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Public versus private? An overview of the debate on private health insurance and pressure on public hospitals[1]

The 7.96 per cent average increase in private health insurance premiums for 2005 marks the third year in a row in which private health premiums have increased on average by more than 7 per cent, as shown in Table 1. Federal Health Minister Tony Abbott's announcement of the increases was greeted with criticism from the Opposition and health consumers, who argued that the premium rises were unnecessarily high.[2] The government and the private health insurance industry argued, however, that 'increasing use of private hospitals as well as … higher health costs' justify the increases in premiums.[3] There is certainly evidence to support this claim: according to the Private Health Insurance Administration Council (PHIAC), in 2004 hospital benefits paid out by private health insurance companies increased by 9.6 per cent, gap payments to doctors increased by 19.2 per cent, and benefits paid for prosthetics increased by 18.7 per cent.[4]

Table 1: Average private health insurance premium increases, 1999–2005[5]

Year	Average premium increase
2005	7.96%
2004	7.58%
2003	7.40%
2002	6.90%
2001	No increases
2000	1.80%
1999	4.90%

The more contentious point made by Mr Abbott in his announcement of the private health insurance premium increases, however, was the claim that 'every patient treated in a private hospital is one less patient on a public hospital waiting list'.[6] In current debates about the Australian health care system, the relationship between private health insurance membership levels and public hospital waiting lists is one of the most hotly contested, and complex issues.

In large part, this is because this issue is a focal point for a broader philosophical debate about the respective roles of the public and private sectors in the delivery of health care in general, and hospital care in particular. On one hand, Labor historically has emphasised the provision of publicly funded health care and health insurance (though its decision to retain the government's 30 per cent private health insurance rebate if elected to government signals a shift in this historical position). On the other hand, the Coalition has a long-held view that the Australian health care system needs a strong and robust private sector.[7] In line with this philosophy, one of the government's central claims about the 30 per cent rebate on private health insurance introduced in 1999 is that it benefits the health system overall by reducing pressure on public hospitals (by enabling more people to seek hospital care in the private system).[8] However, advocates of greater support for the public health system and critics of the government's policy on private health insurance argue that this is not necessarily the case, and that the money the government spends on the 30 per cent private health insurance rebate (currently around $2.6 billion each year), might be better spent 'if invested directly in the public hospital system'.[9]

This Research Note explores these issues by discussing the market for hospital care, and the available evidence on the relationship between private health insurance and public hospital waiting lists.

The market for hospital care

The market for hospital care, and the distribution of care between private and public hospitals is complex. There are many factors which influence the demand for and supply of hospital services.

For example, the most recent hospital statistics released by the Australian Institute of Health and Welfare (AIHW) show that between 2002–03 and 2003–04, the number of separations—that is, the number of episodes of hospital care for admitted patients[10]—increased by 2.1 per cent for public acute hospitals, and 4.0 per cent for private hospitals.[11] Over a longer time frame, between 1999–00 (when the government's private health insurance incentives were introduced) and 2003–04, public acute hospital separations increased by 8.5 per cent, and private hospital separations increased by 30.1 per cent.[12] What these figures suggest is that the overall *demand* for hospital treatment is continually increasing over time (albeit that growth in the private sector has outpaced growth in the public sector in meeting this increased demand).

One explanation for this is that as hospital availability increases, so too does demand for services in the form of more people on surgical waiting lists (and, possibly, vice versa). This may be because:

> … the availability of health services [can change] the decision making process of clinicians, that is, if a service is seen as readily available it is more likely to be recommended to the patient. If elective surgery is seen as readily available, then clinicians [may be] more likely to recommend surgery than a less aggressive treatment regime, or even adopting a 'wait and see' approach'.[13]

Consequently, the length of, or time spent on, waiting lists is not necessarily the best indicator of *need* for services: if

demand is continually increasing, and capacity is continually expanding in order to meet demand, arguably there will *always* be waiting lists. These will fluctuate not just with need, which is difficult to definitively measure, but also with *perceptions* of increased capacity. Of course, increasing demand for hospital services is also driven by demographic changes such as the ageing of the Australian population.

Further, there is also evidence to suggest that the public and private hospital sectors deal with different kinds of caseloads: public hospitals tend to treat more emergency patients and patients with 'severe disease levels', while private hospitals tend to handle surgical and elective cases. This means that the capacity for 'shift in caseload share' between the public and private sectors is limited.[14] Even so, it is sometimes argued (somewhat controversially) that private hospitals, particularly those co-located with public facilities, 'cherry-pick' patients and cases most likely to yield profit, and hence, that private facilities are often underwritten by public hospitals.[15] At the same time, the private hospital industry argues that public hospitals are guilty of the same practice: that is, in order to raise revenue, public hospitals encourage private patients to be treated as private patients in public hospitals.[16] However, these kinds of claims and counter claims are difficult to verify on the available evidence.

What each of these examples demonstrate is that there is no finite number of patients or episodes which need to be treated in the hospital system. Rather, the demand for hospital services is influenced by a range of factors, though not all of them relate to the clinical or medical *needs* of patients. Of course, this is also the case for the *supply* of hospital services: both public and private sector hospital capacity is influenced by many factors (not least of all funding) but also factors such as availability of workforce and availability of new medical devices or technologies. As a result, the market for health care in general, and hospital care in particular, is complex and not widely well understood. Consequently, so too is the relationship between private health insurance and public hospitals.

Private health insurance and pressure on public hospitals: the evidence

When the government announced its plans to introduce the 30 per cent private health insurance rebate, it argued that the rebate would provide an incentive for people to take up private health insurance, and in doing so, it would help reduce the load on public hospitals (by redirecting more people to the private hospital system instead).[17] Private health membership increased markedly in 1999–00, following a steady decline in the mid to late 1990s, though most commentators attribute the spike in membership to the introduction of the Lifetime Health Cover policy in 2000 (rather than to the 30 per cent rebate on private health premiums introduced in 1999).[18]

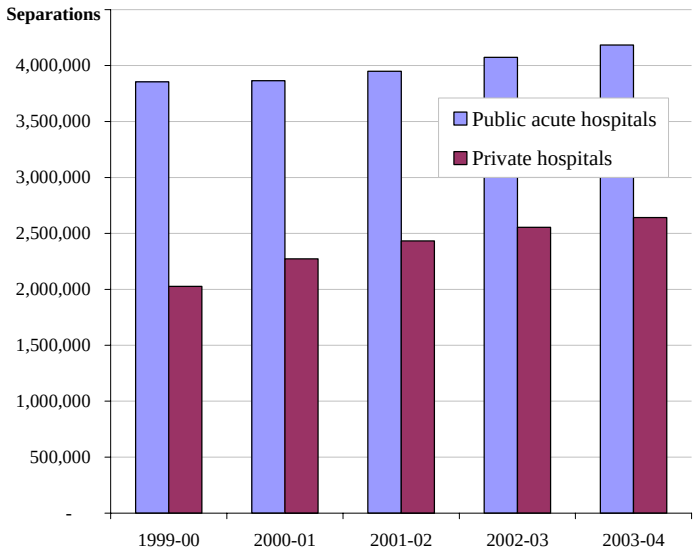
On one hand, some researchers and academics argue that there is strong evidence to support the government's claim that the 30 per cent private health insurance rebate has helped to take the pressure off public hospitals and waiting times. For example, Brian Hanning, Medical Director of Australian Health Service Alliance (a company that negotiates arrangements between hospitals, doctors and health service providers on behalf of private health insurance funds), argues that if private health insurance membership levels had continued to decline at the same rate as they were before the introduction of the 30 per cent private health insurance rebate and Lifetime Health Cover, the public hospital system would not have been able to cope with demand.[19] In a separate article, Hanning also argues that waiting lists for elective surgery in public hospitals would be longer if not for the introduction of the private health insurance incentives, as private hospitals are taking on an increasing proportion of all elective surgery cases.[20] Further, other commentators suggest that public hospitals also benefit significantly through revenue from the private health insurance rebate when private patients are treated in public hospitals, as private patients.[21]

On the other hand, there is also evidence to suggest that pressure on public hospitals has not been reduced as a result of the introduction of the 30 per cent rebate. For instance, as noted above, while utilisation of private hospitals has increased considerably since the introduction of the 30 per cent private health insurance rebate and Lifetime Health Cover, utilisation of *public* hospitals has also increased steadily over this time.[22] The number of separations from both public and private hospitals in recent years is shown in Figure 1.

In other words, as mentioned above, *overall* demand for hospital care has grown over recent years, and while growth of the private sector has outstripped that of the public sector (in terms of numbers of hospital separations at least), this does not appear to have translated into a neat shift in workload or caseload from the public sector to the private sector.

It is worth noting, though, that the increase in private hospital activity has led to private hospitals accounting for an increasing *proportion* of all hospital separations since the private health insurance incentives were introduced: the proportion of separations from private hospitals

Figure 1: Total hospital separations, public acute and private hospitals, 1990–00 to 2003–04



Source: Australian Institute of Health and Welfare

increased from 34 per cent of all separations in 1999–00, to almost 38 per cent of all separations in 2003–04.[23]

Analysis of data on changes in separations from public and private hospitals between 1999–00 and 2003–04 for particular kinds of procedures—shown in Figure 2—demonstrates that there has been a shift from public hospitals to private hospitals *in some areas*, such as diagnostic gastrointestinal endoscopy, hysterectomy and arthroscopy.

Whether this translates to 'decreased pressure' on public hospitals, however, is a different question. For example, Figure 2 also shows that the number of separations for procedures such as tonsillectomies, lens insertions, c-sections and knee replacements increased for both private and public hospitals (though in greater numbers for private hospitals in all cases). This reiterates the point made above about increasing *overall* demand in many areas.

Further, if the shift in caseload from public to private hospitals translated to 'decreased pressure' on public hospitals, it might be expected that this would be reflected in reductions in waiting times in public hospitals. However, AIHW hospital data shows that over the period between 1999–00 and 2003–04, the median waiting time for elective surgery in public hospitals actually *increased* from 27 to 28 days.[24]

In addition, there is some evidence to suggest that treatment undertaken in the private sector is associated with higher rates of surgical intervention than that undertaken in the public sector.[25] This means that a procedure performed in a private hospital is not necessarily one less procedure performed in a public hospital, because for some cases, a different course of treatment may have been recommended in a public hospital setting.[26]

Finally, as briefly discussed above, research on hospital separations since the introduction of the government's private health insurance incentives has also shown that public hospitals still tend to treat patients with more severe diseases (which are more resource-intensive to deal with), as well as handle the majority of emergency cases.[27] This casts further doubt on the claim that the burden on public hospitals has been reduced by the private health insurance rebate and other private health insurance incentives.

Conclusions

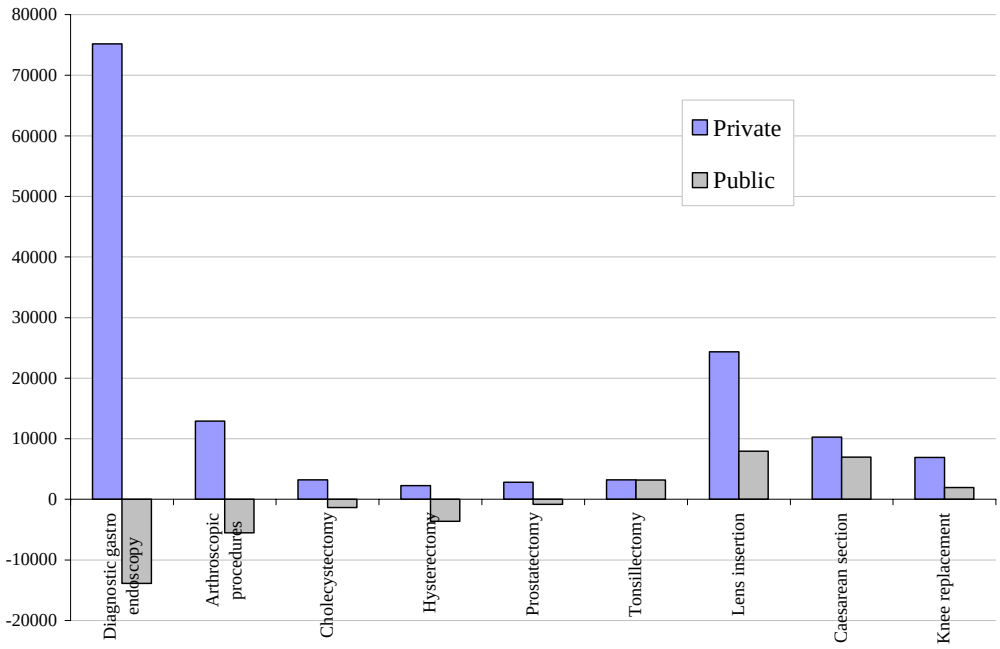
While private hospital activity has certainly increased since the introduction of the government's private health insurance incentives, so too has overall demand for hospital services.

This trend in overall demand for hospital services partly reflects demographic changes in Australian society, and thus can be expected to continue in both the short and long terms as the Australian population ages. Yet at the same time, some researchers argue that the very existence of private health insurance incentives have the potential to create the perception of increased capacity, which in turn may itself create increased demand. In other words, the perception of increased capacity creates a 'tendency for people to use more of a service if it is free or low cost at the time of delivery'.[28]

The research surveyed for this Note suggests that there is no clear correlation between increased levels of private health insurance membership and the extent of 'pressure on public hospitals'. What the debate over private health insurance and public hospitals does demonstrate, however, is the complexity of the Australian hospital system itself. For example, the structure of the market for hospital services is such that public and private hospitals tend to deal with different kinds of caseloads. This helps to explain why the introduction of incentives into the private health insurance market has not led to a neat shift in workload from the public to the private sector. But the supply of both public and private hospital services is *also* influenced by a range of intricate, interrelated factors, such as workforce, financing and resource arrangements, developments in medical technology, and demand.

Further, much of the debate about private health insurance and pressure on public hospitals hinges on the unresolved issue of whether the public and private hospital systems are designed to *complement* one another, or whether they are in competition. Subsequently, whereas the available evidence is inconclusive, much of the debate about private health insurance and pressure on public hospitals in

Figure 2: Change in number of separations for selected procedures, public and private hospitals, 1999–00 to 2003–04



Source: Australian Institute of Health and Welfare

Australia is informed by positions taken in this broader ideological debate.

Clearly, both the public and private hospital sectors play an important role in the delivery of hospital care in Australia. The role that the government's private health insurance incentives play in the distribution of hospital services between the public and private sectors, however, is far from clear cut.

Endnotes

1. Thanks to the following people for helpful advice and comments on an earlier version of this paper: Mandy Biggs, Luke Buckmaster and Carol Kempner from the Parliamentary Library; Paul Mackey from the Australian Private Hospitals Association; and Dr Amanda Elliot from the Department of Sociology and Social Policy at Sydney University.
2. K. Jones and I. Royall, 'Private health fund rises hurt', *Herald Sun*, 3 March 2005, p. 4; Julia Gillard MP, 'Abbott brings out the rubber stamp, again', *media release*, 2 March 2005.
3. The Hon. Tony Abbott, Minister for Health and Ageing, 'Private health premiums', *media release*, 2 March 2005. See also Russell Schneider, Chief Executive Officer of the Australian Health Insurance Association, quoted in D. Wroe, 'Health insurance rise hits Victorians', *The Age*, 3 March 2005, p. 4.
4. Private Health Insurance Administration Council, 'Health Fund Contribution Rate Increase 2005', *media release*, 2 March 2005.
5. 1999–2003 figures are taken from statements or press releases from Minister Wooldridge and Minister Patterson; 2004 figure from Private Health Insurance Administration Council (PHIAC), 'Health Fund Contribution Rate Increase 2004', *media release*, 27 February 2004; 2005 figure from Abbott, op. cit. Note that not all premiums increase by the same amount—these are *average* increases only.
6. Abbott, 'Private health premiums', op. cit.
7. See G. Gray, *The Politics of Medicare*, UNSW Press, Sydney, 2004, pp. 26–33. See also A. Crichton, *Slowly taking control? Australian governments and health care provision 1788–1988*, Allen & Unwin, Sydney, 1990; S. Sax, *Health care choices and the public purse*, Allen & Unwin, Sydney, 1990; J. Gillespie, *The Price of Health: Australian governments and medical politics*, Cambridge University Press, Cambridge, 1991.
8. R. Pollard, 'Public waiting longer despite private health boost', *Sydney Morning Herald*, 1 February 2005, p. 6.
9. J. Hall and A. Marnard, 'Healthcare lessons from Australia: what can Michael Howard learn from John Howard?', *British Medical Journal*, vol. 330, 12 February 2005, pp. 357–359.
10. A separation can either be 'a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation)'. Separation also refers to 'the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care'—AIHW, *Australian Hospital Statistics 2003–04*, AIHW, Canberra, 2005, p. 336.
11. AIHW, *Australian Hospital Statistics*, op. cit., p. x.
12. ibid., p. 16.
13. V. Sundararajan, K. Brown, T. Henderson and D. Hindle, 'Effects of increased private health insurance on public hospital utilisation in Victoria', *Australian Health Review*, vol. 28, no. 3, December 2004, pp. 320–329.
14. ibid.
15. See, for example, 'Unhealthy emergency [Editorial]', *Herald Sun*, 23 July 2002.
16. B. Heffernan, 'Editor's note: Artificial sweeteners a bitter pill for ailing health system', *Private Hospital*, April 2005, p. 4.
17. See, for example, the Hon. Dr Michael Wooldridge, Minister for Health and Aged Care, 'Legislation introduced for the government's 30% rebate for private health insurance', *media release*, 12 November 1998; the Hon. John Howard, Prime Minister, Transcript of Press Conference, Parliament House, Canberra, 13 August 1998.
18. See, for example, Hall and Marnard, op. cit. Lifetime Health Cover is the scheme which rewards people who take out and maintain private hospital cover earlier in life with lower premiums throughout their life (and effectively penalises people who take out private hospital cover when they are older with higher premiums).
19. B.W.T. Hanning, 'Impact on public hospitals if private health insurance rates in Victoria declined', *Australian Health Review*, December 2004, vol. 28, no. 3, pp. 330-339.
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21. 'Why the wait? Private patients fill public beds!', *Private Hospital*, August 2004, p. 17.
22. These figures are based on numbers of hospital separations—Sundararajan et al, op. cit.
23. AIHW, National Hospital Morbidity Database. See http://www.aihw.gov.au/hospitals/NHM_database.cfm, accessed 6 June 2005.
24. AIHW, *Australian Hospital Statistics*, op. cit., p.118.
25. See, for example, C. L. Roberts**,** S. Tracy and B. Peat**,** 'Rates for obstetric intervention among private and public patients in Australia: population based descriptive study', *British Medical Journal*, vol. 321, 15 July 2000, pp. 137–141; I.K. Robertson and J.R.J. Richardson, 'Coronary angiography and coronary artery revascularisation rates in public and private hospital patients after acute myocardial infarction', *Medical Journal of Australia*, vol. 173, 18 September 2000, pp. 291–295.
26. See also S. J. Duckett and T. J. Jackson, 'The new health insurance rebate: an inefficient way of assisting public hospitals', *The Medical Journal of Australia*, vol. 172, no. 9, 1 May 2000, pp. 439–442.
27. Sundararajan et al, op. cit.
28. I. McCauley, *Stress on public hospitals—why private insurance has made it worse*, Discussion paper for the Australian Consumers' Association and the Australian Healthcare Association, January 2004, p. 14.

Angela Pratt
Social Policy Section
Information and Research Service