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Research Insights

Private or Public? The declining growth in the use of private healthcare in Australia

As more Australians drop private health insurance and face financial hardship, private hospital use has slowed, with some evidence of doctors working more in the public system and increased public hospital waiting times.

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The growth in private hospital use has been declining in recent years

Australia has seen a steady decline in private health insurance (PHI) membership in the past five years. Since June 2015, the proportion of Australians with private health insurance has fallen from 47.4 per cent to 43.6 per cent in March 2020 (solid line in Figure 1). The decline is mainly driven by the young and healthy dropping their PHI hospital coverage, while the number of people aged 70 or over joining PHI funds has increased. Increasing premiums and out-of-pocket medical costs in an era of low wage growth have been cited as reasons for increasingly unaffordable private healthcare. Since the private hospital sector relies heavily on funding from PHI, we explore how the decline in insurance membership has affected the private hospital sector in Australia. For more details, see the accompanying Melbourne Institute Working Paper 18/20 (Bai, Méndez, Scott & Yong 2020).

Institutional context:

Australia operates a mixed public-private healthcare system, with private hospitals accounting for 47 per cent of all hospitals (AIHW 2019), providing 1 in 3 hospital beds and conducting 2 in 3 elective surgeries (ABS 2018).

Declining PHI membership does not necessarily mean lower private hospital use:

Several considerations need to be made when determining how the decline in PHI membership affects the use of private hospital services.

First is the composition of the decline in PHI membership across age groups. The overall decline is not uniform across age groups; it is driven by the young and healthy, whose rate of private hospital utilisation is lower. At the same time, PHI membership has increased amongst older age groups, whose likelihood of hospital use is higher than the young.

Second, although PHI policies usually give policy holders greater coverage when using private hospital services, there is a large variety of PHI policies that specify different coverage of hospital services. Ultimately, it remains the consumers' choice whether to use their PHI policy or to obtain treatment in a public hospital. Given recent concerns of rising out-of-pocket medical costs and the increasing prominence of low-value PHI policies, consumers may elect not to use their policies at all and be treated as a public patient, even if they have PHI.

The effect of declining PHI uptake on private hospital use may spill over to public hospitals as patients substitute private with public hospital care. However, this spill over may not be immediate if patients delay or forgo healthcare.

Given the above, it is therefore unclear whether the decline in PHI membership would necessarily lead to a decline in private hospital use, and the extent to which the public system is impacted.

This Research Insight will use publicly available data to showcase recent trends in the private and public hospital sectors and discuss their implications for policy.

Key Insights

1 The slowing growth in private hospital use and falls in profitability have been occurring since 2015/16

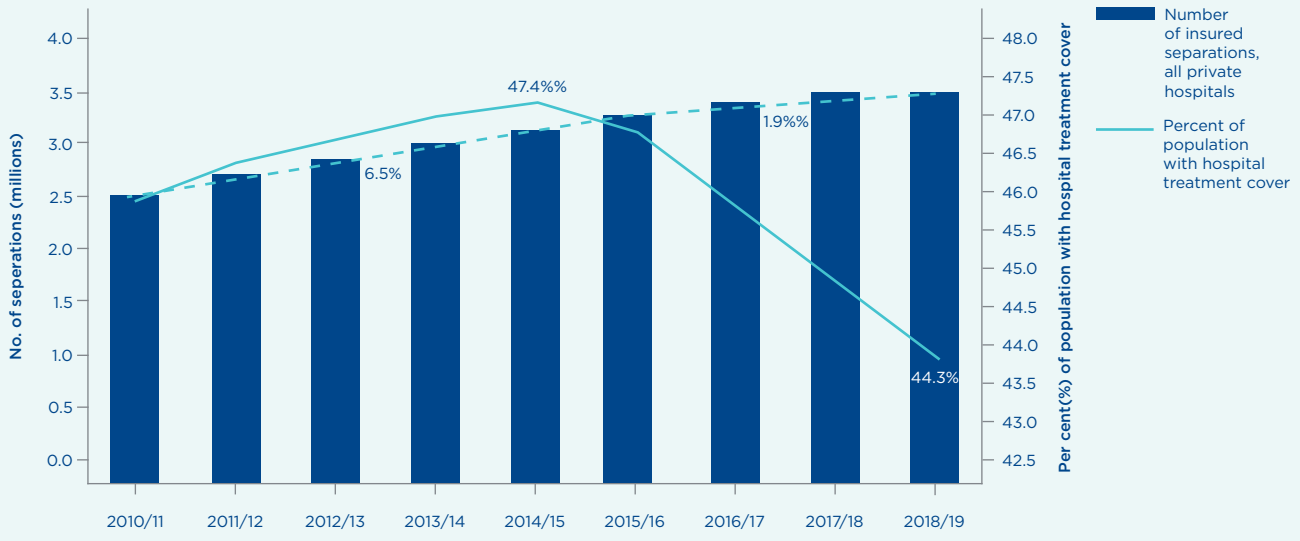
Figure 1 shows that there has been a slowing of the growth in private hospital use since 2015/16 – the time at which PHI membership started to fall. The growth in number of private hospital (day and non-day) separations (see glossary of terms, p. 7) using private health insurance has slowed from 6.5 per cent per year between 2010/11 and 2015/16 to 1.9 per cent between 2015/16 and 2018/19 (dashed lines in Figure 1).

To better understand the drivers of this decline in growth, we look at use by hospital type. The flattened growth is experienced by both day and non-day hospitals. The growth in use of larger private non-day hospitals slowed from 6.6 per cent per year between 2010/11 to 2015/16 to 2.1 per cent between 2015/16 and 2018/19. Historically, there has been much higher growth in the number of private day hospitals compared to larger inpatient facilities. However, growth in use of private day hospitals fell more quickly than non-day hospitals, from 5.8 per cent to 0.6 per cent over the same time periods (Bai, Méndez, Scott, & Yong 2020).

Focusing on specific procedures in non-day hospitals, the fall in growth has affected most surgical procedures. Surgical procedures related to diseases and disorders of the female reproductive system exhibited the largest fall in growth, from 2.9 per cent per year on average between 2012/13 and 2015/16 to -2.2 per cent per year between 2015/16 and 2018/19. For day hospitals, surgical procedures related to diseases and disorders of the digestive system experienced the largest fall in growth, from 3.5 per cent per year to -5.3 per cent per year over the same time periods (Bai, Méndez, Scott, & Yong 2020).

The decline in growth of private hospital use correlates with falls in the profitability of the private hospital sector. The ABS Private Hospitals survey shows a sizable reduction in the growth in profits of the private hospital sector, from an average of 15.5 per cent per year between 2012/13 and 2015/16 to 5.6 per cent between 2015/16 and 2016/17.

Figure 1. Privately insured separations in private hospitals, 2010/11 to 2018/19



Source: The Department of Health, Hospital Casemix Protocol (HCP) Annual report 2018-19. APRA. Private health insurance membership trends March 2020.

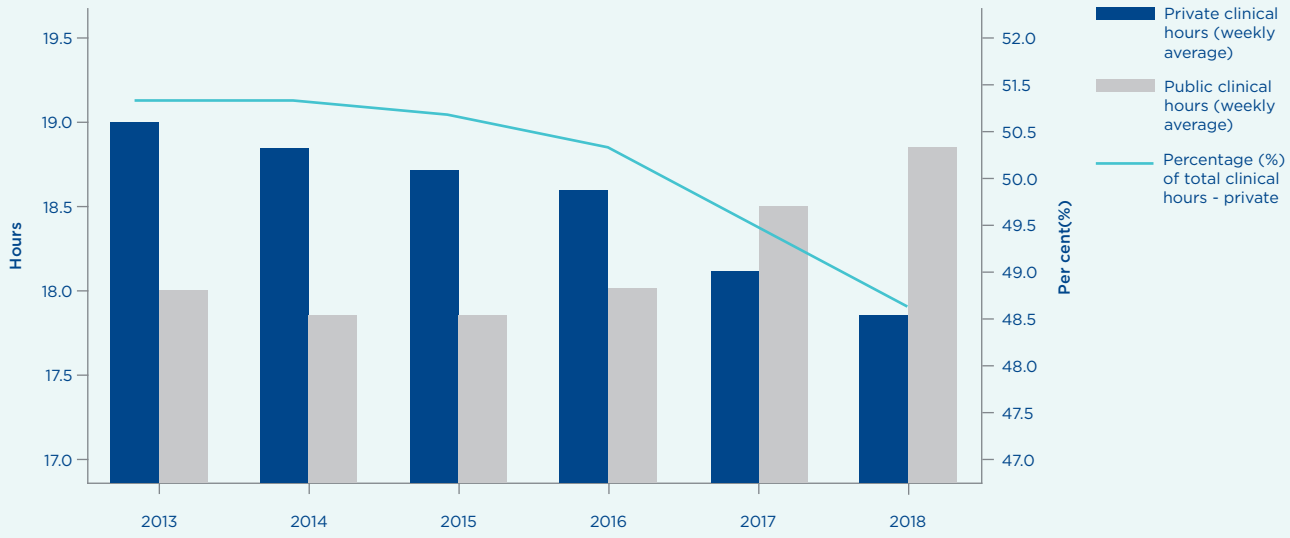
2 Specialists are working more in public hospitals and less in private hospitals

Data from the National Health Workforce Data Set (NHWDS) shows the average weekly clinical hours worked in the private sector by specialists has declined at an accelerated pace since 2016, dropping from 18.6 hours per week in 2016 to 17.7 hours per week in 2018. Accompanying this decrease is an increase in the average weekly clinical hours spent in the public sector by specialists, from 18.1 hours per week to 18.8 hours per week (bars in Figure 2).

As a result, the share of total clinical hours worked by specialists from the private sector reduced from 51.3 per cent in 2014 to 48.6 per cent in 2018, with the decline having accelerated since 2016 (line in Figure 2).

In addition, the number of specialists working only in the private sector has declined from 9,238 in 2017 to 9,069 in 2018 (2 per cent decrease) while the number of specialists working in only the public sector and those working in both sectors have increased, according to data from NHWDS.

Figure 2. Number of clinical hours per week in public and private sector, non-GP specialists, 2013 to 2018.



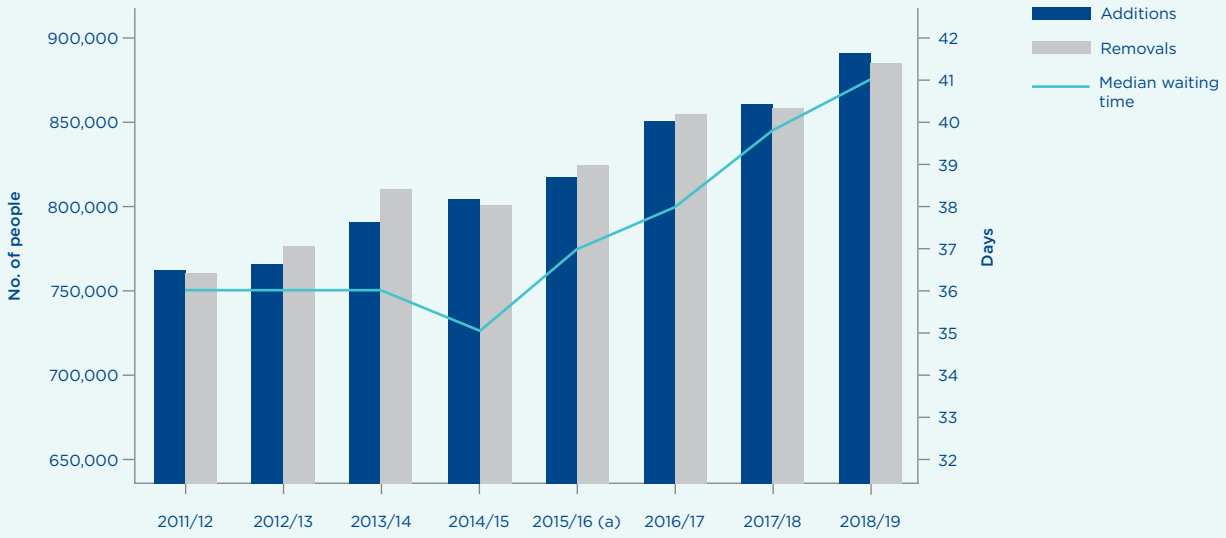
Source: National Health Workforce Dataset, Health Workforce Data Tool. Note: this includes hours spent in clinical work in all private settings, including private hospitals and private medical practitioner's own rooms.

3 There is no increased growth in public hospital use, but some increase in elective surgery waiting times for public hospitals

Recent data from AIHW show no clear evidence of accelerated growth in the use of public hospitals since 2015/16. However, the evidence suggests a slight increase in the waiting times for elective surgery in public hospitals. Between 2015/16 and 2018/19, the number of people added to public hospital elective (non-emergency) surgery waiting lists grew at a slightly higher rate of 2.9 per cent per year compared to 2 per cent per year between 2011/12 and 2015/16, while the rate of removal from the waiting list remained stable at 2.3 per cent (bars in Figure 3).

There is also an increase in median elective surgery waiting times, having been stable at 36 days for several years, this started to increase from 37 days in 2015/16 to 41 days in 2018/19 (line in Figure 3). More detailed data is needed to know whether this is a reflection of increased demand associated with the slowing of private hospital use.

Figure 3. Number of patients added and removed from public hospital elective surgery waiting lists and median elective surgery waiting times, 2011-12 to 2018-19



Source: AIHW. Elective surgery waiting times 2018-19: Australian Hospital Statistics, 2020. Note: (a) Does not include waiting time data from Australian Capital Territory, which was unavailable at the time of AIHW Elective Surgery Waiting Times Report.

Policy responses should focus on effective investment to ensure improved access and value for patients across both public and private sectors

The above stylised facts about the decline in PHI uptake, slowing growth of the use and profitability of private hospitals, along with increased (decreased) time spent by specialists in the public (private) sector and increased public hospital elective surgery waiting times, consistently point towards a private health system that is facing flattening demand. If the trends above continue, what is now a slowing growth may soon turn into an actual decline in the level of private hospital use. Together, these trends raise policy questions about the balance of investment across public and private healthcare to promote better value and accessibility.

1. A focus on improving value-based healthcare and access to needed healthcare

Policy responses to date have focused largely on trying to improve consumer's perceived value of private healthcare and private health insurance. Improving information for consumers to provide more choice has been the focus of policy. The Australian Government introduced and implemented a package of reforms aimed at increasing fee transparency and PHI affordability in 2019 and 2020. A key part of the package was the launch of a doctors' fees price transparency website (Medical Cost Finder) at the end of 2019. The aim of the website is to enhance the information available to consumers so as to aid with their healthcare decisions.

This complements similar websites from private health insurers. However, the information available on the site is rather coarse and of little relevance to consumers' specific circumstances and evidence from other countries suggests such websites may have limited impact (Zhang, Prang, Devlin, Scott & Kelaher 2020). More standardised private health insurance products (Gold, Silver, Bronze, Basic) have also been introduced, that try to signal the 'value' of each policy in terms of coverage and costs.

This information is essential for consumers to make good healthcare decisions. For medical care, the onus is currently on consumers to search for and make sense of information rather than on providers to routinely provide such data as a condition of receiving public funds. Even then, improved information can be difficult for many to access, understand and use. In addition, there remains no information on the quality of healthcare provided to help inform choice. Improving information on not only the costs, but also access to and quality of care will help ensure more efficient allocation of resources within the private hospital sector, and across public and private sectors.

2. COVID-19 will likely accelerate the slowing of growth in private hospital use

As part of the government's response to COVID-19, all non-urgent elective surgeries were suspended in March and April 2020 Australia-wide. In July and August, further suspensions of elective surgeries were put in place in Victoria in response to the second wave. This has significantly reduced activity in private and public hospitals. How the private hospital sector will fare after COVID-19 remains uncertain. Although there has been a recent bounce back in surgical activity, it is unclear what the underlying trend will be once the backlog is cleared. However, in the absence of a vaccine, people may be less likely to visit hospitals for fears of risking infection. In addition, the economic recession triggered by COVID-19 will likely further dampen wage growth, thus accelerating the widening of the gap between wage growth and growth in out-of-pocket medical expenses.

More broadly, only time will tell whether the decline in growth in the use of private healthcare is temporary or a more permanent market correction. If the former, it would be a mistake to introduce any significant reforms at this stage. If the latter, then whether significant reform is necessary depends on how best to improve efficiency and equity in healthcare through maintaining or changing the balance of government investment between public and private healthcare.

Further Information

Datasets

This analysis uses publicly available data. Data on number of separations are from Department of Health Hospital Casemix Protocol (HCP) annual reports, 2018/19. Statistics on elective surgeries are from Australian Institute of Health and Welfare Elective Surgery data tables 2011/12 - 2018/19. Hours worked by non-GP specialists uses data from Department of Health National Health Workforce Dataset (NHWDS).

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Glossary of terms

Free-standing day hospitals: Hospitals that provide investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of health insurance benefits and include those registered with their respective state health authority (ABS 2018).

Non-day hospitals (Private acute and psychiatric hospitals): Hospitals licensed by the relevant state or territory health authority. Private acute hospitals provide medical, surgical or obstetrical services for admitted patients, round-the-clock comprehensive qualified nursing services and other necessary professional services. Most of the patients have acute conditions or temporary ailments. Psychiatric hospitals cater primarily for admitted patients with psychiatric, mental or behavioural disorders. (ABS 2018)

Separation: An episode of care for an admitted patient, which can 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 care to rehabilitation).

References

ABS, 2018, Private Hospitals Australia, 2016/17. Cat 4390.0. In: Australian Bureau of Statistics (Ed.). Commonwealth of Austrlaia, Canberra.

AIHW, 2019. Hospital resources 2017–18: Australian hospital statistics. Cat No. HSE 233, Australian Institute of Health and Welfare, Canberra.

APRA, 2020, Private Health Insurance Membership Trends December 2019 (released February 2020). Statistics. Australian Prudential Regulation Authority, Canberra.

Bai, T., Méndez, S., Scott, A., Yong, J. 2020, The falling growth in the use of private hospitals in Australia. Melbourne Institute Working Paper No. 18/20. Melbourne Institute: Applied Economic & Social Research, University of Melbourne.

Zhang, A., Prang, K.-H., Devlin, N., Scott, A., Kelaher, M., 2020. The impact of price transparency on consumers and providers: A scoping review. Health Policy, 124, 819-825.