

The price of choice: private health insurance in Australia

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Abstract

Private Health Insurance (PHI) is an integral part of the financing of the Australian health care system. PHI is popular and has strong political support because it is perceived to give choice of access and responsiveness. However, in the past increasing premiums have led to a progressive decline in membership. A package of reforms by the Commonwealth Government in support of the private health insurance has reinvigorated the industry over the last three years.

Some strategies for achieving a sustainable PHI industry are described. The key challenge is to control claims cost to maintain affordable premiums. Many techniques to do this compromise choice and challenge the very rationale for purchasing the product. Funds and providers will have to establish a new level of relationship to meet this challenge.

Introduction

Private health insurance (PHI) remains the predominant national health policy issue in Australia, with the key consideration being choice about access and responsiveness. It has a long history, starting with the formation of the first friendly societies in Sydney in the 1830s. The contemporary debate about PHI has its roots in the failed attempts to establish a national health scheme in the 1930s and 1940s, leading to the National Health Act of 1953, which, albeit much amended, still forms its legislative foundation. This period set the key structural features of the Australian health care system: fee-for-service medical practice; Commonwealth grants to the states for hospital services; Commonwealth pharmaceutical benefits and, most relevant to this article, Commonwealth subsidy of voluntary PHI. The Canadian political scientist Tuohy (1999) would describe this as the 'accidental logic' of the Australian health care system.

It is worth pondering why these features have been so robust? In the case of PHI it can be argued that this is because it well suits at least three main structured interests – the medical profession, private hospitals and the funds themselves (Alford 1976). However, the voting public has also shown its commitment to the integrity of the structure of the system. Certain electoral trouncing awaits politicians who would explicitly challenge it. Medicare, our compulsory tax-funded health insurance scheme, has strong public support, although in opinion polls they express concern that the health system is seen to be deteriorating, with waiting times and queues being the most frequently reported problems (Donelan et al. 1999). These concerns reinforce the desire to have a responsive health care system with choice of access, features perceived to be achieved through PHI.

Declining affordability of PHI has been a major challenge for some time, as premiums have escalated well above general inflation. In its pivotal 1997 review of the industry the Industry Commission noted that the affordability ratio of income to premium had fallen from near 45 to 25 in the ten years from 1984-85 and that PHI premiums had increased by an average of 3.5 times that of the Consumer Price Index (Industry Commission 1997, pxxxix).

The importance of choice

There has been a gradual realization in Western health systems that choice is of growing importance for many consumers. The Chancellor of the Exchequer in the UK recently commissioned Derek Wanless, a statistician and former CEO of the NatWest bank, to report on the long-term funding needs of the National Health Service. This is an unusual step for a treasurer to take and reflects the increasing political priority of support for the health service. Wanless notes "...expectations are rising fast and the evidence suggests that people will expect to have more choice in the future.(h)owever, capacity is the pre-requisite for choice" (Wanless 2002). To provide adequate capacity in the future not only applies to buildings and technology, but importantly to the right number and mix of workforce – challenges that also face Australia.

In the United States many forms of managed care have been perceived to reduce consumer choice, which has been attributed as the cause of the 'managed care backlash'. As a result "...managed care has gone from revolution to retreat" (Cunningham & Sherlock 2002, p24). Restrictions on choice of access to doctors, both by locality and specialty, and to hospitals, together with prospective and concurrent utilization review have been the main mechanisms by which managed care has sought to control costs. Each of these mechanisms risks reducing choice. Americans have now tended to shift their health insurance from "tightly managed" managed care to organisations that offer more choice. Many have returned to the traditional health insurers, the 'Blues'.

In Australia choice in health care is of increasing consumer concern. Medicare offers free choice of access to general practice and public hospitals. Access to specialist care is usually by referral, a mechanism well established and accepted. However, waiting lists for elective surgery and delays in emergency care, issues frequently used in the media to whip the government of the day (and not infrequently manipulated by self-interested groups) continue to worry people that they will not have access or responsive care when they need it. PHI is the main mechanism people use to assure this choice. Each of the four consumer organisations providing evidence to the Senate Community Affairs Legislation Committee (1998) considering the legislation to establish the 30% rebate articulated the wish of consumers to have PHI, so as to have choice of access to private providers, even though most did not endorse the rebate policy itself.

Maintaining this choice has been the cornerstone of PHI reform over the last 5 years. The Medicare Levy Surcharge (high income earners who do not have PHI pay an additional 1% Medicare levy), the rebate (a 30% refund of the cost of the PHI premium), gap-cover (insurance cover for an agreed increment above the Medical benefit Schedule of inpatient medical fees) and Lifetime Health Cover (LHC) (persons are charged an extra 2% per year on their premium for every year after age 30 at which they join a fund) have been an interconnected package of 'carrots and sticks' that has reversed the trend of declining membership (44.7% of Australians now have PHI compared to a nadir of 30.1% at the close of 1998), improved the age and hence risk profile of the funds (reducing fund member age by 4.3% from an average of 39.4) and restoring fund prudential reserves (ensuring funds are available to protect members' claims).

Choice through affordable PHI would seem to be a main policy driver in Australia. It has had bi-partisan political support, a key indicator of the endorsement of the majority of voters. However, maintaining affordability will require the control of the cost of claims.

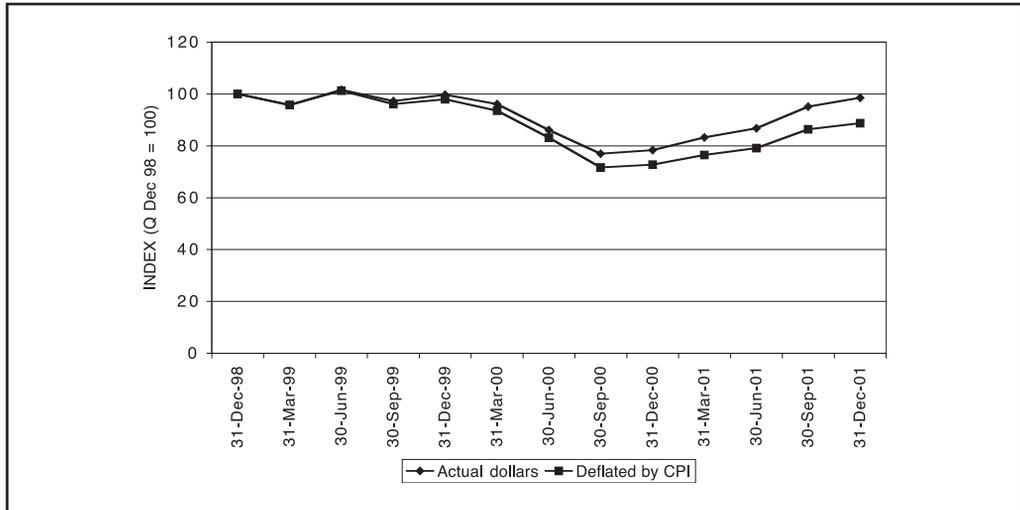
The need to control the cost of claims

The Industry Commission (1997) review noted that in the past the continual increase in PHI premiums above the CPI led to a 'vicious circle of falling membership'. Declining affordability led many people to drop their insurance, leaving growing adverse selection (those expecting high health care costs remaining in the funds) and 'hit and run' membership (those joining for long enough to have planned care, for example maternity care, and then leaving the fund), all leading to higher claims cost and hence premiums, further worsening affordability.

Since the nadir of fund membership in the December quarter of 1998 what impact has the package of reforms had on claims experience? Full details of fund benefit claims can be found on the Private Health Insurance Administration Council (PHIAC) web site from which the following data is sourced (Private Health Insurance Administration Council 2002). Figure 1 demonstrates the index of total hospital benefits paid per Single

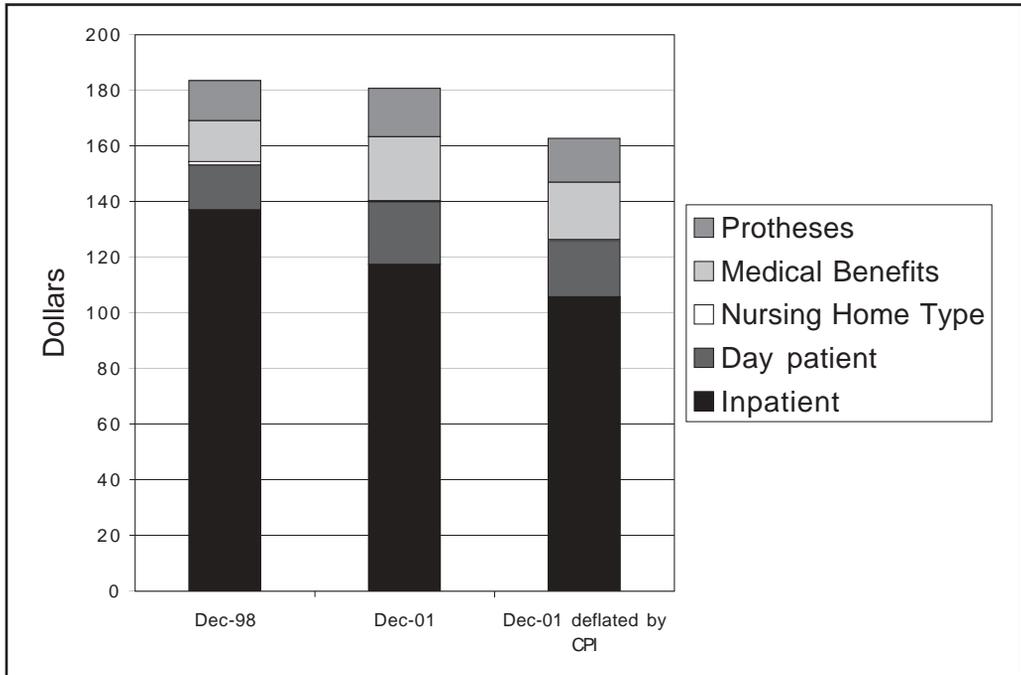
Equivalent Unit (SEU) since the December 1998 quarter. A single member is counted as one SEU and all other categories of membership (couples and families) are counted as two SEUs. The dip in the quarters from June 2000 to June 2001 (inclusive) is a result of the 12 months qualifying period (during which new members cannot make claims) of contributors who joined funds as part of the LHC initiative. The cost of total hospital benefits per SEU has otherwise remained stable in actual dollar terms but, when adjusting for inflation, has actually declined by 11.3% (Consumer Price Index Weighted Average of Eight Capital Cities (Australian Bureau of Statistics 2002)).

Figure 1. Index of total Hospital Benefits claims per SEU per Quarter (Dec-98 = 100)



Within total hospital benefits there have been variable changes to the cost of component parts. Figure 2 shows the changes in cost per SEU by benefit component from the December 1998 quarter to the December 2001 quarter (in actual dollars and deflated by the CPI). After adjusting for inflation the cost of benefits per SEU for overnight stay in acute hospitals has decreased by 22.8% even though cost per day increased by 8.9%. Benefits for 'nursing home type patients', while a very small component, has decreased by 59%. The cost of benefits for day hospital per SEU has increased by 25.6% with the cost per day increasing by 21.4%. Prostheses benefits increased by 8.9% per SEU (primarily due to price increases). The cost per medical benefit increased by 52% during the three-year period, but a reduction in average number of medical benefits per SEU has resulted in an overall increase of 38.3% per SEU.

Figure 2. Comparison of Hospital Benefit claims per SEU between Quarters Dec-98, Dec-01 and Dec-01 deflated by CPI to Dec-98 dollars



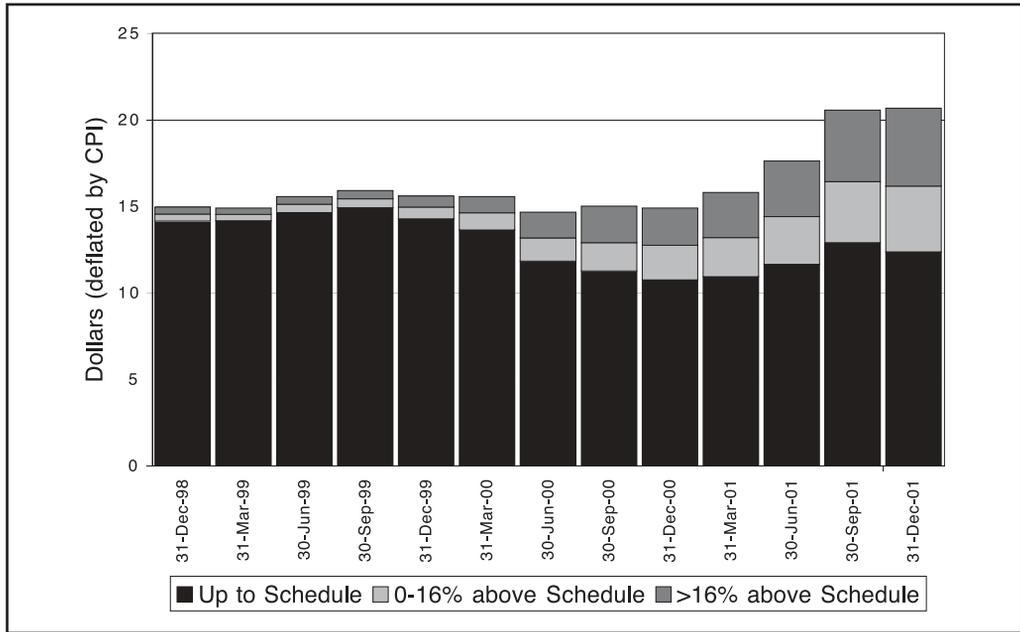
A large reduction in overnight acute hospital utilisation per SEU has more than offset increases in cost per acute hospital bed day and increases in day hospital, prostheses and medical benefits. There are likely to be multiple factors at work here including the trend to shortened hospital stay, greater substitution with day hospital care, increasing private hospital occupancy rates and, perhaps most significantly, the once off reduction in risk profile associated with LHC.

It is difficult to interpret the cause of the massive increase in cost of medical benefits per SEU (see Figure 3.). The impact of the introduction of 'Gap-cover' arrangements, whereby funds were able to arrange for cover for doctors fees above the 85% of the Medical Benefit Schedule, has been compounded by the LHC initiative, both because of the qualifying period and the improved risk profile of the fund membership. One assumes that the increase in payment per medical benefit offsets out-of-pocket payments previously paid by patients. This was, of course, the intention of the initiative. However, data is not available on these out-of-pocket payments and it would not be unexpected if some doctors, following normal economic incentives, now charge higher fees up to the level of insurance coverage because the patient no longer pays a gap.

Ancillary benefit claims (adjusted for inflation) per Ancillary SEU have increased by 11.4% over the 3-year period, mainly due to growth in benefits paid for optical, dental and fitness and lifestyle courses/equipment.

Clearly significant inflationary pressures on PHI premiums persist, although ameliorated by reduced overnight hospital bed use and the improved membership risk profile associated with LHC. Initiatives to control the growth of claims cost will, therefore, remain central to the sustainability of PHI.

Figure 3. Medical Benefits per SEU per Quarter (Deflated by CPI to Dec-98 dollars)



Sustaining the future of PHI

Sustaining a PHI industry will not be without its difficulties. Controlling the cost of claims will be the key challenge. Current cost trends give an indication of where the focus needs to be.

Acute hospital overnight costs are the largest component of total claims cost and therefore remains a focus for attention. Although utilisation of bed days per SEU is down, recent work on comparative efficiency between the public sector and the private sector suggests efficiency gains could still be there to be made (Duckett & Jackson 2000). Private hospitals offer a different product to public hospitals with a completely different structure of capital funding, so we cannot expect equivalent efficiency measures. However, a more widespread introduction of case-payment for private hospitals could lead to efficiency gains, as it did in public hospitals. Case payment could also add encouragement to further substitution of overnight hospital stays with day hospital services and encourage efficient use of prostheses.

Gap-cover arrangements, while responding to public appeal, may yet prove a two-edged sword for the funds. As medical fees become a more significant component of claims the need to control doctors fees will grow in importance. This will not be easy for the funds because of the capacity of doctors to mobilise public support in their own interest.

Here is the nub of the dilemma -- approaches to controlling claims cost, such as hospital contracts and other risk transferring strategies, dare I say 'managed care' strategies, inevitably lead to reducing contributors' choice. Yet it is this choice that forms the basis of their membership in a PHI fund.

The USA experience with managed care provides important lessons, which we do not need to relearn. Experience there has been that 'tightly managed care', in the form of limiting access to doctors and hospitals and prospective and concurrent utilisation review, has been counter-productive in causing a major consumer 'backlash'. The traditional health insurers, the 'Blues', have not only survived the managed care onslaught but have recently been thriving (Cunningham & Sherlock 2002). It would seem that the problem is as much in the method of implementation as in the strategies themselves.

This experience suggests some factors that could contribute to the sustainability of PHI in Australia.

- The traditional insurance disciplines of actuarial expertise, sales and marketing, claims administration and provider management remain important (Richter 2001).
- Provider relationships will be key to implementing clinical utilisation strategies, practice reorganisation and information and clinical technology that can contribute to a sustainable growth in cost yet adequate provider incomes. It is difficult to see the industry surviving cost growth above the general level of real growth in health expenditure of around 2% per annum. Both sides have a vested interest to ensure that this occurs, but it will be a challenge for their respective leaderships. Perhaps a greater commitment on both sides to improving quality and reducing clinical error may help reframe the problem as one not just about cost control.
- Marketing innovations may be required to allow consumers to trade-off between choice and premium cost, such as in the emerging 'tiered networks' in the US. Maintaining the commitment of younger members will be most important. 'Healthy lifestyle' strategies, such as payment of gym fees, seem trivial strategies to enlist their support. Perhaps consideration could be given to establishing 'aging reserves' to enable younger members to save some of their premiums to fund future premium liability when they are older.
- Adequate reserves to buffer against the sharp swings in price and profitability that characterize the insurance underwriting cycle. Access to the capital market is limited to the for-profit insurers. Ten percent of the US 'Blues' have turned for-profit and although having some influence on their recent success it has not proven decisive.
- Horizontal integration of funds with the aim of creating economies of scale has highlighted the complexity of health insurance. The US experience has been that "(m)any of the most important economies of scale in the health insurance business are realized in local markets, especially in provider-related functions such as contract negotiations and utilization management. Certain administrative expense savings such as information systems, while minor relative to total premium revenues, can be important relative to profits in a business with such small margins" (Cunningham & Sherlock 2002) Given the importance of provider relations to containing claims cost, this will be an important consideration in any attempts to consolidate the Australian industry.

Conclusion

PHI is an integral part of the structure of the Australian health care system. The Commonwealth Government has, over the last few years, implemented a set of policy initiatives that have revitalized it. Although the subsidy for PHI has been challenged by some economists on efficiency (Duckett & Jackson 2000) and equity (Palmer 2000) grounds, the political reality, reflecting public views about choice, gives it bipartisan support. It is now up to the funds and the providers to develop effective relationships that will keep the cost of claims at an affordable level, while still assuring consumers about choice.

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