



Australian Government

Private Health Insurance Administration Council

# Quarterly Statistics

September 2009

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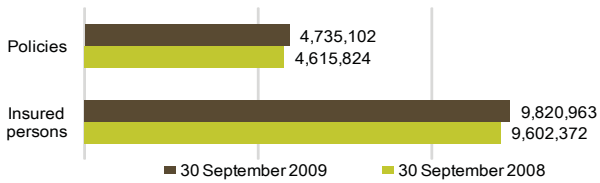
Private Health Insurance Administration Council, *Quarterly Statistics September 2009*, PHIAC, Canberra, 2009

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# Snapshot of the industry

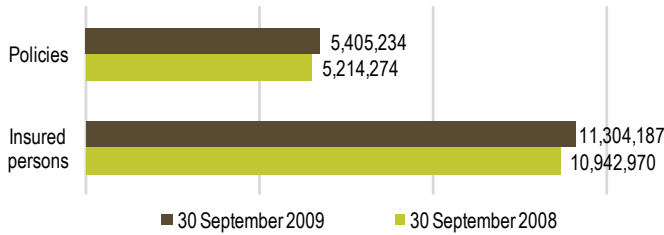
## Hospital treatment membership



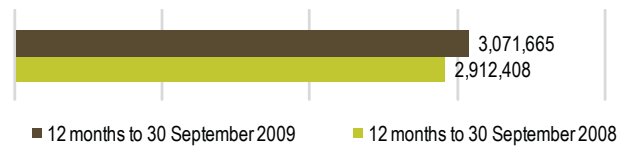
*Hospital treatment membership*  
 44.7% at 30 September 2009  
 ↑ 0.12% points from 30 June 2009  
 ↑ 75,721 insured persons over the quarter

*General treatment membership*  
 51.4% at 30 September 2009  
 ↑ 0.2% points from 30 June 2009  
 ↑ 105,443 insured persons over the quarter

## General treatment membership



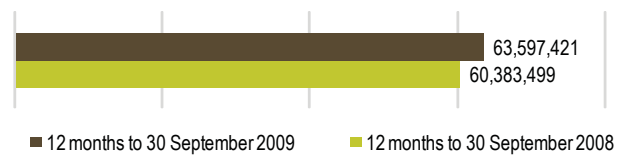
## Hospital treatment episodes



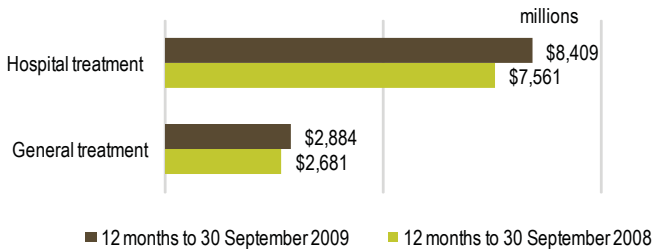
*Hospital treatment episodes*  
 ↑ 5.5% over the 12 months to Sept 2009  
 ↑ 4.2% over the quarter

*General treatment services (ancillary)*  
 ↑ 5.3% over the 12 months to Sept 2009  
 ↑ 5.2% over the quarter

## General treatment services (ancillary)



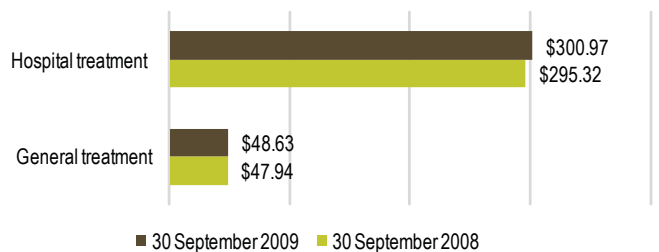
## Benefits



*Hospital treatment benefits*  
 ↑ 11.2% over the 12 months to Sept 2009  
 ↑ 10.5% over the quarter

*General treatment benefits*  
 ↑ 7.5% over the 12 months to Sept 2009  
 ↑ 6.9% over the quarter

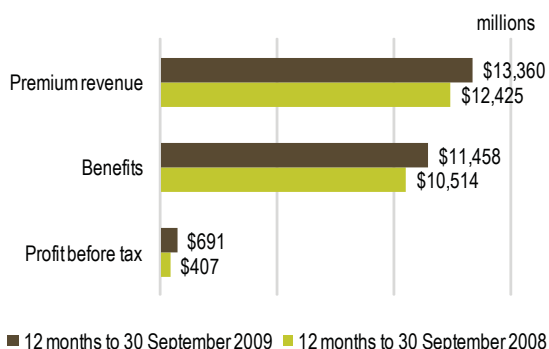
## Out-of-pocket per episode/service



*Hospital treatment out-of-pocket*  
 \$300.97

*General treatment out-of-pocket*  
 \$48.63

## Financial



*Premium revenue*  
 ↑ 7.5%

*Profit before tax*  
 ↓ 69.7%

## Hospital treatment

At 30 September 2009, 9,820,963 persons, or 44.7% of the population, were covered by Hospital Treatment cover. The percentage of the population covered increased 0.12 % points, compared to the June 2009 quarter.

There was an increase in coverage of 75,721 insured persons in the September 2009 quarter. There was an increase of 14,463 single policies and an increase of 17,970 family policies during the quarter. There was a net increase of 32,433 hospital policies. Over the year, from 30 September 2008, the number of insured persons with hospital treatment cover has increased by 218,591 persons and 119,278 policies.

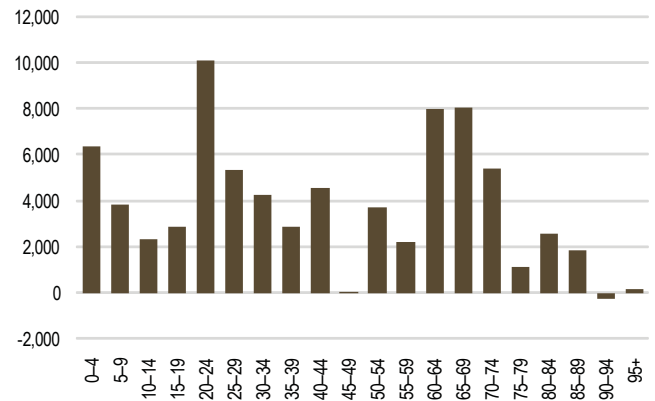
There was a notable increase in coverage during the quarter of 10,136 persons for people aged 20 to 24, reversing a similar decline in this age in the June quarter. There were increases in all age groups over the quarter (except for 90–94, with a marginal decrease of 245). Increases in the older age groups are partly due to ageing of the insured population with people moving from younger to older age cohorts but there is also growing proportions of insured persons in these age groups.

## Lifetime health cover

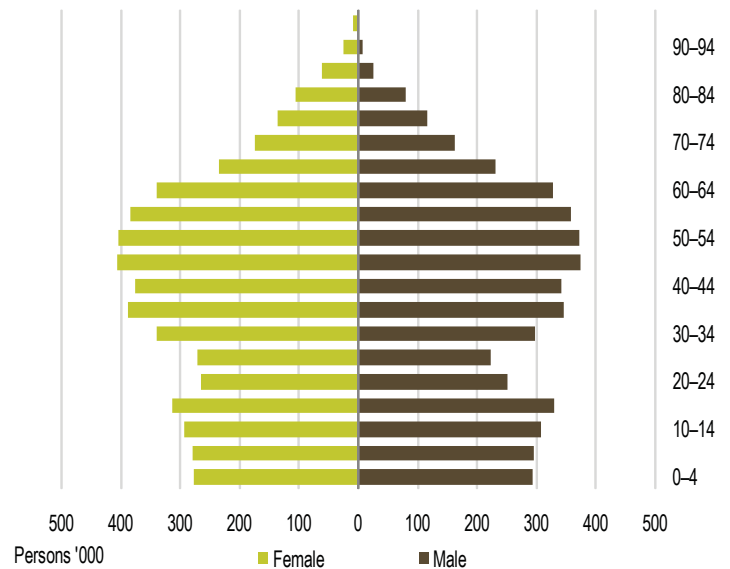
The majority of adults with hospital cover (89.0%) have a certified age of entry of 30, with no penalty loading. However, the proportion of adults with hospital cover paying a loading has increased every quarter since the introduction of Lifetime Health Cover.

At the end of the September 2009 quarter, there were 782,080 persons with a certified age of entry of more than 30 and subject to Lifetime Health Cover loading; a net increase in persons paying a penalty over the year of 89,104.

Net quarterly change in insured persons



Number of insured persons by age



There was a net increase in persons with a certified age of entry of 30 (with no penalty) over the year of 73,923.

## Hospital treatment tables

State/Territory	Insured persons (%)	Non insured persons (%)
Aust.	44.7%	55.3%
NSW	45.8%	54.2%
Vic.	43.1%	56.9%
Qld	42.4%	57.6%
SA	44.7%	55.3%
WA	50.3%	49.7%
Tas.	43.2%	56.8%
NT	34.9%	65.1%

State/Territory	Male	Female
Aust.	4,754,642	5,066,321
NSW	1,662,962	1,765,195
Vic.	1,131,772	1,219,903
Qld	908,545	972,644
SA	349,847	378,289
WA	558,967	576,457
Tas.	104,071	113,698
NT	38,478	40,135

State/Territory	Single policies (%)	Family policies (%)
Aust.	48.1%	51.9%
NSW	47.9%	52.1%
Vic.	51.8%	48.2%
Qld	45.5%	54.5%
SA	48.5%	51.5%
WA	45.1%	54.9%
Tas.	48.8%	51.2%
NT	45.0%	55.0%

## General treatment

At 30 September 2009, 11,304,187 persons or 51.4% of the population had some form of General Treatment cover. There was an increase in percent of the population covered of 0.2 percentage points, compared to the June 2009 quarter.

There was an increase in coverage of 105,443 insured persons in the September 2009 quarter. There was an increase of 20,216 single policies and an increase of 25,299 family policies during the quarter. There was a net increase of 45,515 general treatment policies.

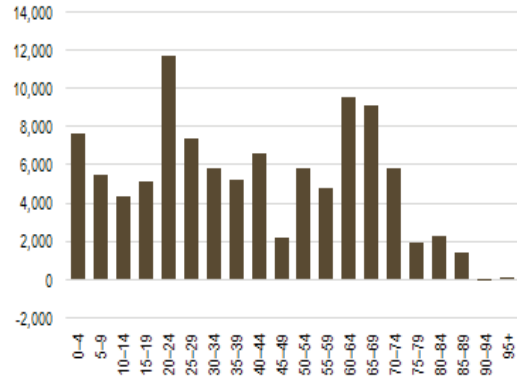
Over the year, to 30 September, the number of insured persons with general treatment cover has increased by 361,217 persons and 190,960 policies.

The General Treatment (ancillary) by age charts and data in this reports show persons that have general treatment policies that cover ancillary services such as dental treatment, and excludes those General Treatment policies that do not cover ancillary treatment. The March 2009 quarter is the first quarter since March 2007 in which data is collected according to this definition. The aim of this change is to map the trend in ancillary coverage prior to 1 April 2007 to the current period.

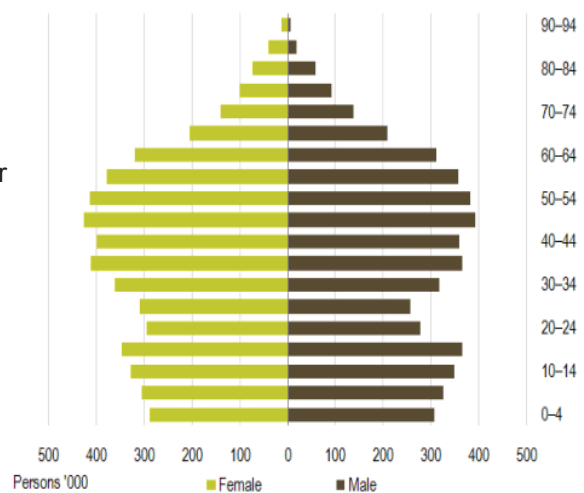
There was an increase in coverage of 102,128 persons with General Treatment ancillary coverage in the September 2009 quarter. The largest increases in coverage, 11,631 persons, was for people in the 20–24 age cohort.

The 20 to 29 age group historically has a lower proportion of persons with general treatment insurance compared to other age groups. The increase in the September quarter reverses a similar size decrease in the June 2009 quarter.

Net quarterly change in insured persons (ancillary)



Number of insured persons by age (ancillary)



### General treatment tables

State/Territory	Insured persons (%)	Not insured persons (%)	Total Insured Persons	Total Not Insured Persons	Single policies (%)	Family policies (%)
Aust.	51.4%	48.6%	4,865,037	5,169,687	48.0%	52.0%
NSW	54.0%	46.0%	1,759,998	1,855,372	47.2%	52.8%
Vic.	47.6%	52.4%	988,887	1,058,323	51.4%	48.6%
Qld	45.8%	54.2%	895,228	961,339	46.1%	53.9%
SA	55.2%	44.8%	401,967	436,242	48.5%	51.5%
WA	62.4%	37.6%	671,518	697,909	45.9%	54.1%
Tas.	48.0%	52.0%	109,127	120,043	49.3%	50.7%
NT	37.2%	62.8%	38,312	40,459	45.4%	54.6%

Includes all general treatment persons

Includes only general treatment persons with ancillary coverage

Includes all general treatment persons

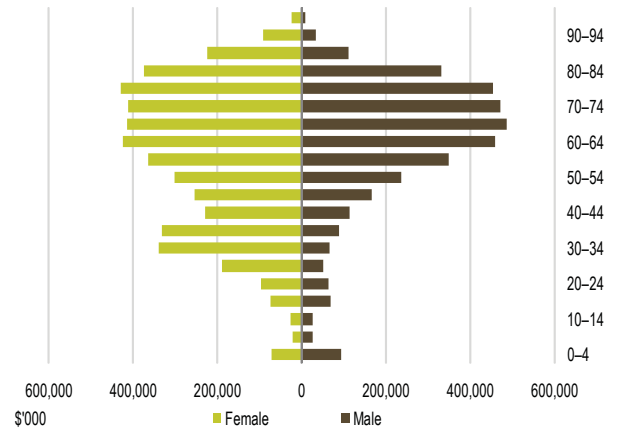
# Benefits paid

## Hospital treatment

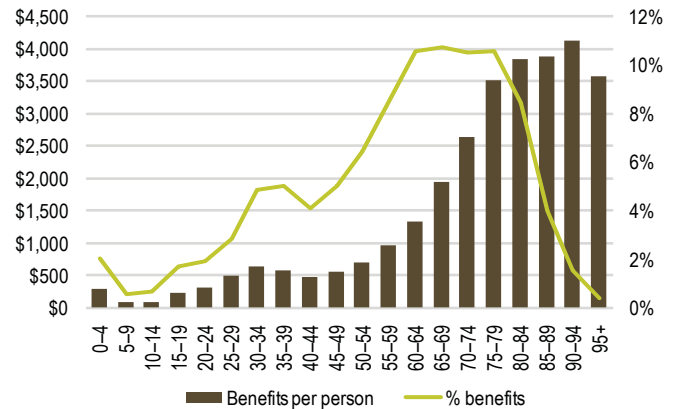
### Benefits per episode/service

	September 2009	Change from June 2009
Hospital Treatment		
Acute	\$1,911.24	1.2%
Medical	\$54.32	0.0%
Prostheses	\$773.88	0.2%
Cardiac	\$5,773.51	1.5%
Hips	\$2,603.81	0.7%
Knees	\$2,215.83	0.5%
Lens	\$429.45	1.6%
Total benefits		
Hospital	\$2,234,547,447	6.4%
General	\$7,30,594,434	0.7%

### Hospital treatment benefits paid by age 12 months to 30 September 2009



### Hospital treatment benefits per person and percentage of benefits paid by age cohort



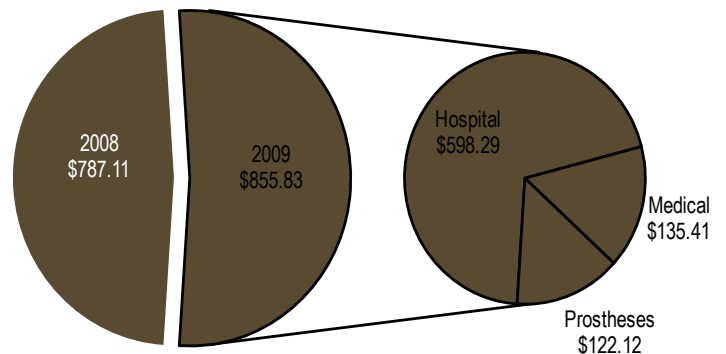
During the September 2009 quarter, insurers paid \$2,235 million in hospital treatment benefits. This was an increase of 6.4% compared to the June 2009 quarter. Hospital treatment benefits were comprised of:

- ◇ \$1,558 million for hospital services such as accommodation and nursing
- ◇ \$361 million for medical services
- ◇ \$314 million for prostheses items.

Benefits paid for hospital treatment by age and gender (top chart) show the total benefits paid in each age group. The age group for which most hospital benefits are paid is between 60 and 79. The benefits per person (middle chart) are affected by the age of the person and the number of persons in each age group. The older age groups have a higher claiming rate. The rise in benefits in 20–39 age cohorts is due to increases in female benefits associated with child bearing.

Hospital treatment benefits per person during the year increased from \$787.11 to \$855.83. The largest amount of benefits per person was spent on hospital accommodation and nursing, followed by medical and prostheses benefits.

### Hospital treatment benefits per person



## General treatment

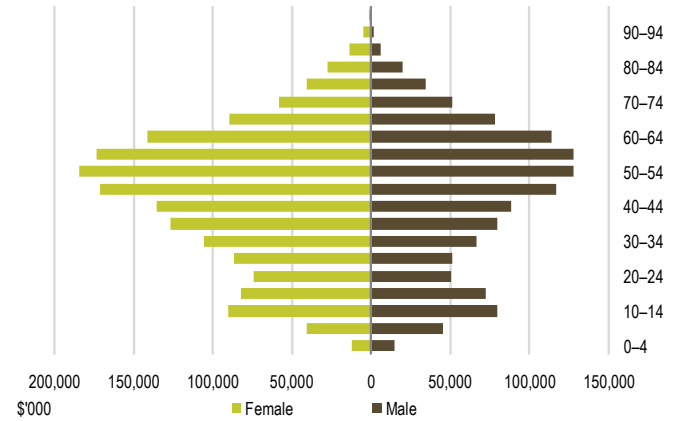
During the September 2009 quarter, insurers paid \$731 million in general treatment (ancillary) benefits. This was a decrease of 0.7% compared to the June 2009 quarter. Ancillary benefits for the September quarter included the major categories of:

- ◇ Dental \$384 million
- ◇ Optical \$114 million
- ◇ Physiotherapy \$60 million
- ◇ Chiropractic \$52 million.

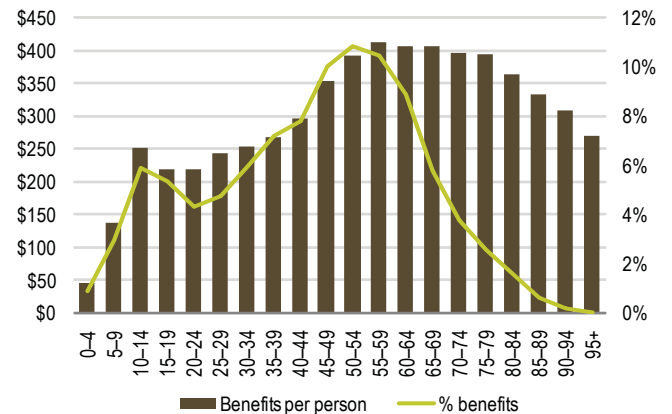
There is a marked difference between the distribution of benefits over age groups between hospital benefits and ancillary benefits. The major difference is the higher claiming rate in older age groups for hospital benefits while benefits per person for ancillary benefits are more evenly spread over the age groups.

General treatment ancillary benefits per person during the year to September 2009 were \$287.36, increasing from \$252.58 in the year to September 2008. The largest component of ancillary benefits is dental for which \$148.06 was paid per person during the year to September 2009.

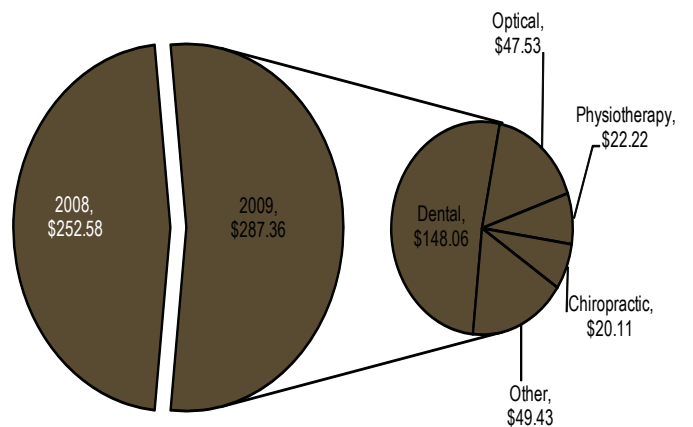
General treatment benefits paid by age 12 months to 30 September 2009 (ancillary)



General treatment benefits per person and percentage of benefits paid by age cohort (ancillary)



General treatment benefits per person (ancillary)



## Medical benefits

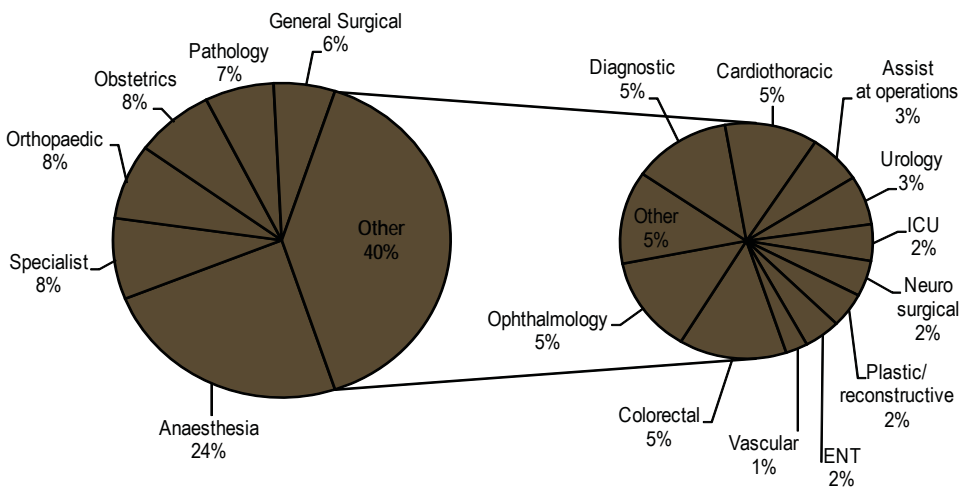
Total benefits for medical services increased 8.0% during the quarter and the number of medical services in the quarter increased by 8.0%. Benefits paid on average for the medical services did not change during the quarter.

The increase in medical benefits per service was calculated over a range of medical services and does not mean medical services overall increased in cost. The increase in benefits paid may reflect a change in the type of medical services utilised, or a change in the overall utilisation of medical services. The medical service for which the greatest amount of benefits was paid was anaesthetics, comprising 24% of all medical benefits and totalling \$86.868 million.

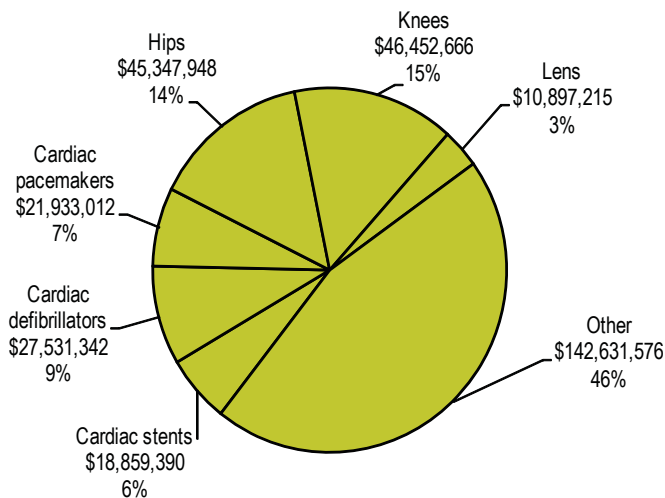
## Prostheses benefits

Total benefits paid for prostheses over the quarter increased 3%, compared to the June quarter. Benefits paid per prosthetic decreased 0.2% per item during the quarter. Similar to medical services, the increase in benefits paid for prostheses was calculated over a range of prosthetics (see chart) and does not mean prostheses overall increased in cost. The increase in benefits paid may reflect a change in the type of prosthetics utilised, or a change in the overall utilisation of prosthetics. The prosthetic groups for which the greatest amount of benefits were paid were "hips" and "knees", comprising 29% of all prosthetic benefits and totalling \$92 million each. The combined cardiac group comprised 21.8% of all prosthetics and totalled \$68 million over the quarter

Medical benefits paid by speciality group



Benefits paid for prostheses



# Service utilisation

## Episodes/Services by type

By Type	September 2009	Change from June 2009
Hospital Episodes	815,109	5.4%
Hospital Days	2,176,948	6.0%
Medical Services	6,643,110	8.0%
Prostheses Items	405,337	3.5%
Cardiac	11,834	-4.2%
Hips	17,416	2.9%
Knees	20,964	2.3%
Lens	25,375	5.4%
General Treatment Services	16,298,647	0.6%
Dental	7,142,690	2.4%
Chiropractic	2,195,694	-0.2%
Physiotherapy	2,151,591	2.3%
Optical	1,769,224	0.7%

Hospital utilisation is distributed over four categories of hospital: public, private, day only facilities and hospital-substitute. During the September 2009 quarter hospital episodes were distributed as follows:

- ◇ public hospitals 116,553 episodes
- ◇ private hospitals 576,554 episodes
- ◇ day hospital facilities 118,714 episodes
- ◇ hospital-substitute 3,288 episodes.

Between the June 2009 and September 2009 quarters hospital utilisation increased in all categories of hospital. These increases continue the trend with increases in utilisation in all categories over the year from September 2008 to September 2009.

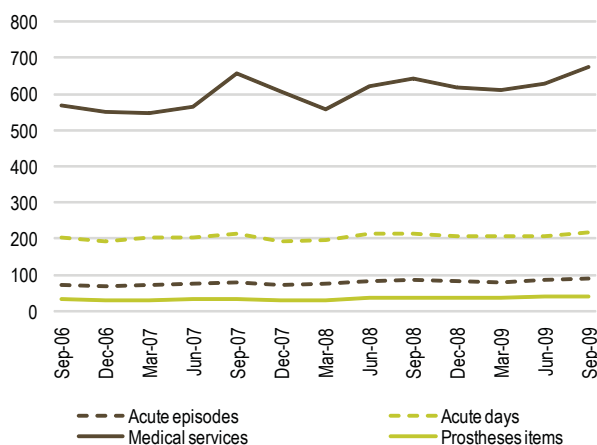
	Change from June 2009	12 months to change
public hospitals	5.1%	6.6%
private hospitals	4.9%	5.3%
day hospital facilities	9.0%	5.4%
hospital-substitute	-18.3%	5.9%

During the September 2009 quarter, insurers paid benefits for 2.177 million days in hospital, arising from 815,109 hospital episodes of care.

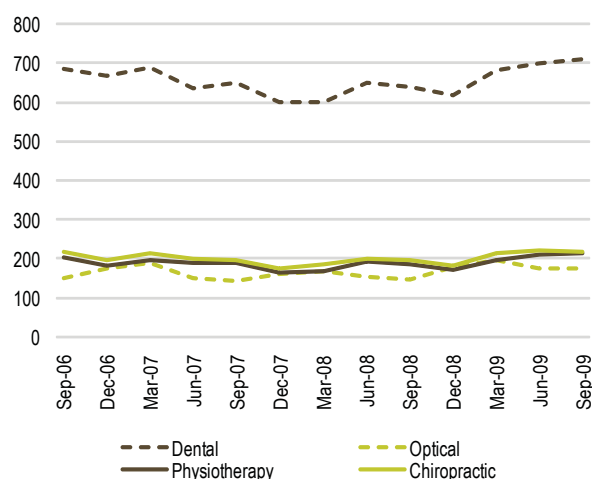
The average length of stay was 2.67 days; an decrease of 0.6% compared to the June 2009 quarter. The utilisation rates for hospital episodes, medical services and prostheses services increased during the quarter, continuing the general trend.

Day-only episodes in the four categories of hospital totaled 512,032, an increase of 6.2% compared to the June 2009 quarter.

## Hospital treatment services per 1,000 insured persons



## General treatment services per 1,000 insured persons



# Out-of-pocket payments

## Average out-of-pocket per episode/service

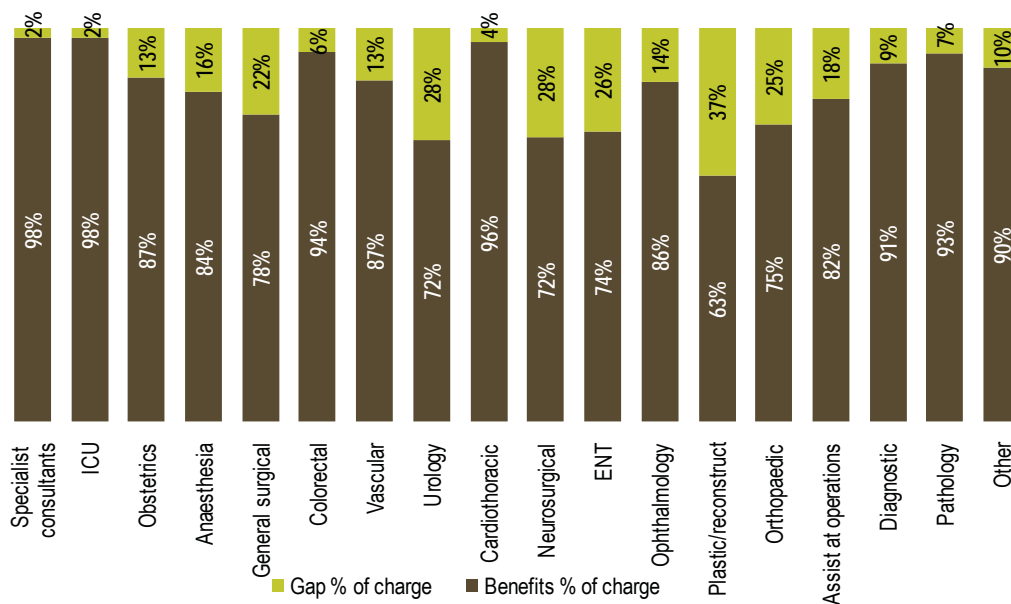
	September 2009	Change from June 2009	Change from September 2008
Hospital treatment	\$300.97	0.1%	1.9%
Hospital-substitute treatment	\$13.22	932.3%	306.4%
General treatment	\$48.63	1.2%	1.4%
Prostheses where gap was paid	\$34.03	15.7%	5.7%
Medical gap where gap was paid	\$140.49	-3.4%	-1.7%

The average out of pocket (gap) payment for a hospital episode was \$300.97 in the September 2009 quarter and included out-of-pocket payments for medical services and some prostheses as well as any excess or co payment amounts relating to hospital

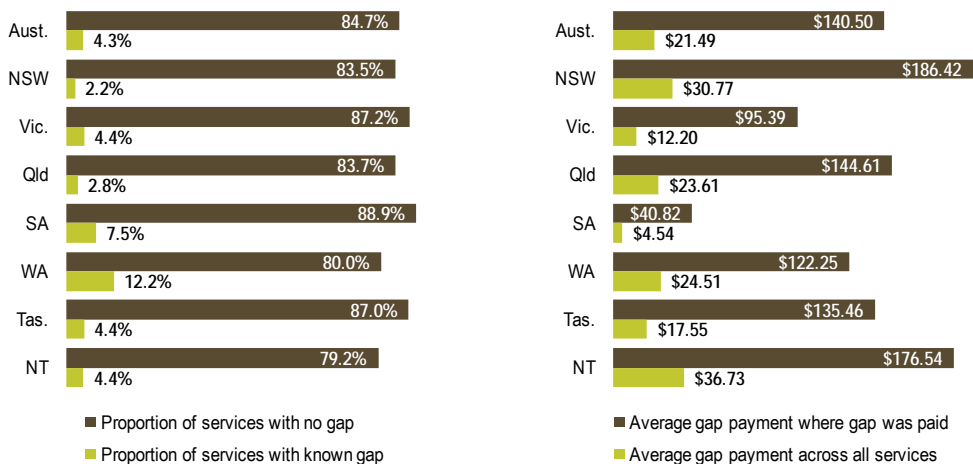
accommodation. The out of pocket payments for hospital episodes increased by 1.9% compared to the same quarter of the previous year.

Out of pocket payments for medical services were \$140.49 where an out of pocket payment was payable. The amount of gap for medical services varies depending on the specialty group. The specialty group with the largest out of pocket payment was plastic/reconstructive with an average gap of \$345.88, followed by orthopaedic with an average gap per service of \$275.12, followed by neurosurgical and then urology. Plastic/reconstructive medical services incurred the largest gap as a percent of the fee followed by urology, neurosurgical and "ear, nose and throat". The state with the highest amount of gap payment where gap was paid was New South Wales.

## Medical benefits and out-of-pocket by speciality group



## Proportion of services and average out-of-pocket payments



# Financial information

## Financial performance

All Figures \$'000	12 months to September 2009†	12 months to September 2008
<b>Revenue</b>		
HIB premium revenue	\$13,360,256	\$12,424,974
Net HRB and other revenue	\$216,189	-\$48,899
<b>Total revenue</b>	<b>\$13,576,445</b>	<b>\$12,376,075</b>
<b>Benefits</b>		
Fund benefits	\$11,457,610	\$10,513,795
State ambulance levies	\$149,811	\$139,063
<b>Total fund benefits</b>	<b>\$11,607,421</b>	<b>\$10,652,857</b>
<b>Expenses</b>		
HIB expenses	\$1,014,651	\$1,055,188
HIB claims handling	\$255,217	\$257,325
Other expenses	\$7,919	\$3,268
<b>Total expenses</b>	<b>\$1,277,788</b>	<b>\$1,315,780</b>
<b>Profit</b>		
Profit/(loss) before tax	\$691,235	\$407,438
Taxation expense	\$106,516	\$87,676
Profit/(loss) after tax	\$584,720	\$319,762
Non HBF related profit/(loss)	\$3,764	-\$1,036
<b>Profit/(loss) of the insure</b>	<b>\$588,484</b>	<b>\$318,726</b>
<b>Margins</b>		
Gross margin	13.12%	14.26%
HIB expenses	9.50%	10.56%
Net margin	3.61%	3.70%

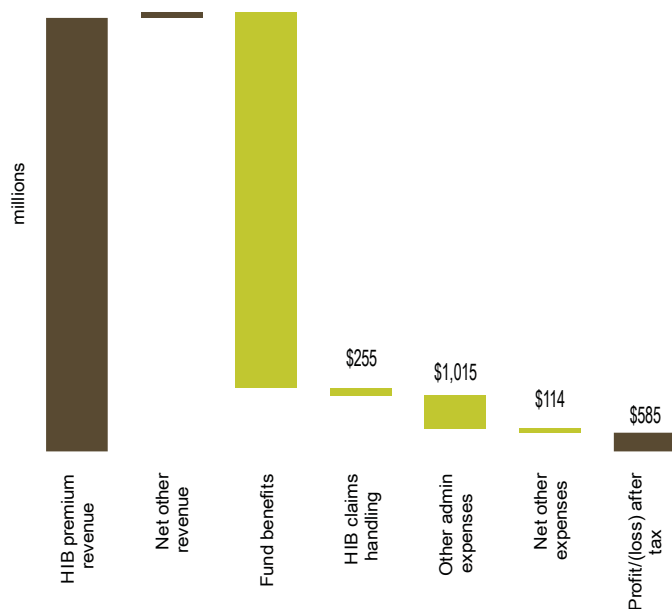
12 months. The underlying cause of the increase has been, and continues to be, the ageing of the population, advancements in technology and membership growth.

Offsetting the increase in benefits, contribution income had also increased by \$935 million over the same period. This increase is due to the growth in membership as well as the average weighted premium increase of 6.02% which was implemented on 1 April 2009.

The reduction in gross margin over the past 12 months was offset by a similar reduction in management expenses thus there was a negligible difference in the net margin for the 12 months to 30 September 2009 and 30 September 2008. In addition, improving economic conditions provided a stronger return on investments resulting in \$691 million in profit before tax for the period. In contrast, the industry had only recorded \$407 million in profit before tax for the 12 months to 30 September 2009.

Total benefits paid by the industry for the 12 months to 30 September 2009 was \$954 million more than the prior

**Health Benefits Fund Profit After Tax Breakdown for 12 months to 30 September 2009**



## Prudential position

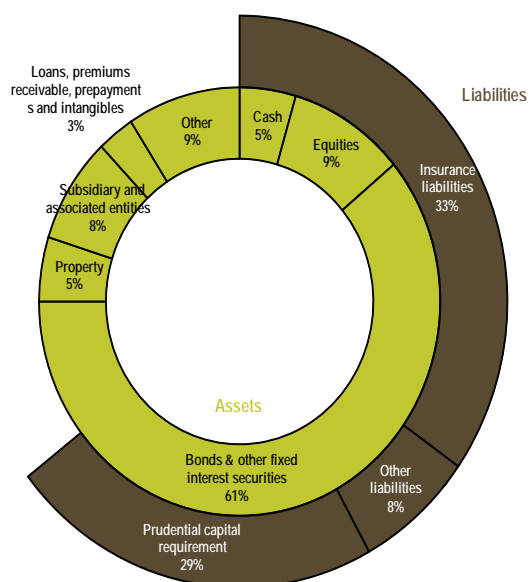
All Figures \$'000	As at 30 September 2009	As at 30 September 2008
Health benefits fund financial assets		
Cash	379,607	1,592,513
Investments		
Equities	791,134	948,553
Bonds & other fixed interest securities	5,122,182	4,509,810
Property	407,629	446,061
Subsidiary and associated entities	673,518	399,352
Loans	86,567	273,301
Premiums receivable	77,893	90,462
Intangibles DAC and FITBS	65,006	70,556
Prepayments	21,428	25,410
Other*	765,290	832,345
<b>Total assets</b>	<b>8,390,254</b>	<b>9,188,364</b>
Health Insurance Liabilities		
Unearned premium liabilities	1,486,066	1,408,452
Unpresented & outstanding claims	1,432,556	1,349,254
Other fund liabilities	125,411	115,229
Interest bearing liabilities	30,363	467,639
Payables, provisions & other liabilities	446,735	504,412
<b>Total liabilities</b>	<b>3,521,131</b>	<b>3,369,998</b>
Health benefits fund capital	4,894,124	5,843,366
Solvency Requirement	5,173,356	5,201,687
Capital Adequacy Requirement	5,413,058	5,517,965

All private health insurers remained compliant with the Capital Adequacy and Solvency Requirements. As at 30 September 2009, the industry as a whole had \$2.98 billion (30 September 2008: \$3.67 billion) in excess of its capital requirements. The reduction of excess assets has been primarily due to the reduction in asset value caused by the impact of the Global Financial Crisis, dividend payments provided for by the for-profit insurers, and consolidation of the industry causing an increase in the inadmissible component.

PHIAC notes that private health insurers continue to increase their asset exposure to more conservative investments that are expected to have a lower return for lower risk.

\*includes health insurance equipment and other assets

### Health Benefits Fund Assets vs Liabilities as at 30 September 2009



The population figures used to calculate coverage are derived from:

Australian Bureau of Statistics, Australian Demographic Statistics, ABS cat no. 3101.0, ABS, Canberra, 2009.

Figures for NSW include ACT

Lifetime Health Cover is a financial loading (LHC loading) that can be payable in addition to the premium for your private health insurance hospital cover (hospital cover). LHC loadings apply only to hospital cover. The loading is 2% above the base rate for each year over the age of 30 in which the policy holder did not have private health insurance hospital cover.

Starting from 1 April 2007 general treatment policies replaced ancillary policies. General treatment policies cover treatment similar to that previously known as ancillary (eg. dental) but can also cover hospital-substitute treatment and Chronic Disease Management Programs.

# Definitions and abbreviations

<i>DAC</i>	Deferred Acquisition Costs
<i>Episode</i>	The period of admitted patient care between an admission and separation (eg. discharge) characterised by only one care type.
<i>Family policy</i>	A policy under which more than one person is insured including: two parents and children; single parent and children; two or more children and no adults; three or more adults.
<i>FITBS</i>	Future Income Tax Benefits
<i>General treatment</i>	Treatment that is intended to manage or prevent a disease, injury or condition and is not hospital treatment.*
<i>General treatment services</i>	Ancillary services such as dental and optical.
<i>Gross margin</i>	The difference between total premium revenue and total cost of benefits (inclusive of state levies) expressed as a percentage of premium revenue.
<i>HIB</i>	Health Insurance Business: the business of undertaking liability, by way of insurance or an employee health benefits scheme, that relates to hospital treatment and general treatment.*
<i>Hospital treatment</i>	Treatment that is intended to manage a disease, injury or condition provided to a person at a hospital or arranged with the direct involvement of a hospital.*
<i>Hospital-substitute treatment</i>	General treatment that substitutes for an episode of hospital treatment.*
<i>HRB</i>	Health Related Business* includes one or more of: <ul style="list-style-type: none"><li>• Providing goods and/or services to manage or prevent disease, injuries or conditions (may include dental or optical centres)</li><li>• Undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare</li><li>• Providing a financial service to assist people meet the costs associated with treatment, goods or services that are provided to manage or prevent diseases, injuries or conditions.</li></ul>
<i>Medical service</i>	Medical specialist services such as the anaesthetist or obstetrician. A hospital episode may involve several medical services.
<i>Net margin</i>	Gross margin less management expenses expressed as a percentage of premium revenue.
<i>Out-of-pocket</i>	Refers to the amount paid by the policy holder for a service after private health insurance benefits and medicare benefits are paid. Out-of-pocket includes medical gap, excess or co-payments for hospital or hospital-substitute episodes, and co-payments for ancillary services.
<i>Persons</i>	Refer to the number of persons covered by private health insurance policies.
<i>Policies</i>	Refer to the number of private health insurance policies referable to private health insurance funds. Each policy may cover one or more persons.*
<i>Single policy</i>	A policy under which only one person is insured.
<i>State ambulance levy</i>	Amounts payable to the New South Wales and Australian Capital Territory governments in respect of levies on policy holders of insurers with hospital treatment cover, for ambulance cover.

## Related publications

### Data Tables

PHIAC produces a number of statistical data tables that are available from

[www.phiac.gov.au/for-industry/industry-statistics/](http://www.phiac.gov.au/for-industry/industry-statistics/). These include:

#### *Membership and Coverage Statistics*

Provides the number of insured persons, by state, for hospital treatment and general treatment and the proportion of the population these persons represent. The tables are shown on both a quarterly and an annual basis and include hospital treatment by age cohort.

#### *Medical Gap Information*

Provides data on in-hospital medical services. The proportion of services for which there was no gap or known gap and the average gap payment are shown for each state.

#### *PHIAC A Report*

Provides the membership and benefits paid by private health insurers for the period by state. These state reports are available both in PDF format and Excel.

#### *PHIAC 3 Report*

Provides data on prosthetic benefits paid by private health insurers by major prosthetic category

#### *PHIAC 4 Report*

Provides data on services, benefits paid and gap payments by MBS Speciality Block Groupings for medical services paid by private health insurers.

#### *Statistical Trends - Quarterly Statistics*

These are two separate tables detailing trends since September 1997 in the number of insured persons and benefits paid for hospital and general treatment.

### Annual publications

PHIAC is also required to produce a Annual Report on the Operations of the Private Health Insurance Industry. This report contains an industry overview and tables of statistics by individual fund. Current and historical versions are available at [www.phiac.gov.au/for-industry/industry-statistics/](http://www.phiac.gov.au/for-industry/industry-statistics/)

# About PHIAC

PHIAC was established in 1989 under section 82B of the *National Health Act 1953* as the prudential regulator for Australia's private health insurance industry. PHIAC continues in existence by force of section 264–1 of the *Private Health Insurance Act 2007*, subject to the provisions of the Act.

PHIAC is an independent statutory authority that reports to the minister. It works closely with other regulatory bodies including the Private Health Insurance Ombudsman (PHIO) to ensure that consumers have access to a well-run and competitive private health insurance industry.

In carrying out its regulatory and supervisory functions, PHIAC is required by the Act (section 264–5) to achieve an appropriate balance between three objectives:

- ◇ fostering an efficient and competitive private health insurance industry
- ◇ protecting the interests of consumers
- ◇ ensuring the prudential safety of individual private health insurers.

Full details concerning the operations of PHIAC are contained in the *Private Health Insurance Administration Council Annual Reports*. These reports are required under section 9 of the *Commonwealth Authorities and Companies Act 1997* and can be obtained from the PHIAC office or are available at <[www.phiac.gov.au](http://www.phiac.gov.au)>.

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