



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

STANDING COMMITTEE ON ECONOMICS

**Reference: Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill
2008**

THURSDAY, 17 JULY 2008

BRISBANE

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**SENATE STANDING COMMITTEE ON
ECONOMICS**

Thursday, 17 July 2008

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

Substitute members: Senator Cormann to replace Senator Bushby

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

Senators in attendance: senators Abetz, Cameron, Eggleston, Furner and Furner

Terms of reference for the inquiry:

To inquire into and report on: Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

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Committee met at 12.58 pm

CHAIR (Senator Hurley)—I declare open this meeting of the inquiry of the Senate Standing Committee on Economics into the Tax Laws Amendment (Medicare Levy and Medicare Levy Surcharge) Bill 2008. On 18 June 2008, the Senate referred the bill to this committee for report not before 26 August 2008. This bill increases the Medicare levy surcharge thresholds for individuals from \$50,000 to \$100,000 and for couples from \$100,000 to \$150,000. The increased thresholds will apply from the 2008-09 income year.

The inquiry will examine the impact of changes to the thresholds on the number of Australians with private health insurance, including an examination of how many will abandon their policies as a result and how many will not take up private health insurance in the future; the modelling underpinning the decision and the veracity of that modelling; the anticipated impact on private health insurance premiums and private health insurance products offered; the impact of the change on the cost of living and the consumer price index, including the threshold, private health insurance rebate and Lifetime Health Cover on increasing private health insurance membership; the anticipated impact of changes to the threshold on the public hospital system including waiting lists and the financial requirements of state governments; the ongoing viability of private health insurance; and private hospitals.

This is the second public hearing for the inquiry. These are public proceedings although the committee may agree to a request to have evidence heard in camera or may determine that certain evidence should be heard in camera. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage witnesses on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may also be made at any other time.

[1.00 pm]

KEARNEY, Ms Ged, Federal Secretary, Australian Nursing Federation

THOMAS, Ms Lee, Assistant Federal Secretary, Australian Nursing Federation

CHAIR—I welcome the Australian Nursing Federation. Would you like to make an opening statement, Ms Kearney?

Ms Kearney—If you do not mind; we have a brief one. We have a somewhat hastily prepared presentation for you. We only agreed yesterday to come and present today and are happy to do so. Our view that we will present today, whilst informed, we want to say, is not one that is necessarily economically analytical. It is based more on our social policy views and our views on public health and health spending. It is also based on what we know from the experiences of our members, some 170,000 nurses across Australia who work in the health system in all sectors, and our understanding of those sectors.

Whilst we are committed to the public health sector and believe that it should be based on equity of access to health care, being a universal right that should be based on need rather than ability to pay, we are also absolutely committed to a robust and viable private sector that provides choice for consumers, provides lots of jobs for our members and one that we believe can be socially responsible and ultimately work in a strong partnership with the public sector.

We should state that the ANF publicly opposed the private health insurance rebate when it was first proposed and also the penalty imposed on those who chose not to take private health insurance through the levy surcharge. We believed then, and still do, that it was ultimately a policy that favoured the wealthier, that it took funding away from the public health system and gave it to third party, for-profit insurers. We believed that it disadvantaged many people who were forced to cross-subsidise other sectors, disadvantaged people who had little or no access to private hospital sector and would result in less funding to the private hospitals as a lot of that money would be swallowed up by administration costs and ultimately profits of the private health insurance industry, and that it would be inflationary for the private hospitals. According to many social analysts, many of those things, if not all of them, have actually played out since the introduction of the health insurance rebate and the surcharge.

It is our understanding, very broadly, that the rebate and the surcharge were introduced to encourage the uptake of private health insurance and that would ultimately decrease pressure on public hospitals and keep private health insurance premiums and private hospital costs low. I am sure you are all familiar with the writings of people like John Deeble, Stephen Duckett and Ian McAuley who have made lots of public comment on the policy. Some interesting facts that we have pulled out that we thought were worth mentioning today were that John Deeble said before the insurance rebate was introduced that 12 per cent of all private hospital costs were from direct subsidies from the government that actually managed to keep prices down for private hospitals and to keep private health insurance premiums low.

The Howard government's policies in this area were introduced with a concurrent fall in funding to the public hospitals—I believe John Deeble says it is around \$1 billion per year—coupled with low bulk-billing rates and poor reimbursements for private health providers. Stephen Duckett estimates that, if all subsidies that were paid into this policy reverted to the public system, we would have about 1.5 million more treatments being able to be done in the public sector. Ian McAuley has written widely on this, as you would probably know. He asserts that the policies simply undermine Medicare by removing funds that could be directed towards that public sector. Ultimately we believed it showed a move away from universal health care for everyone to one that places the responsibility for health care back onto the individual.

It seems to us, and I think that there are many commentators who would agree, that private health insurance uptake did improve; there is no doubt. Some people say it was more a result of a scare campaign, of very clever marketing, and that people thought something dreadful would happen to them if they did not take up the private health insurance option. But, ultimately, the rest of the flow-on simply did not happen.

Costs in the private hospital sector rose; they did not stay low. It was, in fact, inflationary. There are those that argue that this is a direct result of the loss of direct subsidies to the private sector. Private health insurance premiums rose dramatically. It did not keep those costs down subsequently. I think one year we saw nearly an eight per cent rise in premium costs for private health insurance and it definitely did not reduce pressure on the public health system. From what we know, waiting lists are still a problem, presentations to emergency

departments have increased dramatically, and we still know that there is a huge pressure on public hospital beds; so by our estimations, it has been a failure in those terms.

Will people drop out of private health insurance as a result of increasing the threshold? They probably will. But we believe there are many who will stay in private health insurance because the cost is not the reason they are there. There are lots of other reasons that people take out private health insurance. It has been suggested that those who do drop out are those who can least afford it, which we think is a good thing. They most likely will be younger, healthier people who took up the most minimum of policies, that covered the bare minimum in the private sector so that they could simply avoid the surcharge.

Many of these people we know definitely go through the public system anyway, despite them having private health insurance. They do that ultimately to avoid the gap payments and the out-of-pocket expenses. Our members who work in the public sector tell us that public hospitals have diverted lots of money to try to encourage people to declare their private health insurance status so that they can shift the cost to the private health insurance bodies. As somebody who has worked in the public hospital system for many years, I can vouch for that as well. It seems to me to be absurd.

Will the pressure increase on public hospitals? It might. People, if they do not have private health insurance—there is going to be a small amount who did not use the public sector—may go over. Because they are the younger, more healthy people and they are using the public health system already means that I do not think it will be as dire as is predicted by many people.

Of course, the predictions about the move across are wildly fluctuating, depending on who you listen to and who is doing the predicting. However, if there were a move across to the public sector, it makes sense to me, and it seems quite obvious, that resources would be able to be moved back across to the public sector as well. I might be wrong but I believe the rebate is worth about \$5 billion now; \$4.8 billion or \$5 billion. Savings made through this measure could certainly be moved back across to the public sector. Nurses are a constantly moveable workforce, they move in and out of the sectors easily and seamlessly, and I do not think there would be any problem moving the labour workforce back across to the public sector.

There is a view that subsidisation of private health insurers was an attempt by the previous government to undermine Medicare and that it was an ideological move, an exercise to demonstrate the failure of a universal system to be sustainable and to meet the demands of the community. Of course, with the concurrent policy of underfunding the public hospital sector, we believe the former government, with their market based philosophy, believed they could show that that is why choice was necessary and that the public sector was really only a charitable sector for those who are most disadvantaged, and that we would end up with a system similar to that in the United States where there is a vast divergence between private health and what is commonly called, in the States, the charitable health sector.

However, we believe this approach ignored the analysis that we have today that clearly shows the policy has failed in its objectives to reduce pressure on the public sector. Progressive think tanks and health economists, however, suggest that an ageing but healthier population will not lead to unsustainable health expenditure. They point to Scandinavian countries with similar demographics that have relatively low percentages of GDP spent on health. Indeed, we also believe that increasing the threshold, coupled with the government's other intended health reforms on preventative medicine, on dealing better with chronic health disease, focusing on the primary health care sector and actually trying to keep people out of public hospitals, will have a net positive effect overall.

I would like to say that we are unclear why boosting private health insurance membership should be considered the responsibility of the federal government or any other government. Falling private health insurance surely is a problem for private health insurers and not governments. It has been suggested by a number of commentators that, if the private health insurance industry was selling a product that represented good value for money they would not have the same level of difficulty in maintaining membership. However, private health insurance in Australia is only part insurance and, while funds continue to sell insurance that covers only part of one's health service costs, it will not represent the sort of value that consumers are looking for.

The policy of subsidising private health insurers, we believe, undermines Medicare and takes funds away from public hospitals. Any falls in private health insurance membership have more to do with the public realisation that public hospitals are there if they need them. Despite concerns expressed by the insurance industry and the AMA about the lifting of the levy surcharge, there are alternate views that raising the threshold will allow consumers to actually make a choice about how they spend their money on health care.

The support of stakeholders with vested interests, such as the Private Hospitals Association and the Private Health Insurance Association, for the subsidisation of the private sector, is fairly obvious, as this is where we believe their financial interests lie. It also applies to other supporters like the AMA whose members predominantly work in private practice and in the private sector.

However, consumer advocates and many other health care stakeholders, independent policy analysts, actually support the notion of strong public investment in the public sector, with firm regulation of the private sector and without subsidising insurers. We do not believe the viability of private hospitals is threatened by the decline in the number of people with private health insurance. We think it is threatened by the private health insurance companies failing to provide insurance products that people want. It is not necessarily the end of the world for the private sector. We think a truly cooperative relationship between the private hospitals, the public sector and Medicare system can improve the efficiency of the public sector and maintain viability of the private system.

Finally, we believe raising the levy threshold will increase choice and will give income relief to many people who need it. We will move to further equality of access to the health system which will mean much more money, we hope, for the public system. Thanks very much. That is basically our presentation.

CHAIR—Thanks, Ms Kearney.

Senator CORMANN—Ms Kearney, have you done any modelling of the impact of this measure?

Ms Kearney—That is what I said. We have relied on other modelling and we have not really done any economic analysis ourselves, as I said in our opening statement, but we are informed and we have been following health economists' comments on this and have seen that there is a vast divergence of views around the economic modelling and the predictions that this policy will impact. We are taking a, 'Wait and see. Let's not panic now and jump ship. Let's just wait and see what happens.'

Senator CORMANN—But every state government across Australia has said that this will lead to additional pressure on public hospitals. I mean, do you at least concede that it will lead to additional pressure on public hospitals?

Ms Kearney—As I said in my opening comments, there may be an impact on public hospitals. We do not believe that it will be as great as is being predicted by the Private Health Insurance Association. We know that the AHHA did some economic modelling that actually came up with about half the prediction of what the PHIA came up with.

Senator CORMANN—You mentioned John Deeble, and you said that you follow his reading of the matter. He has made a submission that says that about 750,000 people will leave private health insurance. He also said that Treasury had the best estimates of the impact. Treasury has told us a couple of things during Senate estimates. One is that they expect 484,000 adults to leave; not people, adults.

Ms Kearney—We have seen that figure.

Senator CORMANN—And that they also expect to save \$960 million from not having to pay the 30 per cent rebate to the young and healthy that they expect will leave. Now, \$960 million, being 30 per cent, means that the 70 per cent those young and healthy contribute to the system, which equals \$2.24 billion, will also be lost to the system. So we are talking about an amount—

Ms Kearney—Contribute to the private health insurance system.

Senator CORMANN—If people leave private health insurance as a result of this measure and the Commonwealth saves \$960 million, which represents 30 per cent, it stands to reason that those people will no longer pay their part of the bargain, which is the remaining 70 per cent; so we are talking about \$3 billion that will no longer be available to assist them. Where is that funding going to come from for the hospital treatment that it currently funds?

Ms Kearney—As I said in our presentation, we do not believe that all of those people will necessarily go to hospital. We know that they took up the private health insurance rebate. The ones that leave took it up merely because they were either scared that they would not be able to be treated, which is simply not true, or they did it to save tax. The accountants basically told them. They are not necessarily going to end up in the health system as patients.

Senator CORMANN—You are absolutely correct, and I think this is something that is missed in the debate. I totally agree with you that we do not know whether the people that will leave would have accessed hospital treatment. Let's just say that I agree with the federal Minister for Health and Ageing that the people

who will leave are the young and healthy. The important thing is that they are all net contributors into the system; that they are currently contributing funding for hospital treatment for the old and the frail and those that do access hospital services, and that funding will no longer be available. Where are those \$3 billion going to come from?

Ms Kearney—Surely there are going to be savings from the rebate as well.

Senator CORMANN—There are going to be \$960 million worth of savings but the governments that have to fund the actual services are state governments and so far we have not been told by the federal government that they are going to provide any meaningful compensation to state governments for this. Let's just assume that the federal government goes ahead with this. Don't you think that the federal government should provide 100 per cent compensation to state governments for the impact of this measure on their capacity to service patients in public hospitals?

Ms Kearney—My understanding is that the worst case scenario is that it is going to probably cost about two per cent of the health dollar. That is the state government predictions. There are other analysts that say, 'Well, this could be probably one per cent,' but they do not quite agree that two per cent is the worst possible scenario. So it is not going to be that huge an economic impact, in which case I do not have a problem if the states are going to look for compensation, if that is what plays out. Again, it is not a huge amount. The predictions are not that it is going to be totally unmanageable. That is my understanding and my impression.

Senator CORMANN—I am happy to hear that you know what the state governments are saying, because I do not. We have not received one single submission from a state government. The Queensland health department has pulled out of the hearing today so we have not got the capacity to ask them questions and probe them on that. Just asking a different question altogether—

Ms Kearney—Those figures I have come from the AHHA. It is interesting. Did they make a submission? I think that is in their submission.

Senator CORMANN—I have not seen that.

Ms Kearney—That is the Australian Healthcare and Hospitals Association, which, in my understanding, represents public hospitals.

Senator CORMANN—Do you agree that, if the Commonwealth expects a saving of \$960 million, that is only part of the revenue that is going to be lost to the health system?

Ms Kearney—Is it lost to the health system or is it lost to the private health insurance companies?

Senator CORMANN—It is interesting that you should say that. I invite you to have a look at PHIAC. PHIAC will tell you that the cost of administration for health funds is about 10 per cent and across all 40 health funds their net margin is five per cent. So let us take 15 per cent off at \$3.2 billion. There is still \$2.7 billion that is currently funding hospital treatment that would be lost to the system.

Ms Kearney—Who is PHIAC? I am sorry.

Senator CORMANN—The Private Health Insurance Administration Council.

Ms Kearney—Okay.

Senator CORMANN—That is \$2.7 billion that would be lost to the system. Where is that funding going to come from?

Ms Kearney—That is assuming that their modelling is correct. There is other modelling that does not say this. Ian McAuley's modelling is quite different when he models how much money goes into the private hospitals. What they actually end up with in the private hospitals is only a trickle, and those are his words. I cannot quote exactly what percentage that is but I think there is quite a divergence, as I said at the beginning, about agreement on the actual economic modelling around this and that a very large proportion of the private health insurance rebate ends up in administrative costs and stays with the private health insurance industry.

Senator CORMANN—The official data is 50 per cent. Don't you think that in the light of past practice, like looking at the way state governments have dealt with these sorts of challenges in the past, all of the state governments should join together and commission some independent research to properly assess the impact of this? Don't you think that federal Treasury should actually make their modelling available to state governments, because surely state governments should have the best available information in front of them to make a proper assessment of this measure on public hospitals?

Ms Kearney—But so much of it is conjecture. I do not think we can actually know. You cannot predict, really.

Senator CORMANN—Isn't that a reason to do a study?

Ms Kearney—No, I do not think so. The policy was introduced without a study. The other private health insurance rebate was introduced without a study and it has played out to be poor, so let us play it out.

Senator CORMANN—But, if there is going to be an adverse impact, shouldn't there be a study?

Ms Kearney—How do we know there is going to be an adverse impact?

Senator CORMANN—Treasury tells us.

Ms Kearney—It may not play out.

Senator CORMANN—You said that public hospitals would have additional pressure.

CHAIR—This is getting into the nature of a debate, and I know Senator Eggleston has a question.

Senator CORMANN—Can I just have a final question?

CHAIR—Go on.

Senator CORMANN—On Monday in the *Australian* you were quoted as saying:

... to increase thresholds at which people without health insurance face an extra levy would provide much-needed relief for households.

That is what you said, isn't it? What we are really talking about here is a one per cent tax cut for singles earning between \$50,000 and \$100,000; and couples and families earning between \$100,000 and \$150,000. Don't you think that people in those income ranges, that also take out private health insurance, are equally deserving of that sort of tax relief?

Ms Kearney—But it is a choice. They have more of a choice. Certainly they could be. If I had my way we would not have the private health insurance rebate, like I said in my opening statement. We openly opposed the private health insurance rebate from its very introduction.

Senator CORMANN—Thanks for that.

Senator EGGLESTON—It is interesting that you openly opposed it from the very beginning because that implies that you were aware of the circumstances at the time where there were very overcrowded public hospitals with enormously long waiting lists for surgery and other procedures, and adjacent to the public system was a private system which was empty. There were vacant beds. There was a resource there that was not being used. That was the rationale for the introduction of the Medicare levy surcharge: to get people to take out private insurance so that the resources of the public hospital system could be utilised. Would you not agree that is the real situation rather than as you presented it?

Ms Kearney—Not entirely. One of the reasons that were stated at the time for the introduction of the rebate was that health insurance costs were too high and that people could not afford them and that this would actually make those costs more affordable. I am pretty sure that was one of the main reasons, in fact I know it was, and it was argued very strongly at the time.

Senator EGGLESTON—In your opinion, I would have to say.

Ms Kearney—In my opinion. It was argued at the time that it would keep private health insurance premiums low by encouraging people to take up private health insurance. Yes, I do not disagree that public hospitals were pressured and that it is difficult, but it has not had any impact on that. Today, I can tell you—if you speak to our members, they will tell you—there is huge pressure on them, on public hospital beds. There are waiting lists. Emergency departments are still overcrowded. It has had very little impact on the public hospital pressure.

Senator EGGLESTON—It is a question of relativities. If, in fact, people had not been encouraged to take up private health insurance, there would have been greater impact, I put to you, on the public hospital system than there is now. I agree also that the public hospital system is under great pressure—that reflects the fact that governments, Labor governments in particular, are not prepared to fund the public hospital system to a degree which would enable them to provide service to meet the demand.

Ms Kearney—Yes, but the private health insurance rebate costs \$5 billion. As a public sector employee, my mind just boggles if that \$5 billion had been kept in the public sector. One can dream, as well, about how well serviced or how well resourced the public sector might be and where we might be today had \$5 billion been

poured into the public sector. You are talking about, 'Let's think what could have happened.' I would like to think what could have happened if that money were maintained in the public sector.

Senator EGGLESTON—Five billion dollars sounds like a lot but, in government terms, it is not. One could wonder how much money would have been necessary to have been put into the public system to enable it to adequately meet the total demand for health services in Australia.

Ms Kearney—One could wonder, I agree.

Senator EGGLESTON—I assure you it would have been a much greater sum than \$5 billion. You said in your opening remarks that there would be little impact on the public hospital system from removal of the surcharge. I will put to you some figures from Catholic Health Australia, which, as you know, not only run private hospitals but also have a public component. I wonder whether you would agree or disagree with Catholic Health Australia's figures. They estimate that there will be an increase in public hospital surgery waiting times upwards of 200,000 patients. More episodes of care will need to be carried out in public hospitals that would have been carried out in private hospitals. That is what the 200,000 figure represents. Specifically, there will be longer waiting times for older Australians requiring cataract surgery or hip and knee replacements. There will be an immediate increase in costs on public hospitals of somewhere around \$400 million and an initial decline in the state and territory public hospital revenue of \$35 million in direct hospital accommodation benefits, and an additional \$20 million in other services. Surely they are significant impacts? You said there would be no impact.

Ms Kearney—That is Catholic Health's modelling, and there is nothing to say that that is exactly how it is going to play out. It is interesting that they chose cataracts and knee surgery, because the people that we know require cataract surgery and knee surgery are the very people who will maintain their private health insurance. They are not the ones that are going to leap off and drop it.

Senator EGGLESTON—So you are suggesting that having a cataract is somehow related to your income, are you?

Ms Kearney—No. I am suggesting that it is related—

Senator EGGLESTON—Is that because you visit exotic resorts or something like that, and get sand-blasted?

Ms Kearney—No. I am suggesting that it is—

Senator EGGLESTON—I am just interested because it is a fascinating concept. I have never thought that medical conditions were related to income.

CHAIR—Could we allow Ms Kearney to answer.

Ms Kearney—I am suggesting that it is related to the very demographic—that is, that older demographic—that we know take up private health insurance for reasons other than financial costs or tax relief. They are the very ones we know that keep it: the people that potentially need or are at that age, perhaps, or have ongoing chronic problems that they know are going to need knee surgery and cataract surgery. In fact, I am surprised that Catholic Health used those two examples because, along with hip replacements, they are the ones who are going to stay in the private system.

Senator EGGLESTON—I do not think you can substantiate that outcome, sorry.

Ms Kearney—I do not see how Catholic Health can substantiate that, either.

Senator EGGLESTON—Older people are the ones who are going to suffer the most because they will be put on longer waiting lists, I put to you—

Ms Kearney—Under those—

Senator EGGLESTON—for cataract surgery; not only for knees but also for hip replacements and other surgery. It is, in fact, the older demographic in this country who are going to be the people who find these changes most disadvantageous.

Ms Kearney—But what Catholic Health fail to say, and Ian McAuley's assertion is that what will happen, as I said in my presentation, is that resources, hopefully, would flow across. Resources will follow the need. Those waiting lists for those poor people, I am here to tell you, are there now. They are there now. The waiting lists for a hip replacement have not improved over the last 10 years, or whatever, that this policy has been in. In fact, they have got worse.

Senator EGGLESTON—I really do not think that that is the case. Could I just finish that—

Ms Kearney—My point is that the rebate has not helped to make the situation better for those people.

Senator EGGLESTON—You have a charmingly utopian view of what governments might do, but the record is that governments have not put extra money into the public hospital system, and I do not see why you should anticipate that they will. The other thing is that the modelling that has been done by Treasury is shown to be somewhat incorrect, in that it assumes that there will be an enormous dropout initially of young people, of the kind that you have described, when in fact other authorities think that the dropout will be more progressive; that certainly young people will leave initially but then lots of other people in other age groups and demographics will drop their private health insurance and come into the public hospital sector.

Ms Kearney—So you are asking me to accept holus-bolus Catholic Health Australia's modelling and reject Treasury's modelling, and yet why should I do—

Senator EGGLESTON—There have been many authorities, including Access Economics—

CHAIR—Can Ms Kearney finish, please.

Senator EGGLESTON—the AMA and the Catholic health authority who disagree with Treasury.

CHAIR—The Nursing Federation have to go soon. I think they are entitled to finish the question. Ms Kearney.

Ms Kearney—I just find it extraordinary that you are asking me to do that—to accept Catholic Health's modelling and to reject the Treasury's modelling.

Senator EGGLESTON—That is the wrong question. I never said that.

Ms Kearney—So I am not sure what you expect me to say to that.

CHAIR—Australian Nursing Federation, thank you for your attendance here this afternoon.

Ms Kearney—Thank you very much. I am sorry we have to go. I would love to stay.

Senator CORMANN—We had heaps more questions.

CHAIR—That is the program.

[1.31 pm]

GALLAGHER, Mr Kerry, Chief Executive Officer, Australian Medical Association, Queensland

CHAIR—I now call to the table the Australian Medical Association, Queensland division. Welcome, Mr Gallagher. Do you have any comment to make on the capacity in which you appear?

Mr Gallagher—Yes. I have held this position for 12 years, except for a period last year when in a moment of madness I said I would act as the federal secretary-general, but the weather was far too cold!

CHAIR—Thank you. Do you have an opening statement that you wish to make?

Mr Gallagher—I do. But, first of all, I would like to make a very short introductory statement to set the scene, although one can see the scene set every day in our magnificent daily newspaper, the *Courier-Mail*. AMA Queensland wishes to present its evaluation that the impact of the proposed Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008 will have on Queensland, as opposed to how the AMA federally or, indeed, more recently the AMA Western Australia may have presented their evaluation. This amendment must be seen here in Queensland within the context of the public hospital system as it currently is.

Queensland's public hospital system is now only beginning to recover from chronic underfunding. To give you an idea of the significance of the increase in funding, it has risen from approximately \$3.6 billion per annum to this year \$8.3 billion—and this is in less than a decade. Sadly, the Commonwealth contribution—unless today you have brought a bag of gold with you—is still well below 50 per cent. Beds still are extremely short. Queensland has four major hospital constructions or redevelopments underway—Queensland Children's Hospital, the Gold Coast Hospital, Mackay and Cairns—but these will have no impact at all until 2012 at the earliest.

This is the statement which I have prepared and which will be available to the secretary. The Queensland branch of the Australian Medical Association welcomes the opportunity to comment to the Senate Standing Committee on Economics regarding the federal government's Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008. The amendment bill will increase the Medicare levy surcharge threshold for individuals from \$50,000 to \$100,000 and for couples from \$100,000 to \$150,000. The thresholds will apply, as we understand it, from the 2008-09 year of income and later years of income.

The Access Economics report to the AMA on health and on the 2008-09 federal budget states:

The sharp increases in the thresholds for the Medicare levy rebate sends a very confused message—to the private health sector. It continues:

The Government has adopted a policy that harms the insurers and the private hospitals while adding further burdens to an over-stressed public hospital system ...

It is certain to add further burdens to an already overstressed public hospital system. The report continues:

State and Territory Governments could—

and almost certainly will—

legitimately ask for monetary compensation for the extra costs they will face down the track.

AMA Queensland, from its research, strongly endorses and agrees with this assessment.

The reduction in private health insurance coverage: as at March 2008, the percentage of the Queensland population covered for general treatment under private health insurance has increased moderately from 40.3 per cent in June 2000 to 42.2 per cent now, or an increase of five per cent. The average age in Queensland for hospital treatment membership has also marginally increased from 36.6 in September 2003 to 39 years of age now. Changes to the Medicare levy threshold will result in more young people leaving private health insurance and cause a reduction in the percentage population in Queensland covered under private health insurance and an increase in the average age of insured persons.

The total number of people who will drop private health insurance remains somewhat uncertain. Under the federal budget, the government indicates some 485,000 will drop their PHI cover; Access Economics reports that the number could be as high as 800,000, while the Australian Health Insurance Association expects this figure to exceed 900,000 or at least 9.7 per cent of the insured population in Australia. Even with 485,000, this will equate to a greater demand for public health services, a greater number of patients on public waiting lists, and a greater need for the federal government to significantly invest in the health system in order to ensure adequate standards of care for the short and long term.

In Queensland, it will almost certainly mean that the public hospital system, now just recovering from chronic underfunding, will be destabilised again. Even if we take the lower figure, the average Queensland take on most things federally is about 20 per cent. This would equate to 100,000 new presentations each year. The government has confused and mixed the issue of tax relief and health system reform. The amendments do not take into consideration the increases in premiums as a result of the PHI dropout resulting from the proposed threshold increases. Access Economics estimates normal PHI increases to be running already at around five per cent per annum. As more people drop out of private health insurance, less available funds will be available to the PHI providers, who will then be forced to further increase premiums to cover funds lost.

AMA Queensland holds that self-funded retirees are at an age where they have an increasing need for health care and, if they do not buy health insurance, they are going to face a much more crowded public system, particularly in Queensland where bed occupancy is commonly over 100 per cent. Therefore, it will be these age groups that will be particularly affected by the bill amendment.

Public hospital admissions and waiting lists: in 2006-07 Queensland had the second highest percentage of public hospital admissions in Australia at 91 per cent, with the national percentage being 86 per cent. AMA Queensland is of the opinion that Queensland does not have the available additional resources to accommodate the expected number of people who will become dependent on the public hospitals for their hospital care. The Queensland health system is currently undergoing reform, and these amendments to the Medicare levy thresholds will only further slow and negatively impact on this progress.

Private hospitals are now providing a necessary service to the community and relieving the pressure placed on public hospitals. Between 1997-98 and 2006-07, separations per thousand head of population have increased by 6.8 per cent in public acute hospitals and by 42.1 per cent for private hospitals. For 2004-05 there were 1.6 million hospital separations for elective surgery, of which almost one million separations—61 per cent—were private elective surgery, with the remaining 629,000 separations—39 per cent—being for public.

These figures show that private health services are providing a necessary buffer that allows patients the flexibility of choosing private health care while relieving pressure on the public elective surgery waiting lists and the number of available public beds. By amending the Medicare levy threshold, there will be an increase in the number of separations for elective surgery in public hospitals, it will reduce funding available to private hospitals to provide services and this will further impact on available services provided by public hospitals.

Funding: AMA Queensland welcomes the Queensland state government's investment in health and its commitment to improve health services. However, there is still additional underfunding by the federal government and the AMA has advocated for an additional \$3 billion in funding for additional beds in public hospitals across Australia. AMA Queensland also supports the state government's call for a fifty-fifty split, state to federal, funding arrangement for public hospitals. AMA Queensland's position is that the changes to the Medicare levy surcharge will place a heavy toll on the current public hospital services and instil confidence that the public health system in its current state can manage to receive more people. This confidence will not be warranted.

Our public hospitals are beset by tight resources constraints, high levels of demand, medical and nursing workforce shortages, equipment issues and intermittent policy crises. If the government is committed to improving health services while providing tax relief for struggling families, AMA Queensland holds that a method other than that proposed in this tax law amendment must be found. The balance between private and public health care in Australia is so vital to retaining a leading health care system that this legislation, which threatens to destroy this balance, must not be passed.

CHAIR—Thank you, Mr Gallagher. You provide a comprehensive argument for maintaining support for private hospitals and the private health system, but there is an argument, is there not—and I think you indirectly referred to this—that people on the \$50,000 to \$100,000 a year income are bearing a disproportionate amount of support for that system because the threshold has not been changed since 1997? So people on comparatively lesser and lesser incomes are required to either pay a surcharge or take out private health insurance. Should it not be spread more fairly over all income groups?

Mr Gallagher—First of all, can I go back to the importance of the balance. The balance is vital because a robust, first-class private system gives the public system a great challenge. It knows that it must live up to that level that is set by private health care.

CHAIR—I accept that you make that argument.

Mr Gallagher—So the balance is important. I still maintain that there has been confusion between relief for families and health care. Certainly I agree that there must be some relief. Can I here say that I have a clear understanding of the pressure placed on people with lower incomes? For a long time I have been a member of Legacy. Many of my Legacy widows, who have been left widows because of the early death of their husbands who have supported Australia in times of need, religiously maintain, even against my advice, their private health cover because they have seen their husbands suffer, generally for long periods of time. Even though there is a high quality of care provided now through the DVA system—and I am the first to support that—and even though I advocate to them that they do not need to hold their private health care, they still hold it, even though their incomes are significantly lower than that \$50,000 threshold. I think you should be looking at other means of providing income support to people, at the same time enshrining that very balance between private and public health care that is there now in Australia.

CHAIR—You do not place any weight on the fact that that threshold has not changed since 1997, so effectively it is at a lower income level now than it was then?

Mr Gallagher—It is at a lower income level, but that is why I am saying that, if the thrust is to provide relief to those people because certain economic situations have changed or parameters have changed, then look at ways other than something that would impact so negatively on the balance in private health care at the moment. All the numbers tell us that there is going to be a significant dropout.

CHAIR—So that would be in effect a greater subsidy, although indirectly, to private health care.

Mr Gallagher—Indirectly, perhaps.

Senator EGGLESTON—Would you like to comment on the modelling the Treasury adopted for the dropout rate from private health insurance and whether you think that was adequate or not?

Mr Gallagher—It appears that it was not adequate. Within the AMA we have for many years relied on and placed reasonable trust in the accuracy and veracity of the modelling done by Access Economics. Clearly, there is a lot of blue sky between Treasury modelling and Access Economics modelling—not that I would say for a moment that I would distrust that modelling done by Treasury, but I believe that the modelling done by Access Economics is independent.

Senator EGGLESTON—The Treasury modelling suggests that mostly it will be younger people on lower incomes who drop out. I think some people have a different view: that there will be a roll-on effect over a longer period. Would you agree with that?

Mr Gallagher—From what we are seeing at the moment and from the research that we have done, I would have to say that probably predominantly the dropout will be in younger people—not necessarily those on lower incomes, but certainly in younger people, who would probably begin to question their particular outcomes and values of private health insurance. That clearly will then skew the cost of covering older Australians or more-senior Australians under private health care.

Senator EGGLESTON—We have this community rating system in Australia for private health insurance. Does the AMA believe that the impact of this change may be that the private health insurance industry may feel under such pressure financially that consideration could be given to moving away from the community rating system to a risk based premium system?

Mr Gallagher—Clearly the AMA feels that this will create pressures on the private health insurers that will make them look at a whole array of ways of changing how they look at their insured clients. It may well be the case that that is one of the options that they look at, but I am not sure that it will be an option that they will choose to follow.

Senator CORMANN—How much additional funding from the federal government to the Queensland government do you think would be required to fully compensate for the impact of this policy measure?

Mr Gallagher—We have done some modelling. Clearly, the parameters are quite wide. As I said, there is a lot of blue sky in there between the numbers that we are given, but we believe that this impact could add somewhere close to \$2 billion to the already significant shortfall that the Commonwealth has in funding.

Senator CORMANN—Don't you think, firstly, that the state government should, either individually as the Queensland government or all state governments together, commission some independent research forecasting the impact of this change so they can make an informed assessment and put a proper claim to the federal government, or maybe come to the conclusion that they would want to call on the government to reconsider this measure?

Mr Gallagher—I think that there is a requirement for each of the state governments, I would have to say, to do it independently. It is my view that the states are significantly different, Queensland in particular. Usually when I make that statement, most people's eyes roll in their head and they say, 'Yes, Queensland is different and so are Queenslanders.'

Senator CORMANN—Western Australia is different too.

Mr Gallagher—The reality is that Queensland is significantly different and I think the modelling should be done on an individual state basis.

Senator CORMANN—To make sure it is properly informed, don't you think, in the spirit of cooperative federalism on health and ending the blame game, that federal Treasury should make its modelling available to the states so that they can have the best available information in front of them to properly assess the impact on public hospitals?

Mr Gallagher—It is already on the public record in Queensland that, clearly, the state government has called for the modelling, but also the AMA in Queensland has called for that modelling to be made available.

Senator CORMANN—The previous speaker from the Australian Nursing Federation mentioned John Deeble. Of course, he has made a submission to this inquiry, and the last time he was involved with a major change in the funding mix for hospital services, private health insurance membership went from 63 per cent down to 30 per cent before a number of policy measures turned this around. What do you think would be the impact if such a downward spiral were to commence again as a result of this measure?

Mr Gallagher—Queensland has always suffered from low numbers holding private health insurance. We believe that it would get to a level where one would have to seriously question its viability, taken on a state basis only. I can only say that modelling that was done by that person was probably very appropriate for the 1970s when his pronouncements were quite profound. I am not too sure that they are applicable any longer.

Senator CORMANN—Do you think that Australians who take additional responsibility for their health care needs by taking out private health insurance, and who are earning between \$50,000 and \$100,000 as singles and between \$100,000 and \$150,000 as couples and families, are equally deserving of the one per cent tax cut, compared to those that choose not to take out additional responsibility for their health care needs?

Mr Gallagher—In Queensland we came very close to having some sort of public discussion on this particular issue, but very quickly we lost that minister and the discussion finished there. I think it is a discussion that has to be held across Australia, not only in Queensland.

Senator CORMANN—The importance of this, of course, is that you would be able to provide relief to people that the government says are in need of that relief, without having the additional impact on public hospitals and without putting pressure on pensioners earning less than \$50,000, who will be subjected to increasing health insurance premiums. Don't you think that would be a more sensible way perhaps to approach this?

Mr Gallagher—As I said, I believe that there has to be a public discussion on this across all of Australia. In Queensland for a long time we have had significant wait lists. Quite often I receive phone calls from very agitated Queenslanders who have been trying to get access through the public system to see various specialists, and they ask me for my advice. To take one example, not because it is the appropriate example but because it is a speciality: 'How, today, do I get to see a dermatologist?' My answer is, 'Be married to one.'

Senator CORMANN—Can I interrupt you, because the chair is soon going to take the call away from me. What I am referring to is the comment in your opening statement where you said that, if there is a view that singles earning between \$50,000 and \$100,000 ought to get some tax relief, we ought to use a different measure. What sort of different measure would you envisage? Have you given that any thought?

Mr Gallagher—No, we have not. They were some of my summary comments at the end that I made to the chair, in actual fact. What we are saying is that you cannot confuse tax relief with health care. If your primary aim is to secure savings and, at some other position, provide tax relief to those who are considered to be no longer earning what is considered to be a reasonable income, that has got to be a consideration of finance and taxation. Do not confuse it with health.

Senator CORMANN—This is the crux of the issue actually. Thank you for that.

Senator CAMERON—Mr Gallagher, I have a couple of questions that I would like to ask you. In relation to your comments on Treasury modelling and Access Economics, are you saying that the

Treasury is not independent in terms of the advice it is giving government and that Access Economics are totally independent?

Mr Gallagher—I cannot give you an answer. If we were given access to their modelling, I might be able to give you an accurate answer, but you are asking me for an answer on modelling that I have not even been given the privilege of sighting.

Senator CAMERON—What you put today was that Access Economics were independent.

Mr Gallagher—They are independent.

Senator CAMERON—Who paid for the modelling?

Mr Gallagher—The AMA paid for the modelling, clearly.

Senator CAMERON—The AMA paid for the modelling and Access Economics are totally independent?

Mr Gallagher—Yes.

Senator CAMERON—Okay.

Mr Gallagher—I know what you are suggesting, but can I suggest back to you that we did not put to them what answer we wanted out of the modelling. We wanted to know, fairly: ‘What is the impact of this proposed legislation on health in Australia?’ If you are saying that—

Senator CAMERON—And they have come up with a certain model and certain conclusions that are somewhat different from Treasury modelling. It does not mean to say that they are independent and Treasury are not, does it?

Mr Gallagher—No, but let’s see the modelling that Treasury used. Can I also say just simply that I would not like you to get a misapprehension or a misconception of what the AMA is. Let me assure you that the AMA—certainly in Queensland and, I can assure you, across Australia—is made up of a fairly homogenous mix of both private and publicly practising doctors, so we have a very significant interest in both public and private.

Senator CAMERON—That is not what I asked you, but that is fine. On the issue of the private health funds and why people would want to move out, do you accept that there are some problems with the product, with transparency, and with value for money in the private health system? When I look at what I get from the private health fund, I must say it is very confusing. Don’t you think some of the problems for the private health system are not just moving funds from the private health system to the public health system; it is actually the product and transparency and value for money?

Mr Gallagher—Look, the AMA works with, and quite often has discussions with, the private health insurance industry. On an individual level, each of us who continues to hold private health insurance every quarter or every week or every year, when the bill comes in, sits down and says to oneself, ‘Is this value for this money I’m putting in?’ and then it becomes, I believe, a personal choice. Certainly I believe that there has to be continuing improvement in the product delivered by the private health insurance industry.

Senator CAMERON—Chicken Little arguments are being put forward that it is all doom and gloom because of the changes to the surcharge. Do you believe that, if there was an increase in public funding, any perceived reduction in capacity in the private area could be made up in the public health system?

Mr Gallagher—Once again, my expert area, knowledge and experience is in Queensland. As I have said to you, there are four very major constructions or reconstructions of significant hospitals going on in Queensland at this stage. Not one of those four, involving something like \$6-plus billion in current dollar terms, will provide an additional bed in Queensland today or tomorrow. It is not only about dollars but how those dollars are applied and the impact that they may have. As a corollary to that, nor is any relief provided by simply going out and attempting to buy services in the private area by the public sector, because that is a less than satisfactory arrangement.

Senator CAMERON—Professor Deeble raises the question of the unfairness of the levy for lower income people, saying that it is highly unusual and one of the only areas around the world where you are actually not taxed on an amount above the threshold but, as soon as you go above the threshold, you are taxed on the whole amount. Don’t you think that is an unfair burden for low-income earners in this country? Why would the private health industry have the capacity to benefit from what is perceived as an unfair tax impost on lower income families?

Senator CORMANN—Senator Cameron, are you proposing to go further than the bill is proposing?

Senator CAMERON—I am asking a question.

Senator CORMANN—This is actually beyond the bill.

Senator CAMERON—And I am not here to be cross-examined by you.

Senator CORMANN—Fair enough, but—

Mr Gallagher—I think that where government sets its threshold and how it goes about establishing those thresholds and how payments are made should be continuously reviewed. If you are asking me on a personal level does it seem fair for low-income families, as I have said earlier, some of the people that are very dear to me and that I work with are on exceptionally low incomes but still hold dear their private health coverage because of the importance of immediate access to health care. The specific question, ‘Should there be some sort of staged or tiered entry into that threshold?’ is a reasonable question, but once again you would have to do the modelling of how it impacted against the whole raft of other taxation. Right off the top of my head I would think that it is a reasonable proposition to investigate, and it would seem that it would be in line with the way that we apply taxation in many other areas.

Senator EGGLESTON—We have talked about the threshold, and people like Senator Cameron and others are saying that it is unfair to lower income earners and that there should be a surcharge. One of the arguments that has been put forward is that perhaps the \$100,000 level is a bit high and that in fact it should be, and should have been, indexed. Would the AMA have thought that was a reasonable proposition?

Mr Gallagher—I think that indexation actually is one of the things that you should be looking at. One thing that the modelling might lead to is that no-one really has a clear idea of the true impact that this will have and, perhaps when we do get a true idea of it, it may be slightly too late to recover some of the ground we lose, so I think that, rather than giant changes, after a significant period of time some sort of indexation may be a gentler way of approaching it and may be a better way of applying either the brakes or the accelerator, rather than sudden left or right turns.

Senator EGGLESTON—Would the AMA think that an amendment by the government to permanently index the threshold might be of some value?

Mr Gallagher—Once again we would have to look at how they were going to apply those increments. All I can say is that what we have looked at is the amendment that is proposed, and we believe that the outcome would be absolutely negative.

Senator EGGLESTON—The other issue I would raise with you is that in Western Australia we had the acting director of the public health department saying that the public health department was actively encouraging more privately insured patients to be admitted as private patients in public hospitals. I felt somewhat disturbed by that, given the long waiting lists for surgery in public hospitals for public patients and, were there not private patients in public hospitals, those beds could be released for public patient use. Does the AMA have a view on that?

Mr Gallagher—Once again I think it goes back to the need for Australia wide discussion on how we use the services that the government believes they can afford, and one of the issues, very clearly, is the coverage of private or intermediate patients in the public sector. I have already said that in Queensland bed occupancy rates are over 100 per cent. You might say, ‘Well, how the hell do you do that?’ It is special to Queensland how it gets more than 100 per cent coverage. When we say ‘beds’, probably all of us think of things with mattresses. That is not necessarily the case in Queensland. I have seen people occupy a gurney or a wheelchair or indeed I have seen someone on the carpeted floor of the A&E department, where resuscitation was being carried out because there was nowhere else to do it. The question is how we achieve over 100 per cent occupancy. You would have to say that, in the greater scheme of things, if the people who use the public system are those people who desperately need it, then it really does not seem appropriate that some of those vital beds that are in desperately short supply in Queensland are applied to private patients, but I suppose we then get into how much choice there should be available in the system.

Senator EGGLESTON—The other issue, of course, is that the states are funded under the Commonwealth-state hospitals cost-sharing agreement to provide a service for the public through the public hospital system. One would have thought that, if you then admit private patients to public hospitals, the states are in fact double dipping and being paid twice for the utilisation of those services.

Mr Gallagher—I think we are all aware that there is a significantly different direction of the stream that follows a public patient in a public bed and a public patient in a so-called private bed in a public hospital.

Senator CORMANN—Mr Gallagher, in the great state of Queensland you are actually in an ideal position to influence policy nationally for the better. You have got the Prime Minister in Queensland; you have got the Treasurer in Queensland. The Treasurer obviously is fundamentally involved in this policy. My first question is: did you have any discussions with the then Leader of the Opposition, the then shadow minister and perhaps the then shadow minister for health about their approach to public health policy should they be successful at the election? What did they tell you about their commitment to an appropriate private-public balance in the health system? Secondly, what discussions have you had with the Prime Minister, the Treasurer or the minister for health since, making representations in the strongest possible terms to perhaps influence things to achieve a better outcome?

Mr Gallagher—Can I take them in reverse order?

Senator CORMANN—Yes.

Mr Gallagher—Quite clearly, most of the people within this room are aware that the AMA's discussions with the current government have been relatively fleeting more recently, but certainly here in Queensland our position is that there really is not much to be gained by having no communication with government, and we attempt to retain a relatively fair and open relationship with the state government and, through them, certainly in Queensland, we have attempted to put our voice to the federal government. I accept that the Prime Minister and the Treasurer both come from Queensland and that their electorates are here in Queensland, but I am sure they are very busy and do not spend a great deal of time here.

Senator CORMANN—So you haven't had a discussion since that one?

Mr Gallagher—No.

Senator CORMANN—Politicians are always much more enthusiastic to talk to organisations like the AMA before an election and I would assume that, if there had been a meeting with the AMA in Queensland, health policy would have been discussed. Did you get any indication before the election that this sort of change was on the table and, if you had, what would you have said?

Mr Gallagher—I think I can speak safely for both the state AMA and the federal AMA because, as I said, for about seven months of last year I was in the federal AMA and that was in the period leading immediately to the election. Certainly the federal president and I at that stage had discussions with the chief of staff to the then opposition leader and the discussions were fairly broad. There was certainly no discussion in relation to this particular issue or this particular amendment. The majority of the discussions centred around national registration and accreditation, which is also clearly an issue of great importance to the medical workforce. There were no discussions about this particular amendment.

Senator CAMERON—Mr Gallagher, I want to clarify one of your previous answers so that I can be sure in my mind where you are going. You spoke about the public hospital system dealing with patients who are desperate. Is that a view and are you saying that the public hospital should take the desperate cases and that there should be another view for the private sector? Isn't there a broader role for the public hospital system in prevention and bringing people in to make sure that their conditions do not escalate? I am not sure what you were saying there.

Mr Gallagher—You have got a whole raft of issues in there. Perhaps we can take the simplest of them. I do not think anyone would talk against health prevention, but health prevention is a generational change, at best. We have still got an ageing population where, in that progression, there will be a requirement for hospitalisation. Indeed, as we grow older, one might put forward a proposition that there will be an even greater need for hospitalisation from time to time. So health prevention is vitally important. Indeed, the AMA has been involved in health prevention for a long time and—publicly on record—in whatever pressure the AMA can mount on a number of governments over a long period of time to invest in health prevention. That is the AMA's position on health prevention.

If we talk about 'desperate', you might remember that right at the start I said that the balance between private and public sector health services and hospital services is vitally important. In my view—and I believe in the AMA's view—a very robust and high-quality private sector means that you have, in turn, a very robust and high-quality public sector, because public opinion will force one to mirror the other. In terms of 'desperate', if you are suggesting that there are people out there who have no other means of health care and hospitalisation than the public sector, yes, that is right. They have no other means. There are at least 300 people each morning to whom services deliver coffee and sandwiches to and who, I would suggest to you, are

desperate, and they have no other means. That means that, to them, that hospital system must be of equal quality and equal robustness to that which you and I are able to access through private health care.

Senator CAMERON—You have not picked up my question properly. I am not talking in terms of desperation in relation to their financial position; I am talking about desperation in relation to their medical condition. I felt that what you were saying was that public hospitals should deal with the desperate medical conditions and the private sector were not under that pressure to deal with those desperate cases.

Mr Gallagher—If you are now defining ‘desperate’ as the need for them to access services quickly, then I am not for a moment suggesting that there are not desperate people who are seeking private health hospital access. There are both cases of that. The trouble is that this proposed amendment could well force access to close even further in the public area because more desperate people who have a real, urgent need to get there will not be able to get there even as fast as they are now able to get there. Without wishing to bore you, we have seen already that in Queensland certainly there is a waiting list, and there is a hidden waiting list for the waiting list. That forces people to become desperate.

Senator CAMERON—Why wouldn’t the private health system operate on the same market basis as other businesses in this country—that is, on the basis of being able to attract people to their service without massive amounts of government subsidy? And it is massive, compared to any other business.

Mr Gallagher—Can I venture a personal opinion that I think successive governments have confused the system so much by Medicare itself that that in turn makes it less than an even playing field. I am not here as someone to promote, accelerate or in any way make better than it really is the private health care system, but it is difficult for them to operate because there are so many players, so many influences and so many issues involved in it.

CHAIR—Thank you for appearing this afternoon, Mr Gallagher.

[2.15 pm]

SMALL, Mr John, Managing Director, John Small Health Advisory

CHAIR—Welcome. Do you have an opening statement?

Mr Small—Yes. I did put in a submission and I would like to make some comments on that submission now. Firstly, I will speak just briefly on my business. I established the business of Morris Cox Group Pty Ltd 20 years ago this year to act as a broker and adviser on private health insurance in Australia. At the time there were far more health funds operating than there are now and it was a very confusing industry; probably more confused than it is now. I could see a need there, or a niche in the market. In the subsequent years we have been responsible for producing—this is from figures that I took out this morning in my office—in excess of \$15 million on hospital insurance premiums per year. That is new premiums to the funds. I emphasise the word ‘hospital’ because this whole debate really is about private hospital cover, not the full extent of private health insurance. We are not talking about the extras side of private health insurance; we are really talking about hospital cover.

As well as establishing my business, in 2002 I personally became a founding director of the Private Health Insurance Intermediaries Association, which was established to protect and further the knowledge of agents and brokers operating in the industry, and to establish a code of conduct to protect the interests of the consumers. I should say that I personally am RG146 compliant. I have completed DFP1, 2, 3 and 4. I have a fairly good knowledge of the Financial Services Reform Bill. I have established my business as a personal service business. It is not an internet comparison service; it is a personal service business. We make it our policy to speak personally to every person who asks us for any advice or service. Our business split up to the end of 2007 was about 80 per cent retail and about 20 per cent corporate and provided cover for 457 visa holders and other visitors to Australia. We estimate that by the end of 2009 the corporate side of it will increase. We are estimating that it will be about 60 per cent retail and more like 40 per cent corporate.

On the proposed amendments to the Medicare levy surcharge thresholds, I should emphasise that we agree with the indexation. We agree that it is fair to look at indexing the thresholds because they have not been touched, as we know, since 1997. Also, I should emphasise at this stage that I am not an economist. I am not here to throw heaps of figures at you. I am a person who deals with people at the coalface, and that is my reason for submitting it here. So I am not going to throw lots of figures at you and, if you ask me to comment on lots of figures, I will probably have to take most of those questions on notice.

The information that we have been given on indexation is that if the levies from 1997 were indexed they would now be sitting at around \$73,000 or thereabouts for a single person, and around \$140-odd thousand for a couple or family. On that, I can be presumptuous enough to say that we can accept \$150,000 for a couple or family. We believe it is, maybe, a little bit high but, okay, that is fine. We do not see any commonsense or any logic at all in doubling the single threshold from \$50,000 to \$100,000, and we believe that it should certainly be pegged at no more than \$75,000 at the moment. On the subject of indexation, too, we do not believe that if indexation is taken on board it should be done every year because we believe that would become a bit of a mess. Maybe it could be done every five years or three years, whatever the government may choose, but not every 12 months.

However, the main thrust of our submission is on the single threshold. The reason for the Medicare levy surcharge—and I have no doubt that many people have been over this with all of you many times before—and the original design of Medicare was to have a free public health system that would sit alongside a viable private health system—again talking mainly about hospital systems—where as close as possible to 50 per cent of hospital admissions would be taken up by the private system, allowing the public system to handle not much in excess of 50 per cent of hospital admissions and for it to be manageable both practically and economically. Taxpayers were asked to contribute what is now 1.5 per cent of taxable income to assist in funding Medicare.

Private health insurance is based on the community rating principle which dictates that adults of all ages and states of health are entitled to take up private cover of their choice and to pay the same premium for that cover as anyone else. The bottom line of this is that the young and the healthy are, in effect, subsidising the ageing and those in not so good health. We do not see that as a very bad thing. This, and the enforcing of registration on health funds, has helped develop the Australian private health insurance products to be really among the best and best priced in the developed world.

As an aside, I comment again on pricing. I heard this mentioned in discussions with the previous speaker; he was asked if people find the pricing excessive. Of course they do: I find it excessive. I find the cost of my car insurance excessive but it is necessary for me to have it. I personally believe in private hospital cover, so I am prepared to pay the cost for it. We get people every day in our business contacting us and saying, 'I don't know if we should continue with our hospital cover because we've spent so much and we haven't got anything back on it yet.' Our question to them, from where we sit, is, 'Do you want to claim on it?' The answer invariably, when somebody thinks about it, is, 'No, we don't.' We then say to them, 'Do you want to be in control of your health if something horrible or untoward happens to you, or for a normal standard illness or a pregnancy or whatever? Do you want to be in control of how you're treated, who treats you, where and when you get treated?' and the answer to that invariably is, 'Yes.' Our response to that is, 'We aren't trying to force you into taking private hospital cover but, if you want to be in control, you need to have private hospital cover because the public hospital system, unfortunately, is not in a situation where it can handle your requirements to give you exactly what you want at all times, no matter what happens to you.'

I can tell you one story which was very close to me, and it concerned my mother, who has long since passed on. But many years ago she was in her 80s, and she was in hostel care and she was no longer mobile. She said to me one day, 'I'm going to drop my private health insurance,' and I said, 'Why are you doing that?' and she said, 'Well, I'm in hostel care. I don't need it any more. I can't move anywhere,' et cetera. I said, 'Well, it's your decision. I don't believe you should.' Anyway, she did. I got a phone call some weeks after that. She had tried to move herself sometime late at night, fallen out of bed, broken her hip.

She was taken up to the Royal Brisbane Hospital, which is a public hospital. I spoke to the young doctor there who was working that night. He said, 'She needs an operation on her hip.' I said, 'Okay. When can you do it?' He said, 'Probably in about six to seven months.' This, I should add, is about 12 years ago. I said, 'You're kidding. You can't leave an old lady in pain,' and he said, 'She's not in pain. We can keep her out of pain. She's not mobile anyway. It won't be affecting her lifestyle. We cannot get her in inside that time. It is not a life-and-death matter.' So I made the decision to put her into the private system and pay for it; because she did not have cover, I had to pay for it out of my pocket. I was working in the industry then and that reinforced in my mind the importance for people to have private hospital cover for eventualities that might happen to them when the public hospital system may be really struggling to give them the care that they want.

There is no doubt that the proposed changes to the Medicare levy surcharge thresholds will cause drop-outs from private cover. We know that will happen. We people working in the industry have to accept that and find the best ways we can to combat it. The number of drop-outs has been estimated by various people, far smarter than me in estimating these figures, as somewhere between 485,000 and 913,000. One answer that came from the government, I believe, when questioned about raising the single threshold to \$100,000, was that they would then be keeping it in line with the assumed original intention of the previous government of keeping private hospital membership with singles to eight to nine per cent. The Australian tax office figures seem to indicate that it will be about 2012 on the \$100,000 single level before that figure of eight to nine per cent is reached. In fact, the ATO statistics say that the June 2008 projections show 4.46 per cent of single people earning in excess of \$100,000; that, to me, seems to be a long way from the idea of eight to nine per cent. With the threshold of \$75,000, the estimate would be that the reduction would drop by somewhere between 40 and 50 per cent. The ATO figures again say that there are 7.3 per cent earning in excess of \$75,000.

There have been comments made that a great number of people taking hospital cover to avoid the Medicare threshold loading—the tax—are taking high excesses with multiple exclusions. There are two comments I would make on that: one is that in the current legislation the excess is limited to a maximum of \$500 per year, so if anyone takes a hospital cover with an annual excess in excess of \$500 per year, they will still pay the Medicare levy. Perhaps that has not been brought out publicly before, and \$500 is, in my opinion, not really that high an excess. There are excesses available with some funds of \$1,000 and \$2,000 but if anyone wants to avoid the levy they have to keep the excess under \$500.

Exclusions—and I would also put in the word 'restrictions'—on hospital cover are a very sensible thing, and we go into this when talking to prospective clients. There is no reason why a young single male would want pregnancy cover included in his hospital cover. If they are young and fit, there is no real reason why they would need full coverage for things like hip and knee replacements and cataract eye surgery, and we always go into explanations with clients on this saying, 'These are things that don't drop out of the sky on you like, say, a heart attack will or a broken leg. They are things that will give you plenty of advance notice of need, allowing you time to upgrade your cover to be covered when the need comes along for you to get that sort of treatment.' So I do think it is unfair to say that people are taking covers with these exclusions and restrictions purely to

avoid the levy. We sell a lot of covers with exclusions and restrictions because it is sensible for the people at that particular stage in their lives to have those exclusions and keep the price down. That is pretty much the thrust of my submission.

I would like to draw your attention to one example we put in the submission. If the new single levy threshold comes in at \$100,000 and you have two single people, each earning \$100,000, they do not have to take private hospital cover and they do not have to pay a levy. They get together and they form a couple. They then have to pay \$2,000 levy or take hospital cover. Our comment is that it will not take the young, bright minds of today to work out it is better to remain single or appear to be single. That is a problem that has to be faced if the levy for the single person is going to be disproportionate, as it is proposed, to the levy for the family.

In summary, the figures of the percentage of the hospital services and total costs performed within the private hospital system are readily available. A viable private hospital insurance system is needed to fund this and viability will only be kept up if the private health insurance industry can provide products at reasonable prices to certainly well in excess of 40 per cent of the Australian public; ideally, more like 45 per cent. This will certainly not happen if undue pressure is put on private health premiums and this is a spiral that inevitably will happen, leading to even more pressure on our public hospital system. We see it as irresponsible. A complete lack of planning or research has resulted in doubling the single Medicare levy surcharge. This will produce completely unwarranted and increasingly upward spiralling problems for our hospital care systems and we urge senators to refer this bill back, if possible, for looking at an amendment to the single levy. Thank you, Senators.

Senator CORMANN—Mr Small, thank you for that comprehensive opening statement. You have been in the industry for 20 years and you have asked that we do not ask you about modelling and facts and figures, so I will focus on the broader health economic principles. Why do you think a mixed public/private health system is desirable from the point of view of wanting to ensure that Australians can have timely access to quality hospital care?

Mr Small—There is no doubt that we need a public system. There is a large section of our population that cannot afford private cover.

Senator CORMANN—Sure. The question is this: with the way funding of hospital services is structured where it is universal free health care and you have limited resources, however large they are, and potentially unlimited demand, do you think the public health system will ever be able to meet all of the demand for hospital services that is out there in the community?

Mr Small—No.

Senator CORMANN—Why is that?

Mr Small—The demands would be too large. It would require too much money, too much infrastructure.

Senator CORMANN—So what is the role of the private system as part of Australia's health system, which is unique in the world?

Mr Small—I see it as being to provide an alternative to people who do not want to be a slave to the public system and are able to afford private cover if and when it is needed.

Senator CORMANN—If you had a government policy which essentially led to the young and healthy leaving, what would the impact be on older, frailer people that might be earning less and more likely to need access to hospital care and who would perceive a real need to have access to private hospital care?

Mr Small—We do not see it as just the young who will be leaving. The figures we have seen show that somewhere close to 80 per cent of those estimated to leave because of this policy will be over 30 years of age.

Senator CORMANN—The context of my question is this: in the public debate so far the focus, nearly exclusively, has been on how many people will leave and whether the people that will leave would have accessed hospital care or not and how many of those will join the queues in public hospitals. I think there is a component to this debate that has not been properly scrutinised, and you touched on it in your opening statement, hence my question. It goes to the question of intergenerational solidarity: being young and healthy and being prepared to invest in private health insurance at a time when they might not need to access it. But their funding essentially funds treatment for people like your mother, if she had kept her private health insurance. I guess my question is this: if all the people that leave are indeed the young and healthy, like the

federal minister for health is saying, what will be the impact on the old, the frail, those pensioners that might find it difficult every year to find enough money to pay for the health insurance?

Mr Small—There are probably two levels of impact. The first one on the hospital side is probably a little bit harder to predict because, as you are saying, a lot of the young and healthy who are leaving are not likely to go to hospital in the next year or two but they will be out of the private hospital system and not building that up as something that they are going to go on with for the rest of their lives. However, it will mean that, to the private health insurance industry, there will be a large income drop, estimated to be somewhere close to \$3 billion over four years.

That income drop is going to put pressure on premiums. The more pressure that is put on premiums, there is the start of what I briefly referred to as the upward spiral. The premiums will go up, older people who are more worried about their finances will look at it and think, 'That's going up too much. We're going to probably have to drop that.' As they drop it, the spiral goes up again for the next two, three or four years down the track with increases again coming along in premiums in order to keep the private health insurance industry viable.

Senator CORMANN—How much of the revenue that is collected by health funds actually is invested in funding hospital treatment?

Mr Small—I cannot answer that question off the top of my head.

Senator CORMANN—Would you be able to take that on notice?

Mr Small—I will.

Senator CORMANN—Thank you.

Senator CAMERON—Mr Small, am I correct in saying that basically your business relies on walking people through the complexities of the private health fund system?

Mr Small—We do that, yes. We have chosen to do that. As I said, we are not an internet comparison service; we are a personal service business.

Senator CAMERON—So if there is a reduction in the number of Australians in Queensland, or wherever you are, in the private health system, that means a reduction in your capacity to operate as a business?

Mr Small—It could do. We are pretty active. We do not advertise on television et cetera, as such, but we have a lot of centres of influence that refer people to us when they are talking about health insurance and they are referred to us to get advice. When we are giving the advice, we will give a recommendation if we believe that person really should consider taking out some form of private hospital insurance.

Senator CAMERON—So you have a vested interest in the private health system either staying as it is or growing: either maintaining its current status, in terms of people in it, or actually growing. That would be better for your business.

Mr Small—If the private health insurance industry grows, there is an opportunity there for my business to increase, yes. My income is derived from the private health insurance industry.

Senator CAMERON—You say you agree with indexation.

Mr Small—Yes.

Senator CAMERON—What do you say to Professor Deeble's argument that we are really unique in Australia in the context of taxing families and individuals in relation to private health and that the levy kicks in after you reach a level and you are not taxed on your income above that level but you are taxed on the whole income. Is that fair?

Mr Small—In this bag I have John Deeble's writings and I have been through them three times in the last three days and I need to go through them again because I still do not fully understand where he is coming from with that argument.

Senator CAMERON—With that argument? You do not understand that argument?

Mr Small—Not completely, no.

Senator CAMERON—I thought it was a pretty simple argument.

Mr Small—I would appreciate you enlightening me.

Senator CAMERON—It is simply that most taxation is progressive and it is based on what you earn above a threshold, but this taxation is based on not just a threshold but everything you earn. He argues that is fundamentally unfair. Isn't that a simple proposition?

Mr Small—Okay, I am sorry. I understand where you are coming from. It could be argued that it is unfair, but I do not know. The Medicare levy threshold was brought out, I would assume, basically to try and encourage more low-claiming people to come into private health insurance to help keep the costs of private health insurance capped, to some degree, for those who are more likely to need it. So it was aimed at, I believe, people who were earning what was assumed to be an income level at which they could afford hospital cover, to take out that hospital cover to enable support to be given to the older and the more needy. That is my understanding of the levy. I do not see any other way that you could do it, other than to put it on the income as it has been put on.

Senator CAMERON—But this unique system that we have here is not really a system based on free choice. There are certain incentives or disincentives not to go into the system. I am not sure if you know of any other private health system in the world where the government intervenes to the extent that the government has intervened in Australia over the last decade in forcing people into private health funds. Some people see that they are forced into it.

Mr Small—I would say that the British system is far closer to attempting to get a completely nationalised system. I happened to have a gentleman in my office last night who worked in the health insurance industry in England. He was telling me—

Senator CAMERON—Yes, but I am not asking about the British health system.

Mr Small—No, but you asked me about other—

Senator CAMERON—I thought you were an expert—

Mr Small—You did ask me about other health systems throughout the world. The American system is completely at the other end of the scale. If you do not have private hospital cover there, you are in serious trouble. I believe our system is sitting fairly well in the middle. It is certainly not perfect but I think, comparative to systems in European countries and in America, by choice I would take ours.

Senator CAMERON—One last question. In your submission you talk about the 'free health system'. Why would you say that when workers pay 1½ per cent of their income as a levy to pay for the public system? Why would you describe it as free?

Mr Small—If we took out the 1½ per cent, Medicare is still going to be funded by the taxpayers, isn't it? I have always believed that the 1½ per cent Medicare levy is really a token to indicate that we all are, to some degree, supporting Medicare because the 1½ per cent is not going to fund Medicare completely. We know that.

Senator CAMERON—But it is a hypothecated tax. It is not nothing, is it?

Senator CORMANN—It pays for 70 per cent of the health system, I think.

Mr Small—Yes, but you take that away and every taxpayer, from the lowest income worker to the highest income entrepreneur or whatever, is still going to be funding the system through taxation.

Senator FURNER—Mr Small, in respect to your proposal of increasing the individual threshold from \$50,000 to \$75,000, I take it when you surveyed your client base they were supportive of that position; to increase it to that amount?

Mr Small—I think it would be wrong for me to say that they are supportive. No-one is supportive of increasing anything. We have spoken to a lot of young people—and I am talking about people at university age etcetera—who are coming into the workforce or just in the workforce. I can honestly say that I have not spoken to one young person who does not believe that the existing system is a fair system. I mean, I guess the majority of the people that I'm talking to have been brought up by their parents who have all had private cover so maybe they have grown up with it. All the people I have spoken to have a belief in it and they believe that people, when they go into the workplace, should be put in a situation of supporting, to some degree, the health system in this country.

We had one young man who was working in our office—not in my business but in another office in the same complex—when the budget was announced and this came out. He came straight in to see me and his comment was, 'What is the government trying to do with this? Are they trying to make it easier for younger people not to wear a little bit of their share of responsibility?' That was his comment.

Senator FURNER—At this stage that is speculative in terms of what the youth will do. If I can use myself as an example, I joined private medical insurance prior to Medicare coming on board, along with my wife's ability to have that, and fortunately we were able to use that in a situation where she was involved in an unfortunate hospitalisation. I agree with your statement and I think it would be a brave person to disagree with any form of insurance. People take it on board for the use of that: you do not take out car insurance to hopefully drive down the road and smash up your vehicle. You take it on the basis—the same as health insurance—that it is there as a safeguard should you require to use it down the track. I think there is an overestimate of the drop-out rate that people may wish to examine in terms of the figures that have been quoted in these hearings.

Mr Small—I hope you are right.

Senator FURNER—You indicate that the increases should be indexed on either the CPI or the average weekly earnings.

Mr Small—Average weekly earnings, yes.

Senator FURNER—Certainly there is a vast difference between the CPI and the AWE. I would like you to explain which one of those you were proposing, or was it just an example of using one or the other?

Mr Small—When I go into those figures I always use CPI because I do not want to get myself too tied up in the other things. The economists that I have asked and the papers that I have read have all come out with pretty much the same level of indexing, saying that \$50,000 in 1997 would index out to the low \$70,000 now. Whether they are all using CPI or not, I do not know. Quite frankly, I do not want to get involved in that figure crunching. That is not my expertise.

Senator FURNER—Thank you.

Senator CORMANN—Incidentally, Treasury has taken a question on notice about this during estimates so we will have the exact figure on what the indexation would have been if it had been indexed since 1997. It certainly would not be to double it. I note that your involvement in the industry was a couple of years after John Deeble, the father of Medicare, was involved in the early eighties in creating the system that is still largely in place now. I note that during that period private health insurance membership went from about 63 per cent all the way down to 30 per cent. As somebody who has been involved in the industry, can you describe the impact that that has had on our health system?

Mr Small—It was pretty devastating in the late nineties when membership got down to almost 30 per cent, to the extent where—I am not saying the private hospitals were going broke; there were still plenty of people using them—the public hospital system was exhibiting lots of signs of being overloaded. If I remember rightly, around that time waiting lists for major surgery, orthopaedic surgery such as a hip replacement, in Sydney at the time was out to something like seven years. It is not out to that now. It is still a long time but it is not out to that now, but that was the extent that waiting lists for major surgery were getting out to at that time.

Senator CORMANN—Senator Cameron mentioned workers paying the 1½ per cent Medicare levy. I guess there is a perception in the community that essentially the Medicare levy is there for public insurance and that their 1½ per cent Medicare levy means that, as such, they should have access to that free universal health care, having paid that. Do you think that there should be a greater degree of transparency in the true cost of public health services to individual taxpayers and, I guess, working families?

Mr Small—Yes, I do.

Senator CORMANN—Private health insurance premiums are totally transparent because they keep going up as the cost of hospital services goes up. Do you think there is a lack of transparency in comparing the cost of the public system with the cost of the private system?

Mr Small—Yes, most certainly. There is another comment that I would make on that, too. Let's not forget that Medicare does not just pay for hospitalisation; it pays for medical services, visits to doctors and specialists et cetera. I do not know what the split is between what they would spend on hospital and what they would spend on medical.

Senator CORMANN—It is another question on notice to Senate estimates. Do you think it should be more transparent?

Mr Small—Yes, definitely.

Senator EGGLESTON—I would like to ask you a question about who will drop out in the modelling, based not so much on the modelling but on your experience. The Treasury says that the people who will drop out will be the younger people. The AMA and Access Economics have a view that there will be a second wave of drop-outs where older people who will find it difficult to meet the increased costs of health insurance funds will drop out. Do you think that is the pattern which will emerge, from your own personal experience?

Mr Small—That there will be a second round?

Senator EGGLESTON—Yes.

Mr Small—Yes, I do think there will be a second round. The first thing is that, I guess, the ingrown natural apathy of the Australian will mean that the first round of drop-outs is not going to happen tomorrow, just like that. If and when the legislation goes through and becomes law, I would imagine it could be getting close to tax time next year before we start to see the big number of drop-outs happening. But then it will occur probably getting close to tax time each year as people—

Senator CORMANN—Like between 1983 and 1996; a similar downward spiral?

Mr Small—Exactly, yes. We are not going to have half a million people drop out in September.

Senator EGGLESTON—It will not be a one-off, on the basis of your experience?

Mr Small—No. It will not be a one-off, in my opinion.

Senator EGGLESTON—The Medicare levy surcharge was only one of the three measures involved in supporting the private health insurance system introduced by the government back when it was put in place.

Mr Small—Yes.

Senator EGGLESTON—The others were the private health insurance rebate and, of course, Lifetime Health Cover.

Mr Small—Yes.

Senator EGGLESTON—In which people were penalised if they had not taken out health insurance at a younger age group but took it out later and they had to pay a penalty in terms of premiums. What is your view about, particularly, Lifetime Health Cover's impact on people in terms of keeping them in the system, or do you think that they do not understand it well enough so that later on they will be penalised and be locked out?

Mr Small—That is something that is now becoming pretty well understood; perhaps not universally but pretty well understood. It has had a big impact and will continue to do so. It does keep the drop-outs down. There is a thing now where, once somebody is paying an age loading for 10 years it then finishes at the end of 10 years and people are sort of saying, 'Good, I've only got four years to go,' or whatever. That had a big impact in lifting the member numbers for hospital cover.

I should say that the Medicare levy surcharge was not. My belief is that it definitely was not publicised anywhere near enough. Most of our inquiries on that would come into us at tax time every year, when people said, 'I had no idea. I didn't know that legislation was in place, so my accountants told me to get in touch with you and do something about it.' We then talk to them about that. But the Lifetime Health Cover definitely had a very large impact.

Senator CORMANN—I would like to ask a follow-up question on that point. I think what happened—and I will ask you to comment on this because you have been in the industry for a long time—was that after Lifetime Health Cover and the 30 per cent rebate there was a spike.

Mr Small—Yes.

Senator CORMANN—And then in fact it came off a bit and over the last three or four years it has actually started to trend up again; 400,000 additional people with private health insurance to December 2007. Do you think that that second wave of the increasing proportion of people taking up private health insurance is related to the impact of the Medicare levy surcharge and more and more people are becoming aware that it makes financial sense for them to take out health insurance?

Mr Small—Yes, I believe that that has happened, and we have seen that happening in our business. In very recent years more people are becoming aware of the Medicare levy surcharge. I would say going back seven or eight years ago, people were not aware of it until tax time came around, but I think that has been having much more of an effect. We have been getting a lot more calls from people saying, 'Oh, look, I think I'm at that

income level now where I haven't got cover and I need to look at it, and I'm also at the age level where I need to look at it.'

Senator CORMANN—So the policy is working, in effect?

Mr Small—Yes, it is working more now.

Senator EGGLESTON—Coming back to Lifetime Health Cover, though, if people drop their health insurance now—younger people under 30—in 10 years time or 15 years time what percentage of additional premium will they pay, and will that lock them out?

Mr Small—It could be a problem to them. It will cause some serious thought because the Lifetime Health Cover loading applies a penalty of two per cent for every year of age the person is over 30 at the time they take up hospital cover. So if a 30-year-old were to drop out now and then take it up at the age of 40, they would pay a 20 per cent loading on their hospital cover—substantial.

Senator EGGLESTON—Quite significant. That goes up by two per cent each year thereafter, if they have not taken it out.

Mr Small—Yes, that is right.

Senator EGGLESTON—Thank you.

CHAIR—There are no more questions. Thank you, Mr Small, for coming in this afternoon. The committee will adjourn for a short break.

Proceedings suspended from 2.55 pm to 3.17 pm

RHEINBERGER, Mr Gregory John, Executive Manager, Health Fund Strategy, Teachers Union Health Fund Ltd**SELJAK, Mr Robert, Chief Executive Officer, Queensland Teachers Union Health Fund Ltd; Board Member, Australian Health Insurance Association**

CHAIR—I welcome this afternoon the Queensland Teachers Union Health Fund. Would you like to make an opening statement?

Mr Seljak—I would. Thank you for this opportunity to appear before this inquiry into the proposed changes to the Medicare levy surcharge thresholds. I will refer to Queensland Teachers Union Health Fund as TUH, by which the fund is commonly known. I am also here as a director of the Australian Health Insurance Association which has made its own submission to the Senate inquiry. I would like to give a short overview of the fund and, in particular, members to our fund and to the specific effects of the proposed legislation on TUH and a little bit about Queensland in general.

TUH is a not-for-profit organisation, established by the Queensland Teachers Union in 1972 as a service to union members in the education sector. I think there is a potential for the proposed changes to have different impacts on different funds and in different states, and I would like to explain how this could occur.

First, I would like to give the committee a picture of a typical member of TUH. Our typical member is a 50-year-old female teacher, married with two kids. Her salary is \$60,000 and, if she is married to a teacher, his salary will be similar. She has a comprehensive hospital and general treatment policy and will pay \$5,000 per year in premiums before taking advantage of the government's 30 per cent rebate. During her life she will have maternity leave when she gave birth to her two children and, during that time, the family income would have decreased but she chose to continue to pay her private health insurance to ensure coverage of her children. But that was a long time ago.

Soon her children will be over 21—one has finished university; the other works in hospitality. In the intervening years she has made claims on her policy for hospital treatments and general treatments. Benefits paid by TUH are, on average, 85 to 90 per cent of contribution income. So on average her family will receive between \$4,000 and \$5,000 in benefits per year that pay for treatments for her and her family. Some years it will be a lot higher than this, especially as she gets older, and some years much lower.

Hospital claims were made by our typical member when her children had grommets, appendicitis, and other ailments typically suffered by kids. Her husband made a claim for a hospital stay for a colonoscopy and she of course made claims for the birth of her children, one of whom suffered from a postnatal condition. General treatments include multiple trips to the dentist for the entire family, prescription glasses for her and one of her children, and physio treatments for her husband's bad back.

But getting back to the children: they will have to take out their own policies if they want to continue their cover, and often they do not see the value in it, because of course they are indestructible, always drive under the speed limit and do not go to venues or parties where alcohol can impair judgement. As if! Mum will do without other necessities to pay for her kids' private health insurance until they make enough money, or gain enough sense, to pay for their own. When she reaches 60 she will retire and live on a fixed income but the same PHI premiums are still payable, and this is likely at a time when she and her husband will rely on her cover the most. They are of course entitled to an extra government rebate as they get older, but the cost of everything else just seems to be going up so they will struggle to make payments. But they are content to remain in private health insurance because they have the security to know that they will have options for their care if they get sick.

Realistically, they are not destitute but they are not millionaires either. They are ordinary people who choose to pay for the options that the private health care system can provide them and they are comforted by the fact that the public health system is there for emergencies and to treat people who may be less fortunate than they are. This member will be worried that the proposed changes to the levy could impact on her health insurance. Why is that? She has read reports in the media that a lot of people could leave private health insurance, making it more expensive for those that stay.

I would like to turn then to the likely impacts of the proposed changes to our fund to make the picture a little bit clearer for our typical member. What is the impact on premiums? TUH estimates approximately 1,100 single and 225 family policy owners are at-risk policyholders, which translates into 6.8 per cent of policyholders with hospital or combined products. We have assumed that 50 per cent to 70 per cent of the

membership at risk could lapse their policies and that the policyholders will simply not renew their policies when they become due, rather than take action to cancel them from the time any legislation comes into force. This equates to a lapse effect of 3.5 to five per cent of policyholders with hospital or combined products and an estimated loss of income of \$1 million to \$1.2 million over the 12 months after the legislation commences.

Industry-wide impact is important, too. The impact of the industry-wide membership is estimated at between six and 10 per cent. Because those expected to leave are not expected to be high claimers, the impact of their claims will be negligible on risk equalisation. 'Risk equalisation', for the benefit of the committee, is a pool of funds paid for by industry for older people and people with very high cost claims. Because there will be fewer people contributing but the same number of people probably claiming from this risk equalisation pool, the actuaries have estimated that this would cause a net increase for payments for our fund in the nature of \$1 million to \$1.5 million. So the combined negative impact on TUH annually is in the range of \$1.8 million to \$2.8 million. At the high end of that scale, if it did reach let's say in the order of \$3 million, that would represent a seven per cent increase in premiums, based on today's figures.

What is the impact on public hospitals? I believe the impact of the proposed changes could have a higher impact in some states than in others. I will use some statistics to illustrate this effect. TUH, which is a small fund with 20,000 members, spends two per cent of our benefits on public hospital admissions. So for the main, Queenslanders with private health insurance use private hospitals. That is not true in all other states. For example, a much higher percentage of patients with private health insurance in New South Wales use public hospitals. According to PHIAC data—PHIAC is the Private Health Insurance Administration Council, a government regulatory body—25 per cent of hospital admissions, paid for by private health insurance funds, use the public system in New South Wales, whereas in Queensland it is only six per cent.

Why is this? The main reason is because the ratio of public to private hospital beds is higher in New South Wales; in other words, there are more public hospital beds per thousand people in New South Wales than Queensland. The overall number of beds per thousand in both states is roughly similar; however, in New South Wales only 26 per cent of these beds are private whereas in Queensland approximately 38 per cent are in private hospitals. Therefore, people leaving the private health insurance system in Queensland will likely make a more immediate impact on public hospital waiting lists because they are almost certainly getting treated in private hospitals now.

This perhaps explains comments made by some people like the Premier of Queensland when she was asked about increases in private health premiums earlier this year. She said during an ABC radio interview:

I don't want to see any increased pressures on our public health system, so I encourage people, even in difficult times, to stick with their private health insurance.

Now, will members of TUH leave our fund? Analysis by our fund actuaries has predicted that we will lose between 3.5 and five per cent of our members under the proposed changes, as opposed to the six to 10 per cent predicted for the industry. That is about half the impact. Why is this? For one thing, TUH does not sell cheap products, and by that I mean we do not have products that have exclusions or restrictions—for example, products that exclude things such as coronary procedures or hip replacements. It is not likely that many of our members bought our products mainly to avoid the Medicare levy surcharge, because there are much cheaper products on the market that would achieve this. In other words, products obviously can be made cheaper if they exclude more expensive procedures. We simply do not sell those at this time.

Another reason for the difference is that we have extremely loyal members. PHIAC reports that we have nearly a 95 per cent retention rate, the second highest in the industry. In fact, the only fund that surpasses our fund is Teachers New South Wales. I am not sure what that says about teachers except that they probably do not like change. We also have a 96 per cent member satisfaction rate as measured by an independent research company. So our members regard the fund as a long-term investment to improve their health care options throughout their lives. I would like to finish my opening remarks by reading an excerpt from a letter that I received from a member on 12 June—so just last month—just to highlight this last point:

Dear Sir,

This letter is mostly to thank you all very sincerely for the large amount of work carried out and financial help given to my wife and me as a result of her cancer operation and her long spells in the Holy Spirit Hospital and afterwards in the Peninsula Private Hospital for what was termed 'rehabilitation'. We do feel dreadful for having caused so much expense to Queensland Teachers Union Health but are really very grateful. There is no way we will ever leave our private health fund, no matter what happens as a result of government cancellation of the Medicare levy for some people.

The letter is signed by Kevin and Jocelyn. I will leave out their last name, to respect their privacy. They joined the fund in 1976. Kevin is 90 years old and Jocelyn, his wife, is 83. There is the potential that members like Kevin and Jocelyn will not be able to afford their private health insurance cover if this proposed change to the Medicare levy surcharge is implemented and any of the impacts that have been predicted come true. In finalising my comments, I would just like to table a small fact sheet that I have prepared for the committee, and I have a copy for the members, if you would like to look through that, outlining some of the information I have provided today.

Senator FURNER—I seek that that document be tabled.

CHAIR—That is carried. Thank you. Mr Seljak, the Treasurer argues that the stated intention of the surcharge in the first place was to force higher income earners, those that could afford it, to take out private health insurance, and I suppose the argument is that since 1997 when that was done, because the threshold has not been increased, people on relatively low incomes have been paying the surcharge or joining private health insurance. Would you see that there is a kind of equity argument that the people paying that surcharge are no longer high-income earners?

Mr Seljak—Our fund in particular is aimed mainly at teachers. Virtually all of our potential members fall within the threshold or the proposed change to the threshold. In other words, most teachers by their second year are making over \$50,000 and very few—only principals of the larger schools—make over \$100,000. So the whole group is in that category and, from our perspective, we like the threshold where it is for that reason: it does provide that extra encouragement. However, I think that the three pillars on which private health insurance is balanced are the 30 per cent, Lifetime Health Cover and the Medicare levy surcharge, and it is a delicate balance. To disrupt the balance, I think, has the potential for upsetting not so much the balance in private health insurance but the partnership that exists between the private and public hospital systems. In fact, I read today in the local paper, the *Courier-Mail*, that the minister during estimates committee hearings that are going on in Brisbane at this stage was asked about Surgery Connect, which is an initiative by the state government to connect public patients on waiting lists and get them treated in private hospitals. That capacity to treat those people in private hospitals is only there because we have a very healthy private hospital system in Queensland and we just would not like to see that balance interrupted.

Senator CORMANN—Mr Seljak, you mentioned in your opening statement that you are a not-for-profit health fund. Can you just in a few sentences explain for us what that means in practice.

Mr Seljak—We have only two sources of revenue: it is either direct contributions in payment of premiums or investment income that comes as a result of investing any contributions that we do not have need of in a particular year. All that money is returned to the members in one form or another. As I indicated, 85 to 90 per cent is returned in the form of benefits and services to members, but the other 10 to 15 per cent does not go to shareholders, it does not go to any other private investors; basically, it is held by the fund to benefit members.

Senator CORMANN—To cover future claims and—

Mr Seljak—To cover future claims, unexpected spikes in claims, but it also allows our fund to smooth over premium increases. You will notice on the second page of that document I tabled that for the last three years our premium increases have on average been 3.84 per cent against an industry average of 5.06 per cent, and this year we were 2.7 per cent, almost half the industry average. We use any funds that we have in surplus to try and ease the transition from one year to the next for our members.

Senator CORMANN—Thanks for that. I wonder whether you could take a question on notice. I am trying to draw together all of the figures that you have given us in your opening statement, because I am obviously keen to assess the impact of this policy, if it were to be pursued, on public hospitals and the capacity of public hospitals to deliver services. You have told us that, for every dollar you receive in hospital insurance, you spend 85c to 90c on treatment. You have also told us that you estimate a loss in revenue of \$1.8 million to \$2.8 million. All we now need is your market share and, essentially, apply that, to extrapolate what the impact in terms of lost funding for hospital treatment is going to be for the state of Queensland. Are you with me?

Mr Seljak—Yes.

Senator CORMANN—Would you be able to provide us your market share and go through that formula and, on notice, provide us the final figure. In the meantime, I go to my next question. Your members are teachers who are on incomes of around \$60,000 per annum. They take out health insurance and take additional responsibility for their health care needs by taking out that health insurance. Don't you think that they are equally as deserving of a one per cent tax cut as people who choose not to take out private health insurance?

Essentially, the increase of the threshold equates to a one per cent tax cut for people earning between \$50,000 and \$100,000 as singles and between \$100,000 and \$150,000 as couples. It is a one per cent tax cut for people who do not take out health insurance. Your membership is in that threshold, as you have said, and I am sure that they would also enjoy the benefit of a one per cent tax cut, particularly as they are extending themselves further and putting additional resources into the health system.

Mr Seljak—It is a good point, but if you look, again, at the first page of the handout, that red age profile, the red line, shows how many of our members are over 50. In fact, the highest percentage of members are 50 to 59. They are all retiring. They will not be making \$60,000 for much longer. Also we have a component of our membership that works in the education sector, who are union members but are not teachers: groundsman, janitors, admin assistants. They are also members of our fund in that education sector environment. So I think that, although there would be a temptation to say, ‘Yes, I could get a one per cent tax refund’ in that other way you described, the other thing is that that peak you see in that graph, of the 50- to 59 year old group, every year moves a fraction to the right because those people are all getting older. That is when they really need their health insurance, so they might appreciate that is an immediate gain but in the long-term—

Senator CORMANN—That is what I am trying to get at. There is obviously one scenario where nobody gets a tax cut and what I am hearing you say is that you do not think the threshold for the Medicare levy surcharge should be increased. Then there is a scenario where some people get a tax cut and one where everybody in those income ranges gets a tax cut. From an equity point of view, considering that your members, you said, pay an additional \$5,000 into the health system every year, don’t you think that they are equally deserving of getting some tax relief compared to people who choose not to go that extra mile?

Mr Seljak—There is no question about that.

Senator CORMANN—Treasury has made a submission to this inquiry and has said that in its modelling it did not include any assumptions or possible effects of ‘reduction in membership on future premiums as a result of this policy’. I have two questions in relation to that. Firstly, do you agree that it will be a one-off effect or do you take the view that others have put forward in front of this committee that it could be the start of a new downward spiral as we experienced in the eighties and early nineties? And if so, what is your assumption on future premium increases? You mentioned a figure of seven per cent. Do you think that this is going to be the start of consecutive higher premium increases than otherwise would be the case? What is going to be the overall upshot of that?

Mr Seljak—There is certainly the potential for that. Again, if you look at the age profile of our fund, which is not too different from the industry as a whole, if that peak at the 50- to 60-year-old level is constantly moving to the right and the influx of members on the left side of that graph does not happen because that one bit of encouragement has been taken away, that will certainly have a long-term implication on the level of premiums for the people remaining going forward far more than just one year or two years. Then, depending on the impact on premiums, people will make an individual assessment of whether it is still a good investment.

Senator CORMANN—Medibank Private told the Senate estimates committee that their assessment was that, as a result of this measure, they would lose between seven and 10 per cent of their membership. You have mentioned to us that you expected to lose between 3½ and five per cent. What is the reason for that difference?

Mr Seljak—Medibank Private has a lot of products. From recollection, they have 600 products. We have six. None of our products are cheap and the union has always taken the view that they have wanted to provide a quality product, quality service to our members. So I do not think a lot of our members have purchased private health insurance to avoid a Medicare levy surcharge, whereas Medibank Private may have a different experience, so they may lose more members than we.

Also, our membership is very loyal. We have a large health care centre in Fortitude Valley where we have our own dental and optical facilities, where members get virtually free preventative dental treatment. It is like a club. People go there; they know each other. Our staff on the call centre know some of our older members by their first names. Sometimes I think they call just to have a chat. But it is a different environment, I think, in a small fund. I do not know all the modelling that Medibank has done but it would not surprise me that an impact on a fund of our profile would be slightly different than theirs.

Senator CORMANN—You mentioned that you are also director of the AHIA. What would you say is the benefit of having a private health component as part of the overall Australian health system? What does it add? Why should we be different to what is happening in Britain or in—

Mr Seljak—I hope you are not going to say USA.

Senator CORMANN—No. I am interested in your broad—

Mr Seljak—I am from Canada originally and Canada has the most nationalised health service in the world, I think, apart from North Korea which is the only other country that makes it an offence to sell public hospital insurance. It just does not exist. It is sometimes seen as a model for other countries, and I thought it was a model when I was living there, but it is slowly going bankrupt. Either the government has to make a decision to increase taxes significantly or, as happens now, people will go to the United States and pay \$50,000 for an operation.

Senator CORMANN—Is access to health care in Canada free of charge?

Mr Seljak—Absolutely. It is illegal to charge anything. No money changes hands. You just hand in a card.

Senator CORMANN—So what happens to waiting lists?

Mr Seljak—The waiting lists are horrendous. They are good for emergency and that is what the majority of people expect. The majority of people do not have long-term, acute illnesses. The people that access the hospital system have to wait.

Senator CORMANN—What contribution does private health care—

Mr Seljak—Private health provides options. It does take pressure off the public system. It will make the public health system more sustainable in Australia going forward and at a reduced reliance on government funding. People are choosing to invest in private health insurance in Australia. I think it is far better than the British system where you only have access to private health insurance if you work for a large company. The National Health Service is plagued with the same kinds of funding issues as all health systems are plagued with. The AHIA believes that the Australian model is a strong one and it is a partnership between private and public.

Senator CORMANN—Is it fair to say that, by the time we reached 1996 and health insurance membership was plummeting, our health system was getting out of balance a bit? In 1996, health insurance membership was plummeting. It went down to about 30 per cent. What was the impact of that?

Mr Seljak—In terms of the public hospital system?

Senator CORMANN—Yes.

Mr Seljak—I am not saying it laid the foundation for some of the crises we have seen in public health but I am certain that it would not have helped. It would have put an extra load on the public system without the required government funding. Government funds now seem to be pouring into the public health system, which is good, because we need a strong public health system, there is no doubt about it. But if there is a risk, it is that the investment in private health is diminished. It is a balance and it could have implications, I believe, for waiting lists and on public hospitals.

Senator CORMANN—Thank you very much.

Senator CAMERON—Could you give the committee a copy of the assumptions and the methodology that your actuary used to come up with these figures, in terms of people dropping out?

Mr Seljak—We have got actuarial advice. Our actuary is from KPMG, David Torrance. He issued that advice as a draft in confidence but, if the committee would allow me to consult with David, I am sure he would be happy to release it and I can table it.

CHAIR—I will also remind you that we are able to take it as confidential correspondence.

Mr Seljak—In that case, I think there would be no problem.

Senator CAMERON—Thanks. You talk about encouragement to join a private health fund. Lots of people I talk to do not see it as encouragement; they see it as compulsion in terms of, if they do not join now, they are really facing an impossible position further down their lifetime to join at a reasonable price. Is that really a way for the health funds to operate—under this sort of compulsion?

Mr Seljak—I suppose it is the only way to keep the system affordable. If people do not join until they are 60 or 70, it is like getting in a car accident and then buying car insurance; it just does not work in terms of insuring the general risk for the general population. Another great feature of Australian health insurance is community rating: that smokers and diabetics et cetera are allowed to pay the same rate as people that are relatively healthy. Without that, it would be completely unaffordable. Again, in the UK and the United States they are risk-rated systems. In other words, older people, unhealthier people, pay more. I think it is the only

way to keep the system affordable. It might seem unfair—'Why are these tactics used to force me to pay it?'—but from another perspective it is, I suppose, a policy setting that allows the government to keep its public health expenditure in control and provide a level of service that the community deems acceptable.

CHAIR—Sorry, Senator Cameron, could I just follow on from there?

Senator CAMERON—Yes.

CHAIR—You are saying that the only way to keep private health funds at an affordable rate is by increasing the volume of people coming in. You mentioned your facility at Fortitude Valley, I think, and that is presumably your way of keeping your costs under control. If there were a way of containing your costs more, that would also help keep premiums down and encourage people to come in, would it not?

Mr Seljak—That is why we run, and have always run, even for a small fund, a fairly strong health management program. We have a health risk assessment which we are just introducing online, where people can keep track of their health. We try and provide as much information as possible, because really two-thirds of health care expenditure is the last three years of a person's life, so the time that you want to keep them healthy is up to the latter part of their life because that is where their expenditure really occurs. It is those hospital admissions that cost \$100,000, \$150,000, not the dental visit that costs \$50.

CHAIR—So, rather than coercing people to join the fund, you could possibly look at ways to reduce costs for the fund.

Mr Seljak—Health awareness and health promotion have to go hand in hand in the delivery of a viable health care system. I think far too much emphasis is on treatment and not enough on prevention. There is the old adage that an ounce of prevention is worth a pound of cure. It needs to be a holistic approach, but we are dealing in a current environment, and it is an effective way of keeping expenditure affordable. There are other ways, and I think those are things that we should be looking at on a long-term basis—over a decade or two.

CHAIR—Sorry, Senator Cameron.

Senator CAMERON—That is all right. I am interested in exploring the make-up of your health fund. It seems to me that you are in a declining make-up of private health funds. NIB and MBF are going public. You are going to be one of the remnants of this mutual type approach. NIB had an office in Penrith in the western suburbs of Sydney for as long as I can remember, living out there for 20 years, and when NIB privatised they immediately closed that office down, so you have to do everything online.

How do you see being able to delineate between the effects of what you perceive to be the government's decision and some of the moves by the health funds to slash costs and provide not as an effective and a face-to-face service? How do you pick out what is the cause and effect, because you cannot blame every future resignation from the health fund on this initiative by the government.

Mr Seljak—Absolutely. I agree with that. We all work in an environment and there are many varying pressures we have to balance in order to maintain our relevance to our membership. It is vital that we continue to provide great member services and customer support. Our board has no interest in looking at anything other than the mutual model that already is there. We think we will benefit from some of the privatisations that are going on because people will start looking around if they are not happy with the service they are getting.

If what you say does occur and there is a decline in standards and any further pressure on premiums, people are naturally going to look around and now there are more vehicles to do that; for example, the very popular iSelect site that seems to attract a lot of attention. There are more avenues that enable you to do that. Maybe our fund is old-fashioned, but we certainly believe in customer service. We do not have interactive telephone systems. Our call centre people answer the phones directly.

Senator CAMERON—That is why you got an approval rating—

Mr Seljak—Probably. It is probably one of the few call centres that continue to do that. The whole for-profit, not-for-profit debate is another realm. It is vital for all companies to look at customer service.

Senator CAMERON—Can I just explore this a bit. Should there be a different approach by government towards the not-for-profit sector and the for-profit sector? I am asking myself why government would subsidise, to the extent that it is subsidising now, the for-profit sector if executive salaries go through the roof and services decline. Why would that be a good investment for the government?

Mr Seljak—The model we have gives the consumer the choice of which fund to join and whether they want to stay with their fund. The funds follow the consumer. In that way, although it is a subsidy, it is a consumer directed subsidy. You can make the same argument, I suppose, for private schools.

Senator CAMERON—We will not go there.

Mr Seljak—And I am sure you have. But, again, the answer is that the subsidies or the support from the government make the whole system viable. It would be great if not-for-profit companies got a bigger rebate but I do not see that as realistic. We do not want to split the industry. The rebate scheme supports the industry as a whole and there are some big for-profit players out there now. Only 18 months ago it was about nine per cent of the market. Now I think it is over 40 per cent that is for-profit. So it is important that the for-profit and not-for-profit sectors equally provide excellent service to make the whole scheme viable, so I would not support splitting it on those grounds.

Senator EGGLESTON—Relating to the last question, I would like to raise the question of education because 30 per cent of Australia's children are educated in private schools, largely the Catholic sector, as we know. But the government does pay money into the private education sector because the state education sector is not large enough to educate that 30 per cent; in the same way, I would suggest to you, the government contributions to private health insurance, or support of it, reflect the fact that the public hospital sector is not able to service the entire Australian population and, from a structural point of view, the private health sector is therefore important in carrying the load that it does in terms of providing health services to a percentage of the population. Would you agree with that analogy?

Mr Seljak—Yes, I would agree. It is a very good point.

CHAIR—Thank you for appearing here this afternoon.

[4.03 pm]

KENDELL, Mrs Kathy, Consumer Representative Member, Public Hospitals, Health and Medicare Alliance of Queensland

SCHRADER, Dr Tracy, Doctors Reform Society (DRS) Representative, Public Hospitals, Health and Medicare Alliance of Queensland

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

Mrs Kendall—Yes, I do. Thank you for the opportunity to express, on behalf of the Public Hospitals, Health and Medicare Alliance of Queensland, our support for the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008.

The Public Hospitals, Health and Medicare Alliance of Queensland is a coalition of consumers, trade unions, community organisations and health service providers raising community awareness, encouraging debate and lobbying on issues related to public hospitals, public health services and Medicare. PHHAMAQ lobbies federal members of parliament and senators in particular to ask that they oppose all government policy initiatives that will undermine integrity, universality and the ongoing viability of Medicare.

We are not in a position to address the terms of reference specifically, as we do not have the resources to guesswork and make assumptions about how the proposed amendments will impact on private health insurance premiums or on the numbers of policyholders. What we can bring to this table, however, is an important perspective critical to this debate, even if it does not fit nicely within the terms of reference. It is a perspective held by many users of health services, who often have no voice in these things, and we trust that the committee will listen to this perspective.

Private health insurance premiums always rise irrespectively. Over the last five years there has been an average increase of 3.8 percentage points above CPI. In fact, in 2005 the average premium increase was almost eight per cent on the previous year. The average annual health insurance premiums for a family of four in the United States has reached US\$13,000 a year, with major deductibles on top of that, so we do not think anyone should be surprised that private health insurance continues to rise, and one day it is likely we will see those amounts here in this country as well. It is simply the nature of the private system, a system still heavily propped up by this government with taxpayer funds, despite these very minor amendments, which in effect simply gives some people relief and a fair exercise of real choice as to whether or not they choose to buy a product rather than suffer a penalty for not choosing a product.

One of the activities this alliance participated in during 2003 in response to the Howard government's policies, such as lifetime cover, the 30 per cent health insurance rebate incentive and the very legislation these proposed tax amendments will now help to improve, was to discuss these initiatives with ordinary everyday people and conduct a petition, which was ultimately tabled in the federal parliament with some tens of thousands of signatures.

I helped to man the stalls in the Queen Street Mall and the Caboolture Sunday markets over a period of some three weeks. During this activity I personally spoke to nearly 1,000 people individually who chose to approach our stalls. I can easily recall the tenor of the most commonly held fears and views being expressed at the time. People were fearful of Lifetime Health Cover and felt that the carrot and stick policies of the Howard government were not helping them to exercise authentic choice but were instead pushing them reluctantly to take out private health insurance, when what they really wanted was a reliable public health system.

The Howard government's measures were accompanied also by a concurrent reduction in expenditure by the federal government to public hospitals, thereby pushing public hospitals to crisis point in most states and territories and causing people to lose confidence in the public system. People were worried that government policy and financial support for the private system was contributing to and further entrenching the problems and the shortfalls of funding in public hospitals.

People specifically expressed to us they did not want a two-tier health system; they wanted an equitable health system where everybody had the same timely access to quality health care on the basis of need. The political talk around Medicare being little more than a safety net for the poor and a massive advertising campaign by the Howard government at the time raised fear in the minds of people. People felt forced to purchase a product that, if they ever had to use, they feared they could not afford the out-of-pocket expenses.

I refer to an example of a family personally known to me who purchased private health insurance under those circumstances, based on the fear of an underfunded public system, and later the husband was involved in a very serious accident. Due to the contractual nature of his employment, he was not entitled to WorkCover. He was not entitled to Centrelink benefits or benefits of any kind whatsoever, despite his recovery taking over a year before he could return to work. This family was simply without income for the entire year. While in the emergency department, the family denied having private insurance due to their fear of the anticipated lengthy rehabilitation costs involved. The public hospital treatment and home visits were coordinated and were free of charge.

However, further surgery became necessary and, as time was of the essence, this family did disclose that they had private health insurance at that point, and following that disclosure the entire medical regime changed. From then on costs escalated, including costs for the additional surgeries, the occupational therapist, the physiotherapist, the hand specialist, the orthopaedic specialist, and increased wait times in order to find and travel to and coordinate the needed services, which you do not get in the private system as you do in the public system. Private care was fragmented and still hard to get because there were not enough workers in the private system either. In summary, thousands of dollars in treatment were incurred after this family relied on their private insurance, at a time they could least afford it. They were disgusted to learn that often they were paying higher than actual costs for equivalent care in the public system, simply because private services are billed at higher rates.

The Medicare levy thresholds have not been indexed since 1997 and no longer reflect high-end incomes. We believe the proposed amendments are fair and will help relieve the pressure on those who only purchased private health insurance to avoid the extra tax but would financially struggle if they actually had to use their insurance. Those arguing against these threshold increases, claiming that it will cause a mass exodus from private health insurance, should really be more honest and acknowledge the real reason, being the poor value of the product itself. They might as well use the same line of narrow and perverted thinking and argue that any improvements or extra funding in the public system to make it more efficient and effective for more people also is a disincentive to people taking out private insurance and also poses a threat that there will be a mass exodus out of private insurance.

So, rather than focus on and argue the absurd, let's stay focused on what is really important. If private health insurance is not a product of value, then carrot and stick tactics can do nothing to increase the product's actual value; it can only undermine people's choice. We do not believe that these amendments will lead to a mass exodus out of private insurance. This is not because we believe private health insurance offers value for money. It is because people's fears still exist from the Howard era about inadequate access to public hospitals; the 30 per cent rebate incentive; the remaining penalties associated with higher income brackets that will remain; and, of course, Lifetime Health Cover, which people are really fearful of. I have a research study here which showed that when that was brought into effect really was when the big increase in people's private insurance was taken out.

Over the last 12 years significant power and money have been transferred to private health insurance and the private system through government policies and substantial public subsidies. We are deeply concerned when revenue from taxation is used to fund health services that do not provide equity of access and equity of outcomes. We believe it is crucial that all taxpayer funding of private services be critically analysed to ensure such funding fulfils equity requirements and does not in any way, either directly or indirectly, harm the public system. It is also our right as taxpayers to expect that health outcomes per dollar spent in the private system are equivalent to outcomes in the public system. We strongly support risk-adjusted measures of performance, including costs and outcomes, across public and private settings and in both the hospital and community sectors, as the lack of quality evidence across health policy settings is part of the reason we remain in a pointless and costly ideological debate about the real value of running a private system next to a public system.

We have been pleased that the National Health and Hospitals Reform Commission has acknowledged equity as an important guiding principle of reform. If this commission is to be genuine in its commitment to that principle, then it really has no choice but to recommend that any taxpayer funding of private services demonstrate its positive immediate and long-term impact on the entire health system. Thank you very much for listening to me.

CHAIR—Thank you, Mrs Kendell. You referred then to the public health system undergoing review at the moment and that the state and federal governments are negotiating new rounds of agreement about

Commonwealth and state funding arrangements in public hospitals. We have heard some criticism in these hearings that this measure may pull people out of private health insurance and therefore put more pressure on the public hospital system, but I understand you are saying that, in the context of the renegotiated agreement, even if it does occur it should not put undue pressure on the public hospital system.

Mrs Kendell—I think people who actually research this area have been saying that publicly: that there will be just simply a shift.

Dr Schrader—The increases in private health insurance uptake have not taken pressure off waiting lists or off public hospitals; it has not been shown to have done this. And even if people do go back into public hospitals and the public hospital systems, that is not a bad thing in itself. It is actually a good thing, because health service providers go where the people are. That is what has happened. Doctors and nurses have moved towards the private system but, if people move back into the public system, the providers will then move with the patients, and having more people in the public system gives better public support. With the middle class in the public system, it is more likely to be better funded rather than become a run-down, second-rate system.

CHAIR—I think it was the Queensland branch of the AMA in evidence earlier who were indicating that the hospitals in Queensland are in the process of being rebuilt or being built, but they would nevertheless not be able to cope with that kind of increase until, I think he said, 2012. Would you agree with that?

Dr Schrader—I do not have access to the exact figures, but there has been talk about outsourcing to private hospitals as a temporary measure.

Senator CORMANN—Mrs Kendell, Wayne Swan, our Treasurer from Queensland, says there will be an exodus from private health insurance. John Deeble, the father of Medicare, says there will be an exodus from private health insurance. Wayne Swan says 484,000 adults will leave. John Deeble says up to 750,000 people will leave. Yet you say in your opening statement that you do not believe there will be an exodus from private health insurance. Have you got access to any modelling or have you done any modelling that leads you to that conclusion?

Mrs Kendell—I have not done modelling. We do not have a capacity to do that type of thing. In referring to my anecdotal knowledge of people giving information to me, what actually forced people into private health insurance in the first place, more than the 30 per cent rebate, was their fear of Lifetime Health Cover. There is a study that supports what I am saying. It is called the *Distributional impact of recent changes in private health insurance policies*. It is a 2005 study, published by the *Australian Health Review* in May 2005. It specifically makes it very obvious that, more than any other tactic that was put into place, people were most fearful of the penalties associated with Lifetime Health Cover.

Senator CORMANN—You are a consumer representative member with the Public Hospitals, Health and Medicare Alliance of Queensland. Are you aware of whether the Queensland health department has conducted any modelling of the impacts of this measure? As a consumer rep, presumably you would want to be reassured that public hospitals will be able to cope with whatever additional demand is coming their way.

Dr Schrader—Weren't they appearing today?

Senator CORMANN—They were appearing today, but they pulled out at the last minute, and you are the best that I can go to in the absence of the health department.

Dr Schrader—I think you will have to ask them.

Senator CORMANN—Thank you very much. That is okay.

Dr Schrader—Can I reply to that as well—about the exodus?

CHAIR—Yes, certainly, Dr Schrader.

Dr Schrader—We do not have exact figures and have not done the modelling ourselves, but there have been various estimations of the exodus, from lower levels to higher levels, and we are predicting it probably will not be at the extreme level that some people are screaming. The thing is: who will be leaving. They are generally not high users of the system. They are young, and healthier; single people; people who have taken it out for other sorts of reasons like tax breaks or lifetime cover or whatever.

The chronic users of the system are generally using the public system as it is now and, as I said before, I do not know whether it is a bad thing in itself for people to be leaving and going into the public system and for the resources, instead of going into propping up private industry, to be going directly into health rather than through a private industry, and penalising people through tax for not taking up a commercial product. Under

the natural levels of private health insurance uptake, without massive government subsidies, it might be around 30 per cent, 33 per cent, and I do not see why we need this 45 per cent uptake.

Senator CORMANN—Do you think that whatever the impact is going to be, whether it is low, medium or high—and clearly the health department have to go through a proper process to assess that—

Dr Schrader—Yes, the money has to be redirected.

Senator CORMANN—Do you think that there ought to be 100 per cent compensation from the federal government to the state government to ensure that they are able to meet whatever additional demand is coming the public hospital system's way?

Dr Schrader—Yes, there will have to be, but, as I said, that is a better thing: putting it directly into health rather than into industry subsidies.

Senator CORMANN—Do you think that the public hospital system will ever be able to meet all of the demand for hospital services?

Dr Schrader—You can have unlimited demands. I think they can provide it adequately and more efficiently than the private health system.

Senator CORMANN—So you do not think we need a private health system at all?

Dr Schrader—It is not essential. It is an added alternative that people can choose to take up if they want.

Senator CORMANN—At present the membership is about 44 per cent nationally. It was 30 per cent in 1997-98. What percentage do you think would be a sustainable level for the Australian health system?

Dr Schrader—As I said, without the massive government subsidies the level is around 30 per cent, and they are people who will take it out because they want it, rather than being bullied or forced into it.

Senator CORMANN—Medicare is a public insurance system in which all taxpayers are enrolled compulsorily—that is, 100 per cent coverage. Do you think it ought to be more transparent as to what the true cost, and the cost increase, is year on year in terms of the premium that Australians pay for access to the public system?

Dr Schrader—I think the public system is much more transparent than the private system.

Senator CORMANN—Do you think the Medicare levy funds the public system?

Dr Schrader—No. It comes from general taxation, but that is just a supplementary bit. I think this is just one small step that they should remove and that people with private health insurance should pay the levy as well. Then there would be more money going directly into health.

Senator CORMANN—People with private insurance pay the Medicare levy; they just do not pay the Medicare levy surcharge.

Dr Schrader—No, the surcharge.

Senator CORMANN—But the Medicare levy and tax is a percentage of growing incomes over the years whereas for health insurance we look at an absolute premium number which increases year on year and we then look at the percentage increase. Don't you think that there should be more transparency in the year-on-year increase in the cost of the public hospital system to each individual taxpayer so that we actually know how much we contribute into the system?

Dr Schrader—There is information on the AIHW about where the health spending goes.

Senator CORMANN—So you are aware as to how much every individual taxpayer pays?

Mrs Kendall—We can only say that it is there.

Senator CORMANN—You mentioned that the increase in private health insurance membership and underlying that, the various measures that led to that increase, have not resulted in any pressure being taken off public hospitals. Don't you think the pressure would have been worse if it had not been for private hospitals absorbing the increases in demand? I refer you to the Australian Institute of Health and Welfare data on usage of public and private hospitals, which would seem to indicate that most of the growth between 1999 and 2006, which is the most recently available data, was in private hospitals.

Dr Schrader—Heavily government subsidised; very expensive.

Senator CORMANN—For quite a number of years the growth in public hospitals was non-existent, so essentially the private hospitals have absorbed a lot of the growth in demand.

Dr Schrader—At great cost.

Senator CORMANN—Don't you think the system would have been under much more pressure if it had not been for that?

Dr Schrader—No. With that 30 per cent rebate—that is, \$3½ billion a year—just imagine what sorts of health services could have been provided and where that could have gone in health, and more efficiently. There are fewer overheads in the public system than a multiple of insurers. With the one universal insurer there are fewer overheads. In various studies, outcomes generally have been shown to be better in the public system as well.

Senator CORMANN—Increases in Medicare levy surcharge thresholds for singles earning up to \$100,000 is essentially a one per cent tax cut for people that earn between \$50,000 and \$100,000. Don't you think that people who do take additional responsibility for their healthcare needs are equally deserving of a tax cut if they are in that income bracket?

Dr Schrader—What was your wording there—'taking responsibility'?

Senator CORMANN—Additional responsibility by investing additional resources?

Dr Schrader—What about people who pay the full amount of tax rather than getting a tax break so that the money goes directly into health? You only have to take out private health insurance that is less than one per cent of your taxable income to get a tax cut, so you are actually paying less out. I do not agree that people who choose to use the public system and put their money directly into that are not taking responsibility.

Senator CORMANN—But 85 per cent to 90 per cent of those premiums go into funding hospital treatment. I do not believe that out of our taxes 85 per cent to 90 per cent go that way.

Dr Schrader—Private health insurance has about four times the amount of administrative cost that Medicare has.

Senator CORMANN—But admin costs for private health funds are pretty transparent. It is 10 per cent across the board, and then there is obviously having to put a bit of money aside for future claims.

Dr Schrader—I think Medicare is transparent as well. That information is all available, although I do not have it at hand.

Senator CAMERON—Dr Schrader and Mrs Kendell, I would like to put a couple of questions to you and get your response. We have had submissions here today from the Australian Medical Association of Queensland. They made a number of assertions. One assertion was that the changes proposed by government send a confused message to the private health sector. I am not sure what that means or whether you have any idea what the confused message would be to the private health sector, but what they went on to say was that a robust private health system sets challenges to the public system. It is like there is a benchmarking of the public system against the private system. The assertion I am making is that the private system somehow is more efficient, more effective, better for people to be in. That was the Queensland medical association submission this morning.

Then we had the Queensland Teachers Union Health Fund here just before you. They spoke of a partnership between the private and public sector; that this is a unique system and it is a partnership. Do you agree that it is a partnership or do you see it as a competition for available funds? I am not sure if you know about Canada, but they did say that the Canadian system was second only to, I think, North Korea in terms of its push to have a socialised medical system and that this was a real problem. This is the type of position that has been put to us today, and I would like to get your view about how we stand in what people are describing as this partnership in this unique system, which is this mixture of public and private health.

Also—and sorry I am doing all this in one—what is your estimate of how many people are denying that they have private health funding so that they do not face the bills that you spoke about? Do you think that it is something that happens quite often?

Dr Schrader—Can we go back to the beginning, which was the AMA's position. What was it again?

Senator CAMERON—The Queensland medical association said that the changes sent a confused message to the private sector.

Dr Schrader—I do not know about that but I remember about private and public. I think it is actually the public system that sets the standards and is what the private system looks towards. That is where most of the research and care for chronic illnesses and lots of the breakthroughs happen, such as liver transplantation to

give one example. It is the public system where the training is done. All the specialists that then end up in private hospitals started off in the public system learning everything from there, so I think it is the public system that sets the standards.

Senator CAMERON—And the partnership model?

Dr Schrader—I have not off the top of my head got it with me but I have got papers on this. Research often shows that the private system, when it grows, draws money away from the public system rather than adding to it. There seems to be a set amount of resources and money. This happens with doctors and nurses, then they often go across to the private system.

Mrs Kendall—Certainly the doctors charge a lot more in the private system.

Dr Schrader—That is why they support—

Senator CAMERON—The other issue was Canada and North Korea.

Dr Schrader—You may want to talk a bit more about this, Kathy. But I do not know about calling it, what, the socialised?

Senator CAMERON—They compared it to North Korea, basically. They said that the only more regulated system was North Korea.

Dr Schrader—They do actually use their private system. Their doctors do work, but they are either in or out, like with bulk billing and things like that.

Mrs Kendall—So the government does not support the private system.

Dr Schrader—Yes. If they choose to charge over a set fee or whatever, they have to be completely out. So you are either in or out.

Senator CORMANN—Sorry, just to interrupt as a supplementary there: what TUH said to us—and I do not know whether it is right or wrong—was that it would be an offence in Canada for anybody to charge for any health service.

Dr Schrader—You can, but you cannot do it under their Medicare system. You have to be out of the system and totally private.

Senator CORMANN—All right.

Dr Schrader—So you can, but you are either in or out with the Medicare.

Senator CAMERON—So it is delineated; completely delineated.

Dr Schrader—Yes.

Senator CAMERON—Private system, yes.

Dr Schrader—They are privately, but within the Medicare system.

Senator CAMERON—Yes.

Dr Schrader—But if they want to charge what they like, they are out of that system.

Senator CAMERON—This question of people denying that they are in a private fund for fear that it is going to cost them extra in a public hospital, is there much evidence or any research been done on that?

Mrs Kendall—I do not think there are any studies anywhere, but I know that people do that because of their fear, especially in a major accident where there are lengthy rehabilitation costs that are going to be involved. If you are using the public system, they arrange the physiotherapists, the occupational therapists and people that can continue to look after you. But in the private system, under your private insurance, you run out very quickly. You can only see some of these allied health people three or four times before you have reached your top-up.

Senator CAMERON—Yes.

Mrs Kendall—Also, it is pretty scary for people who do have private insurance and they are being asked right up-front in the public hospital, ‘Do you have private insurance?’ and decisions are going to be made about who is going to give you medical care, and all you care about is who is the best doctor for the job—’I’m not going to declare whether I’m private or public until you tell me what penalties I’m going to incur. It seems to make a difference to you. Therefore, I want to know why; what the difference is.’

I come from an American system. My sisters and family currently live in an American system. I do not know if you people understand just how much you are getting into—I am not accusing you—with Australia going down that privatised track. I personally feel that a private system is for cosmetic surgery, those luxury items; if people want a private room, they want their own TV, gourmet dinners.

I believe that when you operate two systems side by side it certainly becomes more expensive, because medical providers can transfer between the two systems, whichever one is going to be paying them more, and it absolutely happens. When they brought in the safety net, my next-door neighbour, who is a neurologist, went from \$125 a visit to \$800 a visit, and he simply said, 'Well, you're going to qualify for the Medicare safety net.' Where there is opportunity for people to generate extra incomes for themselves that is—

Senator CORMANN—A quick comment on your last statement, because that is not actually correct in terms of health insurance funding cosmetic surgery. Most funds, if not all—

Mrs Kendall—That is right, they do not.

Senator CORMANN—actually exclude cosmetic surgery.

Mrs Kendall—Absolutely. I am aware of that, but I am saying if there was a role for private insurance, I see it as something like that.

Senator CORMANN—Interesting. I had one question before, when my call was taken away, in relation to a statement you made that the people that are going to be leaving as a result of this are going to be the young and healthy anyway and so it is not going to matter. Let's assume that 100 per cent of the people that leave are people that do not use hospital services. So under your theory that means that there will not be any additional pressure on the system.

Mrs Kendall—Deeble, even though he says there are going to be about 700,000 exiting, does not believe that it is going to make a huge impact.

Senator CORMANN—Let's assume, just for argument's sake, so I can ask you my question, that out of all the people that leave, not one of them would actually access public hospital services. Isn't it the case that all those people that leave are then contributing all of their premiums into funding hospital treatment for other people? According to budget papers, the Commonwealth expects to save \$960 million as a result of the people that they think will leave. That represents \$3.2 billion worth of private hospital insurance revenue, 85 to 90 per cent of which is allocated to hospital treatment. That is according to evidence that we have had here in the last couple of days. So that is around \$2.7 billion dollars.

Where is that funding going to come from to fund hospital treatment for those people that are currently accessing it? Either health insurance premiums have to increase by dramatic amounts and there is going to be that new spiral, or there is going to be a serious shortfall in the public health system, which will have to pick up the slack. It cannot work.

Dr Schrader—Are you talking about the effects then on private health insurance?

Senator CORMANN—You put the premise in your opening statement that, because the people that are likely to leave are the young and healthy—

Dr Schrader—So the fees might go up.

Senator CORMANN—that are not going to access services, it does not matter. What I am saying—and I am asking you to comment about this—is that, even though some people might not access the services, every single person that leaves health insurance is somebody who at present is contributing additional financial resources into the health system. That is public and private mixed health system.

I know that you are saying you want most of it in the public system, if not all of it, but the reality is this: beyond the 30 per cent rebate, there is a 70 per cent personal contribution from those people who, Treasury tells us, they expect to leave. If what you are saying is correct and the people that leave are the young and healthy, doesn't that make it even worse? Doesn't that mean that we lose the funding from people that are actually investing it in the treatment of others?

Dr Schrader—So you believe that people should be bullied and whatever into taking out a commercial product so that it helps other people who also have that commercial product?

Senator CORMANN—I believe in intergenerational solidarity, but this is not talking about beliefs—

Dr Schrader—That is how Medicare works.

Senator CORMANN—I know, and I guess Medicare, because it—

Dr Schrader—That is the best way of doing it, rather than putting it into this other system where it is flat rates no matter who you are, whereas in Medicare you pay according to how much you earn, through taxation.

Senator CORMANN—I understand—

Dr Schrader—So that would be a more progressive and more solidarity way of paying for health.

Senator CORMANN—I am grateful to the chair for letting me pursue this.

CHAIR—Yes, I have, but now I am coming to an end.

Senator CORMANN—Can I continue, because this is actually an important part of the whole argument. This is the reason, I guess, why we have a mixed health system. Under Medicare, hospital services are available for free.

Dr Schrader—It is free at the point of delivery.

Senator CORMANN—Free at the point of delivery.

Dr Schrader—It is not free.

Senator CORMANN—No, free at the point of delivery, but which means that there is no price signal or no disincentive.

Dr Schrader—Yes, in the health care markets price signals are very shaky, and actually there have been lots of studies done on this.

Senator CORMANN—If I can quickly finish my question so that then the chair can move on.

Dr Schrader—They do not work in health, is what I am saying.

Senator CORMANN—Experience around the world—and we have talked about—

Dr Schrader—Yes, they do not work in health.

Senator CORMANN—Britain and we have talked about Canada. What happens is that if you make something available for free at the point of delivery and you have got limited resources and potentially unlimited demand, some people will miss out and some people will have to wait until they are a high enough clinical priority. The reality is that a proportion of the Australian population is prepared to pay additional resources so that they can get access—

Dr Schrader—So they can queue jump.

Senator CORMANN—when they think they need it and have their choice of doctor et cetera. That of course then takes pressure off. Don't you think that if that is taken away—

CHAIR—Senator Cormann, can we wind up?

Dr Schrader—No, I do not think people should be able to pay to queue jump.

Senator CORMANN—Not to queue jump; to get access to—

Dr Schrader—It should be according to your need, not how much you can pay.

Senator EGGLESTON—I was going to ask you a question, Mrs Kendell, and perhaps Dr Schrader as well, in relation to the story you told about somebody being asked if they had private health insurance in a public hospital. The public hospital system is funded by the Commonwealth government providing funds to the state under an agreement in which the states are supposed to provide a hospital service free of charge under Medicare, but it is true that all around Australia public hospitals do ask people if they have private health insurance and, if they have, they charge them for the services they receive although the state is already being funded for those services by the Commonwealth government, so they are actually being paid twice. Do you philosophically believe that public hospitals should not have private wards and private patients at all, that they should just be for public patients, and if people want to use private services they should go to private hospitals?

Dr Schrader—I have worked in the system where it has been totally public and in the system where it was private and public, which was totally confusing, and I really did not like it. After hours I would have to ask people if they had private health insurance but then I would say, 'Oh, but you don't have to use it if you don't want to.'

Senator EGGLESTON—That is the exact point, yes.

Dr Schrader—That is what I thought: because they pay their taxes, legally everyone is—

Senator EGGLESTON—Entitled to free treatment in a public hospital.

Dr Schrader—Under the public hospital system.

Senator EGGLESTON—It gets quite complicated, or more interesting, when you think that public hospitals have very long waiting lists, and so you then can argue that these waiting lists could be reduced if the beds occupied by private patients were available to public patients. Do you have any thoughts on that?

Dr Schrader—I think it is, again, where the resources go. As I said, if you are then trying to put people into the private system, the staff will go there too, because all these sorts of things are not creating any more doctors, any more nurses, any more beds. It is just spreading the money from here to there. If you move them over to the private system, the doctors et cetera will go there, so their waiting lists will be shorter and the waiting lists in the public system will increase.

Senator EGGLESTON—I am not sure that that is really true, because the private system can treat people more quickly, but we had some evidence the other day in Perth where the Acting Director General, WA Health, said that the state government was seeking to have more privately insured people in public hospitals, which I thought was an interesting policy decision. What do you comment on that?

CHAIR—I do not know that they can comment on policy decisions.

Senator EGGLESTON—What I am fishing for, obviously, is the issue of private patients in public hospitals.

Mrs Kendell—If you were to ask me this, on a gut feeling I would say no.

Senator EGGLESTON—Thank you. Dr Schrader?

Dr Schrader—I probably agree with that.

Senator EGGLESTON—Thank you.

CHAIR—Thank you for coming in this afternoon and giving evidence to the committee. It has been very useful.

Committee adjourned at 4.46 pm