GEORGE BROWNBILL CONSULTING
PROPRIETARY LIMITED

29 January 2013

The Secretary
Senate Community Affairs Regulation Committee
Parliament House
Canberra ACT 2600

community.affairs.sen@aph.gov.au

Dear Secretary

I act for the Australian Osteopathic Association (AOA).

I am attaching my clients' submission to your Committee's enquiry regarding the Private Health Insurance legislation. Your office indicated to me last week that you were prepared to accept this submission a few days late.

I would be grateful if you could let me know when the Commission has authorised the submission to be published. No confidential material is included in the submission.

The AOA would appreciate an opportunity to be heard by the Committee. I understand hearings in Canberra are scheduled for 4 and 5 March. These dates would be convenient for my clients.

Yours sincerely

George Brownbill

George Brownbill Consulting Proprietary Limited
63 Turallo Tce Bungendore NSW 2621 ~ PO Box 336 Bungendore NSW 2621
Email george@georgebrownbill.com.au Phone +61 2 6238 1337 Fax +61 2 6238 0703 Web georgebrownbill.com.au

ABN 52 009 261 965

australian osteopathic association

Australian Osteopathic Association
PO Box 5044,
Chatswood West NSW 1515
p. 61 2 9410 0099
f. 61 2 9410 1699
aoa@osteopathic.com.au
www.osteopathic.com.au

AUSTRALIAN OSTEOPATHIC ASSOCIATION

Submission to the

Senate Standing Committee on Community Affairs

Regarding its inquiry into the

Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012

January 2013

THIS SUBMISSION

The Australian Osteopathic Association (AOA) appreciates the opportunity to make this submission about the *Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012* ("the Bill").

The Australian osteopathic profession is concerned that, if passed, this legislation would force consumers away from accessing health professionals other than medical practitioners. We respectfully urge the Committee to find accordingly and to recommend to the Senate that it not be passed.

THE AUSTRALIAN OSTEOPATHIC PROFESSION

Our profession is one of the "allied health professionals", ("AHP") which is regulated as part of the national scheme. When the Government announced its health reform agenda, it was expected that AHPs would work cooperatively in clinical teams and take some of the load off busy GPs. AOA's members have been more than happy to work in this way, on the understanding that all health professionals have and display mutual respect in the interest of better clinical outcomes for patients. We consider, however, that the reforms have still some way to go.

The Australian osteopathic profession has these characteristics:

- About 1750 practising Australia-wide.
- Significant majority are young (50% are under 35) and about 50/50 female/male.
- The business model is mostly of the small business clinic, with rarely more than two or three professionals. Very few osteopaths practise in public hospitals, although there are no legal barriers to their doing so.
- To practise osteopathy, you must complete a five-year master's degree. Much of the curriculum covers the same areas as found in those for other health professionals.

WHAT OSTEOPATHS DO

In Australia, a registered osteopath may treat patients for a range of conditions of the musculo-skeletal system. It is the case that patients sometimes present with conditions they believe we can treat. However, a trained osteopath, on examining a patient, may come to the view that the patient should be referred for treatment of a kind our members are not trained to provide.[1]

Many conditions that afflict us all, however, can be treated, and at least alleviated, by osteopathic procedures. More and more people are coming to realise this, which is no doubt why our profession is growing faster than any other healthcare profession.

We ask the Committee to note especially that osteopathy is a frontline, primary healthcare profession. Only 15% of initial patient contacts result from a referral. The rest come in "off the street", often because of a recommendation from someone that they have seen get better.[2]

PAYING FOR OSTEOPATHIC TREATMENT

It is AOA's belief that:

- Gross annual fees paid for osteopathic services are $210m – plus.
- Of this, no more than about $29m is recouped by patients.
- Of this $29m, Medicare refunds account for no more than $4.5m, so that
- The rest (say $24m) arises from claims by patients on their private health insurers.

AOA believes that the very few benefits claimable from Medicare represents both an inequitable and a clinically inefficient situation.

---

[1] For example, some carcinomas may be thought by patients to be a "sprain" or other injury. It is vital that such cases be referred on promptly and that osteopaths have the professional training to know when to do so.

[2] In our experience, many patients to not "have" a GP.

- *Inequitable,* because people who use osteopathic services (often as their frontline treatment) must pay Medicare levy and taxes, yet cannot access their preferred treatment.

- *Clinically inefficient,* because our patient base tends to self-select from people who can afford to pay the fees we need to continue in practice. We believe that there are many people who would benefit greatly from osteopathic treatment but can't afford it.[3]

CENTRAL IMPORTANCE OF PHI

It will be apparent to the Committee that all the AHPs are heavily dependent for their viability on patients who can afford treatments. They can afford the treatments, at least in part, because they have taken out PHI. That is, they are taking responsibility for their own health and its management.

It might be otherwise if osteopathic treatments, and those of other AHPs, were covered by Medicare. As we have seen, there is next to no such cover. It follows that, if changes to the PHI create significant disincentives for people to continue their present cover, there will be serious adverse effects on the AHPs.

In speaking of the changes now under the Committee's consideration, the Minister did not seem to realise this. On 24 October 2012, the Minister said:

> "(The rebate) will soon, by around 2022, cost around $8bn a year. In fact, it's already costing us about as much as it costs for everyone to go to the doctor through Medicare. So it was important to reduce it as an area of health expenditure because **it's not a frontline service, it's not paying the wages of doctors and nurses.** It's a contribution to the cost of health insurance."[4]

What the Minister seems to be saying is that the Australian healthcare system comprises "doctors and nurses", *simpliciter*. Yet the Government's own rhetoric has laid much emphasis on the place AHPs must play in the system, as reformed for the future. The people who provide these services have to be paid – somehow. The

[3] In particular, older people with "aches and pains" would benefit greatly from osteopathic manipulation to alleviate their condition. Likewise, while we attend to many work-related injuries, we believe there are many more who could access clinically effective intervention.

[4] Emphasis added. *The Australian*, 24 October 2012.

extent to which PHI is cut back – made more unaffordable to people who need these services – will be the measure of how much the Government's reform objectives will not be achieved.

PROPOSED LEGISLATION – EFFECT ON THE OSTEOPATHIC PROFESSION

Last year, AOA prepared a detailed economic assessment of the Government's proposed changes. This may be found at Attachment 1 to our previous submission to the Committee.

Our consultant economist has now prepared an updated assessment of the combined likely effects of the previous (now enacted) and newly proposed changes. A copy of the advice is at Attachment 2.

In brief the analysis shows that the effects on osteopaths and on all other allied health professionals are likely to be serious.

These effects on the professions will inevitably limit the range of treatments available to patients and raise the cost of those treatments.

The effects on demand for all health services not covered by Medibank (or very limited cover) began with last year's changes and will be compounded if the MYEFO proposals are put into effect.

Attachment 2 shows

- Demand for osteopathic treatments, without this and last year's changes would grow from 749,600 in 2012 to 1.05m in 2016.
- But, with the two changes, demand over the five years is likely to decline to 645,000, or 60%
    - resulting in a decline of 460 in the number of practising osteopaths.

This reduction in demand not only affects the rate of growth of a profession which has been rapidly growing. It will also

- shift demand for substitutable treatments to Medicare-supported treatments – that is, to GPs and public hospitals;
- force PHI providers to contain costs from a contracting base by increasing premiums for those retaining cover, or limited benefits, or both.

These expected outcomes are totally inconsistent with the Government's expressed policy objectives. As we have seen, however, the Minister seems to think that the only health providers who matter are "doctors and nurses".

We urge the Committee to find as above and to recommend that the Bill be not passed.

Attachment 1

Briefing note

Means testing the private health insurance rebate: Implications for Allied Health Professionals

February 2012

Prepared for the Australian Osteopathic Association
by IDA Economics Pty Ltd

1. Key points

- The Australian Government has proposed to again legislate to means test the private health insurance rebate.
- Analysis for Private Healthcare Australia by Deloitte concluded that around 4.2 million consumers would withdraw from general treatment cover (and 5.7 million downgrading their cover).
- In 2010-11, $3.2 billion was paid out in benefits for allied health treatment by private insurers under General Treatment cover. The majority of benefits related to Dental, Optical and Physiotherapy services, but most allied health professions benefited indirectly through consumers receiving rebates.
- Official data show that in 2011 round 69.5 million allied health services were provided to patients covered by General Treatment insurance.
  - 90% of these services were provided by allied health professionals.
  - Providing these services is estimated to have employed the equivalent of 35,000 FTE allied health professionals.
- Membership of private health funds has been growing and with that the number of people covered by General Treatment insurance.
  - Between 2006 and 2011 membership increased by around 4.2% per annum.
  - A continuation of this growth rate would mean that by 2017 some 43,000 allied health professionals would be employed providing services to patients covered by General Treatment insurance.
- The estimated fall in people with General Treatment cover under the Government's policy proposal is estimated to reduce demand for allied professionals by around 28% by 2017, compared to no policy change.
  - Even with the policy change demand for allied health professionals would be 11% less that today
- Under the policy proposal, around 12,000 fewer allied health professions would be required in 2017, compared to no policy change, with demand across all allied professions impacted (Table 1).

Table 1: Estimated reduction in demand for allied health professionals in 2017 with the Government's proposed means testing of private health insurance rebate: By allied health professional, compared with no policy change

Profession	FTE	Profession	FTE
Acupuncture / Acupressure	349	Optical	1,770
Ambulance	34	Orthoptics (Eye Therapy)	1
Chiropractic	1,745	Osteopathic Services	132
Community, Home, District Nursing	3	Physiotherapy	1,731
Dental	5,680	Podiatry (Chiropody)	432
Dietetics	33	Psych/Group Therapy	49
Hypnotherapy	0	Speech Therapy	68
Maternity Services	2	Total	12,074

Source: IDA Economics

2. Background: Australian Government policy proposals

The Australian Government has proposed to again legislate to means test the private health insurance rebate.

Previous Treasury analysis estimated that 25,000 consumers might withdraw from private health insurance under this policy.

More recent analysis by Deloitte for Private Healthcare Australia concluded that the impact would be much larger[1].

- Around 170,000 consumers would initially withdraw from private health Hospital insurance and 575,000 withdraw from General Treatment insurance and, other consumers would downgrade their cover.
- Further, with fewer consumers, private insurance companies would have to increase premiums to cover costs, leading to a further reduction in consumers taking out private health insurance.
- All up, Deloitte estimated that around 4.2 million consumers would withdraw from general treatment cover (and 5.7 million downgrading their cover).

Many people rely on their private health insurance cover to help pay for their other allied health treatment.

Private Health Insurance Administration Council (PHIAC) data shows that in 2010-11, $3.2 billion was paid out in benefits for allied health treatment by private insurers under General Treatment cover (Table 3).

- The majority of benefits related to Dental, Optical and Physiotherapy services.
- On any measure these benefits are important for consumers in reducing the cost of allied health services.

In the absence of General Treatment insurance cover these benefits to consumers and associated fees to all allied health providers would be 'at risk'.

- The issue is relevant to all allied health providers across all states.
- In particular allied health professionals. Benefits paid for services that can be broadly classified as allied health professional services account for 90% of the benefits paid out.

3. Patient services provided by allied health professionals

According to PHIAC data, in 2011 some 69.6 million allied health services were provided to patients covered by General Treatment medical insurance.

- This was increase of 4% on the previous year. By 2017 this is projected to grow to 89 million, given the historical growth rate in the number of people with General Treatment cover (2006-11, 4.2% per annum).
- It is reasonable to expect that the growth in allied health professional services will continue to be about the same as the growth in the number of people with General Treatment cover, if not slightly faster as people increasingly look to allied health service support.

---

1 Deloitte, *Economic Impact Assessment of the Proposed Reforms to Private Health Insurance*, April 2011, Section 4.

Allied health services can be broadly categorised into those provided by allied health professional and those which are other services, primarily services for service items or allowances.

- Allied health professional services account for over 90% of all allied health services, fees and benefits paid (Table 4 and Table 5).

Based on a broad average of 1840 services provided per allied health professional per annum (40 services per week, 46 weeks per annum), the total Full Time Equivalent (FTE) number of allied professionals providing services to people with General Treatment cover in 2012 is estimated at 35,400.

- This is projected to increase to around 43,500 allied health professionals by 2017 — an increase of some 23% from 2012.

4. Fewer people than otherwise with General Treatment cover if policy changes

The proposed means testing policy can be expected to reduce the demand for General Treatment insurance cover,

- With no private insurance cover, especially where there is no, or very limited Medicare cover, consumers would face higher out of pocket costs for allied health services. Consumers would choose to forego treatment, seek other medical support or pay the higher costs of using allied health services.

Consumers withdrawing from General Treatment insurance are more likely to not seek treatment or use Medicare supported services. It is unlikely that many will continue using allied health services — otherwise they would have continued with General Treatment insurance.

- Thus the reduced demand for General Treatment insurance can be expected to result in a direct (ie same percentage) fall in the demand for allied health services (and in turn allied health professionals).

Deloitte has estimated the number of people likely to withdraw from General Treatment insurance. That analysis shows that initially some 575,000 people would withdraw.

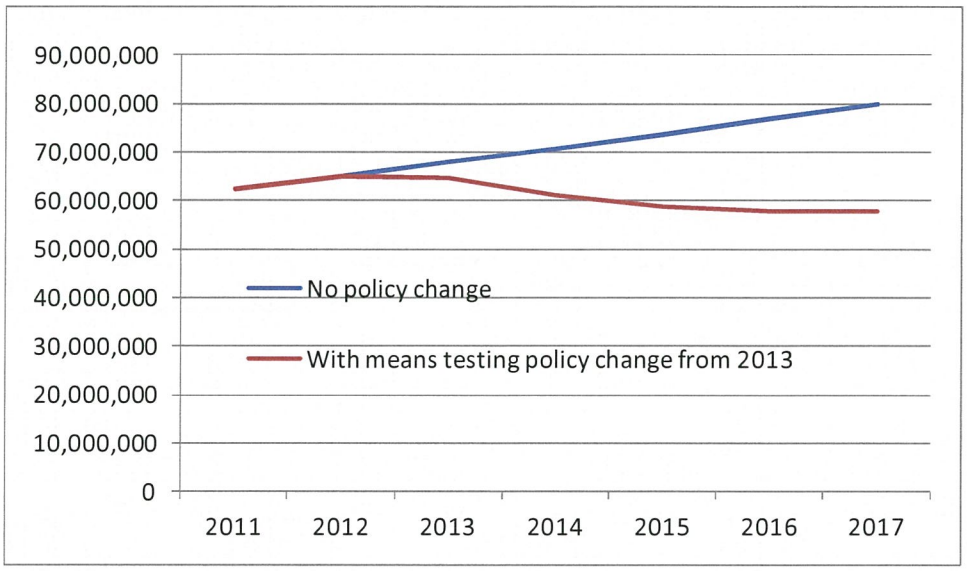
- By 2017 around 4.2 million people fewer people would have General Treatment cover than otherwise, given the policy became operative in 2013.

5. Implications for the demand for allied health services

Using these estimates of withdrawals, in the context of the projected growth in demand for allied health services without the proposed policy change, the demand for allied health professional services would be some 28% lower in 2017 compared to otherwise, ie no policy change (Figure 1).

- Even allowing for the underlying growth in General Treatment insurance cover (and resulting increasing demand for allied health professional services), the demand for allied health professional services over the next five years, with the policy change, would be around 11% less than where it is today.

Figure 1: Allied health professional services provided under General Treatment insurance: Actual 2011, projected 2012-17: With and without policy change



Source: Table 4 and IDA Estimates

These changes in the demand for allied health services flow directly through to the demand for allied health professionals.

- Using again the broad average of 1840 services per professional per annum, it is estimated that some 12,000 fewer allied health professionals would be required in 2017 compared to otherwise — a fall of 28% as a direct result of the policy change.
- Again, the resulting demand for allied health professionals would be some 11% less than today.

These reductions in demand for allied professionals have important implications for both existing professionals and those in training. Instead of expecting demand for their services to grow with increasing numbers of people purchasing General Treatment cover, they will find demand contracting.

6. Impacts on allied health professionals: Detail

Applying the same analytical approach as above enables a profession by profession assessment. That is:

- Estimating the FTE of professionals delivering allied health services undertaken under General Treatment insurance.
- Projecting forward the growth in people covered by General Treatment insurance, assuming no policy change (and by implication the growth in demand for allied health services).
- Estimating the reduction in the number of allied health professionals if the estimated fall in people covered by General Treatment insurance were to eventuate (and by implication flow through to reduced demand for allied health services).

All allied health areas would be impacted by the policy change (Table 2Table 4).

- The reduction in demand is greatest in those areas currently providing the most services.

Table 2: Estimated reduction in demand for allied health professionals in 2017 with the Government's proposed means testing of private health insurance rebate: By allied health professional, compared with no policy change

Profession	FTE	Profession	FTE
Acupuncture / Acupressure	349	Optical	1,770
Ambulance	34	Orthoptics (Eye Therapy)	1
Chiropractic	1,745	Osteopathic Services	132
Community, Home, District Nursing	3	Physiotherapy	1,731
Dental	5,680	Podiatry (Chiropody)	432
Dietetics	33	Psych/Group Therapy	49
Hypnotherapy	0	Speech Therapy	68
Maternity Services	2	Total	12,074

Source: Table 4

Table 3: General Treatment benefit payments by private health insurers 2010-11 ($'000): By allied health area and state

	NSW	Vic.	Qld	SA	WA	Tas.	ACT	NT	Aust.	% of total
Dental	528,935	328,206	329,918	150,865	242,243	31,404	29,371	9,415	1,650,356	51.2%
Optical	198,060	117,325	116,161	49,313	65,387	13,941	9,245	4,522	573,954	17.8%
Physiotherapy	80,266	58,516	45,397	31,415	33,073	4,119	4,068	1,436	258,290	8.0%
Chiropractic	67,584	49,535	45,640	28,347	26,100	3,728	2,804	1,460	225,199	7.0%
Pharmacy	28,105	9,741	14,370	6,312	8,206	2,087	1,389	298	70,508	2.2%
Podiatry	22,526	15,170	15,360	8,309	11,040	2,179	1,058	564	76,206	2.4%
Natural therapy	36,536	18,883	17,225	6,389	4,104	2,194	1,649	259	87,238	2.7%
Acupuncture	20,113	7,365	7,474	1,300	745	313	508	80	37,897	1.2%
Ambulance	6,166	26,714	226	21,469	25,606	93	802	568	81,645	2.5%
Prostheses	14,047	6,679	8,141	5,193	3,305	1,098	613	256	39,330	1.2%
Psychology	3,506	2,754	3,207	1,758	1,885	265	229	104	13,709	0.4%
Hearing aid	7,814	3,347	4,657	2,368	4,320	1,158	339	106	24,108	0.7%
Preventative health services	8,158	1,688	3,872	465	448	265	301	46	15,243	0.5%
Speech therapy	5,002	1,871	2,257	997	2,157	94	89	36	12,503	0.4%
Osteopathic	8,367	8,129	2,543	542	747	707	477	40	21,552	0.7%
Occupational therapy	2,062	820	1,468	434	2,974	20	41	25	7,845	0.2%
Dietetics	1,957	749	1,479	276	560	26	78	40	5,164	0.2%
Other	10,891	4,314	4,243	1,692	916	487	377	58	22,979	0.7%
Total benefits	1,050,096	661,806	623,639	317,443	433,816	64,177	53,438	19,313	3,223,727	100%

Source: Private Health Insurance Administration Council, Data Tables September 2011
http://www.phiac.gov.au/for-industry/industry-statistics/datatablesphiac3/

Table 4: Allied health professional services covered by General Treatment insurance: Estimated demand for professionals with and without policy change: By allied health profession

	Services	Fees charged	Benefits paid out	Est. number of professionals to deliver services (no policy change)			Est. reduction in demand for professionals (with policy change)	
				2011	2013	2017	2013	2017
	no.	$m	$m	FTE	FTE	FTE	FTE	FTE
Acupuncture / Acupressure	1,808,289	$79	$38	983	1,067	1,258	48	349
Ambulance	176,830	$83	$82	96	104	123	5	34
Chiropractic	9,034,881	$442	$225	4,910	5,332	6,285	238	1,745
Community, Home, District Nursing	13,765	$1	$1	7	8	10	0	3
Dental	29,408,010	$3,380	$1,650	15,983	17,354	20,458	773	5,680
Dietetics	169,379	$12	$5	92	100	118	4	33
Hypnotherapy	2,478	$0	$0	1	1	2	0	0
Maternity Services	8,089	$1	$1	4	5	6	0	2
Occupational Therapy	232,330	$16	$8	126	137	162	6	45
Optical	9,162,731	$1,138	$574	4,980	5,407	6,374	241	1,770
Orthoptics (Eye Therapy)	7,290	$1	$0	4	4	5	0	1
Osteopathic Services	685,746	$49	$22	373	405	477	18	132
Physiotherapy	8,962,540	$520	$258	4,871	5,289	6,235	236	1,731
Podiatry (Chiropody)	2,234,590	$151	$76	1,214	1,319	1,555	59	432
Psych/Group Therapy	253,852	$34	$14	138	150	177	7	49
Speech Therapy	352,226	$28	$13	191	208	245	9	68
Total	62,513,026	5,934	2,966	33,974	36,890	43,488	1,643	12,074

Source: Private Health Insurance Administration Council, Data Tables September 2011
http://www.phiac.gov.au/for-industry/industry-statistics/datatablesphiac3/

IDA estimates. Note. Growth rate in the number of people with General Treatment insurance cover (no policy change) 4.1% per annum, uniform across all allied health areas. Reduction in demand for allied health services (with policy change) 4% in 2013 and 28% in 2017, uniform across all allied health areas.

Table 5: Other allied health services covered by General Treatment insurance: Demand for professionals with and without policy change: By allied health service

	Services	Fees charged	Benefits paid out
	no.	$m	$m
Accidental Death / Funeral Expenses	3,791	$25	$4
Domestic Assistance	10	$0	$0
Ex gratia Payments	12,904	$9	$3
Preventative Health Products/Health Management Program	270,124	$37	$15
Hearing Aids and Audiology	48,718	$97	$24
Natural Therapies	3,472,553	$208	$87
Overseas	340	$0	$0
Pharmacy	2,616,270	$182	$71
Prostheses, Aids and Appliances	340,207	$74	$39
School	242	$0	$0
Sickness and Accident	1,069	$0	$0
Theatre Fees	404	$0	$0
Travel and Accommodation	74,270	$3	$2
Other Services	226,383	$22	$11
Total	7,067,285	$659	$258

Source: Private Health Insurance Administration Council, Data Tables September 2011
http://www.phiac.gov.au/for-industry/industry-statistics/datatablesphiac3/

Attachment 2

AUSTRALIAN OSTEOPATHIC ASSOCIATION

MYEFO Proposed changes to Private Health Insurance Rebate: Economic analysis

January 2013

Contents

OVERVIEW

Context

In its Mid -Year Economic and Fiscal Outlook (MYEFO) the Government announced that that:

- the PHI rebate indexed annually by the lesser of CPI or the actual increase in commercial premiums.
- PHI Rebate on the Lifetime Health Cover loading component of PHI premiums would be removed

Taken together these changes were estimated by the government to increase its revenue by around $590m in a full year.

These changes followed the 2011-12 Budget decision to reduce the Government's contribution to private health insurance through means testing the private health insurance rebate. That policy has been estimated to increase Government revenue by around $800m in a full year.

Department of Health and Ageing analysis suggested that for an average person the change to CPI indexation might increase the annual cost of PHI by around $7.50.

The Government implied in its announcement that there would be limited impact on the demand for PHI, a claim made previously with respect to the PHI rebate means testing policy.

Analysis and findings

Contrary to the Government's claims adoption of CPI indexation will be substantial since the rate of increase in commercial premiums has (and is likely to continue to be) faster than the CPI. The resulting compounding effect of the differential, on present analysis is estimated to be $9 in 2014 climbing to $81 by 2020.

Past analysis has shown that people are price sensitive to the cost of PHI. That is, a reduction in the PHI rebate, which effectively increases the cost of PHI, will reduce the demand for PHI. Further, fewer people taking out PHI increases the average cost of providing PHI leading to a further reduction in demand for PHI.

Analysis of the reduction in demand for osteopathy services and osteopaths as a result of the combined effects of the PHI Means test policies and the MYEFO proposed policies, compared to otherwise (ie continuing growth in osteopathy services under PHI) suggests that the demand for osteopaths could fall by 460 by around 2016 (about 25% of current osteopath numbers or 20% of the 'no policy change' projected number of osteopaths in 2016).

Background

In its Mid -Year Economic and Fiscal Outlook (MYEFO) the Government announced that that policy decisions on its payments would be more than offset by a number of decisions that would reduce cash payments. Two specific decisions to reduce cash payments were:

- "changes to the calculation of the Government's contribution to private health insurance, which will now be calculated using commercial premiums as at 1 April 2013 and then indexed annually by the lesser of CPI or the actual increase in commercial premiums. This will be used to determine an individual's private health insurance rebate. This decision will take effect from 1 April 2014 and will decrease payments by around $700 million over three years from 2013-14; and
- removing the PHI Rebate on the Lifetime Health Cover loading component of PHI premiums decreasing payments from 1 July 2013 and reducing payments by around $390 million over three years."[1]

These changes followed the 2011-12 Budget decision to reduce the Government's contribution to private health insurance through means testing the private health insurance rebate.

Appendix A of the MYEFO provided the following explanations.

Private Health Insurance Rebate — indexing the Government's contribution

Table 1: Private Health Insurance Rebate — indexing the Government's contribution: Savings

Expense ($m)	2011-12	2012-13	2013-14	2014-15	2015-16
Department of Health and Ageing	-	3	-36.5	-218.9	-451.7
Australian Taxation Office	-	2.2	1.6	0.1	0.1
Department of Human Services	-	0.2	0.3	..	-
Total — Expense	-	5.3	-34.6	-218.8	-451.6

[1] The Treasury, *Mid-Year Economic and Fiscal Outlook*, Part 3: Fiscal strategy and outlook, pgs 49-50

The Government's contribution to private health insurance will be calculated using commercial premiums as at 1 April 2013 and then indexed annually by the lesser of CPI or the actual increase in commercial premiums. This will be used to determine an individual's private health insurance rebate.

In conjunction with this measure, the Government will streamline arrangements for the 2013 premium setting round. The Government will undertake discussions with industry and consumer groups on options for further simplification of premium setting that will drive competition and continue to deliver strong consumer protection from 2014.

The measure will take effect from 1 April 2014 and will result in savings of $699.7 million over four years.

Savings from this measure will be redirected to partially offset the cost of the Dental Health Reform package announced on 29 August 2012.

Private Health Insurance Rebate — removal of rebate on lifetime health cover loading

Table 2: Private Health Insurance Rebate — removal of rebate on lifetime health cover loading: Savings

Expense ($m)	2011-12	2012-13	2013-14	2014-15	2015-16
Department of Human Services	-	1.3	1.2	0.7	0.7
Australian Taxation Office	-	1.2	1.1	2.8	0.1
Department of Health and Ageing	-	0.3	-124.2	-133.9	-140.6
Total — Expense	-	2.8	-121.8	-130.4	-139.8
Related capital ($m)					
Department of Human Services	-	2.2	0.8	..	..

"The Government will remove the Private Health Insurance (PHI) Rebate on the Lifetime Health Cover (LHC) loading component of PHI premiums.

The LHC loading is an additional two per cent charge to a person's PHI premium for every year elapsed after their thirty-first birthday before they take out PHI. LHC loadings are only payable against the hospital component of a person's PHI premium.

The measure will take effect from 1 July 2013 and will result in savings of $386.3 million over four years.

Savings from this measure will be redirected to partially offset the cost of the Dental Health Reform package announced on 29 August 2012. This savings measure will improve the effectiveness of the incentive for a person to take out PHI early in their life."

Legislative process

The *Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012* was introduced and read for a first time on 28 November 2012. The Second reading was also on the 28 November 2012.[2]

The Bill amends the *Private Health Insurance Act 2007* to: remove the Private Health Insurance Incentive Benefit (the rebate) from the Lifetime Health Cover loading component of affected private health insurance premiums; and cease the Incentive Payments Scheme which allows people to claim the rebate as a direct payment; and *Income Tax Assessment Act 1936*, *Income Tax Assessment Act 1997* and *Taxation Administration Act 1953* to make consequential amendments.

Implementation of the decision to change the basis of indexation of the rebate does not require legislative amendment. It can be implemented through regulation.

Private Health Insurance Rebate – indexing the Government's contribution: The approach in practice

The Department of Health and Aging has outlined how indexation will work in practice.[3]

"From 1 April 2014, the Government's contribution to private health insurance will be calculated using base premiums which will be indexed annually. The base premium will be equivalent to the commercial premium (approved by the Minister) on 1 April 2013, indexed annually from 1 April 2014 by the lesser of the Consumer Price Index (CPI) or the commercial premium increase.

The changes mean that while the rebate percentage remains the same, the rebate rate will be calculated on a 'base premium'.

A policy holder's percentage rebate entitlement will still be dependent on their age and income.

---

2 *Hansard*, 28 November 2012, http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query%3DId%3A%22legislation%2Fbillhome%2Fr4936%22)

3 http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-gov-cont

In conjunction with this measure, the Government will streamline arrangements for the 2013 premium setting round. The Government will also undertake discussions with industry and consumer groups on options for further simplification of premium setting that will drive competition and continue to deliver strong consumer protection from 2014.

How the Measure will work

The Government's contribution to private health insurance will be calculated using base premiums as at 1 April 2013.

Each year the base premium will be indexed by the lesser of CPI or the premium increase and the rebate will apply to the base premium.

Income thresholds and rebate rates will not be affected as a result of these changes.

For example, Jenny is 38 and has a single policy which cost $1,000 p.a. She has an annual income of $60,000 and is therefore entitled to a 30% rebate under existing income testing arrangements.

Assuming the cost of Jenny's premium increased by 5% per year and CPI increases by 2.5% per year the changes are as follows.

Table 3: DOHA: Indexation example to illustrate cost saving to the Budget

	2013	1-Apr-14
Base Premium to which the rebate will apply indexed at 2.5% (indicative CPI)	$1,000	$1,025
Commercial Premium indexed at 5%	$1,000	$1,050
Rebate on base premium (30%)	$300	$307.50
Rebate that would have applied to commercial premium	$300	$315
Difference in rebate that would have applied had the change not been made	$0	$7.50

Source: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-gov-cont

Analysis: Approach

The Government's proposals are specifically intended to reduce its 'cash payments' which means higher 'cash costs' for Australians looking to continue with or take out PHI.

These proposals will have both first round and second round effects.

First round effects

If implemented, the proposals will increase costs to some or most PHI policy holders (PHI consumers).

1. Reduce the real value of the PHI rebate, that is, the value of the rebate adjusted for inflation. Other things being equal, a lower rebate means that the real cost of PHI has increased

- CPI indexation would invariably mean a reduction in the PHI rebate in real terms.

- Historically the CPI has increased at a slower rate that the cost of PHI premiums.

- There is no reason why this will change in the future. Although the Government reviews applications for PHI premium increases, and has established a new Premiums and Competition Unit (PACU) aimed at ensuring cost reflective PHI premiums, the underlying cost drivers of health care (especially the high labour intensity of health care and the relatively high cost of health professionals compared to salaries in general) means that health care (and PHI premiums) will continue to rise in real terms.

2. The reduction on the real value of the PHI rebate would not be means tested, thus **all** PHI rebate beneficiaries would be adversely affected.

- The policy changes made by the Government in 2012 focussed on means testing the PHI rebate.

3. Removing the PHI rebate on the LHC loading component of PHI premiums would further reduce the value of the rebate for new PHI policy holders over 30 years of age.

- The real value of the PHI rebate is reduced for new PHI policy consumers

- The increased cost of PHI is again not means tested.

Second round effects

As a consequence of these first round effects there would be fewer PHI policy holders and, as a consequence, a range of second round effects.

The MYEFO does not identify the reduction in the number of PHI policy holders. However, implicitly it would seem that the Government holds to the view that the

demand for PHI is more or less perfectly inelastic with respect to price. That is, irrespective of what happens to the real cost of PHI to consumers, consumers will not change either their PHI cover or whether they take out PHI.

A crucial aspect relevant in such analysis is the term *ceteris paribus*. That is, compared to otherwise, or what some call the counterfactual. The issue is not whether the overall number of PHI policies increases or not (since the number of polices will be influenced by population growth, rising incomes, consumer preferences) but rather whether the specific policy change has an impact on the level and nature of PHI.

Three groups of second round effects can be identified.

- Effects on PHI premiums generally. Fewer PHI consumers can be expected to lead to a general rise in PHI premiums.
- Effects on other Government expenditure. Fewer PHI consumers can be expected to lead to a decline in private health care and a consequential increase in demand for publicly funded health care.
- Reduced demand for health services more reliant on PHI. In particular Allied Health Professionals whose services are in effect not covered by Medicare and who rely much more on patients with PHI.

Analysis: The real cost of PHI

There are four aspects of the DOHA analysis (and the Government's policy statement) of the real cost PHI and the PHI Rebate which have implications for Australians.

- The historical CPI and Private Health Insurance premium increase suggest that the cost saving to the Government (and cost impost on consumers) will be greater than implied by the DOHA analysis.
- Analysis of the underlying drivers of the CPI and Private Health Insurance premiums suggests that the difference between the CPI and Premium increases could widen.
- The cost impost on consumers is not static: it will increase over time reflecting the compounding effect of the difference between CPI increases and premium increases.
- The cost impact or reduction in the PHI rebate will impact upon all consumers benefitting from the rebate.

Historical CPI and Private Health Insurances Premium increases

Private Insurance Premiums have historically increased faster than the CPI and the differential has typically been of the order of 2% to 3% points (Figure 1, Table 4). In more recent years, the difference between the two has widened.

Figure 1: CPI and Private Health Insurance Premium increases: 2005-2012

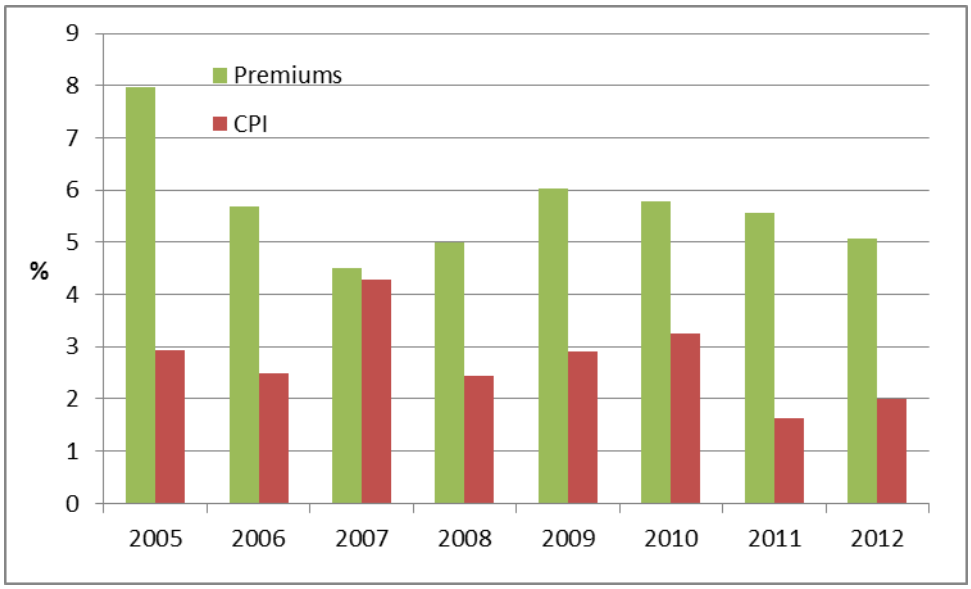


Table 4: CPI and Private Insurance Premium increases: Data and sources: 2005-12

	CPI increase (a)	Av premium increase (industry wide) (b)	CPI - Premium increase difference	Data source for average premium increase (Minister's Press Release)
	%	%	%	
2005	2.92	7.96	5.04	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2005-ta-abb019.htm?OpenDocument&yr=2005&mth=03
2006	2.49	5.68	3.19	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2006-ta-abb023.htm?OpenDocument&yr=2006&mth=02
2007	4.27	4.5	0.23	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/475EAEC6BA0501FCCA25728B00013A3B/$File/abb015.pdf
2008	2.44	4.99	2.55	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/tr-yr08-nr-nrsp060308.htm+?OpenDocument&yr=2008&mth=03
2009	2.92	6.02	3.10	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-nr-nr026.htm?OpenDocument
2010	3.26	5.78	2.52	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr030.htm?OpenDocument&yr=2011&mth=02
2011	1.63	5.56	3.93	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr033.htm
2012	2.00	5.06	3.06	http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-tp-tp019.htm?OpenDocument&yr=2012&mth=02
Average 2005-2012	2.71	5.37	2.66	
Average 2008-2012	2.45	5.48	3.03	
(a) CPI increase March to subsequent March (ABS, Cat. No. 6401.0) broadly comparable with premium period. CPI increase 2012 estimated.				
(b) Average increase for each fund weighted by market share. From April 1 of the respective year.				

Various reasons have been suggested for the relatively faster growth in premiums. Biggs concluded:

> *"Premium rises are driven by a combination of factors, the major ones being:*
>
> - *an ageing population that increases utilisation and benefit outlays*
> - *adverse selection, which sees younger, healthier people foregoing health insurance—despite the financial penalty of higher premiums the longer they forego insurance—but not those most likely to need treatment*

- *rising costs associated with advances in medical technology and new innovative treatments, and*

- *unavoidable cost pressures, such as provider costs rising faster than the CPI, prostheses costs and Medicare Benefit Schedule increases not in line with other cost increases.*[4]

Future premium prices

The relatively faster growth in premiums compared to the CPI seems set to continue. Biggs concluded:

> *…. premium increases above the CPI can be expected into the future as a range of factors will continue to drive costs for health services and subsequently the costs to insurers. These drivers include an ageing population, advances in medical technologies and treatments, a greater prevalence of chronic diseases and the impact of economic downturns (which affects insurer investment returns).*
>
> *The ability of health insurers to control their costs is limited by a number of factors. Insurers cannot refuse membership based on health status; although they can delay providing coverage for a defined period of time for some pre-existing illnesses and/or impose benefit limitation periods for certain conditions. Also, health insurers are prevented from charging members different premiums based on their risk of ill health. Those funds with a high proportion of members with chronic illnesses are likely to have relatively high claim costs, although there are some mechanisms in place to equalise risk across funds. Further, because health insurers do not cover all health services, their capacity to significantly improve their members' health status, reduce health care utilisation and, therefore, the number of claims made, is relatively limited. For example, funds are prevented from covering general practitioner services. Although health prevention services are now offered by a majority of health insurers, growth in take-up of these remains relatively flat.*http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/2011-2012/PrivateHealthUpdate -_ftn21 [5]

Equally, the Government recognises the economic and political issues associated with (and partly a consequence of) a regulated health care market.

While insurers must obtain the Minister's approval for increases, that process does no limit premium increases per se.

The *Private Health Insurance Act 2007* requires health insurers to submit details of proposed premium increases to the Commonwealth Minister for Health and Ageing before they can increase premiums on any of their policies. In their submissions,

---

4 A. Biggs, Social Policy Section, Parliamentary Library, *Private health insurance premium increases—an overview and update*, March 2012.

5 A. Biggs, *ibid*.

insurers must provide detailed financial information and cost and benefit projections to justify any increases they seek. An accredited professional actuary must have certified this information.

The proposed increases are examined by the Department of Health and Ageing and by the Private Health Insurance Administration Council (PHIAC). PHIAC is the independent health insurance financial regulator. PHIAC has the power to require insurers to report on their finances and operations and can independently audit insurers' finances.

Health insurers must obtain approval from the Minister before applying a rate increase. If the insurers cannot provide sufficient information to demonstrate to the Minister that an increase would be necessary to meet their obligations to pay benefits to eligible contributors, then there is no change to the premium.

Further, in the 2012 Budget the Government, through the Private Health Insurance Administration Council, announced funding for the Premiums and Competition Unit (PACU) to further investigate premium pricing. PACU was established to provide detailed advice on industry pricing, cost drivers, insurance premiums and competition policy within the private health insurance industry. PACU is intended to enhance PHIAC's capacity to:

- engage with the industry around products, pricing strategies, premium applications, administrative costs and competition issues;
- assist the Government with understanding cost drivers, opportunities for savings under the rebate and competitive pressures; and
- support the interests of consumers by fostering increased competition in the industry and increasing the sophistication of the scrutiny of premium increases.[6]

Cumulative or compounding effect of the CPI indexation policy proposal

The DOHA "Jenny example" referenced above implies that the cost saving to the Government (but cost impost on eligible PHI rebate beneficiaries) would be minimal – some $7.50 per annum. Considered from a single year perspective, that may be a reasonable conclusion.

However, analysis over time shows that the effect is much more substantial. Essentially, the decline in the real value of the rebate is not the $7.50 in each year (which becomes $9 when recent historical data is used) but a much greater amount as time goes on.

---

[6] PHIAC, Premiums and Competition Unit, see http://www.phiac.gov.au/for-industry/premiums-and-competition-unit/

Since the commercial premium will undoubtedly increase at a faster rate than the CPI, holding the rebate to the CPI increase means its real value fall further behind as time goes on.

Extending the DOHA "Jenny example" out just 7 years to 2020, and using recent historical data for the rates of change in commercial premiums and the CPI, shows that by 2020 the real value of the PHI rebate would have fallen by $81— some nine times the initial year effect (Table 5).

In contrast to the initial year reduction in the real cost of PHI (1%), by 2020 the reduction would be around 7%.

Table 5: Real value of PHI Rebate: 2013 to 2020: Indicative example "Jenny"

		2013	2014	2015	2016	2017	2018	2019	2020
Base Premium to which the rebate will apply indexed (2008-12 indicative CPI)	2.45%	$1,000	$1,024	$1,050	$1,075	$1,102	$1,129	$1,156	$1,184
Commercial Premium indexed at (2008-12 increases)	5.48%	$1,000	$1,055	$1,113	$1,174	$1,238	$1,306	$1,377	$1,453
Rebate on base premium (30%)	30%	$300	$307	$315	$323	$330	$339	$347	$355
Rebate that would have applied to commercial premium		$300	$316	$334	$352	$371	$392	$413	$436
Additional cost to consumer: Difference in rebate that would have applied had the policy change not been made		$0	$9	$19	$30	$41	$53	$66	$81
Additional premium cost to consumer (% of (Premium less rebate received))		0%	1%	2%	3%	5%	5%	6%	7%

Fewer PHI policy holders: Second round implications

Previous analysis

A challenge in examining the effect of changes to PHI rebate is understand the basis of the Governments calculations and the likely flow on effects. The Treasury is reported to be undertaking modelling in this general area but that analysis has not been made public to this point.[7]

The Government has in past noted the rebate changes were unlikely to dampen growth in PHI. Further, it has concluded that 99.7% of people would continue with PHI cover (after the means testing came into effect) 'as a result of incentives such as Lifetime Health Cover and the Medicare levy surcharge'.[8]

---

7 The Senate, *Community Affairs Legislation Committee: Estimates*, 31 May 2011, pg 81.

8 Minister for Health and Aging, *Means Testing Won't Hurt Private Health Insurance Industry*

http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-tp-tp007.htm?OpenDocument&yr=2012&mth=01

In contrast, analysis by Deloitte in the context of the means testing policy would have significant effect on the number of policy holders.[9]

Analysis

For present purposes, in the absence of additional information from the Treasury or others, previous AOA analysis has been used as the basis for estimating the second round effects on the demand for osteopaths.

The combined savings to the Government (and corresponding impost on consumers) of the MYEFO proposals rebate indexation limited to the CPI and abolition of the rebate on LHC has been estimated to reach around $591m by 2015-16 ($452m plus $139m). This compares with the estimated savings to the Government of $2.4 billion over three years for its means testing policy for the PHI rebate introduced in July 2012.[10] (That is, about $800m per year.)

On a (cost impact on consumers) proportionate basis, the 2012 MYEFO proposals can be taken to result in about 70% of the effects of means testing policy. Although a simplified approach it is likely a reasonable approach. Certainly is assumes that that the demand response for PHI is the same for increases in the real cost of PHI as it does for means testing. In the absence of empirical analysis on the issue there is little alternative but to make that assumption.

Impact on demand for Osteopath services and osteopaths

Services by Osteopaths make up about 1% of all General Treatment services undertaken under PHI. A reduction in demand for PHI can be expected to lead to a corresponding decline in General treatment and Osteopathy services and in turn the demand for osteopaths. .

Analysis of the reduction in demand for osteopathy services and osteopaths as a result of the PHI Means test policies and the MYEFO proposed policies, compared to otherwise (ie continuing growth in osteopathy services under PHI) suggests that:

- the combined effects of the means test policies and the MYEFO policies is estimated to result in a 60 per cent reduction in demand for osteopath services (and thus osteopaths) by 2016
- the demand for osteopaths could fall by around 460 by 2016 (Table 6) – or by about 25% of current osteopath numbers (1,761) or 20% of projected numbers in 2016 (2,250).

---

[9] Deloitte, *Australian Health Insurance Association: Economic Impact Assessment of the Proposed Reforms to Private Health Insurance*, Final Report 28 April 2011

[10] Minister for Health and Aging, *Means Testing Won't Hurt Private Health Insurance Industry, op cit.*

Key parameter estimates are as follows.

- Demand for Osteopathy treatments under private health insurance is projected to continue to grow at about the historical rate (2007 to 2012) of 2.2% per quarter (9% per annum), without either the Means Test policy change or the proposed MYEFO policy changes.
- Reduction in demand for all private health insurance services forecast to fall with the introduction of means testing, based on Deloitte analysis. Demand for osteopath treatments forecast to fall by the same percentage, year on year.
- Demand for all private health insurance services forecast to fall further with the introduction of the MYEFO policies. MYEFO policy estimated to lead to a fall in osteopath services demand of 70% of the means test policy. That is, 70% of the fall in demand with the means test policies.
- Reduced demand for osteopathic services otherwise covered by private health insurance, does not result in a corresponding increase in demand for osteopathic services not covered by private health insurance.
- An osteopath estimated to provide around 1400 treatments per annum.

Table 6: PHI policy changes: Estimated impact on demand for Osteopaths

		2012	2013	2014	2015	2016
Annual growth in osteopath treatments under PHI	9%					
Demand for osteoptah treatments (no policy change)		749,670	817,140	890,683	970,844	1,058,220
Reduction in demand due to means testing		-5%	-15%	-24%	-31%	-36%
Reduction in demand due to MYEFO policy proposals		-3%	-11%	-17%	-22%	-25%
Estimated demand fall for osteopath treatments						
With means testing policy		36,567	126,506	213,448	298,544	379,274
With MYEFO policies	70%	25,597	88,554	149,414	208,981	265,492
With means testing and MYEFO policies		62,164	215,060	362,862	507,525	644,766
Change in demand (%)		-8%	-26%	-41%	-52%	-61%
Estimated demand for oestepaths						
Treatments per osteopath (per annum)	1,400					
Estimated number of osteopaths required: No policy change		535	584	636	693	756
Reduction in number of osteopaths with means testing		26	90	152	213	271
Reduction in number of osteopaths with MYEFO policies		18	63	107	149	190
Reduction in number of ostoepaths required with means testing policy and MYEFO proposals		44	154	259	363	461