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ECONOMICS LEGISLATION COMMITTEE

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**SENATE ECONOMICS
LEGISLATION COMMITTEE**

Tuesday, 9 June 2009

Members: Senator Hurley (*Chair*), Senator Eggleston (*Deputy Chair*), Senators Cameron, Joyce, Pratt and Xenophon

Participating members: Senators Abetz, Adams, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Boyce, Brandis, Bob Brown, Carol Brown, Bushby, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Furner, Hanson-Young, Heffernan, Humphries, Hutchins, Johnston, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Moore, Nash, O'Brien, Parry, Payne, Polley, Ronaldson, Ryan, Scullion, Siewert, Sterle, Troeth, Trood, Williams and Wortley

Senators in attendance: Senators Cameron, Hurley, Pratt, Siewert and Xenophon

Terms of reference for the inquiry:

To inquire into and report on:

The Fairer Private Health Insurance Incentives Bill 2009, the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge — Fringe Benefits) Bill 2009

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Committee met at 1.04 pm

CHAIR (Senator Hurley)—I declare open this hearing of the Senate Standing Committee on Economics legislation committee into the provisions of the private health insurance incentives bills. On 27 May 2009, the Senate referred to this committee the provisions of the Fairer Private Health Insurance Incentives Bill 2009 and related bills. The bills taper the rate of private health insurance rebate and increase the Medicare levy surcharge for higher income earners. The bills are intended to ensure that those with a greater capacity to pay make a larger contribution towards the cost of their private health insurance. The bills' amendments will apply to income years starting on or after 1 July 2010. The committee is due to report on 16 June 2009.

These are public proceedings, although the committee may agree to a request to have evidence heard in camera or may determine that certain evidence should be heard in camera. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege; it is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may of course also be made at any other time.

[1.06 pm]

ARMITAGE, Dr Michael, Executive Director, Australian Health Insurance Association

CHAIR—I welcome the Australian Health Insurance Association, which is presenting evidence via teleconference. Dr Armitage, would you like to make an opening statement?

Dr Armitage—Yes, I would, Chair. I shall be brief. I thank the committee for its time in allowing me to be part of the hearing and represent the Australian Health Insurance Association, an association which represents the interests of 23 private health funds who collectively provide private healthcare benefits to over 10 million Australians. We contend that private health insurance plays an important role in providing affordable access to quality health care in Australia. In the 12 months to March 2009, the industry's independent regulator, the Private Health Insurance Administration Council, reported that the total benefits paid by private health funds to the 11 million Australians who hold some form of private health cover was \$10.9 billion, an increase of 12.5 per cent over the previous year.

The Australian Institute of Health and Welfare reports that private health funds also contribute towards important hospital care, with private health funding 56 per cent of all surgery in Australian hospitals. We are well aware of the accusation by some that we do not fund important health care. It is very important for the committee to know that the private health sector contributes funding for 55 per cent of all major procedures for malignant breast cancer, 55 per cent of all cancer chemotherapy, 55 per cent of hip replacements, 70 per cent of same-day mental health care et cetera, none of which are discretionary causes of illness.

Further, AIHW data also demonstrates that the private health sector has contributed to a greater increase in the provision of in-hospital treatments since the introduction of the 30 per cent rebate. Since 1998-99, when the rebate was introduced, in-hospital treatments in the private sector have risen by over 60 per cent, compared to a 25 per cent increase in the public sector's capacity in the same period. The rebate is therefore an important policy component which assists in keeping premiums as low as possible for all Australians with private health insurance, especially the one million Australians who live in households where the household income is under \$26,000 a year.

The AHIA strongly oppose the legislation, as we believe that any moves to means-test the rebate on private health insurance will certainly place increased pressure on our public hospital system, a scenario that the Minister for Health and Ageing has conceded will occur. We also contend that the legislation will ultimately result in higher premiums, particularly for older Australians, as more people exit or downgrade their cover.

We note from the recent Senate estimates hearing that Treasury has not modelled the effects of this policy change on premiums, nor the outcomes on the system from people downgrading their private health cover. We also note quite specifically that Treasury has not modelled the effects on the more than eight million people who hold private health insurance but whose incomes are under the relevant tiers in the legislation. We know that any upward pressure on premiums will

also impact those Australians in those tiers that the Treasury has not modelled. That, the Senate committee needs to know, is a simple matter of long division.

The AHIA estimates, based on detailed market research, that up to 240,000 Australians are likely to exit their cover as a result of the legislation. This number represents a decline in membership 10 times greater than that projected by the Department of the Treasury. Further, we have calculated that 730,000 Australians are likely to downgrade their level of private hospital cover and an additional 775,000 Australians will exit their general treatment cover for matters such as dentistry as a consequence of the policy. Treasury may not have modelled any of those effects, but they will still occur—a fact that the Senate committee cannot ignore.

The significant number of Australians exiting or downgrading their insurance will have a detrimental impact on our public health system and result in additional pressure on premiums as private health funds attempt to balance increasing costs with a diminished membership pool. We are concerned that the committee may be pre-empting the outcomes of other inquiries currently being conducted into relevant aspects of the Australian health system, including that of the Productivity Commission, which was tasked with making a recommendation on the indexation of the Medicare levy surcharge thresholds and is due to report in November 2009. It seems unusual for a policy decision to be forcing people into the public system without knowing the Productivity Commission's recommendation as to whether the public or the private sector is more efficient.

It is also important to note that, in relation to the impact of the Medicare levy surcharge announced in last year's budget, the recent Senate estimates hearings confirmed that the government still expected half a million Australians to leave private health cover as a result of the new thresholds. The Minister for Health and Ageing announced in October last year that, as a result of the compromise by the Senate on the Medicare levy surcharge thresholds, 492,000 people will leave private health insurance. In fact, Professor Deeble, who I understand was to have reported to this committee earlier today, in his submission to the committee last year estimated that 750,000 people would leave as a result of those changes.

In conclusion, the legislation is not considered good public policy, as it places extra pressure on our public hospitals, and we do not believe it should be enacted, especially until the Productivity Commission reports on the relevant efficiencies of the public and private hospital systems.

CHAIR—Thank you, Dr Armitage. First of all, you said that this legislation has the effect of forcing people into the public system. But, in fact, the measures to do with the Medicare levy surcharge and the Medicare levy and the interaction of all of the requirements mean that people will not really be forced into the public system; there will still be strong incentives for them to stay in the private system. Is that not so?

Dr Armitage—No, that is not so. That is what the government is saying, but it is not correct. The simple fact is that the government is saying that there will be sticks that will keep people insured. That is simply incorrect for general treatment. The Medicare levy surcharge, no matter what the government may say, does not apply to general treatment. So what people who are forced into financial pressures may well do is drop general cover. We have estimated 775,000 people will do that. Half of the general treatment coverage is actually in dental care. The

government has spent most of the last years since its election saying that it wants to improve dental care; yet this measure will force people onto the public hospital dental waiting list. That to me seems crazy.

It is also factual that the Minister for Health and Ageing has already conceded that there will be people who will end up on the public hospital waiting lists because of this decision. The facts are that Treasury has asked a computer chip how many people it believes might fall out. We have actually done research into the direct effect on people and that tells us that the figure is going to be 10 times larger than Treasury's estimate. We think this is an extraordinarily major change in private health insurance with immediate consequence effects in the public sector.

CHAIR—Yes, it does seem that there is a huge gap between your estimates and the government's, as they say that approximately 25,000 people may no longer be covered by private health insurance and that might result in 8,000 additional public hospital admissions over two years. This huge gap, I suppose, makes it difficult to make a proper assessment of where things do in fact lie.

Dr Armitage—I certainly agree that it is a big gap, but I do not believe it makes it difficult to know where to go. I think there are several things that are important for the committee to acknowledge. Firstly, Treasury has modelled with a computer chip what it thinks might happen. We have actually gone out and asked people, through the Ipsos survey and through Roy Morgan et cetera: what will you do if your private health insurance cover increases by X per cent? We know what people will do because of that. The facts are also that Treasury has not modelled one of the most important effects of this, which is downgrading. The government's model is focused on the fact that maybe people will not leave private health insurance because of the stick of the Medicare levy surcharge. We acknowledge that will happen in some cases.

We actually believe it is a much greater number than the government is indicating through its computer modelling, but what that does not take into account is how many people will downgrade their insurance. People can downgrade their insurance and not be subjected to the Medicare levy surcharge stick. The obvious effect of that is that, as I said before, using simple long division we can see that the costs of private health insurance will remain the same but the numbers of dollars inputted will diminish. That means that the costs of premiums will have to rise for everyone.

It seems to us as if one of the gaping concerns for the health system in Treasury's modelling is that it has not modelled the effects of premium increases at all and none of its modelling takes account of what is going to happen to the people on less than \$75,000 who do not fall into any of the government's tiers. Treasury can talk as long as they like about how this is a second-round effect and we do not have to model it. They can talk about it until they are blue in the face. The facts are that those people who pay premiums whose income is less than \$75,000 will be affected by this legislation. One of the things that those people will do is leave private health insurance as a form of insurance because there is no stick.

CHAIR—Speaking of premiums, the government also estimates that spending on the private health insurance rebate will grow rapidly and is expected to double as a proportion of health expenditure over the next 40 years. Certainly in the recent past premiums have risen consistently.

Is it not the case that premiums will continue to go up anyway and that this will form only a small part of that premium increase?

Dr Armitage—I think that for a government to use a doubling in a 30- or 40-year period is relatively disingenuous because all sorts of things are going to double in that period of time and as a percentage of the health dollar, in fact, that may well diminish considerably. But, equally importantly, the committee needs to know that we have had a number of interactions with the government about methods to diminish the input of costings into the health system in general, such as ensuring that people who are insured are able to obtain full, informed financial consent in relation to the cost of their treatment before they have it. We have tried to get the government to ensure the release of information related to the performance of the hospitals and the doctors, infection rates, whether the best prostheses have been used and so on, and we just do not get to first base with that. So it seems to us completely disingenuous that the government is using a potential increase in costs over 30 years as a reason for doing something. More importantly, if—and I say if—that is the reason for this decision, we are at a complete loss to understand why the government would make this decision whilst completely ignoring our efforts to help it contain costs. As we make the point continually to the government, if you contain costs in the private sector then you also contain costs in the public sector. When we private health insurers and the government are the only two funders in the whole of the health sector, we cannot understand why we are not seen as more of a partner of the government in trying to contain costs.

CHAIR—I think that is hard to sustain given that the government retains the rebate, the Medicare levy surcharge and lifetime health cover. There are not many other industries that get that sort of assistance, are there? I think that does indicate that the government does very much recognise the interdependency of the two health systems.

Dr Armitage—I could argue that point, but I choose not to because that is not the point that I was making. The point that I was making in relation to your previous question was that costs are going up. What I am saying is that we have actually gone to the government on a number of occasions—I have spoken with the Minister for Health and Ageing on two or three occasions formally and on many more occasions than that informally, I have spoken with her office on many occasions informally, I have spoken with the heads of the Treasury and of the Department of Finance and Deregulation, I have tried to get to see the Minister for Finance and Deregulation and so on—about ways in which costs can be, if not brought down, at least contained. We are not winning that battle. No-one is listening to us as to how we might contain costs. So what I am saying is: if this decision is being taken in the interests of diminishing costs, we can help the government, because we are the other funder. There are only two funders of health care, one being the government through Medicare and DVA and the other being us. We both get our funds, obviously, from the taxpayer, but we think we could be of much greater help to the government if some of these measures for containing costs in the longer term were actually taken. So what I am saying is twofold: (1) I think the use of a doubling of costs of the private health rebate over a 30- or 40-year period is disingenuous and (2) if that is the reason, why doesn't the government help us contain the costs? We need its help to do it.

CHAIR—Thank you, Dr Armitage.

Senator CAMERON—Thanks, Dr Armitage. You indicated that the health funds had paid \$10.9 billion in benefits. Was that last year?

Dr Armitage—Yes, that is correct.

Senator CAMERON—What was the income for the health funds over that period?

Dr Armitage—I am not sure, but the business expense ratios of the funds, according to our regulator, PHIAC—the Private Health Insurance Administration Council—was about 10 per cent. So I would assume it was about 10 per cent more than that.

Senator CAMERON—I am not asking you about management expense ratios; I am asking you what your income was.

Dr Armitage—What I am saying is that every dollar that is not in the management expense ratio is paid out in benefits. So, whilst I do not have the exact figure, what I am saying is that it would be about 10 per cent more than the money expended.

Senator CAMERON—Okay. When you last appeared before the Economics Committee, what figure did you give for members who would leave as a result of the government's legislation on the levy?

Dr Armitage—What I told them was a calculation of the numbers that would leave if the Treasury figures were correct. At no stage has the Australian Health Insurance Association estimated how many people would leave the private health insurance pool. We only ever transposed the alleged savings that Treasury indicated would be made across the board, looking at the figures which we knew were the costs of the health insurance premiums. We pointed out to the committee what would happen if Treasury's figures were brought to fruition—

Senator CAMERON—And what was that figure? Dr Armitage, I do not have a lot of time and I am trying to get—

Dr Armitage—whereas, as I indicated in my opening statement, people like Professor Deeble said 750,000 people would leave, we did not say that.

Senator CAMERON—But how many people did you say would leave as a result of that calculation?

Dr Armitage—I do not have the submission in front of me, but I believe it was of the order of 990,000—

Senator CAMERON—I thought it was 913,000.

Dr Armitage—if the Treasury figures which they quoted in the budget were to come to fruition.

Senator CAMERON—The figure I have here is 913,000. In relation to your methodology for calculating your claim this time that 240,000 will leave, did you apply the same methodology last time at any stage?

Dr Armitage—No. This time we had a survey done by Ipsos in 2007. The survey actually asked people what they would do if their private health insurance cover costs increased by 10 per cent, 25 per cent or 40 per cent. So we actually asked people what they would do and we got numbers of people who would be very likely to drop their cover, very likely to downgrade their cover or very likely to drop their ancillary cover. We then washed those percentages of asking individual people what they would do if the costs of their insurance went up by those percentages—which are close to but under the effects of each of the tiers that the government has chosen—against the income levels of people in private health insurance in those three tiers chosen by the government, which was research validated by Roy Morgan. So we are able this time to go much more directly to specific research.

Senator CAMERON—I am not criticising Roy Morgan, but I have read some Roy Morgan research that I would not be betting my house on.

Dr Armitage—This was not a question of judgement; this was a direct question of: what is your income? The only thing that could be in doubt would be if people had misreported their income levels. All Roy Morgan was doing in this instance was giving us an income band for that various tiers of people privately insured.

Senator CAMERON—You said earlier, ‘We know what people will do,’ but you have just said, as a result of this methodology and survey, ‘It’s very likely.’ What is the situation? Is it ‘we know’ or is it ‘it is very likely’, or is there some other approach that we should think about?

Dr Armitage—It is the way the research puts it. I am sure, Senator Cameron, you have been alert, over the last 25 years of your public career, to the way research teams phrase their outcomes, and in this case ‘very likely to drop their hospital cover’ is their top level of certainty. I am happy to say ‘we know’ that that is the case, particularly given the 10 per cent increase we asked people about is only two-thirds of what the first tier increase is. The first tier increase is an increase of 14 per cent. So I think we are comfortable with our figures.

Senator CAMERON—I would like to be a bit more than ‘comfortable’ with your figures, I must say.

Dr Armitage—Well, Senator Cameron, what I can say to you is they are much greater than the Treasury figures, and the Treasury figures (a) ask a computer chip, whereas we ask consumers, and (b) do not model many of the important effects.

Senator CAMERON—Let me now move to the last submission that you made, where you claimed 913,000 would leave private health insurance. What was the result over that period in terms of health fund membership?

Dr Armitage—Yes. The growth has diminished considerably. I am not sure if you have received it yet, but on page 4 of our submission—

CHAIR—We do have that, Dr Armitage.

Dr Armitage—you can see quite clearly that the level of growth in private health insurance has been dramatically affected already by the Medicare levy surcharge legislation and, as we

have been saying publicly since the legislation was first passed, it would not have its greatest effect until people did their taxation for the year in which it was relevant. That is only about to start, from 30 June. So we would predict that the majority of the effect will actually be noticed in the next six months of the year. It is also fair to say that all of the predictions that people were looking at were based on the original government legislation, which was considerably altered by the time it was put into statute.

Senator CAMERON—I would not have thought ‘considerably’ was the proper description, but never mind. On this graph on page 4, you have got a growth in private health membership over the period since the legislation went in. What is the numerical figure for growth in membership since the legislation was introduced?

Dr Armitage—I would have to get back to you about that. But, as you would know from all of your previous careers, when one sees—

Senator CAMERON—You are very interested in my previous careers!

Dr Armitage—Yes. Well, Senator Cameron, you have had a glittering public career over the last 20 years. And you would know that, where growth diminishes from 4.5 per cent to about 2.3 per cent in a 12-month period, when the major effect is still to come, that is a cause of great concern for any industry.

Senator CAMERON—There have been other economic pressures on the Australian economy as well; that is correct?

Dr Armitage—That is correct, and another factor that I would put into the equation is that, since the legislation was passed, a number of things have happened in public sector health care that are in the public domain. The ‘Dr Death’ case from Queensland has been in the public domain; there has been a lot of publicity about doctors themselves having to pay for the pain relief of the patients on whom they have operated; and there has been a lot of publicity about nurses taking soap from their own homes into intensive care to wash the patients.

Senator CAMERON—Maybe you should concentrate on the deficiencies in Australia’s private health insurance system rather than rant at the public health system. I am interested in your expertise in the private health insurance system. Maybe you could stick to answering questions on that.

Dr Armitage—All I am saying is that all of those things would make people who were potentially going to drop private health insurance less likely to do so.

Senator CAMERON—I do not know who you are arguing for here: the government’s legislation or your oppositionist position. I am a bit confused. Regardless of that, Professor Deeble at the last hearing was probably closer than anyone at having done any analysis in terms of what would happen as a result of the government’s changes. He raised very clearly that this was not a price issue in terms of the prices of the premiums. An income effect was more important. Do you agree with that?

Dr Armitage—Can you explain that? I am not 100 per cent sure what he means.

Senator CAMERON—You did not go to his evidence last time?

Dr Armitage—I would like you to explain it.

Senator CAMERON—I am just asking you: did you go to his evidence? I would have thought that you would have gone to Professor Deeble's evidence and you would have understood what he was saying in relation to the price versus income effect.

Dr Armitage—If that is the point you are making, that is again an economic model and economic models have their place. However, I would prefer to rely on asking someone what they were going to do—asking an individual person: what are you going to do? Rather than have some economic theory point out what may or may not happen.

Senator CAMERON—If you rely on asking people what they would do, you would never have an election in this country. I am not convinced that simply asking people what they are going to do provides a 100 per cent watertight response, as you are trying to portray. A couple of weeks out from an election people say, 'We are going to do X,' and when it comes to the election they do Y. So you cannot tell me that your questions are so watertight that you can be absolutely sure that you know what people will do. Surely you are not putting that to us.

Dr Armitage—What I am putting to you is that in an election campaign when any party gets the result of asking people what they are likely to do they react to those responses overnight because they know that asking people is the critical factor. You cannot tell me—and I know that you are not even trying to tell me—that any political party does research and ignores it. They do not. So what I am saying is that we have done research and we have got the answers. And on behalf of the 11 million privately insured it is important that those answers are taken into account. It is also important for all people in health care in Australia because there will be flow-on effects into the public sector. I know that Treasury does not model those because they say that is a second round effect, but the Senate committee is not Treasury. You have a responsibility to acknowledge that these things will happen.

Senator CAMERON—Because of your submission? I do not think so.

Dr Armitage—It is all very well to say, 'We do not model that because it is a second round effect,' but you know that if people drop private health insurance then premiums for those people who remain will go up. You know that if people drop private health insurance they will become reliant on the public sector. It does not matter whether the Treasury has modelled it or not; it is a fact.

Senator CAMERON—You were every bit as determined in your view last time you came before this committee on these issues and nothing came to fruition—nothing.

Dr Armitage—No, I do not agree with that at all. I can point out to you, as it shows on page 4, that we believe we are already 200,000 Australians below the number we should be if there had not been the Medicare levy surcharge legislation enacted—

Senator CAMERON—But that was not your argument last time. It was that there would be a net loss of 913,000. It was not where you should have been or where you would be or where the market would take you—

Dr Armitage—That is not fair. What I said to you earlier today and what I said in that submission was: those are the numbers that will fall out if Treasury figures are to be sustained. I am not in the business of predicting; I am not foolish enough to make predictions. The people who made predictions were Treasury and they got their figures wrong and so I clarified that, and so did Professor Deeble. Treasury's figures, if they were to be believed, said 913,000 would leave and Professor Deeble said 750,000 would leave. Now what I am saying is: at the moment we are already 200,000 down on where we would have expected to be and the effect of the legislation which was passed is still to be felt because people have not done their tax for the relevant year.

Senator CAMERON—You have said that already. But you were quite happy to let the 913,000 figure into the public arena. You did not qualify it.

Dr Armitage—This is what would have happened if Treasury figures were to be believed.

Senator CAMERON—Okay. Can you take on notice the question I have asked you about the income and the other issues?

Dr Armitage—Yes, certainly.

Senator XENOPHON—I indicate to the committee that I am sorry that I was not available this morning. I did not know that my absence would mean that the committee would not be quorate. I rearranged things as soon as I found out. I understand the coalition's position—they feel that there should be a further inquiry in relation to this—but I am here for as long as you want me this afternoon.

Dr Armitage, in relation to the Ipsos survey that you undertook, that survey was based on a series of questions that do not directly reflect the stick approach that the government has used by altering the surcharge, increasing it. Would that have made a difference in terms of the survey results?

Dr Armitage—It may well have in the relevant tiers. In fact we have made some conclusions from that. But I think the most important thing to note is that as the tiers go up in income the numbers of people privately insured—the raw number—diminishes. The greater majority of the people who are affected will be in tier 1—the \$75,000-\$90,000 bracket for singles. Those people of course have no Medicare levy surcharge additional penalty.

The other important point is that in the past we as an association have done survey work on what would happen if the Medicare levy surcharge had increased to 1.5 per cent across the board. Whilst we did not model 1.25 per cent, it seemed that 1.5 per cent was one of those sorts of things excruciatingly sensitive increases. So we are not sure that the 1.25 per cent will actually be a large enough penalty. The facts are though that the vast majority of people privately insured fall into tier 1 and so the figures from the Ipsos and the Roy Morgan for those are rock solid.

Senator XENOPHON—Senator Cameron asked you some questions about the predictions and the forecasts that were made by your association in the lead-up to the proposed changes to the Medicare levy threshold, but of course what happened in the end there as a result of negotiations was a compromise and the figure was reduced from \$100,000-\$70,000 for singles. Were there any predictions or forecasts that you made in terms of the ultimate figure that was reached as a result of the compromise position?

Dr Armitage—No. We have not gone ahead and surveyed that because the legislation had been enacted and so we felt that it was more a matter of working with what we were given.

Senator XENOPHON—I understand.

Dr Armitage—However, as I did say to Senator Cameron, the original predictions that were made were on the original government legislation, which, as you so adroitly point out, was considerably altered in the final wash-up after the negotiations in the Senate had taken place.

Senator XENOPHON—Thank you. Moving on to the issue of the downgrading of insurance, firstly, how confident are you of those forecasts? And to what extent do you say Treasury modelling has taken that into account in the context of the impact on the private health insurance sector?

Dr Armitage—We are actually very confident of those figures. The whole government argument has been that there will not be a large fallout from private health insurance because of the ‘stick’ effect of increasing the Medicare levy surcharge for the two highest tiers, by 0.25 and by 0.5. However, everyone is completely free to downgrade their cover and there is no change to the Medicare levy surcharge. What we know from the Ipsos survey is that if the cost of their private health insurance were to go up by 10 per cent, 18 per cent of people said they would downgrade their hospital cover; if it went up by 25 per cent, 41 per cent said they would downgrade their hospital cover; and if it went by 40 per cent, 43 per cent said they would downgrade their cover. Those are astoundingly major figures, particularly for reasons of the effect on both the public and the private sectors.

The effect on the private sector is that there will be less income in private insurance, therefore everyone’s premium will have to go up because the outgoings will remain the same. But the major effect that may well occur on the public sector is that when people downgrade their cover they do it by perhaps taking a policy with a higher front-end deductible or they take a policy which maybe excludes some particular treatments. That means if they have gambled with their health care in those areas and then find that they need an operation, they are then likely to have that in the public sector even though they are privately insured. So this is a real sleeper issue for the public sector, and it is exactly why I was stressing to the committee, and to Senator Cameron in particular, that we think the Treasury modelling is gravely insufficient because it does not model these effects.

Senator XENOPHON—Can I go to the issue of modelling and the research that your association has done. To what extent is there a willingness by your association to show Treasury your figures, and vice versa, so that there can be a like-for-like comparison in terms of the modelling and the surveys that have been undertaken?

Dr Armitage—We are extremely happy to give to anyone who wants to receive it how we have done our research.

Senator XENOPHON—You may wish to take this on notice. Could you provide details of that to the committee?

Dr Armitage—Certainly.

Senator XENOPHON—Also, you indicated in your opening submission the whole issue of informed consent and the issues of patients being informed of infection rates and of the failure rate of various prosthetic devices, which was something I raised in estimates with George Savvides, the CEO of Medibank Private. On notice, could you provide details of the representations you have made to government in relation to this and what you say would be the impact on putting downward pressure on health costs if there was informed consent and if consumers had more information about failed devices and infection rates?

Dr Armitage—I would be absolutely delighted to and, in prefacing the formal submission to the Senate committee about that, I will indicate that we believe that, if the use of joints in Australia were to be reflected as it is in other countries where joint registries work better and the effects of those joint registries are taken into account, there would be a saving of several hundred million dollars in the system. And, clearly—

Senator XENOPHON—In a year?

Dr Armitage—this would apply in terms of infection rates et cetera.

Senator XENOPHON—Is that several hundred million dollars annually?

Dr Armitage—I believe it is \$193 million, but please do not quote me because I just do not have figure in front of me. But it is a large quantum of money.

Senator XENOPHON—If you could take that on notice, thank you.

Senator PRATT—I note that currently about 14 per cent of single taxpayers with incomes above \$74,000 receive about 28 per cent of the total rebate paid out to singles, and that after we make these changes those single taxpayers will receive about 12 per cent. Likewise, 12 per cent of coupled taxpayers who have incomes above \$150,000 currently receive about 21 per cent of rebates paid to couples, and that these changes are aimed to reduce that to nine per cent. We want to enable taxpayers' dollars to better target those funds. Surely you have to acknowledge that there are some significant equity issues with the way the rebates are currently structured.

Dr Armitage—The figures I do not deny. I also do not agree with everything Treasury says. I can only hope they have those figures correct. Firstly, I would point out that those people also pay more tax than people in lower tax brackets. Secondly, they are likely to choose to have their operations if they need them in the private sector and they will contribute two-thirds of the costs of their care. Studies have shown that for every \$1 that the government invests in private health insurance, the private sector leverages that by at least another \$2. Anything which would

discourage people from making an investment where the government gets a two to one return, I would have thought was poor public policy.

Senator PRATT—What evidence have you got for that argument?

Dr Armitage—I am very happy to forward the research that has been done. I believe Professor Ian Harper was the person who did it. Also, the simple fact is that for every \$1 that is paid out for a privately insured person, the government pays 30c and the person pays 70c.

Senator PRATT—These measures are set to provide \$1.9 million worth of savings over four years. Are you arguing that we are going to lose that proportion of revenue out of the private health system that people currently pay into private health insurance? Surely, most of that gap is going to continue to be paid by people privately. As you have already highlighted, people have demonstrated a capacity and willingness to pay.

Dr Armitage—I am not sure that I get the import of what you are saying, and if I am not correct please ask the question again. We are saying that the direct effects of this policy will be that large numbers of people are going to either drop or downgrade their hospital cover, which will mean that there is less capacity for the private sector to contribute to the private sector's own health care. And it is incontrovertible that they will drop their private health ancillaries cover because there is no Medicare levy surcharge penalty applying to that. With all of the government's sticks like lifetime health cover and so on, we understand the government's rationale. But, as I have pointed out, the stick of the Medicare levy surcharge, which the government is using as its fallback position for this not having an effect in the private sector, does not apply to ancillary cover. We estimate from direct questioning of people that 775,000 people are going to drop their ancillary cover. Half of our expenditure in the ancillary area goes to dental care, not to mention physiotherapists and chiropractors and so on. If those people drop their private health insurance ancillary cover because there is no stick, they will then become reliant on the public sector.

Senator PRATT—Many of those ancillary benefits are not available in the public sector. A vast number of people are simply used to paying for those themselves whether they do or do not have private health insurance, I would have thought. I would like to ask you some questions about modelling, just to clarify some of your earlier statements. Is it fair to say that you believe that modelling done by Treasury and Access Economics is inferior to an opinion poll conducted for the AHIA?

Dr Armitage—What I have said is that the Treasury has asked a computer chip; we have asked people directly affected. It is up to whoever is reading those results to determine which they wish to believe.

Senator SIEWERT—You may have already answered this question previously: the figures that were stated last time by the industry when the levy was changed last year have proved to be wrong—they were vastly overestimated. I am wondering why we should take the figures you are now quoting as correct when we have not seen any evidence of a massive fleeing, as predicted by the industry.

Dr Armitage—Let me then go through that for your benefit. The figures that we have quoted in our submission in relation to the Medicare levy surcharge were only ever analysing what Treasury's figures actually meant. Treasury did not take the correct cost of an average premium in making their estimations. If the budget line were to remain solid it would have meant that 913,000—according to Senator Cameron; I do not have my previous submission in front of me but I accept what he said—people would leave if the Treasury figures were to be believed. Professor Deeble said that 750,000 people would leave as a result of the changes. We as an organisation made no such prediction. All we did was point out what would be the effect if Treasury's figures were to be believed. What we can say has happened is that there are now 200,000 fewer people than would have been insured if the growth rates had continued, and we can only put that down to the Medicare levy surcharge effect. That is the first thing. Secondly, the full impact of the Medicare levy surcharge legislation will not come into effect until the tax year is complete and people start filling out their tax return and that will not happen until 30 June onwards. We will predict that the major effect of last year's legislation will occur in the next few months. Thirdly, and possibly most importantly, the predictions were made when the original legislative attempts of the government were being discussed. What happened was that there were negotiations in the Senate and the final proposal was considerably altered from the original one. Fourthly, we have actually gone out and asked people and we have washed those figures against the direct income tier levels.

Senator CAMERON—So a whitewash and a black wash.

Senator PRATT—I have a further question on modelling. I want to know whether you think that Treasury, Access Economics and the AMA, who I believe have done some modelling that says that there will not be a dropout, should take opinion polls rather than doing modelling?

Dr Armitage—If we went into a public mall today, together, and asked 100 people whether they would rather believe what an individual Australian told them or a computer chip, we would probably find most people would say that the individual Australian was more important. That is an arguing point and I am making the point and I believe—

Senator PRATT—But that is a poll and you might find that when you actually compare the outcome—

Dr Armitage—The Treasury did not model some of the most important effects. They said they were secondary. They did not model the downgrading. They did not model what would happen to ancillary cover. They did not model what would be the effect on premiums, particularly for those whose incomes are less than \$75,000. So we think there are major deficiencies in what the Treasury have modelled. Whether you believe the modelling they have done or not, we think it is so deficient that it does not allow the Senate committee to draw appropriate conclusions.

CHAIR—Thank you, Dr Armitage, for appearing here this afternoon. We appreciate your time.

Dr Armitage—Thank you.

Senator CAMERON—I have a couple of questions on notice.

CHAIR—Dr Armitage, Senator Cameron has a couple of questions and he is asking if you would not mind taking them on notice.

Dr Armitage—Sure.

CHAIR—We will send them through later.

Dr Armitage—Okay. That is good.

CHAIR—Thank you.

Dr Armitage—Thank you very much.

[2.00 pm]

McAULEY, Mr Ian Alexander, Fellow, Centre for Policy Development

CHAIR—Welcome, Mr McAuley. Do you have an opening statement you would like to make?

Mr McAuley—I do indeed, and in that statement I will make some comments on the previous witness's evidence, if that is permissible.

CHAIR—Yes, certainly.

Mr McAuley—These measures retain the positive incentive to hold private health insurance. They weaken the rebate but they strengthen the stick. In my own modelling, which is simply based on statements on the incentives, no surveys, what I see is that for singles earning between \$75,000 on \$120,000, and similarly for couples, there is a small decrease in the incentive for people to hold private health insurance but it is a decrease in the incentive that is still positive for almost everyone. There is an incentive, say, to take cheaper policies. Let us look at the sheet which the secretariat has handed out. The first set of columns model the current subsidies, which means that everyone has a very good incentive to take out policies between \$1,000 and \$2,000. They are the very cheapest and the most expensive policies being offered, if you look up the schedules. So there is a positive incentive for everyone to take out a cheap policy. For the more expensive policies there is less incentive at present. When we move over to the new subsidies, there are still strongly positive incentives for everyone to take a cheap policy and for most there is an increased incentive to take a cheap policy. To that extent, I agree with the previous witness that there will be some monetary incentive to downgrade. But there is still a positive incentive to hold private health insurance.

If we were all rational, the most rational response would be to shift to a cheaper policy—the previous witness said it was downgrading, but I would not necessarily call it that—and to drop ancillary cover. Another point which I have not seen made to date is that it may even entice some of the 290,000 people who are presently paying the levy to take up private health insurance. But all of the modelling, including this spreadsheet and what Treasury has done, while being robust, assumes that people are rational in their purchasing decisions. What behavioural research in economics shows is that, firstly, we tend to hold on to we have. It is called the endowment effect. Even though we may say in answer to a survey that we will do X, when the crunch comes we do not do X because there is no need to do X. We keep on paying that premium. We do tend to overinsure. The higher our income, the more insurance we take out, which is rather strange because you might think that the higher our income the less we need. But this applies to all classes of insurance. So there is certainly, as Senator Cameron says, an income effect. What behavioural research shows about our decision to take out insurance is that it is fear rather than any rational calculation that drives our demand for insurance.

Another point I would make, which is a strong empirical point, is that since 1999 the increases in private health insurance, in real terms, have wiped out the original 30 per cent rebates, yet there has been no significant net change. So empirically we find that people do hang on to

insurance in spite of what has been in the order of a 40 per cent rise in real terms, inflation adjusted. We also, of course, remember from those experiences in 1997 and 1998, when the previous government changed incentives, that the means-tested rebate had no effect. The Medicare levy surcharge had no effect—in fact, membership continued to fall. There was a little bit of lift in activity when the means test was lifted, but it was really only the lifetime cover and the ‘Run for Cover’ measures—a massive publicity campaign—which saw a jump in private insurance from 30 per cent to 45 per cent. So it is probably the amplified fear, particularly in that campaign.

I might add anecdotally—and I think it would be research well worth doing—that being a university lecturer I have come across students and others who do not know that there is a free public hospital system there. I am waiting for the government to do the equivalent of a ‘Run for Cover’ campaign publicising the fact that there are free public hospitals, because there are many young, fit people even below these income thresholds who have private insurance because they do not understand how our health system works.

I want to comment broadly on the policy. My impression is that it is more concerned with fiscal balance than with health policy. It is not good health policy. It continues to reward queue jumping. With private insurance, particularly the way it is presently structured, the better off you are, the more you are rewarded for queue jumping. We retain those strong incentives—admittedly not so much in the rebate but more in the stick. The policy reasonably expects the well-off to pay more for their health care, but in doing so it tends to entrench what one would call the two-tier system—that we have the well-off encouraged to fund their own system, which is in what I would call the gated community, while the rest, who do not hold private insurance, are channelled into the public sector. I am not saying we should not have a private sector and a public sector but asking why one sector is reserved for one group of people, the better off, and the other is reserved for those who are not so well-off. It does seem strange policy for a government which has a strong stated policy of social inclusion. Here we have a policy which I would say continues a policy of social exclusion.

If people do downgrade, as the previous witness says—I do not think they will, but if they do—it may reduce the amount of activity done in the private sector, but I would ask: does that really matter? Where activity goes, so too will the resources. One clear effect of the rebate since 1999 has certainly been to move activity to the private sector—we have seen that happening—but also to move resources. It has simply shifted resources around. Where the activity has gone, so too have the surgeons, the nurses and the other caregivers.

I would say the policy continues with the perverse incentives. It penalises those on high incomes who do not want to live in the gated community but want to share their healthcare experience with others—and I think many people do have that wish, but they are being penalised for doing so. It penalises those who pay for hospital care from their own pockets. Back in 1999, before the subsidies were given, about 25 per cent of people, not including those on workers compensation, actually paid for private hospital care from their own savings. That has now dropped to 12 per cent.

What I would say has tended to happen—and I am very sorry that the opposition senators are not here, because they have been extremely keen on notions of self-reliance—is that we have really replaced what I would call government-reliance and self-reliance with corporate-reliance.

If I can bring a new phrase into *Hansard*, I hope it is ‘the nanny corporation’, because that is what the private health insurance sector is; it is the nanny corporation which takes away from individual responsibility. It supports a large and expensive intermediary, the private health insurance industry.

I do notice that the previous witness referred to the 10.5 per cent management expense ratio. There is also the profit being made by the firms, particularly now that they are mainly for profit, demutualising. The management expense ratio is part of the story, but on top of that is around—and I do not have the figures with me—another three per cent of accumulation of surplus. Some of that may be to restore their reserves which have been run down, but some of it is certainly profit. So the management expense ratio is still an understatement of the cost of the private health insurance bureaucracy. It is somewhere between \$1.3 billion a year, based on the management expense ratio alone, and \$1.7 billion if we include all of that accumulation of surplus as profit.

But, most seriously, private insurance is a funding mechanism which is inflationary and which cannot provide public goods. I want to stress that inflationary aspect. When I appeared before this committee last year with a prepared submission, I did point out—and I will point out again in a publication about to come out—that, in every developed country, the greater the proportion of health expenditure funded through private health insurance, the higher is their total healthcare cost. This is a problem that the USA is grappling with at present, where it has in most indicators inferior healthcare outcomes to us but it has runaway healthcare inflation. Right now health care accounts for about 17 per cent of GPP. It is projected to rise by 2020 to 20 per cent of GDP. It is already crippling some of the US’s traditional industries, such as General Motors. And we are heading down that territory.

I heard the argument from the previous witness that a dollar spent in private insurance saves so much for the public sector. Well, not when private insurance, being a permissive payer, allows inflation to occur. The US Medicare and Medicaid charity parsimonious systems now cost as much to the public revenue as universal schemes in countries like Norway and Britain. So, even in terms of fiscal policy, it does not make a saving.

Commenting on the downgrading, I would say it is a benefit that we would no longer be subsidising high-income earners for ancillary cover. We do have an extraordinary perverse incentive now where the well-off are subsidised for their dental care and other ancillaries—but mainly dental—yet those self-reliant people on lower incomes have to pay the full lot; they do not get their 30 per cent. This is extraordinarily bad public policy, and I congratulate the government on removing at least that part of the incentive.

I heard the previous witness say that there are only two funders of health care—the government and private health insurance. I beg to differ. AIHW and other data and your own experience when you pay \$30 for pharmaceuticals show that there are also out-of-pocket expenses. Surely the people who can afford out-of-pocket expenses are those who are better off. If we look at ABS wealth data—ABS 6554—households with incomes above \$113,000 in 2005-06 or about \$130,000 now have \$500,000 in financial assets. So the households we are talking about here are easily in that half-million dollar financial asset range. About \$200,000 of that is tied up in super, but that still leaves \$300,000 in reasonably liquid financial assets for people to pay for their own healthcare from their own pockets, which is something that is generally not

acknowledged in the public debate. Some \$300,000 will get you a couple of heart replacements if you need them or, as a bargain, all of your joints replaced. So, yes, they may so-call downgrade to a lower cover, but I hope they do, because what we would see is the introduction of more market forces where people are making decisions based on their own money as to how much care they will need and not being so dependent on, I would say, if the opposition were here, the nanny state—or, in the present company, not so dependent on the nanny corporation.

Senator SIEWERT—Can I go back to that claim that the investment of \$1 in the private system generates \$2 worth of health care. I do not actually get that. Could you explain what you think it means?

Mr McAuley—That is a very big ask. If there were in the short term a one-for-one replacement, that would be understandable. I cannot get the one for two. And even the \$1 in the private system is going to come with higher administrative costs, probably in the order of 10c, when we compare the cost of the administrative overheads of private insurance as against Medicare plus the Australian tax office. So there is about 10c there. Yes, I certainly heard the previous witness talk about the necessary activities done in private hospitals, but there is also queue jumping, reallocation of priorities and probably some displacement, which the government still has to pick up. So \$1 certainly replaces no more than 90c, and it could be down as low as 70 or 80. I certainly would not be categorical on those statements, but it would be less than 90.

Senator SIEWERT—The argument that was run in the nineties when the new system was brought in was that it would take the pressure off the public health system—in other words, we could have an effective public health system and a private health system. It has not done that. It has not taken the pressure off the public health system.

Mr McAuley—Certainly not.

Senator SIEWERT—The public health system looks just as bad, if not worse, than it was then. I have not seen any official data that shows that the situation has improved and that it has accomplished that supposed aim of improving the public health system.

Mr McAuley—If we had a huge excess of surgeons and nurses then there could be pressure taken off the public sector. But we do not have such an excess; we never will have while we have got insurers or the government paying, either free or at a very subsidised rate—what is called moral hazard. It simply does not happen because the previous government's policies at the time—and I appeared before a very different Senate committee at that stage—were looking only at the money spent, not the real resources. That has been the shortcoming.

Senator SIEWERT—I have read some of your work and you have made the comment there as well as here about the shifting of resources from the public system to the private system. Could you elaborate on that a little bit?

Mr McAuley—Certainly. The private sector, backed by private insurance, has tended to be a better payer than the public hospitals. Most doctors, particularly surgeons, do some private and some public work and they can just shift their balance, depending on where the demand is. Public hospitals, when incomes are going up in the public sector, either have to let staff go or

pay them more; either way, pressure increases on their limited budgets. The other effect, which I do want to stress, is the general inflationary effect. Even if the 90c, or something approaching that, holds in the short term, in the longer term the government gets dragged into paying more for its funded services, through Medicare, Veterans or whatever, because prices are being raised overall in the healthcare system by the permissive payments of private insurance.

I am not saying the private insurers are sloppy or that they just throw money away; in fact, their record in relation to general insurance and admin costs is fairly good. But there is no way they can control costs and service providers. If one insurer does not offer to pay, then the insured, particularly when they have got heavy incentives to insure, will simply shift to another insurer which is more permissive. Cost control can be achieved only through one of two mechanisms. Ideologically, you will say through a single national insurer, if you are on the left, or through bringing in more market signals at the time of delivery—and private insurance does neither.

Senator SIEWERT—Thank you.

Senator PRATT—I want to go back to the issue of the subsidy for higher income earners in the current system, and ancillary benefits. What you are saying is that some people may drop out because they are not being subsidised to the same extent for an ancillary benefit but meanwhile that is a much better thing than having people on low incomes bearing 100 per cent of their own costs for those same kinds of services.

Mr McAuley—Yes, in relation to ancillaries I would hope that people do drop their ancillary cover because they can certainly afford to with the sorts of wealth that people in those income brackets hold. They can certainly afford to drop ancillary cover. In fact, almost private insurance ancillary cover with the exception of ambulance is capped—it is not really insurance. Insurance is something that covers you for the big expenses. Here the so-called insurer limits their liability. It would make absolute sense for those on high incomes to drop their ancillary cover.

Senator PRATT—They are, nevertheless being subsidised for those ancillaries, do you think?

Mr McAuley—They are being subsidised through the 30 per cent—or 40 per cent for older people—rebate. They are being subsidised for ancillaries. Indeed, going back to 1997 when I appeared before a committee, the CEO of a private health insurance was asked why ancillaries were included. The response, if my memory serves me well, *Hansard* will serve me better, was, ‘Well, it’s just part of the deal.’ I did not think that was particularly robust public policy.

Senator PRATT—In terms of low-income people who have private health insurance that includes ancillaries, I would have thought that to some extent they are in a lesser position to utilise that part of their insurance because of the continuing gap on many of those services. They probably do not utilise it to the same extent that higher income earners might do. For example, I might be able to afford to go to the dentist twice a year, the chiropractor a couple of times a month and use some other services; but someone on \$50,000 a year, despite the fact that we both have private health insurance, is unlikely to be in the same position in terms of consuming ancillary benefits. So I will receive more back from my private health insurance subsidising those services, surely?

Mr McAuley—I think that is a logical conclusion but I certainly do not have any evidence to support or refute it. It does make sense. The main point is that we at least will see some restoration of equity between those who pay for their own ancillaries from their own pockets and those on higher incomes who are insured. Sure, they will enjoy the benefits of insurance, if there are any benefits, but they will not be privileged in relation to people on lower incomes.

Senator PRATT—So you would place no weight at all on what the Australian Health Insurance Association is saying, which is that it is a bad thing that that cross-subsidisation for ancillary will not exist.

Mr McAuley—I would certainly place no credence on it. In terms of hospital cover it is possible to say it is okay to have private insurance hospital cover—I certainly do not argue this way but there an argument—I have got the back stop of Medicare. But in terms of ancillary cover it has never made sense to subsidise the better off for their ancillaries when others do not get them.

Senator PRATT—Can you think of arguments as to why they would be arguing that in terms of their membership base, or their income, or their perceptions about private health insurance? Why would they be so desperate to hang on to that?

Mr McAuley—I can only speculate. I do know that there is this push which the Hospitals and Health Reform Commission has mentioned—Denticare. If I were a marketing executive in private insurance I would be pushing very strongly for the introduction of Denticare. I am sure the senators are familiar with Denticare. It was a proposal from the reform commission. If people do drop their ancillary cover en masse I would see Denticare looking very much dead in the water.

Senator SIEWERT—I would like to follow up on the ancillary matter. There are two issues. Going to your behavioural insurance arguments, are people likely to drop ancillary cover or will they keep it because they are going to keep their private health insurance anyway?

Mr McAuley—What we are talking about this afternoon are two things: the incentives—and there is an incentive to drop ancillary cover—and behavioural economics, which would certainly suggest that people will not drop it. People on high incomes tend to overinsure. They are more likely to take what is called ‘first dollar cover’. Insurance, as Senator Cameron has said, is what economists call a ‘superior’ good; there is this income effect. Even though there is very good behavioural research and even though theoretically those who have more wealth should need less insurance because they can cover more of their own risks, the reality is that those with more wealth take more insurance and tend to cover themselves to the hilt. So I suspect there will not be much of a reduction in ancillary cover. But it really depends on publicity—not necessarily just on any publicity the government may or may not give but on the health insurers’ publicity. The response is very dependent on publicity—as the ‘run for cover’ campaign shows—and on a couple of notions. One notion is very commonplace and we heard it from the previous witness: without private insurance there is no private sector—you can either have private insurance or North Korean health care. Without private insurance you will not get into hospital. Perceptions count.

Senator SIEWERT—The other thing about ancillaries is this: I have heard people refer to some of the things they can get—the free pair of glasses, for example. They see that as a bonus for having private health insurance. That seems to be a behavioural thing as well. They do not necessarily do the economics but that is how you get the prescription for your glasses or whatever. Have you observed that?

Mr McAuley—I have observed it. I will not say I have observed it in a rigorous academic way but in one of my publications I have a photograph of a farmer saying, ‘If you’ve got private insurance get your spectacles now’—whether you need them or not was the essential message. That moral hazard is well researched in the USA. We have not done that research in Australia.

Senator SIEWERT—That was going to be my next question. But there is research on that out of America.

Mr McAuley—Yes.

Senator CAMERON—Do you have any references for that?

Mr McAuley—I can find them and forward them on to the secretary.

Senator XENOPHON—You are familiar with the terms of the Productivity Commission inquiry into the performance of public and private hospitals?

Mr McAuley—Most certainly.

Senator XENOPHON—Do you see that as a useful exercise to try to determine what the comparative costs are and where the efficiencies are between the two systems?

Mr McAuley—It most certainly is. I am aware—although I have been searching for the reference for some time; it is lost in my library system—of a study done in Victoria about 25 years ago which compared private and public hospitals. That desperately needs updating. What that research found was that there was very little difference in what is called the technical efficiency of private and public hospitals. In other words, if you went into a private hospital or a public hospital, for a given treatment the costs were much the same.

What it did find though is that while the cost for a given treatment in private and public hospitals is much the same, if you went with a given condition, you were more likely to get more treatment in a private hospital than in a public hospital and some of the treatment was likely to be less than necessary. That has been confirmed by some of the research by Professor Richardson of the Centre for Health Program Economics at Monash University, showing extra procedures not necessarily having extra benefits in private hospitals. So an economist would say that on evidence so far—and the Productivity Commission will look at this—private and public hospitals are probably much the same in terms of their technical efficiency but public hospitals, simply because they handle the most important cases, are better on what is called ‘allocated efficiency’.

Senator XENOPHON—If you could provide details of that report, I think it would be interesting, from my point of view at least, in terms of the comparisons between the two systems

given that the commission is now looking at that. You have mentioned comparisons with the American system in the United States. The US is risk rated—is that the case?

Mr McAuley—The US is usually risk rated to the extent that, first of all, private insurance can exclude individuals. But in general they are not risk rated to the extent that it is large employers who take out policies. So the deal that the employer does with the insurer is that they will ensure all of the staff of that employer. And of course as the staff get older—and this is the General Motors experience of course—at-risk rating worsens.

Senator XENOPHON—I see, but the community rating in Australia is fundamentally different though, isn't it, from the American system?

Mr McAuley—I would not say that it is fundamentally different. It is more comprehensive than the US system but it is not fundamentally different. It is the large employers in the US who enforce some form of community rating. Admittedly, it is based on those who are employed so it excludes the sick who cannot get work, but in Australia of course I suspect not many unemployed would have private insurance. So practically, I would not emphasise the difference too greatly.

Senator XENOPHON—Although private insurers are not allowed to exclude anyone in Australia, are they, as distinct from the US?

Mr McAuley—That is right, Senator, but again when a large company ensures its staff the deal is that the insurer will insure all of its staff. The insurers cannot cherry-pick which staff they will cover.

Senator XENOPHON—I will just go to the issue of downgrading and its effects on the system. As I understand it, you can downgrade a policy of private health insurance so if you are a young person you might say, 'I do not need orthopaedic care,' or you could exclude cardiac care. If someone who has excluded themselves from orthopaedic care because they are young and super fit ends up having a sporting injury and they need knee reconstruction or they break a few bones skiing, they would then put themselves into a situation where they would have to go into the public system, wouldn't they?

Mr McAuley—That is certainly correct, and the previous witness did refer to that.

Senator XENOPHON—I am just trying to establish, in terms of the modelling that Treasury has done, to what extent you are satisfied that it allows for the impact of downgrading of cover on the public system.

Mr McAuley—From what I have seen, it does not. The Treasury modelling looks only at the number of insured; it does not allow for downgrading—not from what I have seen of the Treasury submission. There may be other data that they have looked at which do include that, but certainly to that extent I would agree with the previous witness. That will certainly happen. Even some people with quite comprehensive policies may well choose for therapeutic reasons to go to a high-intensity public hospital. We should remember that certain regions in Australia are not served with good private hospitals. It is only the major capital cities that are. So, yes, that will be going on all the time. This is one of the perversities, I would say, of a designed system

and I would say that it is not fixed by stopping downgrading. It is fixed by what I would say is a really fundamental reappraisal of the role of private insurance.

Senator XENOPHON—Thank you. Can I just go to the issue that Dr Armitage raised. He said that one way to put downward pressure on costs in both the public and private systems, particularly the private system, would be to have informed financial consent, giving consumers information about the infection rates in various hospitals and the rate of the failure of prosthetic devices—that could save a couple of hundred million dollars a year, just the prosthetic devices, I think. Is that the sort of thing that should also be looked at as part of a holistic package to keep downward pressure on health costs in this country?

Mr McAuley—Such information would certainly have benefits across the board, private and public, and would help to dispel some myths and help to dispel some overservicing.

Senator XENOPHON—Sure.

Mr McAuley—There are always going to be problems with such league tables, as there are in education, particularly given that some hospitals get the hard cases and we have got to be careful how people interpret that—

Senator XENOPHON—That is right.

Mr McAuley—But, as a very general public policy, such information can do some good. It certainly cannot do any harm.

Senator XENOPHON—Just a couple of final questions. There has not been any modelling done on the impact of people dropping out of ancillary services; is that your understanding?

Mr McAuley—I know of no such modelling.

Senator XENOPHON—There is a potential impact, though, in terms of people shifting. Say, if they have dropped out of private physio, they could end up in the public system.

Mr McAuley—Well, to an extent. Many of the services covered under ancillary benefits are not covered in the public sector. Yes, there are some public sector dental schemes and there are some very restricted physiotherapy schemes, which I understand are restricted as to the number of services and require a reference from a medical practitioner. But, in any event, the point I am making is that no-one can spend a huge amount of money on ancillary services. And we are talking here about a group of people whose reasonably accessible, reasonably liquid wealth is in the order of \$300,000, on average. They can well afford their own ancillary services.

Senator XENOPHON—Are you talking about their net assets or their income?

Mr McAuley—Their net assets. There is data in the ABS wealth distribution survey which links income and assets and finds that households with incomes above \$120,000 a year have around \$300,000 of liquid assets, or reasonably liquid assets, available. That will buy a lot of ancillary services. We do have this notion in Australia that, when you need health care, someone else will pay for it. It may be time—for both the Left and the Right, I would say—to go back and

have a look at those assumptions. Our programs were generally brought in in the post-war era, when incomes were much lower and health care was much more expensive, and now we are a much more prosperous country and we do have a lot more capacity to dip into our own pockets for those minor outlays, such as ancillaries.

Senator XENOPHON—Finally, you referred to the issue of harder cases going to certain hospitals, in terms of doing a like-for-like comparison. But can't you get around that by having an appropriate risk adjustment to allow for that so that you can do a reasonable comparison between various hospitals, both public and private, and within each sector?

Mr McAuley—Senator, most certainly you can get around that, and that is the way any rigorous methodology should approach it. Such data, I am sure, would make perfect sense to every senator and every health economist, but how is it going to feature in the tabloid dailies?

Senator XENOPHON—League tables are published in a number of countries—the UK, the USA and South Africa. I think a number of other countries do publish these sorts of league tables, don't they?

Mr McAuley—They most certainly do. But, in an anecdote from behavioural economics, I will point out the result of a survey done on airline safety. What is the most dangerous airline to fly? It happens to be United. Why? Because it is the biggest airline and has the most crashes. That is the sort of public perception you get from league tables. Yes, I am all in favour of that data being available, but I am not at all confident that it will be well interpreted.

Senator XENOPHON—Thank you.

Senator CAMERON—Is that paper you were talking about the one by Richardson and Deeble from the ANU in Canberra in 1982? It has a box with the number of procedures.

Mr McAuley—No. My recollection, and I will do another search for it, is that it was called something like 'Privatised public hospitals?'. I will certainly have another look for it and go into the dusty archives.

Senator XENOPHON—Do you think the Productivity Commission should through its terms of reference establish information that would be useful in determining issues of public policy with respect to the rebate and where taxpayers would get the best benefit from public health expenditure?

Mr McAuley—Most certainly. If we go back to 1997, there was a major Productivity Commission inquiry into private health insurance with fairly restricted terms of reference. If we have a look at the final recommendation of that report, it says there should be a complete and open study of Australia's funding of health care. That recommendation has never been acted on. Certainly, there has been the National Health and Hospitals Reform Commission, but its terms of reference are likewise restricted. I have been critical in public of that commission, not that they are unprofessional people but they are very close to the systems on which they are reporting. They are expert in their own territory but, unlike the Productivity Commission staff and commissioners, I would argue they do not have the capacity to stand outside and have a look at

health care from the outside. That is the sort of analysis only a body like the Productivity Commission can do.

Senator XENOPHON—Thank you.

CHAIR—Thank you, Mr McAuley, it has been very helpful.

[2.42 pm]

WELLS, Mr Rob, Director, Menzies Centre for Health Policy; and Executive Director, ANU College of Medicine, Biology and Environment

CHAIR—Welcome. Do you have an opening statement?

Dr Wells—Thank you, I have just a couple of points. First of all, I would like to thank you and the committee for inviting me to appear and give evidence. I want to talk for a couple of minutes about the assessments of the impact of the measure proposed in the budget because we have seen varying estimates: as high as up to a million people dropping their cover and Treasury estimates at a much lower figure of 25,000. Clearly, both cannot be correct. Why that would be a matter of concern I think goes to two key factors. First of all, there is the possible impact on public hospitals. If the figure is very high, one might expect an impact on public hospitals. The second issue of concern would be that any increase in premiums as a result of many members dropping out would put more burden on those who remain. They are important questions and I think it is important to make some assessment of that.

I think all the evidence suggests the impact will be at the low end of the scale—that is, closer to what the Treasury estimates are, and therefore, effectively, have a negligible impact I would say on public hospitals and on premiums. I base my assessment of the situation on a number of factors. First of all, the reduction in the rebate for high-income earners does not cut out until singles earn \$120,000-plus per annum and families earn \$240,000-plus per annum. That is where you would expect most of the impact to occur because for incomes below that it is tapered. For those groups, the Medicare levy surcharge increases quite significantly.

I think the Treasury's estimate is that the Medicare levy surcharge and the extra payment because of the reduction in the rebate would more or less cancel each other out. Therefore, it is only very high-income earners who would bear the full effect of the measure. We have seen in a previous budget, the 2007 budget, where the Medicare levy surcharge thresholds were increased, that people at lower incomes than we are talking about, who could well have dropped their insurance, did not. In effect, there has been no reduction in private health insurance since the 2007 budget measure. In fact, there has been a slight increase. There was some dispute as to the mix of the increase and all of that; nevertheless, the numbers have gone up, so I would think the only real evidence we have of a change in these thresholds and whatever would suggest that it will not have much of an impact. I will leave my opening remarks there and welcome any questions.

CHAIR—The Australian Health Insurance Association said that there was no reduction in their membership, but the rate of growth was much decreased. They said this was to the effect of probably 200,000 members and that they expected the effect to be felt more once people had done their tax this year. Would you think that that would be a factor as well, and do you think that would be enough to take it up to around the 900,000 that they estimated previously?

Mr Wells—I would not think so, even if they are correct. Whether the rate of growth has increased or declined is not the point. The point is how many people have private health

insurance, and that number has gone up. That is like saying that interest rates will be lower under this government or that government. You do not know. There are so many factors influencing it. I think it is just a hypothetical statement and perhaps best treated as such.

Senator PRATT—In relation to the question of premiums going up or down, the Australian Health Insurance Association argues that that puts upward pressure on them. What would you say in regard to that?

Mr Wells—There is no evidence to support that either way. The logic of their argument would be—and I think it is a logical argument—that if there are large numbers who drop private health insurance, the people who drop it are likely to be those who, in their own assessment, are less likely to need hospital care and, therefore, the funds would get revenue from those members but would not outlay much in terms of their care. Am I making sense?

Senator PRATT—Yes.

Mr Wells—They would not draw down much on the system. So, if those people leave, those who remain are presumably people who will draw more on the system, so the funds raised through premiums will have to increase to cover a sicker, if you like, profile of membership. The logic of that, I think, stands up. But there is no evidence yet that that is what will occur. Just to add to my earlier remarks, if you take, for a start, the million or 900,000 or whatever it is, the estimate from the government is that roughly 2.3 million people are in the categories affected by this measure. That is people earning \$75,000 and over or \$150,000 and over for families. That is assuming that about 40 per cent of that group would drop out.

If you look at the participation in private health insurance since Medicare came in in 1984, I think the private health insurance participation covered about 77 per cent of the population. It reduced to around 30 per cent, but it took 20 years for that to happen. It was not until the late nineties that it had reduced. So it did not drop quickly. So, if there were to be any drop, history suggests that that would not be sudden—it would be slow and more people would be able to pick it up in time. So I think it is unlikely that their estimates are based on any actual modelling that would stand up.

Senator PRATT—Would you expect there to be a drop in people taking out insurance that equals, say, the rising unemployment rate?

Mr Wells—I would not think so, because if people lose their jobs their income, by definition, would drop and I think they would fall below the threshold levels. That would depend on individuals, but—

Senator PRATT—But they may not insure themselves. That is clearly not the reason they drop out. I would expect that unemployment will impact on the overall numbers, but will we be able to aggregate out the reasons as to why, or is the health insurance industry just going to say, ‘We’ve dropped by this amount and it is your fault because of the changes to the Medicare levy?’ Or are we, because they are being so forthright in their allegations about ‘This is how it is going to be’, going to have to unpack that very carefully so that we can demonstrate the motivations behind people’s insurance status changing?

Mr Wells—You can disaggregate membership by age, but I do not think one can—at least publicly—disaggregate it by income. So I am not sure whether we would be able to pick up whether any drop-out is due to income reduction through unemployment or reduced employment. That could well be a factor, but one would not be able to disaggregate that from the figures publicly currently available.

Senator PRATT—That is an issue.

CHAIR—In the second reading speech, the Minister for Health and Ageing, Nicola Roxon, said that spending on the current private health insurance rebate was growing quickly and was expected to double as a proportion of health expenditure within the next 40 years. That is very significant. Do you think the benefits of the involvement of the private health system in health care is enough to warrant that kind of subsidy just continuing to expand?

Mr Wells—Not as currently constructed. The flaw with the current system I think is that, first of all, it is open-ended. There is no cap on the rebate. The only control the government has is in the annual approval of premium increases. And even there the government's hands are somewhat tied because it cannot not approve a premium increase if, as a consequence of not approving it, the fund would go bankrupt or go out of business. So, effectively, it is uncapped.

It is not clear what return we get from that investment. As previous evidence has shown, there has been no reduction in demand on the public hospital sector. In fact, public hospitals have grown in their activity, as you would expect with the increasing population, changing diseases profiles et cetera. And public funding for public hospitals has gone up. Some would say not enough and others would say accordingly but, nevertheless, public funding for public hospitals has gone up. So I would think a doubling of the current rebate under the current arrangements would not be a particularly good investment of public expenditure.

Senator SIEWERT—As we discussed with the department this morning, 130,000 people will now be included under the surcharge with the new tiered approach and the new surcharge. With the 1.25 per cent and the 1½ per cent, there is an extra 130,000 people who will now be caught up in that—who will either be paying an extra surcharge or who will be encouraged to take private health insurance or not drop out.

Mr Wells—Yes.

Senator SIEWERT—Do you think that, when the private health insurance industry are talking about the number of people who are dropping out, they are taking that into consideration?

Mr Wells—I have not seen the basis for their calculations, so I cannot answer that question. I think one of the difficulties at least some commentators are having is that it is unclear what the basis of these claims are. So whether or not they have included those people, I am not sure. One would hope they have, but I have not seen their figuring.

Senator SIEWERT—Do you think that the increase in the surcharge is going to act as a stick to stop people dropping out?

Mr Wells—Yes, in fact I think if you look back at when the surcharge first came in you will see that it was at a level of \$50,000 for families. I forget what it was now but at that stage it was a relatively high income and I think that was an incentive for people to take out private health insurance. I think there were some surveys done which showed that at the time. But since then I think the scene has changed somewhat. The Department of Health and Ageing gave evidence at the estimates hearings last week from the national household survey. Their evidence, and I have not fixed checked the figures myself since then, suggested that most people who hold private health insurance now hold it because they believe they want to hold it. That makes it even less likely that people will drop it simply because of some rearrangement of surcharges and levies.

Senator SIEWERT—Which is where we come back to what we were talking about with Mr McAuley—that is, the behavioural economics issues around people having it now because—

Mr Wells—Yes, because they think it is worth having—particularly at the high-income end. If your family income is over \$240, 000 a year then you probably have a fair bit of discretionary income in that and you might think it is worth it. The real benefit of private health insurance as I see it is that you get the treatment when you want it, where you want it and provided by whom you want. People at those levels of income would probably think it is worth it for that alone. When you add on that they would have to pay more tax and get no benefit, other than the normal benefits one gets from paying one's taxes, and there is no particular personal benefit in paying more tax, why wouldn't you keep it?

Senator SIEWERT—The industry were also talking about the issue of dropping ancillary cover. How likely is it, do you think, that people will drop their ancillary cover, given what you have just said about behavioural economics?

Mr Wells—I think it is fairly unlikely. I think the department of health gave evidence last week that the estimate is about 10,000 people or 8,000 people. I cannot quite remember the exact figure but it is a very small figure. In terms of my parameters, that would have virtually no impact at all. If people keep their hospital cover and drop their ancillary cover then I do not see any impact on the public hospital system at all because ancillary cover does not cover the sorts of things you get in a public hospital.

Senator CAMERON—The Australian Health Insurance Association gave evidence this morning. They also gave evidence to the last committee hearing on the Medicare levy surcharge. One of the arguments that they consistently use is that without a strong private health system the public health system would not manage the healthcare requirements of Australia. Do you have a view on that?

Mr Wells—I do, and I will give it, but I want to preface that by saying that I do not have a view on whether the public system is better or worse in value than the private system. I am not passing a value judgement. But I would expect that if we did not have a private sector then the public sector would have the resource which effectively is now in the private sector. Mr McAuley gave some evidence that in fact the private sector draws resources in terms of doctors, nurses et cetera from the public sector. There is not an infinite supply; there is a limited supply and people move between the two systems. Presumably the public sector would be resourced more to cope with the demand.

The other point I would make is that if you look at the use of private hospitals then you see that most private hospitals do not provide emergency care. So that it is a big factor. Whether one has private health insurance or not, in an emergency one will end up at a public emergency department. One tends to use one's private health insurance for elective procedures. I am not saying they are trivial, but they are elective so they are not by definition life-threatening. It is a bit of a hypothetical question because we do have a private sector, but if we did not then I would expect we would have built the public sector able to cope with the demand, more or less—with some queuing and all the sorts of things that one would have anyway.

Senator CAMERON—The Health Insurance Association also drew our attention to market research that they had undertaken in terms of the numbers of people who would leave private health insurance because of this government initiative. I am not one for analysis paralysis, but this seems to me to be a lack of proper analysis of the health insurance system in this country. It seems to me that we skip around a lot of the issues. We have only just touched on the issue of ancillary benefits here, but I do not know that there has been a lot of analysis done about the issue of suitability of private health insurance for the role that it is carrying out. I am not sure that the capacity for people to understand the offerings of different private health insurance companies is well understood. I think that it is a very complex and misunderstood area. In fact the health insurance industry itself has set up its own front, if you like, to do this. iSelect is funded by the private funds and people think that they are a bargain, but they are actually going round in a circle with iSelect. What do you think of these areas in terms of the suitability of private health as it is currently structured?

Mr Wells—I would agree with the point that you are making. I think that we do need further analysis. Everybody has to take Medicare insurance—that is part and parcel of a universal health system. You cannot choose Medicare or private health insurance; you can choose Medicare and private health insurance. So for a start if you take out private health insurance you are doubling your insurance. It is a bit like insuring your house with one insurer and then going along and insuring it with someone else. That is not a terribly logical system to have in the first place. The system is built up by accretion rather than by any sort of rational determination of what will be the best way to structure it.

Some countries have done a more rational approach to this. For example, Holland have gone through a process and they have set up a system where the private health insurers are actually involved in delivering the Medicare type of entitlement. We have not done that at all. Basically private health insurance grew out of the risk of catastrophe back in pre-Medibank and then pre-Medicare when, if you did not have hospital cover, you would be thrown into a poorhouse type of service, so people tended to take out cover. I think that is still part of the rationale. Of course under Medicare that is not possible; you will get the care you need in a public hospital by entitlement.

Senator CAMERON—The issue of doing market research to determine matters of public policy like we are determining now: what is your view on that?

Mr Wells—The difficulty with market research is that you get the answer to the question you ask and the way the questions are constructed often will prejudice the findings. So if I were the industry asking the questions, I would expect the questions to be asked in a way that might give an answer that is more positive to the industry. That is a well known feature and risk of market

research: that you will bias the answers by the way you ask your questions and the way you do your sample selection and so on. I am not saying that they have done that—I do not want to be accused of that—but that is a risk in market research.

Senator CAMERON—Every time the government tries to bring some equity issues into private health insurance, you have ‘the sky is falling in’ approach from the health insurance industry. Is that just rent seeking—what do you reckon?

Mr Wells—Senator, the sky has not yet fallen in and, indeed, when Medicare came in the sky did not fall in for the private health insurance industry at all. It took nearly 20 years for membership to decline from the high 70s down to 30 per cent, and it is still a third of the population. We think ‘only 30 per cent’ but that means that one in every three people had it then. So the sky has not fallen in, and I think one has to be careful about this sort of shroud-waving, ‘any change will do it’ approach.

This measure certainly gets to the equity question. Those who can most afford to pay now pay more, whereas as it stood with the 30, 40 or whatever per cent rebates everybody paid the same premium and everybody got 30 per cent back. That 30 per cent back was worth more to some than to others.

Senator XENOPHON—Mr Wells, Senator Cameron refers to a lack of analysis in what we know about the most effective use of expenditure in the public and private systems. Do you think that the Productivity Commission inquiry into the comparative outcomes in the public and private systems will be useful in getting some facts?

Mr Wells—I should think that inquiry, from its terms of reference, will provide that but it perhaps will not shed much light on private health insurance as such. It will shed light on the relative performance of the two sectors. You would also appreciate that people will use their private insurance in the public sector as well. That inquiry, I would think, will give useful information about the comparative performance of the two sectors.

Senator XENOPHON—That information ought to be useful in the context of the level of rebate and how the rebate would be applied in the mix between the public and private systems.

Mr Wells—Senator, I am not sure. Is your question—

Senator XENOPHON—Is there a primary question as to this. Do we need to look at what is the best mix in our health system between public and private in the broader context of considering changes to the rebate?

Mr Wells—One could take that approach. It would be difficult to come to a value judgment. Currently the mix between public and private in the Australian health system is roughly 70-30. It has actually been that for many years. I think the question it would answer is this. The highest proportion of whatever billions are spent on the rebate and goes to the private sector. Is that a good investment in dollars spent and return? It would help to answer that question, yes.

Senator XENOPHON—That would be something that the Productivity Commission if not now could look at? It could have an impartial look. Do you think that would be a useful public policy question that needed to be forensically looked at?

Mr Wells—I think it is a question that needs to be looked at. I think the Productivity Commission in 1997, as Mr McAuley pointed out, in fact recommended that that question in a broader context be looked at in terms of the value of private health insurance overall and the best arrangement.

Senator XENOPHON—Sure. On the issue of downgrading, the private health insurers say that the modelling that Treasury has done does not adequately include the effect of downgrading on the public system so that, if you downgrade your policy so that it excludes orthopaedic cover and you are a young person but have a sporting accident, for instance, and you need major knee reconstruction, that will be a burden on the public system. What is your understanding of Treasury's modelling? Is it sufficiently forensic to look at the effects of people downgrading their private health insurance on the public system and on private health insurance premiums generally?

Mr Wells—What is publicly available does not explicitly go into that, and I suspect it did not because of the way they have described their modelling. I would want to look at the question of how much can one downgrade and still meet the requirement of having hospital cover. If one does not have hospital cover, one gets the Medicare levy surcharge. Some of these sorts of 'hospital cover light' schemes might be sailing close to the wind in terms of whether they are still eligible and whether they are still classified under the definition as hospital cover.

Senator XENOPHON—Are you able to take that on notice? Would it be possible for you to look at that?

Mr Wells—I could have a look at that perhaps in a hypothetical way. I could not obviously cover every scheme.

Senator XENOPHON—No.

Mr Wells—There is a minimum level of cover one has to have to still be eligible to avoid the Medicare levy surcharge.

Senator XENOPHON—You can downgrade. You can exclude certain types of cover. You could exclude cardiac or orthopaedic, for instance.

Mr Wells—I think you can, but there is probably a limit. I would need to look at that more carefully, and I will.

Senator XENOPHON—You are saying that this will not have much of an impact, but to what extent would it be useful for you and others who have particular expertise and interest in this field to obtain further details both from Treasury as to the nature and extent of their modelling and also from the private health insurers who have done their research and modelling in relation to this? Would that be helpful to you in order to give a more expansive opinion on this?

Mr Wells—Yes, it would be very helpful.

Senator XENOPHON—Finally, the private health insurance industry spoke about issues of informed financial consent in relation to the failure rates of prosthetic devices, which I think has been a complaint amongst private health insurers, and issues of infection rates in terms of perhaps publishing league tables as they do in a number of other countries. To what extent would that be useful in getting a better outcome overall and keeping downward pressure on costs in the health system?

Mr Wells—The evidence internationally shows that the benefit of those league tables is more in measuring the quality of care and reducing the risk of adverse outcomes.

Senator XENOPHON—That is important, though, isn't it?

Mr Wells—I think that is very important. There is also evidence that shows that a system that is safer—in other words, if there are less adverse outcomes as a result of the care itself, as distinct from the disease—is obviously a more efficient system as well, because you are not treating conditions more than one has to treat them. Certainly I am in favour of publishing, although I think 'league tables' is an unfortunate term—

Senator XENOPHON—Sorry.

Mr Wells—I am not accusing you, but the tabloids like that, and it does frighten doctors and other providers. As you say, a lot of publishing of proper outcome information is done overseas. In the United States, I can go onto the government website and get all sorts of information about hospital outcomes, individual practitioner outcomes and so on and so forth, and certainly the sky has not fallen in over there, and their providers and professionals have not deserted the system in droves either. I think it does lift the quality and therefore does reduce the cost pressures over time.

Senator XENOPHON—Thanks.

CHAIR—Thank you for coming in this afternoon.

Mr Wells—Thank you.

[3.13 pm]

LAVERTY, Mr Martin, Chief Executive Officer, Catholic Health Australia

TOBIN, Mr Patrick, Director, Policy, Catholic Health Australia

CHAIR—Welcome. Do you have an opening statement you would like to make?

Mr Lavery—We do, and thank you for having us here this afternoon. I would like to put on record that I am actually delighted and proud to be here this afternoon, and I regret that some others who perhaps were intending to be here and to join you around the table have made the decision not to be here today. I think this is an important piece of legislation about which there are some differing views. But it is an important procedure that this parliament has in place to come together to provide that appropriate scrutiny, and I question the reasons why others who would otherwise have been here are not with us this afternoon to hear the issues that Catholic Health Australia has to raise and, indeed, the evidence presented by others who have appeared before you. In that context, I am grateful that you have made the time available to hear from us.

I have appeared before this committee before, so you are familiar with the fact that Catholic Health Australia represents 75 not-for-profit hospitals around Australia and 550 aged-care services. Of our hospitals, 54 are private and 21 are public. We are in the unique position of having a very firm and long-established foot in both the public and private hospital systems. We actually do not see those hospitals as different from each other; we see them as Catholic not-for-profit hospitals that are providing a hospital service to the communities within which they operate. Having that systems approach, seeing those hospitals as operating as one, is I think an important principle that we put before you this afternoon.

In reviewing the proposals announced in the budget that this committee is considering, we have had the opportunity to speak with the operators of our hospitals. Within Catholic Health Australia we have a health policy committee that oversees major policy issues, and my colleague Patrick Tobin oversees that committee. The committee has raised a number of questions, and we are still working through our final position on this particular piece of legislation. We have in fact asked Access Economics to undertake some further analysis of the impacts, to help inform the view that we would like to present to this Senate committee. So, before I go into the five issues that I wanted to raise today, I wanted to foreshadow that within the coming days—we are hopeful, by the end of this week—we are looking to present to this inquiry a formal assessment of the potential impacts that this legislation might have on public hospitals. So, while I would have liked to be in a position to deal with those issues this afternoon, that work not having been completed I would be speaking without evidence, so I will not address them—otherwise, I would. But I seek the indulgence of this committee to wait until perhaps the end of this week for a presentation of that detail for your own scrutiny.

With that as background, we have looked at the manner in which Treasury have modelled the likely impact of this proposed legislation. We have noted that Treasury have used a personal income tax microsimulation model and broken up the three income groups—\$75,000 to \$90,000; \$90,000 to \$120,000; and \$120,000 plus. But they seem to have applied the same price elasticity

formula to those same groups. In asking the question, 'Would someone on an income of \$75,000 exercise their purchasing power in exactly the same way as someone earning \$120,000 plus,' Treasury have applied the same price elasticity formula and said that private health insurance is relatively price inelastic—that is, the price of health insurance is not likely to drive consumers' behaviour all that much. We are not sure about that, and we have asked for some expert advice from Access Economics on this. It would seem unusual that someone on \$75,000 would exercise their purchasing power in the same way as someone on multiples of that amount of income. And, because it is a set of Catholic principles that drives the operation of our organisation, it is the lower income earners—in this case, those on \$75,000 to \$90,000—that we would have the most concern for, rather than higher income earners. So the focus of our question would be: is it appropriate that Treasury have done their modelling on a price elasticity formula that is the same for someone on several hundred thousand dollars as for someone on \$75,000 in determining how many people are likely to drop out of holding private health insurance?

We wondered, as our second issue, what impact the downgrading of insurance might have on the total pool of insured within Australia. We have heard from other evidence today that Treasury has used an average rather than a single premium to calculate the likely cost drivers for whether someone will retain or drop their private health insurance. There has not been consideration given to the prospect of a downgrade. The downgrading of a private health insurance product has an immediate impact on the available insurance pool, which in turn means that future costs of private health insurance would be put into question. So we are asking: has Treasury acted in appropriately in not considering the potential for consumers to downgrade the private health insurance that they own? Has Treasury considered the impact this would have on the total pool of funds available to the insured community which would in turn drive the potential costs of private health insurance in the years ahead?

As a third point, we are unsure whether the forecast net drop of 25,000 that Treasury has suggested would result as a result of this legislation includes those with ancillary cover or if it is purely related to hospital only cover. We have made an assumption in looking at the numbers that the projection or forecast that some 25,000 people might forego holding private insurance relates solely to those with hospital only cover. Indeed, if that is the case, that has a similar impact in that a pool of people who might otherwise drop their ancillary and other covers have not been considered in the forecast that Treasury has made about the number of people that may in fact forego private health insurance as a result of these measures.

As our fourth point, this policy seems relatively expensive to both a consumer and the Australian government. Those on incomes from \$75,000 to \$90,000 are likely to see a 14 per cent increase in the cost of their private health insurance, those on \$90,000 to \$120,000 are going to see a 28 per cent cost increase and those on \$120,000 plus are going to see some 42 per cent cost increase. If we focus on the group we are most interested in, those on \$75,000 facing a 14 per cent increase in the cost of their private health insurance, it is a substantive cost impost on holders of private health. We seek an environment in which those who can afford to contribute to the cost of their private cover can. If private health insurance is to increase by 14 per cent for a person on \$75,000, that is making it more complicated, more difficult, for someone to hold that private health insurance.

We also think that this is an expensive measure to implement. The budget papers have indicated an amount of some \$70 million over five years will be made available to the Australian

Tax Office, presumably to employ officers of the ATO to oversee the implementation of that policy. We understand that public policy has a cost of administration. A \$70 million cost impost seems a relatively large one and money that those of us who oversee not-for-profit hospitals and aged-care services might prefer to see directed to frontline services in the provision of health care.

Finally, I draw to the inquiry's attention a perhaps unintended consequence of associated changes with the definition of income for the purpose of calculating if a person is liable to meet the Medicare levy surcharge. We understand the 2008-09 budget sought to include within the definition of income reportable fringe benefits. We have understood that this budget seeks to include for the purpose of the definition of income salary sacrifice for the purpose of superannuation. If you lump those two changes together, a requirement that income include reportable fringe benefits and that it include sacrifices made for superannuation, you have a scenario where an employee of a public benevolent institution—an employee of a charity or a welfare organisation perhaps—who might be on a take-home wage of less than \$75,000 to date, might inadvertently, without intention, when you include their reportable fringe benefit and their salary sacrifice for superannuation, have their reportable income for the purpose of the Medicare levy surcharge pushed over the \$75,000 threshold.

Treasury has not to date modelled how many people this might affect and, indeed, if that is the effect. And I would encourage this inquiry not to take our word this afternoon, because we are working our way through modelling this particular perhaps unforeseen consequence of the legislation, and to consider someone who is employed by a public benevolent institution is able to take about 30 per cent of their income in effect tax free. Does that mean that someone on about \$55,000, \$58,000 or \$60,000 would then be pushed up into the \$75,000 threshold as a result of this change to the definition of the Medicare levy surcharge? We do not think that the intention of changing the definitions was to have people working for charities, for public benevolent institutions and for hospitals captured by that measure. Indeed, we would ask that this inquiry give consideration to that specific item.

We think additionally that there is going to be a decline in membership of private health insurance because of the current economic environment. This is a matter unassociated with this particular measure, but if you combine this measure with a general downturn in the economy, there has to be a point when we say that private health insurance is going to be out of reach for those who might be impacted by the downturn in the economy. Would this be—those two factors combined—another driver as to why a person leaves or is forced to forgo private health insurance? Why able to Catholic Health Australia be worried about that? Having responsibility for both public and private hospitals, we look at the Australian health system is one. When there are incentives and opportunities for consumers to contribute to the cost of their own care through private health insurance, it frees up public hospital beds, it frees up demand on the public system. We are uncertain as to what the impact of this measure would be on public hospitals at the moment. As a consequence, we have asked for some expert opinion which we hope very shortly to be able to provide to this inquiry, to say with confidence that there is or there is not a major impact on public hospital waiting lists as a result of these budget measures.

Thank you for the opportunity to make these opening remarks. We are happy to take questions.

CHAIR—Mr Lavery, you raise some very interesting points and some good questions for us to take back to Treasury, particularly if we have the results by the end of the week of the further analysis you are doing. The model you have with the public and private hospitals reflects some evidence we have heard from academics—about, in some ways, the strangeness of the current system where we have separate private health and separate public health. Clearly that is not the case for Catholic Health. So it seems a more logical way of doing things. It also means that your experience covers both and is a more useful guide for determining this sort of thing. I do not want to quote too much his statistics but Mr McAuley had a chart for us with the net effect of subsidies. Although you are quite correct in saying that someone on over \$75,000 will experience, according to Treasury, a 14.3 per cent increase in out-of-pocket cost, Mr McAuley says that the net effect will, for \$1,000 payments, still be quite positive for people, but where it is a \$2,000 policy, it will go up quite a bit. I presume that is what you were referring to when you talked about downgrading and the premium pressure there. I could be wrong but I think Treasury, in their private briefing, were saying that that is not such a problem because the payout of the health insurer will not be as high, that you will not have to pay out so much money, so the net effect on profits will not be so bad. Can you go through that and explain the effect?

Mr Lavery—The uncertainty about the Treasury modelling at the moment is that they have applied a one-size-fits-all model; they have assumed that every person in Australia, all 10 million of them who are insured, are holding exactly the same policy and that is certainly not the case. They have then gone further and not given any consideration to the impact on the pool of privately insured people by the response of some consumers, which will be to downgrade—hold the insurance they have, but rather save costs by downgrading. Can I speak to the concern that we have that we do not yet have evidence to provide before you. Our hospitals were established originally hundreds of years ago, to provide access for the poor and the marginalised in the community, those who would otherwise miss out. With time, the funding system in Australia has evolved to be a public and a private system, and we have seen our hospitals grow in both a public and a private capacity. We see that system as one but, rather, it is still funded through the two different mechanisms—through private health and, through state and territory governments, through public health.

Our experience is that for every 100,000 people in the Australia community you can expect, on average, about 36,000 episodes of care or hospital separations per annum—and I am just looking to my colleague to confirm that I have used the right statistic—so that if we have a decline in private health, if there is a downgrading in those who actually hold private health, there is a cost shift to the public sector. When we appeared before this inquiry last year, the measures that were being considered at that stage to change the thresholds for the Medicare levy surcharge were going to result in a much larger decline in private health than this measure that is currently before this inquiry. Treasury, in estimates last week, reconfirmed that some 492,000 Australians are likely to forgo their private health insurance as a result of last year's budget changes. That is not the case this time, so we do not want to mislead the inquiry by saying this particular measure is in the same category as last year's, but there is still an unknown as to what will be the actual fall in the net number of people that hold insurance in the Australian community.

The rule that you can apply is a relatively easy formula: for every 100,000 people that pull out of private health insurance or do not hold it, expect 36,000 episodes of care to be funded within the public hospitals. That is why we are seeking to scrutinise Treasury's assessment around a net

loss of 25,000 as a result of this measure and to push a bit further to ask: how many will downgrade their insurance, such that there may be a need for additional procedures to be undertaken in a public hospital? That is our principal concern, and we have that concern because our Catholic hospitals are founded on principles of social justice whereby the marginalised, the poor, the disadvantaged in the community might have the greatest access to public health. If we add, and to the extent that this measure may add, another pressure on public hospitals, we would have to ensure that some measure of compensation or some mechanism of preventing that pressure on public hospitals was in place, and it is the detail of that that we hope to be able to provide to you by the end of the week.

Senator PRATT—In that context, what weight are you giving to encouraging those who can afford to pay to pay and to the government having a substantial saving and, in turn, seeing significant investment in the public hospital system across Australia?

Mr Laverty—Our proud philosophy is: those that can afford to contribute to their cost of care should; those that cannot, deserve the protection of a robust and well-operating safety net. One of those mechanisms we need is an appropriate balance in the Australian community where those who can contribute to the cost of their care do. So you will have heard by my opening remarks that the income group we are most interested in to get right, the income group that potentially has the greatest impact if the Treasury modelling of price elasticity is wrong, is that lower income group, \$75,000 to \$95,000. That is also why I also raised the question around whether or not we will see employees of public benevolent institutions, charities, not-for-profit hospitals also captured in that \$75,000 to \$95,000 income bracket. I am certainly happy to go on record and say that those who can afford to contribute to the cost of their care should.

What we are asking this inquiry is: has enough evidence around the modelling been presented so that we have a true understanding of the numbers of people who are likely to give up or forgo their private health insurance, so that we can assess properly the impact on public hospitals which, in turn, impacts low-income earners, the marginalised, the disadvantaged within the Australian community.

Senator PRATT—To what extent do you have concerns about the manner in which private health insurance is really being used to cross-subsidise ancillary benefits that lower incomes do not have any access to? It might not be something you have turned your mind to. I use my health insurance for ancillary purposes and I have never had a hospital admission, therefore any rebate I get is subsidising my consumption of those services. I can see that is unjustifiable and I am happy to lose my rebate so that it can be better targeted. What would be your position on that issue?

Mr Tobin—Like everything with private health insurance, there is some complexity here. One of the concerns we would have is if people who currently have an ancillary cover as part of their private health policy then drop that cover and seek to rely on the public system. Some of those people will presumably pay directly from their pockets and, obviously, at the higher end of the scale that is not something that we would be too upset by.

Senator PRATT—Yes. They would be self-insuring.

Mr Tobin—One concern obviously is this. Particularly in dental, where we have a very large public dental waiting list, if there are some—and there will be some—who are currently privately insured and who use their private health insurance to help gain dental treatment, they may end up on the public waiting list. That is a concern for us. It will not be all of them, but it will be some of them.

Senator PRATT—I would imagine that there would be instances where people have private health insurance but are nevertheless still on the public waiting list because they are pensioners or otherwise on quite low incomes. Frankly, they cannot afford the gap when they go to the dentist and they might simply be prioritising hospital cover and other forms of cover. Further to that—and it is slightly off the track, but it is something I struggle to grapple with in this inquiry and struggled with in the previous one—I am interested in the extent to which people with private health insurance use the public hospital system. I have absolutely no problem with them doing that, because people need to access it. But I want to know how much of a disincentive to using the private system the gap fee payments are. When we pay a 30 per cent rebate to people who use private health insurance, to some extent we are on that basis creating a higher subsidy for people who are higher incomes. In fact we are paying twice to those people because we are paying for them to use the public hospital system and we have also cross-subsidised health insurance that those on lower incomes are not using. In turn, that is subsidising people on higher incomes.

Mr Lavery—I understand in New South Wales that as many as a quarter of admissions into public hospitals state wide are reliant on private health insurance admission. Rather, 25 per cent of admissions hold private health insurance. Again, I am looking to my colleague to know if that number is accurate. We will correct the record if I have that 25 per cent wrong. It is certainly the case that there are some within private hospitals who would prefer that a public hospital not be able to accept someone holding private health insurance. The reason for that is that many public hospitals look to the privately insured to fill revenue shortfalls. Those people with private health insurance who go to a public hospital provide revenue that a state government then does not need to provide to a similar extent.

What I think the government should be commended for is the process it has established through the Health and Hospitals Reform Commission of looking at these very issues. I think it would be unfortunate if this particular inquiry concluded without recognising that there were a whole lot of problems in how we finance the Australian healthcare system that the Health and Hospitals Reform Commission is seeking to tackle. We are a very willing and supportive participant in that reform process. I think that is a matter that is appropriate to deal with in the context of the Health and Hospitals Reform Commission—just as dentistry has already had significant review through the Health and Hospitals Reform Commission. I look forward to the final report of that commission and in turn to the government's response to addressing some of these issues. We should not walk away from those issues, either. They are problematic. In the context of where I would encourage this inquiry to focus its attention—

Senator PRATT—That is not a question before us.

Mr Lavery—The focus of this inquiry should very much be on whether the modelling has been done correctly. Is it robust enough? If there are any subsequent impacts on the public hospital—and it is an if—what measures need to be put in place similar to those instructed last

time. When the changes to the Medicare levy surcharge were passed last time, the Council of Australian Governments agreed to undertake a review as to what impacts, if any, there were on public hospital workloads as a result of those changes. I think it would be, again, a very worthwhile recommendation of this inquiry, as the conclusion of your own work, to send to that review process established by COAG a request that it also watch for any impacts on public hospitals as a result of these changes. We do not need a new mechanism.

Senator PRATT—It may have impacts, but surely the question is whether those impacts are then matched by increasing capacity and funding for that capacity. Do you agree?

Mr Laverly—I am happy with that.

Mr Tobin—To add to Martin's answer I think the flows between public and private hospitals are also quite complex. Certainly some of our private hospitals see the public hospitals compete very hard to get private patients and that is an integral part of the funding mechanism. Whether that is to the cost of public patients having access to public hospitals is one of the issues that some of our private hospitals raise with us. At the same time, you cannot stop privately insured people from using public hospitals; they have paid their Medicare taxes and they are certainly entitled to access. Even as a private patient not all private hospitals offer the full range of services, so there are times when, if you want to be a private patient, the only place to get treatment is actually a public hospital.

Senator PRATT—In that context, I suppose, when a public hospital is looking to a private patient to use their private health insurance and questions, clearly not overtly, why they are there, it could be that someone has taken out that insurance largely to avoid paying the levy and it is not insurance they otherwise would have taken out because, for a whole range of other lifestyle reasons and financial constraints, it is not insurance they would prioritise then it is not really a fair question, is it?

Mr Laverly—You have raised the issue as to how the consumer has come to the decision as to whether they hold the insurance or pay the Medicare levy surcharge. I think if the budget has allowed \$60 million to fund additional staff at the Australian tax office it indicates that the implementation of this particular measure is going to add another layer of complexity. There is a role for the Australian government in making it simple for the health consumer. Ideally, you would not have to go to your tax agent to determine whether or not you have to pay the Medicare levy surcharge or hold private health insurance. If the tax office is going to need to employ hundreds of people to oversee the scheme, we are about to introduce another level of complexity. I think it is an important recommendation that this inquiry could make to do all it can to simplify how this measure is communicated and understood in the Australian community for the 10 million or so people who hold private health insurance or those who might otherwise be captured in those three income bands so that this is a readily understood measure because I do not mind admitting, as a consumer who falls within those income bands, it is confusing.

Senator XENOPHON—The Productivity Commission will be looking at a comparison between the private and public systems. Do you think that that would be useful in terms of seeing where the money is best spent or where there is an effective use of health funding in terms of outcomes?

Mr Lavery—We welcome any opportunity to review the operation of Australia's health system. The process the Productivity Commission is proceeding towards is going to be complicated by the absence of comparative data. I have a significant concern that the Productivity Commission, with the best of intentions, will not be in a position to make the comparison between public and private systems and indeed hospitals state by state and in different areas because of the absence of a common method in which data on those hospitals and public and private is kept and indeed because of the inherent differences between the way our public hospitals work in different states and territories. The Productivity Commission has its work cut out for it. Those of us who want to see that process succeed need to put some effort into finding the method by which we can actually undertake the exercise. I do not think that at the moment in Australia we have the baseline data, the information that we need, for that exercise to be as robust and successful as it otherwise could be.

Senator XENOPHON—Is that a fairly clear flaw: we just cannot do that like-for-like comparison between the two systems?

Mr Lavery—For the time being I think that is a risk that the Productivity Commission process faces. I would not want you to misinterpret that observation as saying we should not proceed with it; there is certainly a lack of comparable data in a robust enough shape to make this exercise something that I have 100 per cent confidence in.

Mr Tobin—The more you drill down when you look at hospital costings the more it becomes clear how definitions differ across hospitals, and not just public versus private. When you look at the public system and pick out particular procedures, particular DRGs—diagnosis related groups—different definitions are used, say, New South Wales and Victoria. At the individual procedure level the costs in New South Wales for some of those might be nearly double those in Victoria, which just seems to indicate that what is counted in one state is not counted in another state. What might be part of theatre costs in one state might be regarded as overheads in another. Even within jurisdictions themselves there are different definitions used by the different area health services. There are different definitions used quite often within the same hospitals. The exercise is certainly very worthwhile but we have quite a long way to go to get the sort of consistency that is going to give us a fine-grained analysis. Given the relationship that private hospitals have with health funds where they have activity based funding, for the most part they are well placed to know what their costs are. On the public side it is going to take quite a bit of time before we get some robust data. But I do certainly think it is a worthwhile initiative.

Senator XENOPHON—Apparently it has got further in terms of improving the data sets.

Mr Lavery—I will be cheeky and make this offer: we will throw our books open. That is the contribution that we can make. The transparency of the Australian health care system, the cost of a procedure in a public and a private hospital, is not something that Catholic hospitals are afraid of. It is in fact something that we would seek to have demonstrated in a transparent and robust manner. We can make that offer to the Productivity Commission, the Australian government and to anyone else for that matter. After all, our hospitals are not for profit. That means they are in essence owned by the communities they serve. That is why they exist. So we have no concern about contributing the knowledge, the access to the data, that we can find. But we do think that process has some major setbacks in the way that data is currently captured.

Senator XENOPHON—You refer to another issue of downgrading and people opting out of certain types of cover. Are you saying that the Treasury analysis does not adequately reflect that at this time?

Mr Lavery—The Treasury analysis has used a single purchasing price, if you like. It is assumed that every of the 10 million-plus Australians holds exactly the same type of health insurance policy and in turn when it comes for them to exercise their price decision making they are all operating off the same base. That is certainly not the case. It is likely that some consumers will drop out. Treasury suggested there would be a net decrease of 25,000. Others may remain insured but at a lower level—the base level—in order to avoid the Medicare levy surcharge. The impact of that is on the availability of insured funds in total, which then drives the cost of the private health insurance premium year on year.

Senator XENOPHON—You are saying that Treasury needs to do that type of differential analysis or more forensic modelling?

Mr Lavery—Or it should at least be fully transparent about the basis on which it has come to its calculations. We do not have that knowledge at the moment. We need to know if there will be a substantial downgrading—that is, if there will be a group of people who are currently privately insured who do not drop out but who decrease their premium, which then in turn means private health insurance funds have less revenue at their disposal to fund admissions in private and public hospitals.

Senator XENOPHON—And you think that is the key question that needs to be answered prior to the sort of policy changes being proposed in this legislation.

Mr Lavery—We have two questions for Treasury. The first is that we are uncertain about its adaptation of a price elasticity formula that assumes someone on \$75,000 will behave in the same manner as someone on several hundred thousand dollars. That just does not appear to be logical. Private health insurance as a product and its price is more relevant to someone on \$75,000 than to someone in a higher income band. That is the first issue.

CHAIR—Mr Lavery, I have found—we have it in our briefing papers—that Treasury tabled a document at Senate estimates last week. They talk about their methodologies and assumptions, and they estimate that price elasticity of demand is around 0.3. They said:

Most recently, in August 2008, an Access Economics report estimated a price elasticity of 0.335, but this applies to all income categories. There is evidence that price elasticities are lower at higher income levels, so a price elasticity of 0.2 was used for tier 1.

So they did differentiate it to that extent.

Mr Lavery—We have been made aware of the formula used, and in fact it concurs with the formula that Access Economics would use as well. What we question is whether or not it is appropriate to use the same formula for someone at \$75,000 as at \$85,000, \$95,000, \$105,000—

CHAIR—Oh, I see: it is not the level of elasticity; it is the formula used.

Mr Laverty—Correct. Indeed, I would be even less concerned at the higher income end of this discussion. I question whether or not someone on \$75,000 exercises the same decision-making power when it comes to purchasing a product as someone on \$100,000 or \$120,000. That is the range where we are asking Treasury to perhaps provide more detail as to whether or not a \$75,000 income earner has the same ability to purchase a product when its price increases by 14 per cent as someone at a higher mark. That is a question that we put back to Treasury and that we do not think has yet been answered.

Senator XENOPHON—Mr Laverty, can you confirm this: what proportion of those who have private health insurance or are covered by private health insurance are under the \$75,000 mark, in approximate terms?

Mr Laverty—I think that is a question for Treasury; it is not an answer that I have readily at my disposal.

Senator XENOPHON—Do you have that information handy?

Mr Laverty—Sorry, Senator; we do not.

Senator XENOPHON—Okay, thank you.

Senator CAMERON—Mr Laverty, I am reading Minister Roxon's second reading speech. In that speech, she indicates that the new arrangements are about making the private health rebate fairer. She says:

Firstly, singles earning \$75,000 or less and couples and families earning \$150,000 or less will receive the same rebate as they currently enjoy and will not be adversely affected.

Is that your understanding?

Mr Laverty—It is certainly our understanding. The principal question that we are still uncertain about is: when those income earners between \$75,000 and \$90,000, \$120,000 and so on face an increase in their cost of private health insurance as a result of the declining rebate accessible to them, does that put pressure on public hospitals and to what extent? What, if any, measures need to be taken to mitigate that particular pressure? There will be a pressure. The question that we hope to be able to answer to this inquiry by the end of this week is the extent of that pressure, and that is an uncertainty to us at the moment.

Senator CAMERON—In terms of the argument that there will be further pressure on the public health system, Professor Stephen Duckett from the Public Health Institute at La Trobe has cautioned the policy makers against buying that argument. He argues that the only substantial analysis that has been done has been the Canadian Health Services Research Foundation and they did not find this as a real issue. We get this constantly from the private health industry: you touch us and the public health system will either fall apart or it will not be able to manage with what is there. The rhetoric is really overblown in my view.

Mr Laverty—As a simple rule of thumb, for every 100,000 people who drop out or who cease to hold private health insurance, some 36,000 episodes of care have to happen somewhere.

They previously would have happened in a private hospital, so the consumer has contributed to their health fund and they are in essence contributing, with the help of the rebate, to the cost of their care. If 100,000 drop out, 36,000 people need to be treated in a public hospital. This measure then, if we accept as accurate at the moment Treasury's forecast that there is only predicted a net decline of some 25,000, is not an extraordinary burden on the public health system.

What we are seeking to do by our questioning around the method in which Treasury has modelled—have they used price elasticity formula, have they considered the consequence of downgrading sufficiently—is to test whether there are going to be more people dropping out of private health insurance, who then in turn join a public hospital queue. Is there then a method in place to ensure that public hospitals are in a position to meet potential increase in demand? And I have to apologise to this inquiry that this afternoon I cannot put my hand on my heart and say, 'This is the number that we agree with.' I have only been able point out that we have some doubts about the method in which Treasury has got to its calculation that there will be a net fall of 25, 000, and we do have some significant doubts about that.

I have also been very careful not to say that we actually oppose this piece of legislation. Rather, we have got a set of questions about it that we are seeking to work through. So on this occasion we are not part of the group of doomsayers that take the opportunity to say that the sky is about to fall in. Rather, there is a set of questions as we are seeking to work through.

Senator CAMERON—Something might drop from the sky and hit you.

Mr Laverly—You never know, Senator. I will let you know.

Mr Tobin—Just on public hospitals, one of the things that we do know is that the government has put a lot more money into shortening waiting lists through the public hospital system, and quite a bit of that money has gone into the private system from the state governments. That tells us a few things, but one of the things that it does say is that the public hospitals are pretty well at capacity in quite a number of areas so they do not need too much more extra demand put on them. Obviously if that happens there is capacity for public hospitals to buy services from the private sector, and I have no doubt that some of the state governments, if there were to be an increase in demand as a result of these changes, would be in touch with the Commonwealth.

Senator CAMERON—Mr Tobin, are you an economist?

Mr Tobin—I have had some economic training.

Senator CAMERON—I was just going to make the observation that when economists cannot get it right they have what they call 'elasticity'. Now they have got 'behavioural economics' to make it even more complicated and give them more wiggle room. We have had a lot of this during the day. We have had 'behavioural economics' and 'elasticity' and we have actually had the Health Industry Association saying, 'Forget all that. We will just do a survey and we will find out what people think.' What is it? What should we do? The Health Industry Association is saying, 'Forget all this modelling. We will just go and get someone to do a survey and they will tell us what the problem is.' I must say that I am not sure about either of these approaches.

Mr Tobin—I knew I should have seen you coming with the question and ducked a bit sooner. This is a pretty significant public policy change and I think that before we make it, or confirm it, we should be a lot more certain of what the impact is likely to be.

Mr Lavery—I will take you up on your question about what should be done. Given all of these uncertainties, if there is the risk of a greater impact on public hospitals, I would suspect that none of us in this room want, as a consequence of these changes, to see public hospital waiting lists grow any longer than they already are. None of us in this room, I am assuming, would want to see low-income earners, the disadvantaged and the marginalised who are most reliant on public hospital services, wait longer or, indeed, miss out because of these changes.

The Council of Australian Governments, I think very wisely, as a result of the budget changes last year put in place a monitoring mechanism, and I encourage very strongly that the committee recommend that that monitoring mechanism of COAG be expanded to look at the impacts of this particular measure. Then you will be in a position to be able to say to the doomsayers, 'There is nothing to worry about.' And, for those of us who still have these uncertainties, we will know that the Council of Australian Governments is looking at the impacts on public hospital waiting queues.

Senator PRATT—But to me it is blatantly—

Senator CAMERON—I do not have those uncertainties.

Senator PRATT—No.

Senator CAMERON—The last time when we were talking about the Medicare surcharge levy, it was not just the sky that was going to fall in; the planetary system was going to go off kilter. It was absolutely crazy rhetoric and none of that rhetoric has proved right. I do not put you in that basket, because you did see. I came here last time, and I am basing my analysis on the Treasury modelling and what is going to happen if the Treasury modelling goes ahead. But even then the public position is one of such doom and gloom from everyone, and you did concede last time that you do subsidise your public hospital from your private hospital system, so everyone has a vested interest in this.

Mr Lavery—The Treasury, as recently as last week in estimates, has reaffirmed that some half a million people are still expected to pull out of private health insurance as a result of last year's changes. That still leaves us with the expectation that some 180,000 people will join public hospital waiting lists as a result of that—if you accept the formula.

Senator CAMERON—What has been your experience in the private health area? It has increased—

Mr Lavery—It is underway.

CHAIR—I do think we are dwelling a bit on the inquiry we did last year. I do take it that it is relevant—

Senator CAMERON—It has absolute relevance.

CHAIR—I do not think we are going to get too much further here.

Senator PRATT—If the vast portion of people continue to, without subsidy, support themselves through private health insurance then surely that frees up that investment for the public health system. Provided that investment is redirected and that adequate moneys are there, the argument that there is going to be extra pressure on the public hospital system is overstated—provided that that money is offset towards the public hospital system.

Mr Lavery—The pressure on the public system will arise from those unable to continue to or those who make a decision to not hold private health insurance anymore. It is of that group that Treasury, on this occasion, has suggested the net decrease might be 25,000 or so. It is of that group that a proportion would be seeking to join public hospital waiting queues for their treatments. That is perhaps a summary of the case that I make to you today. Do we have confidence that there will only be a net drop of 25,000? Is that an accurate number? And, in turn, what will the flow-on be to the public system that has its greatest impact on the marginalised, the disadvantaged and low-income earners? We are not, today, satisfied that the process Treasury has used has been sufficiently transparent and robust enough for us to have confidence that we know what the number will be. That is the work we hope to have finished for you by the end of this week: to be able to say yes or no—that we agree with Treasury or we do not.

Senator CAMERON—In the last hearing—and this has got real relevance to the arguments we are hearing—Senator Joyce put it to you that for the payment of a small premium lower socio-economic groups had access to a higher standard of health care. You agreed with that. Could you take on notice—because I am sure you cannot do it right now—to give me some details of how a small premium actually provides a higher healthcare service if you go to private health funds. That is one of the issues that people will consider if they are going to drop out or not. I am not convinced that for a small premium you get any significantly higher healthcare benefit. That is why a lot of these people still use the public health system.

Mr Lavery—Happy to, Senator.

CHAIR—Thank you to Catholic Health Australia for coming in today. It has been very useful. Thank you to everyone who has participated, to *Hansard* and broadcasting and to the secretariat. The committee is adjourned until tomorrow at 8.30 am.

Committee adjourned at 4.05 pm