Public Policy and Private Health Insurance: Distributional Impact on Public and Private Hospital Usage in New South Wales*

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The effectiveness of the new private health insurance (PHI) reforms – in particular the 30% rebate and Lifetime Health Cover - has been studied in terms, for example, of their ability to relieve pressures on public hospitals. Combining the use of two new models - Private Health Insurance and NSW hospitals - we estimate that, with the PHI reforms, a 15% lesser number of individuals would use public hospitals in 2010 than without these reforms (around 18% less amongst the 40% most affluent Australians and 9% less amongst the 40% least affluent).

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CONTENTS

I Introduction

Although in recent decades the health of populations in developed countries like Australia improved dramatically, the related expenditures tended to outpace economic growth. This forced governments to try to contain costs, most typically in the hospital sector. Nations have also searched for new funds or to pass a larger share of the costs onto individuals (OECD 2003a and b). An example of this latter approach is the aim of the Australian Federal government's policies to increase the take-up of private health insurance – that is the 30% private health insurance (PHI) rebate, Lifetime Health Cover and the Medicare Levy Surcharge (Appendix A).[1] A recent Senate inquiry noted that two of the objectives of the rebate were to make PHI more affordable, and to reduce the load on public hospitals (Senate 2003). It concluded that there were not sufficient analyses on whether the new PHI policies had achieved this latter aim and recommended that an independent inquiry be established to assess the equity and effectiveness of the 30% private health insurance rebate and the integral Lifetime Health Cover policy.

In this paper we study the current and projected impact of the new PHI policies on public hospital utilisation in NSW. To do this we link new Private Health Insurance and NSW hospitals models through survey data on the public/private hospital choices of those who had been hospitalised. Because Australians in higher income groups are the ones most likely to have private hospital insurance, we also studied the impact of the new PHI policies on different socioeconomic (SES) groups. Most earlier studies of PHI policies relied on Private Health Insurance Administrative Council (PHIAC) data. We however chose Australian Bureau of Statistics (ABS) survey data because, unlike the PHIAC data, it had information on socioeconomic status (which is needed for distributional analyses). We found that our PHI coverage estimates were consistently higher than those obtained with PHIAC data. The

[1] Although the levy is included in the models used in this study, its contributions to the findings are minimal. For this reason the levy is not mentioned in the rest of the paper.

difference, at an aggregate level, has averaged about 5 percentage points. The ABS (1999a) suggests that a possible reason for the higher coverage estimates arises from different collection methods—the ABS using a population survey and PHIAC membership data. Another reason may be that the ABS surveys only include persons residing in private dwellings. Details on other data used and on the enhanced PHI model are in Walker et al (2003 and 2004).

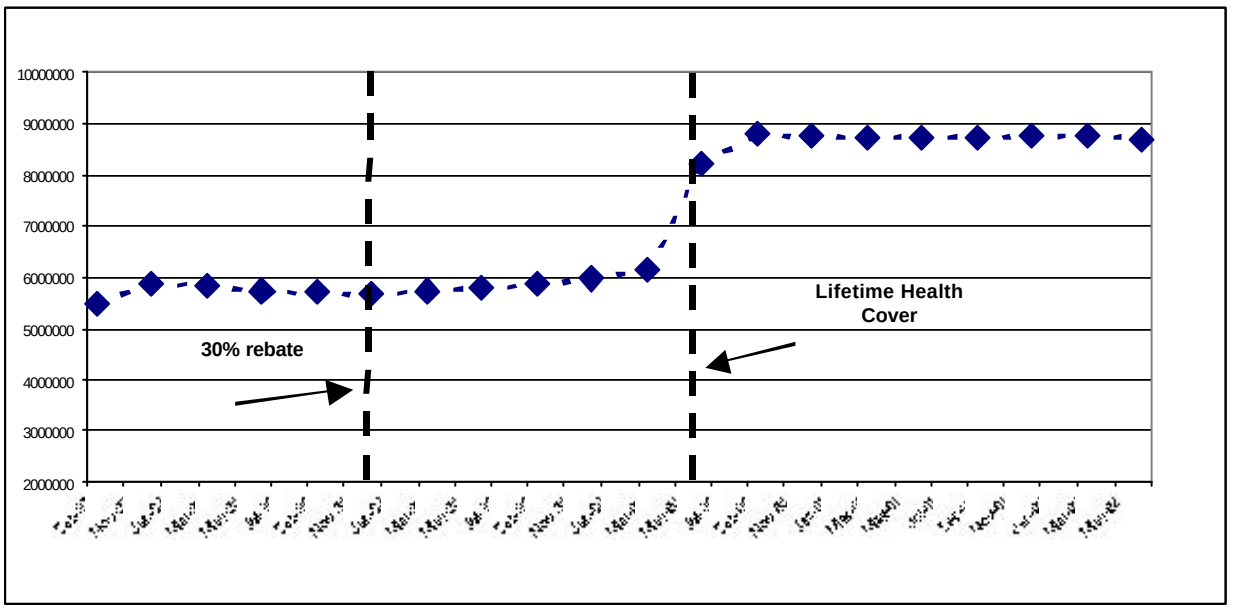
The linked PHI and NSW hospitals models provide the opportunity to more precisely determine who will be covered by PHI and the likelihood that people will choose either a public or private hospital, should admission be required.

II The Private Health Insurance Scenarios

(i) Past and current PHI membership rates

Figure 1 shows that the Lifetime Health Cover had a considerably greater impact on PHI membership than the 30% rebate. [2]

Figure 1: Private Hospital Insurance Membership, Australia, 1997 to 2002



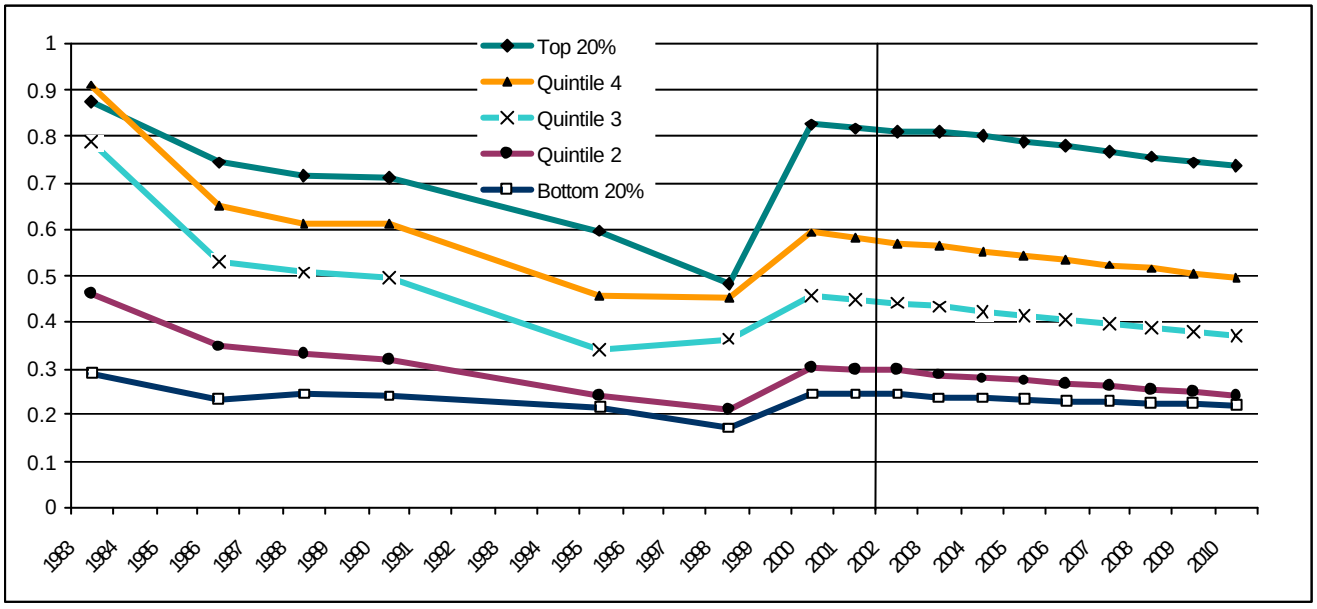
Source: PHIAC (2003).

[2] This was also noted by others – eg Butler (2002), Cormack (2002) and Pearse et al (2003) .

(ii) PHI membership rates by socioeconomic status

To study PHI membership rates by SES, we used a Private Health Insurance model, which is an extended and up-dated version of that developed by Percival et al (1997), Schofield (1997), Schofield et al (1997) and Percival (1999). It is based on ABS survey data (Section I). Briefly, the model uses logistic regression to estimate the probability of a person having private health insurance. Predictive variables included are: Age (0-14 years, 15-24 years, 25-34 years, 35-54 years, 55-74 years, 75 + years); Sex, Gross income unit income quintiles;[3] Year (as number of years from 1983); and Premium costs (as a proportion of average household disposable income). Further details are in Walker et al (2003, 2004). Figure 2 shows that the most affluent group – ie the 20% of the population with highest incomes - were the ones most responsive to the new PHI policies.

Figure 2: Proportion of Australians with PHI by Socioeconomic Status, 1993 to 2010*



* the 30% rebate from 1 Jan1999 and Lifetime Health Cover policies from 1 July 2000 – Appendix A.
Sources: from 1983 to 2002: ABS Health Insurance Surveys (for years 1983, 1986, 1988, 1990, 1992, 1998) and its National Health Surveys (1995, 2001); from 2003: the new PHI model.

[3] Quintiles are obtained by first ranking the population by income, and then dividing that population into five equal parts.

(iii) The PHI Scenarios studied

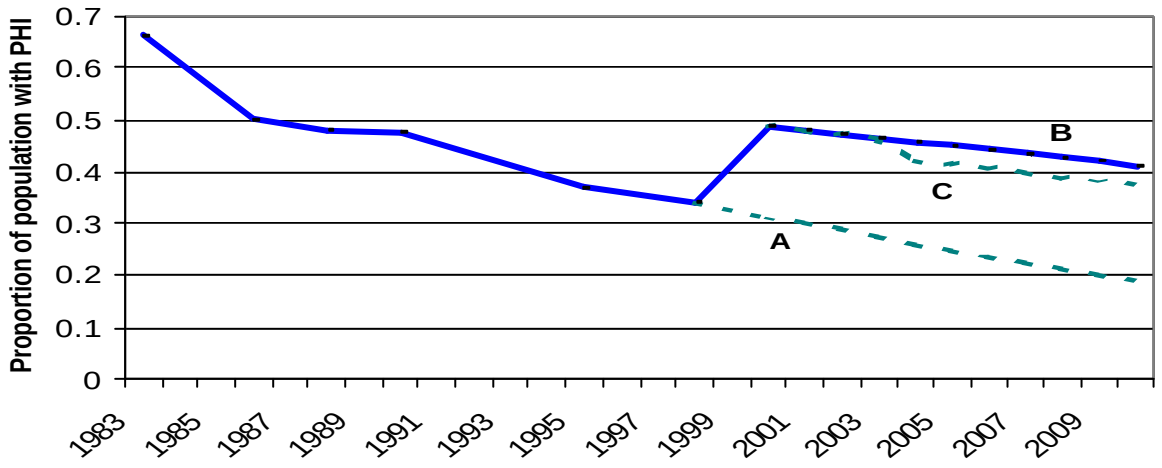
Three scenarios were modelled to study the impact on insurance coverage of the major private health insurance policy changes that have been implemented since the late 1990s (Figure 3):

- **Scenario A**: *a 'base' scenario*: which models the decline in insurance coverage that would have occurred, had there been no 30% rebate on premiums and no Lifetime Health Cover. Under this scenario the proportion of the population covered by PHI drops to just under 20% in 2010.

- **Scenario B**: a *'current world' scenario:* which models the decline in insurance coverage from 1983 to 1998 and the introduction of the 30% rebate on premiums and Lifetime Health Cover. Under this scenario the proportion of the population covered by PHI peaks in 2000 then gradually falls to just over 40% in 2010.

- **Scenario C**: *a removal of the rebate scenario*: which models the same circumstances as for scenario B, but with the 30% rebate removed from 2004. Under this scenario the proportion of the population covered by PHI peaks in 2000, then gradually falls to around 35% in 2010, with a drop associated with the removal of the rebate in 2004.

Figure 3 Proportion of Australians with PHI - historical series and Scenarios



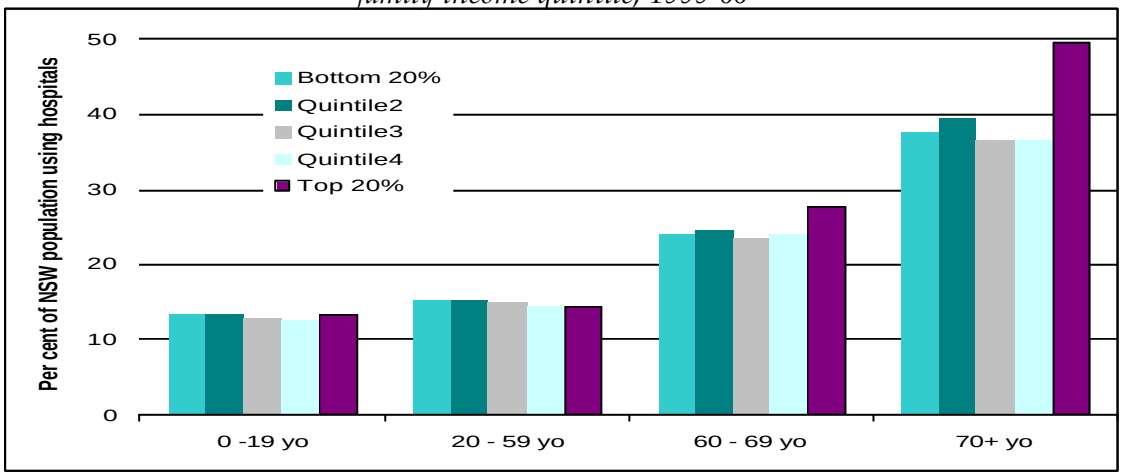
Sources: ABS time series data and the new PHI model

Premium costs in all scenarios were assumed to rise at a real annual rate of 2%. The impact of these Scenarios on hospital usage is discussed in Section V.

III NSW Hospital Usage Projections

The new NSW hospitals model is described elsewhere – Thurecht et al (2003b and c).[4] Briefly, the model is based on time series NSW hospitals in-patients data, in which services used by individual patients can be tracked within each year of the time-series. Also, to each patient in the datasets, we imputed socioeconomic status in the form of 'equivalent family income' (EFI).[5] A novel method of imputation was developed, making use of a special Census data extract, which allowed the age, sex and place of usual residence of each patient to be taken into consideration when imputing SES, and in which SES itself was also a function of family size. Figure 4 shows that the older people were in 1999-00, the more likely they were to be hospitalised. It also shows that, although the SES effect is slight, people with low SES tended, within each age group, to use hospitals more than higher SES people.

Figure 4 Per cent of NSW population using hospitals by age and imputed equivalent family income quintile, 1999-00



Sources: 1999-00 NSW hospitals data; 2000 population data; 1996 Census extract.

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4 While in these earlier publication the analyses were presented as a function of age, in this paper they are studied by socio-economic status.

5 The 'equivalent family income measure of SES has the advantage over geographic area based SES indicators of being a measure of the economic resources available to a family – see Thurecht et al (2003b for definitions).

Onto this enhanced hospitals administrative data series, we built a facility to project ten years ahead - Thurecht et al (2003b) – with projection being based on the assumption that 'past trends' observed in the 1996-97 to 1999-00 time series administrative data will continue in future. This means that in the original projections we do not account for the impact of Lifetime Health Cover, which commenced on 1 July 2000. Another assumption was that the age-sex pattern of EFI remained unchanged between 1999-00 and 2009-10. We chose growth in hospital usage as an indicator of the 'stress' placed on public hospitals. There are a number of other indicators that could have been used, with waiting lists being a popular alternative (see Powers et al 2003 for elective surgery waiting lists). However, waiting lists are more an indicator of 'stress' on patients than on hospitals (Cormack 2002). For that reason we chose patient numbers as the indicator of potential 'stress' on hospital resources. The original projections of patient numbers (Thurecht et al 2003b and 2004) are summarised in Table 1.

Table 1: Actual and Projected Number of Individuals Using Hospitals Within the Year by SES and Hospital Type, 1999-00 and 2009-10

SES		Bottom 20%	Quint2	Quint3	Quint4	Top 20%	All
1999-00							
Public hospitals		173,900	172,500	144,800	128,800	115,600	735,600
Private hospitals		81,900	89,400	80,600	82,400	97,300	431,700
2009-10							
Public hospitals		176,900	177,300	145,600	127,700	114361	741,900
Private hospitals		90,000	99,300	86945	86,200	100,500	462,900
Difference							
Public hospitals	%	1.7	2.8	0.5	-0.9	-1.1	0.9
Private hospitals	%	9.9	11.1	7.9	4.6	3.3	7.2

Sources: enhanced NSW hospitals dataset for 1999_00 and projections using the new hospitals model.

The projected number of patients in Table 1 suggests that the private hospital sector will grow considerably more rapidly over the ten-year study period than the public one (7.2% and 0.9%

respectively). This is based on continuation of the trends observed over the 1996-97 to 1999-00 period, the ageing of the population and the greater propensity of older age groups to utilise private hospitals. Walker et al (2003) discuss some of the reasons for this. Briefly, during the past few years there was an increased preparedness on the part of uninsured patients to pay for themselves accompanied by an expansion of low cost day procedure centres generally offering diagnostic procedures such as endoscopy and colonoscopy. In addition new arrangements for veterans made it easier for these patients to access private hospitals. On the public hospital side growth in hospital admissions has been slower partly because some hospital episodes classified as 'in-patient' in earlier years have been reclassified as 'out-patient'. For example many of the diagnostic procedures that account for a large proportion of growth in private hospitals are classified as outpatient services in public hospitals.

Table 1 also shows that the growth in the number of low SES (quintiles 1 and 2) over the study period was considerably stronger than for the rest of the population. The main reason for this was population ageing, combined with the fact that older people tended to fall into the lower SES quintiles (mainly due to no longer being employed).

In this paper we make use of the *total* utilisation projections for in NSW hospitals reported in Thurecht et al (2003b and 2004), and determine the public/private hospital split in that *total* using the linked PHI and NSW hospital models.

IV Linking the PHI and Hospitals Models

To estimate the proportion of patients with and without PHI who chose either a public or a private hospital, we obtained a data extract from TQA Research's syndicated survey of *Health Care & Insurance, Australia, 2001.* This survey involved 5,194 comprehensive telephone interviews with a random sample of insurable unit heads from all areas of Australia. The sample is weighted to account for, among other things, known health insurance status.

For this paper we chose the 'behavioural' questions on PHI in the survey – which ask those interviewees admitted to hospital in the previous 12 months as to whether they used a public or a private hospital. This type of question is preferable to the 'intentional' ones, which ask all interviewees as to the type of hospital they would attend if admitted. Walker et al (2004) presents the findings using both types of questions, gives reasons as to why the 'behavioural' option was chosen and explains how survey respondents' socioeconomic status was estimated in terms of their family incomes.

Table 2 tabulates these 'behavioural' patterns. It shows, for example, that in 2001 14% of persons without insurance who reported being hospitalised in the previous 12 months used a private hospital. It also shows that amongst patients with PHI a very high proportion used a private hospital (69%), and that among those without PHI an even higher proportion used a public hospitals (86%).

Table 2: Type of hospital usage, by family income quintile and hospital insurance status, Australia 2001

	Type of Hospital Used			
	Has hospital insurance		**Doesn't have hospital insurance**	
Income quintile*	**Public Hospital**	**Private Hospital**	**Public Hospital**	**Private Hospital**
	%	%	%	%
Bottom 20%	40	60	85.8	14.2
Quintile2	32.6	67.4	91.1	8.9
Quintile3	34.3	65.7	89.5	10.5
Quintile4	23.1	76.9	68.7	31.3
Top 20%	29.5	70.5	80	20
All	31.2	68.8	85.7	14.3

***** Family (income unit) quintiles
Source: TQA (2001) survey data and ABS (1999) for estimating the size of the income bands associated with each of the income quintiles.

We linked the PHI and NSW hospitals models through the behavioural data in Table 2 as follows. First we used the PHI model to determine the proportion of Australians with hospital insurance cover. Next we assumed that the same proportions with PHI applied in the NSW population. Finally, the data

in Table 2 was used to split the total number of patients (projected by the Hospitals model) into those using public hospitals and those using private hospitals.[6] For each SES quintile, the total number of patients (from the NSW hospitals model) was first split between those with PHI and those without (based on PHI model estimates). Then, given patients' PHI status, the TQA proportions were applied to assign the patients between public and private hospitals. A key assumption in these computations was that PHI policies only affected the public/private hospital split, and thus had no impact on total NSW hospital utilisation.

V Results

As seen in Section III, the Scenarios studied in this paper occurred in a period when there was a strong underlying pattern of higher growth in private hospital usage than in public hospital usage. Because this pattern was evident prior to the introduction of PHI policies, our projections under the PHI Scenarios should be seen as being superimposed onto this underlying 'non-PHI policy dependent' trend. Limitations of the Scenario analyses are discussed in section VI, together with how some of these might be overcome in future.

(i) Projecting NSW hospital usage – Scenario A (no PHI policies)

Under this Scenario the assumption is that the post 1998 PHI policies – including the 30% rebate and the Lifetime Health Cover - had not been introduced. We modelled this by setting the simulation phase in the PHI model to commence in 1999, with actual data being retained to 1998. The impact by 2010 was a decline in PHI coverage to just under 20% of the Australian population (Section II). The consequent impact on NSW public hospital usage is estimated to be an increase of around 13 per cent by 2009-10, relative to patient numbers in 1999-00 (Table 3). Most of that increase arose from patients with higher SES - who used

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[6] Before using the patient choice information in Table 2 for modelling purposes, we aligned the TQA data so that the numbers of patients in public and private hospitals predicted for 1999-00 through use of the TQA data matched the actual number of patients that year by hospital type (as recorded in the NSW hospitals data).

private hospitals in 1999-00 - shifting to use of public hospitals in 2009-10. The reason for the shift is that, under Scenario A, many will no longer have private hospital cover.

Table 3: Scenario A –No 30% PHI rebate and no Lifetime Health Cover

3SES		Bottom 20%	Quint2	Quint3	Quint4	Top 20%	All
*Number of patients**							
1999-00							
Public hospitals		174,513	172,313	148,269	132,430	117,915	745,439
Private hospitals		83,293	85,390	75,293	83,212	94,990	422,179
2009-10							
Public hospitals		188,799	192,505	167,042	152,788	139,727	840,862
Private hospitals		75,942	69,079	58,196	72,384	75,101	350,702
Difference – 1999-00 to 2009-10							
Public hospitals	%	8.2	11.7	12.7	15.4	18.5	12.8
Private hospitals	%	-8.8	-19.1	-22.7	-13.0	-20.9	-16.9

* That is individuals using NSW hospitals at least once in the year. Note that the results are less robust for private hospitals than for public ones (due to the small sample size of the TQA survey and the lesser numbers using private hospitals).
Sources: enhanced NSW hospitals dataset for 1999_00; projections using NATSEM's hospitals model; and extract purchased from TQA survey (2001).

Other important consequences arise from the older population structure in 2009-10. This was reported in Walker et al (2003). Briefly, for those aged 55 and over, increases of over 30% in patient numbers were estimated for public hospitals. Although there would be some off-setting factors, such as a decline in the numbers of patients aged less than 35 years (due to the shrinking of the 'working age' population), public hospital expenditures under Scenario A are expected to be considerably higher than under the other scenarios.[7]

[7] This is because studies have shown that health service costs are much higher 1 to 2 years prior to deaths than the average (see discussion in Walker et al, 2003).

(ii) Projecting NSW Hospital Usage – Scenario B (Current policies, ie Lifetime Health Cover, levy and 30% rebate)

Scenario B assumes that the current PHI policies remain operational throughout the study period. Under this Scenario the PHI model's simulations commence in 2003 (that is actual data is retained to 2002). The PHI model predicted that in 2009-10 hospital cover would decline to just over 40% (Section II). The consequence of Scenario B in 2009-10 for NSW public hospitals was estimated to be an increase of 10.1% in patient numbers relative to 1999-00 (Table 4) - and a decline of 15.3% relative to the numbers predicted under Scenario A.

Table 4: Scenario B – Continuation of the current PHI policies (Lifetime cover, levy and 30% rebate)

SES		Bottom 20%	Quint2	Quint3	Quint4	Top 20%	All
*Number of patients**							
1999-00							
Public hospitals		167,329	157,032	130,171	110,388	82,264	647,184
Private hospitals		95,131	116,137	100,227	97,143	130,641	539,279
2009-10							
Public hospitals		177,851	174,460	144,583	123,300	92,383	712,578
Private hospitals		93,980	105,390	89,140	91,020	122,445	501,976
Difference – 1999-00 to 2009-10							
Public hospitals	%	6.3	11.1	11.1	11.7	12.3	10.1
Private hospitals	%	-1.2	-9.3	-11.1	-6.3	-6.3	-6.9
Difference in 2009-10 – Scenario A to Scenario B							
Public hospitals	%	-5.8	-9.4	-13.4	-19.3	-33.9	-15.3
Private hospitals	%	23.8	52.6	53.2	25.7	63.0	43.1

* That is individuals using NSW hospitals at least once in the year. Note that the results are least robust for private hospitals, due to the small sample size of the TQA survey and the lesser numbers using private hospitals than public ones.

Sources: enhanced NSW hospitals dataset for 1999-00; projections using the new hospitals model; and extract purchased from TQA survey (2001).

The declines in public hospital use (and the increases in private hospital usage) were greatest for the most affluent 20% of the Australian population – that is for SES quintile 5.

(iii) Projecting NSW hospital usage – Scenario C (Current PHI policies, but of 30% rebate removed from 2004 onwards)

Scenario C assumes that the Lifetime Health Cover is retained, but the 30% PHI Rebate is removed from 2004 onwards. Under this Scenario the PHI model's simulations commence in 2004 (that is actual data is retained to 2003). The impact by 2010 was a decline in PHI coverage to around 35% of the Australian population (Section II).

Our simulations predict a 10.4% increase in public hospital utilisation by 2009-10 relative to 1999-00 (Table 5) - and a decline of 12.7% relative to the numbers predicted under Scenario A. Under Scenario C, this 12.7% arises almost entirely from Lifetime Health Cover. Comparing it to the Scenario B results (Table 4), we estimate that the impact in 2009-10 of the 30% rebate was a 2.6% decline in public hospital utilisation – with Lifetime Health Cover contributing the bulk of the reductions in pressures on public hospitals (12.7%). Once again, the declines in public hospital use were greatest for high SES people.

Table 5: Scenario C – Current PHI policies, but removal of 30% rebate from 2004

SES		Bottom 20%	Quint2	Quint3	Quint4	Top 20%	All
*Number of patients**							
1999-00							
Public hospitals		162,460	157,514	131,412	112,874	100,727	664,987
Private hospitals		103,154	115,168	98,518	95,571	112,178	524,589
2009-10							
Public hospitals		173,207	174,894	145,765	125,855	114,515	734,236
Private hospitals		101,633	104,515	87,512	89,405	100,314	483,380
Difference – 1999-00 to 2009-10							
Public hospitals	%	6.6	11.0	10.9	11.5	13.7	10.4
Private hospitals	%	-1.5	-9.2	-11.2	-6.5	-10.6	-7.9
Difference in 2009-10 – Scenario A to Scenario C							
Public hospitals	%	-8.3	-9.1	-12.7	-17.6	-18.0	-12.7
Private hospitals	%	33.8	51.3	50.4	23.5	33.6	37.8

* That is individuals using NSW hospitals at least once in the year. Note that the results are less robust for private hospitals than for public ones (due to the small sample size of the TQA survey and the lesser numbers using private hospitals).

Sources: enhanced NSW hospitals dataset for 1999_00; projections using NATSEM's hospitals model; and extract purchased from TQA survey (2001).

VI Conclusions, limitations and possible future improvements

(i) Conclusions

The research presented in this paper extends previous analyses by studying the private health insurance to hospital choice link at a greater level of complexity than what had been reported earlier. In relation to analyses of such links Cormack (2002) noted that the assumptions chosen for the modelling exercises, and the impact of the many factors external to the models, needed careful consideration.[8] Overall, because the complex interactions between the many factors impacting on the PHI-to-hospital-use relationship are not as yet well understood, the findings reported in this paper are unlikely to provide 'definitive' answers.

Our simulations of the Scenarios indicate that the introduction of the 30% PHI rebate and Lifetime Health Cover had the effect of reducing pressure on public hospitals. However, most of that was due to Lifetime Health Cover, and not to the 30% rebate – which was the policy with the stated aim of easing the burden on Medicare, in particular on public hospitals (Section I). Findings on distributional impacts were that, with the new PHI policies in place, higher SES people switched to using private hospitals – in particular people amongst the 20% Australians with highest incomes. This implies that a greater proportion of total hospital expenditures were borne by individuals (and thus less by governments) with the new PHI policies in place than what would have occurred without them.

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[8] In this respect, assumptions of causality have been questioned – eg Powers et al (2003) commenting that the data used by Hanning (2002) did not demonstrating a causative relationship between the increase in PHI coverage and the demand for private hospital services. Assumptions by some that the new PHI policies explained most of the rapid increases that occurred in private hospital admissions are also questionable, given that much of the growth in that sector arose from the take up of new medical technologies by that sector – such as emergence of a very entrepreneurial same day surgery sector, which focussed on providing diagnostic services, mainly scopes (Walker et al 2003).

Studying the likely impact of the 30% rebate in isolation – as well as with the Lifetime Health Cover was important because unlike the rebate, Lifetime Health Cover does not involve government subsidies. While some have studied the rebate in isolation (Deeble 2003) others have assumed that the rebate and the Lifetime Health Cover were an inseparable package (Econtech 2004).

Regarding 'inseparability', it is worth remembering that the 30% rebate was introduced 18 months earlier than Lifetime Health Cover, and that the increase in PHI membership that followed the introduction of the rebate was very small (Figure 1). While its withdrawal will impact on the cost of PHI to individuals, it has not as yet been demonstrated that such a withdrawal would not simply have an impact that was the inverse of what occurred following the introduction of that policy. There appears to be some useful new research on this topic – a study Commissioned by the Victorian government, carried out by the Melbourne and Tasman Institutes - which found that most higher income people with PHI intended to keep their PHI cover even if the 30% rebate was removed. Overall, more research on the equity and effectiveness of the 30% private health insurance rebate and the integral Lifetime Health Cover policy – as recommended by a recent Senate Inquiry (Section 1) - is likely to have considerable benefits.

(ii) Limitations and possible future improvements

Future studies using the linked models could improve and broaden the preliminary analyses reported in this paper. Some examples are listed below.

First, once historical data for further years becomes available in the format required, projections based on past trends could be considerably improved through extension of the relatively short period that we were limited to in this paper – that is the four years to 1999-00. While in these four years public hospital separations grew relatively slowly, such growth was more rapid in the early 1990s. It is also possible that growth becomes more rapid in future.

Once past trends can be assessed over a longer time period, the projections estimated by the NSW hospitals model would improve.

Second, alternative measures of hospital use could be considered, in addition to the one adopted in this report: that is the number of individuals who used hospitals in any one year. Other measures of interest could reflect, for example, the number of separations and the number of separations weighted for casemix (that is differences in the nature of conditions for which patients are admitted and the intensity of services provided). Some of these have already been considered in other papers, but without linkages to the PHI model (Thurecht et al 2003b and 2004).

Third, better alignment across private and public hospitals of classification methods that identify 'inpatients' and 'outpatients' would in future lead to more meaningful predictions by our models. The current classification issues related to the boundary between outpatient and same day inpatient care cloud the interpretation of trends.

Fourth, analyses using the PHI model could be extended to estimate the impact that a range of possible future PHI policy settings may have on rich and poor hospital user groups, including the impact of higher or lower premium rises than the 2% annual rate we used. Also, the question could be asked whether, under the scenarios studied, each of these groups would be able to afford the related out-of-pocket expenditures.

Finally, because the PHI model is based on Australia-wide data, similar analyses could be carried out nation-wide if hospitals data suitable for our modelling efforts became available for other States.

Appendix A: Changes in Private Health Insurance Policy – 1997 to 2000

The following table summarises changes to private health insurance policy over the period 1997 to 2000.

1 July 1997 to 31 Dec. 1998:	Incentives scheme introduced to subsidise private health insurance for low and middle income earners (single persons earning < $35,000; couples/families earning < $70,000 with $3,000 threshold increase for each dependant child after the first.
1 July 1997:	1% Medicare Levy Surcharge introduced to encourage high income earners (single people with taxable income > $50,000; and couples/families with taxable income > $100,000 with $1,500 threshold increase for each child after the first.
1 January 1999:	30% Rebate provided for the purchase of private health insurance under the Private Health Insurance Incentives Act (1998) (PHIIA).
24 May 2000:	Eligibility rules with respect to 1% Medicare Levy Surcharge introduced so that high income earners could not avoid the surcharge if they took out hospital policies with front-end deductibles greater than $500 for singles or $1000 for families. This change in eligibility was not retrospective.
1 July 2000:	Introduction of Lifetime Health Cover, an initiative designed to encourage people to take out private health insurance earlier in life and to maintain their cover. People will pay a 2% loading on top of their premium for every year they are aged over 30 when they first take out hospital cover. People who were aged 65 years and over on 1 July 2000 are exempt. All health funds to offer members either a no gap or known gap product if they wish to continue to offer the 30 % Rebate as a premium reduction to their members.

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