



Quarterly Statistics

December 2010

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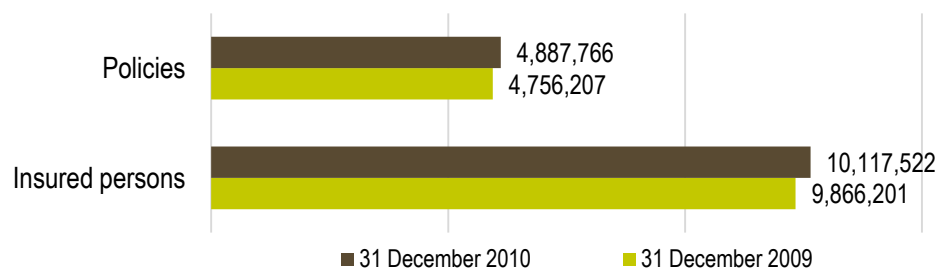
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Snapshot of the industry

Hospital treatment membership



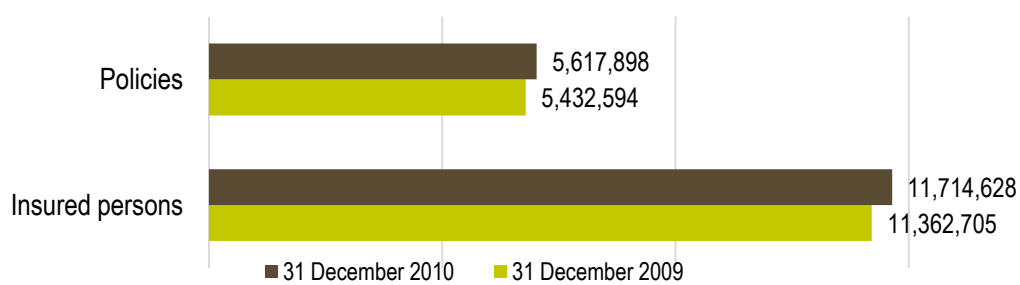
Hospital treatment membership

44.9% of population at 31 December 2010
 0.0% percentage points from 30 September 2010
 ↑ 53,479 insured persons over the quarter

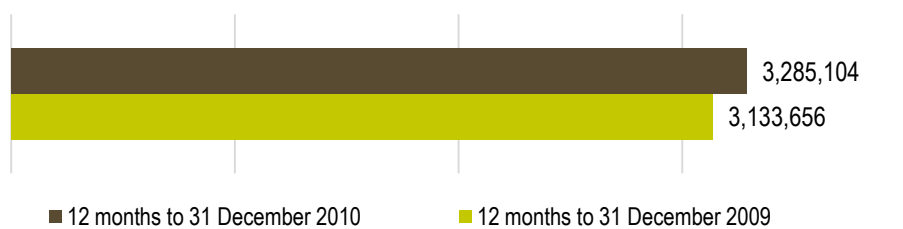
General treatment membership

52.0% of population at 31 December 2010
 ↑ 0.1% percentage points from 30 September 2010
 ↑ 66,827 insured persons over the quarter

General treatment membership



Hospital treatment episodes



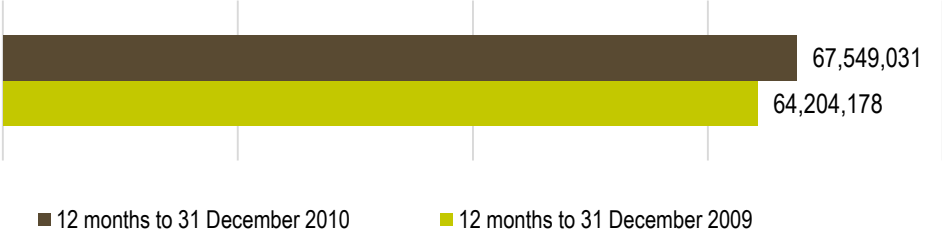
Hospital treatment episodes

↑ 4.8% over the 12 months to December 2010
 ↑ 5.1% over the quarter

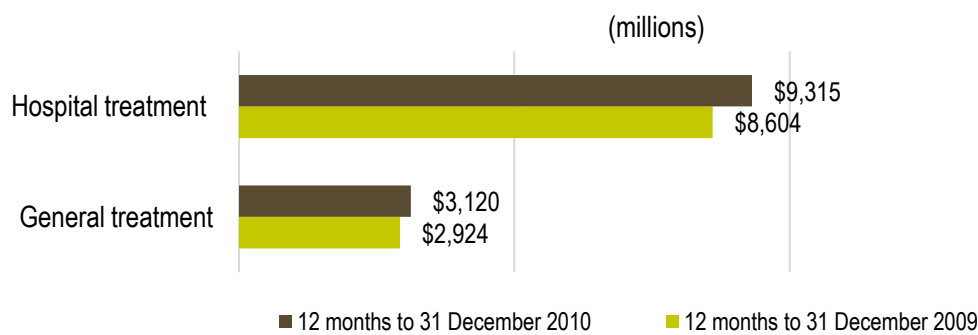
General treatment services

↑ 5.2% over the 12 months to December 2010
 ↓ 0.0% over the quarter

General treatment services (ancillary)



Benefits



Hospital treatment benefits

↑ 8.3% over the 12 months to December 2010
 ↑ 6.4% over the quarter

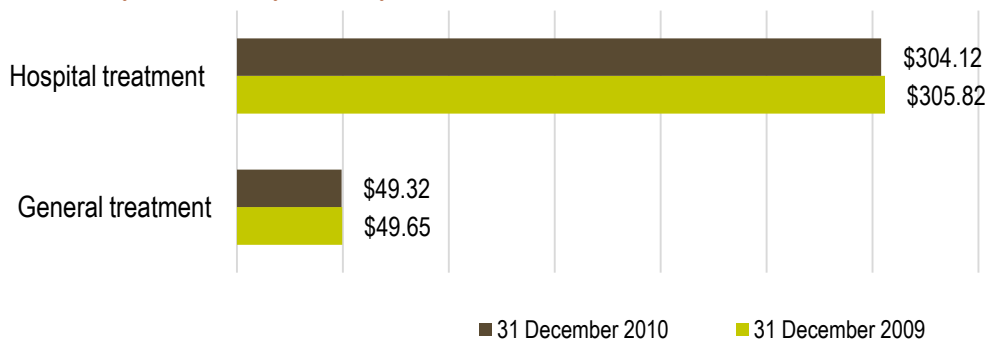
General treatment (ancillary) benefits

↑ 6.7% over the 12 months to December 2010
 ↑ 1.4% over the quarter

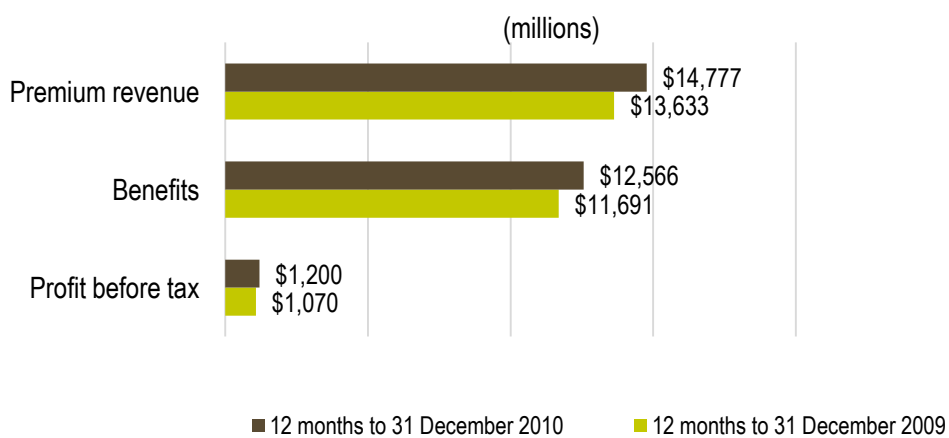
Hospital treatment out-of-pocket
 \$ 304.12

General treatment out-of-pocket
 \$ 49.32

Out-of-pocket per episode/service



Financial



Premium revenue

↑ 8.4% over the 12 months to December 2010

Profit before tax

↑ 12.2% over the 12 months to December 2010

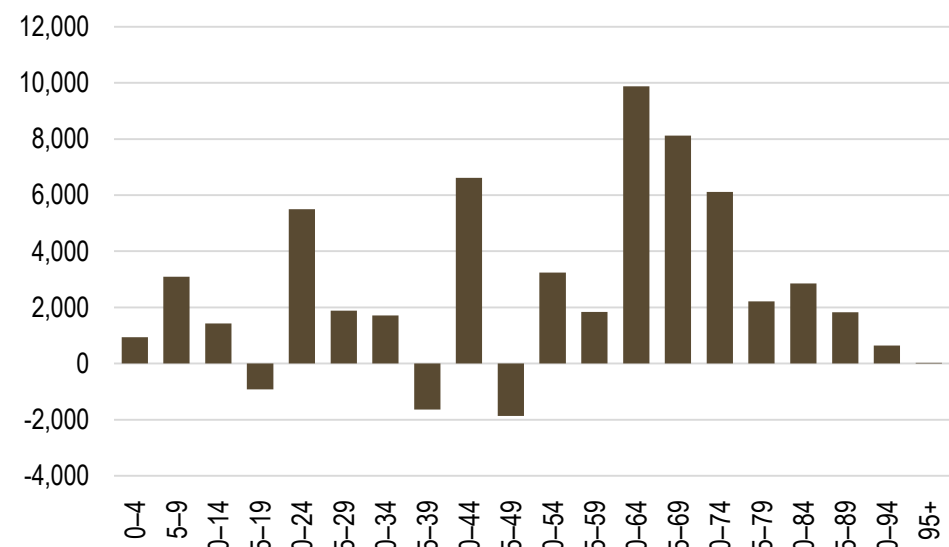
Hospital Treatment

At 31 December 2010, 10,117,522 people, or 44.9% of the population, were covered by hospital treatment cover. There was no change in the percentage of the population covered compared to the September 2010 quarter.

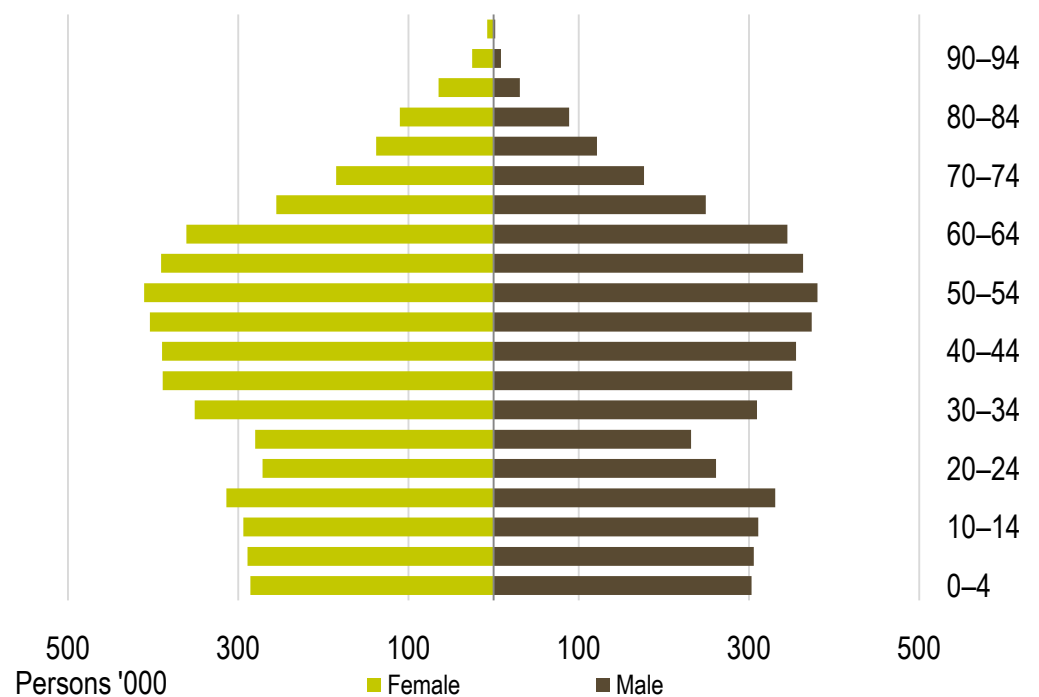
There was an increase in coverage of 53,479 insured people in the December 2010 quarter. Single policies rose by 10,899 and family policies by 14,494 during the quarter. This resulted in an overall increase of 25,393 hospital policies. For the 12 months to 31 December 2010, the number of insured people with hospital treatment cover has increased by 251,321 and 131,559 policies.

The most notable increase in coverage during the quarter was for people aged between 60 and 64, who accounted for 18.5% of the growth.

Net quarterly change in insured persons



Number of persons insured by age



Lifetime health cover

The majority of adults with hospital cover (87.8%) have a certified age of entry of 30, with no penalty loading. Despite this, the proportion of adults with hospital cover who pay a loading has continued to increase each quarter since the introduction of Lifetime Health Cover.

At the end of the June 2010 quarter, there were 893,331 people with a certified age of entry of more than 30 and subject to a Lifetime Health Cover loading; a net increase in people paying a penalty over the preceding 12 months of 93,573. There was a net increase in people with a certified age of entry of 30 (with no penalty) over the year of 91,542. This includes 6,162 people who had their loading removed during the quarter, after ten years of paying a loading.

Hospital treatment tables

State/Territory	Insured persons (%)	Non insured persons (%)	Total Insured (Male/Female)	Single policies (%)	Family policies (%)
Aust.	44.9%	55.1%	4,829,334 / 5,215,563	48.1%	51.9%
NSW	45.5%	54.5%	1,611,538 / 1,707,511	47.8%	52.2%
Vic.	43.2%	56.8%	1,163,185 / 1,252,600	51.6%	48.4%
Qld	42.6%	57.4%	938,714 / 1,003,046	45.5%	54.5%
SA	44.8%	55.2%	356,054 / 384,429	48.5%	51.5%
WA	51.5%	48.5%	589,626 / 605,434	45.5%	54.5%
Tas.	43.4%	56.6%	105,697 / 115,338	48.6%	51.4%
ACT	55.7%	44.3%	96,700 / 104,911	50.2%	49.8%
NT	35.7%	64.3%	40,445 / 42,294	45.2%	54.8%

General Treatment

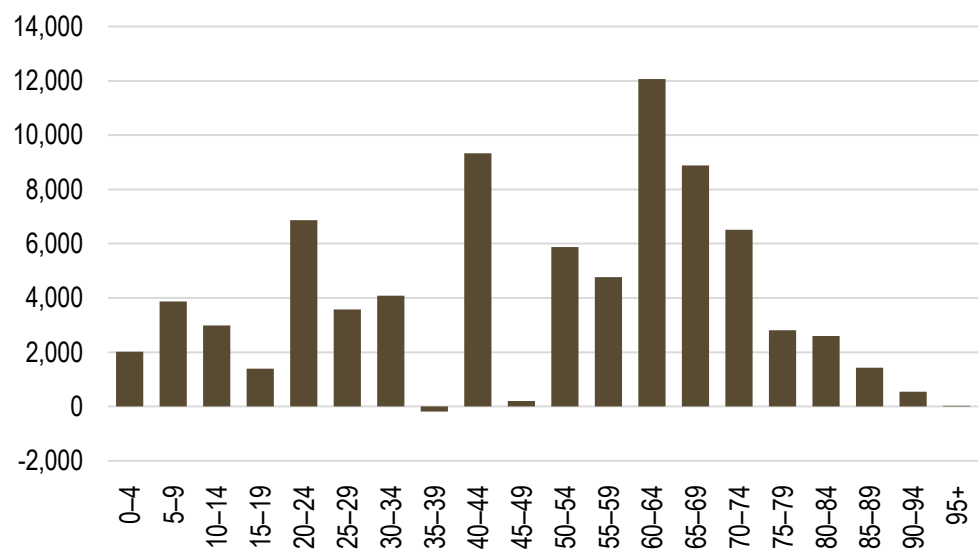
At 31 December 2010, 11,714,628 people or 52.0% of the population had some form of general treatment cover. This resulted in a 0.1% increase (or an increase of 66,827 people) compared to the September 2010 quarter.

The increase in single policies was 14,274 and family policies increased by 17,583 during the quarter. The overall increase was 31,857 general treatment policies. For the 12 months to 31 December 2010, the number of insured persons with general treatment cover has increased by 351,923 and general treatment policies increased by 185,304.

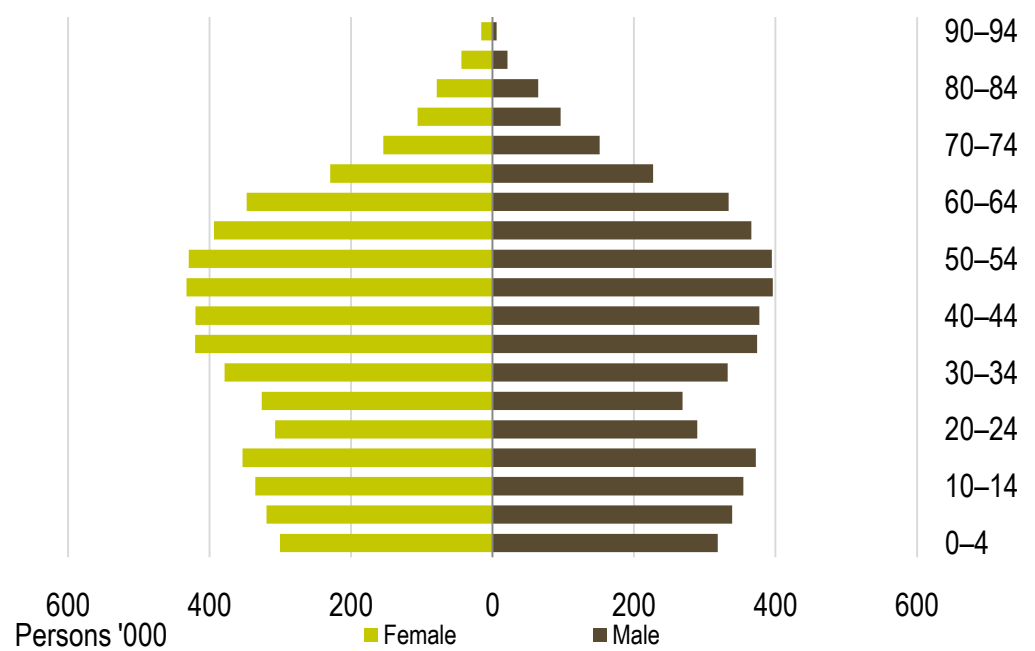
The general treatment (ancillary) by age charts and data in this report show data for those people that have general treatment policies covering ancillary services. This excludes those general treatment policies that do not cover ancillary treatment.

There was an increase of 79,637 people with general treatment (ancillary) coverage in the December 2010 quarter. The largest increase in coverage was for people in the 60 to 64 age group.

Net quarterly change in insured persons (ancillary)



Number of persons insured by age (ancillary)



General treatment tables

State/Territory	Insured persons (%)	Not insured persons (%)
Aust.	52.0%	48.0%
NSW	53.8%	46.2%
Vic.	48.0%	52.0%
Qld	46.4%	53.6%
SA	56.0%	44.0%
WA	64.0%	36.0%
Tas.	49.3%	50.7%
ACT	64.3%	35.7%
NT	38.1%	61.9%

State/Territory	Male	Female
Aust.	4,988,344	5,399,083
NSW	1,723,537	1,815,420
Vic.	1,046,750	1,119,911
Qld	937,434	1,006,051
SA	414,342	449,475
WA	710,793	737,065
Tas.	111,371	122,586
ACT	97,368	105,717
NT	40,574	42,858

State/Territory	Single policies (%)	Family policies (%)
Aust.	48.0%	52.0%
NSW	47.2%	52.8%
Vic.	51.2%	48.8%
Qld	46.1%	53.9%
SA	48.5%	51.5%
WA	46.5%	53.5%
Tas.	49.2%	50.8%
ACT	50.0%	50.0%
NT	45.6%	54.4%

Benefits Paid

Hospital treatment

Benefits per episode/service

	December 2010	Change from September 2010
Hospital Treatment		
Acute	\$2,005.26	0.9%
Medical	\$56.77	4.1%
Prostheses	\$789.04	1.6%
Cardiac	\$6,287.51	3.7%
Hips	\$2,542.18	-0.2%
Knees	\$2,214.99	0.2%
Lens	\$461.88	1.2%
Total benefits and growth rate		
Hospital	\$2,471,591,835	6.4%
General	\$774,634,968	1.4%

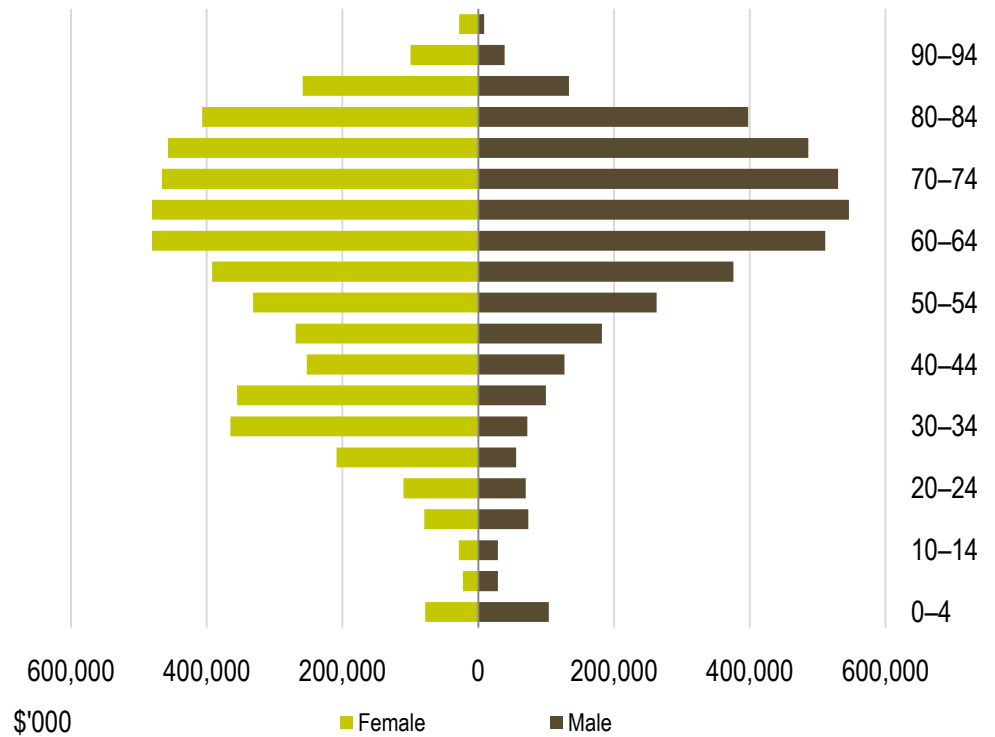
During the December 2010 quarter, insurers paid \$2,472 million in hospital treatment benefits, an increase of 6.4% compared to the September 2010 quarter. Hospital treatment benefits were comprised of:

- ◇ \$1,714 million for hospital services such as accommodation and nursing
- ◇ \$402 million for medical services
- ◇ \$354 million for prostheses items
- ◇ \$2.6 million for nursing home type patients.

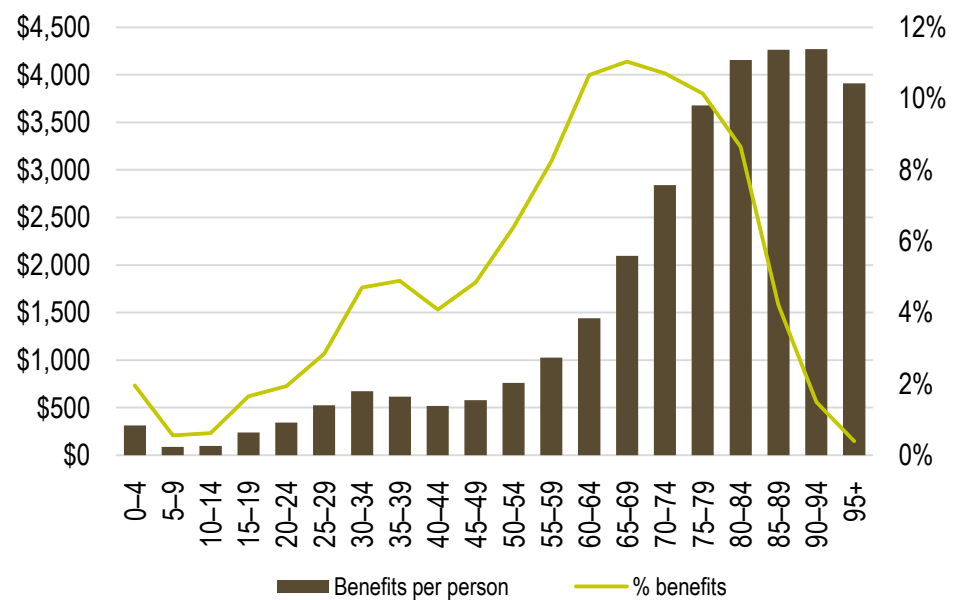
The age group for which most hospital benefits are paid is between 60 and 79 (top chart). Total benefits by age group is affected by the benefits paid per person (displayed in the second chart) and the number of people in each age group. The older age groups have a higher claiming rate. The rise in benefits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

For the 12 month period, hospital treatment benefits per person increased from \$871.67 to \$919.79. The largest amount of benefits per person was spent on hospital accommodation and nursing, followed by medical and prostheses benefits.

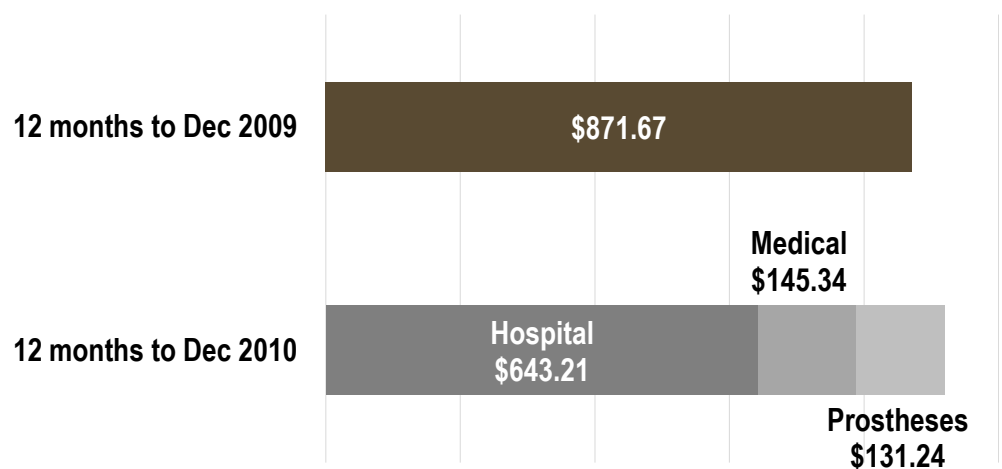
Hospital treatment benefits paid by age 12 months to 31 December 2010



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



Hospital treatment benefits per person



General treatment

Benefits per service

	December 2010	Change from September 2010
Dental	\$55.34	1.6%
Chiropractic	\$23.48	-3.4%
Physiotherapy	\$27.90	-0.8%
Optical	\$60.72	-3.2%

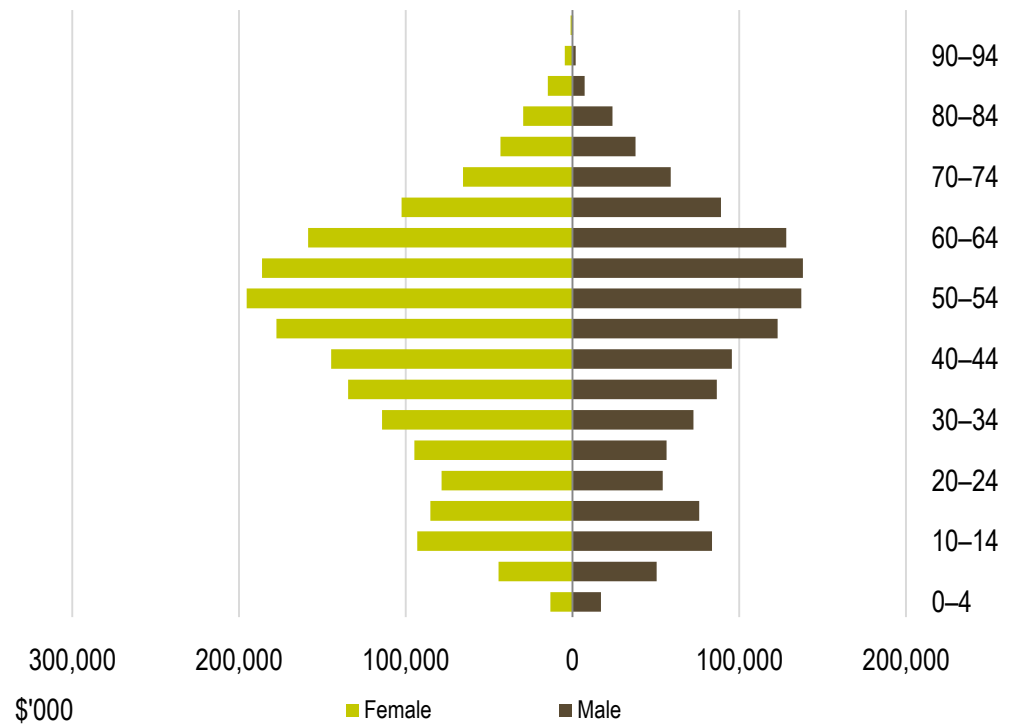
During the December 2010 quarter, insurers paid \$775 million in general treatment (ancillary) benefits. This was an increase of 1.4% compared to the September 2010 quarter. Ancillary benefits for the December quarter included the major categories of:

- ◇ Dental \$398 million
- ◇ Optical \$149 million
- ◇ Physiotherapy \$58 million
- ◇ Chiropractic \$49 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 December 2010 were \$296.95, increasing from \$289.44 for the year to December 2009. The largest component of ancillary benefits is dental, for which \$153.19 was paid per person.

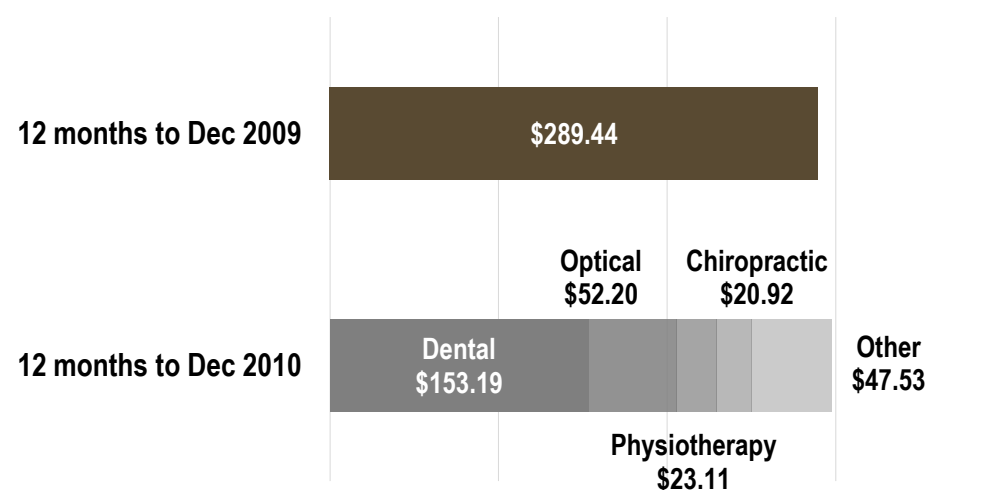
General treatment benefits paid by age 12 months to 31 December 2010 (ancillary)



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



General treatment benefits per person (ancillary)



Medical benefits

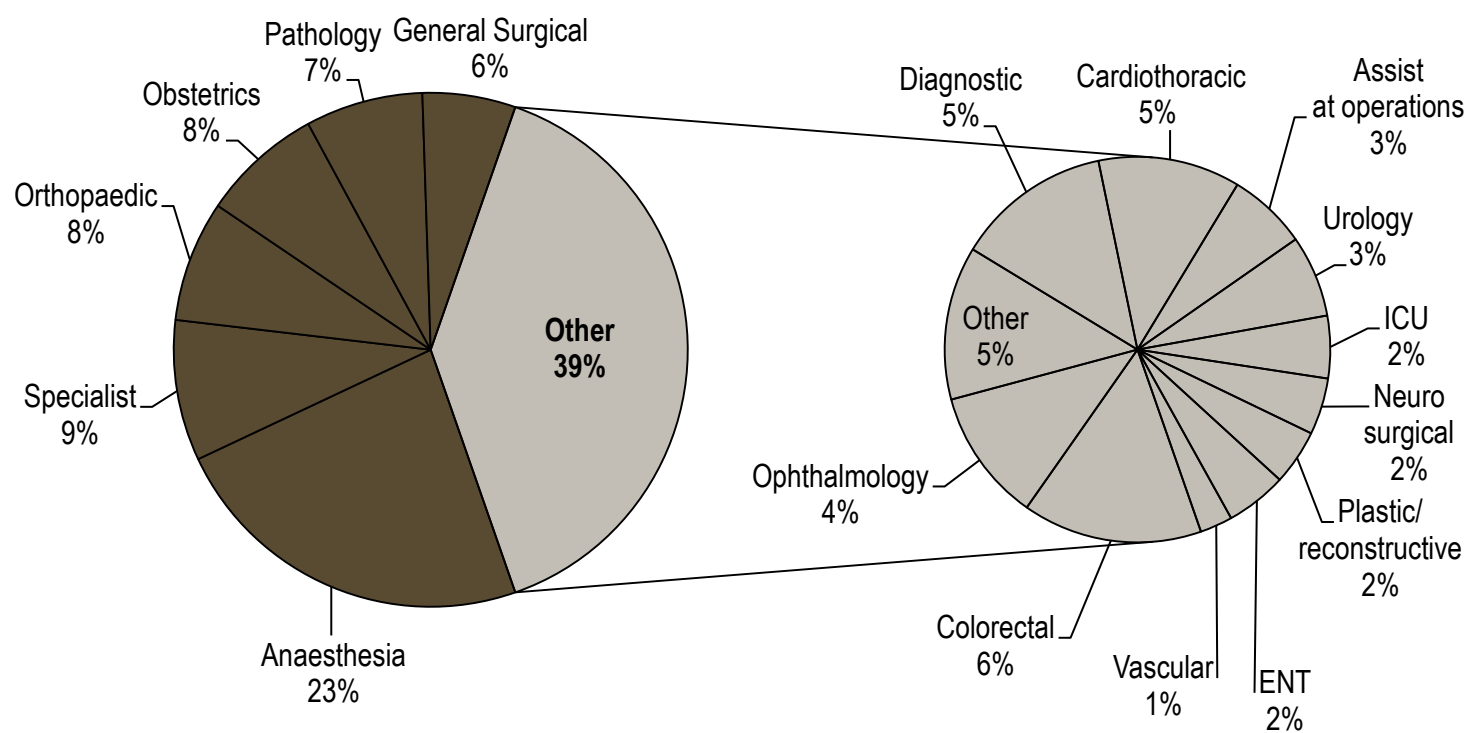
Total benefits for medical services increased 6.4% during the quarter with the amount of benefits paid per service increasing by 4.1%.

The change in medical benefits per service was calculated over a range of medical services and does not mean medical services overall changed in cost. The change in average benefits paid may reflect a change in the type of medical services utilised during the quarter. The medical service for which the greatest amount of benefits was paid was anaesthetics, comprising 23% of all medical benefits and totalling \$94 million.

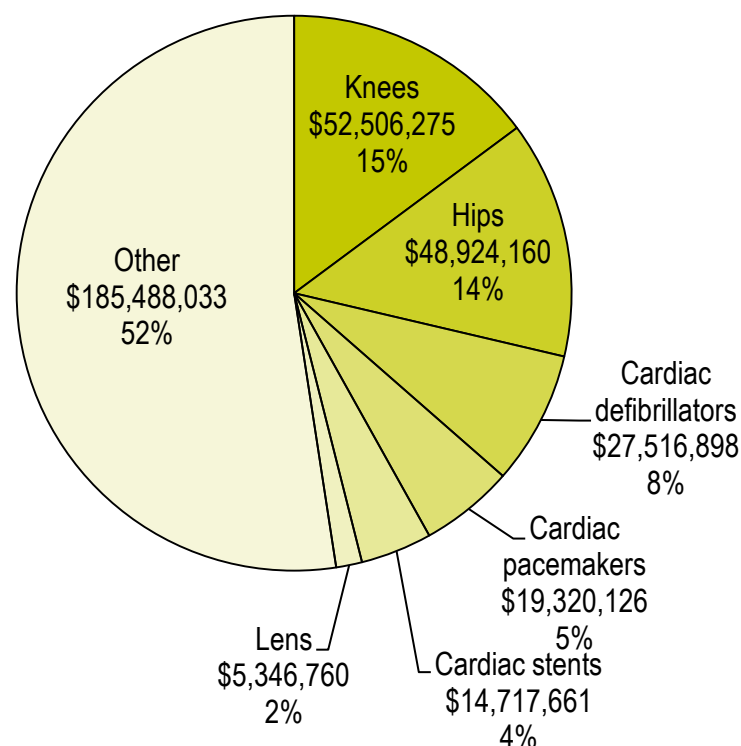
Prostheses benefits

Total benefits paid for prostheses increased by 8.2% compared to the September quarter. Similar to medical services, the change in benefits paid for prostheses was calculated over a range of prosthetics (see chart) and does not mean prostheses overall changed in cost. The change 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 "knees", comprising 15% of all prosthetic benefits and totalling nearly \$53 million. The combined cardiac group comprised 17% of all prosthetics and totalled \$62 million over the quarter.

Medical benefits by Speciality group



Benefits paid for prostheses



Service utilisation

Episodes/Services by type

	December 2010	Change from September
Hospital Episodes	854,537	5.1%
Hospital Days	2,296,460	4.8%
Medical Services	7,075,145	2.3%
Prostheses Items	448,406	6.6%
Cardiac	9,790	10.0%
Hips	19,245	7.1%
Knees	23,705	7.1%
Lens	11,576	-17.5%
General	16,916,614	0.0%
Dental	7,184,930	-1.7%
Chiropractic	2,068,193	-7.7%
Physiotherapy	2,073,661	-8.2%
Optical	2,449,156	25.6%

During the December 2010 quarter, insurers paid benefits for 2.3 million days in hospital, arising from 854,537 hospital episodes of care.

The average length of stay was 2.7 days; a decrease of 0.01 days compared to the September 2010 quarter.

Hospital utilisation is distributed over four categories of hospital—public, private, day only facilities and hospital-substitute. During the December 2010 quarter, hospital episodes were distributed as follows:

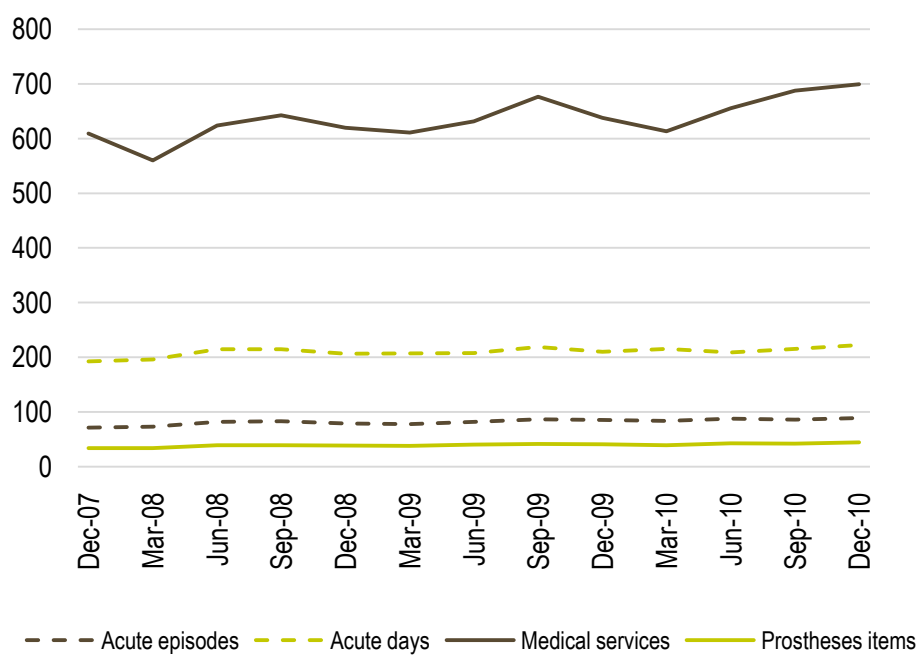
- ◇ public hospitals 124,608 episodes
- ◇ private hospitals 585,750 episodes
- ◇ day hospital facilities 122,972 episodes
- ◇ hospital substitute 21,207 episodes

For the December 2010 quarter, hospital utilisation increased by 5.1% in episodes. Utilisation increased in all categories of hospital over the quarter and the year.

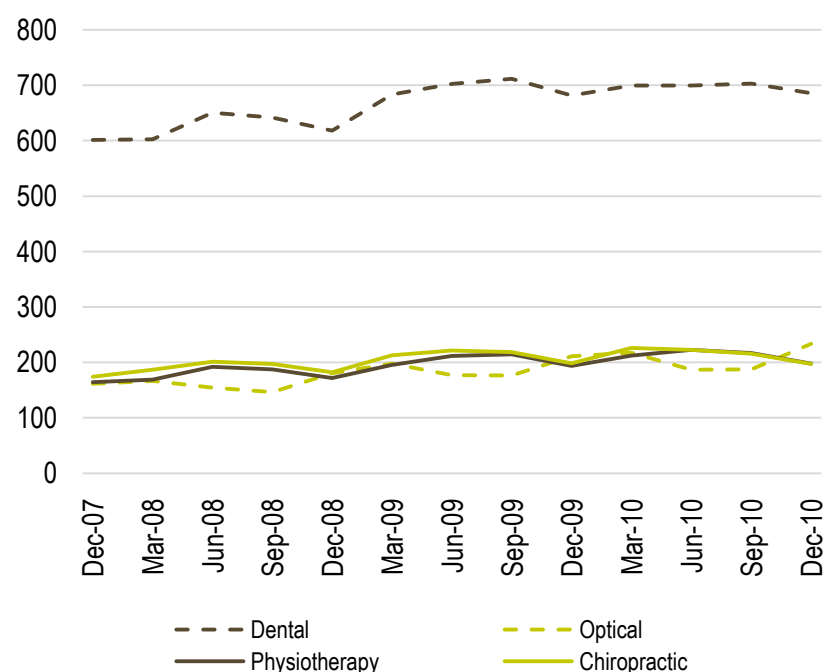
	Quarter change	Year change
◇ public hospitals	↑ 8.5%	↑ 5.1%
◇ private hospitals	↑ 1.6%	↑ 3.4%
◇ day hospital facilities	↑ 6.8%	↑ 6.9%
◇ hospital-substitute	↑ 215.2%	↑ 168.0%

Day-only episodes in the four categories of hospital totaled 539,803, an increase of 5.0% compared to the September 2010 quarter.

Hospital treatment services per 1,000 insured persons



General treatment services (ancillary) per 1,000 insured persons



Out-of-pocket payments

Average out-of-pocket per episode/service

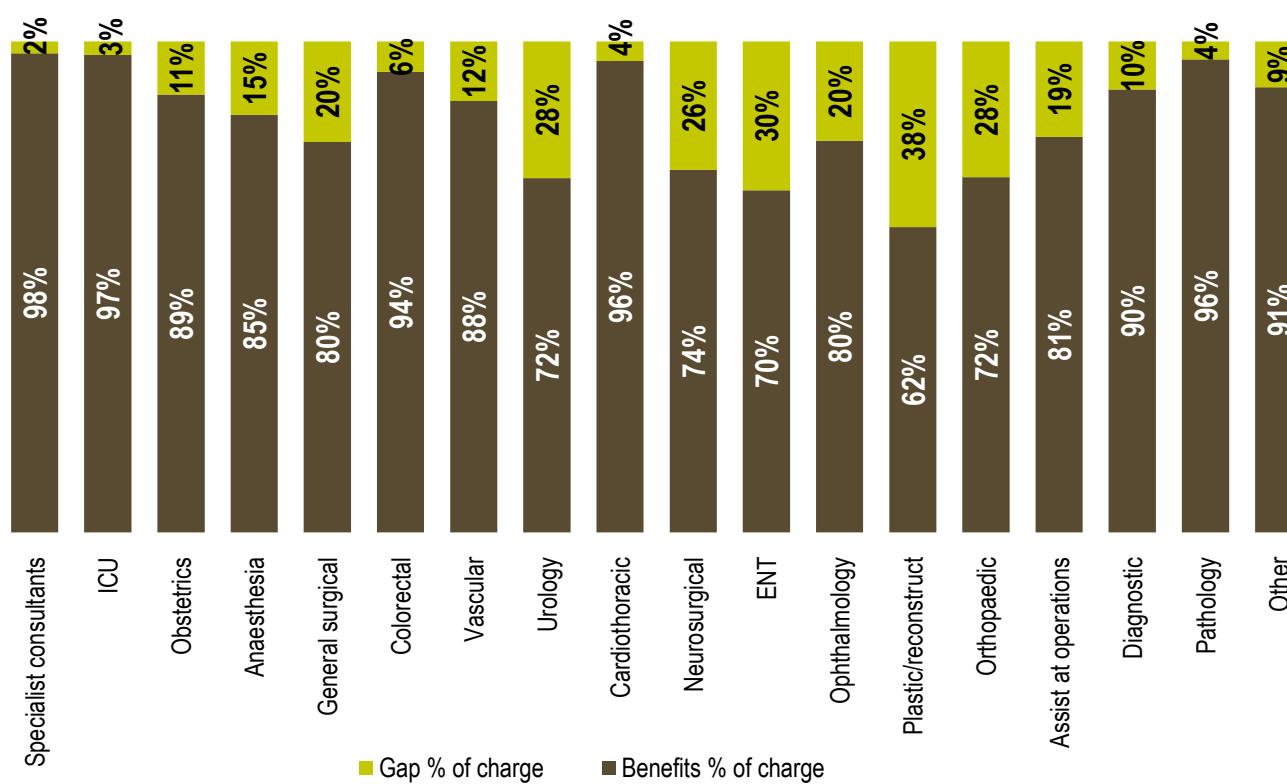
	December 2010	Change from September	Change from Dec 09
Hospital treatment	\$304.12	-0.8%	-0.6%
Hospital-substitute treatment	\$2.05	-57.9%	-90.7%
General treatment	\$49.32	2.2%	-0.7%
Prostheses where gap was paid	\$61.79	34.2%	109.1%
Medical gap where gap was paid	\$182.66	4.2%	24.7%

The average out-of-pocket (gap) payment for a hospital episode was \$304.12 in the December 2010 quarter. This included out-of-pocket payments for medical services, some prostheses in addition to any excess or co payment amounts relating to hospital accommodation.

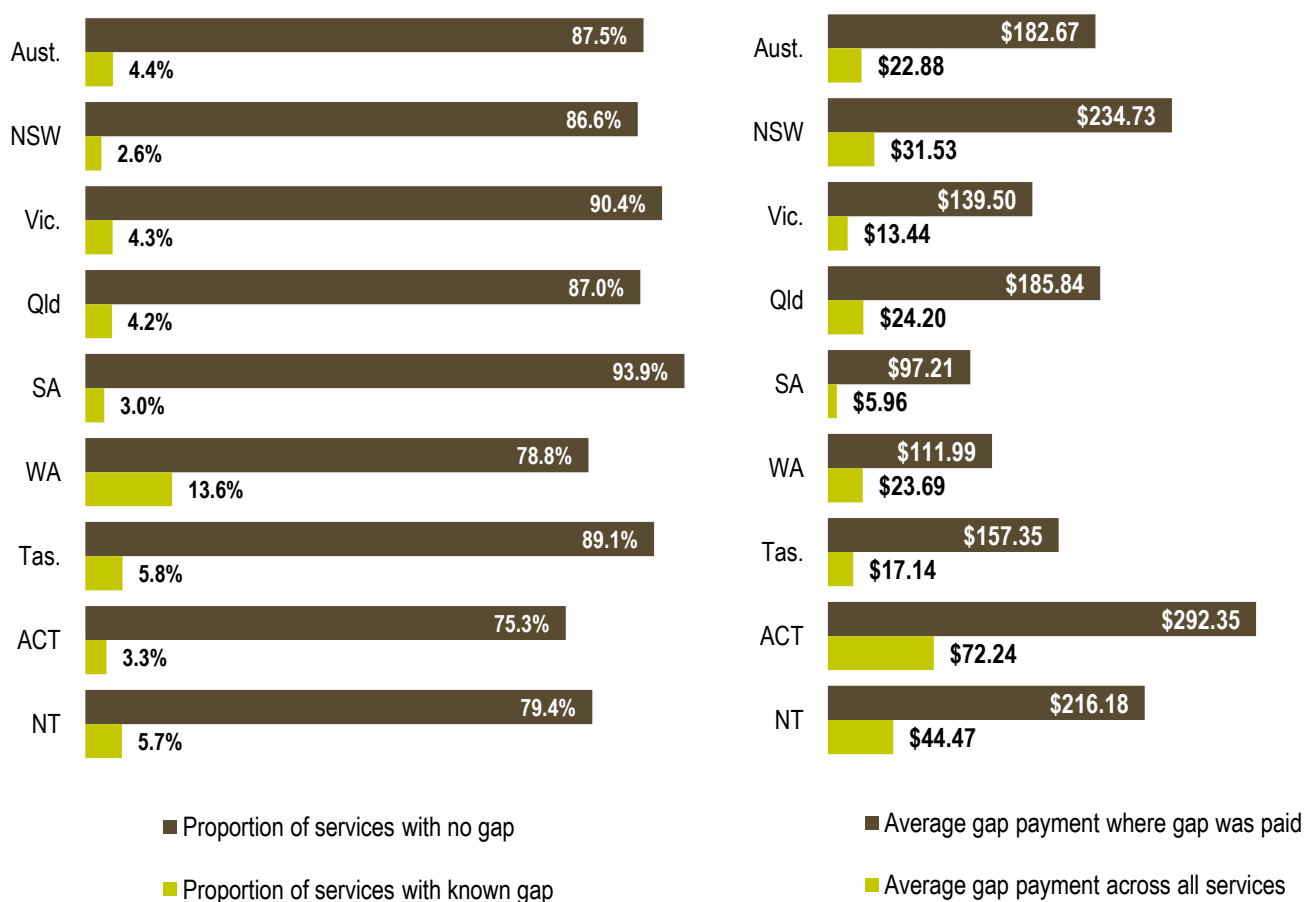
The out-of-pocket payments for hospital episodes decreased by 0.6% compared to the same quarter for the previous year.

Out-of-pocket payments for medical services were \$182.66 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 \$378, followed by orthopaedic with an average gap per service of \$355. Gap incurred for the various medical services are displayed in the first chart. Medical gap also varies by state and territory and these differences are shown in the bottom chart.

Medical benefits and out-of-pocket by speciality group



Proportion of services and average out-of-pocket payments



Financial information

Financial Performance

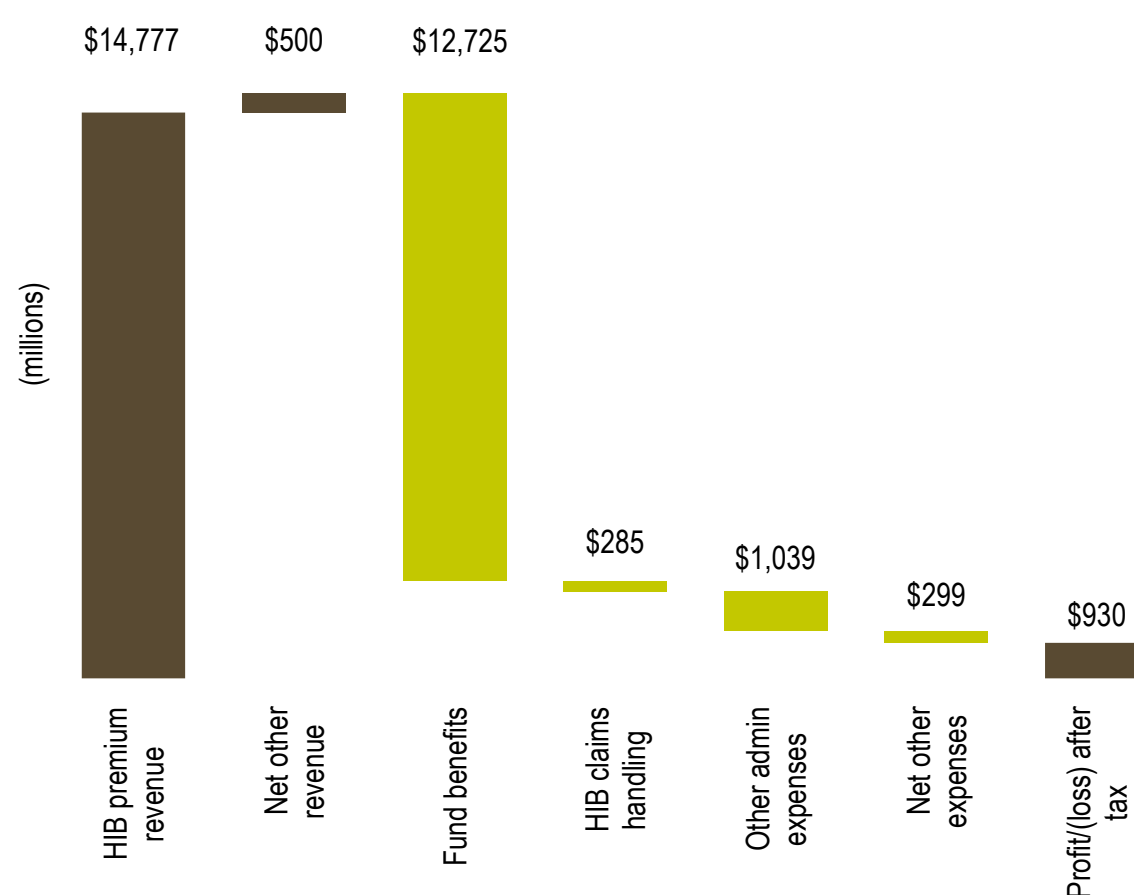
All Figures \$'000	12 months to December 2010	12 months to December 2009
Revenue		
HIB premium revenue	14,777,153	13,633,203
Net HRB and other revenue	499,763	544,055
Total revenue	15,276,915	14,177,259
Benefits		
Fund benefits	12,566,286	11,691,041
State ambulance levies	158,647	151,071
Total fund benefits	12,724,933	11,842,112
Expenses		
HIB expenses	1,038,646	995,103
HIB claims handling	284,717	263,094
Other expenses	28,877	7,405
Total expenses	1,352,240	1,265,602
Profit		
Profit/(loss) before tax	1,199,743	1,069,544
Taxation expense	269,912	156,877
Profit/(loss) after tax	929,831	912,667
Non HBF related profit/(loss)	21,235	3,532
Profit/(loss) of the insurer	951,065	916,199
Margins		
Gross margin	13.89%	13.14%
HIB expenses	8.96%	9.23%
Net margin	4.93%	3.91%

The December quarter is usually a good quarter for the industry in terms of underwriting performance and the most recent quarter is no exception. In fact, both the gross and net margins recorded by the industry for the December 2010 quarter were the highest in the past three years.

For the 12 months to 31 December 2010, the industry's gross margin was 13.9%, an improvement from 13.1% from the previous year. Health Insurance Business premium revenue had increased \$1.14 billion while benefits had increased by only \$883 million.

With the cost associated with the last few mergers and acquisition diminishing, the management expense ratio has also decreased over the past 12 months compared to the year to 31 December 2009. Overall, the higher gross margin and lower relative expenses resulted in a one percentage increase in the net margin for the year to December 2010—4.9% as compared to 3.9% for the 12 months to December 2009.

Health Benefits Fund Profit After Tax Breakdown for 12 months to December 2010



Prudential Position

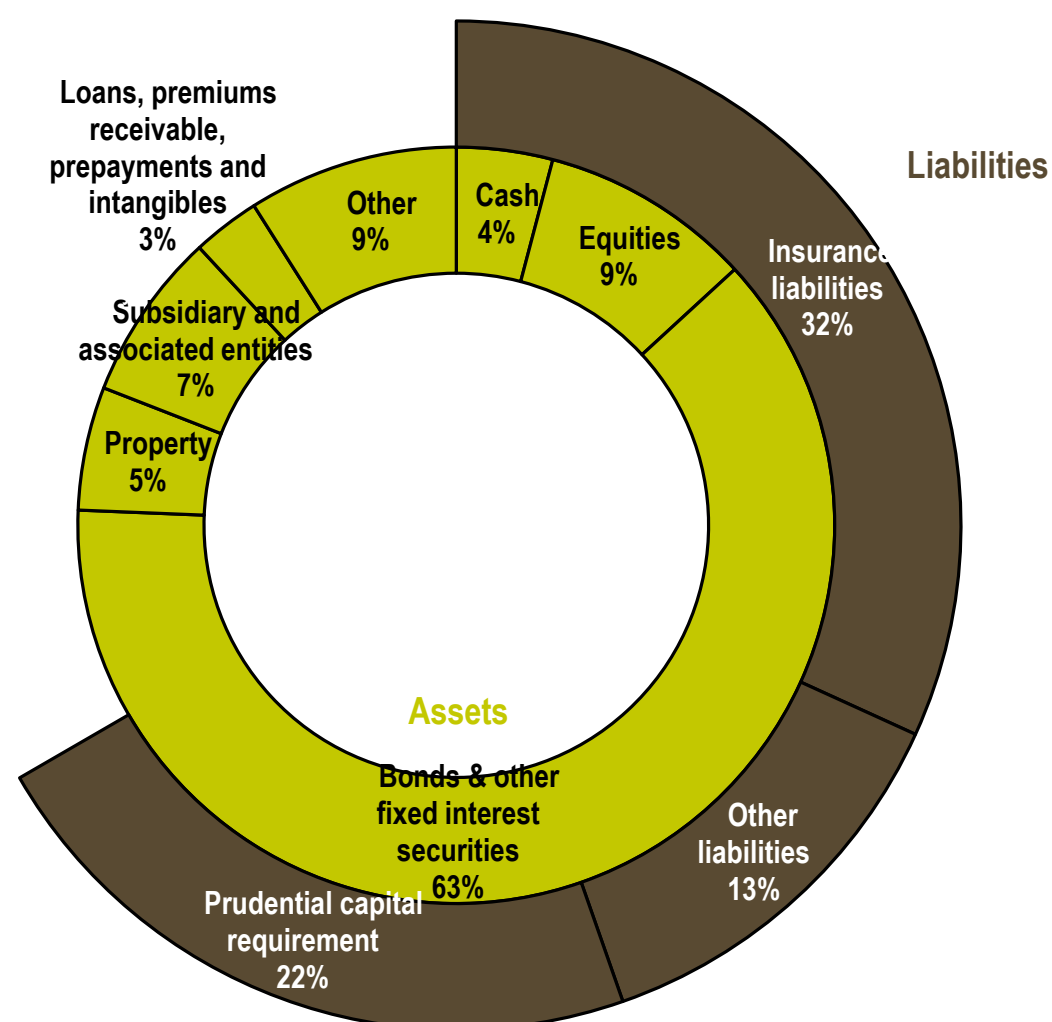
All Figures \$'000	December 2010	December 2009
Health benefits fund financial assets		
Cash	383,548	340,808
Investments		
Equities	846,002	790,583
Bonds & other fixed interest securities	5,831,704	5,195,550
Property	492,420	405,697
Subsidiary and associated entities	672,229	671,621
Loans	90,684	88,691
Premiums receivable	73,913	76,189
Intangibles DAC and FITBS	85,097	64,579
Prepayments	21,042	23,153
Other*	838,375	778,444
Total assets	9,335,015	8,435,313
Health Insurance Liabilities		
Unearned premium liabilities	1,495,100	1,389,343
Unpresented & outstanding claims	1,473,269	1,399,227
Other fund liabilities	126,373	123,028
Interest bearing liabilities	28,138	27,428
Payables, provisions & other liabilities	1,044,603	471,239
Total liabilities	4,167,484	3,410,266
Health benefits fund capital	5,192,531	5,050,048
Solvency Requirement	5,904,237	5,045,270
Capital Adequacy Requirement	6,222,269	5,310,709

* includes health insurance equipment and other assets

Profit before tax for the 2010 calendar year was \$1.2b. However with over 70% of the industry now operating on a for-profit basis, not all of this \$1.2b has been transferred to capital due to the impact of tax and dividend.

As at 31 December 2010, the industry as a whole had \$3.46 billion in excess of its solvency requirement (December 2009: \$3.42 billion). All private health insurers remain compliant with their capital requirements.

Health Benefits Fund Assets vs Liabilities as at 31 December 2010



Notes on statistics

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.

ACT data is collected and reported separately to NSW for the first time in the quarterly data collection for December 2009.

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

DAC	Deferred Acquisition Costs
Episode	The period of admitted patient care between an admission and separation (eg. discharge) characterised by only one care type.
Family policy	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.
FITBS	Future Income Tax Benefits
General treatment	Treatment that is intended to manage or prevent a disease, injury or condition and is not hospital treatment.*
General treatment services	Ancillary services such as dental and optical.
Gross margin	The difference between total premium revenue and total cost of benefits (inclusive of state levies) expressed as a percentage of premium revenue.
HIB	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.*
Hospital	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.*
Hospital-substitute	General treatment that substitutes for an episode of hospital treatment.*
HRB	Health Related Business* includes one or more of: <ul style="list-style-type: none"> • Providing goods and/or services to manage or prevent disease, injuries or conditions (may include dental or optical centres) • Undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare • 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.
Medical service	Medical specialist services such as the anaesthetist or obstetrician. A hospital episode may involve several medical services.
Net margin	Gross margin less management expenses expressed as a percentage of premium revenue.
Out-of-pocket	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 copayments for hospital or hospital-substitute episodes, and copayments for ancillary services.
Persons	Refer to the number of persons covered by private health insurance policies.
Policies	Refer to the number of private health insurance policies referable to private health insurance funds. Each policy may cover one or more persons.*
Single policy	A policy under which only one person is insured.
State ambulance levy	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

Quarterly publications

PHIAC produces a number of quarterly publications that are available from

www.phiac.gov.au/for-industry/industry-statistics/

These include:

[Membership Statistics](#)

A publication which details by State the number of insured persons 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](#)

A publication 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](#)

A publication detailing by State, the membership and benefits paid by private health insurers for the period. These State reports are available both in PDF format and Excel.

[PHIAC 3 Report](#)

A report providing data on prosthetic benefits paid by private health insurers by major prosthetic category

[PHIAC 4 Report](#)

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

[Statistical Trends - Quarterly Statistical trends in membership and benefits paid](#)

These are two separate publications 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/operations-of-the-private-health-insurers-annual-report/

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* (Act), 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 section 264–5 of the Act to achieve an appropriate balance between three objectives:

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

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.