For information

Legislative Council Panel on Health Services
Subcommittee on Health Protection Scheme

Synopsis on Private Health Insurance in Australia (Update)

Purpose

Take-out of private health insurance (PHI) on a voluntary basis is actively encouraged by the government in Australia. This is achieved mainly through financial incentives and disincentives, together with a legislative framework to regulate activities in the PHI market. In response to the request of Members of the Subcommittee on Health Protection Scheme, this note provides an updated synopsis on the policy framework and observed situation of PHI in Australia[1].

Overview

2. The policy direction to actively promote PHI take-out dates back to the mid-1990s when the Australian government saw the declining population coverage of PHI as an undesirable sign of health system development. The population coverage of PHI plummeted from more than 60% in 1984 when Medicare the social health insurance system was introduced to only 34% in 1996. This situation did not align with Australian government's policy desire to encourage the development of a twin-track healthcare financing and delivery system whereby the private segment can operate and advance in parallel with the public sector.

3. The Australian government started to actively intervene in the PHI market in the latter part of 1990s. It has since introduced a lot of financial and regulatory measures to ensure affordability and value of PHI as a product, and enhance access of the insured population to private healthcare. In particular, all PHI products are required to meet the requirements under the regulatory framework (e.g. coverage scope and community-rating), and they cannot cover primary or specialist out-patient care or other healthcare services or pharmaceutical products funded by Medicare or Pharmaceutical Benefits Scheme. The population coverage of PHI coverage rises back to 54% as of June 2012[2].

Incentives and Disincentives

4. The Australian government adopts a "carrot-and-stick" approach to encourage PHI take-out. In July 1997, it implemented the Private Health Insurance Incentives Scheme by which the government started to partially rebate premium paid by individuals for eligible PHI plans that fulfill the statutory requirements. Employees whose PHI plans are paid by their employers are also eligible for the rebate.

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[1] This synopsis is an update of that submitted to Panel on Health Services on 7 January 2011, which had made reference to the consultancy report "Local market Situation and Overseas Experience of Private Health Insurance and Analyses of Stakeholders' Views" submitted by the Milliman Limited to the Food and Health Bureau in October 2010 for the purpose of devising the proposed Health Protection Scheme, as well as other sources of data and information. The reference sources concerned are not liable to misinterpretation of data and information if so occurs in this synopsis.

[2] Hospital Treatment and General Treatment Cover Combined.

5. On the "carrot" side, eligibility for premium rebate was initially income tested, with the rebate amount depending on the household size of those eligible. The income test was abolished from 31 December 1998 to 30 June 2012, but was re-introduced as from 1 July 2012. The rebate amount before April 2005 was open-ended at 30% of the premium amount, meaning that a more expensive PHI plan attracts a larger amount of rebate. Since April 2005, the rebate percentage has been increased to 35% for age 65-69 and 40% for age 70 and above.

6. On the "stick" side of the two-pronged approach, the government imposed in July 1997 a 1% Surcharge on top of the standard 1.5% Medicare Levy (applicable to all Australian residents) on high income earners who do not have an appropriate level of PHI hospital cover. The thresholds of high income earners and adequacy of insurance cover are subject to regular review. From July 2012, the scale of the Medicare Levy Surcharge has been adjusted and the maximum Surcharge has since reached 1.5%.[3] In order to be exempt from the Surcharge, the PHI hospital cover must have an annual upfront deductible of A$500 or less for an individual and A$1,000 or less for a family/couple.

7. Targeting at the young population in particular, the government introduced the Lifetime Health Cover (LHC) program applicable to hospital plans in July 2000. By LHC, a person starting to take out a hospital plan after age 30 is charged a loading in addition to the base rate premium[4] for the hospital plan. The loading is 2% for each year a person delays joining after age 30, subject to a ceiling of 70%. The loading is removed after 10 years of membership. For example, a person starting to purchase PHI at age 40 would be charged 20% above the base rate premium that applies to those starting to enroll at age 30 or below, and this 20% loading would apply until age 50.

Regulatory Framework

8. The Private Health Insurance Act provides a legislative framework to regulate pricing, products and other aspects of PHI business in Australia.

Guaranteed Issue, Renewal and Portability

9. To ensure that people with high health risks can gain access to PHI protection, insurers are prohibited from selecting customers. There is no right of refusal on the part of insurers in handling new enrolments and renewals of insurance contracts. Moreover, no premium loading except LHC loading is allowed, and the entry age is not restricted. This enables consumers to enjoy guaranteed access to PHI regardless of age and health status.

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[3] 2012-2013 Income thresholds for PHI Premium Rebate and Medicare Levy Surcharge

	Base tier	Tier 1	Tier 2	Tier 3
Singles	A$84,000 or less	A$84,001-97,000	A$97,001-130,000	A$130,001 or more
Families*	A$168,000 or less	A$168,001-194,000	A$194,001-260,000	A$260,001 or more
Rebate entitlement				
Under 65 years old	30%	20%	10%	0%
65-69 years old	35%	25%	15%	0%
70 years old or over	40%	30%	20%	0%
Surcharge				
Rate	0.0%	1.0%	1.25%	1.5%

*The family income threshold is increased by A$1,500 for each dependent child after the first child.

[4] PHI base rate premium is community rated by law (see paragraph 24).

10. PHI coverage is guaranteed for life. Insurers do not have the discretion to cancel insurance contracts or refuse their renewals so long as premium payments are not overdue.

11. The insured persons can move from one insurer to another without barrier. The new insurers must provide continuity for the waiting periods that the insured have already served, and cannot impose additional waiting periods except for the extra benefits in the new PHI plans.

Standardized Coverage

12. PHI is supplementary to Medicare. Currently, Medicare finances Australian residents in full the costs of being a public patient in a public hospital. Based on the Medicare Benefits Schedule (MBS)[5], it also finances 75% of doctor fee for a private patient in a public or private hospital[6], 85% of doctor fee for out-patient care by a specialist and 100% of doctor fee by a general practitioner. Medicare also partially pays for the costs of most prescription medicines under its Pharmaceutical Benefits Scheme (PBS)[7]. However, Medicare does not cover hospital charges for private patients, such as room accommodation and operation theatre fees. It also excludes ambulance services, dental care, physiotherapy and home nursing.

13. A PHI plan can be a hospital treatment plan, a general treatment plan, or a plan bundling hospital treatment with general treatment. Hospital treatment plans supplement Medicare by paying for that part of doctor fees that Medicare does not reimburse, and also hospital charges for private patients that Medicare does not cover. General treatment plans pay for non-hospital care that Medicare does not cover.

14. There are mandates on what insurers must cover in hospital plans, mainly for the sake of encouraging the insured patients to receive treatments in the private market. As a pertinent example, all hospital plans must cover at least the 25% co-payment of doctor fees for private patients according to MBS. Besides, all insurers are required to offer at least one "no medical gap" or "known medical gap" hospital plan[8]. They are also required to offer at least one hospital plan which covers the so-called default benefits, which is equivalent to the amount that a public hospital would charge a private patient in a shared room.

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[5] Medicare Benefits Schedule provides a comprehensive list of health service fees determined by the Commonwealth government in consultation with professional bodies. Based on this Schedule, Medicare benefits are provided to patients in the form of reimbursement on fees paid to private medical practitioners for both out-of-hospital and in-patient services.

[6] Different from a public patient, a private patient has the choice of doctor in public or private hospitals.

[7] The Pharmaceutical Benefits Schedule (PBS) provides the basis for Medicare to reimburse part of the cost in buying medicines. The PBS now has a very comprehensive list of prescription medicines. Except for some medicines which are dispensed only through hospital pharmacies, most of subsidized medicines can be dispensed through private community-based pharmacies.

[8] Medical gap refers to the difference between actual in-hospital doctor fees and the sum of Medicare benefit and PHI benefit. If a patient's doctor has a gap cover arrangement with his insurer, the patient enjoys no or limited known out-of-pocket payment due to the medical gap. The doctors participating in this arrangement are required where possible to make known their fees to their patients before treatments or procedures.

15. There are also mandates on what insurers must not cover. All PHI plans are prohibited from covering out-of-hospital medical services that are funded by Medicare (including consultations with specialists and general practitioners) and co-payments on pharmaceuticals listed in PBS under Medicare. These restrictions are intended to contain moral hazard which is inherently more severe for outpatient care.

16. Notwithstanding the aforesaid standardization measures, insurers are allowed to expand or reduce coverage to suit different customer needs and affordability. For example, insurers may provide more affluent enrollees with increased offer that pays for doctor fees considerably in excess of the MBS level. They may also provide reduced coverage excluding obstetrics and cataract to target at young singles.

Benefit Limits

17. No overall benefit limit in a year is permitted for hospital plans. However, an insurer is allowed to enter into contract with selective hospitals and doctors that specify maximum amount payable for a care item or episode which can be defined by Diagnosis-Related Grouping (DRG), International Statistical Classification of Diseases and Related Health Problems (ICD) or MBS. It is quite common nowadays for insurers to make use of case-based payment model as the basis to reimburse healthcare providers in Australia.

18. Overall benefit limit is permitted for general treatment plans. Some insurers set their benefit limits by calendar year or contract year. Some insurers also put a lifetime limit on certain elective benefits, such as orthodontic benefits.

19. All benefits of PHI plans cannot exceed the actual costs spent. This regulation adheres to the principle of indemnity, meaning that the insured persons cannot pocket income through PHI.

Limitations against Exclusion of Pre-existing Conditions

20. Insurers are not allowed to exclude coverage of pre-existing conditions after the insured have served the waiting period. The length of waiting period allowed is up to 12 months on hospital benefits for any medical condition the signs and symptoms of which existed during the 6 months before the insurance contract commences. The insurers are allowed to impose a waiting period up to 12 months for treatments relating to an obstetric condition, and up to 2 months for all other benefits when a person first takes out PHI.

21. Under the general treatment plans, insurers are permitted to impose a longer waiting period, usually 2-3 years, for certain expensive items such as blood glucose monitors and hearing aids.

Cost-Sharing Arrangement

22. There is no restriction on the cost-sharing arrangement in the PHI contract. However, hospital plans with deductible exceeding a certain level would not exempt high income earners from the Medicare Levy Surcharge.

23. Insurers are free to introduce cost sharing components such as deductible and co-insurance in the PHI contracts with the effects of lowering the insurance premium. Many insurers also make use of such components to prevent claims caused by moral hazard.

Premium Control

24. PHI premium is community-rated by law. It means that each insurer is required to charge all its customers regardless of age and health risks a flat premium for the same product. This control can prevent insurers from using prohibitive premium loading to drive away high-risk enrollees without breaching the guaranteed issue rule in principle. Also, community-rated premium is more affordable to people with higher health risks due to implicit cross subsidy by people with lower health risks. Insurers are allowed to set their own premium levels for their products and vary the premium levels of same products by state/territory (but not regions within a state). Insurers can also vary premium by six classes of membership: singles, couples, single-parent families, no-parent families and families with three or more adults.

25. Increases in the community-rated premium rates of PHI products have to be approved by the Commonwealth Department of Health and Ageing (CDHA) in advance. Applications for premium rise have to be filed with CDHA and the regulator of the PHI industry i.e. Private Health Insurance Administration Council (PHIAC), about 6 months prior to the date of increase (usually April 1). Upon the advice from PHIAC, CDHA will ask those insurers to re-submit applications if the rate of increases are deemed excessive. After all applications and re-applications are approved, CDHA will announce to the public the average increase for the industry and for each insurer.

26. In processing the premium increase applications, CDHA is concerned with whether the increase is in public interest and is obliged to disclose the reasons for not approving an application. The public interest in relation to premium adjustment pertains to the minimum rise necessary to ensure insurer solvency, support benefits outlays, and meet prudential standards concerning capital adequacy, while also ensuring the affordability and value of PHI as a product.

Risk Equalization

27. Because of the guaranteed issue requirement and community-rating of insurance premium, an insurer may have a relatively older and less healthy customer profile compared with its competitors. This will put the financial position of the insurer concerned and hence the interest of their consumers at risk, and will distort market competition. In order to enable level playing and maintain financial viability of the PHI funds, PHIAC administers a risk equalization system which transfers and shares costs across all insurers according to their risk profiles. In a nutshell, the system transfers payment from those with lower-than-average risk exposure to those with higher-than-average risk exposure.

28. The risk equalization system has two major components. The first is the pooling of the claim costs for people aged 55 and above who receive hospital care within a state. The proportion of claim costs for this pooling rises with age, from 15% for age 55-59 to 82% for age 85 and above. The second component is a high cost claims pool

whereby claims over A$50,000 for one year for a person are pooled for payment transfer, except those that are already pooled by the first component.

29. To enable a fair distribution of costs, PHIAC obtains from each insurer an enormous amount of summarized data in every quarter to calculate the appropriate amount to be received or paid by an insurer under the system.

Market Transparency

30. Market transparency is achieved through mandatory disclosure of information. Each year, all insurers are required to report the up-to-date key features of each product they offer to the Private Health Insurance Ombudsman (PHIO) in a standard format that is uploaded on the government website for public information. PHIO also publishes an annual report on the state of the PHI industry, showing the number and types of complaints received for each insurer and ranking them in terms of complaint incidents per policyholder.

31. Besides, CDHA announces the average approved premium increase for the PHI industry every year. Starting from 2010, it also makes available for public information the approved average premium increase for individual insurers to show how it compares with their competitors and the industry average.

32. PHIAC positions itself as a collector, repository and publisher of useful information about PHI. It regularly collects and disseminates financial and statistical data about the PHI industry and individual insurers to assist consumer decision.

Quality Assurance

33. Insurers normally do their own quality assurance of hospital providers and do not contract with providers who are not up to the mark. They would not establish or renew contracts with hospitals that are not accredited with the Australian Council of Healthcare Standards (ACHS). Insured patients can use hospitals not contracted with their insurers but the benefits are usually much lower.

34. Insurers also use extensive utilization review procedures to examine lengths of stay and re-admission rates by procedure in hospitals, and may refuse to renew contracts with those hospitals that do not measure up to established norms even though they are ACHS-accredited.

35. Insurers are allowed to establish contractual agreement with individual medical practitioners covering provision of medical services under hospital settings. Such an agreement facilitates price negotiation and enables the insurers to offer 100% insurance for in-hospital doctor fees when they exceed the MBS level.

36. Insurers are prohibited from interfering with the clinical freedom of medical practitioners. However, they may refer suspected cases of inappropriate practices, such as excessive order of services, to the Professional Services Review (PSR) so long as the care also attracts Medicare benefits. PSR is a statutory authority set up by the Parliament to examine health practitioners' conduct to ascertain whether or not they have practiced inappropriately in relation to services and drug prescriptions which attract Medicare benefits, including those linked with MBS and PBS. The assessment is conducted through a

peer review mechanism and the results may lead to sanctions for the practitioners.

Appeals Mechanism

37. PHIO is responsible for resolving complaints related to PHI and acts as an umpire in dispute resolution. Apart from consumers, insurers, medical practitioners, hospitals and insurance brokers may also lodge complaints to PHIO so long as the issues are related to health insurance. Though it does not have direct coercive power, his annual report could lead to the naming and shaming of recalcitrant insurers in the press.

38. Reporting directly to the Minster of Health and Ageing, PHIO can alert the Minister of an insurer causing industry dispute and draw closer regulatory attention to its business conduct, financial position and premium rise application.

Regulators

39. PHIAC is an independent statutory authority that regulates the PHI industry. By the Private Health Insurance Act, PHIAC aims to achieve an appropriate balance between the following objectives: (i) fostering an efficient and competitive health insurance industry; (ii) protecting the interests of consumers; (iii) ensuring the prudential safety of health insurance funds.

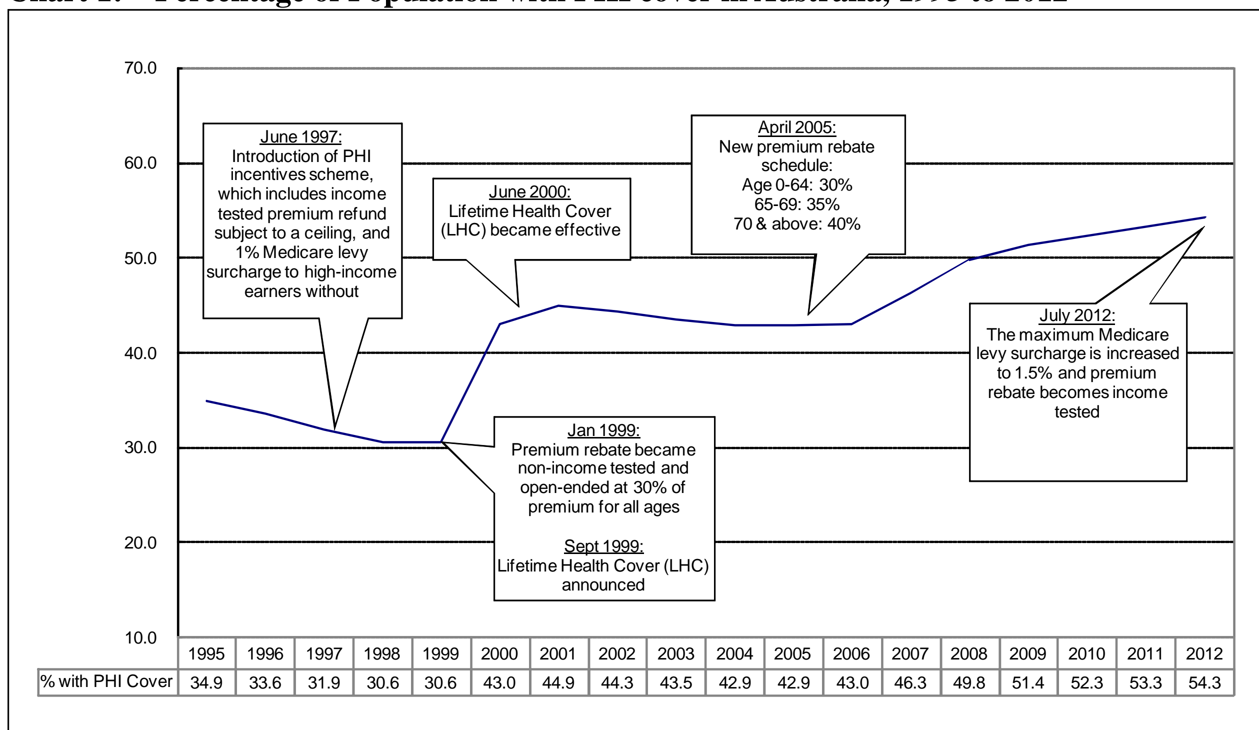
40. PHIAC positions itself as a custodian of both public and consumer interests in dealing with the PHI industry and as an effective and valued adviser to the government and the parliament. In advising CDHA on premium increase approvals, for instance, PHIAC examines the applications to ensure that the premium increases sought are compatible with the continuing prudential security of the insurer, while protecting consumers from unwarranted or unjustified increases.

41. For the sake of prudential supervision, PHIAC obtains informal advice from the Australian Prudential Regulatory Authority (APRA) which is the prudential regulator of the entire financial services industry and oversees life and general insurance as well as banks, building societies, credit unions and the like.

Population Coverage of PHI

42. The incentive from premium rebate and the disincentive from Medicare Levy Surcharge initially had limited effects on the population coverage of PHI in the late 1990s which stayed low at around 30% (Chart 1). Yet the coverage subsequently surged to 43% in 2000 when the government implemented LHC and concurrently launched a massive public promotion campaign with the theme “Run for Cover”. Some observers opine that these efforts created a sense of urgency and made the final push for some people especially the young to enroll and avoid the LHC loading. Yet after this spurt, the coverage of PHI stabilized at 43-45% until 2007. From 2007 to 2012, the coverage resumed increase and reached 54% in 2012. This pick-up was partly due to the stimulus of higher old-age premium rebate to elderly enrolment as from April 2005. Also contributed was increased enrolment of young to middle-aged population amidst steady economic growth.

Chart 1: Percentage of Population with PHI cover in Australia, 1995 to 2012



Source: PHIAC Membership Trend, September 2012

43. Statistics on population coverage of PHI by age are available only for hospital plans from 1999 onwards. Compared with that, the share of population covered by hospital plans increased markedly across all age groups in 2011, with the most profound increase for age 20-34 (Table 1). However, in absolute terms, the coverage for this age group was persistently the lowest, at 36.8% in 2011, meaning that almost two-thirds of people remained uninsured. The population coverage is highest for the older age groups of 50-64 and 65 and above, at 56.3% and 50.5% respectively. This situation owes much to the community-rated premium, under which older-age population find it attractive and to their interest to join while the younger population are less motivated despite the availability of premium subsidy.

Table 1: Percentage of population with hospital cover by age group, 1999 to 2011

(%)

Age group	**1999**	**2004**	**2009**	**2011**
0-19	29.0	41.1	42.5	44.0
20-34	21.3	31.9	35.4	36.8
35-49	33.6	47.5	47.6	48.8
50-64	43.5	56.2	56.4	56.3
65 and above	36.9	41.9	47.9	50.5

Sources: PHIAC; Australian Bureau of Statistics (ABS)

Competition and Profitability in the PHI market

44. As at July 2012, there were 34 private health insurers operating in Australia, including for-profit and not-for-profit organisations. The five largest insurers, insurer groups accounted for a market share of 83% in terms of PHI policies. The remaining insurers had very small market share. The largest insurer group was the Medibank Private Limited/AHM, a government enterprise independently operating, which had a market share of around 30%.

45. The benefits ratio of the PHI industry, as measured by the ratio of total benefits payments to total premiums, held stable at about 85-86% in recent years (Table 2). Management expenses accounted for about 9% of premium revenue in the industry. The underwriting margin was about 5-6%. The profitability was also affected by the other revenue such as investment income and income from associated businesses such as care referrals and lending to the insured members to pay for co-insurance. The total profits for the PHI industry had been relatively stable in recent years, stood at A$1.3 billion in 2011/12.

Table 2: Health insurance funds' reported expenses and revenues, 2009-10 to 2011-12
(A$ million)

Operating expenses and revenue of funds	2009/10	2010/11	2011/12
(i) Premium revenue	14,170	15,421	16,721
(ii) Benefits payments	12,227	13,161	14,337
Benefits ratio	86%	85%	86%
(iii) Management expenses	1,300	1,398	1,572
Expense ratio	9%	9%	9%
(iv) Underwriting Margin (=(i)-(ii)-(iii))	644	863	812
Underwriting Margin %	5%	6%	5%
(v) Profit before tax[(a)]	1,175	1,456	1,269
Profit margin	8%	9%	9%

(a) Includes investment income, other income
Source: PHIAC Annual Report 2010-12.

Financing Role of PHI

46. Along with rising population coverage of PHI, the share of total health expenditure financed by PHI went up from 9.9%[9] in the financial year of 1998/99[10] to 11.1% in 2010/11 (Table 3). The increase was relatively modest compared with that for the PHI population coverage. Supplementary function of PHI is a major reason as it finances only a small part of in-hospital private doctor services that simultaneously attracts Medicare benefits. Besides, the government health expenditure other than premium rebate kept rising remarkably in recent years alongside population ageing.

47. The premium rebate accounted for 5.1% of government health expenditure in 2010/11. After rising distinctly from 3.0% in 1998/99 to 4.3% in 1999/2000, the share stabilized at around 5.0% for most of the time in the past decade (Table 3).

[9] To avoid double-counting, the health expenditure financed by PHI funds under private health expenditure category does not include the government premium rebate which is instead classified under public health expenditure category. The total health expenditure financed by PHI is equivalent to the sum of these two financing items.

[10] The financial year of Australia starts at 1 April.

Table 3: Share of PHI in financing health expenditure, 1998/99 to 2010/11 (%)

Financial Year	(i) Premium rebate as % of government health expenditure	(ii) Premium rebate as % of total health expenditure	(iii) Health insurance funds (net of premium rebate) as % of total health expenditure	(iv) = (ii) +(iii) PHI as source of financing total health expenditure in %
1998/99	3.0	2.0	8.0	9.9
1999/00	4.3	3.0	6.9	9.8
2000/01	5.1	3.5	7.1	10.6
2001/02	5.0	3.4	8.0	11.4
2002/03	4.8	3.3	8.0	11.2
2003/04	4.8	3.2	8.1	11.3
2004/05	4.8	3.3	7.7	10.9
2005/06	4.9	3.3	7.6	10.9
2006/07	4.8	3.2	7.6	10.8
2007/08	5.0	3.5	7.6	11.1
2008/09	4.6	3.2	7.8	11.0
2009/10	5.1	3.6	7.5	11.1
2010/11	5.1	3.6	7.6	11.1

Source: Australian Institute of Health and Welfare (AIHW) Health Expenditure Australia 2010-11.

48. In line with global trend, the ratio of total health expenditure to gross domestic product (GDP) in Australia increased from 7.8% in 1999 to 8.5% in 2004 and further to 9.1% in 2009 (Table 4). It is unclear however to what extent the increases were caused by the more active role of PHI in the healthcare system, as health expenditure growth is driven by various factors, positive or negative.

Table 4: Total health expenditure as a proportion of GDP in Australia vs. OECD median[(a)], 1999 to 2009 (%)

	1999	2004	2009
Australia[(b)]	7.8	8.5	9.1
OECD Median	7.6	8.3	9.6

Notes: (a) Expenditure based on the OECD System of Health Accounts (SHA) framework.
(b) The official figures published by Australian government are usually in financial years. The relevant figures have been adjusted to fit the timeframe of calendar year adopted by OECD and OECD'S definition.
Sources: AIHW health expenditure database; OECD Health Data 2012 accessed on 7 Feb 2013

49. When compared with other member countries within Organisation for Economic Cooperation and Development (OECD), the ratio of total health expenditure to GDP in Australia was similar to the OECD median in earlier years but drifted to below the median in 2008. From 1998 to 2008, total health expenditure growth in Australia actually outpaced that of many other major OECD countries (Table 5), implying that the relatively lower ratio to GDP in recent years was likely related to its relatively faster economic growth. By disaggregating the average expenditure growth in the past decade by major component, it is further observed that growth in utilization was the major contributory factor. Population component is also more prominent than several other OECD countries. Meanwhile, medical inflation in Australia appeared to be under good control, averaging at 3.2% per annum during

1998-2008, less than the corresponding figure of 4.0% for general inflation[11].

Table 5: Components of growth in health expenditure, Australia vs. selected OECD countries, 1998 to 2008 [(a)] (%)

Country	Average annual nominal change	Average annual inflation			Average annual real growth		
		General[(g)]	Excess health	Health	Population component	Utilisation component	Total
Australia	**8.6**	**4.0**	**-0.7**	**3.2**	**1.4**	**3.7**	**5.2**
Canada	7.2	2.7	-0.2	2.6	0.9	3.6	4.6
Denmark[(b)]	5.7	2.4	-0.2	2.2	0.3	3.1	3.4
Finland[(c)]	6.4	1.1	2.5	3.7	0.3	2.3	2.6
France[(d)]	5.1	1.7	-0.2	1.5	0.6	3.0	3.6
Italy	5.3	2.5	0.4	2.9	0.3	2.0	2.4
Spain[(b)]	7.7	3.4	-1.0	2.4	0.8	4.3	5.1
Sweden[(e)]	8.2	1.6	2.2	3.8	0.2	4.0	4.3
Switzerland[(f)]	4.4	0.8	-0.2	0.6	0.6	3.1	3.8
United States	7.0	2.4	1.1	3.5	1.0	2.4	3.4

Notes: (a) Expenditure based on the OECD SHA framework.
(b) 1998 to 2001.
(c) 1998 to 2005.
(d) 1998 to 2006.
(e) 1998 to 2002.
(f) 1998 to 2003.
(g) Measured by GDP deflator.

Sources: AIHW health expenditure database; OECD Health Data 2010.

50. Although the Australian government had predicted that the policy of subsidizing PHI take-out would heighten fiscal burden initially, the government share in total health expenditure turned out to ease slightly in the early years of policy implementation, from 68.4% in 1999 to 66.7% in 2004 (Table 6). This was mainly attributable to downsizing of public hospital capacity in response to the demand shift from the public to private hospitals. Yet the government share has rebounded in recent years and reached 68.5% in 2009, as public hospital capacity has been increasing to cope with rising demand pressure, especially from the expanding old-age population. According to some observers, some elderly take out PHI mainly for selective non-urgent surgeries such as hip replacement surgery, and continue to rely on the public hospitals for other treatments especially for catastrophic diseases. Besides, the increase in premium rebate for the elderly since April 2005 heightened the fiscal burden in recent years. Yet compared with the OECD median of 75.2% in 2009, the government share in total health expenditure in Australia remained on the low side.

[11] On the other hand, there are on-going concerns about rapid premium rises which were consistently higher than inflation in Australia. It should, however, be noted that apart from inflation pressure, PHI premium adjustment is also affected by other factors such as the age profile of customers (that influences community-rated premium level).

Table 6: Share of total health expenditure financed by government, Australia vs. OECD median, 1999 to 2009[(a)] (%)

	1999	2004	2009
Australia	68.4	66.7	68.5
OECD Median	73.5	74.2	75.2

Note: (a) Expenditure based on the OECD

Impact of PHI Policy on Private Healthcare Market

51. The Australian government's policy to promote PHI should have notable impacts on various aspects of its private healthcare market and the interaction between the public and private healthcare sectors in Australia. However, due to data and information constraints, and the complexities of the subjects involved, no information on any thorough analysis is readily available. Based on the limited information available, a general picture is attempted as follows.

52. The policy stimulus has diverted some healthcare demand from the public to private sector, especially for hospital treatments. Manifesting this, the share of public hospital admissions in total hospital admissions fell from 62% in 2001/02 to 60% in 2010/11, while the corresponding share of private hospital admissions went up from 38% to 40% (Table 7). The proportion of patient days in public hospitals decreased from 70.0% in 2001/02 to 68.7% in 2010/2011, less than the corresponding drop in admissions. This phenomenon was due to a significant increase in patient days in free standing private day hospitals.

Table 7: Admissions and patient days in public and private hospitals, 2001/02 to 2010/11

	2001 /02	**2004 /05**	**2007 /08**	**2010 /11**
Hospital admissions				
Public hospitals ('000)	3,966	4,276	4,744	5,279
% of total admissions	62.0	60.9	60.2	59.6
Private hospitals ('000)	2,433	2,742	3,130	3,573
% of total admissions	38.0	39.1	39.8	40.4
Total ('000)	**6,399**	**7,019**	**7,874**	**8,853**
Patient days				
Public hospitals ('000)	16,237	16,662	17,836	18,487
% of total patient days	70.0	69.9	69.6	68.7
Private hospitals ('000)				
Free-standing day hospitals	377	520	668	809
% of total patient days	1.6	2.2	2.6	3.0
Other private hospitals	6,587	6,646	7,139	7,598
% of total patient days	28.4	27.9	27.8	28.3
Total ('000)	**23,201**	**23,829**	**25,643**	**26,895**

Sources: AIHW Australian hospital statistics 2010-11, and earlier editions.

53. In the past several years, the private hospitals have performed a more active role in handling elective surgeries as many insured patients have a greater tendency to go private for non-urgent treatments. In 2010/11, the private hospitals accounted for 66% of all hospital admissions related to elective surgeries, larger than the shares of 63% in 2006/07 (Table 8). These stood in stark contrast to the 40% share of private hospitals in terms of total hospital admissions. Elective surgeries accounted for about 36% of admissions in private hospitals and just about 13% of admissions in public hospitals in

2010/11.

Table 8: Admissions for elective surgery, 2006/07 to 2010/11

	2006/07	2007/08	2008/09	2009/10	2010/11
Elective Surgery, Public Hospitals					
No. of admissions	623,921	625,409	644,176	656,741	669,884
% of total admissions	36.9	35.4	35.5	34.5	34.4
Elective Surgery, Private Hospitals					
No. of admissions	1,068,127	1,140,109	1,172,134	1,245,704	1,279,501
% of total admissions	63.1	64.6	64.5	65.5	65.6
Total					
No. of admissions	1,692,048	1,765,518	1,816,310	1,902,445	1,949,385

Source: AIHW Australian hospital statistics 2010-11

54. On the supply side, private hospital capacity expanded as public hospital capacity contracted along with demand shift in the early years of policy implementation. The number of private hospital beds rose from about 24,367 in 1997/98 to 27,407 in 2001/02 whereas the number of public hospital beds dropped from about 55,736 to 51,461 (Table 9). In more recent years, the government resumed expansion of public hospital beds to cope with rising demand from the growing old-age population.

Table 9: Supply of Hospital Beds, 1997/98 to 2009/10

	1997/98	1999/00	2001/02	2003/04	2005/06	2007/08	2009/10	Average Change (1997/98-2009/10)
Public hospitals	55,736	52,947	51,461	53,599	54,601	56,467	56,900	0.2%
% of total beds	69.6	67.7	65.2	66.8	67.6	67.0	67.2	
Private hospitals	24,367	25,246	27,407	26,589	26,227	27,768	27,748	1.1%
% of total beds	30.4	32.3	34.8	33.2	32.4	33.0	32.8	
Total	**80,103**	**78,193**	**78,868**	**80,188**	**80,828**	**84,235**	**84,648**	**0.5%**

Sources: AIHW Australia's health 2010, and earlier editions.

55. Because of the concurrent increase in demand due to various factors (including demographic changes and induced demand), and reduction in the public hospital capacity in earlier years, the effect of policy stimulus for PHI and the resultant shift of service demand to private hospitals on waiting time in public hospitals was not apparent. Available data since 1999/2000 revealed that the median waiting time for elective surgeries in public hospitals lengthened from 27 days in 1999/2000 to 36 days in 2010/11, possibly as a result of the combination of the aforementioned factors. The long public hospital queue has induced some uninsured patients to take out PHI and target at some selective surgeries of which the waiting period for PHI cover is shorter than the waiting time in public hospitals, such as hip replacement surgery. According to some observers, this situation is quite common for the elderly in Australia.

Table 10: Waiting times for elective surgery in public hospitals, 1999/2000 to 2010/11

	1999/2000	2001/02	2003/04	2005/06	2007/08	2009/10	2010/11
Days waited at 50th percentile	27	27	28	32	34	36	36
Days waited at 90th percentile	175	203	193	237	235	247	252
% waited more than 365 days	3.1	4.5	3.9	4.6	3.0	3.6	2.9

Sources: AIHW Australian hospital statistics 2010-11, and earlier editions

56. As for manpower supply, no much data can be found regarding how the public-private split in the supply of healthcare workers has changed since implementation of the policy to promote PHI. Anecdotal evidence shows that the total number of salaried medical practitioners and other diagnostic and allied health professionals in private hospitals rose by 54% cumulatively from 2000/01 to 2010/11. However, most of the private medical doctors engage in solo practice or work for health maintenance organizations instead of being hired by private hospitals directly in Australia. Thus the change in labour market condition for the majority of private medical doctors remains unclear. As regards the public sector, the number of salaried medical practitioners and other diagnostic and allied health professionals in terms of full-time equivalents in the public hospitals showed a sustained rise which accumulated to 69% from 2000/01 to 2010/11.

Concluding Observations

57. The policy to promote PHI achieves to a certain extent its intended objective of motivating private hospital development in Australia. Data reveal that the private hospitals have shared out somewhat the burden of the public hospitals particularly in handling elective surgeries. The specialization of private hospitals in non-urgent treatments has become more apparent. Some observers also opine that the private hospital developments have helped to keep medical talents from flowing to the more remunerative environments abroad. As to whether the policy has led to a significant brain drain from the public to private hospitals, information available is insufficient to clarify the situation, but it is worth of note that the number of doctors in public hospitals has increased considerably faster than public hospital admissions during the past decade or so.

58. The policy implications for the health system as a whole in Australia are difficult to assess. As health system performance and development are always simultaneously influenced by a host of policy, economic and demographic factors, it is difficult to assess the impacts of the proactive policy towards PHI in isolation. The multi-faceted and inter-related nature of the PHI policy and its objectives also makes it difficult to single out any one dimension (e.g. public hospital waiting time) for evaluation independent of other aspects (e.g. overall system capacity and financing). Moreover, the policy effectiveness involves both efficiency and equity dimensions which sometimes pertain to different values and do not align in measurement. Advocates of PHI tend to focus on how the PHI policy brings about a viable private hospital sector that enhances access to care and increases patient choice, while opponents tend to focus on whether it would be socially justified to subsidize the more affluent people for private healthcare.

59. Community-rated premium in Australia is a notable case demonstrating the policy dilemma. The mandate involves significant cross-subsidization across age which

fulfills community expectation from an equity perspective. However, from an efficiency perspective, it aggravates adverse selection, exposes the PHI system to long-term funding risk in an ageing population, and requires substantial premium subsidy to prevent insufficient participation of the younger population that in turn invites challenges on the issue of equity and results in more significant public funding outlay for healthcare, partially offsetting some of the effects of the PHI policy itself. The involvement of societal values makes it difficult to evaluate the policy objectively from a cost-benefit perspective.

60. Observations about the changes in public healthcare sector after implementation of the PHI policy in Australia should be viewed in perspective. The relief of PHI policy to public expenditure tends to be less significant when the role of PHI is meant to supplement rather than substitute the predominant publicly funded system, as in the case of Australia and some other OECD countries. In fact, it is common within OECD that the privately insured continue to rely upon the public system for more expensive services, such as the treatments of catastrophic diseases to which the growing elderly population is more vulnerable. As in the case of Australia in earlier years, the diversion of service demands especially for elective surgeries to private hospitals was also accompanied by a reduction in public hospitals capacity. The resultant implications for resource allocation makes it difficult to establish any causal linkage between the impact of PHI policies and the waiting time for elective surgeries in public hospitals, which is not apparent in some OECD countries including Australia.

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