

The lore about private health insurance and pressure on public hospitals

DAVID CROMWELL

David A Cromwell is Senior Research Fellow at the Centre for Health Service Development, University of Wollongong, Wollongong, New South Wales.

Since being elected in 1996, the Coalition government has pursued a raft of policies to increase the proportion of Australians with private health insurance. Against some criteria, these policies have been a success. The proportion of Australians with private health insurance had gradually fallen from around 50% in 1984, to be around 30% in late 1998. With the introduction of a 30% rebate on health insurance, and the introduction of premiums based on a person's age at the time of joining a health fund, coverage rose to 45.9% by September 2000 and has dropped only slightly since (AIHW, 2002). Moreover, the cash reserves of the health insurance companies have improved substantially from the unhealthy levels reported in 1997 (Cormack, 2002). It has also succeeded in giving many more people the ability to make a choice about their health care (Department of Health and Aged Care, 1999).

One of the justifications for these policies is the belief that falling levels of private health insurance threaten the viability of both the public and private hospital system (Department of Health and Aged Care, 1999). But the relationship between levels of private health insurance and the use of hospital services is poorly understood, and there are few estimates of the size of the effect. One estimate was enshrined in the 1998-2003 Australian Healthcare Agreement. The effect of each 1% change in the level of coverage on public hospitals was costed at \$82 million (though funding would only change once the level of coverage moved outside a pre-defined range). Another estimate comes from the submission to the Senate inquiry into public hospitals made by the Department of Health and Aged Care. Departmental staff estimated that if the coverage of private health insurance continued its steady decline (average 1.89% between 1991-98), the public hospital sector would need to provide an additional 1.2 million bed-days in 2002-03 (Department of Health and Aged Care, 1999). They also estimated that, if observed trends continued, the Commonwealth would need to pay the States about \$500 million extra per year by July 2001.

Unfortunately, neither document contains sufficient detail to determine how these figures were derived, but the basic elements of the methods may have been similar to the next example. This was contained in the submission to the Senate inquiry from the University of New South Wales (Hindle, 2000). Used to estimate what effect the 30% rebate would have on public hospital activity, their method consisted of the following elements:

- estimating the number of people who would retain membership with the rebate;
- estimating the number of inpatient days that these people would use;
- estimating the proportion of these inpatient days that would now occur in (be transferred to) private rather than public hospitals;
- estimating the expected cost associated with these transferred days.

Using their method and data, a 1% change in coverage is estimated at transferring between 124,480 and 145,800 inpatient days, and costing between \$78 - \$91 million. These figures are broadly similar to the other cited estimates.

In this edition of Australian Health Review, Hanning (2002) uses a different method to estimate how the increased level of private health insurance might be reducing the pressure on public hospitals. The primary focus is on elective surgery in Victoria, and he uses data on elective activity in both private and public hospitals to speculate on what might have happened to surgical waiting lists had the reforms not stopped the downward trend in the level of private health insurance. The data show the number of additions to the waiting list has fallen since 1998, and Hanning concludes that, without the reforms, the number of Victorians waiting for elective surgery would have been substantially higher, with similar situations emerging in other States.

The article by Hanning serves a useful purpose by bringing together a variety of data that show how rates of elective surgery have changed since the government reforms. It had been suggested that the reforms would eliminate waiting lists (APHA, 1998), but there has been little change in their size. Whether the waiting lists would have been much longer if the level of private insurance had continued to fall, as Hanning suggests, is unclear because competing pressures are not examined. For example, the possibility that rates of addition to waiting lists adjusted to reduced rates of elective surgery (caused by the increased rates of emergency admissions in Victoria (Department of Human Services, 2002)) is overlooked. Moreover, experience suggests that, at a regional level, inpatient waiting lists tend to remain fairly stable despite changes in rates of admission and addition (Goldacre et al., 1987; Newton et al., 1995).

Nonetheless, it must be acknowledged that waiting list dynamics are not well understood. The rate at which patients join a waiting list, and the rate (and order) at which they leave it (either as an admission or a removal) are influenced by the many individual decisions of patients, general practitioners and surgeons, decisions which in turn are shaped by, and represent trade-offs between many factors. And these rates are not constant. Demand can vary with background levels of morbidity, the changing geographical distribution of services, the availability of potential substitutes for hospital care, and greater community expectations. Elective surgical activity can change with altered work practices, workforce shortages and disputes, as well as with varying demand for the same resources from other patient streams.

Given this complex interaction of factors, it becomes difficult to quantify their effect on each other or the impact of some specific intervention (eg, a waiting list reduction program). Most studies of waiting lists are either built on insightful, but ultimately unrealistic, theoretical models, or have examined only a few of the many factors that affect their behaviour. One exception was the empirical analysis by Martin and Smith (1995) in the UK. Their model of the determinants of waiting times incorporated both demand and supply factors, and allowed for the fact that these could be influenced by waiting times. Their work was primarily concerned with changes within the UK public hospital sector, but is of interest on two accounts. First, over the long term, the results suggest greater public hospital activity will reduce waiting times, as latent demand will increase by less than the amount of extra activity. Second, the estimated effect of additional private hospital beds was limited; a 10% increase in the number of beds reducing elective surgery demand on public hospitals by 1%. The latter result should be treated cautiously in terms of the Australian context, as the organisation of hospital care and levels of private health insurance differ greatly. However, their model highlights how we might begin to search for a greater understanding of how the private and public sectors interact.

The 1998-2003 Australian Healthcare Agreement committed the Commonwealth and States to explore the relationship between health insurance coverage and use of hospital services by private patients. That work in this area is needed was surely demonstrated by the decision of the Commonwealth not to invoke the claw-back clause in the Australian Healthcare Agreement. And there are various reasons why improving our understanding is becoming a priority. One reason is that the 30% rebate has been shown to be an inefficient way in which to support the public hospital system (Duckett and Jackson, 2000; Healthcover, 2000; Hindle, 2000), and it is not clear that current policies could be afforded when the good economic times Australia is currently enjoying end. Another reason is that a shift of activity to the private system may not always relieve pressure on the public system. This might arise because patients do not necessarily undergo equivalent care in both systems, and so such a shift might result in a disproportionate transfer of medical resources (Robertson and Richardson, 2000). Finally, there has been some disturbing evidence that mortality rates of patients differ among private for-profit and private not-for-profit hospitals (Devereaux et al., 2002).

These studies undermine the conventional wisdom about private health insurance and pressure on public hospitals, but new knowledge is required before it will be discarded. For this, progress must be made on two fronts. First, better models are needed, ones which capture the richness of the interactions between health insurance levels and all hospital activity. It will be necessary to consider at least the following variables: changing demographics of Australia, the geographical distribution of public and private hospitals, the age-sex distribution of the population with private health insurance, and how these groups use hospital services and their insurance. Another key factor is the effect of specialists working in both sectors. Second, this research needs to be supported by improvements in data. In particular, it will be necessary to collect standard measures of clinical symptoms so that levels of access can be monitored. There are still wide variations in hospitalisation rates across Australia (AIHW, 2002), and a better understanding of this variation is required if any progress is to be made in determining how pressures on hospital services are changing.

References

- APHA 1998, 'An open letter to all Labor, Democrat, Green and Independent Senators', *The Australian*, 9 December 1998, pp 9.
- AIHW 2002, *Australia's Health 2002: the eighth biennial health report of the Australian Institute of Health and Welfare*, AIHW, Canberra.
- Cormack M 2002, 'Private health insurance: the problem child faces adulthood', *Australian Health Review*, vol 25, no 2, pp 38-51.
- Devereaux PJ, Choi PTL, Lacchetti C et al. 2002, 'A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals', *CMAJ*, vol 166, no 11, pp 1399-1406
- Department of Health and Aged Care 1999, *Occasional papers: new series no.4, Private Health Insurance*, Commonwealth Department of Health and Aged Care, Canberra.
- Department of Human Services 2002, *Hospital Admission Risk Program (HARP) background paper*, Emergency Demand Coordination Group, Department of Human Services, Victoria.
- Duckett S and Jackson T 2000, 'The new health insurance rebate: an inefficient way of assisting public hospitals', *Medical Journal of Australia*, vol 172, pp 439-442.
- Goldacre MJ, Lee A, Don B 1987, 'Waiting list statistics 1: relation between admission from waiting list and length of waiting list', *British Medical Journal*, vol 295, pp 1105-1108.
- Hindle D 2000, 'Taking health seriously: the Senate inquiry into public hospitals', *Australian Health Review*, vol 23, no 2, pp 3-9.
- Hanning B 2002, 'Has the increase in private health insurance uptake affected the Victorian Public Hospital Surgical Waiting List?', *Australian Health Review*, in press
- Healthcover 2000, 'Criticism of 30% rebated: trickle becoming a flood', *Healthcover*, vol 10, no 5, pp 1-5.
- Martin S and Smith P 1995, *Modelling waiting times for elective surgery*, Centre for Health Economics, University of York, York (UK).
- Newton JM, Henderson J, and Goldacre MJ 1995, 'Waiting list dynamics and the impact of earmarked funding', *British Medical Journal*, vol 311, pp 783-785.
- Robertson IK, Richardson JRJ 2000, 'Coronary angiography and coronary artery revascularisation rates in public and private hospitals after acute myocardial infarction', *Medical Journal of Australia*, vol 173, pp 291-295.