieve fully their original objectives. In the case of health care, this invariably results in consumers drifting back to rely on public health programs. By way of example, the decay in medical Medicare has led to growing price signals. The inevitable response is bulging A&E waiting rooms in public hospitals.

The success of strategies to keep PHI viable depends not only on pitching the subsidy high enough to make PHI affordable to the target groups, but also ensuring that the Budget cost of the rebate is sustainable. The issue is how to straddle these two conflicting pressures.

One option is to more sharply focus the rebate on hospital care. That may mean, for example, no rebate or a reduced rebate in respect of ancillary cover. In Part 3, we saw how the proportion of benefits paid by private health insurance funds for ancillary services is increasing over time (see Chart 13).

4.2.5 Red Tape Reduction

The private health insurance industry is one of the most tightly regulated industries in Australia. This very tight regulation increases costs, stifles initiative and innovation and acts as a barrier to new entry to the industry. It breeds dependency and it breeds indifference.

The Government has very recently completed an internal review of regulation. It is open to debate whether the review has resulted in a decrease or a further increase in regulation.

The regulation is too often self-defeating. The Government regulates reserves for prudential reasons and it regulates prices. It is theoretically possible that the Government could force a fund into default in relation to prudential reserves by refusing to approve necessary price increases. Ultimately, the kindest comment one can make about the regulation of price (apart from the fact that it does not work) is that it shows the

Government's lack of faith in competition between the funds to keep prices in check. And that, of course, points to the solution.

Regulation of PHI cannot be avoided. Some elements of regulation are essential to protect consumers. They make a positive contribution to making PHI a desirable product. The Private Health Insurance Administration Council (PHIAC) has done a very good job in collecting and presenting information on private health insurance. This is precisely what is needed to assist consumers to deal with what can be a very complex and confusing product. Given that the internal review has proven to be a damp squid, what's needed now is a serious external review of regulation of PHI and the fearless application of competition policy to the industry.

4.2.6 Issues in Health Care Delivery

It would be foolish to imagine that the failings in the health system are all failings in the health financing system and that changes can be limited to that system. There are many issues in health care delivery where there is scope for improvement and innovation. Australia does achieve high quality health care, but investigations of quality nonetheless indicate much scope for improvement. The strict regulation of the business of the funds is an obstacle to innovations such as the funding of step-down facilities that could reduce the cost of acute care. Evidence-based medicine has not yet gone far enough. Training can be improved. There are workforce issues to be resolved (eg, the shortage of nurses).

The silos mentality and territorial issues invariably get in the way of resolving these issues. Private health funds could give more thought as to how they could be agents for desirable change over the longer term.

Appendix A: PHI Policy Timeline

Year or month	Policy event	In term of—
1975	**Medibank** introduced (taxpayer funded medical insurance), reducing the role for voluntary private health insurance.	Whitlam Government
October 1976	**Medibank Mark II** introduced. This was an "opt-out" model involving a **Health Insurance levy** (a tax levy) imposed on taxpayers who did not have private health insurance (for themselves and their dependents) and who did not quality for pensioner medical or repatriation benefits. **Medibank Private** created (and operated by the Health Insurance Commission) to compete with other private health insurance funds.	Fraser Government
November 1978 to 1981	**Health Insurance Levy** discontinued. Further evolution towards to voluntary model, with full benefits restricted to the disadvantaged.	Fraser Government
July 1981	Introduction of a **PHI tax rebate** for basic medical and hospital cover only.	Fraser Government
1982-83	**State government levies** imposed on private health funds.	State governments
July 1983	Abolition of the PHI **tax rebate**, temporarily replaced by a rebate for out-of-pocket health expenses.	Hawke Government
1983-84 to 1987-88	The Federal Government's **subsidy to the private health insurance reinsurance pool** phased out over a five-year period (in 1982-83, the level of the subsidy was of the order of $100 million p.a.).	Hawke Government
February 1984	**Medicare** implemented. All medical insurance was nationalised—private health funds were not permitted to offer any insurance cover for medical services.	Hawke Government
November 1985	Private health funds **required to cover 15% of MBS fees** for private in-hospital medical services.	Hawke Government
October 1986	The Commonwealth Government's **bed-day subsidy for private hospital utilisation** discontinued. In the last full year of operation (1985-86), the expenditure on the subsidy was $135 million.	Hawke Government

Year or month	Policy event	In term of—
November 1987	Medicare benefits payable on private in-hospital medical services **reduced from 85% of the MBS to 75%**, and the private health funds required to increase their cover from 15% of MBS fees to 25%.	Hawke Government
July 1993	New 5-year Medicare Agreements provided significant **incentives for public hospitals** to increase their throughput of public patients and reduce throughput of private patients, this shifting workload to the private hospital system and shifting costs to the private insurance system.	Keating Government
1995	Legislative approval for private health funds to enter into **agreements** with doctors and hospitals, establishing a framework in which hospital gaps were all but eliminated and medical gap insurance permitted.	Keating Government
July 1997	**Private Health Insurance Incentives Scheme** (PHIIS) commenced.	Howard Government
July 1997	**Medicare levy surcharge** for high-income earners without private health insurance (1% of taxable income in addition to the 'standard" levy of 1.5%).	Howard Government
January 1999	**Private Health Insurance 30% rebate** commenced.	Howard Government
July 2000	**Lifetime Health Care** (lifetime community rating) commenced. This links the premium payable to the age of the member upon joining. Those aged up to 30 when they join pay the normal premium provided they maintain continuous cover. For those joining or rejoining past the age of 30, there is a 2% loading on the premium payable for each year of age (to a maximum loading of 70%).	Howard Government
August 2000	Legislative approval for **medical gap cover schemes** that permit private health funds to offer gap insurance without needing to have agreements with medical practitioners.	Howard Government

Appendix B: Econometric Analysis

In undertaking an econometric analysis of the coverage of private hospital insurance, it was judged that affordability was a more appropriate indicator to analyse than price per se. Affordability relates the cost of private health insurance premiums to household disposable incomes. Pure price measures (measures which do not also include quality change) are difficult to come by.

We conducted a simple regression analysis of the relationship between the affordability of private health insurance and the rate of coverage. The reason for conducting a simple regression analysis rather than a multiple regression analysis is that there is no satisfactory way to quantify the impact of the other factors that, at one time or another, have had a significant impact on coverage. These factors are the "sticks", the fear factor, the desire to jump queues, members satisfaction with private health funds & products, and the impact of intergenerational equity issues.

The best "fit" occurs for a one-year lag between a change in affordability and a change in coverage.

The relationship between affordability and coverage is expressed in equation terms as follows:

$$C_n = 0.1388 + 0.003799 * A_{n-1}$$

Where:

C = Coverage of private hospital insurance expressed as a percentage of the population; and

A = Index of the affordability of private health insurance, calculated as the inverse of the ratio of PHI contributions per person covered to household disposable income per capita and expressed as an index where 1984-85 = 100.

The results of the regression, the intercept (13%, t=4.8) and correlation coefficient (0.04, t=9.4), are significant beyond the 99.95% confident interval.

The regression equation suggests that if the affordability index fell to 0, the following year PHI coverage would be around 14%. At the other extreme, the affordability index would have to rise to over double its 1984-85 level before coverage would approach 100% of the population. That said, the regression may be less stable at the extreme ends, and would need to be re-estimated in the highly unlikely event that real prices swung to this extent. There is good predictive power in the middle range of the equation, however, when the affordability index ranges between 50 and 100.

Data:

	Affordability index	Actual coverage	Fitted coverage
1984-85	100	48.0%	51.9%
1985-86	98	48.9%	51.1%
1986-87	86	48.7%	46.7%
1987-88	78	47.4%	43.6%
1988-89	82	48.3%	45.1%
1989-90	78	44.8%	43.6%
1990-91	71	44.3%	40.9%
1991-92	61	41.8%	36.9%
1992-93	57	40.1%	35.5%
1993-94	55	38.0%	34.8%
1994-95	55	35.8%	34.9%
1995-96	54	34.0%	34.5%
1996-97	53	32.8%	33.9%
1997-98	53	31.3%	34.2%
1998-99	59	30.3%	36.5%
1999-00	73	34.3%	41.7%
2000-01	81	45.1%	44.8%
2001-02	#N/A	44.5%	#N/A

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