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STANDING COMMITTEE ON ECONOMICS

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

TUESDAY, 12 AUGUST 2008

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**SENATE STANDING COMMITTEE ON
ECONOMICS**

Tuesday, 12 August 2008

Members: Senator Hurley (*Chair*), Senator Eggleston (*Deputy Chair*), 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, Mark Bishop, Boswell, Boyce, Brandis, Bob Brown, Carol Brown, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Ellison, Farrell, Feeney, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Hogg, Humphries, Hutchins, Johnston, 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 Bushby, Cameron, Cormann, Eggleston, Fielding, Furner, Hurley, Pratt and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

Provisions of the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

The inquiry will examine:

- a. the impact of changes to the thresholds on the number of Australians with private health insurance (PHI), including an examination of how many will abandon their policies as a result and how many will not take up PHI in the future;
- b. the modelling underpinning the decision and the veracity of that modelling;
- c. the anticipated impact on PHI premiums and PHI products offered;
- d. the impact of the change on the cost of living and the consumer price index;
- e. including the threshold, PHI rebate and lifetime health cover on increasing PHI membership;
- f. the anticipated impact of changes to the threshold on:
 - i. the public hospital system including waiting lists and the financial requirements of state governments;
 - ii. the ongoing viability of PHI, and
 - iii. private hospitals.

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Committee met at 9.01 am

CHAIR (Senator Hurley)—I declare open this meeting of the Senate Standing Committee on Economics. The committee is inquiring into the **Tax Laws Amendment (Medicare Levy Surcharge Thresholds) 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 threshold 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 year of income and to later years of income. This is the sixth and final public hearing for this inquiry, the committee having taken evidence in Perth, Brisbane, Adelaide, Sydney and Melbourne.

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

[9.03 am]

DUSINK, Ms Pauline, Director, Private Health Insurance Branch, Acute Care Division, Department of Health

FLANAGAN, Ms Kerry, First Assistant Secretary, Acute Care Division, Department of Health and Ageing

HANCOCK, Ms Veronica, Assistant Secretary, Medical Indemnity Branch, Acute Care Division, Department of Health and Ageing

KALISCH, Mr David, Deputy Secretary, Department of Health and Ageing

KINGDON, Ms Anne, Acting Assistant Secretary, Private Health Insurance Branch, Acute Care Division, Department of Health and Ageing

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

Mr Kalisch—We do not wish to make an opening statement, thank you, and are happy to expedite the processes of the committee.

CHAIR—Thank you.

Senator CORMANN—During Senate estimates, the health department made the assertion that underlying growth in private health insurance coverage would continue into the future. Yet Treasury conceded only last week in Melbourne that they now expect 644,000 people to leave private health insurance over the forward estimates, even though the Treasurer led us to believe after the budget it would only be 485,000 people. How is your expectation, as you termed it during Senate estimates, reflected in the government's budget?

Mr Kalisch—Perhaps I can draw your attention to the nature of what was underlying those comments. We are looking at a single change of one element of policy. Government has made an estimate of the impact of that change in policy. However, there are also, behind that, underlying changes that will still continue. So the government have measured the impact of the change in a ceteris paribus environment; they have sought to provide an estimate of the impact of this one policy change. But I think it would be unrealistic to expect that everything else stays still—that this is the only change that makes any impact and that there is no change to policy members, to premiums and to other arrangements as a result of the broader sweep of the private health insurance market and policy framework.

Senator CORMANN—But if you look at membership trends in the period from 1996 to 2008, essentially what you will find is that, after Lifetime Health Cover was introduced—and, some people would argue, boosted by the 30 per cent rebate—there was a significant increase of about 13 per cent in private health insurance membership. You will find that pretty soon afterwards it plateaued and even reduced slightly, and in the last three or four years it has started to increase again. You gave evidence that that is about 200,000 people per year. I would put it to you that the reason it has been increasing again after plateauing and dropping is that the Medicare levy surcharge, in particular, became increasingly effective in doing what it was intended to do. The government decided to increase Medicare levy surcharge thresholds. Treasury, with support from Health and Finance, modelled the impact of this and came to the conclusion, as they told us last week, that they expected 644,000 people to leave private health insurance as a result, including 484,000 adults. That is, in fact, the basis on which the government estimates a \$959.7 million saving, is it not? If you are right, where is it reflected in the budget papers and how will it affect the government's estimated saving of \$959.7 million?

Mr Kalisch—The budget papers reflect the impact of that one-off change to the arrangements that we are talking about in terms of the Medicare levy surcharge.

Senator CORMANN—On that point, the budget papers do not reflect the assertion that you made at Senate estimates that underlying growth would continue to be at 200,000 people per year.

Mr Kalisch—The budget papers, in terms of the estimates around the rebate, reflect participation in private health. What I am saying is that the measure description talks about the specific budget impact of that specific measure, and that is the number you referred to that is in Budget Paper No. 2. But the underlying projection around the private health insurance rebate is within the budget papers themselves. That is the overall magnitude of what we expect to spend on the rebate.

Perhaps I can just talk about the historical dimension that you started referring to and the data that we have seen—and, of course, you are aware that the Medicare levy surcharge was the first of the sweep of government

policy measures to be introduced, around 1997. Surprisingly, that fairly significant change—of actually introducing the measure, which was pegged at \$50,000 for singles and \$100,000 for couples at that time—made a relatively small impact on PHI policyholders. It made a very small impact on the participation rate at that time in 1997, when that was the first and only measure that was introduced at that stage. Then, as you are aware, subsequently the rebate came in.

As you recalled and mentioned, the factor that seemed to make the most difference to participation rates—and, we think, actually caused the big spike in participation—was the introduction of Lifetime Health Cover. That is still part of the major policy parameter that is around private health insurance. Lifetime Health Cover, although it has had some tweaks by the previous government over the last couple of years in looking at the ability for people to basically get back into the swing of private health without paying the Lifetime Health Cover penalty, still remains a core element of the policy framework.

Senator CORMANN—I totally agree with what you are saying. You are saying that in 1997 the Medicare levy surcharge was not as effective as it is today, and the reason it would not have been as effective in 1997 is probably that it was pitched at a threshold that was too high. In recent years, it has become increasingly effective in achieving what it was designed to achieve. But I will move on.

Mr Kalisch—I will just add one thing and respond to one of the speculations that you put out there—that is, over the last three years participation has risen because Lifetime Health Cover has become more effective.

Senator CORMANN—The Medicare levy surcharge.

Mr Kalisch—Sorry—the Medicare levy surcharge has become much more effective. I suppose, if that were the case, you would expect it to have been progressively building participation over the last seven, eight, nine, 10 years, not just having a recent three-year impact. I just cannot understand why you would suggest that it has become more effective only after the last three years. Wages have grown considerably over a number of years; it is not just the last three and four years that wages have grown and more people have got into the volatile areas of being subject to that surcharge.

Senator CORMANN—This is my question very specifically: looking at the \$660 million expected impact on revenue and looking at the \$959.7 million impact on Commonwealth expenditure from not having to pay the rebate to people that the government expects will leave private health insurance, are those figures in any way based on an assumption that the Department of Health and Ageing might have put forward that private health insurance membership will continue to increase by 200,000 people per year?

Mr Kalisch—No. As I explained before—

Senator CORMANN—The answer is no, isn't it?

Mr Kalisch—That is the measure impact.

Senator CORMANN—So the answer is no.

Mr Kalisch—No, that is the impact of the measure in a *ceteris paribus* environment. Where we reflect the changing participation as a result of the broader sweep of the private health insurance policy framework is in the budget estimate for what we spend on the rebate. So what you get in the measures description and in Budget Paper No. 2 is the impact of that measure, taking a *ceteris paribus* environment.

Senator CORMANN—Is there anywhere in the budget papers that you can point me to where there is an assumption reflected that underlying growth in private health insurance membership will continue to increase by 200,000 people per year?

Mr Kalisch—Reflected in our assumptions and projections of the rebate is the broader change in participation. That takes account of not only the measure but also the broader policy framework.

Senator CORMANN—That does not really answer the question.

Mr Kalisch—I do not believe it is possible within the budget papers to actually disentangle that impact or to actually point to where it is specifically mentioned.

Senator CORMANN—Last week, Treasury also told us in their submission that the \$959.7 million saving did not actually include any provision for additional premium increases that will be required as a result of this measure, which I think you have put in one of your answers to a question on notice as well. Some stakeholders have told this committee that they estimate that those additional increases could be as high as 10 per cent. You would probably say that that is an exaggeration, but let us go with Access Economics and with Professor John Deeble. Access Economics has estimated a premium increase of five per cent over and above any premium

increase needed to cover costs. Professor John Deeble, in his submission, has written that a shift of 750,000 people from private health insurance would require a premium increase of only 5.1 per cent. If we look at your yearly allocation for the private health insurance rebate, it was \$3.8 billion last year. You are estimating that that will go down over the next financial year to \$3.6 billion. Without even compounding it over the forward estimates, if we apply a flat five per cent across the forward estimates, that is \$720 million to \$760 million in additional expenditure. That rather eats into your \$960 million estimated saving, does it not?

Mr Kalisch—That depends on what happens to premiums. Here, again, you are using a couple of speculations. I do not know that Access actually modelled the premium increase. I think it was more of an almost mathematical dimension. If there is this number of people coming out, then, if you have no change to the way in which premiums are constructed by firms, this is potentially the mathematical impact. However, I suppose the aspect that does make this very difficult to actually model is that there are a range of different aspects impacting on private health insurance premiums. To the extent to which firms receive investment income from their investments, the extent to which they make business decisions, the extent to which they attract new clients, the extent to which they change their product offer, that makes it more or less attractive for people and also reduces or increases their expenses. These are normal business decisions that companies make every year. It is hard to say, ‘As a result of this change, there will be this impact,’ because companies are making changes to their product offering all the time.

Senator CORMANN—Actuaries in health funds—and I would suggest that actuaries generally are able to do this—make these sorts of forecasts and do this sort of modelling all the time, at least once a year. Even just using the government’s assumption that membership will go down by 484,000 adults, you will find that actuaries can forecast what that will mean across a range of variables, all other things being equal, including what they expect to happen with investment income et cetera. I will ask you again: have you done any assessment of the impact in terms of additional premium increases that will be required as a result of this measure?

Mr Kalisch—We have done some work looking at the potential impact on premiums. I would have to say it is nowhere near the five per cent range that a number of people have talked about.

Senator CORMANN—What is your figure?

Mr Kalisch—It is considerably lower.

Senator CORMANN—By how much?

Mr Kalisch—It is probably less than half that.

Senator CORMANN—So 2½ per cent?

Mr Kalisch—No. As I said, it is less than half. I am not going to give a figure because, again, the modelling is still quite speculative. But certainly what we have done some analysis on suggests a relatively small impact on premiums. Coming back to the actuaries example—yes, we do see those forecasts. They give us their analysis when the premium round starts, generally each year, but then they change their forecast and analysis as that premium round moves through. So they also adjust their forecasts as new information comes to light, which is what you expect.

Senator CORMANN—Any modelling is speculative. The budget is speculative because the budget is a line in the sand against which the government’s performance is able to be monitored. Everything we are talking about is speculative. The question is whether you are basing your speculation on sound assumptions, and that is what we are trying to ascertain.

Mr Kalisch—We are basing our assumptions on the best available evidence. One of the aspects that we will certainly look at in the forward estimates around the rebate costs is what happens to premiums. To some extent it does not really matter what the specific impact is; what matters to the rebate is the total impact. Companies will be very careful. They will not want to have such a large premium rise that it will disadvantage their current customers and cause some of them to leave or, alternatively, will not make the product attractive for new customers.

Senator CORMANN—If your \$960 million figure is correct, I go back to the original argument, which means that you expect \$3.2 billion to leave the health system. There are only two ways you can compensate for that—either by increasing premiums or by cost-shifting demand to the public system. But we will leave that for the moment.

Mr Kalisch—There is a third way, and that was what I was referring to.

Senator CORMANN—What is the third way?

Mr Kalisch—That businesses do make business decisions.

Senator CORMANN—So you are saying that there is—

Mr Kalisch—It is not just a zero sum gain.

Senator CORMANN—You are saying that health funds are able to achieve significant efficiencies in their current operation even though they are already about 10 per cent. I have a question.

Mr Kalisch—I think it would be difficult to make the claim that no company in any industry could not make further efficiencies.

Senator CORMANN—You mentioned in an answer that you provided to me on notice that the financial impact of premium growth on the forward estimates for the private health insurance rebate is currently allocated to the contingency reserve. How much have you allocated to the private health insurance rebate component in the contingency reserve?

Mr Kalisch—If it is in the contingency reserve, we are not going to disclose that.

Senator CORMANN—You are not going to disclose that?

Mr Kalisch—No.

Senator CORMANN—On what basis?

Mr Kalisch—It is in the contingency reserve because it really does give an estimate of what we expect the premium increase to be overall. We are not going to disclose that to the market.

Senator CORMANN—So you are claiming commercial-in-confidence?

Mr Kalisch—No, it is budget-in-confidence. The Treasurer and the government have made a decision that this number will not be disclosed for commercial market reasons, because it is not in the government's interest.

CHAIR—Senator Cormann, I will move to other senators soon.

Senator CORMANN—I have just got two quick areas that I want to talk about. I refer you to your answer to questions on notice in relation to the 30 per cent rebate in Lifetime Health Cover and ask you again: have you provided or are you providing advice on either abolishing Lifetime Health Cover, increasing the ages at which Lifetime Health Cover will kick in, abolishing the 30 per cent rebate or means testing the 30 per cent rebate?

Mr Kalisch—No, we are not providing any advice around those matters.

Senator CORMANN—And you have not provided any advice?

Mr Kalisch—We have provided advice to government around a range of PHI aspects. We are not currently providing any advice on those matters.

Senator CORMANN—I refer you to an answer that the senator representing the government at the table gave us at additional estimates in February. I asked a question about whether the government was considering any changes to the Medicare levy surcharge thresholds, and I was told that the government was not considering any changes, and departmental officers at the table did not correct the senator representing the government, either then or afterwards. So I can take it that you have not provided and are not providing any advice on any of these issues.

Mr Kalisch—We are not providing any advice now. We are not in the budget process at the moment anyway.

Senator CORMANN—Has the government asked you to consider any of these measures?

Mr Kalisch—Government has asked us to look at a range of aspects in terms of incentives and various other changes to PHI, but I am not going to disclose those workings within government.

Senator CORMANN—This is the final question. Has the government asked you to consider means-testing the 30 per cent rebate, abolishing Lifetime Health Cover or increasing the age at which the Lifetime Health Cover measure kicks in?

Mr Kalisch—I am not aware of any change around those aspects.

Senator CORMANN—Has the government asked you to consider it?

CHAIR—Senator Cameron.

Senator CAMERON—Mr Kalisch, we have had some modelling mania, I think, over the last few days on a number of government proposals. I am not sure if you are an expert on econometric modelling, but you have given some evidence on your views, and I would like to get your views on some of the issues that have come before us—for instance, the argument that it is really difficult to make a proper assessment of the effect of any changes to the surcharge, on the basis that many consumers are ignorant of the issue, that many are apathetic and may do nothing, that many are uncertain and will not do anything, that there is a habit built into how consumers behave, that there are social reasons why people continue to take out private health insurance, that there is risk aversion, that there is a preference for private over public services and that there are these issues of business efficiencies in terms of what the effect is going to be. These are hugely complex issues and would be almost impossible to model. Don't you agree?

Mr Kalisch—In modelling, what we, together with Treasury, have sought to do is to use the best available evidence. Treasury have good data, drawing on their individual taxpayer data. We have some survey information that suggests that there might be an impact of around 20 per cent of the people within that income range who might consider dropping out of private health insurance if the tax surcharge were not there, but I would have to say that you do mention a number of the aspects that people will take into account. I suppose one example is young families who may be considering having a child and using the private hospital industry or a doctor of choice for, hopefully, an upcoming birth in the family. They may choose to retain their private health insurance at that particular time. Others have different risk profiles and may be more risk averse and want to have the opportunity and the security of using the private hospital sector for elective surgery if, for example, it were necessary for them in an unforeseen manner. So there are a range of factors that come into this.

As I say, we, together with Treasury, have used what we consider to be the best available evidence. I have to say that the Treasury taxpayer data, which is not generally available, is the best source of information on the number of people who are in that income range. As I say, we have supplemented that with the information that we think is the best available to give us a bit of a sense of those who might get caught or influenced by this measure and might take that choice. But at the end of the day we, like everyone else, will be monitoring what potentially happens to private health insurance participation.

There are a number of factors that influence people's decisions, and one of those factors is going to be also the response of companies. Companies themselves do offer products in the marketplace. Government has modified one element of the policy parameters that work around private health insurance. However, there is still Lifetime Health Cover. There is still the 30 per cent rebate. These are the major policy parameters that are still in place, and people who are over 30 years of age will need to think pretty carefully about their decision.

Senator CAMERON—We just received yesterday a model from Access Economics. They describe the model as follows: 'The underlying principle of the model'—that is, the Access Economics model—'is that individuals weigh up their benefits and costs when deciding to purchase or hold, if already a member, private insurance.' It is not as simple as that, is it?

Mr Kalisch—Certainly not with the government's other arrangements. To some extent you can probably model the 30 per cent rebate as one of the incentives to take up private health insurance and a way of reducing the cost to premium holders, but Lifetime Health Cover is the one big policy to mention that is really difficult to model, and whose impact is difficult to model, because it really does have quite an impact on people's future preferences and future desires.

Senator CAMERON—Professor Deeble has written a submission and will give evidence this morning. He is saying that admissions in the public sector could increase by about two per cent, but expenditures will be slightly less, and that is because the Commonwealth pays a significant amount now for private health patients. That has been described—and I am not describing it as such—as people 'freeloading'. I do not agree with that, but that is what it has been described as. How much of this type of behaviour is people with private health insurance using the public system, and have you factored that into your models?

Mr Kalisch—We have not modelled the impact on public hospitals. I will explain some of the reasons why. We do know that about 11 per cent—I think—of public hospital admissions are private patients. It varies from state to state, but on average that is about the mark, I think. Public hospitals do utilise those private patients for benefits. They receive payment. It also helps some of the VMOs and consulting specialists to earn additional income while still working in the public system. A lot of specialists have a mix of public and private patients, even within a public hospital environment. It enables them to use their facilities to a greater extent and

maintain a workforce, which might be more difficult if they could not attract private patients to those public institutions.

The real issue around public hospitals is just that, when you are getting to potentially an impact on public hospitals, the assumptions become very heroic and very speculative. You are getting into an area where there is very little information. People are essentially making best guesses and not having much information that they can draw upon in making those best guesses. So there are a whole range of issues around public hospitals.

I would have to say that some of those commentators, particularly, say, in the private health insurance industry and to some extent around state ministers of health, have an interest at the moment in potentially playing up the public hospital impact. We are in an environment where the next healthcare agreement is being negotiated. This is not a benign environment at the moment. People have some incentive to, I suppose, go toward the top end of the range of some of their best guesses in some of these areas.

But, against that, the federal government are also providing additional funding to the states for the public hospital system at the moment. In 2007-08 there was an additional \$500 million. In 2008-09 they have guaranteed the states at least an additional \$500 million through indexation, and then there is the additional money that is coming through in 2007-08, 2008-09, 2009-10 and 2010-11 for improving elective surgery. Together, we expect that to comprise about \$600 million. So it is quite a moving feast and, as I say, further discussions and negotiations are taking place around the next healthcare agreement.

Senator CAMERON—So this modest initiative from the government to try and bring some fairness back into the taxation of individuals who are paying the levy will not have devastatingly bad effects on the public health system, will it? Because that is the sort of rhetoric we have heard from some submissions.

Mr Kalisch—As you might appreciate, we have had discussions with state and territory health officials. There is an understanding that we will continue to monitor the environment, but they and we also recognise that this is not the only aspect that is influencing the way in which public hospitals are operating—that issues like workforce, utilisation of public hospital facilities and average length of stay are also big aspects that play out in the public hospital environment. What I think we have agreed is that, yes, there may be some impact on public hospitals, but certainly our sense is that it is likely to be modest, and we are looking at it within an environment, as I think I mentioned in reference to another aspect, where this is one of the aspects that is changing in a system that is also changing. Certainly we have seen no evidence that would suggest that there is a major problem that is going to occur as a result of this policy change.

Senator CAMERON—Thank you.

CHAIR—There has been a lot of discussion about younger people dropping out and leaving older people in the private health insurance system, but it is also true, I think, that a lot of older people drop out just when they are in need of care because they feel that they can no longer afford private health insurance. Do you have any kind of figure, not for the reason but for how much older people do drop out of private health insurance?

Mr Kalisch—I am not aware of that. We can take that on notice. Certainly the past government did increase the rebates for older people, and that has been kept in place by the current government as a way of trying to improve the affordability of private health insurance for older people.

Senator SIEWERT—In answer to a question from Senator Cormann, you talked about the membership rate as wages go up. Could you just clarify that for me? Were you saying that membership has not increased or that it has increased as wages have gone up and people have gone over the \$50,000 mark?

Mr Kalisch—Participation has been going up, as Senator Cormann mentioned, over the last three to four years—but I suppose it was more a response to his speculation that participation in private health is going up because the Lifetime Health Cover has been kicking in. But you would expect that to be over quite a number of years. Wages growth has been going up over many years, not just the last three.

Senator SIEWERT—Has any modelling been done on the fact that there has not been an indexation of the \$50,000 and on how that has impacted on the number of people who would or would not take up private health membership?

Mr Kalisch—Within the budget measure, we, together with Treasury, have done some modelling on the impact of reducing the thresholds. I am not aware of any modelling that has tried to estimate what the impact of indexation of those thresholds would have been.

Senator SIEWERT—Okay. Thank you. You have not done any modelling of the impact on the public health system?

Mr Kalisch—No. We have looked at the range of issues and, as I was mentioning to Senator Cameron, talked about and looked at a range of the other factors that would also be impacting on public hospitals in the way that they are managed by states and territories, as well as the additional funding that the Commonwealth government has provided to them, and come to a policy assessment that we would not expect anything more than a modest change.

Senator SIEWERT—Part of this comes down to what impact this is going to have on the public health system. I want to be assured that the additional money going into the public health system is going to cover any impact of changing this threshold. None of the information you have just given me assures me that there is enough money in the system to deal with even a modest impact when hospitals are struggling as they are. I would have thought that the increase the government has given in the budget would have been to make up for the fact that the public health system is struggling as it is—without even the modest impact of this change. Some insurers and some health providers are saying it is not going to modest but rather six per cent, and I will get to the Catholic health service modelling in a minute. How can we be assured that in fact even a modest impact is going to be covered by the increases the government is giving to public hospitals?

Mr Kalisch—There are two aspects. One is what government has already announced. They have already announced at least \$1.1 billion of extra funding to public hospitals.

Senator SIEWERT—With all due respect, my question still stands: how do I know that that is actually going to deal with the increase in the public system?

Mr Kalisch—The other aspect which I cannot really give you a number on is what I referred to earlier—that the federal government is talking to the states and territories at the moment about the next healthcare agreement. That is going to be the vehicle for potentially more money going into the public hospital system. Perhaps I will reframe that. Really, the issue that is being discussed is how much more money is going to go into the public hospital system. It is really about what the number is going to be at the bottom of the page.

Senator SIEWERT—That is the crux for us. We will be coming to make a decision in the Senate about this. I want to be assured that if this passes there is enough money to deal with the impact on the public health system, and quite frankly nothing you have told me yet reassures me of that.

Mr Kalisch—I suppose I can give you the assurance that on the basis of the numbers that we know are being discussed and our assessment of the impact—

Senator SIEWERT—With all due respect, you have just told the committee that in fact you have not done any modelling on the impact on the public health system.

Mr Kalisch—No, I said we expect that number to be quite modest—

Senator SIEWERT—I understood you as saying you have not modelled.

Mr Kalisch—and I said we cannot do any specific modelling.

Senator SIEWERT—You have not done any modelling, so we do not know whether the figure that, for example, the Catholic health system are saying of around a six per cent increase is correct. I am not here defending the Catholic system, but I am just saying that they are the figures that are out there publicly, as well as the Access Economics figures. They are saying six per cent. How do I know that they are not right?

Mr Kalisch—I think we can certainly point to some of the major difficulties around their assumptions. A number of those assumptions about a very big impact on the public hospital system make some fairly heroic assumptions around a very high proportion of those who drop out of private health insurance requiring public hospital treatment, which is completely out of kilter with what we see even in the broader population. I think the chair talked about some suggestion that younger people may be more likely to drop out of private health insurance as a result of this change. If that is the case, they are not the sort of people that turn up to public hospitals for admitted procedures.

CHAIR—We are short of time.

Senator SIEWERT—I will ask my final question. The issue that has been put is that it is not just the immediate impact now but also the subsequent impact. I take the point that young people dropping out are not going to be turning up in hospital necessarily straight away. But, in subsequent years if they have not then gone into the lifetime process that we have been talking about, have you modelled or looked at what impact it is going to have on the public system in subsequent years?

Mr Kalisch—No, we have not in that level of detail. I would have to say that the modelling is almost impossible to do around that dimension. What you have seen is a number of commentators and submissions suggesting a significant impact within a very short space of time. They are not looking at a change over five or 10 years. They are looking at a change within one or two years. It is hard to quite get to all of the assumptions behind their so-called modelling. I would have to say they are more using assumptions and then driving some numbers through them, but their numbers seem to imply that a very high proportion of people who would be dropping out of private health insurance do turn up at public hospitals.

Senator SIEWERT—Have you done a critique of both the Access Economics modelling and the Catholic Health Services modelling?

Mr Kalisch—We have done some critiques. I am not sure whether we have got to the more recent Access Economics work. Certainly, we had critiqued some of the earlier work that was done.

Senator SIEWERT—I will ask this on notice: is it possible for you to provide any critiques that you have done of the modelling that has been done by the private sector?

Mr Kalisch—We can certainly provide some information to the committee on what seems to be the nature of some of the assumptions that people have drawn out. We would like to draw some of the concerns that we have about those numbers to the committee's attention.

Senator SIEWERT—That would be appreciated. Thank you.

Senator FIELDING—I am very interested in the secondary impact, which is the waiting list issue. I think the waiting lists that we have in Australia already are appalling. I think the modelling is fairly key. Even though you have not modelled this, I will just ask the general question first: do you model the amount of doctors that we are short of in Australia? That impacts waiting lists. Do you model that to start with? I am a bit worried about what you model now. Do you know what I mean?

Mr Kalisch—There is some modelling that takes place between the Commonwealth and the states and territories on workforce. This is not just something that the Commonwealth does. There is a process where the Commonwealth and the states and territories together focus on workforce planning and workforce modelling. Some of that data has been a bit dated; some of the more recent modelling has been from around 2005. We are working actively with states and territories on modelling workforce requirements. There are two things I will allude to. One is that states and territories have a large stake in this because they are a major employer of the health workforce and so the information that they provide to the modelling is quite critical.

The other aspect that is also critical in this is that it is not just driving demand into existing workforce patterns. There are ways in which, as you would see in any workforce, changes to the use of different professions and different types of professionals—so any modelling that does start to go out a number of years needs to make assumptions not just about how many nurses, doctors and allied health professionals you will need but also about what actual task they will do and whether there will be any change in the tasks that people do, particularly as technology and other means enable people to do different tasks. The other aspect that, of course, you are aware of in the medical workforce is that it does take quite a number of years for people to become fully trained as, say, a specialist from the time that they start their medical training.

Senator FIELDING—The concerns I have are, if this change is made, what pressure will it then put on public hospitals and what issues will it have for the waiting lists? Given that you are telling me it takes a long time to change the lead time, this could put more pressure on a system that is already buckling at the knees.

Mr Kalisch—Yes. If we are seeing a switch or a substitution between private sector activity and public sector activity, we would expect to see a commensurate shift in the way that the workforce is utilised. As I mentioned earlier, there are quite a number of people who work across both sectors. I would expect that, if their private sector activity is declining modestly, they would enhance their public sector capability.

Senator FIELDING—Okay. Thank you.

Senator PRATT—We had a discussion before about the number of people within the public health system who do have private cover and it seems that those numbers have not been quantified. How can we go about quantifying the extent to which the taxpayer is paying twice for the public health services for those people who, when admitted to a public hospital, are not making a claim on their private health insurance for those services? What kinds of arrangements are you making with the states to try to get to the bottom of that particular issue?

Mr Kalisch—We have some information. I think I mentioned earlier that around 10 or 11 per cent of public patients have private health cover. I suppose it goes really to the core—

Senator PRATT—Sorry, I was not clear. The answer you gave before was that 10 or 11 per cent are claiming against their private health cover when they are in a public hospital. I am interested in the proportion of patients that are not making a claim against their private health insurance when they are in a public hospital and the extent to which we know that.

Mr Kalisch—Perhaps we can provide some detailed information about this to the committee. It also then goes back to the core of the agreement between the Commonwealth and states and territories around free provision of public hospital care for anyone who wants it.

Senator PRATT—I am not necessarily advocating that they should be made to make a claim because, in actual fact, they may have historically done it for tax purposes and they simply cannot afford the kinds of gap payments that they would be asked to make. To what extent do you know of that being a problem for patients?

Mr Kalisch—In terms of that detail, we are not aware down to that level of specificity. Certainly there are some issues around gap payments particularly in some areas of hospital activity. It is improving but it still is an issue in some areas of specialty and some areas of activity.

Senator PRATT—Can you highlight some of those areas of activity for us where patients do most obviously struggle with gap payments for certain kinds of care?

Ms Hancock—Survey work that we have done over the last few years in respect of informed financial consent asks people a series of questions about their gap experiences for private hospital admissions. That suggests that the areas where people are paying the bigger gaps tend to be specialties like obstetrics and neurology. There is also a greater frequency of gaps in anaesthetics.

Senator EGGLESTON—Is the 11 per cent of patients the number the hospitals claim from the private health funds, or is the 11 per cent the Medicare admissions who are known to have private health insurance but no claim is made to the insurer?

Ms Hancock—We will double-check the numbers for you, Senator, but we have two numbers. There is the number which is the number of people who are private patients in public hospitals and—

Senator EGGLESTON—Whose claims are made to the insurance fund?

Ms Hancock—Yes. Then there is a number which is about the same, but I would need to check it, which is the only figure we have. It is derived from a question in a survey which is asking people who were admitted as public patients whether they had private health insurance. I need to check but it is about the same.

CHAIR—Can I ask the Department of Health and Ageing to wait at the table as the committee is going to go into a private meeting.

Proceedings suspended from 9.48 am to 9.52 am

DEEBLE, Dr John Stewart, Private capacity

CHAIR—Welcome. Would you like to make an opening statement?

Dr Deeble—You have my submission which I will talk to very briefly. Those numbers that you have there anyone can check because I have shown you where the figures came from and I am sure the committee staff could check anyone of those and the calculations I hope.

By way of brief introduction, I would like to say that nobody at all can say what the exact result of this change would be. As I think I said in the submission, most of the information is around but nobody has it all. The Taxation Office has the best access to information, because it knows the characteristics of the people—their income, the number of people involved, their ages and so on—who have claimed the exemption from the surcharge. It also knows the number who are paying the surcharge. But it does not know the healthcare use of those people. On the other hand, the healthcare funds know the use. I should say that in one of my capacities I was, for 17 years, a commissioner of the Health Insurance Commission; and, as the only person on that commission who was an insurance expert, I was responsible for Medibank Private's pricing and business operations for most of that time. So I do come with a background of very detailed knowledge of how a private health fund works. The health funds know the use but they do not know the incomes—and it is no use going to the taxation statistics, because the taxation statistics are meaningless. They tell you the income of individual taxpayers but they do not tell you family incomes. Family incomes are not linked through the tax system. They can be approximated but they cannot be determined exactly. The only information on incomes comes out of family income surveys, which I pointed to very briefly.

That is one thing: the information is not held in one place, but Treasury should have access to most of it and it is best placed to make the estimates. The other thing is that even if you did know those things you do not know why people buy private insurance and you do not know what factors went into their decisions. Therefore, you cannot predict on the basis of one change alone, as I think I said in my submission. The effect of that is to reduce the price of public care—which, if you were over the income threshold, would have cost you another one per cent of your taxable income. That is the price of public care if you are above the income threshold. That will now drop. So that is just a price change; it is not a change in anything else.

The other reasons why people buy private insurance remain exactly the same as they were. So one has to try to estimate what proportion of those people might be influenced enough by price to change. Everybody believes that they are, but I know from my experience and from the international literature that health insurance is a product that is very sensitive to incomes. When incomes rise or fall, insurance membership goes up and down. But it is not particularly sensitive for price, because people see all health matters as semi-necessities. It is not a necessity to take out private insurance but health care itself is regarded as a necessity. I can tell you anecdotally that when I was pricing Medibank Private's products back in the 1990s we could be a dollar or two different from anybody else and it made absolutely no difference to our market. People are not very sensitive to price at all. The net effect of this, for a family—if my calculations are anywhere near right, and I am confident that they are—would be an increase of about \$70 a year in a family premium. I think that is trivial. I think it would have very little effect in the long run.

You have my general conclusions which are that there will be an effect, but it will be small. The way in which the system works is that it is a community rated system apart from some pricing according to family size. The younger, good-risk members cross-subsidise the older ones. It follows then that, if there were a movement and that movement were over the whole of the population including the older as well as the younger members, the effect on premiums would be almost nothing. You are taking out a typical slab of people and contributions would go down but payments would go down by the same amount. There would be almost no change in premiums at all.

Conversely, if all of the membership reduction, whatever it was, were in the young the effect on premiums would be greatest. The opposite applies to the effect on the public hospitals. If the movement were in the younger non-using people, their transfer to the public hospitals would have very little effect because they are not users. If it came from across the whole board including the older members then the effect on the public hospitals would be greater, but it is not the same. It is the opposite effect.

I have to say that in many of the submissions I have read all of these effects are mixed up and people pick the one that suits their cases the best, but there is a lot of inconsistency. While I do not usually comment on other submissions, mine is probably a little different to most of the others. I think you probably have 13 all

coming from the same source, so I will have to make some comments on where I see some of the faults in that source. I think the effect will be—as far as the public hospitals are concerned—about a two per cent increase at the most. Effects will occur over a longer period because I would not expect people to be totally aware of this—it is not the sort of thing people read every day and happily devour, they learn about a thing like this once in a while—so you could expect that a large proportion of the population, despite all of the publicity, will not even know that the change has taken place. They may know when they go to see their tax accountant and he tells them that they may not have to do this any more, but nevertheless there will be a considerable lag. The second thing is that I expect that there will be a considerable publicity and advertising campaign pointing out why the public system is so bad and why you should retain your private insurance, and the third one is that the public and private systems operate in quite different ways.

A fair proportion of the people who may have used services in the private sector in a particular way will not use the same services in the public one. The public sector is actually, despite all of what is said, much more integrated than the private one, which is broken up into little bits. The physiotherapists and the dieticians in the hospital are all running their own businesses and that means that they generate a lot more admissions to hospital and more fragmentation than in the public one. The public one will have one admission in which the X-ray is done, other diagnostic tests are done and you go on to your surgery or whatever—it is not only surgery that we are talking about. That is done in one block, one bit. In the private sector, the diagnosticians, the pathologists, the radiologists are somewhere else. The physiotherapist is not employed by the hospital and practices on her own. So the net effect is to generate more statistical admissions, which are not real—they are real enough in the sense that they happen—and not comparable. If you were to take 100,000 people who move, with one admission a year, from the private sector to the public, this will not generate 100,000 public admissions, it would probably generate about 80,000. I do not need you to take that as numerically correct, but it is the general thrust of what I want to say. So, for all those reasons, I think it will have a very small effect. But there will be an effect. I think it will probably be delayed over two or three years, whatever the final effect will be.

What I have done in my submission is taken certain possibilities. Firstly, I do not believe that the highest users of private health insurance, who are the older people, would move. Many of them will not be caught by the levy surcharge anyway because their incomes are not in this range. But for those who are older—say, a retired person or a person over 60, when income starts to fall—to have incomes of \$100,000 for an individual and \$150,000 for a family is fairly rare. We are talking about one per cent or less than one per cent of the population. I do not think they will move. What they are seeking is access and security, and I think they would hold it.

I have taken two other possibilities, one that any shift comes from all people under 50 and then—the worse case scenario for the health funds—that it comes from those under 35. I have actually taken the average of those as my best estimate, in which case I think the cost of the shift—which is the main thing I was concerned about—to the public hospitals would be about \$360 million a year. In a system which I think last year cost \$26 billion—it will be about \$27 billion this year—that is trivial. The number of admissions I estimate in total is about 100,000 nationally, and the public hospitals admitted 4.8 million people. Those are my general conclusions.

CHAIR—Thank you, Professor Deeble. In relation to the surcharge, your submission states:

... unlike almost any other income-based tax, it operates in a reversionary way—that is, it applies to all of the taxable income of people earning above the thresholds, not just to the excess. I know of no other tax that works in this way and it is extraordinary that an Australian parliament should have approved it. The result is a very high marginal tax rate for people with incomes at or close to the thresholds.

To me, that is one of the key issues here—that single people in the \$50,000 to \$100,000 range are currently paying a higher marginal tax rate so that everybody else in the private health system can benefit. I perfectly understand the private health insurance people being concerned about raising premiums and being concerned about their loss of membership, but my argument is: why should a discrete group of people in that income range have to bear the burden of this rather than increasing premiums and spreading it across all private health insurance members? Would you concur with that?

Dr Deeble—I think it is extraordinary that a parliament should have approved the tax—because it is a tax measure. I cannot think of a tax anywhere in the world—I have worked in health services in four or five countries—that works in that reversionary fashion, where at the margin, on the first dollar over the \$50,000,

the tax is almost infinity, because it goes right back to the first dollar. It breaks every rule of progressive taxation.

I was not coming to discuss policy, but if you want to know what I would have done instead, I would have made the rate progressive right from the bottom instead of the same rate all the way along. That would have had a lesser effect. The present thing almost compels you to move. Admittedly you do it only because you are faced with two alternatives: pay the money for what you see as nothing or pay it for what you might see as something. But it is an extraordinary tax and it does fall now at about the average wage level and not, as it was when it was first introduced, at a very much higher level. I do think that it is extraordinary that the Australian parliament did that, given that it is an income tax. It is not a levy, it is not a duty, it is an income tax and it is the only income tax that works backwards like that.

Senator FIELDING—Your paper covers the effects on the public hospital system, the premiums and a couple of other issues. Your focus is on the costs. I am more worried about the waiting lists. There are already people struggling to get into the bloomin' public system at the moment, which is a disgrace, frankly, and here we are potentially putting more people in there. I am a bit concerned that that is not covered in your paper. I am not having a go at you; I am just saying generally that waiting for basic medical services is the issue that most Australians are worried about.

Dr Deeble—I agree with you; the waiting lists are longer than they ought to be. Can I also point out that the waiting lists are equivalent to about two weeks work. The waiting lists, by the way, only apply to relatively few things. The public hospitals take nearly all the medical patients in the country. The private hospitals take a large proportion of the elective surgery patients, but the public hospitals take nearly all the emergencies. Half the admissions to public hospitals are emergencies. Eight per cent of admissions to private hospitals are emergencies. Private hospitals work under a scheduling system which allows them to organise their work in a certain way because it is not going to be interrupted by emergency situations.

The expansion of the public hospital system is partly due to lack of funding—I agree with you on that. Your question is directed to governments and the policy of how much funding should be given to public hospitals. Waiting lists are in very particular areas. They are in the surgical areas where the surgeons are working on elective surgery in the private hospital area. Shifting money will not fix that. There is somehow a view that it is all right; in the private hospital system everything will be okay. But everything will be okay in the private hospital system because the surgeons want to go there. I just heard the last little bit of the department of health's evidence; there is to some degree a fixed supply of surgical manpower. Where it goes to work depends on what the circumstances are and where they would prefer to be. If there is a fall off in the private system, some of them will move back. I have to get into a question of philosophy here: in a short supply situation, should the government be encouraging people, through private insurance, to gain an advantage to those fixed supplies, or should it be doing its best to see that what is in fixed supply and what may be in short supply—that is, surgical manpower of a certain kind—is available broadly across the community? You know what my answer would be. I think that it is unfortunate if we solve the problem of short supply by ensuring that we support people who already have most of it as against the people who do not. But that is a philosophical position, I suppose.

Senator FURNER—The committee heard evidence from Dr Woodruff in Melbourne last week indicating that, in his view, the fallout rate would be impossible to measure. You also indicate that the fallout rate would be minimised as a result of ignorance, apathy and uncertainty. I would like you to elaborate a bit on that. My second question is: on what modelling did you base your increase of \$70 per week, please?

Dr Deeble—Did you say \$70 a week?

Senator FURNER—Sorry; \$70 per year.

Dr Deeble—Yes. It actually comes out of that. If you take the figures that I have given here, the average amount of benefit that is paid to a privately insured person, or at least the premium relating to it, is about \$900 a person—I think \$930 is the figure in here. That is the premium the funds get per person covered for hospital alone. The AHIA stuff goes backwards and forwards, but actually it is wrong because they have taken the whole premium including ancillaries, which is not relevant. The ancillaries take about 35 per cent of all the premiums, but they are not part of this. So the figure per person is a lot lower than one of the figures that they have got there. If we have a five per cent increase in premiums, as in one of the conclusions that I come to—which is not, I might point out, greatly different to the private health association's figure for this particular effect—then it is five per cent on a premium which for an individual is \$930, and that is \$45. For a family, there are different family pricing structures depending on whether it is just a couple or whether it is a couple

with children, which makes it a little difficult to be precise about what it will be, but, on the average, it is about 1½ persons per contributor. One and a half times \$930 is about \$1,400, say, and five per cent of that is \$70. Can you understand that?

Senator FURNER—That is fine.

Senator CAMERON—That is clearer than some of the modelling we have been presented with.

Dr Deeble—Well, it is not much. It is a bit over \$1 a week. Let us get some reality in this. The world is not going to fall in at \$1 a week.

Senator EGGLESTON—Professor Deeble, you have been around a long time.

Dr Deeble—Forty years.

Senator EGGLESTON—You have a very famous name as ‘the father of Medicare’. I would like to just take you back in history a little way. After Medicare was introduced in 1984, private health insurance participation steadily declined, and by 1998 membership had fallen to close to 30 per cent of the population.

Dr Deeble—Yes.

Senator EGGLESTON—Can you just tell us about the relativities between the private and public hospital system at that point in time? What was the state of the private hospital system and the rate of usage and also the public hospital situation in terms of waiting lists and usage by comparison?

Dr Deeble—Just as a comment, I started working in hospital management 51 years ago, and I did my PhD at Melbourne about 40-something years ago. The system has not changed in its basic structure in all that time, and I am quite sure that, if I went back to the beginning of the 20th century, its structure would not have changed at all since then. The proportion of people who go into public hospitals as public patients now is not much different to what it was in the 1960s. Changing the healthcare system is like a baby pushing an elephant: it just does not move. I have always been well aware of this.

Medicare—Medibank and Medicare—altered the cost to people. It gave people better access because it did not put a financial barrier, and it also did something which is often forgotten. The old system, which was based primarily on private health insurance subsidised a bit by government, could never have met the technological demands of this century. It had to be structured with a bigger access to money, and the public hospitals are entitled to have that. That is what people want.

As far as the change after that is concerned, I have to say that I disagreed with one thing about the government’s policy at the time. Though I had advised them, I did not have any influence in this. I always believed that Medicare as a system included the private hospitals as well as the public. It has been a big mistake—Australia’s biggest mistake—to allow these two systems to develop quite separately and in competition with each other, as if they did not have anything to do with each other, when the same doctors work backwards and forwards between them. Most specialists have dual appointments. There is a rational distribution of work between them. The private hospitals do the elective, less traumatic and less emergency stuff. The public hospitals take a different group, and the public hospitals have the biggest group of difficult-to-handle medical patients, who cannot be fixed by a simple operation.

In the original Medicare design, there were subsidies to private hospitals. They were about 12 per cent of their costs, and I was responsible for that design, so I supported it. I always thought that the 12 per cent was a bit low, but that recognised that the private hospitals were part of this system and not something outside it. Unfortunately, in 1987, in a cost-cutting splurge around the public service, there was an ultimatum, as it were, put by Treasury: ‘Cut.’ One of the casualties was the private hospital subsidy. I think it was a big mistake. I think many things could have been cut other than that. I believe now that the private hospital subsidy, a 30 per cent subsidy, of itself is not unreasonable, but it should be done in a way that makes certain that the two systems are viewed as one, not systems in competition, that the private hospitals should be associated with the public hospitals and that they should be run as a single system and not two.

I think also that the funding in the public hospitals has always been on the tight side, but it has got a lot worse in the last 10 years, particularly in the last five years, because the escalation factor for cost, even the unavoidable cost of things like wages and salaries, has just been way underestimated, and the public hospitals have been pinched. Of course there is the question of who is responsible for what. Should the states have made up the difference? Well, they did—not as much as people would have liked, because they would have liked them to put in more and made it even bigger, but they have certainly put in a good deal of money in the last few years. Does that answer the question?

Senator EGGLESTON—It does, in a way. Our system has been described as the ‘best, worst’ system in the world because we have this balance between private and public. The American system is largely private, and the Canadian and British are largely public, but our system depends on a balance. Where I was going really was that, with that decline in private health insurance, by the mid-nineties we had an imbalance and some action was needed.

What concerns me here and what concerns a lot of members of this committee—and I take your point about elective surgery being done in private hospitals rather than public and so on, and more medical patients in public hospitals—is that this measure may disturb the balance and, with a drop in private health insurance, we may find that again we have undue pressure on public hospitals, although that is unquantifiable at this point. There was that imbalance, I am sure you will agree, in the late nineties.

Dr Deeble—I think there was an imbalance because that subsidy was taken away. Let me not call it a subsidy; it was a payment to the private hospitals which recognised that they were working in the same system. I think that should have stayed. I do not object to a 30 per cent assistance to the private providers. I am not sure that it necessarily means that you have to subsidise their insurers, but I can understand the simplicity of subsidising the insurer rather than the provider. Nevertheless, in a perfect world I would have subsidised or paid the providers—that is, the hospitals and the doctors—and allowed people to cover the rest through whatever arrangements they wanted to make. If that was insurance, that was fine. But I probably would not have subsidised the insurers. I still have some difficulty in subsidising the insurers’ administrative costs and surpluses when all but one of them are now large profit-making businesses. They must be among the few companies in Australia that get a direct subsidy of that kind. But I agree with you that in the absence of assistance the private health industry slid and it was not made up by a similar increase in the public sector. Had the public sector got the extra money, there would not have been any effect, but they did not get it.

Senator CORMANN—I have two quick questions, because I think we are running out of time. The first follows up on Senator Eggleston’s question. You are referred to as the father of Medicare. Peter Jennings from the AMA in Western Australia related to us a conversation he had with you in 1984. I do not expect you to remember the conversation, but essentially what he told the committee was that, in response to one of his questions at the time of the introduction of Medicare, you said you expected the fallout rate from private health insurance to be about six per cent. Can you relate to us what the expectation was when the changes were made in 1984 in terms of the impact on private health insurance?

Dr Deeble—In 1984 there were the subsidies that I mentioned. It is now 30 per cent or more. It is about 33 per cent if you take the average. I have not taken that into account in my paper, by the way. But I believed the subsidy would be more than that 12 per cent. I saw the government at least maintaining that 12 per cent subsidy to the private providers. It did not go to the insurers; it went to the providers, the hospitals.

Senator CORMANN—But the subsidy now does not go to the insurer either, does it? It is a tax offset for individual Australians that take out private health insurance, is it not?

Dr Deeble—It is assigned—that is all. Yes.

Senator CORMANN—So it is a tax offset for individuals.

Dr Deeble—No, it is not a tax offset. The 30 per cent subsidy is a direct payment to individuals who may, if they want to, claim it on their tax but may assign that to—

Senator CORMANN—The insurer.

Dr Deeble—the insurer.

Senator CORMANN—The Commonwealth describes it as a tax offset, I think you will find.

Dr Deeble—But the Commonwealth pays the money directly to the insurer. It is the same as the Medicare payment for a doctor.

Senator CORMANN—You say that the effect of this measure will be small but there will be an effect. However small the effect is going to be—and you have done your own modelling—don’t you think that, before implementing a measure like this, the government should have done some modelling that went beyond the impact on revenue and expenditure and that was an assessment of the broader public health policy implications?

Dr Deeble—Well, if I could do it, they could do it.

Senator CORMANN—That is a good answer.

Dr Deeble—But it is different. I am a citizen who has done this calculation to the best that I can and brought some past knowledge to it. I suppose a Treasury is unwilling to quite go out on a limb about saying what the effects will be.

Senator CORMANN—But this is the government, isn't it? Your answer is quite accurate: if you can do it, the government can do it. If it is the government's intention to relieve pressure from a tax point of view and it is going to have implications from a public health policy point of view and you say that the effect would be small but there would be an effect, shouldn't the government have assessed that impact so that they could have provided appropriate compensation to the public hospital system in the context of this measure?

Dr Deeble—Yes. I finally agree almost entirely with the figure that the Treasury came up with, which means that they must have gone through much the same sort of process in their modelling.

Senator CORMANN—Except that they did not assess the impact on public hospitals.

Dr Deeble—No, they did not assess the impact on public hospitals. By the way, I do have to say that some of the numbers in what is really the source for many of the other submissions you have got, which is the private insurance funds, eventually came to a figure of \$440 million, which is not greatly different from my best estimate of about \$370 million. So at the end there is not much difference. But on the way there is almost every difference that you could imagine.

There is one thing that I would be critical of them for—and I have always been friendly with all of these people. We both agree that the effect of this will be in the order of five per cent on premiums. They have said publicly and to you that there will be a 10 per cent increase in premiums, but five per cent was going to happen anyway. I do not think that that is entirely fair and honest and I understand the purpose for which it was done. But the effect of this five per cent could in principle be offset by them doing something about the other five per cent—do you understand what I mean? They have put in five per cent for utilisation growth, then five per cent of this to come up with a dramatic 10 per cent. I do not think that even 10 per cent would have a very big effect but it would have much more than five. But there are things that can be done and I know that they will say that it is very difficult for them to do them. But there are things that can be done to mitigate it a bit. As far as the government's modelling was concerned, they have got it now the same as you have.

Senator CAMERON—Thank you very much, Professor Deeble. I would like to change the questioning a bit from the modelling to one of the issues that adds costs to the overall system and that is the operation of the private health funds. We have had evidence before us that in the process of demutualisation executives are being 'rewarded' by \$1.3 million a year to demutualise. Given that the government is subsidising these health funds to the tune of 30 per cent, do you believe that that is a reasonable approach to be taking? What is your view on these costs that are being pushed into the funds? How do we stop this happening?

Dr Deeble—In all of the 17 years that I was on the Health Insurance Commission I never got more than \$20,000 a year. In all that time the managing director and the chairman, I think, got something like \$40,000. I believe that the chairman of Medibank Private now gets well in excess of \$200,000. Now I might be wrong about that so I should not say it, but it is very much different.

Private health insurance is a very easy business to run. The hardest thing in the Health Insurance Commission was the public sector; running the private one was a doozy—it was easy. If you know something about what the risk factors are and what the flow of funds is, it is easy. Besides that, you can always put the premiums up, and if people are not very sensitive to comparative prices, if you put the premiums up it does not lose you business. So I do not think that running a private health fund is a tremendously difficult job. It should not carry extraordinary rewards, but it does if you are in a profit-seeking business and that business can make big profits.

Senator CAMERON—The other development is this new industry that has attached itself to the private health insurance industry—companies like iSelect that are about providing consumer information on the best policy option. I am just concerned that we will get burgeoning executive salaries, increased costs in the private health system, a new industry starting to burgeon within the private health insurance industry and really forget about the effect that is going to have on providing services to the general public.

Dr Deeble—Yes. That is why I have always had reservations about subsidising the health funds rather than the providers, because I do not want that industry to develop when I know that it is a fairly simple business that should not be developing into a high-cost industry with big margins and high salaries and high profits. As far as the other is concerned—and this gets a bit philosophical—the main purpose of all of the advice, if you take it at the philosophical level, is to make sure that you do not share with anybody else. In other words, it is

for you to do the best deal you can, which means that eventually, because it is a pot of use, the amount of sharing is reduced.

I have been to hearings like this in America, where a ridiculously enormous amount of time and effort is spent on deciding whether the cost—and remember that they have hundreds of payers—that was charged by a hospital included a particular syringe or a different kind of syringe because no insurer will pay one cent more than they feel they should and no contributor will pay in their system one cent more than they think they should. That degenerates into something like 30 per cent of their administrative healthcare costs. At the most, we run at about 10, even in the private sector.

The main outcome of it all is to look after No. 1 and not to share with anybody else, whereas the essence of Medicare is that it is mutual. That is the criticism I have of it. I think individuals might be able to gain but I do not see how the community can gain if the main purpose of the advice is to make sure that you get your thing for the minimum possible amount and that somebody else pays more as a result.

Senator SIEWERT—I was asking the department about covering the cost of transferring patients from the private system to the public system. You have said it will cost around \$360 million to \$370 million.

Dr Deeble—Yes. I think the Commonwealth should pay that—not all of it, but some of it.

Senator SIEWERT—And that brings us to my question. The answer the department gave to me indicated that in fact they had not actually compensated the public health system for the extra costs that the public health system will pick up. There is extra money going to the public health system, but that was not calculated on any modelling of the impact on the public system. I would certainly argue that the public system needs more money anyway, despite the transferred money. Do you think that the public health system has been adequately compensated with the budgetary measures that government has announced?

Dr Deeble—One of the reasons why the last five-year agreement was very hard on the public hospitals was that at the beginning of that—and that was just after the present regime of private health insurance subsidy and lifetime health cover and so on came in in around 2000—the Commonwealth actually withdrew \$700 million arbitrarily because they believed, or said they believed, that that was the savings that the public hospitals would accrue because of the private health changes, the so-called ‘this will relieve the public hospitals’ thing. In fact it did not relieve them at all. The public hospital admissions dropped for two years and then started increasing even more. So the amount that was taken off in anticipation actually never materialised. The public hospital admissions only dropped a little and then came back and have increased since then.

I think that there is a backlog of money anyway, which was taken away from the public hospitals under those last agreements, plus a very, very niggardly adjustment for cost inflation, most of which is unavoidable. Its principle says, ‘We will take the cost of inflation for the public hospital workforce at the lowest possible rate.’ It is the minimum wage rate. They are in competition for doctors and nurses at the top of the professional level where wages are going up, not down. One gets the feeling that there was a really quite deliberate squeeze.

So I think there is a backlog. Some of it has been addressed in the most recent announcement but not all of it. It then becomes a really awkward question because there are federal-state relations which run right over the top of what happens in health. I am aware of the way the states behave because I have helped them on occasions. They will use whatever the law is to their advantage, and so will the Commonwealth, so everybody is not completely innocent. But it ought to be possible to get a better arrangement. As far as this is concerned it seems to be that, if you follow that paper, there was \$376 million. The Commonwealth already pays for everything in a public hospital—all the medical services, all the nursing, all the drugs, everything is in there. In the private hospitals the Commonwealth and the patients pay the doctors. They have access to the Pharmaceutical Benefits Scheme. Those payments are already going on anyway in the private sector. In a sense they will not happen for those people who switch away. So that money is available to go to the public facilities. Then there is the other question which is—I have to agree with the Treasury—about \$230 million would be saved to them on the rebate. That leaves only about \$100 million more which I think is tiny in the scheme of things.

CHAIR—Thank you, Professor Deeble, for coming in this morning. It has been very useful for us. Could I ask Mr Ian McAuley to come to the table.

[10.43 am]

McAULEY, Mr Ian, Private capacity

CHAIR—Welcome. Would you like to make some additional comments before we start?

Mr McAuley—I might just summarise, as most of what I have to say, I think, you have heard from others. My own modelling, which is not as sophisticated as John's, shows a very wide range from a few thousand up to possibly 1.5 million people, but I will qualify that. That 1.5 million people would assume that everyone is calculating rational and risk-neutral—in other words, taking a calculated view of their risk. The reality, of course, is that we just do not know. Remember that the threshold change did not have any effect in 1997, when it was introduced. I assume there was modelling done before that.

We also know that there is what economists call the endowment effect. Once we have something we tend to keep it. Something which we also know, which is well researched and which I did not include in my submission but it has come up this morning, is that there is a strong tendency for people, particularly with means, to insure far more than they need. People do not question the need for insurance. That is very well researched in the areas of household and car insurance, but it is quite reasonable to expect it to extend into health insurance. In fact, the research done by the ABS some years ago now on why people hold private health insurance showed that it is hardly a rational reason. The financial reasons for holding private insurance were tiny. The dominant reasons were: security, protection and peace of mind. I think that was about 70 per cent or so. There were also reasons which were flawed. People said, 'It allows choice of doctor. It allows treatment in a private hospital.' In fact, anyone can have choice of doctor and anyone can have treatment in a private hospital provided they pay themselves or are covered by insurance. There is a myth—and I want to get back to this—that the only way to access the private system is through private insurance. That has been very well perpetrated both by the insurers and, I would suggest, by the 'run for cover' campaign.

It is going to be very hard ever to say what the effects were because there are other pressures on private insurance. There is the income effect—in other words, as our discretionary income gets squeezed, through gasoline, groceries and interest rates, private insurance becomes one of the things which could get dropped off. There is the poor return on reserves this year, which will be a pressure for cost increases. There are the forces of demutualisation, which will increase the cost of capital. There is a public perception which is partly subject to political manipulation: will the public sector look after you or will the private sector look after you? That can be subject to fear campaigns. After all, we should remember that the run for cover campaign had the subtle message that the public sector is not going to look after you.

There is the general point made very clearly by Dr Michael Armitage that, really, private insurers cannot control costs. This has been the experience in other countries which have relied on private insurance for health funding. There is a very direct relationship between the total cost of health care and the proportion to which it is financed by private insurance. I always hasten to add—because sometimes I have been misrepresented by the industry—that I am not advocating socialised medicine but I am a strong advocate of a single national insurer, to the extent that we need insurance. What governments have tended to do has been to see a fall-off in the use of the private hospital sector and to panic and say, 'We need to support the private sector through supporting private insurance,' without questioning the possibility of supporting the private sector more directly.

Private insurance has been a very, very clumsy and high-cost way of supporting the private sector and of supporting choice. We have many ways of doing it without using the intermediary of private insurance. In fact, to give one illustration, one of the effects of the subsidies in private insurance has been a huge fall-off in the proportion of people using private hospitals without insurance. That was in the order of 27 per cent before the subsidies were introduced. It has now fallen to 12 per cent. In other words, contrary to the claims of those who brought it in, there has been a tremendous fall in self-reliance. People have substituted self-reliance and for dependence on what I would perhaps call the 'nanny corporation'—the private insurance companies—which is very little different from the nanny state. What we are not looking at is the role of self-reliance or the role of price signals in health care. We have a huge mess, ranging from free public hospitals through to \$30 pharmaceuticals through to very high copayments in private hospitals and there is no rhyme or reason. This is via misallocation of resources because of the huge mess of funding.

Of course, the point that John Deeble has made—and I would emphasise it strongly—is that, with the way we have separated the private hospital sector from the public hospital sector, they do not compete. They

operate on different business models and we are not allowing for intersectoral competition. So I would argue very strongly that the government not only needs to implement this change but that this change does not go far enough. One of its absurdities is that it cuts out at \$100,000 and \$150,000. Those highest wealth quintile households have liquid wealth in the order of \$700,000, yet they will still be subsidised to hold private insurance even though they are the very people who could afford to use private hospitals from their own resources. I cannot work out why—and the government has never explained why—the government has kept the surcharge at all, because it still vastly overcompensates those who least need it.

My final point and warning to the government—and we are not just talking about this particular surcharge—is that what we are seeing in this industry is escalating assistance without review. We have had various interventions—the initial surcharge, the general rebate with the means test lifted, lifetime rating, the run for cover campaign, the increase in subsidies to older people—and all the time there has been creeping assistance to the financial sector. When the surcharge was introduced, around 12 per cent of households had an income above \$100,000, but it is now 26 per cent. That is creeping assistance without any review. It has hitherto been the policy of both coalition and Labor governments to subject industries to review by the Productivity Commission rather than allowing assistance to increase.

Let us remember that what we are talking about is assistance to the financial services sector. If the government wants to subsidise the private healthcare sector—and I think there is every reason why we should sustain a mixed and competitive system—then it should support that sector directly, bypassing the insurers. I have argued strongly that subsidies for private insurance should come not out of the health budget but out of the budget for Treasury, because Treasury is responsible for financial services. If Treasury has some good reason for subsidising the financial services sector then it should bear the weight of supporting the private health insurance industry. Of course, if we want market signals in health care—and I think there is a very good reason why we should—then we should do that through structured, rationalised copayments. One of the things that happens in insurance of any type, private or public, is that it muzzles price signals. The very logic of ‘Medicare will pay for it’ is substituted by the logic of ‘HCF or MBF will pay for it’. There is moral hazard in all insurance. There is no intrinsic virtue in private insurance.

I conclude by saying that if this does result in an exodus from private insurance—I do not believe it will—I see that as no bad thing because it will force the government into more rational ways of funding the private sector, providing choice and finding price signals in health care.

Senator CORMANN—I take it from what you are saying that you are supportive of the government’s measure as a first step but you think it should go further. Do I understand you correctly when you say that, in your view, the government should abolish the Medicare levy surcharge altogether? What do you think should happen to the 30 per cent rebate and Lifetime Health Cover?

Mr McAuley—You are absolutely correct. I would say that the surcharge should not be there, because obviously the assistance effect escalates as people’s incomes get higher. So for someone on an income of \$200,000 there is a \$2,000 subsidy to buy a product which you can buy as cheaply as \$500—or even less with some of the tax-dodge promotions going on. Never in the days of high tariff protection was I offered an FJ Holden with a 150 per cent cash bonus on top of it. It is not an effective way to subsidise people. The further point I make, though, is that those people with high incomes tend also to be people with high wealth.

On your broader question, I think it is a very strong point you have raised and I have heard you raising similar points with other witnesses. I think we have a flaw in the way governments provide public finance and in the way governments budget. If governments can come to look at private insurance as privatised tax they would come to say, ‘If X dollars is taken out of private insurance then we should increase official taxes by X dollars.’ In fact, I would say slightly less than X because private insurance is costly to collect, much more costly than the Australian tax office. I am sure you have seen the argument that the combined administrative cost of the tax office and Medicare is around four or five per cent and the administrative cost of private insurance is around nine or 10 per cent. So we could actually substitute \$1 of private insurance for 90c of tax. I think what we should be looking at is not ‘what is the tax burden of private insurance?’ There is a myth going around that unless we have private insurance the tax burden of Medicare will send us broke. The point is that whether we fund our health care from taxes or Medicare they will make the same demands on us. There is no particular virtue, however from a left or right perspective, in favouring privatised tax over official taxes. In fact, as we have seen with this measure, attempts to achieve community rating through private insurance are really costly and clumsy and inevitably lead to high inequities.

Senator CORMANN—If we take a step back and take a more high-level public policy view, the challenge as I see it for any government is to ensure that all Australians have got timely access to affordable and quality hospital care. Because the public system is free of charge at the point of delivery there is only one way to ration, and that is to make people wait if the demand exceeds supply. The private system provides an opportunity for people to pay extra into the system to get access at a time of their choosing rather than at the time that they are seen to be a high enough clinical priority. The question then is: if the system is out of balance, which in 1996 it clearly was, is there a case for government through a public policy measure to support the private side of the mixed health system? Do you think there is a case for the federal government to support the private side of the health system?

Mr McAuley—I would argue, even more strongly, that there is a case for the government to ensure that public policy puts both private and public hospitals on the same funding footing, be that through insurance—and as I said there would be a single national insurer—or through co-payments; that there is intersectoral competition; and that they are both working to the same business model.

Senator CORMANN—But by providing subsidies to a private hospital, and Dr Deeble touched on this before, aren't you in effect making private hospitals part of the public hospital system, albeit that they are privately operated?

Mr McAuley—I am not too sure what we mean by this thing, 'the public hospital system'. When we look at an idealised, well-run, corporatised public hospital, really the difference is only who holds the equity in the hospital. We seem to have assumed too much about a distinction between private and public systems. But certainly with the managerial reforms which have taken place now—and I know that they have not penetrated public hospitals as far as they have penetrated other GBEs—there is no reason really to maintain this distinction between public and private entities. They are both business entities trying to do the same thing.

Senator CORMANN—You made the point in your opening remarks that you think the impact on public hospitals, on health insurance membership and on a range of other things is going to be much less than has been speculated. It is very difficult to model and forecast these things, but don't governments that are planning responsibly have a responsibility to properly assess what they think their best estimate is? And, if they do have to assess what their best estimate is, shouldn't that go further than just the impact on revenue and expenditure through the 30 per cent rebate? Shouldn't they also—and others have done it—properly cost, model and assess their best estimate of the impact on public hospitals?

Mr McAuley—I would agree that the government should do that. It is perhaps the first time I have ever defended Treasury before a Senate committee, but Treasury work within certainly limited parameters. They have to do this largely as a set of constrained procedures whereby budget estimates are drawn up.

Senator CORMANN—But it is up to the government to change those parameters. One thing that has intrigued me is that when I asked the question: 'Have you costed, modelled or assessed the impact on public hospitals?' I was told, 'No, they are second-round effects and, consistent with convention, we did not cost those.' We had a change of government in November last year and one of their pre-election, dare I say, mantras was about starting a new era of cooperative federalism in health. If you introduce a public policy measure at the federal level, there is a very high and reasonable expectation it will have a flow-on impact on state and territory governments and their capacity to deliver services in public hospitals. Shouldn't that have been part of the overall public policy consideration? Is this something that the Senate should insist should happen?

Mr McAuley—I certainly agree, but not even Treasury can change its way of thinking that quickly.

Senator CORMANN—But this is not just a Treasury matter; this is a budget that has been put forward by the government.

CHAIR—Senator Cormann, could you allow Mr McAuley to finish?

Senator CORMANN—Yes.

Mr McAuley—The point at which I agree with you, Senator, is that Treasury has to widen its thinking. But the point of widening, I would say, goes even beyond the concepts of widening we have heard here—that is, to think not just on the budgetary costs of various measures but on the community costs so that they include not only official taxes but also the tax burden—and I call it a tax burden—of private health insurance.

Senator CORMANN—From my point of view, this is the crux of the matter. Some people say there will be a small effect and other people say there will be a significant effect—and it will probably be somewhere in between—but shouldn't we go out of our way through actuarial expertise, from a government point of view, to

come up with the best possible estimate of what the impact on public hospitals, on private health et cetera is going to be so that the Commonwealth will be able to adequately compensate state governments for the impact on them?

Mr McAuley—In an ideal world, if research were easy and free, I would agree thoroughly, Senator. But there are diminishing returns from research and there are contingencies. I do not think anyone could have forecast, say, the financial crisis which has come to hit us which is probably far greater than the effect of any surcharge change. At some point all the forecasters can say is, ‘This is our best estimate; we could do better but there are diminishing returns from putting in that extra effort.’

Senator CORMANN—If this was the beginning of a new downward spiral like we have previously experienced which takes us down to a membership level of about 30 per cent, do you think that that would cause a problem to our overall health system?

Mr McAuley—It would cause a problem to the private health insurers but, provided the government respond adequately and find ways to support the private hospitals as they should be supported and provided they sustain choice and rationalise co-payments, it should not matter at all. If we lose bureaucratic overhead, that does not matter. If we were to lose surgeons, doctor, nurses and operating theatres, that would be serious. But nothing being considered by the government really has any effect on the overall resources devoted to health care.

Senator CORMANN—Can I just test you on that point. Why would it be a problem to private health insurers? I put it to you that private health funds could actually be very profitable, even if only five or 10 per cent of the population was covered, because it is just a matter of pricing—how much you have to spend in claims for the people that you are insuring and how much you charge. The question is whether there would be anybody left who would actually get value out of it, particularly in the context of the government enforcing community rating, which everybody agrees is an important part of our system. This is not really a problem for health insurers as much as it is a problem for people who are using the health insurance system to get timely access to quality hospital care, is it not?

Mr McAuley—What is the problem to which you are referring? Is it the problem that those who are insured may find they no longer need it? Is that a problem? I am not certain that it is.

Senator PRATT—Your paper raises some good arguments in relation to stopping subsidies for what should be prohibited items within health insurance. I appreciate you were talking about the possibility of a universal system, but I want to ask you in that context about the extent to which we have a problem with people who hold health insurance policies really only for tax purposes and cannot afford to use them because they cannot afford the gap payments for many of the services they would like to use. Therefore, to what extent are those policyholders, and also the taxpayer, subsidising wealthier policyholders through the 30 per cent rebate for ancillary benefits within health insurance?

Mr McAuley—One of the points to come out of the PHIAC statistics is that there has been a very big but fairly recent rise, just over the last two or three years, in people aged between 25 and 30 taking up private insurance. That is obviously the effect of the one per cent, because they are not yet affected by the lifetime rating, which kicks in at age 30. It is reasonable to assume that these will be people who feel pressured into taking private insurance. Of course, what has happened over the years without the indexation of the threshold is that whereas \$50,000 was once a salary not many people in that age group could aspire to it is now a fairly common salary, so they feel, probably on the advice of their accountants, they should take out at least a minimalist policy. What they are expected to do, as you correctly point out, is to subsidise older people who are more dependent. There is a very large cross-subsidy; in fact, private insurance, even with all the incentives, apart from the one per cent, does not become a value proposition until you are aged about 60. So there is this forced cross-subsidy, and it adds to a number of cross-subsidies which this generation is being forced to pay. HECS, which our generation was not required to pay, is one of the strongest ones, and the other one, which is difficult to explain, is all the building costs and developer charges which are now built into housing prices which used to be financed out of general revenue. So there is a huge inequity here for younger people.

You raised the point, Senator, about ancillaries. Many of these people will not be taking ancillaries cover, but there is a strong pressure. That is a very interesting inequity in private insurance generally, that that majority of the population who do pay for their own ancillaries, particularly dental care, from their own resources get no support, whereas that more prosperous part of the population get their ancillaries covered, at least to a large extent. Again, it is another absurdity, not just in terms of equity but in terms of self-responsibility and market forces. This is not good socialism and it is not good capitalism.

Senator PRATT—Thank you. Your paper also highlights—and we have had some discussion about this already—the issue of the surcharge and the rebate for very high income earners and our need to turn attention to the question of why it would be a rational decision for governments to subsidise private health insurance for people who would hold it anyway, people who have very high incomes. What kind of policy measures do you think government should be looking to to correct those kinds of problems?

Mr McAuley—I will use the usual academic defence and say, ‘I don’t know, because it depends on community values.’ I think the government really needs to shift its thinking from private-public, from private insurance and public insurance, to the much broader policy question: what part of our health care do we want to share among ourselves and what part should we be paying from our own pockets? That is a question of community engagement. Governments of both persuasions have been reluctant to raise that. As I have said, we have this incredible mess of free; open-ended payments; capped payments; et cetera, which is not only inequitable but also leading to a misallocation of resources. We really need to start thinking of health care as one system. I will use the example of Sweden, a country which we often see as the epitome of socialism. Where once there was a universal free system, there is now a universal system but people are required to pay initially from their own pockets. So there is a nice mixture there of market forces and of universal coverage. That was arrived at by a process of consultation and engagement with the community. Instead of thinking private-public, we really need to ask: what part of our health care should we cover collectively through insurance—and I would advocate strongly that that insurance should be a single insurer—and what part should we be funding through market forces, through our own pockets? We are nowhere near that because what we have is a dreadful mess.

Senator PRATT—Thank you.

Senator CAMERON—I am a bit confused, I must say. We talk about market forces and yet the very reason the government is subsidising the health insurance cum private health area is market failure. If there was no market failure, government would not need to be there. How do we get a balance between cooperation between the two sectors and competition? I am really confused about this and I must say you have not helped me on that this morning.

Mr McAuley—Private insurance, or insurance of any sort, is not a market solution. People insure their cars, their health care or whatever to buy out of the discipline of market forces. You are indeed correct: in private insurance, there is a lot of market failure. One of the market failures which became very evident at a recent conference on private insurance is that the private insurers are very keen—and I can quite understand why—to see people take more responsibility for their own health care. They are very keen to see more emphasis on prevention and promotion—and, of course, that is very much the government’s agenda. No-one could argue with those agendas. Yet the very marketing message of private insurance has to be: you will need high-end health care. Insurance sells itself on fear, so there is another market failure.

There is a contradiction between what the insurers would like to see: a healthy, self-reliant population—that would be great for the balance sheet of HCF, MBF or Medibank Private, but of course that very perception would cause people to start dropping private insurance, which is why we need to capture those benefits of prevention, promotion and self-reliance in a single insurer. If HCF, say, goes and promotes self-reliance, prevention and promotion, the benefits are going to flow to all other insurers. They are going to flow to Medibank Private, to MBF et cetera. We have what is called in economics a free ride or a prisoners dilemma effect. It is just not going to happen. The business model of private insurance just does not work.

Senator CAMERON—I was quite shocked by some evidence that we have received that the demutualisation process in the private health insurance industry has resulted in executives being provided with a bonus of about \$1.3 million. We have also heard evidence that you do not have to be the smartest person around to run a private health fund; it is not the high end of operation in the business area. Given that this sort of money is going in and we are now on this profit motive, how do we deal with that from a government policy position? We have that happening and we have the iSelect type thing happening—which is another group growing in this private health area, where they can afford to get Access Economics to do some questionable modelling for them. Where does all this end? What problem is this going to create for delivery of decent health services in this country?

Mr McAuley—I do not know where it ends, Senator. This is what I would call escalating assistance—costs rise, assistance rises to balance that cost and eventually we need the sort of intervention where the Hawke-Keating government with Senator Button said, ‘Enough is enough; we’ve got to review assistance and see

what we are really trying to do and see whether this is the best way of doing it.' I heard John Deeble's response to a very similar question, and I must say that I agree with him thoroughly.

CHAIR—As there are no further questions, I thank you, Mr McAuley, for coming in today to give your evidence.

[11.17 am]

O'DEA, Mr John, Assistant Secretary General, Policy, National Branch, Australian Medical Association
SULLIVAN, Mr Francis, Secretary General, National Branch, Australian Medical Association

CHAIR—Welcome. Mr Sullivan, do you wish to make an opening statement?

Mr Sullivan—I do, thank you.

CHAIR—Please go ahead.

Mr Sullivan—Thanks for the opportunity to appear before you today. The AMA's first concern with the government policy contained in this bill is that it is not health policy; it is tax policy. When the Treasurer announced this policy just prior to the budget, he said to the people of Australia that it is okay to drop your private health insurance even if you can afford it and even if you are using it. But this message is inconsistent with the government's efforts to make the public hospital sector perform better, particularly because it comes at a time when our public hospitals are already struggling to meet the existing demand for their services.

It is hard to see that this policy will do anything other than further add to the burden on the public hospital system. It is hard to see how an inevitable reduction in membership will not adversely impact the private health insurers and the private hospitals. The result will be a rapidly eroding hospital Medicare entitlement, and that is unfair. If, as part of tax policy, the government wants to provide financial assistance to working families on lower incomes, it can do so by providing true tax relief. If, as part of health policy, the government feels that families on lower incomes struggle to maintain their private health insurance, it can help with financial assistance.

There is now some recognition that the government's policy to raise the Medicare surcharge levy income thresholds will have an impact on public hospitals. I noted in the Australian Health Ministers Conference communique of 22 July 2008 that negotiation of the next Australian Health Care Agreements will take account of 'all factors driving growth in demand for public health services'. I assume this includes changes in private health insurance membership rates. It is very easy to factor, to measure and to compensate for growth in demand for public hospital services. As the AMA said in its submission, if the bill is passed by the parliament then agreements 'should contain an explicit provision' for additional funding for every half a percentage point decrease 'in private health insurance participation rates'. The AMA hopes the state and territory governments will pursue this in their negotiations.

Much has been said in the past month about the potential impact this bill will have on private health insurance membership and on public and private hospitals. There might have been less talk if the Treasury had modelled a long-term health policy instead of a short-term tax policy. The AMA believes that this policy is a significant health policy and its long-term impact on the healthcare system must be considered. The AMA believes that the Treasury should be asked to redo its modelling to take account of second round effects and to make it available for public comment. The modelling should factor in the increase in premiums that will undoubtedly follow any decline in membership and the spiralling effects of further drop-outs.

As you know, the AMA is a strong supporter of the current private health insurance arrangements in Australia. The health minister is of the view that Lifetime Health Cover has kept membership rates constant for the last eight years. The AMA believes that it is the co-existence of the three support mechanisms—the Medicare levy surcharge, private health insurance rebates and Lifetime Health Cover—that has kept membership constant. Any significant change to any or all of these mechanisms will see a change in membership. A decline in private health insurance membership will upset the delicate balance between the public and private hospital sectors and undermine the efficiency of the health system in providing acute care to Australian people.

In conclusion, may we say that this issue goes to the heart of affordability of health insurance and goes to the heart of expanding access to essential acute services. We reiterate this: as we read it, this policy announcement from the budget will further undermine expanding access to acute health services, will further undermine affordability for average-income Australians to purchase health insurance and, as far as health policy is concerned, will undermine the objectives for the system.

CHAIR—Thank you, Mr Sullivan. Access Economics, at 2.1 on page 4 of their report, say Lifetime Health Cover discourages people from gaming the system and joining later in life only when they expect their health

to deteriorate. But doesn't to some extent the opposite occur? In fact people drop out later in life when their income declines and they feel that they can no longer afford private health insurance.

Mr Sullivan—My experience with a lot of the reports over the years is that for every report there is great anecdotal evidence to the contrary. When you look at some of the participation rates of health insurance funds, you see that the elderly, as we are told, sacrifice to keep health insurance. The first question we have to ask ourselves is: what is the point of the insurance? I think it is fair to say that these days people buy insurance for assurance and people take a decision as to their own household budgets about the degree to which they want cover for assurance. It is assurance about access, and affordability is obviously an important factor. People will take a decision in their own households about whether they can afford degrees of car insurance, housing insurance, personal life insurance and health insurance. So I do not believe it is an easy pattern to put a trend across a demographic.

Senator CORMANN—Mr Sullivan, how effective do you think the three-pillars policy of Medicare levy surcharge, 30 per cent rebate and Lifetime Health Cover has been in restoring balance to the Australian health system?

Mr Sullivan—The best indicator is that there has been an increase in private health insurance participation from a number close to 30 per cent to a number around 44 per cent now. What that tells you, from a health policy perspective, is that you have well over 40 per cent of the population who notionally, if needing hospital care, will probably go to a private hospital. That puts better balance in the equation around capacity. This whole conversation cannot be had without understanding the context of the capacity of our health system. So when we are talking about balance we are talking about capacity and we are talking about where demand hits. Fifteen years ago public hospitals were under a lot of strain and we often heard the mantra about waiting lists and we heard about the pressure coming from state governments to fund and so on. But at the same time 15 years ago we heard about spare private hospital capacity. You do not have the same spare capacity in the private sector as there once was, which therefore tells us that the balance between the two systems is finely tuned. It is our view that the three factors that we mentioned have contributed to a better balance.

Senator CORMANN—You mentioned increases in private health membership. Of course, while all three elements of that policy were important they would have had different effects at different times. If you look at the membership trend since it bottomed out at 30 per cent in 1998, you see there was a sharp increase of about 30 per cent, it flattened out and there has been a slow but steady increase of about 200,000 per annum. In fact, there have been 400,000 additional people in private health insurance in the 12 months to March 2008. Would you agree with the suggestion that, while the Medicare levy surcharge was not as effective in 1997, when it was first introduced, it has become increasingly effective in achieving what it set out to achieve in recent years?

Mr Sullivan—There have been a number of academic articles written both ways on this debate. I think you need to ask me whether the levy surcharge goes to a deeper question, one which I heard in the previous presentation, about the balance between community obligation and individual participation as policy goals in health care. The levy, to a degree, asks people with a capacity to cover some of their own health costs to do so. Therefore it is part of a broader design of the system. It goes to the question about how personal responsibility comes into the old financing of a healthcare system based on an understanding that we provide people with a universal entitlement. This is not based on an understanding that personal responsibility is a component of a system where we have a safety net. No, it is based on an understanding that personal responsibility actually contributes to ensuring that we have a universal entitlement.

Senator CORMANN—Mr O'Dea, do you have something to add to that?

Mr O'Dea—No, I do not think so. I think all three measures came in roughly at the same time and that the impact was dramatic. It is hard to separate the effects of each of them. They were all price measures in a way.

Senator CORMANN—Treasury told us that they expect 644,000 people to leave private health insurance as a result. It went up from 485,000 people initially to 644,000 people once children were added into it. But Treasury think it is going to be a one-off effect. Do you agree that it will be a one-off effect or do you think that this could well be the start of a new downward spiral like we experienced in the eighties and early nineties?

Mr Sullivan—There are two points to that question. Firstly, the AMA could only analyse the Treasury figures rather than do modelling in the broad. That is all we have provided in our submission. Of course, the Treasury figures do demonstrate an immediate one-off effect. That might be a quirk about how Treasury

provide their figures and their forward estimates. That might be a separate thing. History, if it is any teacher at all, shows that as people leave health insurance, particularly those who are considered to be the better risks, the premium prices increase and you get into a vicious cycle—and it is usually a downward cycle—of participation based on affordability.

Senator CORMANN—Before the election the then opposition talked about wanting to end the blame game in health and enter into a new era of cooperative federalism. I assume that, as a national body representing doctors, you would have had discussions with the then opposition about health policy matters.

Mr Sullivan—The AMA discusses health policy with all parties.

Senator CORMANN—Did the then opposition give you any indication as to what ending the blame game and entering into a new era of cooperative federalism in health would mean in terms of the relationship between the federal government and state and territory governments?

Mr Sullivan—There are two things. Firstly, I was not with the AMA then but, secondly, we would not divulge private conversations with your party or any other.

Senator CORMANN—Let me rephrase the question. Are you surprised that an incoming government that was elected on the mantra of starting a new era of cooperative federalism on health would not assess the impact on public hospitals of a measure like this?

Mr Sullivan—I would not assume that the government of the day had not looked at the impact of its policies. All we are simply saying is that, as we read it, we would like to emphasise the particular impacts of the policy.

Senator CORMANN—The government have told us that they did not assess the impact on public hospitals because they consider it to be second-round effects. You mentioned in your opening statement that this is not tax policy; this is health policy. As the AMA, do you think that a government introducing a health policy measure should have assessed the impact of the measure on the health system overall—on private health insurance premiums as well as on public hospital waiting lists and the capacity of public hospitals to provide services?

Mr Sullivan—Without putting it in your context, our submission is simply saying that, as it currently stands, this particular policy will have a negative impact on how public hospitals can address their demand. It will have a negative impact on affordability for average and just above-average people and families, and it is our hope that as the Senate considers this policy those issues will be at the forefront, because from our perspective these are significant health policy issues. Whether others are more concerned with how tax relief can be effected to Australians is another matter, but, as we said in our submission, if you want to give average Australians tax relief then give it to all average Australians, not just to those who were paying the levy.

Senator CORMANN—So what you are saying there—and tell me if I am paraphrasing you wrongly—is that single people on incomes of between \$50,000 and \$100,000 who also take out private health insurance are equally deserving of a one per cent tax cut. Is that what you are saying?

Mr Sullivan—What I am saying, and what the AMA has always said, is let us not confuse tax relief with the financing of the health system. We have seen numerous public polls that talk about a relationship between tax, the tax take and the funding of essential services. In this case we have a bit of confusion going on, because, in an attempt to get tax relief to a group of individuals, at the same time the same demographic of individuals will find purchasing health insurance more expensive and will find their access to public hospitals less than certain. From a health policy perspective, these are worrying trends.

Senator CORMANN—Do you think the government should reconsider this measure?

Mr Sullivan—We would like the Senate to suggest to the government to reconsider how it will enable average- and low-income Australians to achieve greater financial assistance to keep their insurance if, as a result of this measure, it becomes more expensive for them.

Senator CORMANN—I am sorry; I do not quite follow that. Do you think that the government should reconsider this measure? What is your ultimate view? Do you think that this should be opposed or do you think it should be supported?

Mr Sullivan—We do not support the current policy.

Senator CORMANN—So you think the government should reconsider it. If the government persists, do you think that this committee should be given some assurance that appropriate compensation is provided for public hospitals to deal with the additional demand coming their way?

Mr Sullivan—Just to be clear, Senator, firstly, we oppose the policy on the suggested thresholds. The reasons we oppose the policy are to do with affordability for average- and low-income Australians and the issues to do with accessibility and their reduced accessibility to acute care services. Secondly, we obviously believe that if this policy in any shape goes forward then some type of financial compensation is needed.

Senator CORMANN—‘Some type of’ or 100 per cent, in which case it has to be properly costed before we can proceed?

Mr Sullivan—Clearly, I have not met a Treasury department that will just pull it out of the air. But the reality is that, as we have already said in our opening statement, a facility inside the healthcare agreements would be needed to compensate state governments for percentage drops in health insurance, and we are saying that average- and low-income Australians who are trying to hold on to their health insurance will need more financial assistance.

Senator CORMANN—You are saying that you are opposed to the threshold change. Would you support any other threshold—not \$100,000 but if it were indexed to, say, \$75,000, which, if it had been indexed since 1997, would be the level it would be at now?

Mr Sullivan—There was obviously a reason why it was not indexed by the previous government, and you would need to ask members of it to give you the answer to that. Secondly, which level it should be indexed at becomes quite a delicate issue. It is my understanding that if we still talk around figures of somewhere between \$70,000 and \$75,000 we are talking about up to nearly two-thirds, I think, of the target group potentially shifting out of health insurance. So, intellectually, the argument still holds that there would be a massive impact on the future premium prices. Again, if we keep coming back to the issue, if it can be more transparent about what will happen with this policy vis-a-vis affordability for people trying to hold insurance, vis-a-vis how readily people will be able to access public acute care—which are two health policy questions—then you might be able to answer the question around what level the threshold should be at.

Senator CORMANN—Do you think the federal government should release its modelling on this?

Mr Sullivan—I am sure that would be a great idea.

Senator CORMANN—Were you consulted about this measure either before the election or before the budget, and what sorts of discussions have you had with the government since this measure was announced?

Mr Sullivan—As I said, I was not with the organisation before the election, but—

Senator CORMANN—I am talking of the AMA.

Mr Sullivan—John might be able to fill that in. Certainly, before the budget, no, we did not have discussion about this measure.

Mr O’Dea—No, I do not think there was any discussion. I am not aware of any discussion before. There was some public coverage of the issue in the media about indexation of the threshold.

Senator CORMANN—Has the government met with you to discuss this issue since it was announced in the budget?

Mr O’Dea—We have met with the Treasurer’s office—one meeting.

Senator CORMANN—Not with the Treasurer or the minister for health?

Mr O’Dea—I do not believe we have on this issue, no.

Senator CORMANN—Thank you.

Senator EGGLESTON—I am interested in this issue of the surcharge being seen as a tax measure rather than as a health measure. In your submission, which is one we have seen before, you say:

After the introduction of Medicare in 1984, private health insurance participation steadily declined ... By 1998 membership had fallen to close to 30% of the population.

Since these three measures were introduced, including the surcharge, of course, it has gone back up. The key thing to me seems to be that our whole system in Australia is based on a balance between private and public provision of health services, and we have this concept of community rating. With the fall in health insurance

numbers which occurred before the levy was introduced, the community rating principle had to be under some threat if further decline in health insurance occurred. Would you like to comment on that?

Mr Sullivan—That is exactly what does happen. When health insurance becomes out of the reach of certain individuals, they obviously leave. People on average incomes and low incomes are often, unfortunately, more than likely to be the people who also have chronic conditions or need ongoing acute medical care. It is a factor in our community. Thus, the individuals who are sick—and, increasingly, older—are placed under more financial strain to keep insurance. That is why we community rate the insurance: so the young and the well can cross-subsidise. Unfortunately, when people take a rational choice, when they might factor in only some aspects of their considerations—particularly if they are younger or healthier—they will say, ‘I will take the chance and not have the insurance.’ Insurance then becomes the realm of people who are older, who are sicker or who know, from their own family history, that they are at risk of some type of condition. So the community rating principle becomes undermined. That is one of the reasons why governments then decide that they have an obligation to come back in—I noticed the earlier conversation—and intervene. Whether you want to call that market failure, product failure or financial structuring of the insurance industry failure, the reality is: it is a failure and governments then intervene by way of the three measures we have heard about.

Senator EGGLESTON—That is right. What concerns me, in a general way, is that Australian governments traditionally have not really funded the public hospital system to a level where it could provide total health cover to the Australian community—in much the same way that the state education system provides for only about 70 per cent of the community and private education covers the other third. In this context where the government is claiming the Medicare surcharge was a tax measure, it seems to me that that argument simply cannot hold up, because quite clearly it was a measure designed to preserve this balance between private and public health that we have in Australia and, in the absence of a government committing to a huge increase in funding for public hospitals, there is a community and public policy interest in maintaining an adequate and sufficiently viable private health system to provide that additional percentage required to cover the Australian population. Is that a reasonable point of view?

Mr Sullivan—It is certainly one that would echo what we have written in our submission. Just to add to it: obviously if you go to an accountant the accountant will say to you, ‘These are all the ways you are paying tax’, and will probably list the Medicare levy surcharge as a tax. So, in some people’s minds, the perception is ‘it is just a tax’, whereas, as I tried to say previously to Senator Cormann, ultimately the levy surcharge is also part of a social policy that talks about individuals contributing because of their capacity to pay into the health system.

Senator CAMERON—It seems to me that your submission is a defence of the health insurance industry, as distinct from focusing on the effects on the public in the context of: what health benefits we get through this mixed system, and it is only the insurance system that can deliver a good outcome.

Mr Sullivan—In what sector?

Senator CAMERON—The private sector.

Mr Sullivan—I would like to take issue. If you are going to need to access a private hospital in Australia it is best to be insured. Therefore, this is not a defence of insurance per se but rather of the financing models that give you the access to get in. Insured populations are what we are interested in and the people in them. To be honest, we are more concerned—which is what we are saying here—about average-income and low-income people and their affordability into private hospital care. This is not a blatant defence of health insurance per se but rather of the mechanisms you need to get you into hospital care. Hospital care is the most expensive care; it does not matter where it is. No matter what the mechanism is, we want to ensure in this case that average-income and low-income people are not going to be discounted in one sector. Our submission makes the point that this legislation, in effect, will discriminate against low-income people having that option because of affordability. As I said, many people buy health insurance for assurance of access. That is our point.

Senator CAMERON—What has been described as the fear factor?

Mr Sullivan—I think many people worry about their health care and whether they will get services when they need them.

Senator CAMERON—Professor Stephen Duckett, from the School of Public Health at La Trobe University, cautions policymakers to be careful about the rhetoric that the private hospital system delivers reduced waiting lists in the public sector. He quotes from a Canadian Health Services Research Foundation

analysis. His conclusion is that there is no evidence anywhere that the private sector reduces waiting lists in the public sector. Do you have any evidence, any modelling or have you done any research that would challenge that view?

Mr Sullivan—Mr O’Dea may be able to give you some details. I have read Professor Duckett’s report and, as I said earlier, there has been a lot of academic debate around this issue. But Mr O’Dea may want to show you something we have here.

Mr O’Dea—I do not think there is any knockdown argument in this field. In 1998 the private hospital sector and private insurance were going over the cliff, I think. Had there been no intervention I think we would have had minimal insurance coverage in Australia—perhaps 15 per cent—and a private hospital sector that seriously struggled. But since the intervention we have had—and I have it on a chart here, based on the Australian Institute of Health and Welfare data—since 1995-96 an 87 per cent increase in admissions to private hospitals and a 30 per cent increase in admissions to public hospitals over the same period. I am happy to hand that chart up to the committee, if it would help.

CHAIR—Yes.

Mr O’Dea—Someone must be getting access—waiting lists must be improving by this. It cannot be otherwise, I do not think.

Senator CAMERON—Is that an assertion you are making or is this all of your evidence?

Mr O’Dea—It is data from the Institute of Health and Welfare. I am saying that, if you have an 87 per cent increase in admissions to the private sector over that period, which is the relevant period, and a 30 per cent increase in admissions to the public sector over the same period, there must be improved access as a result of the intervention. I just think it is axiomatic. Had this not happened, I think we would now have a seriously troubled public sector.

Mr Sullivan—Can I add to that, out of interest. I respect Professor Duckett. The question is, taking his assertion: would that activity which has just been outlined all have gone to the public hospital sector? That is a very interesting question. The answer would probably be no. Because of the way the system is set up, the capacities of the system and where people can find services, it is highly likely that his assumption that none of these measures would have taken the strain off public hospitals would not have been correct.

Senator CAMERON—I found your submission and your opening statement this morning a bit like a Chicken Little approach: the sky is falling in. It is at odds with two previous submissions we have heard, especially the one from Professor Deeble. The private health insurance system provides significant benefits to your members, does it not?

Mr Sullivan—To the members of private health insurance?

Senator CAMERON—To the AMA.

Mr Sullivan—Not particularly. The private health insurance pays for hospital care, nursing care, the theatres and for a degree of medical care depending on the relationship the health insurer has with the participating doctor.

Senator CAMERON—It does make a contribution to your members’ incomes.

Mr Sullivan—Health insurance can cover some aspects of the medical income.

Senator CAMERON—So your response of ‘not particularly’ is not correct. It does make—

Mr Sullivan—Before there were products called ‘no gap’ or ‘known gap’ people still went to private hospitals and had their hospital bills to some degree covered but not their medical bills. The insurance system, for want of a better term, that definitely covers aspects of the medical bill is Medicare.

Senator CAMERON—I am interested in the argument you have put forward that this should be about health policy and not tax policy. Surely, you cannot disengage health policy and tax policy. Are you seriously putting that proposition to this inquiry—that you can disengage health policy and tax policy?

Mr Sullivan—No, I did not say that.

Senator CAMERON—That is why I am asking you because that is the impression I had when you made your opening statement.

Mr Sullivan—What we did say in quoting the Treasurer and the health minister was that both of them called this tax relief. None of them mentioned this as a health policy. So I think the question is probably more

rightly put in those circles. What I would like to say to you is: obviously, the financing of health is both public and private. In the case of the Medicare levy surcharge, there is a social policy that could argue that people with a capacity to pay should contribute more.

Senator CAMERON—But it does not have to be through an insurance type system; there can be other options.

Mr Sullivan—All we are dealing with today is the fact of what we have in front of us, which is the Medicare levy surcharge and the insurance systems that are there. Possibly your question could go to the Health Reform Commission for their consideration about other funding models.

Senator CAMERON—In your submission you do talk about some of the modelling. What do you say to Dr Deeble's point of view that it will not be like the Chicken Little approach that underpins lots of the submissions we have had? The fallout will not be as great because some people are ignorant of the change, there will be apathy amongst some people, there will be uncertainty amongst some, people will stay in out of habit, there will be social reasons, there will be risk aversion reasons, some will have a preference for private services over the public services and the private health funds will have business decisions to make to make the business more effective. When you add all of those issues together, it is almost impossible to model that type of behaviour. What is your view on that?

Mr Sullivan—Two things. Firstly, I am sure what Dr Deeble outlines as components of how the product works now will continue. There is no question about that. This is a product where people, as I tried to say at the beginning, sometimes take decisions separately to others in a similar circumstance. Of course there is going to be adverse selection, of course there are going to be people who keep products out of loyalty and so on. One thing we do know is that, as subsidies begin to withdraw from the product, people begin to leave it. History has shown that. I am sure Dr Deeble would admit to that. Secondly, the most interesting thing was that, in the days prior to the announcement in the budget, the Treasurer was on radio, I think that weekend, telling people to drop their insurance. I do not think some people in some settings—

Senator CAMERON—That might be good advice to some individuals.

Mr Sullivan—To answer your first question, I do not think some people in some settings are going to allow people to forget it.

Senator CAMERON—What is wrong with people dropping their health insurance if they cannot afford it?

Mr Sullivan—Our problem with it is that if the only reason why individuals who have insurance now let it go is because of affordability, I would say that if they are on average and low incomes, why should they be the first to be the victims of the policy? Why should they be the first to have their range of access options reduced because of affordability? Why should they be the ones who are told, 'Don't worry about it; let it go.'

Senator CAMERON—That really depends where you look at it from.

Mr Sullivan—Exactly.

Senator PRATT—To pick up where Senator Cameron left off, you have asked why they should be the ones who are impacted and have their range of options reduced. In my experience many of those people are accessing the public hospital system because they cannot afford the gap payments that they would otherwise be subject to. In effect, the taxpayer is paying for those people twice in that they have had their 30 per cent rebate but they are also being serviced by the public health system. Do you know if Access Economic's modelling took account of those kinds of attributes that show who is going to move out of the public system?

Mr O'Dea—I am not sure what modelling you are taking about.

Mr Sullivan—Are you talking about our modelling that we got Access to do?

Senator PRATT—Yes. Your modelling that you commissioned.

Mr Sullivan—We asked Access, on the night of the budget, to analyse the numbers in the budget papers, not to model scenarios. So it is a different exercise. Therefore, in the budget papers there is no commentary about the issues that you have raised.

Senator PRATT—It does seem to be something that has been unaccounted for in a range of the modelling that has been done. Further to that, you have talked about those who can afford to pay being encouraged to pay. What would you say to subsidies for very high income earners being dropped and that money returning to the private health system through other means?

Mr O'Dea—It has gone the other way, hasn't it? The rebate for older people, which is not related to incomes, has gone to a higher rebate. I do not know if that is consistent with what you are proposing but it could be done and if it had to be done in a cost neutral way, we would prefer a higher subsidy to go to the lower incomes and a lower subsidy to go to the higher incomes who can afford it.

CHAIR—Thank you both for coming in this afternoon.

Committee adjourned at 11.58 am