Table 5.11 ranks the health system costs of diseases and injuries in the six National Health Priority Areas, together with musculoskeletal disorders. Other diseases have not been included in this table. Ischaemic heart disease and hypertension are the leading causes of health system expenditure, together accounting for 5.5% of total health expenditure. Following these are accidental falls, dementia and back problems, then diabetes, affective disorders and stroke. The majority of health system costs for dementia are for nursing home patients. Osteoarthritis costs the Australian health system almost as much as stroke.

Total health system costs for females are 32% higher than those for males: $17.9 billion compared with $13.5 billion. Costs are higher for females than males for all disease groups apart from injury and congenital anomalies. Total health system costs per person in 1993–94 ranged from a minimum of around $800 for boys aged 5–14 years to $7,500 for women aged 75 years and over. The male–female difference in per person costs is greatest in the peak reproductive years, where average annual costs for women aged 25–34 years were $1,716, almost double the average cost of $888 for men of the same age.

It should be emphasised that this analysis does not attempt to estimate the total economic impact of diseases in the Australian community and that, as well as the health system costs described here, there are substantial costs relating to absenteeism, lost productivity, the burden on carers and family, and lost quality and quantity of life.

5.3 Private health insurance

Funding of health services by health insurance funds

The introduction of the Private Health Insurance Incentives Scheme (PHIIS) and its replacement by the 30% rebate on premiums substantially altered the role of the health insurance funds in the funding of health services after 1996–97. Total recurrent health expenditure in 1997–98 was $43,994 million. Of this, $4,685 million was directed through private health insurance funds. However, the Commonwealth Government subsidised $459 million of that expenditure through the PHIIS.

The PHIIS was paid in two ways—either as a direct subsidy (in which case the private health insurance fund would charge the contributor a reduced premium and claim the subsidy from the Commonwealth) or as a rebate through the taxation system (in which case the contributor would be charged the full premium and would be reimbursed when he or she lodged a taxation return). A total of $252 million was paid through the direct subsidy during 1997–98 and $207 million was claimed through the taxation system.

As a result of the PHIIS, the amount paid from non-government sources through the health insurance funds was $4,434 million. The $207 million claimed through the taxation system meant that the net, unsubsidised amount paid by health insurance funds was $4,226 million. This represented 9.6% of recurrent health expenditure in 1997–98. By 1998–99, total expenditure through private health insurers had increased to $4,840 million. The net expenditure by the funds (after deduction of Commonwealth subsidies) was $3,785 million (Table 5.12, page 253).

Box 5.5: Private health insurance arrangements

Since the introduction of Medicare in 1984, health insurance funds operated by Registered Health Benefits Organisations[1] have offered benefits to members for approved services provided in both public and private hospitals. They have also operated ancillary tables which provide benefits for a wide range of non-hospital health and health-related services.

There are four categories of health insurance membership – singles, couples without children, sole parents, and couples with children – providing a wide range of benefits cover. These include 'exclusionary tables' under which funds are able to tailor the range of benefits provided to meet particular needs of different groups of contributors. They can, for example, offer tables that exclude benefits for obstetrics or hip replacements. The contribution rates for such tables reflect the particular exclusion(s) and are lower than similar tables that do not contain such exclusion(s). 'Front-end deductible' tables are also available, which allow contributors to meet a set proportion of the charge for hospital care from their own pockets.

Changes to health insurance arrangements will be introduced from 1 July 2000, to encourage people to take out and retain private health insurance cover. From that date, people who join a health insurance fund early in life and maintain their hospital cover will pay lower premiums throughout their life compared with someone who joins later in life.

1. A Registered Health Benefits Organisation is an organisation registered under the *National Health Act 1953* for the purpose of conducting a health benefits fund.

Expenditure on hospitals, both public and private, during 1997–98 was $16,510 million. Of this, $2,485 million was funded by the health insurance organisations. During 1998–99, the health insurance funds paid $2,200 million for hospital services from their own resources.

The hospital expenditure funded through health insurance was largely concentrated in private hospitals. In 1998–99, the benefits paid in respect of private hospital care ($2,524 million) represented 89.7% of all hospital-related benefits paid through health insurance funds. Similarly, 84.1% of total hospital bed-days for which hospital benefits were paid during 1998–99 were in respect of care in private hospitals.

Administration of health insurance funds accounted for $591 million in 1998–99. This represented 14 cents for each dollar of benefit paid from the funds and accounted for 12% of contributions income receivable by the funds in that year.

Trends in private health insurance coverage, membership and premiums

The proportion of the population with private health insurance at the end of March 2000 was 32.7%, an increase on the 30.5% coverage at 30 June 1999. This was the same level as at 30 June 1998. However, between the time of the introduction of Medicare (February 1984) and 31 December 1998 the trend in private health insurance coverage had been generally downwards. In June 1984 just over half of the total population (50.2%) were covered by some level of private health insurance. At 31 December 1998 this had fallen to 30.1% (Figure 5.3, page 254).

Table 5.12: Expenditure through the private health insurance funds, by area of expenditure and income, by type of income, current prices, 1996–97 to 1998–99 ($ million)

	1996–97	1997–98			1998–99				
		PHIIS subsidy[a]			PHIIS subsidy[a]		Subsidy on premiums[b]		
	Own funds	Tax	Direct	Own funds	Tax	Direct	Tax	Direct	Own funds
Expenditure									
Institutional	*2,890*	*126*	*153*	*2,586*	*125*	*79*	*41*	*396*	*2,295*
Public hospitals[c]	360	14	17	297	12	8	4	39	226
Private hospitals	2,437	107	130	2,188	107	68	35	340	1,974
Ambulance[d]	93	5	6	101	5	3	2	17	95
Non-institutional[e]	*1,279*	*58*	*70*	*1,154*	*56*	*35*	*18*	*177*	*1,028*
Medical	229	12	14	206	11	7	4	34	198
Dental	596	26	32	542	26	16	8	81	472
Other professional	225	10	12	204	10	6	3	32	184
Home nursing	1	—	—	1	—	—	—	—	1
Pharmaceuticals	44	2	2	32	2	1	1	5	28
Aids and appliances	184	8	10	169	8	5	3	25	146
Total benefits	*4,169*	*183*	*223*	*3,740*	*181*	*114*	*59*	*572*	*3,323*
Administration	530	24	29	487	25	16	8	80	463
Total benefits plus administration	**4,699**	**207**	**252**	**4,226**	**206**	**130**	**67**	**652**	**3,785**
Revenue									
Contributions receivable	4,404	207	252	4,254	206	130	67	652	3,872
Non-contributions income	240	n.a.	n.a.	140	n.a.	n.a.	n.a.	n.a.	149
Total income, all sources	**4,644**	**207**	**252**	**4,394**	**206**	**130**	**67**	**652**	**4,021**

(a) Commonwealth direct outlays and taxation expenditure on Private Health Insurance Subsidy Scheme is allocated by area of expenditure.

(b) Commonwealth direct outlays and taxation expenditure on the 30% rebate on premiums is allocated by area of expenditure.

(c) Public hospitals include both recognised public hospitals and repatriation hospitals.

(d) Ambulance includes levies imposed by some State and Territory Governments in respect of ambulance transport.

(e) Non-institutional excludes administration.

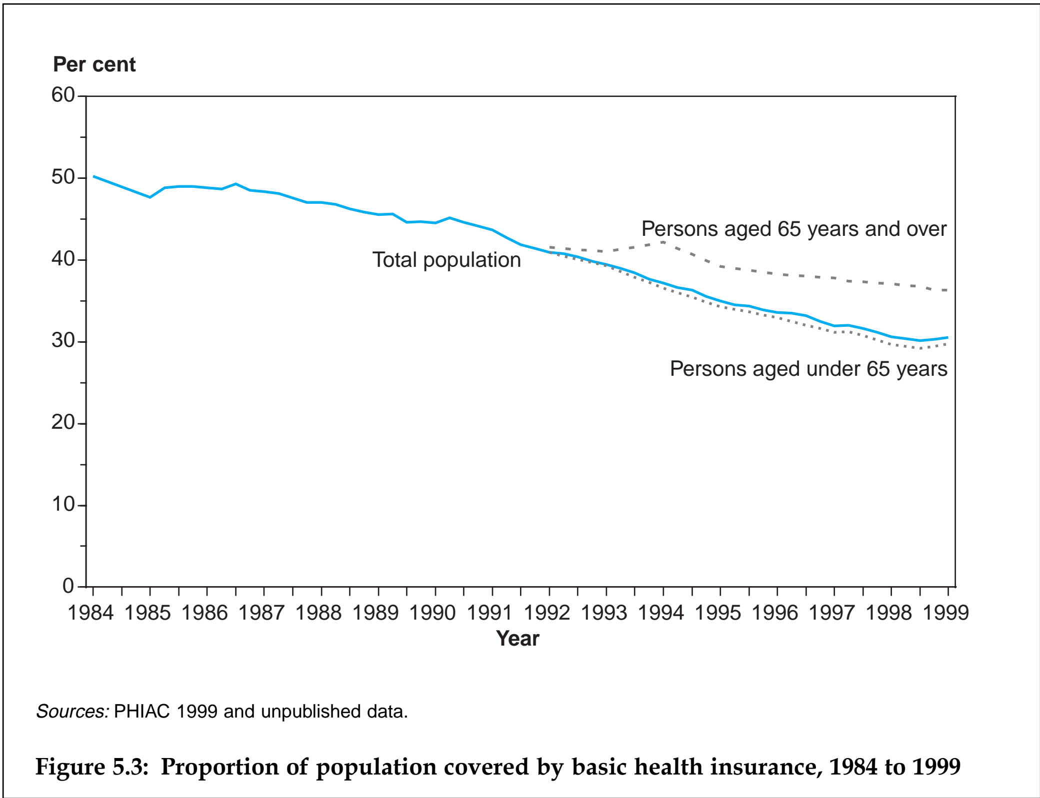
Source: PHIAC unpublished data.

A number of incentives were introduced to help arrest the decline in membership and coverage. These included:

- Introduction of 'front-end deductible' (FED) tables in the late 1980s. These enabled funds to offer tables that provided cover for that part of hospital charges that exceeded a given amount (excess) in a year. Between 1995–96 and 1998–99, coverage by FEDs grew by 0.8 million and coverage by non-FED tables fell by 1 million (Figure 5.4, page 255).
- Introduction of 'exclusionary' and 'non-exclusionary' tables in 1995. Exclusionary tables did not provide benefits for some types of treatment (e.g. obstetrics) and were

aimed at enabling funds to tailor their benefits cover and premiums to meet particular groups of low-drawing members.

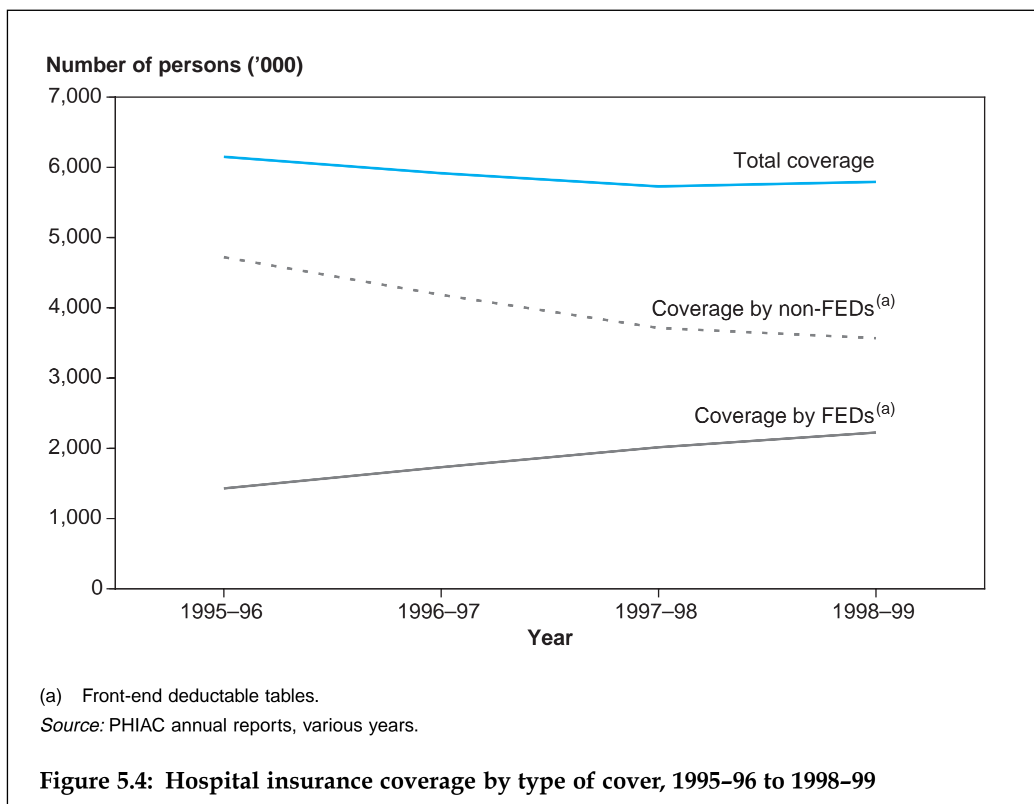
- Increasing the number of membership categories from 2 (single and family) to 4 (single, family, single parent and couples) in 1997. This was to enable funds to further differentiate their premiums.
- Introduction of the PHIIS in 1997.
- Replacement of the PHIIS with a 30% rebate on private health insurance premiums in 1999.



Sources: PHIAC 1999 and unpublished data.

Figure 5.3: Proportion of population covered by basic health insurance, 1984 to 1999

Despite these incentives, coverage by health insurance continued to decline until December 1998. At the same time, expenditure by the funds in the form of benefits, levies and administration continued to increase and the proportion of total health expenditure that was met by health insurance funds from their own resources remained relatively stable at between 10.6% and 11.5%. The introduction of the PHIIS and the rebate on private health insurance premiums have both had an effect in slowing the decline in coverage. After reaching 30.1% in December 1998, coverage increased in each quarter of 1999 to reach 31.2% at the end of December 1999.



(a) Front-end deductable tables.

Source: PHIAC annual reports, various years.

Figure 5.4: Hospital insurance coverage by type of cover, 1995–96 to 1998–99

Growth in contributions income

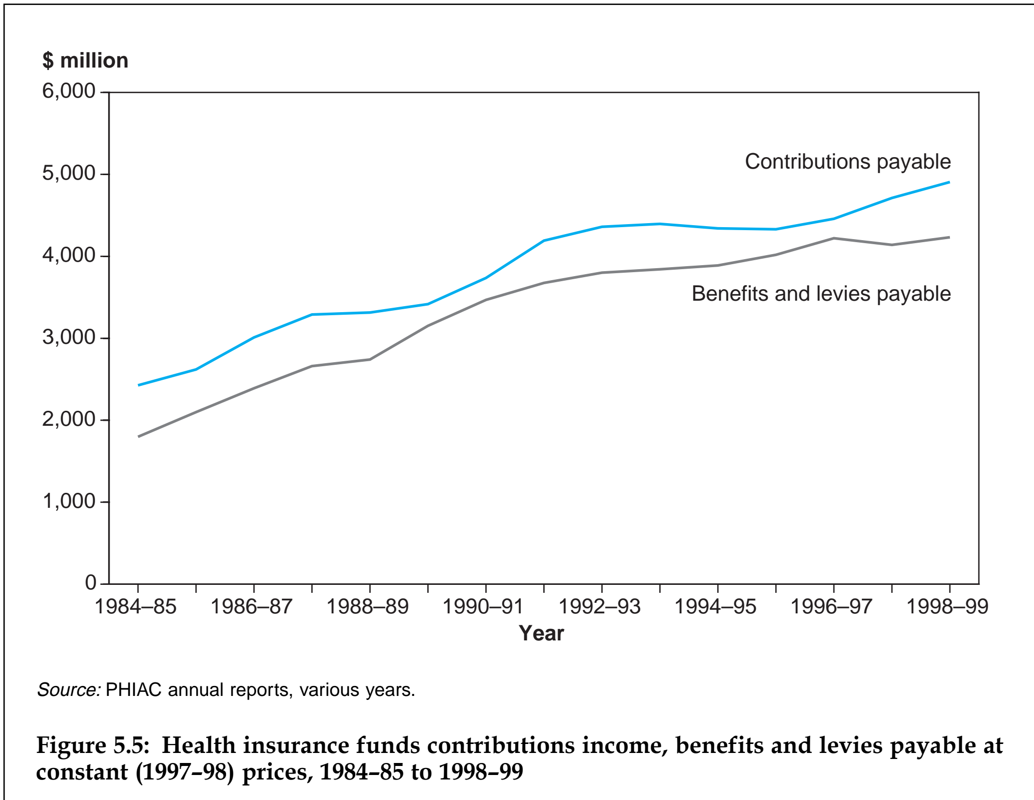
Despite their falling coverage, health insurance funds have maintained their capacity to generate income through premiums.

Between 1984–85 and 1998–99 real growth in contributions income averaged 5.2% per year. Between 1989–90 and 1998–99 the rate of growth averaged 4.1% and since 1995–96 it has averaged 4.3% (Figure 5.5, page 256).

Growth in the total amount of benefits and levies payable by health insurance funds was higher than that for contributions income between 1984–85 and 1998–99, averaging 7.4%. However, since 1995–96 the rate of growth in benefits and levies payable has been much lower (1.7%) than that of contributions income.

Ancillary benefits tables

In addition to their hospital tables, health insurance funds offer tables providing ancillary benefits in respect of services such as dental, optical, therapeutic and other (generally non-accommodation) non-medical services.



Source: PHIAC annual reports, various years.

Figure 5.5: Health insurance funds contributions income, benefits and levies payable at constant (1997–98) prices, 1984–85 to 1998–99

About 6,049,000 persons (31.9% of the total resident population) had some form of ancillary cover at 30 June 1999 (Table 5.13). Of these, 4,423,000 were covered for both hospital and ancillary cover with the same organisation. A further 1,626,000 either had ancillary cover only or had ancillary cover with one organisation and hospital insurance with another organisation.

Changes in the characteristics of the insured

The structure of the insured population changed substantially between 1983 and 1998. The proportion of contributor units with hospital insurance cover more than halved over the period, from 62.1% to 30.3%.

In all age groups below 60 years, the level of coverage by hospital insurance fell markedly. Excluding the age groups 60 years and over, coverage ranged from 54.6% to 75.6% in 1983 and from 16.3% to 41.9% in 1998 (Table 5.14). The largest falls were in the youngest age groups. In the case of contributor units headed by persons aged 60 years and over, the fall-off in coverage was less dramatic. Coverage for contributor units headed by persons aged 60–69 years fell from 45.3% to 39.6%, while those headed by persons aged 70 years and over remained relatively constant at around 36%.

Table 5.13: Membership and persons covered by ancillary tables, by type of membership, States and Territories, 30 June 1999 ('000)

Membership type	NSW[a]	Vic	Qld	WA	SA	Tas	NT	Australia
Combined with hospital insurance[b]								
Single	353	183	135	111	86	29	6	904
Family	232	118	105	85	54	19	6	618
Single parent	10	5	4	4	2	1	[d]	26
Couples	173	81	91	77	47	15	4	488
Total members	768	387	335	277	189	64	17	2,036
Persons covered	1,653	834	745	617	399	136	39	4,423
Without hospital insurance cover[c]								
Single	127	32	39	106	35	8	1	349
Family	96	34	24	48	28	4	1	236
Single parent	6	3	2	12	2	[d]	[d]	26
Couples	50	12	12	38	16	2	[d]	131
Total members	280	80	76	204	82	15	3	741
Persons covered	635	202	163	400	189	31	6	1,626
All ancillaries								
Single	480	215	174	217	121	37	7	1,253
Family	328	152	129	133	82	23	7	854
Single parent	16	8	6	16	4	1	[d]	52
Couples	223	93	103	115	63	17	4	619
Total members	1,048	467	411	481	271	79	20	2,777
Persons covered	2,288	1,036	908	1,017	588	167	45	6,049

(a) New South Wales includes the Australian Capital Territory.

(b) Members and persons covered where both hospital insurance and ancillary cover are provided with the same fund.

(c) Members and persons covered by ancillary tables only (may include members who have hospital insurance cover with a fund other than the fund providing ancillary cover).

(d) Less than 500.

Source: PHIAC 1999.

Table 5.14: Private health insurance, proportion of contributor units[a] with hospital insurance cover by age group, 1983 to 1998

Age group of head of contributor unit (years)	1983	1986	1988	1990	1992	1995	1998
15–24	54.6	29.3	30.0	29.5	29.3	20.8	16.3
25–34	70.4	46.5	43.0	40.1	35.8	27.2	22.1
35–49	75.6	55.5	53.8	52.7	46.7	40.3	32.0
50–59	71.4	56.4	56.5	55.6	52.2	48.4	41.9
60–69	45.3	42.0	43.4	45.1	45.5	42.9	39.6
70 and over	36.0	31.5	34.9	36.8	36.4	39.0	36.4
All ages	**62.1**	**44.2**	**43.6**	**43.1**	**40.5**	**35.1**	**30.3**

(a) A contributor unit includes all persons within a family unit or a single person unit that would be coverable by a health insurance policy. For example, a 'couple with dependants' contributor unit includes the parents and all dependent children and is counted as one contributor unit.

Sources: AIHW analysis of ABS Private Health Insurance Survey data.