



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

STANDING COMMITTEE ON ECONOMICS

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

TUESDAY, 22 JULY 2008

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**SENATE STANDING COMMITTEE ON
ECONOMICS**

Tuesday, 22 July 2008

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

Substitute members: Senator Cormann to replace Senator Bushby for the committee's inquiry into the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

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

Senators in attendance: Senators Cormann, Hurley and Minchin

Terms of reference for the inquiry:

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

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Committee met at 1.01 pm

CHAIR (Senator Hurley)—I declare open this meeting of the Senate Standing Committee on Economics inquiry into the [Tax Laws Amendment \(Medicare Levy and Medicare Levy Surcharge\) Bill 2008](#). On 18 June 2008, the Senate referred the bill to this committee for report not before 26 August 2008. This bill increases the Medicare levy surcharge 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 2008-2009 year of income and to later years of income. The inquiry will examine, among other things, the impact of changes to the thresholds on the number of Australians with private health insurance, including an examination of how many will abandon their policies as a result and how many will not take up private health insurance in the future; the modelling underpinning the decision; the veracity of that model; and the anticipated impact on health insurance premiums and private health insurance products offered.

The committee has so far taken evidence in Perth and Brisbane. 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.

[1.03 pm]

GREGORY, Mr Byron John, Chief Executive Officer, Health Partners Limited

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

Mr Gregory—Yes. Thank you for this opportunity to appear before the Senate economics committee inquiry into the proposed changes to the Medicare levy surcharge threshold. I am appearing as the Chief Executive Officer of Health Partners Ltd and speaking in part to our industry body submission and, importantly, on the specific effects the legislation is likely to have on Health Partners. Health Partners is a very proud South Australia based mutual fund that was established over 70 years ago. In 1937 a group of visionary officials from the Public Sector Employees Union decided to establish this fund so that members of their union could be provided with peace of mind that they would be able to access hospital services at an affordable price. Soon after the fund was started, it expanded its charter to include the families of these workers. From that time, Health Partners, as it is now known, has continued with this priority of caring for and helping its membership.

We now have over 34,000 memberships and cover over 70,000 people, predominantly in South Australia. We have grown to have eight per cent market share in South Australia. The South Australian market has traditionally been dominated by two larger health funds, but, despite this domination, our members have remained loyal and we have been able to strategically grow our business without losing sight of our charter. In order to provide high levels of service to our membership, we employ over 200 South Australians in professional, semi-professional, administrative, clerical and other roles. Throughout our proud history we have worked under a mutual or not-for-profit structure with the aim of providing the best possible value to our membership while maintaining the required prudential standards. We remain totally committed to this not-for-profit structure on behalf of our members.

As a not-for-profit health fund, we only increase our premiums by the amount necessary to continue providing members with access to the services they require. In April 2008, we increased our premiums by an average of 2.5 per cent. This increase is half of the industry average and, to my knowledge, was one of the lowest, if not the lowest, premium increases throughout Australia. As a purchaser of services on behalf of our members, Health Partners pays out in benefits approximately 87c in every dollar we receive from premiums. This is above the industry average. Our management to expense ratio is below 10 per cent.

The products and services provided by Health Partners to its members in South Australia are unique; not only do we operate a health insurance fund, we also own and operate a dental service for our members. This service started in 1988 and now employs over 100 staff, including 35 dentists plus dental assistants and support staff. It provides over 60,000 consultations to Health Partners members each year. It is the largest private dental practice in South Australia. Since 1991 we have owned and operated our own optical service. We now have two optical centres. In 2007-2008 we provided over 15,000 optometrist consultations to members. These dental and optometry services are greatly valued by our members, not only for the quality of service provided but also because we are able to pay extremely good benefits in order to minimise out-of-pocket expenditure to members. Health Partners also provides to its members access to the state's largest pharmacy network scheme: there are over 40 pharmacies throughout South Australia at which our members receive significant benefits.

Private health insurance provides access and choice. It allows a member to have access to a hospital and other health related services promptly and it allows them to choose the facility and service provider they wish to use. Having that access and choice provides enormous comfort and surety that, if and when a service or treatment is needed, it is available without having to wait extended periods of time and it is affordable. These key tenets underpin the importance of health insurance to our members. At Health Partners, we want to ensure that our members can afford to continue to have private health insurance. From an actuarial perspective, for Health Partners to remain orientated to the market, we must achieve a good mix of risk across our membership profile to maintain financial stability. We must continue to provide appropriate levels of benefits and to price our products adequately. Pricing has to be set at a level at which it covers costs.

We know that the proposed changes to the Medicare levy surcharge will result in the erosion of our membership. Our analysis indicates that the proposed changes to the levy will, in fact, create a disincentive for some members to maintain their cover. Unfortunately, this can only result in an increased burden of cost on those members who remain. We at Health Partners believe that this is unfair on those people who are taking responsibility for the cost of their health care and have joined our health fund knowing that we can provide them with access, choice and the comfort of accessing services when they need them. It would be particularly

unfair if many of these people, particularly those who are pensioners, can no longer afford to have private health insurance, especially at a time when they need it the most. A loss of membership from Health Partners, and from health insurance generally, will mean more pressure on an already crowded public hospital system. South Australia and Australia do not need this. Health Partners fully supports the Australian Health Insurance Association and we stand by the industry body's submission on the potential impact of the changes proposed to the Medicare levy surcharge.

On behalf of our members, we want to continue to be an active contributor to the financing of our members' healthcare needs and to share the burden of health financing with the public hospital and private hospital sectors. We at Health Partners are extremely concerned that the proposed changes will upset the current balance and hurt people in the public hospital system, as well as our members. Health Partners strongly urges this committee to recommend that the proposed changes be reviewed prior to the legislation proceeding any further. As I said at the outset, Health Partners has a very proud history and tradition in South Australia, and I would like to thank the committee for allowing me to speak on behalf of our 34,000 loyal members.

CHAIR—Thank you, Mr Gregory. Have you done any analysis of how you expect the changes to affect your membership in terms of the age profile or overall figures?

Mr Gregory—Yes, we have done some significant analysis of our data. To give some background, over 87 per cent of our membership is over the age of 30. We have 45 per cent of our membership on single cover and 55 per cent on family cover. Whilst we do not collect directly the average income of our membership, we do know from a recent survey that a high proportion of our membership have household income of \$70,000 or less. In the last year we paid for over 18,583 hospital procedures, and the highest proportion of those were for our members over the age of 30.

CHAIR—We have had evidence, and indeed I think this is the government's view, that it is likely to be younger people who will leave the private health sector as part of any fallout from this change. Would you agree with that?

Mr Gregory—Not necessarily. People tend to buy the product so they can claim against it. I am not sure what you deem to be younger membership. Our claims experience shows that people over 30 up to the higher age groups are the major claimants, so if they were to drop out of private health insurance they would also be claiming on the public hospital system, which would put an increased burden on that system.

CHAIR—There has also been a suggestion that there will not be such a burden on the public health system as would be indicated by the figures, because the government expects them to be younger people, who have fewer hospital admissions generally.

Mr Gregory—Only 13 per cent of our membership is under 30. Eighty-seven per cent are over 30, so any movement in those higher age groups would impact clearly.

Senator CORMANN—In any one year, how much of your revenue from hospital cover would be spent on funding hospital treatment?

Mr Gregory—Of our total contributions income, over 40 per cent is paid out in hospital payments.

Senator CORMANN—But out of your hospital contributions income what proportion is invested in funding hospital treatment?

Mr Gregory—I am sorry; I do not follow your question.

Senator CORMANN—Essentially, for every dollar that a member on hospital cover pays into your fund, how much of that dollar is spent funding hospital treatment in any one year?

Mr Gregory—I cannot give you a specific number, but in our total contributions income over 95c in the dollar is paid out, 89c on behalf of members—and we are higher than the industry average. On top of that we have administrative and management expenses, which leaves us a margin of around five per cent.

Senator CORMANN—Eighty-nine cents in the dollar sounds much more like it. If you look at PHIAC data, roughly 15 per cent on average across the industry is the cost of administration and the net margin covering future claims. You are saying 89 per cent of your income from hospital premiums in any one year—

Mr Gregory—That is in total payments, both hospital and general treatment cover. I cannot give you hospital specifically.

Senator CORMANN—You may have covered this in your opening comments: how much do you expect to lose in hospital revenue as a result of this measure?

Mr Gregory—We have not done that detailed analysis, Senator.

Senator CORMANN—Have you made an assessment on the impact of this measure on your fund in terms of membership trends?

Mr Gregory—Yes. We support the view put forward by the Australian Health Insurance Association and a number of other bodies which we are associated with. That membership loss could be up to 10 per cent.

Senator CORMANN—Are you aware that the government expects to save \$960 million over the forward estimates period by not having to pay the 30 per cent rebate to those the government expects to leave health insurance?

Mr Gregory—Yes, I have seen that.

Senator CORMANN—That is only 30 per cent. There is also the 70 per cent contribution made at this point by those whom they expect to leave, which would also be lost to the system. Do you agree with that?

Mr Gregory—Yes.

Senator CORMANN—Doing the maths, that is another \$2.24 billion. That brings us to \$3.2 billion. To take you back to your 89c in the dollar, wouldn't it be fair to say that there is a loss in funding for hospital treatment of somewhere between \$2.7 billion and \$3 billion as a result of this measure?

Mr Gregory—Based on the facts you have put forward, you could assume that, yes.

Senator CORMANN—I am asking that question because—and the chair, the Minister for Health and Ageing and others have made this point—the people who will leave are the young and healthy. Let's assume for a second that that is right. Wouldn't it be fair to say that, even if they do not access hospital treatment, in any one year they fund hospital treatment for those who do—they contribute to funding?

Mr Gregory—Yes, they contribute to the risk pool. The philosophy is simple: you have young, fit and healthy paying into a risk pool; theoretically, they do not claim, but the older people do claim, and one offsets the other. That is the basic risk-pool analysis.

Senator CORMANN—The minister for health and the Treasurer have also said that health funds like yours ought to become better at providing products attractive to young people. In the context of community weighting, can you talk to us about how, if more and more young people leave and more and more high-risk people stay with your fund, that is going to impact your capacity as a fund to provide products that are attractive to young people?

Mr Gregory—If young people do not join, or if they fall out of the fund, that unbalances the risk pool and what you are left with are high claimers, which puts up your premium cost because you have not got the nonclaimers coming into your fund. Increased payments puts pressure on premiums, and increased premiums become a disincentive for people, particularly younger people, to take out health insurance.

Senator CORMANN—You said you supported the industry view in terms of the effect on membership trends. Treasury have put in their submission that they think it is going to have a one-off effect, whereas others tell us you will have the first effect and then a second wave, so to speak, as the first cohort of younger people leaving puts upward pressure on premiums. Essentially, we could be at the start of a new downward spiral. Could you comment on that for us.

Mr Gregory—I have seen that analysis, and we support that view. I think it would have been put forward by the Australian Health Service Alliance, who have done a lot of analysis in that area, and we believe there is a lot of merit in that analysis.

Senator CORMANN—Why do you think it is important for the government to have policies that support private health insurance?

Mr Gregory—Australia clearly has the best healthcare system in the world. You have a public system and a private system that work in unison. One complements the other. It is very finely balanced. Upsetting that balance is going to put unnecessary pressure back on the public health system. That impacts those people who rely on it. It also has the effect of putting premium pressure on health insurers. Premium pressure forces people out of health insurance, and the downward spiral in membership continues. I think we only have to look back to the late nineties to see when participation rates in private health insurance were around the 30 per cent mark.

Senator CORMANN—Obviously, after that, the previous government introduced a three-pillar policy of the 30 per cent rebate, Lifetime Health Cover and the Medicare levy surcharge. Can you talk us through your assessment of how effective those policies were in turning that trend around.

Mr Gregory—Over time there has been an increase in the participation rate for private health insurance. I think what we have got to understand is that purchasing health insurance is an investment in our health. People buy it because they like it and they can use it, and it gives them what they want in their healthcare needs. It gives them access to services and it gives them choice. I think awareness of private health insurance and the structure around incentives has ensured that we continue to have that reasonable mix of public and private. It has kept private health insurance affordable, and that affordability has helped people move into the product.

Senator CORMANN—Looking at the data, there was an initial spike of about 13 per cent in membership after those measures were introduced, and I think there is a view that the 30 per cent rebate and, particularly, Lifetime Health Cover were the reasons for that. Then there was a plateauing—a slight dip, in fact—but in the last three or four years membership has started to increase again. I put it to you and I ask you to comment: the measure that has had the most impact in recent years is probably the Medicare levy surcharge because of its impact in terms of the thresholds that apply. Over the last 12 months about 400,000 additional people have taken up private health insurance. What is your assessment of that?

Mr Gregory—The threshold has been one of the contributing factors to people taking out private health insurance.

Senator CORMANN—More so in recent years?

Mr Gregory—I think the Lifetime Health Cover levy has also impacted on that, and the initiatives of government to advise people turning 31 at their next birthday to take out private health insurance has been advantageous for our industry. That happened last year and also this year. They are drivers of membership growth.

Senator CORMANN—Federal Treasury has told us that they did not model the impact either on public hospitals or on private health insurance premium increases required in the future as a result of this measure. They call it ‘second-round effects’. In South Australia the health department does not appear to have it on the agenda. In Queensland they pulled out, and in Western Australia they did not seem to have done much modelling. Are you aware as to whether the health department in South Australia has done any modelling on the impacts on public hospitals of this measure?

Mr Gregory—I have not seen any modelling by the South Australian health department.

Senator CORMANN—Do you think that federal Treasury should make its modelling available to the state government so they can make a proper assessment of the impact on public hospitals in South Australia?

Mr Gregory—That may be of assistance. I do not understand that process well enough, Senator, to comment on that.

Senator CORMANN—You mentioned in your opening statement, at the tail end that I captured, that you thought there would be a significant impact on public hospitals, and I think there is overwhelming agreement across the board that there will be additional pressure. The questions are: how much additional pressure; how much will it cost; and will there be compensation from the federal government to the state governments that are impacted by it? Similar to what the health funds and the private hospitals have done, don’t you think that the state governments, which are responsible for the good running of public hospitals, should do the same thing and commission some proper modelling? Don’t you think they should have in front of them the best possible data to inform that modelling?

Mr Gregory—If that assists them to continue to provide a high level of service, that would be valuable.

Senator CORMANN—What has been the trend in South Australia in terms of the number of private hospital episodes over the last six or seven years? Has it been the same experience as in other states, where most of the growth was absorbed by private as opposed to public hospitals?

Mr Gregory—Yes, that is correct.

Senator CORMANN—Have you got some facts and figures around that?

Mr Gregory—I cannot give you anything off the top of my head, but we could give you some information on notice if you requested that.

Senator CORMANN—Did you provide in your opening statement any information about the additional increase in premiums that you expect as a result of this measure?

Mr Gregory—We work very closely with a number of bodies. We would expect that premium pressure will result in premium increases, realistically, to meet the prudential standards of anywhere between seven and 10 per cent in this year and onwards.

Senator CORMANN—Is that seven to 10 per cent on top of your normal increase or is that seven to 10 per cent in total?

Mr Gregory—I would say between seven and 10 per cent flat, not on top.

Senator CORMANN—I am not aware of the specific experience with your fund, but in recent years across the industry the percentage increase in premiums has actually been coming down as membership has been increasing, so that would be a reversal of that trend, would it not?

Mr Gregory—Yes, it would be. What has been happening is that premium increases have been going down but payments out have been increasing. Payments and benefits have been increasing by about six to eight per cent, but the premium increase in this last year for Health Partners was 2.5 per cent.

Senator CORMANN—Has your fund got a view at all about the concept of indexing the Medicare levy surcharge threshold?

Mr Gregory—We do not have a strong view on it other than that the whole system is very finely balanced and anything that can be done to keep the current participation rate would be to everyone's advantage, particularly the public hospital system.

Senator CORMANN—But is it fair to say that the government is not actually proposing to index it, because they are just doubling it? Indexation would take us to \$67,000 per annum according to the briefing I was provided with by the Senate. Are you concerned that it seems to be a bit of a stab in the dark, 'Let's double it'?

Mr Gregory—The best position, I think, is no change to what we have, to be quite honest.

Senator CORMANN—The government is trying to sell this as a tax relief measure for people who are doing it tough. The chair, in previous hearings, has made that point quite strongly. Don't you think that if we take the view that people in those same income ranges are doing it tough and deserve a tax cut then newer members who take out private health insurance and who take additional responsibility for their own healthcare needs by doing that would be equally deserving of a one per cent tax cut? That is what we are talking about.

Mr Gregory—People take out private health insurance for a range of reasons. If they see value in it, they will build it into their income level and into their budget so that they can have the best health care they can get when they need it. It is very finely balanced and every household is going to think differently, but we do know that people have built private health insurance in its current form into their budgets and they are purchasing it because they can get value out of it.

Senator CORMANN—Is there a percentage of coverage that you think is a sustainable level? If membership drops below a certain percentage, do you think that it would actually create that downward spiral that we experienced between 1983 and 1996?

Mr Gregory—I do not know that there is a set number, but I have worked in the system long enough to know that when that downward spiral was occurring there was enormous pressure on public hospitals. Private health insurers were struggling because they were left with the high claimers. The product was expensive. There are enough checks and balances in the system now to control annual premium increases. I do not know what the level would need to be to create a downward spiral but the public hospital system is there; it is servicing a group of people now and, at times, it struggles to service them; and any more pressure from people dropping out of private health insurance is only going to impact on them more.

Senator CORMANN—So what is your recommendation to the committee: to keep things as they are?

Mr Gregory—Correct.

Senator CORMANN—Thank you.

Senator MINCHIN—Mr Gregory, you said that your fund was actually started by the Public Service Association; is that the history?

Mr Gregory—Correct.

Senator MINCHIN—What is the history from that point? Was it owned by the PSA and then it opened up?

Mr Gregory—No. The fund is owned by the members.

Senator MINCHIN—When did that occur?

Mr Gregory—In 1995 the board of directors took a decision to become an open membership fund, not a closed membership fund. That allowed Health Partners to go out into the broader marketplace and compete with the other open membership funds. That is the market we compete in now. A good proportion of our base is still public servants.

Senator MINCHIN—Could you give us the proportion of your membership that is?

Mr Gregory—About 34,000 members are public servants.

Senator MINCHIN—Have you got any data on the rest of your membership? Do you know how many of the rest of your membership are members of other unions?

Mr Gregory—Trade unions have a number of closed membership funds—for example, for teachers and transport workers. They are probably the two main ones. Police are another one; they purely look after policemen. The remainder of our membership is open to and is taken up by the general public in South Australia whether they have union membership or not.

Senator MINCHIN—You do not record that in your data?

Mr Gregory—We do not record that, no.

Senator MINCHIN—Do you actively market yourself to a trade union audience in particular?

Mr Gregory—We have got a very close link with the Public Service Association still, and that is a good link. A number of their officials—

Senator MINCHIN—How is that link manifested or what is the basis of it?

Mr Gregory—We have three—

Senator MINCHIN—Are they on your board, for example?

Mr Gregory—Yes, correct. Three of our directors are closely involved with the Public Service Association, and we do a lot of work promoting our products to grow our membership within the Public Service. The rest of our advertising is on TV and radio, and we compete with the mutual communities and the Medibanks of the world in order to obtain our market share.

Senator MINCHIN—Have you surveyed your members at all about this issue? Have you sought any information from them in any way?

Mr Gregory—We survey our members, but on which issue in particular do you mean?

Senator MINCHIN—The issue we are talking about—this proposed increase to the Medicare levy surcharge.

Mr Gregory—No, we have not surveyed our members on that.

Senator MINCHIN—Okay. Thanks.

CHAIR—Mr Gregory, you were talking about affordability being one of the keys to participation in private health insurance. Are there any other ways that government can assist in improving affordability—and not only government but anyone else? You mentioned that you have a dental service and an optical service and links with pharmacies as well; presumably, they are a way of keeping down your costs.

Mr Gregory—That is right. We offer those services. We employ the staff who work in them. When our members join Health Partners, they have a choice. When they have their dental treatment they can go to an outside dental practice, where they will have an out-of-pocket expense; or, if they are without a fund and they go to our dentist, they will have a lower out-of-pocket expense. The same thing happens with optical services. So, basically, if you have got top cover with Health Partners and you go to our dental centre, you will get an 85 per cent benefit. For glasses, it is a 70 per cent benefit. They are things that are important to members, and one of the reasons we have been able to grow our fund is those good benefits we pay which minimise out-of-pocket expenses. That has been a driver of membership growth for Health Partners.

CHAIR—And that is not a facility you have been able to provide for general medical services and costs?

Mr Gregory—No, just for ancillary cover.

CHAIR—So, if there were ways to contain costs with the medical services, that would also help with affordability?

Mr Gregory—Yes.

Senator CORMANN—Isn't that something you do in the normal course of business—doing everything you can to contain medical costs?

Mr Gregory—We are price takers, not price setters, in that regime.

Senator CORMANN—Yes, but aren't you focused on keeping your premiums as affordable as you possibly can by minimising your claims costs?

Mr Gregory—We are always focused on that. What you hope is that, every time a member accesses a service, it is the optimum service they can get—that they are not being overserved and they do need the treatment they are receiving. What we do know in our optical and dental business is that our optometrists and our dentists do not get people back to overservice them. I guess—

Senator CORMANN—Yes, but do you have significant further scope—

CHAIR—Order! Senator, I was asking questions.

Mr Gregory—they get the treatment they need.

Senator CORMANN—It was just a follow-up.

CHAIR—Sorry, Mr Gregory. Go on.

Senator CORMANN—Do you have significant further scope to reduce your claims expenditure?

Mr Gregory—It is very difficult to reduce your claims expenditure. If a member comes along and says, 'My doctor wants to put me in hospital for an arthroscopy or a knee reconstruction so I can continue to play golf,' we cannot stop that member from accessing that service and we have to pay the benefit to the hospital and the doctor that provide the services.

CHAIR—I suppose both the public and private health insurance systems would like to have a bit more control, or at least a bit more information, about those kinds of issues in terms of servicing and costs associated with medical treatment. It is one of the key drivers of increased health costs over the last few years, I think.

Mr Gregory—Correct.

CHAIR—I think that is also something the government is having a look at currently—that is, a review of the health system.

Mr Gregory—I think that would be very beneficial.

CHAIR—Any other questions?

Senator CORMANN—Regarding young people's perception of value, there is a view that Medicare is funded through the Medicare levy and the Medicare levy surcharge, but, of course, that is only a small proportion of it. It is essentially funded through taxpayers to a significant extent. As you are trying to demonstrate value to your younger members, how do you see your competition in terms of the value proposition in the context of Medicare and the perception that perhaps Medicare provides access to free public hospital care whereas through your fund you have to pay out-of-pocket expenses? There are a couple of questions in this. Firstly, do you think that there ought to be more transparency in the true cost of Medicare? Secondly, how do you see that?

Mr Gregory—I think a young person paying their tax probably does not even realise they are paying a Medicare levy. How do you make the product more attractive? Young people are invincible—they do not think anything is going to go wrong with them. We always encourage our members to consider taking out general treatment cover and hospital cover. Regarding our products, in general treatment we know that young people like the dental product and the optical product. They are things that make them feel good and that they can claim against.

Senator CORMANN—I guess what I am trying to get at is, as the cost of treatment increases, there is a very transparent correlation in terms of the cost of health insurance premiums. In the public system there is not the same transparent correlation. You will have a five per cent increase if your cost of claims and your utilisation increases, and it is there for everybody to see.

Mr Gregory—Yes.

Senator CORMANN—Do you think that that makes it harder for you to demonstrate value, particularly to younger members?

Mr Gregory—I think that is true, yes.

CHAIR—Speaking of transparency, one of the things I have heard anecdotally from people I have spoken to is that one of the things that puts them off private health insurance is covering the gap charge. Wouldn't it be more useful also to have more transparency and certainty in what those fees would be and what costs people are likely to face for any given procedure?

Mr Gregory—Certainly with our general treatment products our members are aware of what their out-of-pocket expense will be. It is different with hospital treatment and payments to medical specialists. Fortunately, South Australia has the highest level of informed financial consent and people going into hospital knowing whether or not there is going to be a gap. It is something that our industry associations work very hard at; it is something that we as a fund have worked very hard at. We encourage our members, if they are going into hospital, to contact us so that we can confirm what any out-of-pocket expense may be. There is no doubt that is one of the single biggest factors of why people drop out of private health insurance.

CHAIR—Yes, precisely.

Senator MINCHIN—Against the background of your history as a trade union health fund, were you aware in the lead-up to the last election of any indication, either written or unwritten, in Labor Party policy that the change that this bill proposes was envisaged, imminent or even possible?

Mr Gregory—No.

Senator MINCHIN—There was no indication to you that there was any thinking—

Mr Gregory—None at all.

Senator MINCHIN—Did you have meetings with shadow health ministers or shadow treasurers in advance of the election at which discussions were held?

Mr Gregory—No, we did not.

Senator MINCHIN—You were not aware of any suggestions in the ether that a newly elected Labor government might change one of the fundamental tenets, as you have described it, in relation to this?

Mr Gregory—No awareness of it at all.

Senator MINCHIN—On the other side of it, did you seek, and either were or were not given, assurances that there would not be or were not proposed to be any changes to the fundamental underpinnings in a policy sense of private health insurance in Australia?

Mr Gregory—It is my understanding that the Health Insurance Association was given some undertakings with regard to the rebate.

Senator MINCHIN—So, from your fund's point of view, the budget announcement was a complete shock?

Mr Gregory—It was a complete shock. I read about it in the paper like most other people.

Senator MINCHIN—So there was no consultation—nothing of any kind in the lead-up to the election?

Mr Gregory—No consultation, no.

Senator MINCHIN—Thank you.

CHAIR—Thank you for your evidence this afternoon.

Mr Gregory—Thank you, senators.

[1.40 pm]

SEGAL, Professor Leonie, Private capacity

CHAIR—Welcome, Professor Segal. Please give the capacity in which you are appearing today, before you begin.

Prof. Segal—I am the Chair of Health, Economics and Policy at the University of South Australia. I appear here as an expert—as a health economist—particularly through my work in looking at the economics around private health insurance.

CHAIR—Thank you. Would you like to make an opening statement or any opening remarks?

Prof. Segal—My interest or what I have to offer is an understanding of the role of private health insurance in the context of a universal health system. I have not made a particular study of the change to the surcharge itself. I have done some broad work looking at whether supporting private health insurance will contribute to the efficiency and equity of the Australian health system. I have written a number of papers on that, which I will table or leave for people's interest. That work is consistent with a strong international trend and suggests that essentially subsidising private health insurance in any way actually undermines both the universality of the health system in terms of both equity of access to health care and the possibility of achieving workable outcomes. It also undermines the efficiency of the health system. So my position is really that any move that reduces the subsidy for private health insurance is a move to the better and one that will contribute to the overall equity and efficiency of the health system and the overall value to the community of what they get for the health dollar. I do not know if you want me to go into any of the components of that argument at this point.

CHAIR—Yes; if you could elaborate a bit, that would be useful.

Prof. Segal—There are a number of arguments that have been put up to support private health insurance. I suppose the first is a concern about whether taxpayers or government can fully fund the health system. One of the things that are clear is that in Australia we are spending a bit over nine per cent of gross domestic product on health care, which is about the middle range for major advanced countries, so it is not excessive. In terms of the government spending of 67 per cent, it is actually lower than all but about four countries in the OECD. So Australia has one of the lowest government contributions to health care. In terms of global parameters, there is no reason to suggest that we need to bring more private dollars into the health sector. The premise on which some of these changes were made does not seem to be valid. Also, if you look at the drivers of the health cost, there has been a lot of concern about ageing and the cost of health care. In fact, all the evidence suggests that ageing per se is not a major driver of healthcare costs. The evidence is that it is associated with illness, particularly the time before death. Partly because of the ageing population the number of deaths per year is going up very slightly; it is something like 0.4 per cent per year, so it is a very small increase in the number of people dying per year. The main sources of increased costs are actually the cost of medical care—the medical fees, technology, particularly drugs et cetera.

When the private health insurance rebate was brought in, combined with the lifetime rating, which did encourage a lot more people to join private health funds, we found that, rather than government expenditure on health care, as in the share of the total health bills that went to government, being reduced, it rose. The expectation was it would fall. In fact, there is a simple graph in the AIHW publication *Health Expenditure Bulletin* which shows that private health insurance contributions fell from about nine per cent to about 7½ per cent and government expenditure went up, partly because of the 30 per cent rebate. That means that for each person who shifts into private health insurance the government is spending a straight 30c for each dollar on that. But the point is that that rebate was allocated to everybody with private health insurance, which included the two-thirds who already had private health insurance. So there was actually a massive increase. It is a very inefficient spending of dollars. In fact, the rebate is now costing \$3,200 million. The total Commonwealth government expenditure on the public hospital system is only \$10,200 million, so in fact the value of the rebate is a third of the total Commonwealth spend on public hospitals.

Translated another way, if we were not supporting private health insurance and those dollars were available to go into health in other ways, they could be used to increase the Commonwealth contribution to public hospitals by one third. One of the main purported advantages of supporting private health insurance was to take those people out of the public system, to take pressure off the public system. The estimates are that, if anything, it might have achieved a five per cent reduction, if that—and that has been contested—compared with a 30 per cent increase in government spending through the dollars that went to the private health insurance rebate. That would have had a much greater impact, if the primary objective was to do something

about the pressures on public hospitals. When you think about promoting private health insurance, the first thing is that 20c in every dollar goes on admin and profit, so you lose 20 per cent up-front. Thirty per cent goes on extras—physio, dental et cetera, which does not help public hospitals—and two-thirds accounts for people who already have private health insurance, and people will take out private health insurance without subsidy.

Where I am coming from is that, if people want to take out private health insurance, that should be a private decision. There is no reason for them not to, but there is actually no advantage in using taxpayers' dollars and other policies to try to support that. In fact, it undermines the universality of the health system, it undermines the basic principle of accessing health care on the basis of clinical need and it brings in an alternative way of accessing health care, which is much more tied to income as people on higher incomes tend to be those who have private health insurance. That is a summary of my issues.

CHAIR—We have already heard some evidence about the Canadian medical system, which I understand is a universal public medical system but provides people with the ability to choose private health insurance, if they wish. That is a completely separate system. Have you had a look at that system?

Prof. Segal—Not in detail. One of the major differences, as I understand it, is that it is not only separate in terms of insurance; it is separate in terms of providers. So providers work either in private or in public. There is probably no expectation, no likelihood and no reason to perhaps head in that direction. One of the issues with promoting use of private hospitals, where the fees tend to be much higher, is that you then have a major problem of public hospitals then competing for clinicians. I think that aspect is important. Given the tight market, particularly for surgeons and anaesthetists—a whole range of hospital specialists—a challenge for public hospitals is to retain their specialist staff. They face competition from private hospitals.

CHAIR—Can you just go over the figures. They probably do not directly correlate, but you mentioned that the contribution by the private system to overall health is down from nine per cent to 7½ per cent. Did I get that right?

Prof. Segal—Yes. In 1995-96, health insurance funds contributed nearly 11 per cent of total health expenditure. In 1998-99, just after the rebate came in, it went down to about eight per cent. So there was a three percentage point reduction in that.

CHAIR—You said that a third of government expenditure is on the rebate, so a third of government expenditure covers that eight per cent?

Prof. Segal—I said that over \$3 billion is being spent on the rebate, and the primary reason the contribution by the private health funds fell was that 30 per cent of all their contributions come from the government. So, effectively, you would expect they would use only two-thirds. Even though the total number of members went up, it did not actually go up enough to compensate for the fact that private health insurers were only contributing two-thirds, or 70 per cent, of that. It is not even 70 per cent, because 20 per cent actually goes into profit and admin. So yes, it is a combination of those elements. That is the reason why in fact the contribution fell.

Senator CORMANN—Do I take it from your opening comments that you do not support the continuation of the 30 per cent rebate?

Prof. Segal—Correct. I think if we could wind it back, it would lead to a more efficient and equitable health system.

Senator CORMANN—You see this measure as a first step in what you hope will be a continuation of reforms that will, essentially, ultimately get rid of any subsidisation, as you call it, from government?

Prof. Segal—Looking at whether it is a step taking us in the right direction in moving to a more efficient and equitable health system, I think yes, having fewer people subject to that levy penalty is part of the step and I hope it will continue.

Senator CORMANN—We have a mixed health system. As you make adjustments to one side of the health system there will be flow-on impacts on the other part of the health system—that is, if we progressively move towards what you think is a more efficient system which is directing all of the funding towards a public hospital system, shouldn't there be some sort of assessment of how these transitions are properly managed?

Prof. Segal—Absolutely. I think it is important to distinguish between supporting private health insurance, which, essentially, is what the various packages and policies do—and it is by far the largest industry subsidy ever—and supporting private hospitals. In fact, the use of private hospitals was very strong and has continued

to be strong, and there is no reason at all why one cannot move to a system—and this is happening—of purchasing beds and services from private hospitals. So it depends on how one then moves. You are right; you have people using private hospitals and there is a capacity there, but it does not have to be supported by private health insurance.

Senator CORMANN—In 1996, a lot of private hospitals were more than half empty while there were huge queues in all of the public hospitals. You quoted the Australian Institute of Health and Welfare data before, and I watch that data very closely. Every year they release a report on hospital statistics, including hospital usage. If you look at the various reports that have been released since 1999-2000 onwards, up until the most recently available report, you will find that the growth in private hospital episodes has been about 45 per cent whereas the growth in public hospital episodes has been about 20 per cent. So most of the growth in recent years has been in private hospital treatment. In that context, don't you think that a government that introduces a measure like this—and I acknowledge that you support the measure—should properly assess the policy consequences and the implications of that change for public hospitals and the demand faced by public hospitals so that they can properly prepare themselves for the impact? And shouldn't funding go directly into the public system to make sure they are able to cope with that additional demand?

Prof. Segal—I think that any policy should be properly analysed. I would not support policy change without analysis, but the fact that private hospitals have been growing faster is a lot of to do with the nature of the work. A lot of what they do is very short turnover procedural work. You will find that, in terms of length of stay, the difference is not anywhere near as great as it is in terms of admissions. So a lot of what they are picking up is a lot of day surgery and new day surgery hospitals—and I think a lot of that would have happened anyway.

Senator CORMANN—You are a health economist. Treasury has told us that what they have modelled and assessed is the impact in terms of the money that they will save as a result of not having to pay the 30 per cent rebate to the people they expect to leave the system and what it is going to cost them in terms of the revenue lost from not being able to charge the Medicare levy surcharge to people in those income brackets. They did not assess or cost the impact on public hospitals because they call it a second-round effect. I would have thought, in this era of corporate federalism, that it is a serious, top-of-mind consideration when you are introducing a policy change that goes to the heart of the balance in the health system, that you actually do a proper assessment and proper costing of the impact on public hospitals and hence the state government's capacity. What is your comment on that?

Prof. Segal—I think there is a major issue with our health system at the moment in the split in funding and responsibility between the Commonwealth and the states. In the last several years the states have increased substantially their share of funding of public hospitals. I think it is a major burden on the state governments and they do have quite limited revenue sources within which to make that obligation. So anything which has the potential to increase the pressure on public hospitals will be an issue for the states. I think there are other reasons anyway to be looking at that share, because there has been a major reduction in the Commonwealth contribution to public hospitals.

Senator CORMANN—The South Australian state government was invited to attend this inquiry but has chosen not to. In Queensland the state government pulled out five minutes before we were due to sit. In Western Australia the state government clearly had not gone through a proper assessment of the impact on them, the reason being that the federal government had not made its modelling available to them. Don't you think that Treasury should at least make its costings and its modelling available to state governments so they can make a proper and informed assessment of how much additional pressure they have to expect and how much it will cost so that they can then make an informed claim? I see you nod, but Hansard does not pick that up.

Prof. Segal—I think it would be helpful to have that modelling available. I would have to say that the work that has been done over the last decade shows that it is not simple to do that modelling, but it is something that would be useful. I would not disagree at all that it would be valuable to look to see if there is any likely impact on the public hospitals and to ensure that there is some flow of funds from the Commonwealth to the state to address that.

Senator CORMANN—You have made some comments about your assessment of the role of private health in the context of our overall health system. Do we need a private health system?

Prof. Segal—There will probably always be a role for private health. Most of our primary care system is private. We have a mix. It is privately provided but publicly funded. We have a very complex mix. All of the

medical services in private hospitals are largely publicly funded through Medicare, so we actually have a very mixed and complex system. I am sure we will always have private components in the system.

Senator CORMANN—If you look at the UK system, you will see that it is essentially a publicly funded system, just with a private component at the extreme end for the very rich. Is that the sort of system that you would envisage for Australia?

Prof. Segal—I think our history has been quite different. We have had a very long history of a very strong private sector. If you take away subsidies it is very hard to know where it would settle, and we do not have the history to know.

Senator CORMANN—Do you think that a quasi exclusively publicly funded public hospital system will ever be able to meet all of the demand in a timely fashion?

Prof. Segal—Absolutely, in the sense that everything suggests that a publicly funded system is far more efficient, so whatever dollars go into the health system, if we actually put it through a universally funded public system, we will actually get more health care for our dollars. If we add together the total public dollars and total private dollars going to health care, we will actually get more health services if we allocate it through the public system.

Senator CORMANN—Can you point to an example anywhere in the world?

Prof. Segal—There are a lot of examples. When Taiwan moved from a very mixed public-private system to essentially a system that was universal cover, they provided health care for all the population, which included the 40 per cent who were not covered at all before, with almost no increase in total spending on health care. That is published in a number of papers. The United States has done modelling. California did some detailed modelling and found that if they moved to a universal system they could actually cover everybody at almost no additional cost.

Senator CORMANN—If they moved to a universal system? So they have not?

Prof. Segal—Correct. There is a whole range of political reasons why they have not. But, in terms of using the whole community's dollars in a way that is efficient and equitable, all the evidence suggests that a universal system will do that. We want to maximise the level of health service and provide it in a way that maximises the health of the community. That is why most developed countries have strong universal systems.

Senator CORMANN—Looking at health economics—this is your area of expertise—if you have limited resources and unlimited demand and there is no rationing by price at the point of delivery, to use economic language, essentially the way you ration the public system is by making people wait. The only way to fit 300 people in 100 beds is by having some sort of prioritisation. If you have high enough clinical priority, the other 200 have to wait until they have moved up the list. There is a view that, even if you keep expanding resources, demand keeps increasing at a faster rate, particularly as it is free of charge at the point of delivery.

Prof. Segal—I think health care is a bit more complex because, generally, people do not prefer to go to hospital. It depends on clinical need. It is a very complex relationship. It is quite possible that, in fact, offering higher quality, more comprehensive and better targeted care in a timely fashion does not necessarily involve higher costs. The other side of it is that, under most public systems, there is some queueing, and that is one of the reasons why you will probably always have a private system alongside a public system, if it is allowed to exist.

Senator CORMANN—What is your assessment of the current situation in South Australian public hospitals?

Prof. Segal—I have not looked at that in any detail.

Senator CORMANN—So you don't actually know. Have you done any modelling whatsoever on the impact of this measure?

Prof. Segal—No.

Senator CORMANN—So you actually have not got a good sense as to the level of additional pressure that would come?

Prof. Segal—Correct.

Senator CORMANN—But you agree with the principle that, if there is a proper, rigorous process that is able to cost the impact on public hospitals, there ought to be compensation for that for the states?

Prof. Segal—I would think that would be desirable, yes.

Senator CORMANN—But, of course, for the states to put in that claim, they would have to be able to do their homework and put the figures together—is that right?

Prof. Segal—That would be helpful, yes.

CHAIR—Professor Segal, you have probably been following reports about discussions between federal and state governments on the health system coming up; it was something that the current government promised during the last election. Would you see that—and I know it is only just beginning—as starting to redress some of the imbalances between the Commonwealth and the state health systems that you spoke about earlier?

Prof. Segal—Certainly a conversation about how health services are funded and the relative contribution of levels of government is an important conversation. It always has been and will continue to be. There will be people who will be involved in that discussion and hopefully they will make the right choices around that.

CHAIR—As I said, we have just begun this, so I would not hold you to this by any means. But might that potentially have the ability to look at how health systems operate—the kind of modelling Senator Cormann was talking about of how the state system operates and what redress is needed for funding and operation?

Prof. Segal—Whatever policy changes one is looking at, modelling the impact is a standard way of determining whether the policies are good policies and—

Senator CORMANN—Isn't that when you consider the policy? Shouldn't you do that modelling as part of considering the policy?

CHAIR—Professor Segal was answering my question and I would like her to be able to finish, please, before you ask your next one.

Prof. Segal—I think developing policy is a complex process and modelling can be done at any time. The other option is actually to make some policy changes because, from a theoretical perspective, they are changes that need to be made, and to monitor the impact of that and then make adjustments ex post facto. So there are various ways of doing that. I think in this case that could well be a sensible thing to do, because I think the policy is very well grounded in strong theoretical and empirical arguments. As I said, an alternative would be to monitor the impact and then make an adjustment, but to have an in-principle agreement around that.

Senator CORMANN—But don't you think that, as you are considering the policy change, it would be preferable to assess costs and model the likely impact of that policy before implementing it so that you can make a decision as to whether or not it is desirable? I understand that, ideologically—

Prof. Segal—It is not 'ideologically'. The arguments are really strongly based. I suppose I am starting from the premise that we really do want a health system that is efficient and equitable, and that we do want to allocate the total dollars a community puts into health in a way that is going to enhance health and wellbeing. If you start off from that perspective then this sort of policy actually makes sense. So it is not really about whether to implement it; it is about understanding what the impacts are and ensuring that any consequences are properly adjusted for. But I think that that could happen ex post facto; it does not necessarily have to be done in advance.

Senator CORMANN—But, as you say, you do look at it from a particular perspective. We are talking consequences and monitoring consequences. There are people who will end up having to wait longer than is appropriate for treatment. There are people involved in all of this. Don't you think that the government should make a proper assessment of the likely consequences so that they can cater for them before implementing it?

Prof. Segal—Frankly, if people have to wait longer for treatment than they should, that is an issue for the health system. That is precisely the reason why you want to be allocating dollars on the basis of clinical needs, so that we are not finding that people are queue jumping just because they have the money to afford health insurance. I would rather that someone gets hip replacement surgery because they are the person who most urgently needs it, not because they can actually afford the health insurance. So, I think the policy position is directed by concerns of people's health and wellbeing and looking at the financial adjustment that needs to happen as a secondary point. I do not see a problem with that, frankly.

Senator CORMANN—You can look at it a different way. You can say that we should have as many people as possible in a position where they can afford to buy health insurance, where they can afford to get access to services when they need it and not when the system tells them they are a high enough priority, and to keep a

safety net in place to make sure that people who cannot afford health insurance are able to access services when they need them and are not finding that beds are taken up by private patients.

Prof. Segal—That is a model of health care which the United States subscribes to, and it tends to be a very expensive model of health care. They have something like 10,000 deaths per year associated with people not being able to access the care they need. That sort of system really does not achieve the health outcomes that I think the community as a whole would be happy with.

Senator CORMANN—You mentioned the United States. I think that in Australia we have the good fortune of not totally running health the way the UK or the US do; we are on a very happy, medium ground. That is why I am keen to scrutinise any policy initiative that is going to have an impact on that fine balance one way or the other. I do not think it would be fair to say that we are anywhere near the health system that the United States has.

Prof. Segal—The United States' government puts more dollars into their health system than the government sector here, so we are actually not far away at all. These sorts of policies that promote private health insurance take us very close to a United States model. It is basically where we were in 1975 before Medicare, and there were a number of features of these sorts of policies that take us back in that direction. I think that having a mixed system is sensible but it is very hard to find an argument that arises out of efficiency, equity, quality of care or anything that would suggest that private health insurance should be treated as anything other than a standard product—that if people wish to buy, they can.

Senator CORMANN—I assume you are referring to the proportion of GDP of the health funding in the US. Is that what you are talking about?

Prof. Segal—In Australia the government spends 5.9 per cent of GDP on health, whereas in the US the figure is 6.9 per cent.

Senator CORMANN—So do you think that putting more money into the system necessarily means that the system is more efficient?

Prof. Segal—It is absolutely not. It is to do with, as I said, private health insurance taking out 20c in each dollar before it even gets to health care, whereas in the public system only 3c in the dollar goes into admin. You already have major differences in efficiency there. Exactly how you spend the dollar is very important.

Senator CORMANN—I do not know if that comparison with the US is valid because over the years I think there have been all sorts of reasons why the cost of health care in the US has been more expensive at the point of delivery than in Australia.

Prof. Segal—But part of the point I was making is that if you move to a system where you encourage people to take out private health insurance and leave a safety net then you will find that a lot of people will not be accessing clinical care when they need it. You will then have very high mortality and morbidity costs associated with the lack of access to health care, which, in the United States, is 18,000 deaths a year—more than deaths from either HIV-AIDS or diabetes. That is the consequence of a system which does not support access to health care on the basis of clinical need.

Senator CORMANN—All right. Just to sum up, as you mentioned in your introduction, essentially you have come at this from the point of view of somebody who thinks that we should not continue to have the 30 per cent rebate, in the same way as we probably should not have the Medicare levy surcharge at all. Presumably, you have a view on lifetime health cover as well—is that right?

Prof. Segal—I think that any policies which are designed to support private health insurance are unnecessary, wasteful and undermine the efficiency and equity of the health system. I think a strategic sort of gradual process to wind back those supports would be a good thing, and I think this is a very sensible and appropriate first step in that direction.

Senator CORMANN—And you think the government should continue to go down that path?

Prof. Segal—I think that that would enhance the health of the community, provided the dollars saved in that process were re-allocated back into health, yes.

Senator CORMANN—Thank you.

CHAIR—The committee has received some evidence—that private health insurance is more sensitive to income than to price—that is, people of a certain income will take it up more or less regardless of price. Have you done any work on that, or do you know of any work in that area?

Prof. Segal—No. I am not even sure what the latest health insurance survey is. There was a survey probably eight years ago which made it clear that a much higher percentage of the wealthy have private health insurance than people on lower incomes. I have not looked at any work on price sensitivity and income sensitivity. There is a group in Western Australia that have done quite a lot of work looking at private health insurance, but I do not know if they have done anything.

CHAIR—Is that one of the university—

Prof. Segal—Yes. I am trying to remember who was doing it.

CHAIR—Curtin or—

Prof. Segal—Yes. I know they have been doing some modelling and using their linked data set. They have a linked data system that they have been using for that. I think it is the people at Curtin; I would follow it up with them.

CHAIR—Thank you. Thank you, Professor Segal, for coming in this afternoon.

Proceedings suspended from 2.17 pm to 2.43 pm

GERICKE, Professor Christian Ansgar Otto, Professor of Public Health Policy, and Director, Centre for Health Services Research, University of Adelaide

CHAIR—Welcome. I invite you to make an opening statement.

Prof. Gericke—First of all, I would like to thank you for the opportunity to speak here today. I have prepared a small opening statement. I recently gave evidence to another parliamentary inquiry. They gave me 10 minutes, so I pitched it to the 10 minutes. However, I have just read that it is five minutes here. Are you okay with 10 minutes?

CHAIR—Ten minutes will be fine.

Prof. Gericke—In Western democracies, political decisions are usually guided by a set of basic objectives: the attainment of efficiency, the achievement of equity or social justice, the preservation of individual security and the safeguarding of individual liberty. Security has little to do with the issue at hand, so I will analyse the proposed changes to the Medicare levy surcharge using the criteria of efficiency, equity and liberty. In doing this, one major complication arises: it is difficult to analyse the proposed tax law amendments in isolation as these are only one piece of the puzzle in public versus private financing of health care and, in particular, they are closely linked to the 30 per cent tax rebates on private health insurance.

Let us first turn to the question of whether an increase in the income threshold for the Medicare levy surcharge is an improvement in efficiency. To answer this question I will use a utilitarian approach and the concept of Pareto efficiency: will anyone be better off after the changes without making anybody worse off?

Who will be better off? It will primarily be those individuals and families who are within the income brackets between the old and new income thresholds who do not have private health insurance as they will no longer be required to pay the Medicare levy surcharge. This group constitutes about half of people in this income bracket and about 10 per cent of the Australian population.

Who will be worse off? First, high-income earners earning incomes above the new thresholds might be negatively affected by rising insurance premiums if a large number of people within the income threshold leave private health insurance. Second, those with an income between the old and new thresholds who discontinue their private health insurance might lose some utility from no longer having private health cover. On the other hand, the decision is left to them whether they want to discontinue or continue private health insurance without the penalty of having to pay the surcharge. Those that choose to remain privately insured will also face the risk of higher premiums. Third, there is no direct effect on low-income earners. However, as the segment of the population within that bracket is quite large—about one-third of the Australian population—a number of secondary changes that affect the whole health system's functioning can be expected. These might in the medium to long term lead to a change in resource allocation from the private sector to the public sector. This applies both to monetary and scarce non-monetary resources and in particular to doctors and other health professionals who are currently siphoned out to the private sector because of the higher earnings and better working conditions in private hospitals. However, because of the higher costs of private healthcare provision per health unit gained, this is inefficient and, from a societal perspective, not desirable. The proposed change in legislation can thus be seen as a first step in redressing the imbalance between public and private financing of health care, with an improvement of aggregate efficiency from a utilitarian perspective.

What are the implications of the proposed changes for equity or social justice? I will use two concepts used widely by health economists, because equity is a more complex entity than efficiency. The first is the ability to pay principle, which examines equity and financing. It requires that payments for health care are organised in a way that individuals pay according to their means and not according to the benefits received. Out-of-pocket payments and private health insurance premiums are not considered equitable forms of financing health care, whereas financing from general taxation or from social health insurance is equitable. For out-of-pocket payments this is very clear, as those who are ill have to pay at the point of care. This is the most regressive form of health financing. However, private health insurance premiums are also health-risk and not income rated; therefore, private health insurance is regressive and socially unjust. The predicted shift of a part of the population from the private to the public sector is thus an improvement in equity.

The second principle—equal treatment for equal need—examines the question of equity and access to care. It requires that those with a similar need for treatment should receive similar treatment and that the amount of treatment they receive should not depend on any factor irrelevant to their needs—their income, gender or

ethnic origin, for example. Clearly, the two-tier system of public and private health care funding and provision in Australia does not comply with this principle. In particular, the shorter waiting times in the private sector are a main issue in this respect. Again, the proposed changes to the Medicare levy surcharge are desirable in the long-term.

The third question is whether the proposed changes affect individual liberty. One might argue that those individuals who are currently privately insured and who freely choose to discontinue their private health insurance because of the surcharge value private health insurance less than spending their money on other goods and services, so the proposed changes do not constitute a loss of individual liberty.

In conclusion, increasing the income thresholds for the Medicare levy surcharge is not Pareto efficient as there will be both winners and losers. However, from a utilitarian perspective, they can be considered an efficiency improvement.

The equity considerations with regard to financing and access to care are all in favour of the proposed changes, as the current system of favouring private health insurance with a 30 per cent tax rebate and the related exemption from the surcharge for a large part of the population is highly inequitable, distorts consumer preferences and decisions and undermines the functioning of the public health service. The argument used by the Howard government to promote these changes in the first place, namely to ease demand on the public service capacity, is severely flawed.

Finally, the proposed legislation changes do not lead to loss in individual liberty. I would, therefore, endorse the proposed textual amendments and I see them as a first step to bringing a better and fairer health system to all Australians in the future. The next logical and desirable step would be the abolition of the Medicare levy surcharge and of the 30 per cent tax rebate. The introduction of the tax rebate led to a sharp increase in private health insurance coverage from 38 per cent in 1998 to 51 per cent in 2001, and it is reasonable to assume the same magnitude of effect if the tax rebate is abolished, so the freed resources could then be reinvested in improving the public health system. Thank you.

CHAIR—You were saying that those who may be worse off include those on a higher income, because they may pay more for higher health insurance premiums as a result.

Prof. Gericke—Yes.

CHAIR—Do you know of any work being done around price sensitivity and whether take-up of private health insurance has more to do with income than the price of the actual product?

Prof. Gericke—I see a number of questions there. One is whether premia will really rise. This is likely because the calculation of private health insurance on certain premia is related to the risk for the company. So if you get a smaller pool of insurees, if 2 million people are really going to leave private health insurance, the risk pool shrinks, the risk of higher costs for the company increases and they just put that on the consumers and have to raise premia. I do not know of any studies on the price sensitivity of the product versus income. Different health systems have very different set-ups for private health insurance schemes, and the one in Australia comes under the voluntary health insurance set where basically everyone is covered by the public system and the private insurance is on top for extra services or extra care. This is very different from health systems, like in the US or some European countries, where the private health insurance is separate to the public. Most of the research being done on this is actually from the US. Some is from Switzerland or Germany; there is a little bit from the UK. The only country that is a bit comparable is the UK, and I have not seen any studies on the price sensitivity on private health insurance in that case.

CHAIR—Do you have any view about the idea that as a result of this change it would be mostly younger people who would be leaving the private health insurance system? Would you agree with that view?

Prof. Gericke—Probably, because they have a lower health risk, so for them it makes less sense to have private health insurance than for people in more advanced age groups, who have higher risk of ill-health.

CHAIR—And that would contribute then to the possibility of premiums being raised, because in a sense those younger people contribute to the overall profitability of the private health insurance system?

Prof. Gericke—Yes, because they are lower risks. So that would also increase the premium.

Senator CORMANN—I just want to confirm that you are supporting this measure as a first step that should automatically lead to the abolition altogether of the Medicare levy surcharge and the 30 per cent rebate.

Prof. Gericke—Yes.

Senator CORMANN—Okay.

Prof. Gericke—I think the two others would be even more desirable than just increasing the income thresholds. This is just one step in the right direction. Normally the two other steps would be even better, let us put it that way. Seen from an incremental perspective of policy making, I think this is a step in the right direction.

Senator CORMANN—Having established it as a basis, do you concede, though, that, because at present we have a mixed health system with a clear interrelationship between public and private health, as you make changes to one there are necessarily going to be consequences and flow-on funding implications for the other, particularly in the transitional period?

Prof. Gericke—The two are always linked if they are happening at the same time. This is one of the problems here. One of the big mistakes that are made even in the scientific literature and even more so in the political discussion about health systems is the mixing of financing and provision. All that is private is not bad. Actually, it is to the contrary. There are some countries that run their health systems on a private care provision basis with public financing very successfully. However, there is no country where private financing has been shown to be positive. So in this discussion we have to be very careful to keep private financing apart from private provision of care.

Senator CORMANN—I obviously accept and understand that you are more in favour of public financing of the provision, whatever the method of provision of the services, but do you agree that, if you make a change to the current financing arrangement of health care, there is necessarily going to be an impact on the current balance? Do you agree that there will be additional pressure on public hospitals even if the amount of funding that is going to come out of the system is what Treasury estimates in terms of the number of people who will leave?

Prof. Gericke—Not necessarily.

Senator CORMANN—How can there not be?

Prof. Gericke—I think that capacity arguments for the public sector to drive what is basically public money into the private health financing sector is an inefficient move. If we free that money and recycle it into the public sector, we can achieve more health and better outcomes—

Senator CORMANN—Okay. I hear what you are saying. You are saying that, in your view, at this point in time the money is not as efficiently spent as it could be. But the reality is—and bear with me on this—Treasury have come to the conclusion, reflected in the budget papers, that they will save \$960 million because they will no longer have to pay the 30 per cent rebate to those they expect to leave. Consistent with your view, you think that is a good thing and you think that that money can be better and more efficiently allocated elsewhere. The problem is that, so far, it has not been allocated elsewhere; it is \$960 million that is a straight saving that offsets the loss in revenue from not being able to collect the Medicare levy surcharge from those who do not take up private health insurance in those income brackets. The Commonwealth is \$300 million in front. On top of that, we will also lose the funding for hospital treatment that is currently contributed by those privately insured who will leave. That is another \$2.24 billion. So we have a pool of \$3 billion. I understand that your view is that that \$3 billion could be better allocated, but at the moment it is actually leaving the system altogether. How is that not going to have an impact?

Prof. Gericke—Yes, but that money is not really leaving the system, is it?

Senator CORMANN—Where is it going?

Prof. Gericke—That is one of the perceptions. People will still require health care and we still have the capacity in the private sector. There will be a match between the demand and the supply. You cannot just assume because now there will be some changes in the short term that there will be an imbalance with a drowning of the public health services.

Senator CORMANN—I agree with you that demand will not change. There will not be a change in demand and the demand ultimately will have to find supply somewhere. But what I am talking about is \$3 billion worth of funding: a combination of the 30 per cent rebate that will no longer have to be paid because the Commonwealth expects people to leave private health insurance, nearly \$1 billion, and the contribution that is currently made by people who would otherwise be in private health insurance whom the federal government expects will leave. So we have a total of \$3 billion. Like you have just said, the demand is not going to reduce, but the funding is no longer in the system. You might well say that you can buy those same

services to meet that same demand cheaper. Let us even say that I understand that that would be your argument. But you cannot find \$3 billion worth of efficiencies in the system, surely?

Prof. Gericke—I would not be so sure about that.

Senator CORMANN—Have you done any modelling to suggest that there are \$3 billion worth of efficiencies within the system?

Prof. Gericke—No, I have not, but I am sure we could find a lot of efficiency improvements in the system here, from what I see on a very frequent basis in how hospitals are run and also the private-public interface. There is a lot of efficiency reserve here. If your concern is the immediate money that is going to be redistributed here, in the overall budget I understand that the current government is investing heavily in the public health sector, so this is where your \$3 billion is going, in the same budget—and this is where it should go.

Senator CORMANN—But the thing is, you have not done any modelling. The federal government has not done any modelling. State governments have not done any modelling. I have not come across anybody yet who has done any credible modelling of the actual impact that can be expected by way of flow-through in terms of additional efficiency in public hospitals. You are sort of making broad assumptions. I am aware of the figures that are being used at present by the government around what they think is some sort of compensation for the impact. There is the pre-election commitment for the \$600 million elective surgery reduction strategy, but, if you look at the detail in the fine print, \$150 million of that is a one-off payment into services. Another \$150 million is funding for improvements in systems and infrastructure. It is not an increase in actual funding for public hospitals. Then there is a further \$300 million that has not actually been committed yet; it will be available in two years subject to the states meeting certain performance agreements. There is a bit of mismatch between \$3 billion and \$300 million. I guess what I am saying is: to prove you are right in your gut feeling that maybe there are all these efficiencies, surely somebody ought to do a credible assessment, with proper modelling and proper costing, with the best available data in front of them from Treasury and from various health departments to reassure us that this is not going to lead to some disastrous consequences at the hospital door.

Prof. Gericke—As we discussed before, the people most likely to leave private health insurance are those who are healthier and at a lower risk anyway. So, in the short term, there will definitely not be any catastrophe happening, because those with ill health and private health insurance cover will keep their private health insurance whatever the income threshold. In the short term there will be no change. What I see in your argument is that basically the opposition should argue for the government to pledge more money for the public health system to make up for the proposed changes. I would support you in that.

Senator CORMANN—With all due respect, I think there is an inconsistency in your argument there, and I am just trying to probe this a bit. You said earlier that there is not going to be a change in demand for hospital services. Then you have told us, ‘The people who will leave health insurance are the young and healthy who will not access services.’ And you know what? I agree with you on that one. But, if the people who will leave are the young and healthy who do not access services and the overall pool of demand for hospital services across private and public is not going to change, then those people who leave are currently funding treatment for people in that overall pool. If the funding is going to disappear, how are we going to deal with the impact of that loss of funding to the tune of up to \$3 billion?

Prof. Gericke—No, I do not follow your argument. The changes you just highlighted will probably lead to a rise in premiums in private health insurance. I think we agree on that. So, if the young and healthy leave health insurance, the premium levels will rise for the remainder of people with private health insurance. But why that should lead to an increased demand—

Senator CORMANN—I am not talking about an increase in demand overall. Let us just assume that the demand is continuing to track the way it has been tracking, that there is not going to be a change either way in overall demand. The question is who is going to fund the supply of services to meet that demand and who is going to provide the services? That is really where the crux of the argument is. Leaving that aside, you have just mentioned that there is going to be an increase in premiums. Have you made an assessment of what that increase in premiums would be in percentage terms as lower risks leave and higher risks stay?

Prof. Gericke—No, I have not.

Senator CORMANN—I have a final question to round this off. You mentioned in the early couple of paragraphs of your opening statement that the people who will be better off are those who earn between

\$50,000 and \$100,000 and who do not take out private health insurance. Essentially, this is a one per cent tax cut because it comes off their tax thresholds. Don't you think that people who are in that same income range—if you take the view that they are people on, as the government puts it, 'average incomes' who are 'doing it tough'—and who, on top of that, take additional responsibility for their own healthcare needs also deserve a one per cent tax cut?

Prof. Gericke—No.

CHAIR—You were talking about the next step possibly being looking at the surcharge and the tax rebate associated with private health insurance cover. We have had evidence from at least a couple of private health insurance industry people that it is the lifetime cover aspect of the three prongs of the former government's approach that they thought contributed most to the number of people joining the funds. Clearly, if you take out the surcharge and the tax rebate, that will affect the lifetime cover. How would you see that playing out? Would you see that as a sudden reduction or a reduction so that you gradually got to a natural level of people who want to take out private health insurance?

Prof. Gericke—I think, in reality, this is how our western democracies work. The big shifts are difficult to accomplish, so we go in small steps. I guess it would not be politically acceptable to scrap all of these measures at the moment, because, basically, private health insurance companies would lose out and there would also be quite a number of shifts required in the private health provision sector—by private hospitals, mainly—that would be severely affected by a dramatic change. So how we work is in small steps. That is why I am saying this is one step in the right direction.

But you are absolutely right. Out of the three measures taken by the last government, it is very hard to take them apart and say, 'Oh, most of the changes we saw can be attributed to one of them,' because they came in a package. They came in a package and we see the statistics over time, so it is very hard to say whether it was the 30 per cent tax rebate, the lifetime cover or the surcharge. I think it is all three of them. They all influence people's behaviour in one direction.

CHAIR—It is true that, when these measures first began, there was something of a crisis, particularly in the private system. They were not seen to be doing very well. Indeed, private health insurance companies were not that strong. We have had evidence—and I cannot remember the exact figures—that the for-profit sector of the private health insurance industry has increased quite considerably as a percentage of the total private health cover system since these measures were introduced. Would you have any comment on that?

Prof. Gericke—I have not seen these figures but I am not surprised that that has happened. This is how business works: you go where the money is.

CHAIR—To again change the subject slightly, are you aware of any policy similar to the Australian levy surcharge that other nations have in their health systems in order to encourage people into private health insurance?

Prof. Gericke—No, I have not come across a penalty for not taking out private health insurance. As I say, one complication is that private health insurance works very differently in different countries. Sometimes it is employment related, such as in the US, for a large part of the population, although they also offer other policies. In other countries it is subsidised. I have not come across a system such as exists here where, in a country which has a reasonably well-functioning public system, there is a deliberate move to take money out of that and put it into the private sector. As I say, it undermines the basic functioning of the overall system, and it is not in the interests of the nation. I have not seen that. In the UK, due to erroneous thinking that by putting extra money into the private sector you can ease the demand on the public sector, the Tony Blair government have instigated a number of measures, getting more private financing into the health system. But they have not done that via private health insurance; rather, they have done that by private funding for hospitals, the so-called PFI—private finance initiative—for financing the construction and management of hospitals. But they did not go down the path of supporting private health insurance.

CHAIR—It would be what we call a public private partnership in building and operating, with public financing. That is a measure that reduces costs to the government so that the government are, in effect, providing the services rather than the building. Is that what you are talking about?

Prof. Gericke—Yes. It is supposed to be a cost saving for the government. But if you look at the situation in the UK you will see that it is, more or less, a disaster. The contracts were not very good and so the public sector still carries all the risk. It was not a very fortunate deal for the public sector in the UK.

CHAIR—You were recently a delegate for the health stream of the 2020 Summit. Are you able to tell us about any directions that came out of that for the health system?

Prof. Gericke—I was quite surprised that an overwhelming majority were in favour of a unified health system. It concerned the split between the Commonwealth and the states—the state responsibilities for funding health care and the ensuing imbalances and difficulties arising out of the split, such as the blame game. There was an overwhelming majority. The topic of public versus private financing was not as high on the agenda there. I think the ballpark of the arguments, in that short time there, was more on the states versus Commonwealth responsibilities. That is the main message in that regard.

CHAIR—The government currently is in discussion with the states regarding the overall structure and funding of the health scheme. Have you been following that debate? Do you think it might address some of the issues that you are talking about?

Prof. Gericke—Not really. There has not been much thinking going on about the issue at hand: public versus private financing, which is a separate story. In some European countries, such as Germany, Switzerland and the Netherlands, the public sector basically purchases care, for example, in private hospitals. For example, in Germany there is no difference between public and private hospitals in the terms in which they deal with the public funding of care. That is a very successful model. We do not have shortages of hospital beds; we do not have waiting lists. In that regard, it is a very successful system. And there is a strong private sector. So you can have a strong private sector which abides by the public regulation and plays its part in the overall scheme of things, whereas here in Australia I find that the public sector and the private sector are very much disjointed and do not work well together and there is a lot of cream-skimming on the part of the private sector, with higher salaries siphoning out all that is good. So the public hospitals are struggling because of that.

CHAIR—So what is the incentive in Germany for people to pay for their own private health system if there is no difference?

Prof. Gericke—I was talking about the provision part. For the financing part, it is very different because the duplicate health insurance, like here, is basically nonexistent because the public benefit package is very good. In Germany we also have an inequitable system where the 10 per cent richest of the population can choose to be privately insured or to be in social health insurance, whereas all those under a certain income threshold have to be in the public scheme. So we lose the highest contributors, those with the highest incomes, to the public sector. This is also historical and is not ideal either. But on the provision side, I think—

CHAIR—On the provision side, how are doctors salaries then organised if there is no difference between private and public? Does the public health system pay private doctors a set fee?

Prof. Gericke—Whether they work in private or public hospitals does not make a difference for doctors. It is a bit like here. They are on agreed salary schemes, but they are open to negotiation. On top of that, there can be additional income from private health insurance patients.

CHAIR—As there are no further questions, thank you very much, Professor Gericke, for coming in this afternoon.

[3.19 pm]

WALKER, Mr Stephen Ross, President, South Australian Branch, Australian Private Hospitals Association

CHAIR—Welcome. I invite you to make some opening remarks.

Mr Walker—First of all, thank you for the opportunity to appear before the committee today. I am attending today's hearing in my capacity as the president of the South Australian branch of the Australian Private Hospitals Association. I would also state that, as a director of the Australian Private Hospitals Association—APHA—I fully support the association's submission to the inquiry. Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian healthcare system. I would suggest this balance is currently envied around the world. The latest data for South Australia indicates that private hospitals treat 37 per cent of all hospital patients—or 230,000 episodes in 2006-07—provide 32 per cent of all hospital beds, perform 55 per cent of all surgery, treat nearly 89,000 patients aged 65 years and older and employ 3,800 full-time equivalent staff. Information arising from the federal budget indicates that Treasury expects at least 484,000 people to either drop out of private health insurance or to not take it up as a result of the federal government's proposal to increase the thresholds at which the Medicare levy surcharge apply.

The projected impact of the measure proposed by Treasury also depends to a large extent on its underpinning assumptions. Regardless of the actual number of people who drop their private health insurance or do not take up cover, there will be an impact, much of which is likely to be accumulative. There will be an impact on the profile of the privately insured population. Common sense tells us that people at risk of hospitalisation or likely to make a claim will remain covered by private health insurance. It is the good risks that will drop out—that is, the young and the healthy.

Health insurance funds have two fundamental strategies of dealing with this drop: increase the price of their product or reduce outlays—or, indeed, both. Reduced outlays will certainly result in less money for private hospitals. From a South Australian perspective, this may well jeopardise a number of private hospitals who are already struggling financially. A recent independent report conducted for the APHA SA branch raised grave concerns about the long-term viability of a number of South Australian private hospitals. This would only exacerbate the problem. In addition, privately insured patients comprise 86 per cent of patients treated in South Australian private hospitals, which is higher than the national average. Therefore, this measure is likely to have a greater impact on South Australian private hospitals than in some other states. The impact is also likely to be felt in the public sector in two ways: more people may present as public patients and, as the measure is likely to have an impact on the numbers of people with basic health insurance cover, the number of private patients treated in public hospitals may well decrease, leading to a fall in revenue for public hospitals.

The question here is really about whether we want a private healthcare system. If the answer is yes, the proposed Medicare threshold levy increase will significantly jeopardise this and, I suspect, it will be very difficult to recover from. Alternative approaches are available. As APHA stated in its submission to the committee:

If policy change is required in this area, it would appear to be more equitable (and sensible) to increase the thresholds for the Medicare Levy Surcharge by using a transparent measure of changes in earnings or prices over the period since 1997.

Using the total average weekly earnings index, APHA estimates that the threshold would have increased to approximately \$76,000 (single income earner) and \$152,000 (couples and families) by February 2008. In order to ensure that a similar situation does not arise again in the near future, it would seem sensible to index the thresholds for the Medicare Levy Surcharge from 2009-2010 in line with the total average weekly earnings index.

Thanks for the opportunity to make that statement. I am happy to answer questions.

Senator CORMANN—Thank you very much for that opening statement. What is your view on the fact that the federal government has not done any proper modelling of the impact of this particular policy measure on state public hospitals?

Mr Walker—To be honest, I am not completely aware of what modelling has been done by the federal government. As I stated, I guess it depends on what assumptions are made.

Senator CORMANN—What is the current rate of utilisation across South Australian private hospitals?

Mr Walker—Are you talking about occupancy levels?

Senator CORMANN—Yes, occupancy levels.

Mr Walker—That really varies from hospital to hospital. There certainly are a number of hospitals in South Australia that have low occupancy—some of the smaller ones. Some of the larger ones like us are fairly busy.

CHAIR—'Us' being?

Mr Walker—St Andrews Hospital. I am the chief executive at St Andrews Hospital, which is a large private hospital here in Adelaide.

Senator CORMANN—If you had to give us an overall trend line over the last seven or eight years, have utilisation rates, occupancy rates gone up?

Mr Walker—I can talk specifically about St Andrews. It has probably remained fairly constant. It has come up in some years and gone down a little bit in other years.

Senator CORMANN—Have you invested in additional capacity over that time?

Mr Walker—We are actually investing in additional capacity as we speak.

Senator CORMANN—What sort?

Mr Walker—We are looking at introducing another operating theatre into St Andrews.

Senator CORMANN—Will there be additional beds as well?

Mr Walker—Down the track, day stay beds will come, yes.

Senator CORMANN—So would this sort of measure impact on these sorts of investment decisions?

Mr Walker—Absolutely. As I stated, if this occurs there is no doubt that it will have an impact on private hospitals. As I mentioned, private hospitals in South Australia at the moment are the lowest funded of all the hospitals in this country. Private hospitals in South Australia certainly appear to be struggling financially much more than those of the other states.

Senator CORMANN—We have had two professors giving evidence today, and one of their points was that we have to separate the consideration of public and private financing from the consideration of public and private service delivery. They were expressing a preference for public financing. What is the linkage and what contribution do you think private financing makes to the overall health system in Australia in the mix that you have described?

Mr Walker—I could not answer that, I am afraid.

Senator CORMANN—That is not something that the APHA have considered as part of this?

Mr Walker—The APHA have done some reports into capital expansion at all the private hospitals. They have information that would answer that question, and I can certainly obtain it for you.

Senator CORMANN—Why is it important for you as a private hospital operator to have private health insurance as opposed to just relying on public funding of your services?

Mr Walker—In South Australia it represents 86 per cent of our business; 86 per cent of the people that come in use private health insurance. The others either are not insured and pay for the product themselves or are under WorkCover et cetera. But the vast majority—and that is even more so in our case at St Andrews—are privately insured patients.

Senator CORMANN—Presumably, if there were fewer insured patients then the proportions would change, but you might still be able to provide the same amount of services?

Mr Walker—No, I would not think so—not at all. There would be a reduction in activity.

Senator CORMANN—Okay. But why is it important to have, as part of the mixed Australian health system, private health insurance as well as private hospitals? I understand why you would say private hospitals provide an important service, but what is the importance of, specifically, private health insurance as a means of financing access to those services?

Mr Walker—I am sorry, I still do not know that I understand the question completely.

Senator CORMANN—I am just trying to pick up on some evidence that was given earlier. Perhaps you might not be able to answer the question. You might want to take it on notice and perhaps get back to us. The two professors today both made the point that they wanted to make a separation between the financing of health care and the provision of service delivery. You are at the service delivery end; Medicare and the taxpayer are at the public-financing end; health insurance, health funds, people with health insurance are at the

private-financing end. I guess I am just trying to understand from your point of view as a service deliverer whether you think the private health financing component of our health system is something that is important to you.

Mr Walker—Absolutely.

Senator CORMANN—Why?

Mr Walker—They are the vast majority of our business.

Senator CORMANN—Have you done or are you aware of any modelling that APHA has done on the impact of this measure on the extent of your business?

Mr Walker—Not specifically the APHA, but of course I attend a number of forums and I think there is various debate as to what sort of an impact it would have. As I mention in here, any sort of impact is probably going result in decreased revenue for private hospitals and, as a result, will cause them to struggle financially.

Senator CORMANN—St John of God Hospital in Western Australia told us that they expect that, following on from these measures, the number of episodes that they would be able to perform in the first year would be 10,500 fewer. Have you made an assessment for your hospital?

Mr Walker—No, we have not. From my perspective I do not know how significant it will be initially. I would suspect, as I said in the submission, that most of the people that will fall out will probably be the young and the healthy. So in fact the activity in the first year or so may not actually come down.

Senator CORMANN—Okay. Let me pick up on that point. The minister for health focuses on the argument that the people that leave will predominantly be the young and healthy; hence, they do not really use it and there is not going to be a big impact. I draw your attention to the budget papers which say that the Commonwealth expects to save \$960 million worth of expenditure as a result of not having to pay the 30 per cent rebate to people they expect will leave private health insurance as a result of this measure. That is only 30 per cent, then there is the 70 per cent private contribution, which is another \$2.24 billion. We are talking \$3 billion. Assuming that demand for health services is not going to start reducing all of a sudden, presumably we are going to have at least the same demand and it is going to continue to increase at similar trends as in past years. What is going to take the place of that \$3 billion worth of funding to pay for services, be it in your private hospital or in public hospitals?

Mr Walker—That is a good question. I think the issue from our perspective is that these people are going to move away from the health insurance funds, and they may well be the people that are not claiming, so it is going to increase the risk profile of those funds. It goes against how insurance works in terms of community rating. The funds are going to be left with people who are claiming more and more; therefore, they are going to have to either decrease their product or reduce their outlays. Reducing their outlays is going to have an impact on private hospitals.

Senator CORMANN—That is my point. You said earlier that, because the people that will leave will be predominantly the young and healthy, there is not going to be much of an impact in the early stages.

Mr Walker—In the early stages.

Senator CORMANN—But the government is telling us that they expect to save \$960 million over the forward estimates—\$230 million in the first year, which means \$700 million less revenue for the private system in the first year and \$3 billion less over the forward estimates. Isn't it true that the young and healthy, even though they do not access services, fund hospital treatment for those that do?

Mr Walker—They do, absolutely.

Senator CORMANN—So how can you then say there is not going to be an impact in the early stages? According to the Treasury modelling—

Mr Walker—There is not going to be an initial impact—this is just a personal view—purely on activity straightaway, on numbers coming through the private hospital doors.

Senator CORMANN—There will not be an impact in terms of demand, I grant you that, but who is going to pay for it?

Mr Walker—I agree—that is the problem.

Senator CORMANN—Obviously there are private hospitals and public hospitals. People that cannot get treatment in your hospital would have to present—

Mr Walker—To a public system—and I think to a public system, if you do not mind, that is certainly struggling at the moment. All the evidence is pointing to more and more elective surgery being required in Australia. There would be many more people that could tell you this: joint replacement work in this country is going to increase significantly. We are doing the vast majority of it—60 to 70 per cent of joint replacements. If we see a drop in private hospitals there are not going to be so many places to do that particular type of surgery. It will have an impact.

Senator CORMANN—Don't you think then that before we implement a measure like this there should be a proper assessment and some proper costing and some proper modelling of the impact of this measure beyond savings and revenue lost to the Commonwealth?

Mr Walker—Definitely.

Senator CORMANN—Can you describe to us the current situation in South Australian public hospitals?

Mr Walker—In the public hospitals?

Senator CORMANN—Yes. You work in the system.

Mr Walker—I work in the system, and I am generally the liaison between the private sector and the public sector, to be honest. Clearly, the recent industrial issues here in South Australia with regard to doctors and their salaries are well known. Specialists who work at our hospital, for example, work in the public system, and there is no doubt in my mind that they argue that the private hospital system is much more efficient in delivering the same sorts of services, whether elective procedures or procedures for whatever type of medical condition. I think the public system certainly appears to be struggling with the demand, particularly in the areas of emergency demand, and therefore elective surgery goes down. Of course, there are the doctors who work in the public system and who need this balance themselves as well to be able to maintain their private sector involvement.

Senator CORMANN—Can you describe for us the difference in the way hospital treatment or hospital episodes are funded in the private hospital system versus the public hospital system?

Mr Walker—In most cases, as at St Andrews, the majority are funded by a private health insurance fund.

Senator CORMANN—But, in terms of the methodology, aren't you funded on a fee-for-service basis, whereas the public system gets an overall funding allocation?

Mr Walker—We are funded accorded to case mix, so it is according to DRGs—diagnostic related groups. There are approximately 650 types of DRGs or types of clinical services, and they are coded. Each health fund pays an amount for that particular type of DRG, and it really varies; the difference in what you can be funded for by one health fund compared to another could be 50 per cent. But the majority of South Australia's services are funded on a DRG basis; it does not matter how long a person is in hospital, you still receive the same amount of money.

Senator CORMANN—But, the more people go through the system, the more treatment you provide and the more revenue you are able to generate?

Mr Walker—Yes. Clearly, it is similar to the public hospital system. For example, if a person is coming in to have a thyroidectomy and they are in there for two days, we would get X number of dollars. If they are in there for three days, we still get the same number of dollars, but we obviously incur more costs for maintaining it.

Senator CORMANN—But the more people you are able to put through a theatre and provide services to the better it is, from a purely financial point of view, for your hospital.

Mr Walker—That is the case. However, judging by this recent report that was done here in South Australia, it is fair to say that, on about 40 per cent of those people coming in, hospitals actually make a loss.

Senator CORMANN—But isn't that, to some extent, what drives the efficiency, I guess, in the private system—

Mr Walker—Yes.

Senator CORMANN—because in the public system there is an overallocation and you have to get as many people through the door as you possibly can.

Mr Walker—I understand what you are saying. That certainly drives the efficiency. I think—once again, this is a personal view—that, for example, the amount of work that can be performed in a private hospital operating theatre compared to a public hospital operating theatre is significantly greater.

Senator CORMANN—Have you got any statistics or data that would substantiate that?

Mr Walker—No, not factual material—only anecdotal discussions with surgeons who would talk to me about their 3½-hour session in the public sector compared to what they can do in the private sector.

CHAIR—Wouldn't that be because public hospitals tend to do more complicated operations that are not encouraged in the private sector—longer and more detailed procedures?

Mr Walker—No. I think that that is correct to a certain extent—there certainly is a greater degree of complexity in the public sector—but now, in the private sector, we do the full range of DRGs except for organ transplants and major trauma, so every type of procedure is done in a private hospital. But, indeed, there are more comorbidities with a public hospital patient; so, yes, I think part of that is correct. In fairness to the public sector, I think it is also about the teaching component, which adds some inefficiencies. But I have worked in both sectors, both here in Australia and in New Zealand, and there is no doubt in my mind that the efficiency is much greater in the private sector.

Senator CORMANN—But, with the way the funding system is structured on the private side, isn't there an inherent incentive, dare I say, for as much throughput as possible—

Mr Walker—Absolutely.

Senator CORMANN—whereas, in the public system, I guess every patient becomes a liability as soon as they walk through the door. What is your recommendation to the committee as to what we should do with this measure?

Mr Walker—As I concluded in my opening comments, if anything, it should be tied to the increases that have occurred over the past 10 years, and it should be something that—

Senator CORMANN—So we should have indexed it rather than doubled it?

Mr Walker—Indexed, absolutely.

Senator CORMANN—And, if it had been indexed, the advice from the committee secretariat is that the threshold would be at \$67,000 per annum now. Is that a more reasonable figure, to your mind?

Mr Walker—Yes, it is. Indeed, that would still have an impact on this sector. I travel each year internationally to look at healthcare systems and participate in forums, and, as I said earlier, the Australian system is envied because of that, I think, wonderful balance between private and public. In fact—obviously, I am here wearing a private hat but, as I said, I have worked in both sectors—I think in the future it will be necessary for the private sector to actually take up more because of the amount of joint replacement and elective surgery that is occurring, and you can see the private sector is increasing its workload. I think that is a good thing about our system. It seems to work very well. In the system now, even from a South Australian perspective, there seems to be much more dialogue occurring between the public and private sectors as well, which is something that I would certainly encourage and hope to see continue.

Senator CORMANN—Treasury, in their submission to this committee, said that they took the view that there would be a one-off impact on private health membership as a result of this measure and then we would go back to normal rates of growth. Do you share that optimism or do you think that this could be the start of a new downward spiral like the one we experienced between 1983 and 1996?

Mr Walker—I think it is more likely to be the latter.

Senator CORMANN—Before the election, were you involved in any campaign events or meetings with the then shadow minister for health, the shadow Treasurer or—

Mr Walker—No. I am not aware of the APHA being involved in any either.

Senator CORMANN—So there were no discussions between the APHA and the shadow minister for health prior to the election?

Mr Walker—Not that I am aware of, no.

Senator CORMANN—That would be unusual, wouldn't it?

Mr Walker—I would think so.

Senator CORMANN—Could you perhaps take that on notice and see whether there were any discussions between the shadow minister for health and the APHA prior to the election; and, if so, whether the then opposition gave an indication in any of those discussions that in government they would be pursuing a measure of this nature.

Mr Walker—Yes, I can.

Senator CORMANN—Can you also take on notice whether there was any consultation before the budget with the APHA on the introduction and impact of this measure.

Mr Walker—Yes.

Senator CORMANN—Thanks.

CHAIR—Mr Walker, you talked about private hospitals doing 60 to 70 per cent of joint replacements and seeing this as one area where the workload might increase because the private sector does it very efficiently. One of the concerns that have been brought to the committee is that this starts to sound much more like the American health system, whereby if you can afford to have a procedure because you are privately insured then you get it done, but it takes more and more resources away from the public system. In fact, whether you get a procedure done depends on whether you can afford it rather than your clinical condition. Do you agree that there might be some concern around that?

Mr Walker—I can understand the discussion; I do not see the need for the concern. As I said, I think at the moment the balance is a very nice one. Indeed, I think that people should be given an incentive to take out private health insurance, particularly the young and the healthy, to assist in that community type rating. But I would reiterate that I think the balance is quite a good one at the moment and, if anything, should be strengthened for the overall delivery of health care.

CHAIR—But those incentives do come at a cost—

Mr Walker—Yes, they do.

CHAIR—and quite a heavy cost, and there are people who have been saying that that cost should go directly into the public system.

Mr Walker—That is correct.

CHAIR—And, clearly, you do not agree with that.

Mr Walker—No.

CHAIR—But there is that concern that increasing the subsidies to private health might lead to more of a system where the poor are shut out of what are termed elective procedures until they are at a very critical stage.

Mr Walker—I certainly understand that. You made reference to the American system. Our system at the moment is far from that. We have a public system that really does not shut out. We have some issues in terms of elective surgery in some areas but, as I said, the balance at the moment is good. I would argue that the money spent, in terms of rebates and incentives, is very worth while.

CHAIR—Getting back to the point about indexation and the level of the threshold, the threshold has not been changed for some years. In terms of their taxation burden, you could argue that people on \$50,000 and just over that amount have been bearing a disproportionate amount of taxation for their public health care and that it is only right that that threshold level be increased at this stage.

Mr Walker—As I said, increasing it is one thing but doubling it seems excessive. I am not aware of the modelling that has occurred and why that decision was made, but, as I said, it seems more sensible to be able to index it as opposed to just doubling it and then continue that on so that we do not actually see the situation arise again.

CHAIR—You mentioned that some South Australian private hospitals were struggling and that this is perhaps more so in South Australia than in other states. Would you see that as a result of South Australia having a slightly higher age profile and therefore probably lower income levels and that that is why people feel that they are not able to take up private health insurance?

Mr Walker—There is no doubt that demographics play a part in that. I think the health insurance fund would be able to answer the question better. Clearly, though, the report that we have undertaken identifies that South Australian private hospitals receive 13 per cent less than the national average, in terms of revenue. We

were talking about the DRGs before—thyroidectomy. If you get \$1,000 for it in South Australia, you are more than likely to get \$1,200 for it if you are in a hospital in New South Wales. The funding levels are much lower. The health funds would certainly be able to articulate more clearly as to the demographics and why that is the case.

CHAIR—To improve the viability of those public hospitals, what would you see as the requirement for that?

Mr Walker—Personally, from purely a South Australian perspective, I would think that it requires a more equitable funding method across the country to ensure equity.

CHAIR—In terms of how much you will pay for particular procedures?

Mr Walker—Yes.

CHAIR—Wouldn't that encourage the people involved in performing the procedures to charge ever-increasing amounts to put pressure on that funding limit?

Mr Walker—No. As a hospital we are regulated. So, when somebody comes in, the money is paid to us by the health insurance fund. We are not in a position to charge; we are a receiver of the revenue, so it would not encourage us at all—no.

CHAIR—Thank you for appearing here this afternoon, Mr Walker.

Mr Walker—It was a pleasure.

Proceedings suspended from 3.48 pm to 4.09 pm

FORD, Dr Peter William, President, Australian Medical Association, South Australia Branch

CHAIR—We welcome our next witness. I invite you to make some introductory remarks.

Dr Ford—Before commencing my remarks, I presume a certain amount of information has already been imparted to you from the AMA federally and in other states, so I will perhaps not subject you to a repetition of that. I would like to emphasise certain issues with regard to South Australia, but in the context of what the AMA has put to you previously. The AMA has basically acquired its position on this from information provided to it after the recent federal budget by Access Economics. In summary, our concern is that changing the private insurance thresholds will potentially impact on the revenues of private health insurers. The projections we have indicate that some 700,000 people would have to drop out of private health insurance for the government to receive the benefits that it projects—some \$230 million, I think it was; at least \$200 million. That is the first issue.

That, we feel, will cause a flow-on effect in that it will increase the price of private health insurance to those who remain in it. We feel that this has to be projected over a longer period than the 12 months which the federal government and Treasury have advised. We see that, over the couple of years beyond the implementation date, older people particularly would find it unaffordable. We see that there is going to be a need to increase the rates of private health insurance perhaps by some additional five per cent beyond the CPI and indexation factors. That would bring it up by 10 or even 12 per cent in ensuing years. We see that then causing another repercussion, which is that older people, the people who particularly require hospital medical care, would flow into the public hospital sector in the states. With regard to that, I am sure you appreciate that South Australia has the oldest population profile in the country. In fact, we are advised that in South Australia one older person in six is over the age of 65 and in the next 15 years that population will nearly double as the baby boomer generation ages and the number of over-65s further increases.

So we see that there is going to be potentially an immense demand that is not accounted for in the projections of Treasury. I think that there are many areas where that has not been predicted. One is in state budget projections. In South Australia's most recent budget there has been no allowance for this factor. On the same day that our budget was handed down, the Country Health Care Plan for South Australia was delivered. Although that is the subject of considerable controversy at the moment, the Country Health Care Plan, of which I have a copy before me, makes no reference to any issues around private hospital and health insurance.

What we are seeing in South Australia is a hospital system that is congested. There are immense waiting lists and, despite the \$13.6 million initiative of the federal government a few months ago with respect to dealing with long-term waiting lists for surgical care, the system is still very congested. Quite frankly, we do not see how it can cope with any added load that might be the consequence of the announced changes to the private health insurance threshold.

CHAIR—Thank you. In discussion about that, we heard that, in South Australia, membership of private health funds has increased from 34 per cent of the population in 1996 to 44.5 per cent in 2008—yet you are still referring to long waiting lists and congestion in hospitals. We have had evidence today that funding would be better delivered directly to the public health system rather than to the private health system via subsidies and so on. Wouldn't the fact that the system is still congested argue against putting more funds into the private health system? Wouldn't that suggest, 'Well, we've had this period of time under the current system; perhaps it is better to go back to putting funds directly into the public health system'?

Dr Ford—I guess it is partly a question of philosophy. In reality, the private health system here has its load as well. In fact, it concerns us that, even now, we see some cherry-picking in the private health sector. I think that is probably a topic for another day, but we would certainly like to see some work done about the products delivered by private health insurers and by the private hospital system. We do know that some elderly patients who have numerous and complex medical problems, when they do get a surgical issue such as a fractured hip, for example, may not be preferred in the private system and may be pushed over to the public sector. I think both are carrying their load. I think there is evidence to suggest that the private health system is more efficient. You may find, for example, that the Department of Veterans' Affairs finds it cheaper to utilise care in the private sector.

CHAIR—You are saying that people falling out of private health cover will put more strain on an already congested public system. We have 44.5 per cent in the private system now, yet we have heard evidence from Mr Stephen Walker from the private hospital system that there are some private hospitals in South Australia that are struggling because they do not have enough patients. Doesn't it seem contradictory that the private health system, even though it has over 44 per cent coverage, is still not attracting enough patients?

Dr Ford—The tertiary private hospitals, as far as I am aware, are quite congested. We have private emergency departments, for example, in at least three urban hospitals, and they are frequently on bypass because the hospital is full. I may say in passing that that applies to some public country hospitals. Murray Bridge and Port Pirie hospitals, in the last two weeks, have been on bypass, too. Perhaps in the lower level private hospitals there may be some vacancies, but I am not aware of those in the tertiary private hospitals.

CHAIR—To get back to the actual threshold, it is being increased from \$50,000 to \$100,000 for single people. It could be argued that, when it was first introduced, it was introduced as a measure to try to force people on higher incomes, who could afford it, to go into the private health system. Now it is at \$50,000, which is roughly around the average wage, and it has not been increased in that time. Couldn't you argue that people on that wage have been paying a disproportionate amount of tax compared to other people and that this measure is long overdue?

Dr Ford—I agree that there is a case to be made for giving greater support to those people—for example, the kind of support that is given to older people, whereby they have a 40 per cent rebate rather than a 30 per cent rebate. So that kind of process or some other taxation relief could be provided. I agree that the lack of indexation to that group has been a problem, but at the end of the day we do have a transgenerational support system in our funding, and to change that dramatically, as I think this would do, will lead to the sort of repercussions that I have outlined.

CHAIR—So in talking about increasing subsidies in your submission, you again were getting back to the idea that the government puts more funding into the private system rather than into the public system. We have had evidence from a couple of academics that that is neither efficient nor equitable. But you do not agree with that, clearly.

Dr Ford—If you look at the statistics for procedural medicine in the private sector, while they have somewhere in the order of 40 per cent of cases, they are doing a much greater caseload of surgery, for example. The surgical throughputs in private hospitals are much greater proportionately than they are in the public system. There are reasons for that. For example, the complexity of work and the nature of the teaching hospitals are obviously going to inhibit the rate at which they can operate. So there is a case to be made for encouraging a more efficient system.

Senator CORMANN—Would you be able to give us a snapshot of the current situation in South Australian public hospitals as far as waiting times and lists are concerned?

Dr Ford—I could direct you to the statistics that were published around October last year by the AMA. Some 20 per cent of people are waiting beyond the recommended waiting time. For example, category 2 patients have a waiting period of up to 90 days, but a fifth of the people who should be eligible for that service are not receiving it.

Senator CORMANN—How many people are there in numbers? For instance, you said 20 per cent of the people that should be clinically eligible, presumably, are not receiving it.

Dr Ford—Yes.

Senator CORMANN—What is that in terms of numbers?

Dr Ford—I do not have the numbers with me.

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

Dr Ford—I could take that on notice, but I can tell you from my own practice—I am a general practitioner myself—that we frequently have people with a need, for example, for hip replacement or joint replacement surgery waiting in excess of a year for an appointment to be seen and then another year to have a procedure. So you are looking at between one and two years. That is an anecdotal issue, I realise, but I would be happy to provide you with the statistics.

Senator CORMANN—In broad terms, how do you think this budget measure will impact on that? Will it have an impact?

Dr Ford—I believe it will. I do not think that our public hospital sector can deal with any more than it has now without an immense injection of funding. I think it is well recognised that the funding from the federal government to the state system has been disproportionate and inadequate. As I recall, our hospital costs in South Australia are somewhere in the order of \$1.9 billion and the Commonwealth is providing somewhere around \$700 million, so there is a shortfall of some \$300 million that the state would not receive if it were to

have a fifty-fifty funding. There is a lack of indexation in the healthcare agreements, so I think that we have fallen behind over time on that basis.

Senator CORMANN—On that point: has there ever been a fifty-fifty formula of federal-state funding?

Dr Ford—I believe that it was around that figure probably 10 years ago.

Senator CORMANN—Are you aware of whether the state government in South Australia has done any modelling or any analysis or any costings? You mentioned that there was no provision for it in the South Australian budget, which I think was brought down just before the federal budget. Are you aware of whether the state government has done any modelling or any costing of the impact of this measure?

Dr Ford—The state budget was brought down just after the federal budget, as I recall, but, no, and I have spoken to the health minister. I think it was initially the federal AMA that highlighted this potential problem, and I certainly carried the message to the state minister and raised concerns about the potential flow-on effects. He has indicated to me that it has not been a matter of their assessment at this stage.

Senator CORMANN—Did he indicate to you that he did not agree? Or did he indicate that they have not assessed the impact?

Dr Ford—He indicated that he felt it was more a problem of the secondary flow-on effect to other people who would find it difficult to sustain their insurance rather than the loss of and the impact on those younger people who may not meet the Medicare thresholds and therefore be excused from this process. As I recall, he felt that it was the secondary effect on the older people, who would find it unsustainable.

Senator CORMANN—You say ‘he felt’, but are you aware of whether, since your meeting, he has asked his department to do any modelling or costings to test his feelings?

Dr Ford—I am not specifically aware of that, no.

Senator CORMANN—We asked questions of the federal Treasury following the budget, during Senate estimates, and federal Treasury have told us that they did not conduct any modelling, any costing or any assessment whatsoever on the flow-on impact on public hospitals because they consider it the second-round effect. And even though this is supposed to be the era of cooperative federalism and the end of the blame game on health, I would have thought that there would be an integrated policy consideration of a measure like this that was clearly going to have flow-on implications. The federal government has not done any assessment and, as far as you are aware, the state government in South Australia has not done any assessment. Don’t you think that somebody should make a proper assessment as to what the implications for the public hospital system in South Australia are likely to be?

Dr Ford—I agree entirely. The AMA is asking that this measure is not approved in the Senate, at least until some further determination is made about the repercussions. And in the event that it does go through, we believe that the states should be provided with an adjustment through the healthcare agreements to deal with the repercussions.

Senator CORMANN—Do you think that should be 100 per cent compensation for the impact of this particular measure?

Dr Ford—I cannot see any reason why not. I think the states are really struggling to deal with the costs of hospital care and health care that they have to provide, and, as I am informed, they could not manage it.

Senator CORMANN—But surely the only way the state government in South Australia can put in an informed claim for additional funding from the Commonwealth to compensate for the impact of this measure is if they actually go through a rigorous assessment, some actuarial forecasting, of what the likely implications are going to be. Don’t you think that, as the AMA in South Australia, you should be urging the state government to conduct such a process beyond the feelings of the state minister?

Dr Ford—Certainly we have flagged this as an issue in meetings that we have had with the minister and the department and we have said that we feel that it has the repercussions I have outlined. As I understand it, there is a health ministers meeting around now, or in the next week or so, and I believe that that was going to be a topic for discussion and presumably, as a result of that, they would do the analysis that you suggest. But it is worthy of consideration, certainly.

Senator CORMANN—Do you think the federal Treasury should make its modelling available to the states so that the states, like South Australia, have got the best possible data in front of them as they are making that assessment?

Dr Ford—I think it would be very useful to have the information—but, as you say, perhaps it has not been done in its entirety. For example, the number of people who would be disenfranchised, if you like, or removed from the private health sector was not properly accounted for. They basically worked on the number of insured entities, but you have to account for single people and families. They had a number for adults but they did not include children. So I think there are many discrepancies or potential discrepancies in the assessment of the repercussions.

Senator CORMANN—I am well aware of that particular aspect of it, even though the media continues to refer—as do some of the submissions we have been receiving—to a Treasury assessment that 485,000 people will leave private health. The reality is that Treasury conceded in Senate estimates that that is actually a figure that relates to adults and does not include dependent children, so the figure is well in excess of that.

I have a further question. Everybody focuses on the number of people that are expected to leave private health, and then there is the overriding comment: ‘However, it will be the young and healthy who leave in the first instance, and they wouldn’t have accessed health care anyway.’ We agree with the proposition that the young and healthy would not have accessed services anyway. But isn’t it the case, then, that their total contribution is going into funding the treatment of those who do? And if people making a net contribution to the health system end up leaving, who is going to fund the treatment of those who will continue to require access to hospital services?

Dr Ford—Exactly. I would dispute that younger people do not utilise health services. I have some statistics here that give an indication of that. To some extent, the federal government have balanced the anticipated savings on subsidies for health insurance to that moiety of people, and certainly with regard to the health funds I think that they are anticipating—I would have to refer to my notes, but I think it is around \$200 million that they would save in expenses from losing that group of people. But, on the other hand, they are losing somewhere around \$500 million, I think it is, from insurance premiums.

Senator CORMANN—Actually, the figures are \$232 million in the first year and about \$700 million that they will lose. Over the forward estimates, the Commonwealth expects to save \$960 million, and that equates to an overall loss to the system of \$3.2 billion. Essentially, PHIAC data, Private Health Administration Council data, will tell you that 85 per cent of hospital insurance contributions fund hospital treatment; we are talking about \$2.7 billion. But if the young and healthy are indeed the ones who will leave, predominantly, because they would perceive a lesser risk in doing so, how is that going to impact on the capacity of health funds to actually offer attractive products to young people, in light of the fact that the pool in the health funds overall is going to be significantly lower and the cost is going to be higher?

Dr Ford—The health funds have to comply with certain prudential requirements, so they have to maintain their premiums to cover those issues. We are concerned that that would lead them down the path of certain restrictions on outgoings, and of course one of the methods of doing that is to have so-called managed care. That then creates a product which is less attractive to people who feel that perhaps they are not so imminently in need of care and they may then drop out.

So you finish up with a pool of people who are ill and highly demanding of the insurance and you are really perpetuating a problem. If you look back over time to when Medicare came in and insurance rates declined you can see that it was not an overnight thing but that gradually these changes occurred as people had their expectations changed and the products changed. I think that it can only lead to a greater expense for those who remain and therefore potentially a bigger load again on the public sector.

Senator CORMANN—Federal Treasury, in their submission to the committee, said that they expected that the impact of this measure on private health insurance membership would be a one-off event. We have had evidence from a wide range of other witnesses who thought that this one-off event would actually lead to a second wave and essentially have the potential to lead to a new downward spiral in private health membership similar to the experience between 1983 and 1996. Do you want to comment on that? What is your view? Do you think it will be a one-off event or do you think there will be a—

Dr Ford—No, I do not because of the reasons that I have just tried to outline. I think that it will be an ongoing problem and that the rates will have to increase. The people who remain insured will be those with a greater demand and that will lead to an exponential escalation of the insurance rates. So, although the government undertook in the election lead-up to maintain the subsidy for private health insurance, if the subsidy is going to be on a percentage basis, they may find themselves outlaying more there. I think that, as you indicated earlier, a much greater detailed assessment of the ramifications of this proposal is required before such a move is implemented. As I said, I think there are other ways to support the people who the

government is wishing to support, the younger people on the lower income levels, without any threat to the private sector, which I see as important.

Senator CORMANN—And there is a balance in the health system.

Dr Ford—Yes.

Senator CORMANN—Dr Ford, you are the president of the AMA in South Australia. Were you in that position before the federal election?

Dr Ford—Yes.

Senator CORMANN—Did you participate in any meetings with the then shadow minister for health, the then shadow Treasurer or the then Leader of the Opposition?

Dr Ford—Yes.

Senator CORMANN—Did they at any point in time raise with you their intentions or ask you for your advice on a proposition to increase the Medicare levy surcharge threshold like we saw at budget time?

Dr Ford—No.

Senator CORMANN—So they never consulted you on this prior to the budget?

Dr Ford—No.

Senator CORMANN—And it was not raised before the election as far as you are aware?

Dr Ford—No.

Senator CORMANN—Thank you very much.

CHAIR—Dr Ford, do you think the balance between public and private health is about right at the current time?

Dr Ford—I think that both areas have deficiencies and they could be corrected by different approaches, I guess. One is the approach that you intimated earlier about more going to the public sector. As I said, I think there are some issues with that. I think that, firstly, there is the efficiency factor compared to the private sector. Secondly, I think that there is the nature of public health and particularly public hospital care. The Australian public wish to have a choice in their health care so that they can appoint the medical professional of their choice. That is not a benefit that you receive in the public sector. I think they both need attention, and I could go on.

CHAIR—Do you think that is a critical factor in private health insurance, that people want the doctor of their choice?

Dr Ford—I believe that that is so. I believe that the way private health functions is preferred by people who can afford to participate in it—that, first of all, they do have the opportunity for a doctor of their choice, and to some extent a hospital of their choice. They see that as being more responsive to their needs, whereas the public sector, which has historically struggled, I think, for funding and resources and, quite frankly, has become quite run-down over a number of administrations in South Australia, has limitations which they prefer to avoid.

CHAIR—I think you are saying in effect that you would prefer to see the private system increase its services.

Dr Ford—I think that it is necessary to maintain a certain viability in the private sector for it to be sustainable. I do not think that falling below the current rate would achieve that. I think that if it fell it would be unviable for the sorts of reasons that were evident when insurance rates fell to somewhere around 30 per cent.

CHAIR—They are currently at 44.5 per cent.

Dr Ford—And I think South Australia is on a par, basically, with the rest of the country in that respect.

CHAIR—Thank you for appearing. The committee is now adjourned.

Committee adjourned at 4.41 pm