

The Rise of Private Health Insurance in Australia: Early Effects on Insurance and Hospital Markets

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Abstract

Over a three year period from July 1997 to July 2000, the Australian government introduced a series of policies designed to increase the proportion of the population with private health insurance. The combined effect of the policies was an increase in the population coverage from a low point of 30.1 percent to 45.7 percent. The motivation for these policies was to force more Australians to use the private sector for their hospital care and in so doing reduce the pressure on the public sector. We piece together fragmentary early data from various sources and various time periods. We find that the increase in activity in the private hospital sector and the reduction in public hospital waiting times has indeed occurred.

Introduction

From 1984 to 1998, the percentage of the Australian population with private health insurance declined from 50 percent to 30.1 percent. This decline

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raised concerns about the place and survival of private hospitals in the Australian hospital system. The decline was itself a product of Australian health policy. Since 1984, Australians have had access to free treatment in public hospitals under Medicare, the universal, compulsory, tax-financed public health insurance system. On top of the free access to public hospitals, government regulation of the private health insurance industry mandated community rating. This type of mispricing makes the insurance expensive and unattractive for low risk consumers, particularly young people and inexpensive and attractive for high-risk consumers, particularly the elderly. In theory the net effect might go either way, but in practice community rating usually makes insurance less attractive overall. As we shall see, Australia fits the usual case. As a result, membership declined and the pool of persons privately insured was increasingly high risk and elderly, therefore adverse for the insurers.

As the percentage of the population with private health insurance declined, there was considerable excess demand for public hospital beds. The result was extensive nonprice rationing of hospital care, especially rationing-by-waiting. The government chose to address the problem by changing the regulation of the private health insurance industry to make it more attractive to middle and upper income Australians rather than expanding the public hospital system by injecting more tax money. The idea is to attract more private financing into health care, reducing the burden on the public system and taxpayers. This is a common policy approach in countries with tax-funded, centralised systems. Increases in the percentage of the population with private health insurance are evident in Ireland, New Zealand and the United Kingdom in response to extensive waiting times for public treatment (Harmon and Dolan 2001; Hopkins and Cumming 2001). The policy has been spectacularly successful as the percentage of Australians with private health insurance increased from 30.1 in December 1998 to 45.7 in September 2000. As we shall see, almost all of the increase occurred in the three-month period from March to June 2000.

The ultimate goal of the new policy is to shift hospital demand from public hospitals to private hospitals and thereby reduce hospital rationing-by-waiting in the public sector. It is important to find out if the policy has had much success. Research at this early date is complicated by lags in data availability and by the eligibility requirements in health insurance policies. For most policies, pre-existing conditions are not covered for 12 months. Much orthopaedic surgery is not covered for 24 months.

We piece together fragmentary early data from various sources and various time periods. We find that an increase in activity in the private

hospital sector and a reduction in public hospital waiting times has indeed occurred. Private health insurers have already experienced an increase in claims. We also find that the revenue position and overall financial viability of both the health insurance funds and the publicly listed private hospitals has improved.

The New Policies

Three new policies towards the private health insurance market were introduced over a three year time period. Each of the successive changes was designed to encourage the growth of private health insurance.

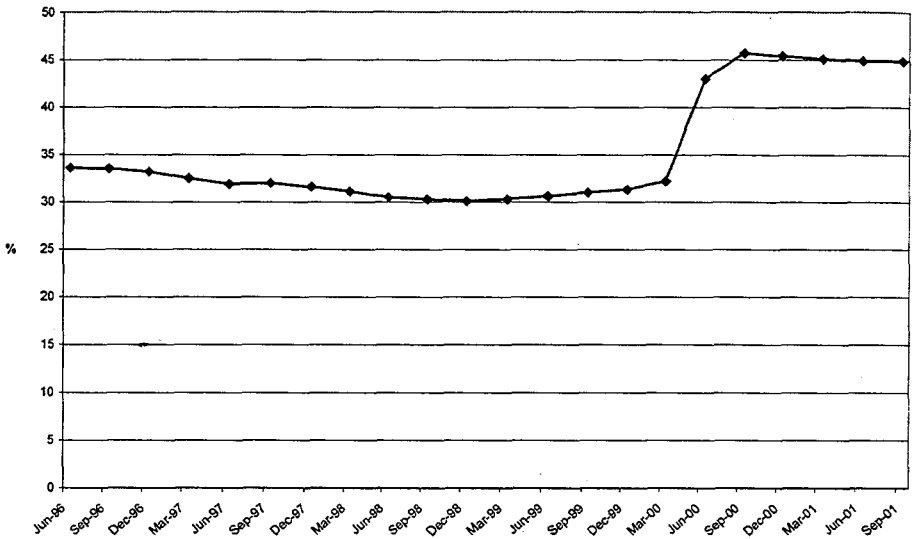
The Private Health Insurance Incentives Act was implemented in July 1997. In a two-part response to falling numbers of privately insured, high-income earners were encouraged to take out private health insurance by the introduction of a tax surcharge. Those with an annual income above \$100,000 for couples or \$50,000 for singles were charged an income tax surcharge of 1 percent of their income if they failed to purchase private health insurance. The second part of the policy instituted a means-tested partial refund on health insurance premiums to encourage those with lower incomes to also purchase private health insurance. Low-income earners were defined as singles earning less than \$30,000 per annum and couples earning less than \$70,000 per annum. The income threshold for families was raised by \$3,000 for every dependent child. The maximum rebate was \$125 (Hall, De Abreu and Viney, 1999).

The immediate response to this policy change was underwhelming, even perverse. The percentage of the population with private health insurance actually declined from 31.9 at the 30th June 1997 to 30.1 at the end of December 1998 (refer to Figure 1).

Since the first new policy did not have much effect, a second policy change was introduced in January 1999, with a change to the Private Health Insurance Incentives Act. It provided for a 30 percent rebate (subsidy) on both existing and new health insurance policies. The rebate was not means-tested. The response to this substantial rebate was surprisingly slow, but the rebate did lead to a small increase in the percentage of the population with private health insurance, from 30.1 percent at the end of 1998 to 31.1 percent at the end of 1999 (Private Health Insurance Administration Council, 2001a).

These new policies having been so restrained in their impact, the government was forced to change its tack. The next new policy focused on the pricing of health insurance by softening the regulations mandating

Figure 1. Percentage of the population with private health insurance – quarterly data June 1996 to September 2001



Source: Private Health Insurance Administration Council, 2001a

community rating. The new prices took effect in July 2000, under the National Health Amendment Act 1999. The policy, known as “Lifetime Health Cover” introduced a limited amount of age rating into private health insurance. The regulatory change enabled anyone who was insured by the time they were 30, or older persons prior to the cut-off date of the 30th June 2000, to take advantage of a base premium. For those signing up after the deadline, the base premium increases by 2 percent for each year the individual is over 30 at the time of first joining, with a ceiling of 70 percent over the base premium. So, someone joining at age 43 would pay 26 percent over the base premium. But, the maximum, even for someone 80 years old, would be 70 percent over the base.

Lifetime Health Cover as the name implies, was designed to prevent opportunistic “hit and run” behaviour. Consumers were joining a private health fund when they anticipated they would use private hospital treatment and withdrawing from the fund once the treatment had been completed. In the new pricing system, there is a strong incentive to remain insured once one joins the system.

The effect of the introduction of age rating was impressive. The policy was announced in 1999 and widely advertised under a "Run for Cover" slogan in the period leading up to the end of June 2000. The promotion was so successful that the government extended the deadline to the 15 July 2000 to accommodate the backlog in the processing of new policies. The percentage of persons with private health insurance jumped from 31.3 at the end of 1999 to 43 at the end of June 2000. A year later, it was 44.9 percent.

The privately insured pool became much younger, making it less adverse for the insurers. At the end of 1999, 5.9 percent of the insured pool were aged 30 to 34 and 10.75 percent were aged 65 plus (Private Health Insurance Administration Council, 2001a). By the time the Lifetime Health Cover had had its main effect, at the end of September 2000, 7.5 percent of the pool were aged 30 to 34 and 7.2 percent were aged 65 and over.

The introduction of age rating under the rubric of Lifetime Health Cover appears to explain most of the increase in insurance coverage. Support for the view that the change in community rating lead to a considerable portion of the large increase in insurance coverage is provided by the work of Butler (1999). He estimates that the demand for any type of private health insurance (hospital with ancillary, hospital only or ancillary only) is -0.5 or price inelastic. This elasticity would explain an increase in coverage of only 15 percent over the base, while the actual increase was over 40 percent. Moreover, the timing of the actual increase in private insurance coverage lines up with the liberalisation of the rating. We are not willing, however, to exclude the possibility that the 30 percent subsidy may have had a delayed impact on the decision to purchase private health insurance.

Another change, which became effective at the end of June 2000, was a major liberalisation in the types of insurance policies that could be offered. The change allowed insurers to pay all or a specified part of the gap costs associated with hospital admission as a private patient (Hall, De Abreu and Viney, 1999). The gap is the difference between the payment made by the insurer and the medical fee, which is paid out-of-pocket by the consumer. This was a major policy reversal because insurers were actually required to offer such policies after June 2000, whereas they had been prohibited from offering them in the past. This change was announced at the beginning of 1999 but became effective at the end of June 2000. Prior to this change, funds had been prohibited from paying more than the medical benefit schedule fee, which is a set of fees for medical services determined by the Health Insurance Commission. Many doctors charge amounts considerably in excess of the schedule fee, often up to 100 percent more than the schedule

fee, so private patients in either public or private hospitals faced a considerable gap between the medical fee and the payment made by the insurer.

A gap payment between the doctor's fee and the health insurance benefit creates a significant disincentive to admission to hospital as a private patient. Because public hospital treatment is entirely free for public patients, the out-of-pocket gap payment created a deterrent not only for using private hospitals or for being privately admitted to a public hospital but also for having private health insurance. The disincentive is heightened in the Australian hospital system because the differences in the quality of care between the public and private system are negligible.

Private health insurers now offer a range of more complete policies, reducing consumer financial risk and consumer co-payment. The new policies allow customers to either enjoy what is called no gap or known gap treatment in hospitals. To provide this type of coverage, the insurer negotiates with individual doctors to provide services for their members at a specified fee. This specified fee is, naturally, higher than the payment formerly paid by the insurer.

Early Effects on Insurance and Hospital Markets

Data on the effects of these policy changes and the shift to private health insurance are problematic. The most thorough data cover up to the year ended June 2000, which is very early in the new regime. But, by piecing incomplete data together we are able to present a reasonably clear picture of what is happening.

Hospital Utilisation

Reports on changes in hospital utilisation, both public and private, come from a number of sources. Interpretation of the changes in the utilisation of private hospitals and of public hospital beds by private patients has to account for the exclusion clauses in most insurance policies. This means that for a specified time period, benefits may not be claimed for treatment for a pre-existing condition.

The most complete reporting on hospitals is in the Australian Institute of Health and Welfare (2001) report on Australian Hospital Statistics. Unfortunately, collecting and checking this data is time-consuming, so the most recent data covers the period up to the end of June 2000. The sharp jump in the numbers privately insured occurred in the June quarter 2000. Nonetheless, there is some evidence of a slowdown in admissions to public

hospitals and an increase in admissions to private hospitals, leading up to the period ending June 2000. Between 1998-99 and 1999-00, the increase in admissions to public hospitals was 0.3 percent, or about 12,000 extra patients (Australian Institute of Health and Welfare, 2001). This compares with a 2.4 percent increase over the previous year. This evidence has to be balanced against the decline in public hospital beds of 1.7 percent over the period 1998-99 to 1999-00. Private hospital admissions increased by 8.1 percent over the period 1998-99 and 1999-00 compared with an increase of 4.6 percent for the previous year. Total admissions (public and private hospitals) increased by 2.8 percent between 1998-99 and 1999-00.

An additional factor, which impacts on hospital admissions over time, is the tendency for more procedures to be carried out on a day-only basis. In New South Wales, the Minister for Health estimates that "120,000 services that would have required admission to hospital before 1999 were now being offered as non-admission procedures" (Kerin, 2001). The Australian Institute of Health and Welfare report (2001), however, shows that day-only admissions increased more in private hospitals than in public hospitals in the period under scrutiny. In public hospitals, same day separations increased by 5.8 percent over the year ended June 1999 and 2.8 percent over the year ended June 2000. In private hospitals, same day separations increased by 7.9 percent in the year ended June 1999 and 10.6 percent in the year ended June 2000.

More recent data are available, but not for the entire hospital industry. For example, the Private Health Insurance Administration Council (2001b) reports data from Private Health Insurance Funds on membership by age, payment of benefits, claimed episodes of care and total bed days. This data is available through the June quarter of 2001. This data strongly reinforces the picture of higher private hospital utilisation described above.

One limitation is that the Private Health Insurance Administration Council data omit the self-insured who use private hospitals but pay the full cost of the service out-of-pocket. The extent of self-insurance in the population, prior to changes in health insurance policies detailed earlier in this paper, has been estimated at 9 percent (Vaithianathan, 2001). Many of the people who formerly self-insured are likely to have now purchased health insurance, though there is no study yet available to confirm this. For this reason, the numbers in Table 1 may slightly underestimate the utilisation prior to June 2000. Still, the differences are large compared with any possible bias from excluding the self-insured consumers.

Table 1 shows that for the year ended June 2001, all privately insured episodes have increased, in some cases quite substantially. For the year

ended June 1999, the last full year prior to the latest reform, all privately insured episodes of care apart from private day hospitals had decreased. During this year the percentage of the population with private hospital cover was at its lowest and was stable (see Figure 1).

Table 1. Growth in Privately Insured Episodes by Type of Institution

	Year ended June 1999 %	Year ended June 2000 %	Year ended June 2001 %
Day hospital*	22.67	15.61	37.06
Public hospital – day only	-5.85	-6.63	16.39
Public hospitals – over night	-21.48	9.76	14.30
Private hospitals – day only	5.47	10.28	25.31
Private hospitals – overnight	-9.31	17.01	6.24
Total acute episodes	-2.75	12.20	17.55

Source: Private Health Insurance Administration Council, 2001b

* day hospitals are free standing day hospitals, which are private

The results in Table 1 also show that day-only procedures have increased over all periods. This observation is in line with the evidence from the Australian Institute of Health and Welfare (2001) figures, which shows large increases in day only separations over the year 1999 to 2000.

Changes in Utilisation and Profitability in Private Hospitals

Another source for partial, but recent data, is the hospitals themselves. Many hospitals are either privately traded or are nonprofit firms, thus do not make their data public. Luckily, there are three large publicly listed private health groups in Australia. The three companies, Ramsay Health Care, Mayne Nickless and Healthscope, together account for about one-third of private hospital beds (Anonymous, 2000). The statutory annual reporting requirements under Australian Corporations Law means that we have ready and speedy access to financial information. The figures on profitability and revenue have to be interpreted with some caution for Mayne Nickless Ltd because it has two core activities: logistics and health. Its health care services are provided under the brand name Mayne Health, and include private hospitals and diagnostic services. Ramsay Health Care and Healthscope predominantly operate private hospitals.

The three health groups report increases in health care revenue in the year ending the 30th June 2001 ranging from 26 to 14 percent. Increases in net profit ranged from 142 percent for Ramsay to 34 percent for Healthscope

over the same time period (Mayne Nickless Ltd 2001; Ramsay Health Care 2001 and Healthscope 2001). The improvement in revenue and profits is attributed, in each of the annual reports, to improving market conditions associated with increases in private health insurance coverage. Ramsay reports that the “stronger results can also be attributed to improved health fund reimbursement rates, continued strong management and a focus on cost controls, some increases in occupancy rates and a general improvement in trading conditions in the private health care sector” (Ramsay Health Care, 2001).

Improvements in the market environment in which the companies operate is also reflected in their share prices. All have at least doubled in price over the financial year ended 30th June 2001. Two of the companies have increased their bed numbers and number of private hospitals by taking over smaller publicly listed health groups during the year 2000/01.

Episodes of care increased by 14.6 over the previous financial year in Healthscope hospitals. The occupancy rate improved from 64.5 percent in the 1999/2000 financial year to 71.5 percent in the 2000/01 financial year.

Waiting Times in Public Hospitals

Long waiting lists for care, especially for elective surgery, are an issue of contention in countries where there is nearly complete insurance, without managed care, and free public hospital treatment. The quantity and quality of care demanded by consumers at a price of almost zero is far more than the government is willing to provide.

Reducing the waiting list provides the motivation for governments forcing and encouraging people to hold private health insurance. Even if this weren't a motivation for the new policy, shifting consumers away from public hospitals should reduce waiting times, unless the government simultaneously reduces public hospital capacity. A decline in public hospitals' waiting lists is the expected outcome of a higher percentage of the population with private health insurance.

Although data are not available for all States yet, there is some evidence of a decline in public hospital waiting lists. In Victoria, the waiting list for all cases increased in the December quarter 2000 and declined in the March quarter 2001 by 1 percent. Over a one year period, from March 2000 to March 2001, the waiting list in all Victorian public hospitals declined by 3.9 percent (Department of Human Services, Victoria, 2001). In New South Wales, the waiting time in months has declined from an average of 1.6 months over the 1998/99 financial year to 0.99 months at the 18th Septem-

ber, 2001 (NSW Health, 2001). In Western Australia, the number of cases on the waiting list has declined dramatically from a high point of 16,998 on the 30th June 1998 to 9778 at the 31st August 2001. The median waiting time has declined over the same period from 7.5 months to 5.75 months (Healthwest, 2001). In South Australia, the median waiting time for all three categories of urgency (urgent, semi-urgent and non urgent) was higher over the six month period ending June 2001 than it was in the six month period ending June 1999 (South Australian Department of Human Services, 2001).

The inconsistency across states is a bit odd. Nonetheless, since there are far more people in Victoria, New South Wales and Western Australia than in South Australia, it follows that on a national basis, waiting lists and times have probably already been reduced. We would expect more reduction in the future.

No-Gap Policies

The newly-available no-gap policies were immediately popular and are still gaining. The percentage of in-hospital services provided with no gap was 60 percent in the September quarter of 2000. By the June quarter 2001, it was 71 percent. For those who do pay a gap fee, the average payment by patients for medical services has increased slightly over the same period, from \$54.20 to \$67.31 (Private Health Insurance Administration Council, 2001c). The gap was expected to increase as the doctors who charge smaller gaps are likely to be among the first to sign up to no gap schemes or arrangements

Some specialists are allegedly using the no gap scheme to increase their fees. HBF has written to 200 specialists asking them to justify increases in their billings since the scheme started in April 2000 (Mallabone, 2001) The specialists whose billing behaviour is under scrutiny have reportedly increased their bills by an average of 14 percent. Some have increased their bills by 50 percent. Since the no-gap insurance makes it possible for some physicians to charge more without driving customers away, it makes economic sense that some of them would raise their prices in response.

Health insurance industry

In five of out of ten years leading up to the 1999/00 financial year, the health insurance industry returned operating losses. The accumulated losses exceed the surpluses by about \$350 million. Improvements in contribution income, due to new members of 11 percent in the 1999/00 financial year combined with a 6 percent increase in benefits have improved the financial

viability of the industry as a whole (Private Health Insurance Administration Council, 2001d).

There are ongoing pressures on the financial viability of health funds. Increasingly, more members will have access to hospital benefits as the exclusion period in their policies expires. The provision of more no-gap policies over time will make health insurance more attractive but also adds to the benefit outlays of the funds and raises the demand for hospital care by reducing the out-of-pocket price. Finally, there is ongoing tension between private health providers and the health insurance funds about the distribution of the gains from changes in government policy. If private hospitals raise their fees substantially, this would cut into the operating surpluses of the funds and in turn put pressure on them to raise their premiums.

The increase in private coverage was achieved with a disproportionate increase in the enrolment of young people (Private Health Insurance Administration Council, 2001a). This is obviously advantageous to the health funds, as the pool became much younger making it less adverse for the insurers. The problem from the government's viewpoint is that decreases in public utilisation may not occur as younger persons are relatively healthy (Vaithianathan, 2001). This concern seems to have been largely unfounded, since there has already been a substantial increase in hospital benefits paid and utilisation by consumers with private insurance.

Table 2 shows the percentage increase in episodes of care across all ages and the 30 to 34 age group. Episodes of care are from taken from claims data and refer to claimable care received as a private inpatient or outpatient in any sort of hospital.

Table 2. Total Episodes of Claimed Care and Percentage Changes: June Quarter 1998, 1999, 2000 and 2001

	1998	1999	2000	2001
Age 30-34:				
Total episodes	23,201	21,242	23,960	30,331
% change over previous period		-8.44	12.79	26.59
All ages:				
Total episodes	381,299	371,031	415,516	488,078
% change over previous period		-2.69	11.99	17.46

Source: Private Health Insurance Administration Council, 2001b

Episodes of care declined for all ages and the younger age group between 1998 and 1999. Between the June quarters for 1999, 2000 and 2001, all episodes of care increased. This is consistent with the increases in utilisation in private hospitals and increases in numbers of privately insured patients discussed earlier in this paper. The claimed episodes of care increased faster for the younger age group, which is consistent with a higher rate of take-up of private health insurance in the younger age groups (Private Health Insurance Administration Council, 2001a).

Conclusion

The third health insurance policy change, allowing limited age rating, appears to explain most of the movement into private health insurance funds. Even though the insurance policy contractual waiting periods for pre-existing conditions and surgery did not end until June 2001, the patchy preliminary data suggest that private hospital demand is up and public hospital demand is down. As a result, it appears that public hospital waiting lists and waiting times have declined. As a natural side effect, private health insurer profits and private hospital profits are up. We would expect this process to continue for at least another year as the contractual waiting periods finally end. We are aware that the continuation of the market changes that we have reported here will depend on the maintenance of the current percentage of the population with private health insurance. At this early stage, that percentage has declined from a high point of 45.7 at the 30th September 2000 to 44.9 one year later (Private Health Insurance Administration Council, 2001a).

In the near future, there are several interesting policy questions that may require attention. There is no evidence that the policymakers have carefully considered the full impact of their policy changes. An initial issue is whether the large government subsidy of private health insurance is necessary or efficient? Can it be reduced?

The subsidy appears to be electorally popular and there are early indications that the insurance coverage would decline if it were removed. A survey on attitudes to health insurance conducted in November 2000 found that 16 percent of people currently with health insurance said that they would drop it if the 30 percent rebate were removed. Another five percent said that they were undecided (Australian Health Insurance Association, 2001). The survey results fit reasonably well with the estimates of Butler (1999) that the elasticity of demand for private health insurance is about -0.5. On the other hand, the survey, and Butler's result, directly conflict

with the observed effect of the introduction of the 30 percent subsidy. It is difficult to apportion the causation of the increasing coverage between the 30 percent subsidy and the liberalised rating, but the increase seems too large to be attributed entirely to one policy change. Clearly, more research is required on this issue.

Future possible policy changes include further changes in allowable risk rating of premiums. The introduction of age rating into the private insurance market lead to large increases in private health insurance coverage. More risk rating may lead to continued increases or at least stability in health insurance market share.

The full ramifications of the increases in private health insurance coverage have, quite obviously, not been realised. We may yet see large increases in demand and utilisation as a result of no-gap insurance. These moral hazard effects have implications for the total expenditure on health as a percentage of GDP and the split of resources between the public and private sector.

Finally, the policy changes have created considerable gains for both private hospitals and private health insurance funds. Already there is evidence of tension between the two about the distribution of the gains. The merger and takeover activity in the private hospital market is indicative of a market which is in a state of flux. Clearly, the evolution of these markets deserves continuing attention by both scholars and policy makers.

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