PATIENT ELECTION IN AUSTRALIAN HOSPITALS: HOW DO PRIVATE AND MEDICARE ADMISSIONS DIFFER?

Jeromey Temple

Recently, the Premier of Queensland has proposed placing restrictions upon privately insured patients electing to be treated as Medicare patients in public hospitals as is currently permitted under the Australian Health Care Agreements. The purpose of this paper is to examine differences in four kinds of patient admissions in Australian hospitals. Results drawn from the 2001 Australian Bureau Statistics (ABS) National Health Survey show that almost 11 per cent of all hospital admissions in 2001 were by privately insured patients admitting themselves as Medicare (public) patients. A further 37 per cent were by privately insured patients in either private or public hospitals. Of the remaining 48 per cent of hospital admissions, approximately six per cent were by uninsured persons who are admitted as private patients in either private or public hospitals. The final 42 percent of admissions were uninsured Medicare patients in the public hospital sector. These four groups of patients are found to differ considerably by their socio-economic characteristics, use of hospitals and also by reported reasons for purchasing or not purchasing private health insurance.

INTRODUCTION

In October 2005, Queensland's Premier Beattie and the Minister for Health, Stephen Robertson, launched an *Action Plan* to improve Queensland's public health system, at the cost of $6 billion over five years.[1] Although the plan is quite comprehensive, one aspect that has generated considerable interest is implementing a program to increase the proportion of privately insured patients in public hospitals who elect to be treated as private patients rather than as Medicare (public) patients. The reform package also includes the introduction of co-payments or means testing for non-urgent surgical procedures, as well as for dental and specialist outpatient services. Beattie has argued: 'We're sick of the public system being ripped off. We actually believe those people who are making a financial contribution to a private health fund would expect their fund to contribute'.[2]

Currently, under the Australian Health Care Agreements (AHCA), all Australians regardless of health insurance status, are entitled to admit themselves as Medicare patients in public hospitals, thereby receiving free treatment. Upon entry to hospital, all patients are required to fill in a patient election form which records whether they are to be treated as a public patient, thereby avoiding out of pocket expenses, or as a private patient, enabling them to skip the public sector surgical queue for elective procedures. Indeed, the Federal Minister for Health, Tony Abbott, has stated that Beattie's proposed reforms constitute a breach of the AHCA, and he is investigating means of blocking them.[3]

Beattie, however, is not the first to draw attention to the use of public hospitals as public (Medicare) patients by privately insured patients. In February 2005, The Productivity Commission released the *Review of National Competition Policy Reforms*.[4] This report summarises '... it is generally accepted that the financing and delivery arrangements give rise to considerable inefficiency and waste in the health system'.[5] One of the proposals for reducing this inefficiency was 'allowing, or obliging, those people who can afford adequate private health insurance to opt out of the public system'.

A month later, the Australian Government Department of Health and Ageing released a report examining the

use of public hospitals by private patients.[6] This study found that, of the privately insured who had admitted themselves as private patients in public hospitals, about 65 per cent made the choice freely. About eight per cent reported that they were pressured into being admitted as private patient, and a further 10 per cent said they were not given a choice as to whether they were to be admitted as a Medicare or private patient.

More recently, in September, the *Queensland Health Services Review* was released; the precursor to Beattie's new health plan.[7] This report estimated that about six per cent of patients in Queensland's public hospitals are privately insured but do not elect to use their private insurance when being treated. The report makes a list of recommendations for reform, including, to 'encourage all patients with private health insurance to use it as private patients in public hospitals or in the private hospital system'.[8]

The aim of this paper is to examine how privately insured patients who admit themselves as public patients differ from other types of hospital admissions. More specifically, this paper seeks to provide evidence on the following: firstly, why do the privately insured who admit themselves as public patients in public hospitals purchase health insurance if they do not use it for hospital care? and; secondly, how do the economic and demographic characteristics of the privately insured who admit themselves as Medicare patients differ from other patients?

THE PRIVATE/MEDICARE PATIENT DECISION

Between 1997 and 2004, the Federal Government introduced key reforms to the private health insurance market: the Private Health Insurance Incentives Scheme (PHIIS), the Private Health Insurance Incentives Act (PHIIA) and Lifetime Health Cover.

PHIIS encouraged private health insurance membership through a series of subsidies and tax penalties that were applied at different income levels. PHIIS introduced the Medicare levy surcharge, which is an additional one per cent tax on annual income paid in addition to the 1.5 per cent Medicare Levy. Singles with incomes higher than $50,000 per annum and couples with an income in excess of $100,000 were required to pay the one per cent Medicare surcharge, in addition to the 1.5 per cent Medicare levy, if they did not purchase a registered private hospital insurance policy. PHIIA replaced PHIIS in January 1999. The key component of this new policy was a 30 per cent subsidy on household health insurance premiums for all persons regardless of their income. PHIIA retained the one per cent Medicare surcharge. The final reform over this period was 'Life Time Health Cover' (2000), which changed the age component of community rating, by offering low premiums to people who invested in health insurance prior to turning 30. All persons aged over 30 at July 2000 are required to pay a two per cent surcharge on their insurance premium for each year that they remain uncovered. One important provision in Life Time Health Cover was that individuals born before 1st July 1934 were exempt from the surcharge.

At the time of these changes, the then Minister for Health and Aged Care claimed that these reforms would 'take pressure off the public hospitals'.[9] The current Minister for Health and Ageing, Tony Abbott, has continually supported the notion that increasing private health insurance coverage leads to less pressure on the public health care system.[10]

A growing body of literature has questioned the assumption that increased health

insurance coverage in the population relieves 'pressure' from the public hospital sector through shifting surgical procedures to the private hospital sector. Many argue that the 30 per cent rebate in particular is an inefficient, expensive means of reducing pressure on public hospitals and that the rate of increase in health insurance premiums is continuing to increase the public subsidy cost.[11] The 30 per cent rebate has also been criticised as it covers many non-essential ancillary services not offered in the public hospital sector.[12]

Vigorous debate also continues on the effect of the reforms on public sector waiting lists for elective surgery. Some researchers have provided evidence that waiting lists have remained stagnant or actually increased, while others argue waiting lists would have been larger without the reforms.[13] It has been suggested that differences in wages paid to doctors for different surgical procedures performed in private and public hospitals result in a flow of services being offered in the private hospital system, resulting in increased public sector waiting lists.[14]

Through the Australian Health Care Agreements (AHCA) all Australians covered by Medicare are eligible for treatment and accommodation in public hospitals. Medicare patients are not entitled to choose their doctor, nor are they eligible to be treated in a private hospital. For some elective procedures, Medicare patients may be placed on a considerable waiting list. However, the advantage of being treated as a Medicare patient in a public hospital is that all costs are met through Medicare. A privately insured patient may elect to admit themselves as a *Medicare* patient in a public hospital. When admitted to a hospital, all patients are required to sign a 'Patient Election Form' recording whether the patient is admitted as a Medicare or private patient.[15]

Alternatively, a patient may elect to enter a public hospital as a private patient, giving the advantage of choice between doctors and a shorter waiting period for elective surgical procedures. A private patient may also admit themselves as a private patient into a private hospital. A patient is defined as 'private' if they have private hospital insurance, or if they meet the expenses for hospital care out of their own pockets, that is, they self- insure. As will be discussed, the disadvantage of treatment as a private patient is the possibility of out-of-pocket expenses through 'gap' fees, or Front End Deductibles (FED).

In the context of the health insurance reforms and debate about the effect on the public hospital sector, it is suprising that only a few studies have examined the characteristics and prevalence of privately insured patients admitting themselves as public patients in public hospitals. In a recent study Walker and colleagues, find: firstly, among the privately insured about 31 per cent who had been admitted to a hospital in the previous 12 months were admitted to a public hospital as either private or Medicare patients and; secondly, low income earners, with or without health insurance, were more likely to use a public over a private hospital.[16]

In an earlier study, Sullivan et al., examined the difficulty of encouraging the insured to use their health insurance when admitted into public hospitals.[17] They showed that about 33 per cent of insured patients in Victorian metropolitan hospitals declared and used their private health insurance. Out of a small sample of 38 respondents, about 31 per cent cited out of pocket expenses as a reason for not using their health insurance. A further 47 per cent cited 'no extras/benefits' for not declaring their private health insurance status.

Among the limited data available, results from the 1998 ABS health insurance survey show that about 15 per cent of public hospital admissions are by privately insured patients electing to be treated as public patients. A further 13 per cent of public hospital admissions are by privately insured patients admitting themselves as private patients.[18] Given the timing of recent reforms to the private health insurance industry, these figures require revision. The health insurance reforms have increased the proportion of the population with health insurance, creating a higher propensity for hospital admissions to be from those who are privately insured. This implies a differing distribution of those entering hospitals by health insurance status.

TYPOLOGY OF PATIENT ELECTIONS

Data from the 2001 ABS National Health Survey enable an examination of the socio-economic characteristics of persons who have been hospitalised in the past 12 months tabulated by health insurance status and by whether the patient was admitted as a private or Medicare patient.[19] An important limitation of these data is that it is not possible to separate those patients admitted into private hospitals from public hospitals. However, given the rules governing access to private hospitals, it is possible to formulate the hospital admission typology shown in Table 1.

Respondents in cell A have private health insurance but admit themselves as Medicare (public) patients in public hospitals. This group accounts for almost 11 per cent of hospital admissions. These patients have been the focus of recent government reports and are the target of Beattie's new health funding reforms as discussed above. A further 46 per cent of admissions are uninsured patients who admit themselves as public patients (Cell B). Cells A and B represent fully funded Medicare patients in the public hospital (most large public hospitals have private wards for such patients) sector. One caveat, however, is that the ABS defines Department of Veterans Affairs patients as Medicare patients. Some of these admissions may have occurred in private hospitals.

In contrast, cell C consists of the privately insured who admit themselves to private hospitals or admit themselves as private patients in public hospitals. These patients are estimated to account for about 37 per cent of all admissions. The final six per cent of hospital admissions are the uninsured, who elect to be treated as private patients in either public

Table 1: Typology of hospital admissions, by insurance status and patient election type, Australians aged 15 years and over

	Hospital Health Insurance Status	
	Insured	*Uninsured*
*Medicare Patient**	A. In the public hospital sector as a Medicare patient. **10.7%** (CI =9.5, 11.9) n=282	B. In the public hospital sector as a Medicare patient. **46.0%** (CI =44.2, 48.0) n=1,213
Private Patient	C. In the public or private hospital sector as a private patient. **37.4%** (CI =35.5, 39.2) n=984	D. In the public or private hospital sector as a private patient. **5.9%** (CI =5.0, 6.8) n=155

Source: 2001 ABS National Health Survey
Notes: CI = 95 per cent Binomial Wald Confidence Interval; n = cell size;
* includes an undisclosed number of Department of Veterans Affairs patients who may be treated as public patients in private hospitals, hence the term Medicare patient.

or private hospitals (cell D). These patients are the self insured and meet the cost of hospitalisation out of their own expenses.

WHY PURCHASE OR NOT PURCHASE PRIVATE HEALTH INSURANCE?

The AHCA guarantees free accommodation and treatment in public hospitals for all Australian citisens. Given this subsidised alternative, why do Australians who are admitted to hospital purchase health insurance at all? Tables 2 and 3 present results from the 2001 National Health Survey, which asked respondents why they purchased health insurance and, in the case of, non-purchase, why they did not. Respondents could select more than one option. These data enable an examination of the differing reasons for purchasing or not purchasing health insurance by patient election type.

As shown in Table 2, there are shared reasons given by Medicare and private patients regarding why they chose to purchase hospital insurance. Both agree that access to shorter waiting times for surgery and security or peace of mind were important factors driving their decision to purchase hospital insurance. In contrast, private and Medicare patients differ significantly when asked whether Life Time Health Cover or to gain government benefits were significant factors in their decision to purchase health insurance. About 7.5 per cent of public patients cite Life Time Health Cover as a reason for purchasing insurance, when compared to just two per cent of private patients. A further nine per cent of public patients cite to 'gain government benefits or to avoid the Medicare levy surcharge', compared to just 4.5 per cent of private patients. However, private patients are more likely than Medicare patients to report allowing treatment as a private patient in a public hospital (10.2 versus 3.6) and having always had it (17.1 versus 9.6) as reasons for purchasing health insurance.

Table 2: Reasons for purchasing hospital insurance, by patient election type, Australians aged 15 years and over, 2001.

	Insured, Medicare Patient per cent	Insured, Private Patient per cent
Security / peace of mind	13.8	10.8
Life time cover / avoid age surcharge	7.5	1.9 ***
Choice of doctor	1.8	3.1
Allow treatment as private patient in public hospital	3.6	10.2 ***
Provides benefits for ancillary services	4.6	4.3
Shorter waiting time	16.7	17.8
Always had it / condition of employment	9.6	17.1 ***
Gain government benefits / avoid medicare levy (surcharge)	9.2	4.5 **
Other financial reasons	5.7	4.9
Has condition that requires treatment	7.1	8.1
Elderly / getting older / likely to need treatment	9.2	8.4
Other reason	11.4	9.0
Total (N)	282	984

Source: 2001 ABS National Health Survey
Notes: Base category for test of proportion is Insured Medicare Patient; *** p<0.001 ** p<0.01.

Table 3: Reasons for not purchasing hospital insurance, by patient election type, Australians aged 15 years and over, 2001

	Not Insured, Medicare patient	Not Insured, Private patient
	per cent	per cent
Can't afford to	49.8	17.7 ***
High risk category	0.5	0.7
Not worth it	5.1	10.2 *
Medicare cover sufficient	10.7	2.0 ***
Don't need it / in good health	4.6	0.7 ***
Won't pay both medicare levy and insurance	1.3	2.0
Disillusionment about out-of-pocket costs / gap fees	3.2	2.0
Prepared to pay out of own resources	0.6	5.5 **
Concession card adequate	11.5	48.3 ***
Not high priority	4.9	4.1
Other	7.9	6.8
Total (n)	1171	147

Source: 2001 ABS National Health Survey
Notes: Table excludes 50 respondents who have ancillary insurance only; Base category for test of proportion is Insured Public Patient; *** p<0.001 ** p<0.01 * p<0.05.

These results provide evidence that many insured persons purchase health insurance simply to avoid government levies through the Medicare Surcharge and Lifetime Health Cover. One potential consequence of this is that, when they do purchase health insurance, they tend to purchase lower cost policies, which include high Front End Deductibles (FED). A FED is an excess that must be paid by patients to the health insurance fund before they can be admitted as a private patient in either a private or public hospital. Many commentators contend that high FED's are a reason that the privately insured do not use their private health insurance when admitted into hospital.[20] That is, rather than admitting themselves as private patients and therefore incurring the deductible, a person can admit themselves as a Medicare patient and have no out-of-pocket costs.

Figure 1 displays the proportional growth in FED products relative to non front-end policies over the period 1997-2001. At the time of the implementation of PHIIS, approximately 32 per cent of policies had a FED. By 2000, with the introduction of Lifetime Health Cover, FED products grew to 52 per cent. In 2000, the Federal Government excluded products with a high FED from the list of registered health insurance policies that enables the purchaser to avoid the Medicare Levy Surcharge. A high FED policy is defined as one that involves an excess payment of more than $500 for single contributors and $1000 for single parent, family or couple memberships.[21] All persons who had purchased a high FED policy prior to May 2000 are excluded from this clause so long as they maintain the same policy. Despite this policy change, the proportion of FED products relative to non-FED health insurance policies has continued to rise. As of June 2005, approximately 60 per cent of all policies have a FED. Due to the clause excluding purchases prior to 2004, a substantial proportion of FED policies may have a high FED.

In addition to FED charges, a disadvantage of admission as a private patient into a public hospital is the possibility of

'gap fees'. The Commonwealth Government has established a 'recommended' schedule of fees and services, known as the Medicare Benefits Schedule (MBS). Medicare covers approximately 75 per cent of the MBS fee, and the patient's health insurance fund covers the remaining 25 per cent for in hospital services.[22] However, doctors and specialists are not legally obligated to charge in accordance with the MBS. For example, a doctor may charge 120 per cent of the MBS fee, leaving a 20 per cent 'gap' in expenses that are not meet by Medicare or by the patient's health insurance fund. Gap insurance can be provided by the patient's health insurance policy. However, gap insurance rests on the provision of an arrangement between the patient's health fund, doctor and/or hospital to have a gap agreement or gap cover scheme in place. This undermines one of the key advantages of private health insurance: choice of doctor. A recent report commissioned by the Commonwealth Department of Health and Ageing showed that 44 per cent of private patients experience gap payments and 36 per cent perceived the gap payment to be 'considerable'.[23] Responding to these findings, the Minister for Health, Tony Abbott stated: 'There will always be some cases where patients face unanticipated costs. Still, the sector needs to do better than this if private medicine is to continue to flourish'.[24]

From either perspective, through gap payments or payment of an excess on FED insurance policies, the insured can incur significant out-of-pocket health expenses for care as a private patient in the public or private hospital sector. This acts as a strong disincentive to admit oneself as a private patient in a public or private hospital. However, the strong incentive to purchase a hospital health insurance policy remains: to avoid the additional one per cent Medicare surcharge introduced under PHIIS and to avoid the two per cent tariff imposed under Life Time Health cover.

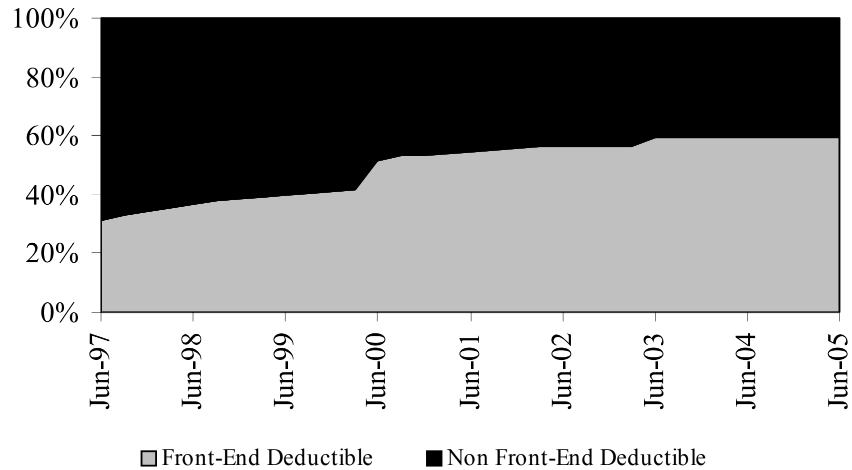
Table 3 displays the percentage of persons reporting different reasons for not purchasing private health insurance, classified by their most recent patient election type. Compared to uninsured private patients, uninsured Medicare patients are far more likely to report 'Can't afford to' as a reason for not purchasing health insurance (49.8 versus 17.7). Medicare patients are also more likely than private patients to report 'Medicare cover sufficient' (10.7 versus 2) or 'Don't need it' (4.6 versus 0.7) as reasons for not purchasing health insurance. In contrast, private patients are far more likely to report a health concession card as providing adequate health coverage when compared to public patients (48.3 versus 11.5).[25] Private uninsured patients are also more likely than Medicare patients to report that health insurance is not worth it or that they are prepared to pay for health care out of their own resources as reasons for not purchasing health insurance.

These data provide evidence that uninsured private patients are wealthier and, by virtue of their concession card status, older than uninsured public patients. Unlike younger Australians who are only eligible for the low income health care card, many older Australians may be eligible for concessions through the Pensioners Concession Card Commonwealth Seniors Health Care card or the Veterans Affairs card. The income eligibility requirements are particularly generous for the Commonwealth Seniors Health Care Card.[26]

DIFFERENCES IN PATIENT ELECTION BY SOCIO-ECONOMIC AND HEALTH CHARACTERISTICS

Table 4 classifies type of patient

Figure 1: Percentage of health insurance policies with a Front End Deductible (FED), 1997 to 2005



Source: Private Health Insurance Administration Council, 'Statistical trends — memberships and benefits', 2005

admission by selected demographic, economic and health characteristics, using two comparison categories. In the first panel, Medicare patients with no private hospital insurance are compared with private patients who hold no private health insurance. In the second, privately insured patients admitted as Medicare patients are compared with privately insured patients admitted as private patients.

Relative to uninsured Medicare patients, uninsured private patients are older. For example, just over half of all uninsured private patients are aged 60 and over, compared with just 31 per cent of uninsured Medicare patients. Reflecting this older age profile, uninsured private patients are more likely to have multiple long-term health conditions and are also over represented among higher income earners. It is important to recall that all persons born before 1934 were excluded from the Lifetime Health cover rules, as discussed earlier.

Compared to the privately insured admitted as Medicare patients, the insured admitted as private patients are more likely to be older but, interestingly, there is no distinction in the income profile between these patient admission types. Results from the National Health Survey also show that, compared to insured Medicare patients, insured private patients tend to have a larger number of long-term health conditions. Importantly, the insured Medicare patients have also held their insurance policies for a much shorter period of time than the private patients. For example almost 52 per cent of privately insured public patients purchased health insurance in the past two years, compared with just 14 per cent of insured public patients.

DISCUSSION

In light of continual criticisms of the recent health insurance reforms, Premier Beattie has suggested implementing a policy to 'encourage' private patients to admit

Table 4: Differences in hospital admission, by insurance and patient type, and selected Factors, Australians aged 15 years and over

	No Private Hospital Insurance		Private Hospital Insurance	
	Medicare Patient, per cent	Private Patient, per cent	Medicare Patient, per cent	Private Patient, per cent
Age				
15-29	28.8	13.6 ***	17.4	12.7 *
30-44	23.9	21.3	37.9	28.7 **
45-59	16.1	14.8	23.8	22.7
60-74	18.7	11.6 **	13.8	23.8 ***
75+	12.5	38.7 ***	7.1	12.2 **
Total	100.0	100.0	100.0	100.0
Equivalent Income				
0 – 20%	41.7	26.6 ***	12.3	14.9
20 – 40%	30.3	36.2	14.4	16.9
40 – 60%	14.3	12.5	21.6	20.1
60 – 80%	8.7	10.9	23.3	21
80 – 100%	5	14.8 ***	28.4	27.1
Total	100.0	100.0	100.0	100.0
Has Concession Card?				
No	32	36.1	69.9	64.4 ††
Yes	68	63.9	30.1	35.6 ††
Total	100.0	100.0	100.0	100.0
Length of Time Held Health Insurance				
< 1 Year	n.a.	n.a.	27.7	5.1 ***
1 – 2 Years	n.a.	n.a.	23.7	9.4 ***
2 – 5 Years	n.a.	n.a.	7.1	7.8
> 5 Years	n.a.	n.a.	41.5	77.7 ***
Total			100.0	100.0
Number of Long Term Health Conditions				
0	8.3	1.9 ***	9.2	4.4 **
1 - 2	26.6	24.5	31.9	27.7
3+	65.1	73.6 *	58.9	67.9 **
Total	100	100	100	100
Total N	1213	155	282	984
Total per cent	46.1	5.9	10.7	37.4

Source: 2001 ABS National Health Survey
Notes: *** p<0.001 ** p<0.01 * p<0.05 †† p<0.10

themselves as private patients, rather than as Medicare patients, in public or private hospitals. Such a policy is an exercise in cost shifting, from the state government to private health insurance companies and ultimately individuals (through insurance premiums, FEDs and gap payments).

Due to the substitution between Medicare and private election status, the health insurance reforms are acting against the policy's stated intention: reducing pressure from public hospitals. For example, results from this study show that, when admitted to hospital, significant proportions of the insured do not declare their health insurance status and admit

themselves as public patients. Given the billions of dollars that the Australian Government has spent on subsidising private health insurance in recent years, 11 per cent is a very significant figure. These groups of insured Medicare patients were more likely than insured private patients to report Lifetime Health Cover or to gain government benefits as the reason for purchasing health insurance. That is, they were encouraged to purchase a health insurance policy to avoid penalties imposed upon them by the Government, rather than necessarily choosing a policy that best meets their health care needs. Moreover, this former group tends to be younger and healthier Australians who have held their insurance policies for a much shorter period of time: about 52 per cent of respondents had purchased their policy between 1999 and 2001.[27]

A potential explanation for the admission of insured patients as public patients is the risk of out-of-pocket expenses through FED policies (which have accounted for a greater proportion of insurance purchases) or through gap fees. So long as a free alternative exists through Medicare, there will be a strong incentive for patients subject to FED policies or high gap fees to admit themselves as Medicare patients. This poses important implications for any policy aimed at forcing the privately insured to admit themselves as private rather than as Medicare patients. Many of the insured Medicare patients may have purchased health insurance simply to avoid the one per cent Medicare surcharge, or to avoid the two per cent Life Time Health cover surcharge and thus their policies may not adequately cover hospital services without significant out-of-pocket costs. Moreover, any policy that 'forces' a patient to admit themselves as 'private' undermines the key foundation of Medicare: free universal health care for all Australian citizens.

This paper has also provided significant insight into the characteristics of the uninsured who chose to admit themselves as Medicare or private patients. Whereas there was little difference in the income profile of the insured Medicare and insured private patients, the decision for the uninsured to admit themselves as private or Medicare patients is strongly related to their household income. About half of uninsured Medicare patients didn't purchase health insurance because they couldn't afford to, compared with about 18 per cent of uninsured private patients. The later group also tended to be older, and consisted of a larger number of retirees with access to a health concession card. It is important to recognise that this older group of patients (born before June 1934) were exempt from the two per cent Life Time Health Cover surcharge. That is, they have the alternative to self-insure without being subject to the penalties under Life Time Health Cover. An important question for ongoing research is: will cohorts subject to the Life Time Health cover surcharge have adequate financial resources to maintain their private health insurance coverage into advanced old age? If so, will they choose to admit themselves as private or Medicare patients?

The problems surrounding patient choice upon admission to public hospitals underscore how hard it is for the recent health insurance reforms to realise their proposed aim: reducing pressure on the public hospital sector. Rather than tinkering at the edges of health care financing at the state level, what is required is an overhaul of the interaction between private and public health care markets in Australia.

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[19] These data include information on 2,634 individuals who reported admission into a hospital in the previous 12 months, and who fully reported their health insurance status and patient admission type. Although persons under 15 reported admission to hospital, it is not possible to measure their health insurance status using the basic NHS and they are therefore omitted from the analysis. Information on the hospital admission refers to the most recent admission. It is important to recognise that a patient may choose to be either private or Medicare patient at each admission

[20] Sullivan, Redpath and O'Donnell op. cit., 2002

[21] Department of Health and Ageing. *Private health insurance — Medicare levy surcharge*, 2005. Available from: http://www.health.gov.au, accessed: 10/2005

[22] The one exception to the treatment of the privately insured in private hospitals is that different rules apply if the patient is presented at the emergency department of the hospital. In this situation, patients are treated as 'not admitted patients' and Medicare subsidises 85 per cent of the MBS schedule fee as when visiting a GP. If tests are required at the emergency department there is no gap arrangement in place between private hospitals, doctors and private health insurance funds. In this situation, the gap fees could be quite substantial.

[23] TQA Research, op. cit., 2005

[24] Abbott, op. cit., 2006

[25] Commonwealth concession cards include the Pensioners Concession Card, the Health Care Card and the Commonwealth Seniors Health Card. Two additional cards are issued by the Department of Veteran's Affairs: the Gold Repatriation Health Card and the White Repatriation Health Card. Although benefits offered by these cards differ, they all provide subsidised pharmaceuticals through the Pharmaceutical Benefits Scheme.

[26] J. Temple, 'The seniors concession allowance and utility allowance: equity implications' *People and Place*, vol. 13, no.1, 2005, pp. 23-30

[27] During this time period, both PHIAA and Life Time Health cover were introduced.