



COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

## SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

**Reference: Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009; Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009; Fairer Private Health Insurance Incentives Bill 2009; Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009**

TUESDAY, 14 JULY 2009

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**SENATE COMMUNITY AFFAIRS**

**LEGISLATION COMMITTEE**

**Tuesday, 14 July 2009**

**Members:** Senator Moore (*Chair*), Senator Siewert (*Deputy Chair*) and Senators Adams, Boyce, Carol Brown and Furner

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

**Senators in attendance:** Senators Boyce, Carol Brown, Cormann, Furner, Moore and Williams

**Terms of reference for the inquiry:**

To inquire into and report on:

Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009; Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009; Fairer Private Health Insurance Incentives Bill 2009; Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009



**Committee met at 8.29 am****LAVERTY, Mr Martin, Chief Executive Officer, Catholic Health Australia****TOBIN, Mr Patrick, Director, Policy, Catholic Health Australia**

**CHAIR (Senator Moore)**—Good morning everyone. I welcome back Catholic Health Australia. Thank you for making yourselves available this morning. We do appreciate it. We have a mixed day today. We are dealing with a few bills in the one day because of availability. This morning we are starting on the private health insurance incentives bills. Then we will move to NRAS for the rest of the day. You are very familiar with information on parliamentary privilege and the protection of witnesses. After your appearance before the Senate Standing Committee on Economics you sent us the Access Economics report which you mentioned. I invite you to make an opening statement and at the conclusion of your remarks we will move to questions.

**Mr Laverty**—Thank you for having us before the committee and on this topic for a second time. When we last appeared we expressed some uncertainties about our response to this legislation, and those uncertainties were represented on behalf of the 75 not-for-profit hospitals that exist within our network. Those 75 hospitals represent about 10 per cent of all hospital beds in Australia. Some of those hospitals are public; some of them are private; so we speak in a slightly unusual capacity in that we are represented in both the private sector and the public sector—quite proudly so—and have been for in excess of some 175 years. The work that we have been able to do since appearing before the committee that dealt with this issue previously—

**CHAIR**—The economics committee.

**Mr Laverty**—Thanks. The work that we have been able to do was to have our external advisers look at the Treasury estimates as to what the likely impacts of this legislation would be. Treasury has said that, as a result of the changes to the 30 per cent rebate, some 25,000 individuals are likely to withdraw from private health insurance. The estimate that Access Economics has provided to us is that that number is likely to be closer to 100,000.

Why is there a difference between the Treasury estimate and the estimate that we are putting forward as our evidence, given that both Treasury and Access Economics have used exactly the same data? It is a very simple explanation. Treasury is assuming that an income earner on \$75,000 a year has the same spending power as an income earner on some \$250,000 a year. Treasury has applied a price elasticity formula to someone on \$75,000 as it has to someone on \$250,000. If you think about that for a moment, it is assuming that, if there is a 10 per cent increase in the cost of private health insurance for someone on \$75,000, that would mean an average policy is going to be about \$2,000. That would represent 3.4 per cent of the take-home income of someone on \$75,000 as opposed to 1.2 per cent of the take-home income of someone on \$250,000.

I am not an economist, but I am going to propose to the senators before me that someone on \$75,000 does not have the same spending capacity as someone on a quarter of a million dollars. That is, in essence, how we have come to a different outcome using the same data as Treasury has to determine that it is possible that upwards of 100,000 people may drop their private health insurance as a consequence of these changes against Treasury's estimate of some 25,000 people.

In that capacity, our own forecast is relatively conservative. The private health insurance association is actually estimating that some 240,000 people might drop their private health insurance. It has used an entirely different formula, market research, to come to that. But the evidence we are putting before you is that the Treasury estimate needs some scrutiny. This inquiry should ask itself: is it satisfied that someone on \$75,000 behaves in exactly the same way as someone on a quarter of a million dollars when it comes to making purchasing decisions around private health insurance? We are suggesting that you are likely to see some different behaviours at higher income levels compared to lower income levels and that these factors have not been properly considered by the Treasury.

The Treasury assessment also has not given consideration to what the second round of future impacts of these proposed changes might be. We have suggested that, even if you accept a Treasury assessment that only 25,000 people will drop out, that means there will be a decline in the pool of insured funds available to provide for private care and that, at some point in the future, the cost of a private health insurance product is likely to increase. If you have people dropping out, it means over time the cost of private health insurance is likely to increase. It has not been considered by Treasury in its work to date.

We are also just as concerned that a more likely consequence is that larger numbers of people will downgrade their product, that as the private health insurance product increases in cost a rational response of a consumer would be to downgrade the type of product that they have. That also reduces the total amount of

insured funds available. It is a cost pressure on the future cost of a premium for someone holding private health insurance. But it also raises the question of what happens when a consumer who has downgraded their product enters the health system for a procedure and unexpectedly sees that they now have a larger gap than they may have had previously. There has not been a significant consideration of the consequence of the downgrade of those who hold insurance on the prevalence of gaps. Are we likely to see, as a consequence of this change, a modest or a large increase in the number of gaps that are paid because people have decided to downgrade their insurance product because private health insurance has become more expensive for them? They are uncertainties. I do not have specific forecasts to give to you, but I raise those questions as uncertainties at this time.

Access Economics has also led us to another factor which at the moment, in their words, 'might have a larger impact' on the number of people with private health insurance in Australia than these changes—that is, the potential impact of the economic downturn on those who hold private health insurance. Treasury has forecast that unemployment, which at the moment is somewhere around 5.5 per cent, is likely to rise to 8.5 per cent. Some commentators say that that forecast is a bit pessimistic. I am not able to comment on what unemployment is likely to reach, but I would suggest that if unemployment increases in any significant way it will be another pressure on the ability of an individual or a household to hold private health insurance.

What are the combined effects of the recession on the likely cost increase of private health insurance as a result of these charges? More people withdrawing from private health insurance suggests an increase on public hospital waiting lists. This is an argument familiar to this committee. It is an argument that we made previously, when changes to the Medicare levy surcharge were being considered last year. Treasury affirmed at that point, and it has reaffirmed this year, that some 490,000 people at some point in time are expected to forego their private health insurance as a result of changes in the Medicare levy surcharge. If you add those who are expected to let go of their private health insurance this time, we can estimate that some 216,000 people are likely to join public hospital queues as a consequence of last year's and this year's budget changes. If we are specific about the changes being considered by this inquiry, the Treasury estimate is that some 8,000 people will join public hospital waiting lists. Our estimate is that it is closer to 36,000—that if you accept our initial assumption that some 100,000 people will forego private health insurance that is likely to mean 36,000 people joining public hospital waiting queues. That is our principal concern.

There has been some discussion around whether our forecasts are accurate, whether the private health insurance association's forecasts are accurate and whether Treasury's forecasts are accurate. I would like to put that aside and say that in the last year the waiting time on public hospital waiting lists around Australia has grown by about six per cent. The average hospital waiting time in Australia has grown from 32 days to 34 days. Within that environment, whether Treasury is right or whether Access Economics is right, any pressure on public hospital waiting lists is an unwanted one, and why would we be taking a risk without putting in place a safety net, a monitoring mechanism or a compensation arrangement to ensure that those public hospital waiting lists are not increased? That is the principal concern that I put before this inquiry. Because we have a foot both in private hospitals and in public hospitals and because the mission imperative of Catholic hospital services in Australia is ultimately for low-income earners, for those poor and marginalised, any pressure on public hospital waiting lists is not something that we would be comfortable with.

I am grateful for the opportunity to make those opening remarks, and of course as usual we welcome scrutiny of our views.

**CHAIR**—Mr Tobin, do you have anything to add at this stage?

**Mr Tobin**—No, I am happy to go to questions.

**Senator CORMANN**—Did you see this measure coming?

**Mr Laverty**—No. If I can speak on behalf of the CEOs who work within our hospitals, they took quite seriously the commitment that was made by the government prior to its election and that was repeated since the election that the 30 per cent rebate was not to be considered or revised—it was not to be reformed in this term of government. So the CEOs in our hospitals were somewhat surprised when this measure came in. Within that, the CEOs of our hospitals have also made capital expenditure decisions and budget forecasts, long-term forecasts, around there being no substantial change to the rebate within this term of government. It did come as a surprise in that context. In making business decisions, planning decisions were made around commitments that were given by the government not to visit the 30 per cent rebate during this term of government.

**Senator CORMANN**—Last year we had the changes to the Medicare levy surcharge. This year we have the changes to the rebate. Are you worried about what might be in next year's budget?

**Mr Laverty**—We recognise that the budget position has changed dramatically in the last 12 months, and it is appropriate within that context that government gives consideration to its expenditure. The case we have made repeatedly is that key to the efficiency and the easy ability to access the public health system is a strong and robust group within the Australian community of those who hold private health insurance. We believe in a strong balance between private health insurance and access to public services. In fact, we would say a key to the current ability of public hospitals to perform their job correctly is to have a strong pool of people with private health insurance. It takes the pressure off the public system. Anything that downgrades or changes the balance between those who hold private insurance and those who do not is going to impact public hospital waiting times around Australia.

**Senator CORMANN**—Treasury, and the government in its budget estimates, still expects about 492,000 fewer people to be in private health as a result of last year's measure. You estimate up to 100,000 fewer people as a result of this year's measure and you come to the conclusion that this means some 216,000 extra admissions to public hospitals. Can you talk us through the methodology or your thought processes for how you get to that 216,000 extra admissions?

**Mr Laverty**—The experience of Treasury, the Department of Health and Ageing and Access Economics, and our own experience, is that for every 100,000 people in Australia there will be on average 36,000 or 37,000 separations per 100,000 people. So, if 100,000 people who previously held private health insurance would have received their treatment in the private system, you can make the assumption that that same group are going to need treatment somewhere, but because they do not hold private health insurance anymore it would have to be in the public sector. The very simple maths, which is the assessment of the Treasury, the Department of Health and Ageing and Access Economics—

**Senator CORMANN**—So it is 36,000 times six, essentially?

**Mr Laverty**—Pretty much.

**Senator CORMANN**—The government has told us that they expected about 25,000 people to leave. But the real impact, as you have said in your opening statement, is that the most rational response is to downgrade your cover, go for a cheaper policy. There are two things you can do to make your policy cheaper. One is to increase your out-of-pocket expenses, and you have touched on that. The other is to exclude services like orthopaedics, cardiac et cetera. What happens to those who downgrade and exclude services from their cover?

**Mr Laverty**—They are the people who join the public hospital waiting queue. There will be a group in the community who still hold private health insurance but have made a decision as a result of these changes to downgrade the type of cover that they hold. They then, perhaps unfortunately, find that a procedure that they require is not covered by the insurance product that they actually hold. They have two choices—they pay for that out of their own pocket or, more likely, they join a public hospital waiting queue. In their assessments, Treasury and Access Economics have not assessed the impact of those who will downgrade their insurance to a lower type of product and who will not have all of the previous cover that they had but will still need to receive treatment. They will be a group of people who will join public hospital waiting queues in numbers that we are not able to assess.

**Senator CORMANN**—For the people in the top two tiers, those who are hit both with a reduction in their rebate and an increase in the Medicare levy surcharge, the most rational response, if they want to avoid the impact of the increase, is to go for a cheaper policy. Treasury has not made an assumption around that at all, so, really, it is fair to say that the Treasury modelling underestimates the ultimate impact on public hospitals, isn't it?

**Mr Laverty**—That is the evidence that we have presented. I would say of our own assessments that we are only able to use the data that Treasury has made available. Using that data, the only opportunity we have had to scrutinise their numbers is around the level of price elasticity that Treasury has applied, and that does not give consideration to this much larger prospect of downgrading and what it means for out-of-pocket costs. I think it is quite important to consider that we are likely to see more consumers complaining about the out-of-pocket costs or the gaps that they are likely to pay. We have not been able to assess what that impact will be and Treasury has not been able to assess what that impact will be. It is an uncertainty, and in that context we would ask: if it is that uncertain, should we support this particular measure?

**Senator CORMANN**—Do you think that Treasury should do some more work on the basis of a scenario where the effects of downgrading cover are taken into account and where perhaps those second-round effects are taken into account?

**Mr Lavery**—I would welcome a further scrutiny of Treasury's work on the forecast that it has made public. I also want to indicate that I have received a letter from the Department of Health and Ageing within the last fortnight inviting our participation in a workgroup that has the name 'private health insurance rebate tiers implementation group', or words to that effect.

**CHAIR**—That is extraordinarily catchy!

**Mr Lavery**—That group was extending an invitation to a number of participants in this particular debate to move to the implementation stage of these measures.

**Senator CORMANN**—It is a bit premature, isn't it?

**Mr Lavery**—There are two observations that I would make. Firstly, the Senate has not passed this measure and yet the department is moving to implementation.

**Senator CORMANN**—It is a very confident government.

**Mr Lavery**—I should commend the department for anticipating the likely decision of the Senate, but perhaps that group could undertake some further scrutiny and some further work on these forecasts.

**Senator CORMANN**—I am very short of time. I do not mean to cut you short. One of the witnesses before our inquiry has suggested that the private health insurance rebate was bad policy because it had not taken pressure off public hospitals and because it had shifted professional staff resources away from public hospitals to private hospitals. Given your role across both public and private hospitals, you are probably in a unique position to comment on the extent to which private hospitals have absorbed a large part of the growth in demand in recent years.

**Mr Tobin**—The AIHW in its latest report clearly sets out the respective rates of increase of separations in the public and private sectors. Certainly, separations in public acute hospitals between 1998-1999 and 2000-2008 have increased by 23 per cent in public hospitals and 66.9 per cent in private hospitals. That in itself demonstrates that the demand for health care overall is increasing. It is going to increase a lot more. The private sector has been taking a much increased proportion of that increased demand, and anything that might impact on the ability of the private sector to continue to do that is going to be a problem for the public sector.

**Senator CORMANN**—When you released your Access Economics report, one of your comments was:

Our experience is that changes to private health insurance have their biggest impact on public patients.

Can you give us a bit more detail around that? That is quite a strong statement, so I am interested in a bit of context around that.

**Mr Lavery**—The average waiting time for elective surgery in a public hospital today is 34 days. That has grown at six-and-a-bit per cent in the last 12 months. Despite the very good efforts of the Commonwealth and the constructive work of state and territory governments around the country it is still the case that public hospital services are patchy, struggling and pressured. Within that context we have a network of private hospitals around the country that have the ability to relieve the load on the public sector. If you look to Queensland, where the average hospital waiting time is 27 days, well below the national average of 34 days, Queensland Health is adequately utilising the infrastructure of the private hospital system. It runs a terrific scheme called Surgery Connect, where on a regular basis public patients are transferred to the private sector to have their procedures, recognising that private hospitals are just as capable as public hospitals in providing the same quality of care with efficiency and with an ability to lessen the load on the public system. I, as an administrator or an overseer of 75 hospitals around the country—public and private—do not see the difference between them. I see them as hospitals—places that provide care and treatment to Australians. I think it is time we changed our attitude around how we define them. We should not be just defining our hospitals by how we finance them, by their inputs—public financing and private financing. I see them as hospitals. They are all capable of providing quality treatment and care.

**Mr Tobin**—Senator, could I add to a previous point you raised about a previous witness saying that resources will follow if there is a shift from public to private and vice versa. It is true that a lot more resources have gone to the private sector as a proportion in recent years. That is mainly because of the increase in contributions—the increase in the number of people covered by private insurance—made to the system. If there is a shift back to the public system from the private system I do not think you could automatically

assume that resources will follow. What will have to happen is that if resources are to move then the financing will have to increase, which means that there will be an increased burden on the tax system. I do not think it is quite as glib as that witness indicated.

**Senator FURNER**—As you have indicated, Treasury has used a different modelling process than Access Economics. They use the tax micro-simulation model. I think that is one of the relevant questions we will need to ask them this afternoon: how that differs to the modelling of Access Economics. However, Access Economics indicate that the downgrading will also reduce the effect on the rebate expenditure. Are you able to comment on what they inferred in the report based on that?

**Mr Tobin**—Access Economics accept the premise of using the micro-simulation model. One of our issues is that Treasury appear, on the public information available, to have based their assumptions on there being an average private health insurance product when in fact what Access Economics have done is develop a number of scenarios of different reasons for which people have private health insurance. If you are going to be accurate in working out what might happen you need to look at the reasons why different groups of people hold private health insurance and then analyse their responses by the different income tiers. That is one aspect that we would certainly like to develop with Treasury. I think downgrading is the big black hole. It is certainly difficult for organisations such as ours to know what the full composition of the privately insured is in terms of the different products that they have, but if you are going to make changes to the rebates and to the underpinning incentives to have private health insurance I think we need to get some more information on the public record so that all of the groups can have a look at what sorts of decisions people might make based on the levels of cover and motivations that they have.

**Senator FURNER**—The assumption has been drawn that there will be downgrading, but there could possibly be downgrading currently as a result of the global financial crisis as well, couldn't there?

**Mr Tobin**—Yes.

**Mr Laverty**—We are very comfortable to say, and to take Access Economics' advice, that the global economic downturn may in fact have a much larger consequence than these measures being considered today. Within that context it would be important to consider, if you are going to have a decline in private health insurance because of the economic environment and you then create another pressure, what measures we have in place by way of a safety net for the public system. The evidence that we have put to you is really quite simple: we are uncertain.

We have some advice from Treasury that there might be a 25,000-person decline in private health insurance. Access Economics says it is 100,000. Overlay that with a global economic crisis and I think we can all agree there is likely to be a substantial downgrade in the number of people who hold private health insurance. Within that context, what measures are we putting in place to ensure that there is not a significant burden on the public sector around Australia so that we do not have a continuing trend of an increase in waiting times for public elective surgery, given that in the last 12 months it has increased by 6.5 per cent, which is a trend up and a trend that we do not welcome?

**Senator FURNER**—Really, there is no evidence to demonstrate that there is downgrading currently or that there is to be in the future. In fact, a number of the submissions that we have received, submissions from Mr Wells, Mr McAuley and also Dr Deeble, indicate there is a strong likelihood that that will not happen. In fact, they draw the assumption in a number of fields that the 130,000 people who will be caught up in the new surcharge will certainly compensate to some extent people who might possibly join private health insurance as well.

**Mr Tobin**—One of the issues with that is that people who are motivated by the surcharge are more likely to go for the lowest cost policies. Obviously there will be some people who will join private health insurance who are not currently insured. But they are not necessarily going to take out the full comprehensive policy, so the impact of those new members will be less, perhaps, than the impact of people who have full comprehensive policies leaving private health insurance. The other observation I would make is that, from our perspective, across the two systems there is a lot of interdependence and fine balance between public and private health sectors. If you do make some significant changes in one then that is going to have an impact on both, and that is certainly something that we see in our sector.

**Senator FURNER**—Those other submitters who I just quoted also inferred that there is a strong likelihood that people will not drop their private health insurance. They based that on the fact that it is probably the last

type of insurance that people, looking at their budgets, will stop, because they do not believe that it is worth the gamble to drop your health insurance to gamble with your health or your family at that particular point.

**Mr Laverty**—That is perhaps illustrated by the number of people on incomes of less than \$26,000 who hold private health insurance. I will be corrected if I am wrong but I understand—

**Senator FURNER**—They are not affected by it.

**Mr Laverty**—I understand, but a million people who have an income of less than \$26,000 hold private health insurance, indicating that a number of people within the community, regardless of their income, even those who have modest incomes, value private health insurance. There is no question that there will be a group within the community that are going to hold on to it no matter what happens. I think it is very important for the national health system that we have a group in the community that are so committed to contribute to their own health care, which in turn takes pressure off the public sector.

The evidence that we put before this inquiry acknowledging the contributions of the submitters that you refer to, and they are commentators that I have great respect for, is that we are uncertain. There are a number of factors that lead us to an uncertainty as to what the impact of these changes is going to be on the public sector in Australia. We are just as concerned about the global economic downturn as we are about the potential of those who will downgrade or forego their private health insurance because of this particular measure. With that uncertainty, we certainly think that there is an opportunity for the Treasury to better disclose the workings and the forecasts that it has made to date and that government considers, as it did in response to the Medicare levy surcharge changes of last year, a commitment, perhaps through the Council of Australian Governments, to monitoring the ongoing impact of these changes on public hospital waiting lists. That commitment was made, I think very wisely, last year as a result of the Medicare levy surcharge changes.

We are looking for a similar commitment this time around. If the government is certain that the impacts we are suggesting are not going to come to pass, it is no skin off anyone's nose if we put in place a monitoring and compensation system for that. That would be our quite specific recommendation to this inquiry. Do not trust us—if you like, scrutinise our numbers and do not trust us—but put in place a long-term system to check if there are these impacts on the public hospital waiting times that we are suggesting.

**Senator FURNER**—Are you referring to the commitment COAG made for \$64 billion in the next five years?

**Mr Laverty**—No. At the time that commitment was made there was specific reference to monitor the impact to the Medicare levy surcharges. That \$64 billion dollars that was contributed—the Commonwealth government and state and territory governments deserve a pat on the back for that—is money overdue, but it was not money that was committed in relation to the Medicare levy surcharge changes—

**Senator FURNER**—No, I realise that.

**Mr Laverty**—and it was not money committed in relation to these changes. What we are suggesting is that there be a commitment to monitor these impacts, as the commitment was made last time. If it requires a compensatory measure through the health care agreements to the states and territories, that should be considered.

**CHAIR**—Thank you, Mr Laverty. Both Senator Boyce and Senator Cormann have questions on notice for you.

**Senator BOYCE**—Just getting back to the subject of uncertainty, we received evidence in Melbourne that there was no way of knowing, given the changes that have gone through, whether the industry is looking at an incremental dismantling of the private health insurance system and the effect that it is having on planning and investment into the future. Would you be able to comment on notice on the effect of this on Catholic Health Australia?

**Mr Laverty**—I am happy to do so.

**Senator CORMANN**—You mentioned that for every 100,000 people there are fewer people in private health insurance—there would be about 36,000 additional public hospital admissions. I am interested in any sort of authoritative material around that. You quoted Treasury and Access Economics. The second question is about whether there is an equivalent figure for every 100,000 people who downgraded their cover—whether there is an estimate as to what that would mean in terms of additional public hospital admissions.

**Mr Laverty**—I will take that on notice.

**CHAIR**—Thank you very much, Mr Lavery and Mr Tobin. If there is anything else you wish to add in terms of the process, please let us know. You are a regular correspondent.

**Mr Lavery**—Thank you for having us.

**Proceedings suspended from 9.02 am to 3.14 pm**

**COLES, Mr Tony, Manager, Individuals Tax Unit, Department of the Treasury**

**MONTEFIORE GARDNER, Mr Rob, Manager, Health Policy Unit, Department of the Treasury**

**O'CONNOR, Mr Mark John, Principal Adviser, Personal and Retirement Income Division, Revenue Group, Department of the Treasury**

**ROBINSON, Mr Marty, Manager, Household Modelling and Analysis Unit, Department of the Treasury**

**CHAIR**—The committee will now resume its inquiry into the provisions of the Fairer Private Health Insurance Incentives Bill 2009 and related bills. I welcome officials from Treasury. I know that we do not often have officials from Treasury before the community affairs committee, so you are very welcome. I take it you are very experienced witnesses, so you would understand parliamentary privilege in the protection of witnesses and also that as public servants you are not required to answer questions on policy. Senators may still try and ask them, but you do not have to answer questions on policy, just on the role that you have taken in the process.

I understand that your opening statement to the Senate Economics Legislation Committee on 9 June 2009—before the reference for this inquiry was transferred to this committee—remains as your opening statement, and I ask that those comments be incorporated into this committee's *Hansard*.

*The statement read as follows—*

I would like to take this opportunity to make some opening remarks regarding the provisions introduced by the fairer private health insurance bills and the impact they will have on the population with private health insurance. I have colleagues from our fiscal group to answer any policy questions and colleagues from our tax analysis division to assist with any issues relating to costings and the revenue estimates.

From 1 July 2010 the government will introduce three new private health insurance tiers to rebalance its range of policies supporting private health insurance. Spending on the private health insurance rebate is growing quickly and is projected to double as a proportion of health expenditure by 2046-47. The introduction of the new tiers by these bills will generate savings that increase over time. Tier 1 will apply to singles with income for surcharge purposes of more than \$75,000 per annum and families with income for surcharge purposes of more than \$150,000 per annum based on current projections. Those individuals and families who hold private health insurance policies that attract the rebate will have their private health insurance rebate reduced by 10 percentage points. The Medicare levy surcharge will remain at one per cent for those singles and families who do not hold appropriate private health insurance.

The second tier will apply to singles with income for surcharge purposes of more than \$90,000 per annum, and families with income for surcharge purposes of more than \$180,000 per annum who hold a complying private health insurance policy will have their private health insurance rebate reduced by 20 percentage points. The Medicare levy surcharge for those singles and families will be increased by 0.25 percentage points for those singles and families who do not hold appropriate private health insurance.

The final tier, tier 3, will apply to singles with income for surcharge purposes of more than \$120,000 per annum and families with income for surcharge purposes of more than \$240,000 per annum who hold a complying private health insurance policy. Those people will no longer receive any private health insurance rebate. The Medicare levy surcharge for those people will be increased by 0.5 percentage points where those singles and families do not hold appropriate private health insurance.

The singles threshold will be indexed according to movements in the average weekly ordinary times earnings. The families' thresholds will double the singles threshold. In addition, family thresholds will be adjusted for families with more than one child, in the same manner as existing arrangements for Medicare levy surcharge—that is, increased by \$1,500 for each child after the first. These reforms will reduce the proportion of the rebate being provided to higher income earners.

Under current projections, by 2010-11 it is estimated that approximately 14 per cent of single tax-filers who have incomes above \$75,000 would receive about 28 per cent of the total private health insurance rebate paid to singles. Under the new reforms introduced via these bills, they will receive around 12 per cent. Similarly by 2010-11, it is estimated that approximately 12 per cent of coupled tax-filers who have incomes above \$150,000 would receive approximately 21 per cent of the total private health insurance rebate paid to couples. Under the new reforms, they will receive around nine per cent.

We at the Treasury estimate that means testing of the rebate will impact on around the top 23 per cent of private insured population, measured at single equivalent units by income level. It is estimated that around nine per cent of all single equivalent units fall into the first income tier, around 7 per cent in the second income tier and a further seven per cent in the top tier. People aged 65 or more make up around 12 per cent of privately insured single income equivalent units. But the proportion in that age group and impacted by the measure accounts for less than two per cent of the total.

The modelling we have undertaken suggests that the policy is expected to have very little impact on private health insurance coverage, with around 99.7 per cent of the private health insurance population estimated to retain their insurance. Overall, the measures introduced via these bills rebalances the support for private health insurance so that those with greater capacity to do so will pay a greater share of their private health insurance costs while continuing to provide the existing 30, 35 and 40 per cent rebates for those earning below the Medicare levy surcharge thresholds. This conforms with the concept of vertical equity in that those with a greater capacity to pay make a greater contribution.

**CHAIR**—That is, Mr O'Connor, the statement that you made in the private briefing to the economics committee. Is that right?

**Mr O'Connor**—That is correct. I thought we would do that rather than go through it again.

**CHAIR**—Sure. It would have taken a while, so that is fine. Do you wish to add anything at all at this stage, or shall we go straight into questions?

**Mr O'Connor**—No, that is fine. I think we will go to questions. I do note, as I said in my initial opening statement, that I have colleagues here from fiscal group and tax analysis to handle the revenue estimates and policy issues. Mr Coles and I are here to assist with the bills from a legislative perspective.

**CHAIR**—Thank you. Senator Cormann?

**Senator CORMANN**—Just to clarify: we are not supposed to ask officers questions about opinions in relation to policy but we are quite entitled to ask explanations of policy, as I understand it.

**CHAIR**—The background of policy and the political makeup, no; information or what the officers can control, yes.

**Senator CORMANN**—To start off, I would like to clarify something in relation to the three tiers. One comment that was made by Mr Robinson in the private briefing of the Senate economics committee was that people in the top tier would see a 30 per cent reduction in their private health insurance rebate. It is worded a bit differently in the explanatory memorandum, which talks about a 10 per cent reduction for tier 1 and a 20 per cent reduction for tier 2. For tier 3 it does not actually talk about a 30 per cent reduction but rather the abolition of the rebate altogether. It says that those in tier 3 'will no longer receive any private health insurance rebate'. Can you clarify which of the two it is?

**Mr Robinson**—Yes, Senator. People in the top tier would not be entitled to any rebate, and for the majority of those people who are currently under 65 it would be the full loss of the 30 per cent rebate; however, for people between 65 and 69 it would be the loss of 35 per cent rebate; and for those 70-plus it would be the loss of 40 per cent rebate.

**Senator CORMANN**—So people aged 65 to 69 and 70 and over would be hit harder than people under 65?

**Mr Robinson**—They would lose a larger percentage rebate than the 30 per cent; that is correct.

**Senator CORMANN**—So, by way of explanation of policy—and I am happy to take your guidance on this if you feel I am straying too far—what is the rationale behind that? It would have been logical, I would have thought, to make it 10 per cent, 20 per cent and 30 per cent, and then people over 65 and over 70 would have had a rebate reduction similar or equivalent to everybody else's. What is the rationale for abolishing it altogether for people in that third tier?

**Mr Coles**—I guess the policy rationale is a matter for government in the sense that those over the upper income threshold would not be entitled to the rebate. That is pretty much the rationale.

**Senator CORMANN**—If that is what it is, I am happy to take that on board. I guess I was wondering whether there was a logical reason brought up by Treasury as this measure was being considered. What you are saying is that, essentially, the government decided to reduce the rebate by 10 per cent for tier 1 and by 20 per cent for tier 2 but abolish it altogether for tier 3.

**Mr Coles**—That is correct.

**Senator CORMANN**—Okay. I want to look at the numbers of people impacted. We discussed this in the economics committee private briefing and during Senate estimates as well, to a certain degree—and I am hopeful you have got some more numbers for us today. Your starting number is 9.7 million Australians with private hospital insurance?

**Mr Robinson**—That is correct; that is according to the latest Private Health Insurance Administration Council data.

**Senator CORMANN**—And you excluded from your modelling 1.4 million Australians with private health insurance, like those with general treatment cover, because you have no income data for them?

**Mr Robinson**—Senator, as I said at the budget estimates session when we discussed this, our view is that the majority of people with ancillary-only cover would be under the Medicare levy surcharge threshold. I say that just on the basis that people will generally make a decision whether or not to engage in private health insurance and it would not seem rational for someone to take out ancillary-only cover if they are in the income ranges above and pay the Medicare levy surcharge for not having complying hospital cover.

**Senator CORMANN**—Nevertheless, the health department did modelling which suggests that, out of 1.4 million people with ancillary cover, 5,000 people would drop general treatment cover. That is right, isn't it?

**Mr Robinson**—That is correct.

**Senator CORMANN**—And Treasury was not involved in that modelling whatsoever?

**Mr Robinson**—We were consulted in the context of that modelling.

**Senator CORMANN**—How did the figure of 5,000 people come up? What is the thinking? You say, 'We expect hardly anybody at all to leave.' The figure we are given is 5,000, 10,000 dropping ancillary out of combined hospital-ancillary cover and 25,000 overall. How did you get to the 5,000 figure? I understand the methodology that you used in relation to the hospital insurance side of things, but I am trying to understand the methodology around the ancillary side of things.

**Mr Robinson**—I think that is probably a question best directed at the department of health, given that they undertook the estimates.

**Senator CORMANN**—Fair enough.

**Mr O'Connor**—Mr Robinson gave evidence at the private hearing on 9 June, and, from memory—I just cannot find it in the *Hansard*—Mr Robinson said, 'In our view, the 5,000 is on the upper component.'

**Senator CORMANN**—Which is also consistent with what he said during Senate estimates.

**Mr O'Connor**—That is right.

**Senator CORMANN**—Yes, the 5,000 figure is there, and 5,000 seems like a small number out of 1.4 million—but we do not know how many of them are going to be hit with it. You say you do not think it will be many, and I understand the rationale as to why you think that, but we do not really know. You have essentially excluded them. Two-point-three million people out of those 9.7 million will see a reduction in rebate—we have now established—of between 10 per cent and 40 per cent, not between 10 per cent and 30 per cent. Do you have a state-by-state breakdown of that figure, of where those 2.3 million people are from?

**Mr Robinson**—No, we do not have a state breakdown for that.

**Senator CORMANN**—Why can't you have a state-by-state breakdown? It is based on your personal income tax microsimulation model. Does that model not allow you to identify it on a state-by-state basis?

**Mr Robinson**—I am not sure whether we have the state identifier on that data. We do not have every single item that is on the tax return as part of our model. So, for example, as part of the confidentialisation of the sample file that we receive from the Australian tax office, certain information such as address information of tax files is removed from the data.

**Senator CORMANN**—So you do not assess if there is a state-by-state variation in terms of the impact? For example, let us say in Western Australia private health insurance coverage is more than 50 per cent. In the ACT it is very high, I believe—I have not got the exact figure at hand. In other states it is much lower. So you do not actually assess whether there is a state-by-state variation in terms of impact?

**Mr Robinson**—We have not undertaken that analysis.

**Senator CORMANN**—Can you please take on notice whether it is data that is available. What I understand you have said is that you are not aware as to whether it is there or not. If it is possible to get a state and territory breakdown, I would very much appreciate it. In the private meeting, you mentioned that nine per cent were expected to come from the first income tier. Doing a back-of-an-envelope calculation, across 2.3 million that is 873,000 people. Does that nine per cent include people of all ages or only those under 65?

**Mr Robinson**—That is all ages.

**Senator CORMANN**—I thought as much. Then there is 70 per cent in the second income tier. For ease, I am just going through the numbers that I believe. If you think that they are incorrect, please—

**Mr Robinson**—I actually took this on notice from you at our budget estimates hearing, and I have got some figures I can give you now in terms of the breakdown of the tiers.

**Senator CORMANN**—That would be great, if you could.

**Mr Robinson**—We estimate, as you mentioned before, about 9.7 million being the total insured population. Of that, we estimate around 7.4 million, or around 76 per cent of the insured population, are under the threshold and therefore not impacted. We estimate about nine per cent, or 870,000 people, are in the first tier; 720,000, or seven per cent, are in tier 2; and around 690,000, or seven per cent, are in the remaining tier.

**Senator CORMANN**—You went through that very quickly.

**CHAIR**—Could you table those figures?

**Mr Robinson**—Yes.

**Senator CORMANN**—I went through the percentages in your private briefing, and I came up with 86 for tiers 1, 2 and 3. But I assume that tier 3 was broken up between those under 65, those aged 65 to 70 and those aged 70 and over. Is that right?

**Mr Robinson**—Sorry, the 86—

**Senator CORMANN**—In tier 1 and tier 2 there are reductions of 10 per cent and 20 per cent, whereas tier 3 has reductions of 30, 35 and 40 per cent. So I suspect that tier 3 has been split up into three different figures. Is that right?

**Mr Robinson**—That is correct.

**Senator CORMANN**—Can you give me the breakdown of tier 3? The figure given in the private briefing was seven per cent, but I assume that excludes people over the age of 65.

**Mr Robinson**—No, the seven per cent includes those over 65.

**Senator CORMANN**—The figures that were given were nine per cent in the first tier, 70 per cent in the second tier and seven per cent in the top tier. That totals 86, so we are missing another 14 per cent.

**CHAIR**—Are those figures correct?

**Mr Robinson**—Which figures are you referring to?

**Senator CORMANN**—I am happy to hand them to you. They are from a private briefing of the economics committee on 9 June. They were provided by Mr O'Connor in his opening statement, actually. If you were to review the opening statement you would see them in the second last paragraph before the chair starts talking.

**Mr Robinson**—We were saying in the opening statement that the means-testing of the rebate will impact on around the top 23 per cent of the privately insured population.

**Senator CORMANN**—That is the 2.3 million.

**Mr Robinson**—That is right. That is equivalent to nine per cent of the insured population in tier 1. Seven per cent—

**Senator CORMANN**—Seventy per cent in the second—

**Mr Robinson**—No, seven per cent in the second tier and seven in the third tier.

**Senator CORMANN**—The *Hansard* that I have says 70 per cent in the second income tier.

**CHAIR**—I am very relieved that it is actually seven, Mr Robinson. Even my math made 70 look a bit strange there.

**Senator CORMANN**—This is where I was getting confused. So you are saying: nine per cent, seven per cent and seven per cent. That is of the total insured population, presumably.

**Mr Robinson**—Of the privately insured population with hospital insurance.

**Senator CORMANN**—Of the 9.7 million. People aged 65 or more make up around 12 per cent of privately insured single income equivalent units. How many of those are in the third income tier?

**Mr Robinson**—Was that 70-plus?

**Senator CORMANN**—No, 65-plus.

**Mr Robinson**—About 50,000 people in the 65-plus group.

**Senator CORMANN**—Then the 70-plus age group is about—

**Mr Robinson**—We estimate it is around 20,000 people in the 65 to 69 group and about 30,000 in the 70-plus group, which is equivalent to around about half of one per cent of the total population with private hospital insurance.

**Senator CORMANN**—So where does the figure two per cent of those aged 70 or more come from? Two per cent of the privately insured population are 70 or older, are they?

**Mr Robinson**—That is two per cent of the privately insured population who are impacted by the rebate.

**Senator CORMANN**—Two per cent of the privately insured population who are impacted by the rebate is two per cent of 2.3 million, which is 46,000, isn't it?

**Mr Robinson**—If you are interested in those in the top tier, as I mentioned before, it comes to about 50,000, but that is the top tier. There are also people in the 65 to 69 year age group and the 70-plus age group in tiers 1 and 2 who are impacted. If you are referring to the two per cent we mentioned in our opening statement, it is less than two per cent of the total population with private hospital insurance, of 9.7 million. Less than two per cent of them are people who are 65 or older.

**Senator CORMANN**—But essentially there are 50,000 people over the age of 65 who are losing the rebate altogether and consequently will see a cost increase in their private health insurance of between 53.8 per cent and 66.7 per cent.

**Mr Robinson**—That is right, so around half of one per cent of the total population.

**Senator CORMANN**—We discussed the 2008 Medicare levy surcharge measure in estimates, and the evidence from both Treasury and the health department was that the estimated savings of \$740 million over the forward estimates had not been revised, that you still expected the savings to eventuate, which meant that you also still expected 492,000 fewer Australians to be in private health insurance as a result, because that is the way you achieve the savings.

**Mr Robinson**—The Department of Health and Ageing and the Department of Finance and Deregulation actually look after the expense measures and any adjustments to those estimates, through parameter or other variations, but I think I mentioned at the budget estimates sessions that, at the time, in the lead-up to the budget, when those parameter and other variations would normally occur, there was only one quarter of available information in relation to private health insurance coverage, being the December quarter data.

**Senator CORMANN**—Well, the December quarter was not even a full quarter. The December quarter was half a quarter.

**Mr Robinson**—That is correct.

**Senator CORMANN**—We have still only had one quarter, and that was pre rate change and pre first tax return. I was surprised to read statements in the private briefing that you see negligible impacts on overall private health insurance membership as a result of last year's measure, given the discussion we had that it was too early to really make that assessment. It is still too early to make that assessment, isn't it?

**Mr Robinson**—As I think I said at the private briefing, initial indications are that the first two quarters of available data have shown a small increase in private health cover. I think that is a fair statement to make.

**Senator CORMANN**—Growth is of course slowed, but did Treasury expect, when it modelled the impact of the Medicare levy surcharge, that the impact would be felt in the first half quarter or in the quarter after that, or was there an expectation that this would work its way through the system over a period of time?

**Mr Robinson**—When we undertook the estimates for the Medicare levy surcharge, we did not really take into account any sort of phase-in of people dropping their private health insurance. We assumed on a rational consumer type of basis that people might opt out immediately if they felt that the only reason that they were privately insured in the first place was to avoid the Medicare levy surcharge.

**Senator CORMANN**—It took a while for people to understand that they were hit by the surcharge and to take rational action as a result, so you would expect that it will not be from one day to the next that people will change their behaviour. The most likely time, surely—and I am sure we established it at the time—would be tax return time, wouldn't it, when people sit down with their accountant to assess what the impact of various policy changes will be on their income situation?

**Mr Robinson**—That is possibly the case.

**Senator CORMANN**—Can you just talk me through the assumptions in your modelling of price elasticity for those in the \$75,000 to \$240,000 per annum income bracket. Have you assumed the same price elasticity across there?

**Mr Robinson**—At our budget estimates session, we talked briefly about the methodology we had assumed. We consulted some of the academic literature about price elasticities on the basis of observed historical behaviour—of which there is not much evidence in the public arena. The evidence that we found indicated some estimates in the vicinity of about minus 0.3 as a price elasticity for private health insurance. That was some estimates undertaken on the basis of the introduction of the 30 per cent rebate, and it was on the basis of observed behaviour.

When we undertook our modelling, we felt, however—and I think there is also a generally accepted view from the literature—that higher income households are less price sensitive to health insurance and that in fact incomes are the main driver of people's decision to purchase private health insurance. On that basis, we made the decision to discount the assumed price elasticity for our modelling and assumed a price elasticity of minus 0.2. So, for example, for every 10 per cent increase in the price of health insurance for a consumer, we would assume about a two per cent drop in cover in the affected ranges.

Given that the government's announced policy was to also increase the Medicare levy surcharge at the time that the rebate was being withdrawn at different levels, amongst the top two tiers in particular, we also formed the view that, given that the percentage increase in cost for someone if they did not have complying private hospital cover would be roughly equivalent to their increase in premiums as a result of the withdrawal of the rebate in the second and third tiers, the number of people retaining private hospital insurance would be roughly the same in those two tiers.

**Senator CORMANN**—Did you make an in-and-out calculation? Did you make an assumption about how many people in and how many people out, or did you just say, 'We think it's about the same'?

**Mr Robinson**—We took the view that it would roughly balance out.

**Senator CORMANN**—So you did not make an in-and-out calculation?

**Mr Robinson**—The percentage increases in out-of-pocket costs we estimated to be about 29 per cent for people in tier 2 and about 25 per cent on average for at least the increase in the Medicare levy surcharge going from one to 1¼, and about a 43 per cent increase in out-of-pocket PHI and of course the Medicare levy surcharge going from one to 1½ per cent in the top tier. While there might be some movement in and out within those two tiers, we felt that there was going to be a roughly balancing effect and that the net overall effect within the two top tiers would be about the same.

**Senator CORMANN**—So there is a 25 per cent increase in the Medicare levy surcharge in tier 2 and a 50 per cent increase in tier 3. What is the dollar effect of that in those income brackets, because the increase in the stick is quite a bit more than the effect on the rebate, isn't it?

**Mr Robinson**—For someone in the top tier on \$120,000 as a single, for example, it would be equivalent to about a \$600 increase in the Medicare levy surcharge.

**Senator CORMANN**—So that would be the reduction given the estimates on average premiums that you have made for somebody in the top tier losing the 30 per cent rebate?

**Mr Robinson**—I do not have that figure with me.

**Senator CORMANN**—Do you remember what your average premium estimate was?

**Mr Robinson**—I think it was in the vicinity of about \$1,500.

**Senator CORMANN**—I think it was, so it is 30 per cent of that and so it is about \$450. Is that so?

**Mr Robinson**—Yes.

**Senator CORMANN**—Dr McAuley of the Centre for Policy Development has appeared as an expert before this committee from time to time. In fact, he supports what the government is trying to do, so he does not come from a critical perspective. But he says that the most rational response that anyone can make, given the way the rebate reduction and the increase in the Medicare levy surcharge are structured, is to go for a cheaper policy and downgrade their cover and drop ancillary cover. We have talked about ancillary cover, so we will leave that to one side. The government is assuming that there will not be any downgrading of cover, even though that is the only way you can avoid the increase in the cost of up to 66.7 per cent. It is a bit unrealistic, isn't it?

**Mr Robinson**—One of the key things here is that we do not really have any information available to us on the basis of academic literature, for example, that estimates any price elasticities or people downgrading their cover in relation to an increase in private hospital premiums.

**Senator CORMANN**—So you are not saying it will not happen; you are saying we did not really know what we could base any assumption on credibly so we decided that we were not going to include it in the model at all. Is that a fair summary of your thought processes?

**Mr Robinson**—I think it is fair to say that trying to estimate people's behavioural response to policy change is inherently difficult.

**Senator CORMANN**—But that is what actuaries do every day.

**Mr Robinson**—Sure, and I think people like to see evidence based on observed behaviour in the past. We do not have access to the industry data in terms of people's behaviour in response to things like premium increases. We only have what is available largely in the public domain.

**Senator CORMANN**—Did you ask for that?

**Mr Robinson**—That goes to the level of consultation in relation to a budget measure. It is a difficult position for us to go and consult with industry in the lead-up to the budget in relation to a budget measure.

**Senator CORMANN**—But it is fair to say that across the board—and I am quoting Dr McAuley because he cannot be accused of being an advocate for health funds or for privately insured people—there is a view that the most rational response to what is being proposed by the government is to go for a cheaper policy and downgrade your level of cover. Yet that is something that is not included in the modelling done by Treasury, so isn't it then fair to say that the conclusions that you have reached underestimate the impact of the measure on a range of variables including the number of people expected to leave and the impact on public hospitals in particular. Downgrading cover means an increasing number of exclusions going to higher front-end deductibles. When we talk about cheaper policies we talk about excluding orthopaedics or cardiac or mental health. That is how you reduce your level of premiums if that is what you want to do. Now that means you are underestimating the impact on public hospitals, aren't you?

**Mr Robinson**—I think it is difficult to quantify. There are going to be a number of factors which influence people's decision to retain the level of cover they currently have. It may be that, as a result of the policies, people do go and revisit the level of cover they have. But I think it is also fair to say that people will look at the level of cover they require for the needs that they have for private hospital cover. We also need to take into account that we are talking about the top quarter of the insured population being impacted. The whole basis of the government's policy is to withdraw assistance from those who have the capacity to pay for their private health insurance.

**Senator CORMANN**—When you say the top quarter are being impacted, what you are meaning to say is that the top quarter is being directly impacted. You have not modelled the second-round effects, for example, so you are only talking about the top quarter being directly impacted, aren't you?

**Mr Robinson**—That is right.

**Senator CORMANN**—Have you reviewed the Access Economics assessment of this measure that was commissioned by Catholic Health Australia? They estimate up to 100,000 fewer people in private hospital insurance as a result of this. Why the difference?

**Mr Robinson**—I think people from different areas will use different methodologies in undertaking their estimates.

**Senator CORMANN**—But they have used the same data and the same methodology, haven't they? Haven't they just changed some of the assumptions, in particular those in relation to the number of people downgrading cover? I see you have got some advice there, so maybe you can talk me through it.

**Mr Robinson**—I am not directly familiar with the Access Economics analysis, but my colleague has just passed me a statement in relation to that analysis. Access Economics state that in summary they have reached broadly the same conclusions regarding coverage as the Treasury based on a conceptually quite different scenario analysis.

**Senator CORMANN**—I accept that their conclusion is that up to 100,000 fewer Australians will be in private health insurance as a result. The health department has previously told us that, based on Ipsos data, about 35 per cent of people over a two-year period will require access to a hospital. So the estimate of 8,750

people all of a sudden becomes an estimate of 35,000 people. That is reasonably material, isn't it? I do not think that it is not materially different. I think it is quite materially different.

**Mr Robinson**—In broad terms we need to put that in perspective as a proportion of the entire insured population. Our estimate is that around a quarter of one per cent of people would potentially drop their private health insurance. On that basis that would suggest as to Access Economics—and I think they are acknowledging this in their analysis, and you are saying up to 100,000—that there is obviously some range in the estimate that they have undertaken. That is around one per cent. So what we are really talking about is a figure of a quarter to one per cent in terms of the total of people dropping their hospital cover.

**Senator CORMANN**—Can you put on record for me why, for measures like this, there is not any modelling of second-round effects given that obviously there are public policy implications from these sorts of measures that go beyond the immediate fiscal impact?

**Mr Robinson**—As I think we have mentioned on several occasions, when behavioural response is a key element of a policy and there is significant uncertainty in the first round, let alone the second round, it is standard practice, under our Charter of Budget Honesty guidelines, to not engage as to the second-round impacts of any policy.

**Senator CORMANN**—You say that yet you have sort of made assertions in the budget and these have been made in statements before this committee and during Senate estimates that spending on the rebate would double as a proportion of health expenditure within the next 40 years. For you to be able to make that assumption, and it was said in a private briefing of the economics committee, you have got to make assumptions on how premiums are going to develop over a 40-year period. You have got to make an assumption on how healthcare costs are going to track over that period. How can you make a comment like that without making assumptions as to second-, third- and fourth-round effects and as to a whole series of effects?

**Mr Montefiore Gardner**—The modelling that is in the IGR is of a different sort to the modelling that we do. It is a long-run projection. It takes how much is being spent by the government per person on private health insurance over the historical period and it projects that forward based solely on the growth rates that we see in historical data.

**Senator CORMANN**—But this data is used by the government as a justification for what it is doing. If it is good to use that figure on one side, why don't you look at these sorts of longer term impacts on the other side? Part of our argument is that this will have a negative medium- to long-term impact. You are talking about the long-term impact of one policy scenario but you are not modelling or giving a perspective on the medium- to long-term impact of a different scenario. I am not sure that is the most objective presentation of a forward-looking trend. Specifically in relation to the 40-year forecast, you are saying that the expenditure on the private health insurance rebate would double as a proportion of health expenditure over the next 40 years. That means, all other things being equal, the private contribution made by people who are privately insured would also double as a proportion of federal government health expenditure over the same period, doesn't it?

**Mr Montefiore Gardner**—I am not sure I quite understand the question.

**Senator CORMANN**—The 30 per cent rebate is just that—30 per cent of the contribution made to the private health system. There is the 30, 35 or 40 per cent, and then there is the 70, 65 or 60 per cent. If you expect the Commonwealth proportion to double over a 40-year period, that would be proportional to what you expect to be the total private health expenditure over that period, wouldn't it?

**Mr Montefiore Gardner**—The comparison is that the rebate is expected to double as a proportion of Commonwealth expenditure on health over the next 40 years.

**Senator CORMANN**—If the cost to the Commonwealth of the 30 per cent proportion of the private health funding pool is going to double then 70 per cent proportion is going to double as well, isn't it? It is not part of the Commonwealth expenditure, but if you take it as a figure and make it proportionate to Commonwealth expenditure over that same period it would have to double. It is absolutely basic maths. Surely if the 30 per cent proportion is going to double then the 70 per cent proportion of the same figure would have to double, if you compare it to the same overall expenditure item.

**Mr Montefiore Gardner**—That sounds correct.

**Senator CORMANN**—So essentially what you are doing is containing that proportion of the expense that is carried by the Commonwealth and forcing a larger proportion on those that continue to be privately insured. That is also correct, isn't it? The cost is not going to reduce. The cost is still going to have to be carried.

**Mr Montefiore Gardner**—That is correct. That was, in fact, the point of the measure—to ensure that those who had the capacity to pay paid a larger share of their private health insurance costs—

**Senator CORMANN**—You mean the private healthcare cost, because it is not just their private health insurance costs. In the private briefing you said you expect private health insurance premiums to increase to the extent that they will because of what you expect will happen to the cost of health care over that period, didn't you?

**Mr Montefiore Gardner**—It is a projection based on what has happened to the cost of private health insurance to the government over the last period.

**Senator CORMANN**—I go back to the statements that you made a couple of weeks ago—

**Mr Coles**—Perhaps we could clarify this with the press release put out by the Treasurer and Minister Roxon. The opening paragraph says:

The Government is rebalancing the suite of policies supporting private health insurance—so that those with a greater capacity to pay for their own private health insurance do so.

**Senator CORMANN**—I understand that. That is the government's stated objective. I am now going by the evidence provided at the private briefing, where the chair said:

... spending on the current private health insurance rebate is growing rapidly and is expected to double as a proportion of health expenditure within the next 40 years—

and she asked why. Essentially your answer was: 'Those projections are based on the methodologies that we use in the IGR, the Intergenerational report. It looks at the benefits paid out by age groups'—that is, benefits paid out, not health insurance costs. These are benefits paid out for health care. So there is an effect there from the ageing of the population. Obviously the benefits paid to people who are privately insured vary with age and tend to get larger as people age, so there is an impact there. There is also the effect of increasing costs in health. What we are essentially going to get as a result of this is that those who do decide to remain in private health will have to pay an ever-increasing proportion, whereas the Commonwealth proportion is going to be significantly contained. That is the effect of the measure, isn't it?

**Mr Montefiore Gardner**—No, that is not the effect of the measure. The effect of the measure is that those who are earning over the income limits will pay the whole cost of their private health insurance, if they choose to take it.

**Senator CORMANN**—No, sorry. Your statement here is that over the next 40 years, if the parliament does not change anything regarding the private health insurance rebate, the cost to the Commonwealth is going to double as a proportion of overall expenditure on health. That is what you have said, isn't it?

**Mr Montefiore Gardner**—Yes, that is right.

**Senator CORMANN**—Over 40 years. Now you are saying, 'We're proposing to change something, so it will not double.' Does that mean that you expect the cost of health care to increase by less?

**Mr Montefiore Gardner**—No.

**Senator CORMANN**—Exactly. So if the Commonwealth now is paying less than it would if you do not make this change, somebody will have to pay. Who is that going to be?

**Mr Montefiore Gardner**—The private citizens.

**Senator CORMANN**—Exactly. Essentially, looking at your figures, given what your expectation is as to what will happen to private health insurance premiums over the next 40 years, what you are essentially saying in those statements is that you expect significant additional increases in the private health insurance premiums because the proportion that the Commonwealth will pay is going to reduce significantly as a result of this measure. It is no longer going to double. Given the change that you have introduced, what do you now expect to be—

**CHAIR**—Senator Cormann, is this your last question?

**Senator CORMANN**—There is one more after that.

**CHAIR**—No, Senator Furner has a question and that will be the end of it.

**Senator CORMANN**—Maybe this could be taken on notice and then I will ask the one question I would like to ask.

**CHAIR**—Do you have that question clearly in terms of taking it on notice?

**Senator CORMANN**—The question on notice is: in 40 years if the parliament passes this measure what will be the expenditure on the private health insurance rebate as a proportion of overall health expenditure?

**Mr Montefiore Gardner**—Sure, I can take that on notice.

**CHAIR**—And this question will be on notice as well.

**Senator CORMANN**—Okay. My final question on notice is: what is your estimate of the cost of administration of the means testing of the private health insurance rebate?

**Senator FURNER**—If I take you to the Access Economics report, it certainly concurs that Treasury used, in their words:

... appropriate tool for forecasting the impact of the means-testing of the PHI rebate and the associated changes ...

I take it there is no way, in relation to when Treasury did what I think you referred to as micro—help me here; what is the modelling method?

**Mr Robinson**—Microsimulation modelling.

**Senator FURNER**—That is it. There is no way of ascertaining what a tax payer's income is when you do that modelling?

**Mr Robinson**—Do you mean in order to derive an estimate for the price elasticity? Sorry, you will have to elaborate.

**Senator FURNER**—Sorry—to ascertain the effect of the changes as a result of dropout, downgrades—I know you did not do any modelling on downgrades—and all the indications that witnesses have indicated will be a direct result of the outcomes.

**Mr Robinson**—The literature upon which we base our price sensitivity is not available by income level. As I mentioned earlier, the price elasticity of minus 0.3, which we subsequently discounted to minus 0.2, is basically a broad estimate of aggregate price sensitivity in the market. Where we do have the detail within our microsimulation model is in knowing how many taxpayers fall into each of the income gap categories, broken down by age group as well so that we can model the impact of the rebate for individual taxpayers on an aggregate average premium assumption.

**Senator FURNER**—Can you explain in some brief detail the difference between the 0.3 and the 0.2 elasticity in the result?

**Mr Robinson**—As I mentioned previously, the minus 0.3 is price elasticity which has been estimated on the basis of historical observed behaviour. It is a figure which appears in the literature. That basically means that, for example, for a 10 per cent increase in price you would assume about three per cent of the insured population would drop their private health insurance. The key thing is that, that being an aggregate, price elasticity is across the full private health insurance population. As I have mentioned previously, the government's policy impacts on about the top 23 per cent of people with private hospital insurance. We know as well that it is people's incomes which drive their decision for private health insurance and people on higher incomes are typically less sensitive to price changes in the insurance market. We discounted the assumed price elasticity from minus 0.3 to minus 0.2 on the basis of the view that price sensitivity is less at higher incomes.

**Senator FURNER**—Treasury also indicates that there will be 130,000 people captured by the new MLS and therefore the likelihood of balancing those that may drop out resulting in a lessening of the overall outcome and effects on PHI—

**Mr Robinson**—I will just qualify that number there. The 130,000 is the number of people in the top two tiers who are directly impacted by the higher Medicare levy surcharge. We estimate that there are around 310,000 Medicare levy surcharge payers altogether and the 180,000 in tier 1 will not be impacted by any increase in the Medicare levy surcharge.

**Senator FURNER**—But the effect will be in tiers 2 and 3 on 130,000—

**Mr Robinson**—That is correct.

**Senator FURNER**—and that is broken up into the numbers that you have indicated. I do understand that for tier 2 there will be an increase of 0.25 per cent and for tier 3, 0.5 per cent.

**Mr Robinson**—That is right.

**Senator FURNER**—A number of witnesses have indicated that the stick is not big enough to entice people to take up PHI. Do you have any comment on that?

**Mr Robinson**—As I mentioned previously, the percentage increases for people in those top two tiers are roughly commensurate with an average out-of-pocket cost on their private health insurance premium. For example, based on an average premium in the second tier it would relate to about a 29 per cent increase in private hospital cover whereas it is obviously going to be a 25 per cent increase in their Medicare levy surcharge, so in percentage terms they are very similar. The increase in out-of-pocket costs is about 43 per cent for someone in the top tier versus a 50 per cent increase in their Medicare levy surcharge.

**Senator FURNER**—A number of witnesses indicated that there will be a degree of downgrading, a dropping of ancillary matters and drop out as a result of these changes. Certainly, all of the witnesses from the various insurance groups were unable to identify the income of their members, because they just do not hold that data. I understand you have predicted that 8,000 will be tipped into the public hospital arena. I am wondering if you have a different point of view on what you have heard as a result of the inquiry so far.

**Mr Robinson**—The key thing there is, as I mentioned before, there is a lot of uncertainty. The private health insurers themselves do not, as you have mentioned, have income information for their members. There is no empirical evidence based on observed behaviour which estimates any price elasticity for people downgrading health cover. That is not to say that it will not happen, but, as I mentioned before, there are in the order of 20,000 health insurance products out there and the government's policy may induce people to reassess the policy they currently have. People retain their private health insurance for many different reasons. Peace of mind is one of the key reasons why people take out private health insurance. People will look at what sort of cover they need to achieve that peace of mind.

**Senator FURNER**—Some of the witnesses appear to support the government's proposals—Mr Wells, Mr McAuley and Dr Deeble. In particular Dr Deeble went to the extent of claiming that the proposal will result in costing a couple of cups of coffee. I am wondering whether you are able to comment on the assessments that have been made by those witnesses.

**CHAIR**—Mr Robinson, I do not think you can make—

**Mr Robinson**—No, I am probably not in a position to comment on the evidence given by other witnesses.

**CHAIR**—I do not think comparison with the price of coffee is something that Treasury has modelled, but you may want to put something on record about the amounts.

**Mr Robinson**—A couple of witnesses have also taken the view that people with private health insurance are not particularly sensitive to price change. They have also given evidence that they feel that the overall impact on private health insurance coverage will be quite minimal in the longer term.

**Senator BOYCE**—An issue that came up during our hearing in Melbourne was corporate purchased health insurance. I was hoping that you might be able to give me a sense of what percentage of the market this was and whether you took that into consideration in your assessment and modelling. The evidence we were given was that this area is likely to be decimated or cease to exist. I would like an assessment of how important you regard that to be to private health insurance viability.

**Mr Robinson**—We can take that on notice.

**CHAIR**—Thank you very much for your time and evidence. The secretariat will provide you with the specific questions taken on notice.

[4.09 pm]

**CALDER, Professor Rosemary, First Assistant Secretary, Acute Care Division, Division Executive, Department of Health and Ageing**

**ECCLES, Mr Richard, Acting Deputy Secretary, Departmental Executive, Department of Health and Ageing**

**SHAKESPEARE, Ms Penny, Assistant Secretary, Acute Care Division, Private Health Insurance Branch, Department of Health and Ageing**

**CHAIR**—Good afternoon. As experienced witnesses, you know about the protection of witnesses and evidence. As departmental officers you will not be asked to give opinions on matters of policy, though this does not preclude questions asking for explanations of policy or factual questions. Professor Calder, I understood you were not going to make a statement. Do you have an opening statement?

**Prof. Calder**—Because of some feedback from the earlier hearings, we have prepared a statement which really goes into how this operates. However, we could just hand it over, if that would be useful.

**CHAIR**—It would be better to table it. It may come up in Senator Cormann's questions anyway.

**Senator CORMANN**—The figure of 8,000 additional public hospital admissions has been mentioned and we touched on it during Senate estimates. I went back through the evidence, and it is an underestimate, isn't it? You said the methodology you used was based on Ipsos survey data that 35 per cent of people will require hospital treatment over a two-year period. Even just looking at that level, 35 per cent is 8,750 rather than 8,000. Why was it rounded down rather than rounded up, if it was going to be rounded at all?

**Ms Shakespeare**—It was just an estimate and I think the general figure was rounded to the thousand.

**Senator CORMANN**—The nearest thousand from 8,750 is 9,000. I am just trying to understand why 8,750 becomes 8,000. Anyway, I think I have made my point. We have heard from Treasury and you made the comment during estimates that the government did not expect any downgrading of cover. There is a slight difference between the evidence from the health department vis-a-vis the evidence from Treasury. Treasury say they have not made any assumptions on it because they did not have any reliable data, whereas your statement at estimates was a bit firmer. You essentially said the government did not expect any downgrading of cover. It is a bit different to say 'the government doesn't expect any downgrading' than to say 'we haven't got any basis on which we can assess it', so which one is it?

**The Ms Shakespeare**—We have had a look at it from the perspective of working out whether there is going to be significant downgrading. We do not think that there will be for a number of reasons. We have not just been looking at it in terms of: if we were to model it, what would the impact on the rebate be? I am happy to take you through again why we do not expect that there would be a significant downgrading.

**Senator CORMANN**—I am not sure that you did take us through it before. Everybody, including people that are very supportive of what the government is trying to do, is saying to us that the most rational response of anybody trying to avoid the increase in the cost of private health insurance as a result of this measure, given that there is also an increase in the Medicare levy surcharge, would be to go for a cheaper policy. Are you saying there is not going to be any of that?

**Ms Shakespeare**—When you look at the reasons why people take out private health insurance, by far the most significant reason that people give is that they want to buy private health insurance for protection, security, peace of mind. That comes from national health surveys. In the most recent data from 2007-08, 54 per cent of people gave that as the primary reason they took out private health insurance. If you are buying private health insurance for those reasons you are less likely to buy an exclusionary product, particularly in the circumstances where, if you are facing a cost increase, that is offset by significant tax cuts that by far exceed the increasing costs for most people in the affected tiers.

**Senator CORMANN**—I am not sure about what you describe as 'significant tax cuts', but let us leave that aside, because the measures are not related. There are people who are going to be facing increases in the cost of their health insurance of up to 66.7 per cent. I think that is now well established. You were expecting that some people would leave. It is actually less likely that people would leave than that people would downgrade, I would have thought, yet you are not expecting anybody to downgrade. Your evidence there is different from what Treasury tell us. They tell us they think it might happen, but they just do not have a basis on which to calculate how many people would or would not.

**Prof. Calder**—What we are saying is that we think, on the basis of a number of factors, that the impact of downgrading is not likely to be significant. We are not saying that we do not expect any downgrading.

**Senator CORMANN**—If it is not going to be significant, how much downgrading do you expect?

**Ms Shakespeare**—We have not worked out the number that we expect. It would be very difficult to tell if somebody did downgrade their insurance. People do downgrade. I think from the last Ipsos survey something like four per cent of people had downgraded their insurance from when they had first taken it out.

**Senator CORMANN**—People do it now, yes.

**Ms Shakespeare**—But that might be for other reasons.

**Senator CORMANN**—It is generally because the cost goes up and as part of your total budget it becomes—

**Ms Shakespeare**—Not necessarily. It is not just because cost goes up. People might reassess their health needs. We generally find, because these are the reasons people give for taking out health insurance, that people are purchasing insurance to suit their health needs and the health needs of their family.

**Senator CORMANN**—I have got to move on because I have not got that much time, but what we have established is that you think there will be some downgrading, although you do not think it will be significant. You have not put a figure to that. The way people downgrade is by increasing the number of exclusions or having high out-of-pockets. Increasing the number of exclusions means that those people would have to present at a public hospital, wouldn't they, if they needed access to hospital care?

**Ms Shakespeare**—If somebody buys an exclusionary product and they need the service that has been excluded, then they cannot have it covered by their private health insurance. It does not mean necessarily that they have to present at a public hospital. People do self-insure the costs at private hospitals on occasion.

**Senator CORMANN**—Gee, you are really going for the realistic scenarios, aren't you?

**Ms Shakespeare**—I am just setting out what the options are.

**Senator CORMANN**—So somebody is going to drop their cover because they are trying to avoid a price increase in their health insurance and, if they need access to a service, then you think that they are most likely to pay for the cost of the hospital service.

**Ms Shakespeare**—No, I did not say that they were most likely to.

**Senator CORMANN**—Do you know how much it costs to have open-heart surgery or to have a defibrillator installed?

**Prof. Calder**—Again, the evidence in the Ipsos survey and the National Health Survey is that people choose health insurance to match their health needs. On that basis, there is an expectation that any exclusionary policies would be related to health care they do not expect to use.

**Senator CORMANN**—We have gone through all of that. Given that I have not got much time, I am just going to go very quickly. On the cost of administration, how much has been allocated to the Department of Health and Ageing to administer the implementation of this measure and to manage the operation of means-testing the rebate moving forward?

**Ms Shakespeare**—One-point-nine million dollars over the forward estimates period.

**Senator CORMANN**—In the private briefing, you said that you did not anticipate significant additional administrative costs to insurers. There is the word 'significant' again. Can you tell us how much 'not significant' is expected to be?

**Ms Shakespeare**—What we mean by that is that the implementation of the incentives tiers has been designed in a way to minimise the impact in terms of administration costs on insurers. They will not have to collect income tax data or check income tax data. They will be able to rely on nominations made by their members. The administrative costs to insurers will be associated with making systems changes to allow them to recognise the additional rebate tiers. At the moment, they would need to be able to recognise four different levels of rebates. After these changes are introduced, they will need to recognise eight different levels of rebate. We have actually had a look back to see what happened last time we introduced additional rebate tiers that their systems needed to recognise, and that was again doubling from two to four, in 2005. For premium submissions made in that year no insurer mentioned additional administrative costs associated with the

introduction of the additional rebate as a reason for additional premium increases. In fact, management expense ratios decreased.

**Senator CORMANN**—You are now answering a question I have not asked yet, because you are anticipating what you think I might ask down the track. The question that I asked specifically was: what is your assessment of what constitutes ‘not significant’ in terms of an additional administrative cost for health funds? Have you costed it? Is there any modelling?

**Ms Shakespeare**—No.

**Prof. Calder**—We do not have an estimate. We have an expectation.

**Senator CORMANN**—But that is a sort of ‘gut feel’ expectation.

**Prof. Calder**—Based on previous experience.

**Senator CORMANN**—Well, we have not had an experience like this before.

**Prof. Shakespeare**—We have, when we introduced two additional rebate tiers in 2005.

**Senator CORMANN**—How many are there now—eight? Have you costed how much of an increase there was at the time?

**Prof. Calder**—Previously it was a doubling of the existing tiers. This is a doubling.

**Senator CORMANN**—Quickly going back to the downgrading, Treasury said that they did not have any basis on which to make an assessment. I meant to ask them but I will ask you and I will put it on notice for them: is this going to be something that you track moving forward? Your expectation is that there will not be significant downgrading, but will you track the impact of this policy on people downgrading their level of cover?

**Prof. Shakespeare**—We do track exclusionary policies. There is PHIAC data available. We already track what is happening there.

**Senator CORMANN**—You have set up a meeting for 23 July with stakeholders to start organising the implementation of this measure. Given that this is only due to come into effect on 1 July 2010 and the parliament has not actually made a decision yet on the measure, is it not a bit premature to move on implementation now?

**Prof. Calder**—It is to start the conversation about implementation, not to move into implementation—to understand their issues.

**Senator CORMANN**—Yes, but you are moving to implement something. The government implements what parliament decides. The parliament has not decided anything yet, and you are trying to implement something that has not gone through parliament yet, a year out from when it is supposed to be coming into effect, even if it is passed by parliament. There are some issues there, aren't there?

**Prof. Calder**—Can I correct: we are not trying to implement; we are starting a conversation with the stakeholders about the issues that will be raised if this moves to implementation so that we can anticipate some of those and do some forward thinking.

**CHAIR**—Is this a standard practice, Professor?

**Prof. Calder**—Yes.

**Senator CORMANN**—Is this a standard practice?

**CHAIR**—It is a standard practice in planning in your organisation.

**Prof. Calder**—It is, to work with stakeholder advisory groups about implementation planning, yes.

**Senator CORMANN**—The thing is, I would have thought that there would have been some consultation to identify issues before the measure is introduced. You are now essentially identifying issues after it has been introduced. Should we then wait before finalising this before we know what sort of issues will come out of your process between July and October 2009? How can we make a decision on this if we do not know what the issues are going to be that you will identify between July and October 2009?

**Prof. Calder**—As I said, this is to start a conversation with the stakeholders who are involved in this.

**Senator CORMANN**—The additional COAG funding for public hospitals has been mentioned in the private briefing. That was to deal with demand pressures. They were already in the system, weren't they? That was certainly committed well before this measure was introduced, wasn't it?

**Prof. Calder**—Yes.

**Senator CORMANN**—I will finish on this, Madam Chair. To enable you to clarify some comments that were made by you, Professor Calder, in relation to the 40,000 people modifying insurance, you said in the private briefing that 40,000 people ‘modifying’ insurance meant taking out cheaper cover. That is not quite right, is it? It is 25,000 people dropping hospital and general treatment cover, 10,000 people dropping general treatment cover from their joint hospital and general treatment cover and 5,000 people dropping general treatment cover who have only that cover. That is right, isn’t it?

**Prof. Calder**—From memory I think that is correct.

**Senator CORMANN**—Reading the *Hansard* of the private briefing, if somebody was to work on that basis, the way it was written was that modifying the insurance of those 40,000 people meant taking out cheaper cover. I want to clarify for the record that that is not the case.

**Prof. Calder**—Yes, that is correct.

**Senator FURNER**—Firstly, I would like to explore the point that certainly Senator Cormann has been consistent with—the 66.7 per cent increase. I would like to know from your point of view who that particular group is and what the dollar amount represents. It is fine presenting percentages, but I would like to get some understanding from your point of view of what that dollar amount is and who it represents.

**Ms Shakespeare**—The 67 per cent would be the increase in cost experienced by a person who was aged 70 or more and who was in tier 3, so as a single earning more than \$120,000 a year or a family earning more than \$240,000 a year. At the moment the average policy cost for a single is \$1,667. A person who is aged 70 or over at the moment would be paying \$1,000 and the government rebate would be funding \$667 of the policy cost on an annual basis. After these changes are implemented that person would no longer receive any rebate, so they would be paying an extra \$667 a year for their policy. That is a 67 per cent increase on what they were paying before, which was \$1,000 a year. That would be the most extreme example of somebody affected by these changes.

According to PHIAC data, at the moment there are about nine per cent of people receiving the 40 per cent rebate and of that nine per cent a much smaller proportion would actually be earning more than \$120,000 a year and be a single or more than \$240,000 a year and be a couple or a family. Most people aged over 70 are either retired or not working full time.

**Senator FURNER**—Is that nine per cent of policyholders or nine per cent of persons on that particular income?

**Ms Shakespeare**—Nine per cent of people receiving rebates.

**Senator CORMANN**—Treasury told us that 30,000 would be over 70 and losing the rebate altogether.

**Ms Shakespeare**—But that is people in all income ranges aged over 70 receiving the 40 per cent rebate. A much smaller proportion of that nine per cent would be in tier 3.

**Senator FURNER**—Half of the issue identified by the insurance firms is that they do not keep data on the income of their policyholders. It is extremely difficult to get a conclusion on those sorts of results.

**Ms Shakespeare**—That is right. It is quite difficult to match up data on private health insurance membership, whether it is collected by insurers or by PHIAC, and the Treasury income data.

**Senator CORMANN**—Treasury have done exactly that. That is what they have told us before.

**Senator FURNER**—In respect of downgrading and exiting altogether PHI, certainly throughout the inquiry people have raised that as an issue and made the observation that that will have impacts on funds, but in some cases conversely this will mean a reduction in claims and a possible reduction in premiums as a result of fewer people making claims or having access to hospitals or whatever the case might be as a result of those circumstances. Is there any way to ascertain what that impact might be—and I know it is difficult because there certainly has not been any modelling that I am aware of on downgrading? I am wondering whether you can provide us with some information on what the result might be on funds if it were the case that people downgraded their cover or exited from funds.

**Ms Shakespeare**—It is very difficult to work out, first of all, the impact on funds. As you say, if someone does take out an exclusionary policy then, while that will result in less premium income to the fund, if that person requires services the fund will not pay for them so there should also be a decrease in outlays for the fund. If people take out a policy with a higher excess or a higher copayment, the individual will be

contributing more to the costs of their medical treatment if they then use their private health insurance when they do need medical treatment.

It is also very difficult to work out what the impact would be on public hospitals because everybody who is eligible for Medicare is entitled to be treated as a public patient in a public hospital whether or not they have private health insurance and whether or not they have comprehensive private health insurance. It would be quite difficult for us to tell if somebody were presenting to a public hospital because this measure had resulted in them taking out a product with an exclusion or whether they would have decided to be treated as a public patient anyway.

**Senator FURNER**—We do not have any data on PHI policyholders using the public hospital system; is that data just not available?

**Ms Shakespeare**—I do not have any reliable data about that. People are not required to identify whether or not they have private health insurance when they present at a public hospital, either at an emergency department or as an admitted patient.

**Senator FURNER**—There was some evidence given and the scenario was put that people with private health insurance accessing public hospitals were still obliged to pay, in some cases, emergency fees as a result of gaining access to the hospitals. Are you familiar with any policies that provide 100 per cent coverage on any fees, using that type of example?

**Ms Shakespeare**—For a private emergency department?

**Senator FURNER**—That is right.

**Ms Shakespeare**—No. There is difficulty with funds actually covering costs. They are not able to cover non-admitted medical costs, so funds are not permitted to actually cover all of those costs. They can cover facility fee charges and some other costs but there are prohibitions under the Health Insurance Act for covering the medical fees there.

**Senator FURNER**—The notion of 130,000 people being caught up in the new Medicare levy surcharge and that balancing out or sustaining towards a lessening of the impact of the changes—have you got a position on how that will affect the outcomes?

**Ms Shakespeare**—We know that, according to the Treasury modelling, there are 130,000 people who do not currently have private health insurance who will experience an increase in the Medicare levy surcharge that they have to pay. We have not modelled that a proportion of those people would take out private health insurance, because it is difficult to model their behaviour. If they were going to take out private health insurance because of the Medicare levy surcharge, you would assume that they would have done that already, but for some people the increase that they will experience in the surcharge might be enough to tip them over into private health insurance.

**Senator FURNER**—Some witness indicated that the stick was not big enough. Should the stick have been greater to get them into PHI, or do you think that we have struck the right balance?

**CHAIR**—Ms Shakespeare, you do not have to answer that question.

**Prof. Calder**—We cannot express an opinion on that.

**Senator BOYCE**—I want to follow up from some of the questions that Senator Cormann was asking about the consultation process that is now underway. We have quite a bit of evidence suggesting that the insurance bodies are very concerned and confused as to what is going to happen. Did I understand you to say before, Ms Shakespeare, that people who have insurance policies will have to nominate their income to their private health insurers?

**Ms Shakespeare**—No. The opposite is the case. They will not have to nominate their income to their private health insurer or to Medicare. The reconciliation, if people have underestimated or overestimated their income in nominating a rebate that they want to receive as an upfront premium deduction, will occur through the tax office and through tax returns. So the only people that will be receiving income tax information are the tax office.

**Senator BOYCE**—What will then happen if people have overclaimed their rebate?

**Ms Shakespeare**—Then there will be a tax debt that they will need to pay through their income tax return.

**Senator BOYCE**—This would not have been a very normal situation in the past. There have not been a lot of people who have needed to do that, have there?

**Ms Shakespeare**—It is a similar approach, I suppose, as has been used with other government payments, such as family tax benefit.

**Senator BOYCE**—Which we have just simplified so that it does not have to happen at all, presumably. Your meetings are with the tax office, the Department of Health and Ageing and private health insurers. Is that correct?

**Ms Shakespeare**—We have had quite a range of meetings. We have had bilateral meetings with private health insurers, private health insurance associations, brokers, consumer groups and hospital groups. We have also had public information sessions about the legislation to explain the detail to people and how it would be implemented at a high level. We have held those in different cities around the country.

The implementation working group, which we are now setting up to meet on 23 July, again, includes representatives of a range of people. Insurer groups have been nominated and some particular insurers have been asked to provide representatives; actuaries; brokers, again; the Consumers Health Forum; and the Private Health Insurance Ombudsman.

**Senator BOYCE**—And the ATO?

**Prof. Calder**—The ATO attended the public information sessions and provided advice on how it will work.

**Ms Shakespeare**—The ATO and Medicare Australia will also be attending the implementation working groups.

**CHAIR**—Thank you. There are a couple of questions on notice. We will just check with the secretariat. We do appreciate your time.

[4.36 pm]

**KINGDON, Mr Antony Charles, First Assistant Secretary, Medical Benefits Division, Department of Health and Ageing**

**LEARMONTH, Mr David Andrew, Deputy Secretary, Department of Health and Ageing**

**ROBERTSON, Ms Samantha, Assistant Secretary, Medical Benefits Division, Medicare Benefits Branch, Department of Health and Ageing**

**CHAIR**—Welcome to the department officers who are looking after the Medicare safety net. As experienced witnesses you understand issues around parliamentary privilege and protection of witnesses and evidence. As departmental officers you will not be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions about how and when policies were adopted. You are all experienced, so you know how it works. I invite you to make an opening statement.

**Mr Learmonth**—It is much shorter than it might otherwise have been, as I busily hacked out paragraphs.

**CHAIR**—If you would like to make an opening statement then we will go to questions. Do we have a submission from you this time?

**Mr Learmonth**—It is coming. I did want to take a very short amount of time and give a little bit of background and get a few facts on the record this time.

**CHAIR**—Certainly. That is excellent.

**Mr Learmonth**—Just briefly, for a bit of background and context, the Medicare safety net was introduced in 2004 to make medical services more affordable for all Australians, particularly those with complex health needs, for families and others with high healthcare needs. It was meant to reduce the number of people with extraordinarily high out-of-pocket costs for out-of-hospital services and to assist people with conditions such as cancer and chronic disease. But in doing that there was also an inherent risk that the government could end up paying for excessive increases in fees charged by some doctors. In fact, this possibility was first mooted in the inquiry of the Senate Select Committee on Medicare that reviewed the policy in 2003.

The independent review which came out of that inquiry was conducted by the Centre for Health Economics Research and Evaluation, or CHERE. The report was tabled in both houses of parliament in May this year. Broadly, it found that the safety net had been of general benefit in many respects. It found that the number of patients with very high out-of-pocket costs reduced substantially after the safety net was introduced. It found that out-of-pocket costs for cancer patients and so on were reduced. It also found that, broadly, in many areas, such as GP attendances, specialist attendances, the safety net did not contribute materially to medical inflation. Importantly, though, the review found that more than 50 per cent of total expenditure under the safety net was being directed to just two specialty areas, obstetrics and assisted reproductive technology.

Between 2003 and 2008, fees charged by obstetricians for in-hospital services reduced by six per cent. Fees charged for out-of-hospital services increased by 267 per cent. Fees charged for assisted reproductive technology, or ART, provided in hospital fell by nine per cent over that period. Fees charged for out-of-hospital services increased by 62 per cent. The review found that, with most of the benefits flowing to services that are used more often by wealthier sections of the community, the extended Medicare safety net may, to a significant extent, be helping wealthier people to afford even more high-cost services.

The review gave an estimate that, for every dollar spent on the safety net in 2008, providers received 43c in the form of higher fees and patients got 57c to reduce their out-of-pocket costs, but for some items this split was as high as 78c to the provider and 22c for the patient. The CHERE review found that the biggest risk to the program is where the doctor knows that the patient has already met the safety net threshold or they will meet it during some point in the episode of care, and that particularly includes things like ART and obstetrics.

Since the introduction of the safety net, expenditure has grown significantly, with a 30 per cent increase between 2007 and 2008 to \$414 million. In 2008, 30 per cent of safety net expenditure was spent on private obstetric services and 25 per cent on ART. To give you an idea of some of the relativities, in one year, between 2007 and 2008, the number of ART cycles, IVF cycles, increased by about six per cent. MBS funding increased by 27 per cent. Benefits paid through the safety net for that period increased by 45 per cent. Between 2005 and 2008, the average fee charged for Medicare services by the top 100 obstetricians increased by about \$400,000 each, to \$1.8 million each. The MBS benefits, including the safety net, for the same group increased

by a quarter of a million dollars, to \$1.1 million. On the IVF side of things, again between 2005 and 2008, the average fee charged for Medicare services for the top 10 per cent of IVF specialists increased by \$1.7 million each, to about \$5.9 million each. This includes an MBS benefit increase of about \$1.3 million, to \$4.5 million each.

So, while there is broad benefit being achieved by the safety net in some areas, it is fuelling significant growth in fees, costs to the taxpayer and, in some cases, costs to the patient. As a consequence and to maintain the integrity of the policy and to ensure it remains sustainable, the government took the decision to introduce caps which will directly impact on those services where some doctors are taking advantage of the policy. This bill will allow the minister to set a maximum limit on the amount of safety net benefits payable for an MBS item. In terms of the individual caps that are being proposed, cataract surgery, varicose vein treatment and injection-into-the-eye items have been chosen because the review found that, with high out-of-pocket cost for items such as these, for every dollar paid in safety net benefits 78c was spent on fee increases rather than reducing patient out-of-pocket costs. Hair transplantation, for the treatment of alopecia, is identified as one of the top items for safety net spend per service. Just to give you an idea of what this is like, Medicare data shows that in some cases the fee charged for this item is in excess of \$10,000, with a scheduled fee of \$437. So capping safety net benefits for this select group of items will help improve the sustainability of the safety net and, more importantly, the safety net will remain intact to provide assistance for those who need it more broadly.

**CHAIR**—Mr Kingdon or Ms Robertson, do you want to add anything at this stage?

**Ms Robertson**—No, thank you.

**CHAIR**—Before I go to Senator Boyce, I will just check: have you seen the Australian Medical Association submission?

**Ms Robertson**—No.

**Senator BOYCE**—When do you intend to provide that statement?

**Mr Learmonth**—We have a submission which will come very shortly—something more complete.

**Senator BOYCE**—The data is intense; it is very difficult.

**Mr Learmonth**—It is.

**Senator BOYCE**—I gave up taking notes after the third or fourth incremental change. We received evidence in Melbourne suggesting that it is not simply doctors putting up fees that could be seen as responsible for the increase in costs to consumers, particularly in the area of ART. There are a lot of other players—we were told there are nine or 10 technologists and other health practitioners, and the technology itself—the processing itself—was also a cost involved. Can you tell me about assessment of those costs?

**CHAIR**—Mr Learmonth, we received that evidence on the IVF process. That is the area that we are talking to.

**Mr Learmonth**—Sure. A general proposition I have heard is that some of these relate to practice costs—and I would say a couple of other things. One is that these kinds of practices are not alone in being, in some cases, fairly capital intensive in terms of technology. We have not seen anything like those increases in other specialties. I am sorry to give you a couple of other stats, but when you talk about fees having increased by 267 per cent for obstetrics, or even 62 per cent, over a relatively short period you cannot reasonably accept that this is all about practice costs and not simply fee income.

**Senator BOYCE**—You have separated out the technology costs as something that other areas bear. You also have, I think, fairly large human resource costs as well—that was noted. Did you assess those?

**Mr Learmonth**—We do not necessarily know what the individual costs are for each of these things or the individual cost components and so on. We know what fees are charged as a by-product of paying Medicare claims.

**Senator BOYCE**—I think that without some data I do not have any other questions.

**CHAIR**—Senator Furner.

**Senator FURNER**—Reflecting on evidence provided in Melbourne, there was talk about changes to technology. You would think that, in general terms, when new technology comes in there is in some cases a reduction in fees as a result of those changes. However, that is not the case in your field.

**Mr Learmonth**—It is hard to know in some ways. Certainly there are other specialty domains which are very capital intensive such as pathology and radiology, and we have not seen anything like those increases. They are also subject to technology refreshment cycles and so on.

**Senator BOYCE**—What sorts of increases have you seen in those areas? I am just trying to get some sort of comparative information.

**Mr Learmonth**—We will see if we can get that for you, but they are comparatively very small. Our submission is nearly ready, so, in light of some of today's questions, we might add to and supplement it to provide you with some further information on some of these things.

**Senator FURNER**—In respect of the CHERE report, I am wondering whether you are in a position to give us some indication of its benchmark use in the CPI—as against other submitters, who have indicated that there should be something different.

**Ms Robertson**—Such as?

**Senator FURNER**—Some indicate that it should be based on wage price indexes or average earnings.

**Ms Robertson**—There are many different indicators out there. Medicare benefits rebates are indexed annually by a different index altogether that is generally less than CPI.

**CHAIR**—In their evidence today and on Friday, the AMA indicated that they had great difficulty with the background of the CHERE report. Evidence we heard in Perth—which I know you have not seen because we do not yet have the *Hansard*—went into some comparisons with CHERE and with the increase in the standard Medicare cost. The committee was benefited by having a number of graphs presented to it on Friday which showed that the increase in the standard Medicare rebate to a doctor has gone up by a level which has been greatly outstripped by the costs. The argument was drawn that the response to the medical practices has not been great. Also, I would really appreciate you having a look at the AMA submission to see the issues raised about how this was done from the perspective of the AMA and see if you can respond to the argument. Senator Boyce and Senator Furner touched on it. One of the key things mentioned was:

CHERE has assumed that Medicare data on medical fees charged for certain MBS items in 2003 is an accurate representation of the actual fees charged by doctors at that time and has compared those fees to 2007.

The evidence we had in Melbourne on Thursday said that, particularly in ART, certain costs were not included in the fees in 2003 and have been rolled into 2007 to give quite a false view of the increase. That was one of the particular issues raised. Also, it went on about the aspects around the costs of delivering services and, in particular, the technologies. ART is the only specialist area that has given evidence to our committee, but we are aware of the others that you mentioned in your opening statement that have also been looked at and, after you, we will be hearing evidence from a group that is going to look particularly at those things. Particularly in the ART, there was a feeling that the government had taken their advice from the CHERE report earlier this year. They feel that that did not include effective consultation with medical groups or practices to see these differences discussed at that time.

**Mr Learmonth**—There are a couple of things there, Senator. There is a broad notion that there is a technology driver here which is particular to one or both of these obstetrics or ART items. As I said, there are many other domains which are technology dependent and some which are not. Broadly, nothing has experienced the fee increases that these two have. The real thing that distinguishes these two is that they are known, planned events—the cycle of care, the whole obstetrics issue of planning pregnancy and delivery and of ART cycles. They are quite predictable in that sense and they are amenable to using the safety net in such a way as to support higher fees, more so than many other things. That is one of the things that very clearly distinguishes them, and I am not sure that technology does in any particular way. We will have a look at the issues that the AMA has raised and we will respond to them in our submission.

The other thing to note in terms of consultation is that, whilst the CHERE report certainly was very data driven, there has been consultation with the professional at the AMA and with the National Association of Specialist Obstetricians and Gynaecologists for some years about the safety net. There have been regular management meetings with the AMA. That was where these progressive increases have been discussed, where our concern about the level of the rises has been exposed with some evidence. There has been some discussion. There were, I think, undertakings for expressions of restraint, so at the end of the day some of the issues about fee increases and opportunities to take issue with their reasonableness, or their apparent unreasonableness, have existed in consultations over the last couple of years between us and the AMA and some of the craft groups.

**CHAIR**—That is with the obstetricians and gynaecologists?

**Mr Learmonth**—And the AMA.

**CHAIR**—And how about the IVF and assisted reproductive technology groups?

**Mr Learmonth**—The IVF specialists are within that same organisation—NASOG, the national association.

**CHAIR**—So you have not had separate discussions with them?

**Mr Learmonth**—They are part of that group. They are represented by the group.

**CHAIR**—Okay. What about the other groups that you mentioned in your opening statement, Mr Learmonth—the varicose veins and the hair—

**Mr Learmonth**—Not specifically with those craft groups, to my knowledge. The AMA is an overarching body.

**CHAIR**—So you had discussions with the AMA rather than with those particular craft groups?

**Mr Learmonth**—Yes.

**Senator BOYCE**—Some of the private hospital associations are suggesting that bookings for obstetrics procedures are falling off as a result of the uncertainty around this legislation. What does the department know about that?

**Ms Robertson**—We have no evidence of that, Senator.

**Senator BOYCE**—Would you expect them to have if it were the case?

**Ms Robertson**—You would have to presume that in that case there was not an excess supply. My understanding is that it is quite competitive to get into some of the private hospital birthing suites.

**Senator BOYCE**—You would expect if it were quite competitive that the fees charged would be quite competitive too.

**CHAIR**—Dr Learmonth, are you aware whether the fees in these areas are publicly advertised? My understanding is that there is a wide range. That is the proposition that the government has put forward—that there is a wide range of fees. The information we have is that you have taken what is always difficult to take, an average; averages always create difficulties. In obstetrics and gynaecology including the IVF area, are the fees publicised so that people know what they are getting into before they go into it?

**Mr Learmonth**—I think the answer is mixed. I am not aware of the extent to which individual obstetricians might publicise their fees. I know that some of the IVF clinics have fee schedules on their websites. In fact, I was reading a media report just before which was centred on the lucrateness of the IVF industry last year and large private equity groups such as ABN AMRO buying into IVF clinics. Reference was made in that media report to the fees charged being on their websites. I take it from that that some would.

**CHAIR**—What about the other craft groups to which you referred? I often ask about public knowledge of fees charged.

**Mr Learmonth**—I think it is mixed. In terms of individual specialists, they would probably tend not necessarily to publicise their fees. My impression is, and Ms Robertson might know better, that some specialists, in particular some operators within some specialties, operate fairly large corporate practices, such as Melbourne IVF and various eye centres specialising in cataract and other corrective surgery, which tend to have fairly sophisticated websites, patient interaction, financial counselling and those sorts of things and which may well publicise their fees.

**CHAIR**—In its submission, the AMA has two specific recommendations about the future of the process. One is that the bill be amended to include an additional provision that requires the minister to consult with the relevant medical groups before making any change. That is so that, if we are looking at changing or instating a cap, there is a clear process of consultation beforehand and that the caps actually reflect the industry needs. The other one is: ‘The AMA recommends the bill be amended to include a requirement for government to commission an independent evaluation of the impact of this measure and the associated determination by January 12 and for the report to be tabled in parliament as soon as it is completed.’ Do you have any comment on those two recommendations?

**Mr Learmonth**—I would need to consult with the minister on her view about these things. In terms of the initial commentary, as I said—and I stand to be corrected—there has been significant consultation with the

profession in relation to at least some of these craft groups and with the AMA overall. In fact, I believe the notion of capping some of these items came out of some of that consultation.

**CHAIR**—What about the idea of an independent evaluation of the impact of the measure? I know that every measure has an automatic review process, but my understanding of this is that it would be more than that, using consultants to have a look at the overall impact and to table a report in parliament.

**Mr Learmonth**—Yes, in a similar way to what has been done. Again, I would need to take a policy direction from the minister, and one of the questions I would ask would be about the time frame. Given that it is a calendar year for the safety net to operate, there is some lag in terms of data being received, and then you need time to do a study. Something that reported in that time frame might well only have one year of data to collect. In providing advice to the minister and seeking her policy direction, I would give some thought to that, for example.

**CHAIR**—The other suggestion that came from the Melbourne evidence was that, in the discussions that the minister and the department have leading up to a determination about a cap or changing a cap, they could use the Medicare Benefits Advisory Committee, which is already engaged in the whole process of Medicare costing and fees. I was wondering whether that has been discussed.

**Mr Learmonth**—I do not know whether it has been discussed. There is an obvious tension there between the objectives of the relevant groups. However, there will be a number of ways in which it might be appropriate for the department to take advice on this. If that proposition is put forward, we will seek some direction from the minister on it.

**CHAIR**—That will be in the *Hansard* of our meeting on Thursday in Melbourne. Can we have any indication of when your submission in response to those things would be available?

**Mr Learmonth**—As soon as possible. We will now need to review the AMA evidence.

**CHAIR**—We are due to report on 6 August.

**Mr Learmonth**—It will be well before that.

**CHAIR**—Thank you very much.

[5.01 pm]

**PESCE, Dr Andrew, President, Australian Medical Association**

**HENSHAW, Dr Richard, Chairman, IVF Directors Group of Australia and New Zealand**

**MOLLOY, Dr David, Deputy Chairman, IVF Directors Group of Australia and New Zealand**

**JOYCE, Dr Hilary, President, National Association of Specialist Obstetricians and Gynaecologists**

**CHAIR**—Good afternoon and welcome. We are pleased you could join us this afternoon. It has been a struggle to get you in, but we are able to do so. I want to assure you that the number of senators does not reflect the interest in the item. All your evidence will be in the *Hansard* so that the whole committee will have access to it. It was just a timing issue. Senator Furner will have to leave somewhere in the middle of your presentation to catch a plane, but Senator Boyce and I are struggling on.

**Senator BOYCE**—We will be here.

**CHAIR**—Before you start, I just want to acknowledge that we are all going to be involved with your evidence. Is there anything you would like to add about the capacity in which you appear today?

**Dr Molloy**—I am Vice-President of NASOG and Vice-Chair of the IVF Directors Group of Australia and New Zealand.

**Dr Pesce**—I am the immediate past president of the National Association of Specialist Obstetricians and Gynaecologists.

**CHAIR**—I am going to immediately forget all the acronyms for your organisations but I know you are here from the IVF Directors Group. You are all welcome to make an opening statement, but have you worked out the order in which you are going to do so?

**Dr Molloy**—Yes. Dr Joyce will kick off.

**Dr Joyce**—Thank you for providing our two groups with an opportunity to address you concerning the proposed changes to the Medicare safety net. The National Association of Specialist Obstetricians and Gynaecologists and the IVF Directors Group will deliver a joint presentation today which should make the best use of the available time and avoid duplication of information which would have occurred if our presentations had been delivered separately. As you listen, please keep in mind that I speak for our patients.

In 2003 the former government faced a crisis in affordability and access for patients to a range of medical services, including obstetric care and assisted reproductive technology services. Inadequate patient rebates did not enable patients to afford necessary out-of-hospital treatment and state governments were not providing adequate services to meet increasing patient needs. In the case of assisted reproductive technology services, state governments did not and still do not provide any treatments. Medical indemnity insurance had escalated to the extent that it threatened the viability of obstetric practice and an older medical workforce in obstetrics was not being renewed by new entrants because practice was both extremely demanding and financially marginal. It was this perfect storm which brought together the drivers of, firstly, an increased demand of services and, secondly, a reduced commitment to service provision by the state public sectors. Also, because of the declining obstetric medical workforce and an undermined viability of obstetric practice the then government introduced the Medicare safety net as part of a package of measures, including assistance with professional indemnity insurance and the Medicare reform initiatives.

These measures, as a whole, did much to address the issues of access of patients to services and helped encourage older obstetricians to extend their careers and others to enter the specialty as the financial viability of practice was restored.

While not a perfect instrument, the Medicare safety net has provided hundreds of thousands of Australians with the security of affordable service access when they need it, particularly those faced with high-cost services or recurrent medical expenses. The public clearly strongly supports the benefits it provides, and the Prime Minister, then the Leader of the Opposition, and the then shadow health minister acknowledged this during the 2007 election when they undertook to retain the Medicare safety net without change, because families had come to rely on the support it provided.

The introduction of the safety net did, however, present some difficulties for both the profession and the Department of Health and Ageing in the management of billing structures. Obstetricians and fertility specialists have led specialist medical practice in informing patients of the extent of their financial

commitment when entering treatment. This has been achieved through structuring billing arrangements in practice that met patient needs. When the Medicare safety net was implemented, the less flexible rebate arrangements operating in Medicare and the lack of data in the Medicare records about the pre-existing structure of obstetric and ART treatment costs gave rise to difficulties for specialties seeking to simultaneously meet Medicare and patient expectations around billing.

Much of the data drawn from billing submitted under this new funding approach by the government provided interpretational challenges for the Department of Health and Ageing.

In obstetrics, the splitting of the all-inclusive obstetric fee into an in-hospital and an out-of-hospital component produced extended negotiations between my colleague Dr Pesce and the department before a solution was agreed, although then, regrettably, this was not implemented formally by the department. You may wish to seek a more detailed explanation on this item from Dr Pesce during questions.

In assisted reproductive technology treatments, before the implementation of the Medicare safety net practitioners had taken two quite different approaches to billing, based on their experiences of patient preferences, in establishing their fee structures to recover the costs of the provision of their services. Some offered a low upfront planning and management fee and a high per cycle fee, while others implemented a higher upfront planning and management fee with a lower cost per cycle. You may wish to seek clarification from Dr Molloy on this issue during questions.

When the safety net was introduced, practitioners sought direction from the department and from Medicare officers as to whether they would need to change their billing practices to suit the more rigid rebate structure of Medicare. There was no consistency in the advice that practitioners received from Medicare, probably because there was little or no policy guidance for the Medicare officers themselves on the matter.

The surviving diversity of billing practices creates difficulties when trying to draw out trends and interpretations from the data. This is evidenced by the department's own use of the term 'inferred safety net costs' rather than actual costs, because Medicare's systems simply do not store the data in a form that could provide absolute financial information on the splits. They were not designed to do so. The absence of pre-Medicare safety net billing data also means that comparisons drawn are often problematic in the analysis.

In March this year the AMA was invited to attend a meeting with representatives of the Centre for Health Economics Research and Evaluation, CHERE, who had been engaged by the department to undertake a review of the extended Medicare safety net. CHERE had previously published a working paper, in 2006, critical of the Medicare safety net, written substantially by the same authors, which attracted broad criticism for the subjective nature of its findings and some fundamental errors. During that meeting, the CHERE representatives sought input from specialty representatives and undertook to meet with them to review progress in the report prior to submission to the government of the final report.

CHERE also indicated that, because of the complexity of the data and analysis, the report could not be completed until some time in July 2009. In the days following the May budget, the minister, however, cited a finalised CHERE report as the authority for the decision to reduce rebates for obstetric and assisted reproductive treatments. The report was released some days later. In our view, the report is flawed, both in its assertions concerning fee inflation and the basic data upon which it has been drafted. The report has failed to separate the impact of the transfer of the non-Medicare booking fee in ART to MBS items and has used an errant base fee in its analysis of item 13209 in the Medicare schedule.

**CHAIR**—Which I take is the ART management fee?

**Dr Joyce**—I do not—

**CHAIR**—Sorry, Dr Joyce. I just wanted to get that clear.

**Dr Joyce**—The report also failed to analyse the changes in delivery costs of individual services as a fee driver and there is doubt about the reliability of the sensitivity analysis which underpins its conclusions. The report fails to identify the value of benefits derived through better access to both obstetric and ART services as an offset to the cost of the Medicare safety net. The CHERE report has been inferred as the authority to substantiate claims of fee rorting and excessive doctors' incomes, which fuelled media reports, presumably initiated to tap into the politics of envy. We reject these claims. Dr Molloy and Dr Pesce will provide examples of how the Medicare claims processes focus the recovery of costs in a fully staffed clinic onto a single doctor's provider number.

In Australia we enjoy the second highest standard of maternity services outcome through the established obstetrician-led model. In assisted reproductive technology, we enjoy the world's best outcomes at about half the cost in the USA and less than two thirds of the cost in the UK. Far from our medical practitioners rorting the system they provide services at the top level of outcomes for costs below the OECD average. Australian patients enjoy a level of access to quality, safe and effective obstetric services and fertility treatments overall at a cost below the OECD average. In both obstetric and fertility services, we have seen significant growth in the number of services being delivered. The number of children born has increased from a low of around 240,000 in 2003 to around 280,000 in 2008. The increase of 10 years in the average age of women and men having their first child since the middle of the last century, driven mainly by social and economic factors, is a driver of increased utilisation of fertility treatments. One in 20 Australians is subfertile and one in every six Australian couples will suffer from infertility. One in every 25 children now born in Australia was born to parents who received fertility treatment. That refers to last year.

Better access to services and treatment has certainly driven growth in costs to the Medicare safety net, but it has seen a corresponding improvement in outcomes for those patients who have been unable to gain access to appropriate treatments before the implementation of the safety net. Both NASOG and the IVF Directors Group have done significant work on the impact upon patients of the proposed cuts to the Medicare safety net. There has been much speculation in the media about just what the impact of the proposed changes will be if implemented. In a nutshell, it would mean that all Australian families seeking access to private obstetric care and all Australians who seek access to fertility treatment will be substantially worse off in financial terms at a time when the financial burden on families is at its most demanding. It will mean that some costs will be shifted from the safety net to private insurers who will then pass the costs on to families through increased premiums.

I close my introduction by asking you to note that the enabling legislation currently before the Senate in my opinion extends beyond the current proposed changes to the Medicare safety net and would enable the minister and future ministers to change or add caps to the Medicare safety net payments without needing to refer to parliament. I thank you for your time and attention. I now pass on to my colleague Dr David Molloy to make some specific observations about the impact on patients seeking fertility treatments. Please remember this is all about our patients.

**CHAIR**—Dr Molloy, before you start I have to acknowledge that I have been told that Senator Xenophon is on the phone.

**Dr Molloy**—I thank the senator for his interest. Thank you very much for allowing us to appear. The Queensland Fertility Group in Brisbane is Queensland's largest IVF unit. I have been practising in IVF for about 20 years and delivering babies that I made for about 18 years. We have a very long and honourable history in the provision of IVF services in Australia. Most of the international innovations that have occurred in IVF to make it safer and more successful for patients have actually come out of Australia and have been applied internationally. It has now got to the point, as Hilary said, where there is an IVF child basically in every classroom in this country. About one in 23 to 25 children born are from IVF treatment.

Since 1990, Medicare underpinned the cost of IVF services through the Medicare schedule, but over the past 19 years, as one of the senators has already pointed out, the indexation of Medicare has been about one to two per cent per year but the cost of providing a technology such as this has risen dramatically. So, with simple medical fee inflation or the medical inflation index, which is actually used for most medical services, usually running at around eight to 10 per cent per year in most cities, and the increased technology and increased compliance costs that we have, the cost of the services, particularly in the early or mid-2000s, had started to move a long way away from the actual Medicare rebate.

I would also point out that we have the most compliant IVF group and provision of services anywhere in the world through an organisation called RTAC, where we are formally accredited to practise in this field. No other country has such a compliant and audited group of clinics as the IVF units in Australia. You certainly will not find IVF units in Australia making eight babies at once, and this creates a very high level of both success and safety for patients. But with compliance comes cost. Certainly our compliance costs have significantly increased over the recent years. When the safety net was introduced in 2004, what was becoming quite a large gap suddenly was underpinned by the safety net as IVF was basically considered an outpatient service.

IVF item numbers are basically global item numbers: they cover 30 days provision of services for everything that the unit does—doctors' fees, ultrasound, pathology, scientific fees and psychological

counselling are all bundled into one fee. Then, because of the Medicare Australia Act, it is put against a doctor's provider number. That is why, when the services increased due to increased access and affordability between 2004 and 2009, those top 10 doctors that the department presented to you had an increase against their names. It was basically the billing for a global item number, on behalf of their clinic, against their provider number. It has nothing to do with their personal incomes. It is like pathologists or radiologists billing on behalf of these quite large practices.

It is also important to reiterate Hilary's point—and I know that the senators are aware of this—that pre-2004 with the introduction of the safety net the data on gaps was missing, both in obstetrics and in IVF. It was often billed separately on a separate invoice and it was not entered into the Medicare computer at all. It was a major failing of the CHERE report that they tried to back-model that on the flimsiest of data and then show an increase going forward. The data simply did not exist in the public domain.

However, the safety net has been successful. There is no doubt that in all of our clinics there is increased access and affordability and we have seen a new social stratum of Australian working families come and seek treatment for their infertility who could previously not afford the gaps for treatment. I think a wonderful thing that the safety net has done is that it has made a high-technology service quite affordable for people. The other really good thing that it has done is that IVF services are one of the few high-technology medical services that translate well into rural and provincial areas—it is actually transportable technology. Most major provincial cities in Australia do have an IVF service so patients do not have to travel for treatment. That is relatively rare in high-tech medicine. It is more expensive providing those services in country areas, which are often poorer areas and less able to afford medical gaps. The safety net definitely made transportability of and access to those services for rural and provincial patients much, much better than they would otherwise have been.

This is about Australian families. It is about mothers and fathers who would not otherwise be so. But, as representatives of the Australian people, you have to also realise that this extends beyond simple mothers and fathers; it is about people who may not become grandparents and about sisters and brothers who may not become aunts and uncles. These changes to the safety net actually have a really important social implication. We believe that 100 per cent of infertility patients who wish to access IVF services will be worse off as a result of these changes.

The department have actually published on their website the changes to the safety net. The changes that they are making and the tentative and predicted IVF changes have actually been posted on the Medicare website and are available in document form.

I refer to *Hansard* on Monday, 15 June, where the health minister, Ms Roxon, said:

The cost of IVF should not increase for most patients. On average, patients are charged around \$6,000 per IVF cycle, yet there are some doctors charging in excess of \$10,000 per cycle. Patients who see specialists who charge \$6,000 or less for a typical IVF cycle will not be worse off under these changes.

This is a position that we could basically start to live with. In fact, the charging bands for IVF units—and we are doing our own study of this at the moment—are relatively narrow. It is a very competitive industry, if you like.

The second thing is that the data that we have and the data that we have been able to get suggest that the minister is not far off the mark. The average fee is probably somewhere between \$5½ thousand and \$6½ thousand—around the \$6,000 mark. What the department have published is, between the Medicare rebate and the safety net cap, a total subsidy of \$3,000. There is a \$3,000 difference between what the department have published and what the minister has stated will happen, and that has been included in the budget savings. Somehow we have to reconcile those figures, because, at the moment, 100 per cent of the average fee being charged by all units is \$6,000—as the minister states, I believe not incorrectly. The department has published \$3,000. There is a \$3,000 shortfall that patients will have to look at paying. That means 100 per cent of infertility and IVF patients in this country will be worse off because of these changes, and we believe, on behalf of our patients, that that is unacceptable.

We believe the safety net has been good for patients, whichever side of politics you sit on. If you are inclined more to the right of politics, it has encouraged patients to come into the private sector. Because it does not pay 100 per cent of costs, patients are taking care of their own health, contributing, in a cost-wise sense, to their own health and accessing a service that is completely unavailable in the public sector. There is no public hospital IVF to speak of in this country that the patients can otherwise access. They are accessing it at their own cost. If you come more from the left side of politics, the safety net has genuinely increased access and

affordability for working families in this country to have children. Senators, thank you very much for your attention.

**CHAIR**—Thank you, Dr Molloy. Dr Henshaw, do you want to add anything at this stage?

**Dr Henshaw**—No. I am happy to answer any questions.

**CHAIR**—Dr Pesce, do you want to add anything at this stage?

**Dr Pesce**—Yes. Because I am here for the AMA submission as well, I would like to make an opening statement. Thank you very much for allowing us to combine. I think it is better that we are all here together, especially since I was NASOG president until recently and there might be a few questions that I might be needed to answer.

At the outset, I would like to declare that I am an obstetrician in public and private practice in Westmead in Sydney. My private patients will be affected by the measures in the bill and the accompanying ministerial determination. Having said that, I would like to focus on the overarching impact of the measures rather than the direct impact for the medical services specifically targeted in the government's budget measures.

The purpose of the extended Medicare safety net was to protect individuals and families from high out-of-pocket expenses when their need for medical services outside the hospital setting was unusually high. The extended Medicare safety net has helped many people get timely access to medical care and it is quite likely to have prevented downstream costs. In introducing the bill, the government has introduced a framework under which it can systematically withdraw its financial assistance to individuals and families who experience high out-of-pocket costs for health services provided outside the hospital setting.

In deflecting criticism of this bill, the Minister for Health and Ageing has made much of doctors' charges and will have you believe that the extended Medicare safety net benefits are a windfall for doctors. The minister has said very little about government support for people who need to access private medical care outside of hospital. The reality is that the Medicare rebates do not cover the costs of most doctors' practices. Successive governments have failed to index the Medicare schedule fees in line with the other indices, such as CPI and average weekly earnings, let alone the increase in the cost of delivering medical care. With year upon year of indexation that has been well below par, today there is now quite a disconnect between the Medicare schedule fees and the realistic cost of providing the services.

For private in-hospital services the health insurers have, for the most part, picked up the difference on behalf of their members. In the out-of-hospital setting this responsibility must fall on the government. When this responsibility became obvious as out-of-pocket costs grew, the government had two options to respond: one, it could revise the Medicare schedule fee or, two, it could introduce a limited safety net that shared the additional costs of out-of-pocket costs between patients and government. They introduced the extended Medicare safety net as their response.

In its recent budget measure, the government has targeted very specific medical services for which it will now withdraw its support to patients. These services happen to be those that appear at the top of Medicare spreadsheets as attracting the highest amount of extended Medicare safety net benefits. There are also services for which much of the package of care is provided outside rather than inside hospital, which is just the nature of the care needed by patients undergoing these treatments. Once benefits for these services are capped, these medical services will slip lower down the government's spreadsheets and will be replaced by a new suite of medical services that attract the highest amount of benefits. We can then expect that those services will be the subject of a new ministerial determination to put caps on benefits for those services.

The AMA has concerns about how the government has modelled the effect on patients. The minister has made assertions about patients in particular scenarios not being any worse off. I appreciate that the minister is convinced of this based on the modelling she has been shown. However, doctors know what their fee arrangements are and know that patients in the minister's scenarios will be worse off. That is why the AMA is seeking to have a clause added to the bill that requires the minister to consult with the relevant medical groups about their fee structures before making any future decisions about the caps for particular services. In this way the minister and the community will be better informed about the impact on patient out-of-pocket expenses.

We are also concerned about the actual impact of these measures in the short term. We would like to see a requirement in the bill for an evaluation of the minister's power to impose caps as well as the actual caps that will be introduced as a result of the 2009-10 budget announcement. Thank you.

**CHAIR**—Thank you, Dr Pesce. Senator Furner, as you have to go, do you have time to put your question?

**Senator FURNER**—I have just one question on notice. When we were in Perth last Friday we heard from Mr Peter Jennings, who I understand is from the AMA. Unfortunately we ran out of time due to his lengthy submission. We did not have an opportunity to pose as many questions to him as we would normally pose. He demonstrated a graph, which he used as an exhibit, which I personally had some problems with because some of the figures were, in his words, compounded figures, hence giving an inflationary figure at the end. What I was going to ask him, and hopefully you can answer this on notice, is: why does it appear to be necessary to use CPI figures as opposed to average weekly earnings? I put that on notice and will read your response. Thank you very much.

**Dr Pesce**—Thank you.

**Senator XENOPHON**—One of the concerns that has been expressed is that, if these changes go through, one of the consequences of the increase in gap charges will be that you will have more embryos being used each time and there is a risk of multiple births and more neonatal care. Do any of the witnesses have any comments in relation to that?

**CHAIR**—I saw Dr Henshaw lean forward. He will take that question.

**Dr Henshaw**—For the record, I am the medical director of the largest IVF clinic in South Australia. We do about 3,000 cycles of IVF a year. I started working in that clinic about 15 years ago and it was routine for us then to replace three embryos inside the patient's womb and it was quite routine for women to have two or three babies. As a result of that, the costs of neonatal care were very significant. Twins and triplets have a higher incidence of preterm delivery and a much greater need for neonatal intensive care. In my clinic now, 94 per cent of women have one embryo replaced. We have virtually eliminated twin and triplet pregnancies and all the costs that go along with that. The flip side of the coin is that, if you put fewer embryos back inside the womb, the chance of a pregnancy is less and therefore patients have to undergo more cycles to achieve a pregnancy.

The fact that patients have been able to afford to undergo more cycles is one of the great things about the Medicare safety net. It has enabled us to practise a safer form of medicine. We can now persuade patients to have a single embryo put back. They will only have one baby, with reduced costs for neonatal intensive care, and they know that a significant part of that cost, 80 per cent of that cost, is going to be picked up by the Commonwealth. That has been a huge benefit.

You will be able to tell from my accent that I have also worked in the United Kingdom. Five years ago I was the medical director of the largest private UK clinic. The cost for patients was about \$10,000 at current exchange rates. We could not persuade patients to have a single embryo put into their womb. They all wanted two or three embryos put back because they knew they could not afford to come back for repeat treatments. In the United States it is quite routine for women to have four to six embryos placed in the womb and then, if they do fall pregnant with multiple pregnancies, to undergo a procedure called 'selective reduction', which we, thankfully, do not have to practise in Australia. One of my great fears is that if the costs that are published on the Medicare website come into play then our patients will ask for two or three embryos to be put back and we will go back to where we were when I started in Adelaide in 1995, which would be a bad thing.

**Senator XENOPHON**—I have one more question, Dr Henshaw. You work in Adelaide. Is Adelaide impacted on differently as a result of these proposed changes because, as I understand it, at the moment there are not any public providers of IVF, which is different from other states?

**Dr Henshaw**—There is no public provision of IVF services in South Australia.

**Senator XENOPHON**—What does that mean if you live in South Australia, then?

**Dr Henshaw**—If you are a South Australian, at the moment if you come to my clinic and you have reached the Medicare safety net you pay about \$1,000 out of your own pocket. If this fee schedule goes through, it will mean that you pay \$3,000 out of your own pocket. That is the bottom line.

**Senator XENOPHON**—Will it necessarily be as high as that, though—from \$1,000 to \$3,000?

**Dr Henshaw**—I have done the sums myself. They are pretty easy to do. Our fees are on our website if anyone wants to have a look at them, and the proposed caps are on the Medicare website. Anyone can do the maths and see what the cost difference is.

**Senator XENOPHON**—Finally, Dr Henshaw, are you saying that because there is a lack of public IVF facilities here in South Australia that the impact will be greater on South Australians as a consequence of these proposed changes?

**Dr Henshaw**—I do not believe it will be greater in South Australia than anywhere else. There is no public provision of IVF services in Queensland.

**Dr Molloy**—No.

**Dr Henshaw**—I do not believe there is any significant provision in New South Wales or Victoria. We also provide services in the Northern Territory, and I do not believe there are any significant public services in Western Australia or Tasmania.

**Senator XENOPHON**—If these changes go through, do you think inevitably there will need to be public services because people will not be able to afford it?

**Dr Molloy**—We believe that the state governments are struggling to provide basic services in a whole range of areas for sick patients who need category 1 surgery. I just cannot see them being able to provide adequate IVF services to replace the losses and the decrease in access that will be caused by these safety net changes.

**Dr Pesce**—I am the clinical director of women's health at Westmead Hospital, which is probably the only public hospital IVF unit in New South Wales. That unit can only exist because it charges Medicare the fees that the patients pay. Even though some of its infrastructure costs are met through the public hospital system—and because of that the fees are a little bit lower than the private IVF units—it is not that much cheaper. Because patients will lose public funding through the Medicare system with this, it will impact even on the only existing public service in New South Wales.

**Senator BOYCE**—Is it the only one in Australia?

**Dr Pesce**—I think there is one in Melbourne as well.

**Dr Henshaw**—It is very small and I think it is about to close.

**Dr Pesce**—Basically, if patients cannot afford private treatment they will not have access to IVF. That is the line that needs to be understood. Because of the lack of any meaningful investment in this in the public hospital system, if you cannot afford private treatment you will not get IVF.

**Senator XENOPHON**—Thank you.

**Senator BOYCE**—IVF Directors, could you explain who you are?

**Dr Henshaw**—Yes. The Fertility Society of Australia has a subcommittee called the IVF Directors. The Fertility Society of Australia also has another subcommittee called the Reproductive Technology Accreditation Committee. The Fertility Society is the overarching body that is recognised in current Commonwealth legislation, NHMRC documents et cetera, and we are a subcommittee of that group. The subcommittee is made up of every medical practitioner who runs an IVF clinic in Australia and New Zealand.

**Senator BOYCE**—Thank you. I want to get back to some of the comments that were made earlier around whether technology costs have gone up unusually in your profession compared to overall medical costs. Could anyone comment on that?

**Dr Molloy**—They have risen substantially. Part of what Richard said underpinned that, in terms of our drive down to single embryo transfers. In 2000-01 there was a major leap in IVF pregnancies in Australia. We had to completely retool our laboratories for a completely different way of growing embryos. That drove pregnancy rates up for a patient under the age of 35 from around 17 per cent per cycle to between 40 and 50 per cent per cycle. It was a megaleap forward. The retooling of the laboratories, which has actually continued over the last eight years, has been extremely expensive. We have also seen an expansion of services called ICSI, where we inject sperm into eggs, which has become the gold standard treatment. This ties up a scientist for most of an afternoon with a quarter-of-a-million-dollar microscope. Also, we have had to purchase more freezers and better storage facilities because we are freezing more embryos, as we have dropped down to only putting one embryo back under optimal circumstances. There has been a large flow-on of costs for that as well. The other point I would make is that our compliance costs with our auditing programs and quality assurance programs have dramatically increased. Units like Dr Henshaw's and mine now have a full-time quality assurance officer, and most of us have employed such a person in perhaps the last three years. That is a high-level position to oversee quality management in each unit.

**Dr Henshaw**—I support Dr Molloy—there have been significant increases in technology costs.

**Senator BOYCE**—But you would see these as unusual within the overall outpatient medical procedures area.

**Dr Henshaw**—It is fantastically different to the standard outpatient provision of services. Do not forget that the most complex medical procedures are performed in hospital and are subsidised by private health insurance and so on and so forth. IVF is essentially an outpatient procedure and the technology costs are significantly higher.

**Senator BOYCE**—We need to get to some sort of explanation as to why the department of health on the one hand is saying their technology costs are not any different to anybody's and what you are telling us, which is that they are very different and very much higher.

**Dr Henshaw**—I will take that question on notice and will provide a written answer.

**CHAIR**—That would be really useful.

**Senator BOYCE**—That would be good. Dr Joyce, you mentioned that there had been some reference by the minister in relation to the budget, but when did you actually see the CHERE report?

**Dr Joyce**—It would have been after the minister's presentation of the budget. We have done an analysis and there is a critique that we will be contributing in our written submission.

**Dr Pesce**—The report was released about a week after the budget announcement.

**Senator BOYCE**—That is when you first saw it?

**Dr Pesce**—Yes.

**Senator BOYCE**—In some cases you were basically flying blind in terms of trying to respond to the comments in the budget. Were these measures a surprise to you?

**Dr Pesce**—It was a surprise in that for a number of years I have been talking to the department and they have been discussing concerns about how the safety net arrangements were delivering a disproportionate amount of total safety net expenditure to certain groups. They indicated this was a potential problem. NASOG certainly have always said that we were willing to talk to them about their specific concerns and suggest ways that they could be addressed. We offered them several solutions. At the time they said, 'No, we're just going to keep gathering the data and we'll see.' At the end of the day we got to a situation where it was flagged that there were going to be changes. As NASOG president, I was concerned to make sure that, if there were going to be changes, they should improve things rather than make things worse. I asked for consultation with the department and the minister's office, and that may have been referred to in previous submissions. There were only one or two meetings.

Basically we indicated that we recognise that, if they had a problem, we could work with the government and the department to address those concerns. We basically flagged changes to the way the safety net operated and recognised that, on the basis of what you have heard today, if the underlying funding through the medical benefits schedule were changed to reflect the true cost of providing the services, it might be reasonable to say, 'That means we don't need the safety net, to the extent that it's currently underpinning those expensive outpatient services, to be in place.' We offered to work with the department and the government to identify and talk about what might be an appropriate adjustment of the MBS schedule if there were going to be changes made to the safety net. That was the consultation, and it seems that half our suggestion was taken up and the other half was not, and there was no consultation about what the real fee schedules were to enable a commensurate adjustment to be made for the decreasing reliance on safety net funding. I would still like to think that that discussion could take place one day, but at this stage there is no indication.

It is quite salient to point out that a lot is made of the top 10 charging obstetricians or the top 10 per cent of charging obstetricians, but if you actually look at the bottom quartile, the bottom 25 per cent, of charging obstetricians, Access Economics modelling has shown that those patients will be at least \$400 worse off. That is the bottom 25 per cent.

**Senator BOYCE**—Worse off than the patient—

**Dr Pesce**—Than they would have been if the previous safety net arrangements had been left in place.

**Senator BOYCE**—You are suggesting that a way the legislation could be improved is to put in something requiring the minister to consult about fee structure with the relevant medical groups. Could you tell me how you think that would work. What would happen?

**Dr Pesce**—I would expect that, if the government had an issue about the way its money was being spent and was worried that it may not be equitably distributed and that some patients were getting more benefit than others, we could talk about whether there needed to be some redistributive process—how that could be put in

place. But at the end of the day we work from the disadvantage of not knowing what the charges are. We do not have that data. That data is not shared with us. The only reason I can give you the figures that I have given is that the CHERE report put on the record what the charges were for the various quartiles. We did not know that. We need to have data so that we can give back information to the department to make sure that they understand what the impact of their proposed changes is going to be.

We would like to see, when there is a perceived problem, that that problem is articulated to us and that we are provided with data to enable us to have a look at the problem, and then we can have a two-way conversation as to what the best solution to that problem is. We recognise that the government has the right to make policy and that the department implements that policy, but we are left out of the loop and then we are in the position of having to criticise government policy when we are actually quite willing to work with them to address the concerns they have.

**Dr Molloy**—We have a long and honourable history of working with the department through the MBCC process, where we present this sort of problem to the department. With a combination of our specialist medical knowledge on behalf of the patients and an understanding of the procedures that we do, we help the department interpret their data. Medicare data is very blunt data. It is basically data designed to rebate a fee. It has no other real purpose, and its use in statistical analysis to try and understand the provision of medical services is very blunt and very crude. When the department tries to use it for that purpose, sometimes they do not understand all the nuances and the effects that it can have.

**Senator BOYCE**—Because there is no context, you are suggesting?

**Dr Molloy**—Exactly correct. And when we talk together, particularly through the MBCC process, we actually do solve these problems in a very consultative way. I have been involved in MBCCs now for 15 or 16 years, and it is a good process. It is just that when things like this happen, such as with these published fees, when there has been no consultation you get a \$3,000 difference, which could be a \$3,000 per cycle hole in the government's budget calculations—and that could have been saved and the difficulty that we are facing on behalf of our patients could have been very simply solved by an episode of consultation. We understand the budget process has an element of secrecy about it, but a problem like this can be solved by consulting with the medical profession, because we have a good history of working with the department on these problems.

**Senator BOYCE**—There was a comment earlier about the effects that this bill would have on IVF procedures if it were passed in its current form. In your view, would there be any effect on other obstetrics areas?

**Dr Joyce**—Yes, there would be. Thirty per cent of women have their children under the care of private obstetricians, and if there is less choice to do so because of reduced affordability then there will also be an impact on the public system, which is already overloaded, if those women turn to the public system to help them out of their predicament. Certainly for the future mothers we do see reduced choice, reduced access, and reduced affordability.

**Dr Pesce**—Apart from that, unlike IVF, there is a public system that women can go to. But I just wonder whether a saving of \$500 to \$1,000 in the private sector from MBS expenditure—

**Senator BOYCE**—Do you think it is going to come at a cost?

**Dr Pesce**—When a mother goes into the public system I think it is going to cost a lot more. In a sense, it is cost shifting to a different purse, but I do not think it is going to generate as many savings.

One of the other things that I really need to emphasise is the statement that we hear lots and lots of times that obstetricians' fees have gone up by 267 per cent. That is just wrong. I was doing obstetrics before the safety net, and we just asked them to pay a booking fee. What that did was allow us to get our gap fee upfront, and we did not have to chase the patient later. It gave us the ability to give them fully informed financial consent.

**Senator BOYCE**—Was it a deposit?

**Dr Pesce**—It was a payment to say, 'I am retaining a private obstetrician.' The gap in my case was \$1,500, and once the patient paid that I would bulk-bill her for the rest of the services. It enabled fully informed financial consent. The patient paid a single expense that allowed them to cover the gap, and I knew that I had no bad debts at the end of it. So it was—

**Senator BOYCE**—Win, win.

**Dr Pesce**—Win, win for everyone. When the safety net came in, I had the opportunity to raise my antenatal visit charges to take advantage of that underpinning by the government. The patients knew that they were committed to this expense; the government had said that out-of-hospital services would be underpinned by a safety net. When I heard the announcement of the safety net, I rang the department to say, ‘I’ve heard this announcement and it’s made in the context of a lot of GP enhancements—to enhance general practice,’ and I waited for the qualification to say, ‘This is to underpin general practice treatment of chronic disease,’ and that qualification never came.

After a few days I rang the department and said, ‘Can you please confirm that the safety net is meant to apply to private obstetrics as well? My impression was this was an enhancement measure, but I can tell you that, because of the way that it’s structured, obstetric patients will be able to qualify for safety net support. You’re exposing yourself to big charges that you don’t even know about, because it’s not going on the books. Please tell me whether or not you intend this to be the case—that you want the safety net to underpin private obstetric practice.’ About a week later I got a phone call from parliament saying, ‘Yes, we’ve checked and, yes, we’re happy for the antenatal component of private obstetrics to be paid for through the safety net.’ I remember saying to the guy quite clearly, ‘That’s fine, but if you see that there’s going to be a problem let me know and we can talk about it.’ I offered a number of pre-emptive solutions to avoid it, but they said, ‘No, we’re just going to see what happens.’ I said, ‘I don’t want to read that greedy obstetricians are ripping off the safety net. I’ve told you that you will now be exposed.’

In 12 months, all of a sudden Medicare expenditure on private obstetrics doubled because the previous amount, which had not been booked to Medicare, was now being booked to Medicare. To put it in perspective, more Medicare funding went to obstetric ultrasound than obstetric services in the pre safety net days. All of a sudden this unbooked amount was put on Medicare’s book and, surprise, surprise, there was twice as much Medicare expenditure on obstetrics. It was not because doctors put up their fees; it was because they transferred an out-of-pocket expense of the patient to something that the government had said, ‘Yes, it’s available.’ That has not been adequately explained or understood and, unfortunately, the statement that obstetricians’ incomes have gone up by 267 per cent is just plain wrong. I wish people would stop saying that.

**Senator BOYCE**—I think the point was made earlier by Dr Molloy that fees do not actually represent what goes into the practitioner’s pocket, for a start, but what you are saying is that it is not even the fee, the overall cost, that has gone up 267 per cent?

**Dr Pesce**—Correct. The exposure to the Medicare system has gone up because that is what the safety net did. It was not because the fees moved and changed the goalposts.

**Senator BOYCE**—Nevertheless, I think you have something of an image issue. I appreciate the work that the witnesses in this area have done to try and help people to understand it. There is certainly quite a lot more work to be done.

**Dr Pesce**—One of the problems is that you use the top-earning specialists, who have been in practice for a long time and have large-volume practices and charge the same per delivery as an obstetrician working in a rural area, who may only do 40 or 50 deliveries a year. Unfortunately the system is like that. The higher volume practice will generate the high income. You could use the top-billing obstetrician to determine the structure of fee support, and that affects the bottom 10 per cent of charging obstetricians who have been working really hard and have been underpaid for a long time. Interestingly, in my consultations with the department, they said that the inflation in safety net expenditure over the years since its introduction was not a result of the top doctors increasing their fees; it was as a result of the bottom doctors increasing their fees, because they obviously saw that for once they had a chance to actually charge a realistic amount. The highest charging doctors have not put up their fees; the lower charging doctors have been changing their fee structure.

**Senator BOYCE**—Where was this information?

**Dr Pesce**—That was just informally given to us at a consultation meeting about 18 months ago.

**Senator BOYCE**—By the department?

**Dr Pesce**—By the department, yes.

**Dr Molloy**—The department did allude to the fact that we had had these consultation meetings with them, which is quite true. Dr Pesce, Dr Joyce and I attended them frequently with David Learmonth and other senior members of the department, where there was a particular review, mostly of obstetric expenditure. In fact, my understanding of the data over the last two years is that the average safety net exposure, around Australia, as a fee for the management of a pregnancy for nine months is actually only \$1,700. Whilst these very high fees are

being quoted, the average for the country is about \$1,700. That fee had only risen by—correct me if I am wrong, Andrew—about \$100 a year over the time of the safety net. Basically you have your pregnancy and your precious child looked after for less than the cost of a TV screen. We could understand how the top 10 centile might have been politically unpalatable to either the department or the government, but in fact the average working obstetrician looking after the average patient out there was only charging about \$1,600 or \$1,700. Now 100 per cent of these women are going to be worse off because the caps have been set so low in the obstetrics section of this document that most of them will not even get to the threshold to access the safety net. So patients are going to be enormously disadvantaged, even if they are going to the 25 per cent cheapest obstetricians in this country.

**CHAIR**—In the discussion we had with the witness on Thursday, I actually asked if there was opposition in principle to a cap or whether it was to the size of the cap. The whole cap arrangement is being introduced in this legislation, in terms of looking at a cap for certain processes. From your perspective, is it the cap itself or the amount that is in the cap to which you object?

**Dr Molloy**—We can understand that, with the rebate system, the government is looking to something like a cap to limit its risk. We can actually understand the economics and the mathematics of that, and indeed that may even be sensible. We think what has happened here is that an unconscionable level of cap has been set, in that there is now four or five years of the market data showing what the costs of the services are to patients, providing a lot of good data showing access and affordability for patients across a broad social spectrum. We believe, as a first step, that these caps have been set at unconscionably low levels, to the point that all 100 per cent of patients are going to be affected in a very negative sense by that. We accept that the government may make a policy decision to limit cost exposure. That indeed might be a sensible thing for government to do. The limits that are being placed here are unfair and unreasonable to the women in this country.

**Dr Pesce**—One of the other things which are very difficult—and I am not confident that the modelling the department has done has taken this into account—is that the caps are set at a level which makes me feel that no single pregnancy is going to trigger the safety net threshold. You have to remember that the patients have to meet the first \$1,100 per calendar year in out-of-pocket expenses before the safety net is triggered. Because the caps have been set at a fairly low level, I find it hard to see that a pregnancy in itself is going to trigger any safety net support. It is not just a question of capping; it is a question of capping in combination with a trigger threshold level for safety net support. If you are going to be, for all intents and purposes, removing safety net support, then you need to recognise either the patient is going to be a lot worse off or you have to make up for it in some other way.

The other thing which is really puzzling to me is that, if you look at the schedule of fees in obstetrics and the safety net caps which have been published by the department, there are a whole lot of services which can only be provided in hospital which have a theoretical safety net cap. I am talking about caesarean section, which cannot be done anywhere but in a hospital, so it could never attract any safety net support—and yet the new fee structure suggests that there is a safety net cap of a certain dollar amount. I am really worried that this is being used in the modelling to say, ‘This is what we’re going to be spending money on,’ when they are not. Unfortunately this is the problem with the lack of consultation with the profession. There is a blatant error there, as far as I can see. It is there on the public record and no-one is doing anything to correct it. I have pointed it out to the department on a number of occasions. They have not given me any satisfactory explanation as to why it is there. That is the price you pay for lack of consultation. I suspect they are going to find that they have made an embarrassing mistake.

**Dr Joyce**—You may not be aware, Senators, that the first women who are going to be affected by this proposed change, if it takes place, are not yet pregnant. They are probably going to become pregnant over the next month or so, to be 20 weeks on 1 January. Someone may have the exact date of conception worked out. The public, the women of Australia—our patients—are really not yet aware of what is in store for them and they will not be happy when they contact their obstetrician’s office or attend for their first visit and find out what the financial outcome is going to be for them.

**Senator BOYCE**—It could give a whole new meaning to the Christmas break!

**CHAIR**—When you gave your original evidence you talked about the fact that you had met with the CHERE people and that there had been a previous report written by the same organisation that seemed to have some negativity about the industry. I hope I am not verballing you, but you said words to that effect. The way it has been presented is that the CHERE report had a significant impact on the decision about which parts of the professions were going to be looked at and which areas were going to have the focus placed on them. I do

not know about the size of the cap, but that is from the department's evidence, and we have not seen their submission yet. Have you had any subsequent feedback or discussion with those people? I think in your evidence you said you had one meeting and expected that there would be others before it became public. However, the budget happened and the report became public. I know Dr Molloy and Dr Pesce also met with them, but I am just quoting from your original evidence. Has there been any further discussion with the organisation that did the original report and the modelling?

**Dr Joyce**—Your assessment is very accurate.

**Dr Pesce**—I was at the meeting, David was at the meeting and Hilary was not yet present, so she was not. We went to the meeting. It seemed to go quite well. We had the opportunity to say all the things that we have said to you.

**CHAIR**—The same kinds of things you have said to us?

**Dr Pesce**—They said to us: 'This is going to take a long time. It's very complex. We don't anticipate we're going to publish the report before July.' We asked: 'When is this going to be ready? Is it going to be used in the budget process?' We were trying to read the tea leaves. They said, 'There is no way this will be done before July.' We said: 'To avoid us having to go out and potentially criticise anything that we see has been done incorrectly, would you give us the opportunity to have a look at your draft report? We can't tell you what to write, but at least give us a chance to have input into what we see you're doing and give you some feedback.' They said, 'Yes, we'll be able to do that.' Then all of a sudden we were overtaken by events, the report was published in time for the budget and we had not been consulted.

**CHAIR**—Your meeting was in February, I believe.

**Dr Pesce**—Correct.

**CHAIR**—There may well be more questions that come to mind when we have a chance to see the department's submission, which, as you heard, will now take up some of the questions we asked. We tried to get some of the AMA issues into the questions so that they are on record. Are we getting something in writing from your group?

**Dr Molloy**—That is correct.

**CHAIR**—We would like to put those two together and go through them. We will definitely continue this discussion. Thank you for your time.

**Committee adjourned at 6.04 pm**