Public hospitals: who's looking after you? The difficulties in encouraging patients to use their private health insurance in public hospitals

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Abstract

Private health insurance (PHI) is an important part of the Australian health system. During the introduction of the recent PHI reforms it was argued that, without the reforms, the public hospital system would undoubtedly collapse under the increased demand for public health services. The increase in PHI coverage might also have been expected to result in an increase in the revenue earned by public hospitals as a result of treating privately insured patients. However, the decline in numbers of privately insured patients using their PHI in public hospitals has continued, with adverse impacts on public hospital budgets in some states. This article addresses the complex interactions between various policy instruments and their impact on public hospitals, and reports the results of a study conducted at the Austin & Repatriation Medical Centre (A&RMC) which examined the reasons for privately insured patients electing not to use their insurance in public hospitals, and methods by which they might be overcome.

The private health insurance reforms and use of private insurance

Reform of private health insurance has been a primary health policy focus of the Howard Government since its election in 1996. The reforms were a response to continuing substantial decline in the number of people covered by health insurance since the introduction of Medicare in 1984. The proportion of the eligible population covered for hospital insurance in 1996 was 33.6%, down from 41.0% in 1992 (PHIAC 2001). The decline was almost exclusively in the under 65 year age group, with no discernible decline in the number of insured persons aged 65 or over (PHIAC 2000).

The reform process has focussed on price, product, promotion, legislation and regulation. In 1997, the Private Health Insurance Incentives Scheme (PHIIS) was introduced. This was aimed at making private health insurance more affordable for lower and middle-income earners by providing either reduced premiums or a tax offset. Part of the PHIIS included the Medicare surcharge, which is a disincentive for high-income earners to rely on Medicare. In 1998, the Government's tax reform package introduced a 30 per cent tax rebate. The new scheme, which includes the Medicare surcharge, replaced the PHIIS from 1 January 1999. On 1 July 2000, Lifetime Health Cover was introduced. This arrangement required funds to set different premiums depending on the age at which a member first takes out hospital cover with a registered health fund, and is an incentive to

join a fund by the age of 30 and maintain membership for life. Although the 30% rebate resulted in some arrest in the long-term decline of PHI coverage, the largest effect occurred with the introduction of Lifetime Health Cover. By the September 2000 quarter, 45.8 percent of the Australian population were covered by private health insurance (PHIAC 2001).

The 30% rebate combined with lifetime cover has resulted in one of the largest new Commonwealth health outlays in recent memory, and has been very controversial (Clarke 1999; Coote et al 1999; Duckett & Jackson 2000; Palmer 2000; Hindle 2000; Butler 2001). However, despite these massive outlays of funds, with the primary stated objective being to "take pressure off the public hospitals" (Wooldridge 1998), there is no apparent decline in demand for public hospital services to date.

Impact on public hospitals

There are many factors surrounding the increased coverage that have the potential to limit the impact of the reforms on the public hospital sector. Most of the new PHI members are younger and are less likely to be admitted to hospital (81.5% of them were aged less than 50). In September 2000, 89% of all persons covered were aged less than 65 years (PHIAC 2000), while patients under 65 accounted for only 57% of total separations at the A&RMC acute campus in 2000/2001.

The Australian Health Care Agreement requires that public hospital patients be given the choice of being admitted as public or private, irrespective of their health insurance status or ability to pay. In this context, the range of PHI products purchased by members also has an impact on use of their newly acquired insurance coverage. As of June 2001 54.5% of Australians (and 48.9% of Victorians) covered for PHI had a Front End Deductible (FED) or exclusionary policy (PHIAC 2001). The high use of FEDs and exclusionary health insurance policies, and the desire to avoid out of pocket expenses, is expected to have a strong impact on patients' decisions regarding use of private or public hospitals and election of public or private status in public hospitals. This impact is likely to apply to both lower and higher-income earners who hold policies with high FEDs.

An assumption that there is a clear inverse relationship between the overall level of PHI coverage and the workload of public hospitals is incorporated in the 1993-1998 Medicare Agreement and the subsequent Australian Healthcare Agreement 1998-2003, which both made provision for fluctuations in the private health insurance participation rate. Should the participation rate decline, Commonwealth funding under the Agreements would increase at around $82 million per percentage point change. Should the participation rate increase above certain levels, funding would decrease at the same rate per percentage point (DHAC 1999). While the policy assumption is logical, there is not only a lack of evidence of reduced demand on public hospitals, but also some evidence which indicates that insured people, while continuing to use the public hospital system, are now slightly less likely to declare or use their PHI.

Declining use of public hospitals by private patients was well entrenched before the PHI reforms. In the period from 1990 through to 1999/2000 the proportion of public hospital bed days occupied by private patients declined from 23.6% to 7.5% throughout Australia (AIHW 1991; AIHW 2001). Within the Austin & Repatriation Medical Centre private separations for acute patients for 1999/2000 averaged 5.4% and 5.3% in the 2000/2001 financial year (see Table 1). This slight decline also occurred across Victoria, while the percentage of the population covered by private health insurance increased from 30.1% in 1999 to 45.8% in 2000 (PHIAC 2001).

Table 1: Comparison of the utilisation and declaration of private health insurance between the A&RMC acute campus and Victorian Metropolitan public hospitals

	A&RMC (acute campus)				VICTORIAN METROPOLITAN HOSPITALS			
	1999/2000 Separations	%	2000/2001 Separations	%	1999/2000 Separations	%	2000/2001 Separations	%
Public declared								
No insurance	32,849	84.4	30,824	80.7	599,521	88.9	606,006	87.5
Private								
Non insured	116	0.3	88	0.2	12018	1.8	10,087	1.5
Declared insured, elected public	3,854	9.9	5,263	13.8	37,244	5.5	50,421	7.3
Private insurance								
Private election	2,082	5.4	2,006	5.3	25,523	3.8	25,906	3.7
TOTAL	38,901	100	38,181	100	674,306	100	692,420	100
'Conversion Rate'								
[% of insured patients electing private]		35		27.6		41.3		33.6

Note: DVA/Compensable and ineligible patients are excluded.

Source: Department of Human Services, September 2001. VAED data

The June 1998 health insurance survey indicated that 15.4 per cent of Medicare patients in public hospitals had private health insurance (ABS 1998). The results of a study commissioned by the Senate Community Affairs Committee Enquiry into public hospital funding, which matched public hospital separations with membership of five major health funds, showed that only 39 per cent of the privately insured patients used their insurance. The remaining 61 per cent did not declare their private health insurance status and were admitted as public patients (Senate Community Affairs Reference Committee 2000). In comparison only 33.6% of insured patients at Victorian metropolitan hospitals declared and used their insurance, and 27.6% at the A&RMC in 2000/01.

Managing the financial impact on public hospitals

State health authorities vary in their policies regarding treatment of revenue collected from private patients. In Victoria and some other states, revenue targets are set annually and the targeted amount is effectively deducted from government funding. Hospitals therefore have an incentive to meet and exceed targets. In this context public hospitals have two options in relation to fees for private patients. The first is that they charge private patients an amount equal to the benefit they will receive from their health insurance policy. The second is that they charge the patient the full cost of treatment, in which case the patient will have to pay substantial out-of-pocket costs beyond the available insurance benefits (DHS 1996). Because of the availability of a 'free' alternative, most privately insured public hospital patients will elect to be treated for free as public patients if asked to make a substantial co-payment. The A&RMC, like many other public hospitals, has a policy ensuring that no privately insured patient will be 'out-of-pocket' (OOP) for fees raised by the hospital. Medical staffs treating private patients are encouraged to comply with this policy, and bill no more than the Medicare scheduled fee.

In view of the private revenue targets set for the A&RMC by the DHS, it is imperative that the number of patients who elect to use their private health insurance is maximised, but there are many barriers to overcome. The primary culture of public hospitals in Australia is such that equal treatment is given to all patients. There is no difference in treatment between public and private patients other than the right of the private patient to choose their consultant doctor. Furthermore, within the A&RMC there is a perceived resistance to the concept of encouraging private election. This may be due to the lack of incentives for many parts of the organisation

and/or a lack of understanding of what private patient revenue means to the organisation and departments financially. For different units and staff within the A&RMC there is considerable disparity between the benefits and disincentives for either treating or alternatively referring on private patients. For example, the Emergency department may choose to refer private patients elsewhere whenever possible in order to reduce pressure for emergency admissions, while the diagnostic services and some allied health services encourage private work as a valuable revenue stream.

In order to address these issues, the hospital intends to embark on an education campaign addressed to all admitting staff regarding the importance of private patients to the financial viability of the organisation. The aim is to identify as many privately insured patients as possible through the multiple entry points to the organisation including elective admissions, direct admissions, hospital transfers and the emergency department. The organisation believes that if patients are informed about the implications of using their private insurance, more will choose to do so. Whilst every patient has the right of election as to the use of private health insurance, staff will be encouraged to market the advantages of using private health insurance and address any misconceptions or concerns patients may have regarding the implications.

The Study

The current study aimed to investigate the reasons for patients electing not to use their private health insurance, in order to target specific education and training programs for staff. It was also proposed that interviewing patients might assist in identifying any other activities that the A&RMC could undertake to compliment the education campaign and encourage patients to use their private health insurance. Recommendations were formulated based on the results of the study.

Method

A survey of patients was undertaken using a representative sample. The survey tool was a questionnaire based on the results of a pilot study, conducted by interviewing Day of Surgery Admission (DOSA) patients who had private health insurance. The twenty patients who were in the pilot study were asked why they were using or not using their PHI in a public hospital. A number of recurrent themes were evident, and were used to develop a multiple-choice questionnaire. For some of the questions, respondents could choose more than one response. The pilot enabled the development of a survey that better targeted the area of interest and was more user friendly for both the respondent and the study team.

The questionnaire was designed to be administered by personal interview by a member of the project team. A personally administered questionnaire, undertaken during working hours, minimised the cost of information gathering, ensured immediate data collection, allowed for the clarification of questions as required, and ensured a high response rate.

The total sample was 200, including patients from the pilot study (n=20). The remaining sample (n=180) was constructed from daily admission lists, which indicate the financial status of the patients, that is, whether they were public, private, or third party (such as TAC, Workcover, DVA etc). Each Monday, Wednesday and Friday over a four-week period during the months of August and September 2001, a random sample of 15-16 public patients, who had been admitted the previous day, was surveyed. In total, 180 public patients were surveyed the day after their admission including 38 patients who had private health insurance but had been admitted as public. Considering these patients were admitted as public, it was initially assumed that these patients had elected not to use their PHI. The criterion for inclusion in the results was patients who had PHI but elected not to use it. Therefore, the results from the 16 patients in the pilot study who elected not to use their insurance are combined with the 38 survey patients who met the same criterion, giving a total of n=54.

During the interview process, it was found that 16 patients who had private health insurance and had intended to use it were admitted as public. These respondents were further questioned as to what influenced their original intention to use their private health insurance. This enabled comparison of responses from those intending to use their PHI with those who had no such intention.

As part of the survey, respondents were asked how long they had been privately insured, in order to ascertain

whether people had recently joined PHI agencies as a result of government initiatives. It was thought that patients may have taken out minimum health insurance policies to avoid higher tax and were still relying on Medicare. This question also enabled recognition of newly insured patients who were in an initial no-claim waiting period and were therefore unable to claim through their health insurance.

Respondents were also questioned as to their perceived level of knowledge of their health fund entitlements in order to identify whether patients who did not have good knowledge of their entitlements were less likely to use their PHI. The final question asked if patients were aware that the A&RMC would pay any excess they may incur from using their PHI. This question enabled the team to measure the awareness of the A&RMC's 'no out-of-pocket expense' policy.

The structure of the questionnaire allowed us to develop quantitative data from our survey results. The sample is too small to allow for meaningful analysis of statistical significance, but the results identify areas in which further study could be focused.

Results

Twenty-nine percent of the 200 patients interviewed had private health insurance, a higher proportion than the 2000/01 average of 19.1% (see Tables 1 and 2). The majority of the insured patients had held their insurance for more than 12 months (87%). Of the 54 insured patients who did not use their insurance, the majority (70%) never intended to use it for this admission. However, 16 patients (30%) with PHI had intended to use their health insurance, but apparently had not been given the opportunity to do so. This missed opportunity is of concern and further supports the need for extensive training of admission staff at all entry points to the hospital regarding the procedure of patient election in the admission process.

Of the 16 patients who had insurance and had intended to use it, 13 patients had multiple responses to the question regarding the reasons for electing to use their PHI. 43% indicated that the fact that there were no OOP expenses was the reason they would use it. Another 31% indicated that their reason for using the PHI was out of concern for the A&RMC and the public health system. Only 25% of the patients with insurance indicated that being able to choose their treating doctor was benefit enough to influence their choice (Table 3).

The remaining 38 patients with PHI who did not intend to use it reported a variety of reasons for their decision, with 28 patients giving two responses. 47% indicated that there was no incentive to use their PHI as they received no extras or benefits and 37% indicated that they thought it was 'a waste' of PHI and not value for money (Table 4).

82% of patients who intended not to use their PHI on admission were unaware of the hospital's policy to waive all out of pocket expenses. In contrast, 68% of the patients who did intend to use their PHI on admission to the hospital were aware of the hospital's waiver policy, and 43% of them said that having no OOP expenses was a reason why they would choose to be admitted as a private patient. This result indicates that patients who intend to use their PHI in a public hospital are more aware of the hospital initiatives to eradicate OOP expenses for private patients and that this is a significant factor in their decision-making (Table 5).

Regarding health fund knowledge, 50% of the patients who intended to use their PHI rated their knowledge as good to very good, 44% fair to poor and 6% very poor. In contrast, only 16% of those who never intended to use the PHI rated their knowledge good to very good, 63% fair to poor and 21% very poor. These results support our initial theory that patients with inadequate knowledge of the PHI entitlements were less likely to use their PHI in the public health system (Table 6).

Seven respondents (13%) were insured for less than 12 months and reported not using their health insurance on this admission because they were unable to claim through their PHI agencies due to being in an initial 12-month 'no-claim' period. It is not possible to estimate whether these patients would elect to be admitted as public or private in any future hospital admissions, or if they would choose a private hospital.

Table 2: Number of patients with Private Health Insurance

	Number in Sample	Number of patients with PHI
Pilot Study (n=20)	20	20
Survey (n=180)	180	38
TOTAL	200	58

Table 3: Reasons why patients would elect to use PHI.
(13 patients had more than one response to this question)

RESPONSE	Number of responses (n=16)	% total responses
Encouraged by staff	5	31
No OOP expenses	7	43
To help the hospital/public system	5	31
Did not consider NOT using it	8	50
Choose own doctor	4	25

Table 4: Reasons why patients did not elect to use PHI.
(28 patients gave two responses to this question)

RESPONSE	Number of responses (n=38)	% total responses
Have OOP expenses	12	31
No extras/benefits	18	47
No value for money/waste	14	37
Discouraged by medical / nursing staff	5	13
Not approached/told about it	10	26
Other (have waiting period – unable to claim)	7	18

Table 5: Awareness of A&RMC's no Out of Pocket Expenses Policy

RESPONSE	Patients who had intended to use their private health insurance		Patients who did not intend to use their private health insurance	
	Number (n=16)	Percentage (%)	Number (n=38)	Percentage (%)
YES	11	68	7	18
NO	5	32	31	82

Table 6: Knowledge of health fund entitlements

RESPONSE	Patients who had intended to use their private health insurance		Patients who did not intend to use their private health insurance	
	Number (n=16)	Percentage (%)	Number (n=38)	Percentage (%)
Good to Very Good	8	50	6	16
Fair to Poor	7	44	24	63
Very Poor	1	6	8	21

Discussion

Private health insurance coverage

Identifying potential private patients is difficult as patients not only have the right of election, but they also have the right not to disclose their private health insurance status. The Australian Health Care Agreement clearly states that "a patient election in relation to admitted patient services will not be directed by a hospital employee towards a particular decision" (DHAC 1999). This direction restricts the ability of the hospital to encourage people to utilise their insurance within the public hospital system.

However, there is reason to believe that the A&RMC could improve its private patient revenue. In 2000/01, the acute campus of the A&RMC reported a total of 19.1% of admitted patients who held private health insurance, whereas only 11% of the total separations in Victorian Metropolitan Hospitals reported the same. However, the conversion rate of those patients actually electing to use their PHI is only 27.6% at ARMC, compared to 33.6% conversion in Victorian Metropolitan Hospitals.

Perceived benefits and disincentives of using private health insurance

Although the majority of respondents did not see the benefit in using their PHI in a public hospital, some did. The two benefits considered worthwhile by patients were firstly, to help the A&RMC and public hospital system and secondly, their right to choose to be treated by their preferred doctor. The respondents who indicated their concern for the A&RMC and the public health system demonstrate a level of altruism. In order to appeal to this altruistic motivation the A&RMC needs to develop strategies to promote the social benefits of using PHI (eg assisting the hospital to meet the costs of equipment and of treating public patients).

Patients also indicated that they considered material items such as free television/telephone, better food, and a single room as being worthwhile benefits. The ability of the hospital to respond to these preferences is limited. The cost of providing these 'extras' is prohibitive in the current climate of public health care funding, and the costs involved will not necessarily see a commensurate increase in the number of privately insured patients using their PHI at the A&RMC. With respect to private rooms, the policy of the A&RMC, in common with most public hospitals, is that the limited numbers of single rooms are allocated according to clinical need.

Issue of out of pocket expenses (OOP)

A large proportion of publicly admitted patients with PHI were not aware of the hospital's policy to waive OOP expenses. While this issue alone is not likely to sway the decisions of all such patients, it is reasonable to assume that it will influence some, particularly those patients with high front-end deductible health insurance. As these patients will tend to favour the public hospitals to avoid OOP expenses, the A&RMC needs to identify and convert them to private admissions.

Conclusions

Health policy, like all public policy, is best judged by its results, not its intentions. The introduction of new financial incentives into the complex network of Australian health services, mediated as it must be by the behaviour of individual citizens as well as that of health care providers and insurers, is always at risk of producing unintended consequences, or failing to achieve its goals.

The apparent failure of the PHI reforms to produce a useful impact on the level of demand for public hospital admission is perhaps not surprising. Hindle (2000) argued that the causes of increasing pressure on public hospitals are not limited to the decreasing number of privately insured, but also to increased efficiency, growing expectations and demographic changes. He also points out that even if spare capacity emerged due to PHI reforms, patients who had been in waiting would quickly fill it.

A more recent impact analysis (Butler 2001) concluded that it was Lifetime Cover, not the 30% rebate, that convinced large numbers of younger Australians to purchase PHI. This finding adds fuel to concerns that the estimated $2,300,000,000 annual cost of the 30% rebate would have been better spent on public hospital and other health services (Duckett & Jackson 2000).

This study has shed some light on another unintended result of the PHI reforms: the apparently increasing trend for some insured patients to behave, at least in their admissions to public hospitals, as if they are uninsured, thus further reducing one important source of income for public hospitals. However, it has also highlighted that there are opportunities for public hospitals to maximise the 'conversion rate' of privately insured patients electing to use their insurance. Strategies include promoting and marketing of "No Out of Pocket Expense" policies and the benefits of selecting a doctor of choice. Further, the number of private elections could be increased through improved admission processes, and staff training, aimed at ensuring that private patients are identified and informed of their right of election and the associated benefits. There are also potential gains to be made from appealing to patients' sense of community by emphasising the contribution of private patient revenue to the financial viability of the hospital. It is vital that the A&RMC takes up these opportunities, in order to maximise its chances of meeting private revenue targets, an essential component of its operating budget.

In summary, the recent reforms to PHI have been highly effective in increasing the proportion of Australians covered by PHI, and in increasing admissions to private hospitals, but the intended benefits in reduced demand for public hospitals seem unlikely to eventuate. Further, patient responses to the complex rules governing use of PHI in public hospitals seem to limit the direct contribution increased PHI rates might have made to public hospital revenue. There are some strategies available to public hospitals to mitigate this negative impact.

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