
COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# SENATE

## ECONOMICS LEGISLATION COMMITTEE

**Reference: Fairer Private Health Insurance Incentives Bill 2009**

(Private Briefing)

TUESDAY, 9 JUNE 2009

CANBERRA

BY AUTHORITY OF THE SENATE

**SENATE ECONOMICS**

**LEGISLATION COMMITTEE**

**Tuesday, 9 June 2009**

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

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

**Senators in attendance:** Senators Cameron, Hurley, Pratt and Siewert

**Terms of reference for the inquiry:**

To inquire into and report on:

The Fairer Private Health Insurance Incentives Bill 2009, the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge — Fringe Benefits) Bill 2009

## WITNESSES

**Committee met at 8.45 am**

**CHAIR (Senator Hurley)**—The secretary received an email at 12.09 this morning from a senator who is not a member of this committee, advising that coalition senators would not be participating in this committee meeting this morning. We have allowed 15 minutes and they are still not available, so we presume they are not participating. I have not yet heard from any of the coalition senators on the committee. I have spoken to Senator Xenophon, who said he had other commitments this morning and is unable to participate. That means this committee is inquorate and we are not able to continue with a meeting this morning. Senator Xenophon said he would be available after lunch by teleconference and then we will have a quorum.

I advise the committee and the witnesses that the meeting on the private health insurance incentives bills will not be able to continue in a quorate manner this morning. I apologise to all the witnesses who came along today that that is the case. We were not aware that this was going to occur. I regret that people have made the effort to come and are not able to be heard. We ask that departmental officials remain for a private briefing for the committee. We will, hopefully, continue with our meeting at 1 pm. In the private briefing, of course, we will not have the benefit of parliamentary privilege. I ask officials to be aware of that.

[8.47 am]

**COLES, Mr Tony, Manager, Individuals Tax Unit, Treasury**

**MONTEFIORE GARDNER, Mr Rob, Manager, Health Policy Unit, Treasury**

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

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

**CHAIR**—Welcome. Do you have any opening remarks that you would like to make?

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

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

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

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

The singles threshold will be indexed according to movements in the average weekly ordinary times earnings. The families' thresholds will double the singles threshold. In addition, family

thresholds will be adjusted for families with more than one child, in the same manner as existing arrangements for Medicare levy surcharge—that is, increased by $1,500 for each child after the first. These reforms will reduce the proportion of the rebate being provided to higher income earners.

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

We at the Treasury estimate that means testing of the rebate will impact on around the top 23 per cent of private insured population, measured at single equivalent units by income level. It is estimated that around nine per cent of all single equivalent units fall into the first income tier, around 70 per cent in the second income tier and a further seven per cent in the top tier. People aged 65 or more make up around 12 per cent of privately insured single income equivalent units. But the proportion in that age group and impacted by the measure accounts for less than two per cent of the total.

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

**CHAIR**—If you could table that statement so we can get copies to the committee members that would be useful.

**Mr O'Connor**—Certainly, though I may have added a word or two to the *Hansard*.

**CHAIR**—In terms of the impetus for this policy, it provides budget savings as well as, as you said, a rebalancing of the private health system.

**Mr O'Connor**—That is correct. The budget savings by these bills are—

**Mr Coles**—Around $1.9 billion over five years. That is on page 311 of Budget Paper 2.

**CHAIR**—So the savings come from not paying the surcharge and the increase in the Medicare levy—sorry, from not paying the rebate, plus the surcharge.

**Mr Coles**—That is correct.

**CHAIR**—What proportion?

**Mr Coles**—The increase in revenue is around about $145 million between 2011-12 and 2012-13 and the rest, the $1.8 billion, comes from the savings in expenditure through not paying the rebate.

**Senator SIEWERT**—The surcharge is $145 million for the two years 2011-12 and 2012-13?

**Mr Coles**—That is correct.

**Senator SIEWERT**—Regarding the savings that you mentioned, the $1.9 billion over five years, what is the surcharge component of that?

**Mr Robinson**—The total savings over the five-year period are the same as the savings in that final two years relating to the Medicare levy surcharge. The measures come into effect from 1 July 2010 and, because the Medicare levy surcharge is collected in arrears at the end of the tax year, the first income that is actually received from the higher Medicare levy surcharge is not collected until 2011-12 and 2012-13, being the two years that we actually collect revenue. The impact from means testing of the rebate obviously takes effect from 1 July 2010.

**Senator SIEWERT**—Thank you.

**CHAIR**—To go back to the plus-65s, I think you said that they constituted 12 per cent, Mr O'Connor.

**Mr O'Connor**—Yes, that is right. Around 12 per cent are privately insured single equivalent units.

**CHAIR**—Then you said those who would be affected by this legislation make up less than two per cent of the total?

**Mr Robinson**—That is correct. It is a bit less than two per cent of the total population with private hospital insurance.

**CHAIR**—Do you have the percentage of the plus-65s who will be affected?

**Mr Robinson**—I do not have that calculation but it would be easy enough to calculate. I could take that on notice and get back to you.

**CHAIR**—Thank you.

**Senator SIEWERT**—Percentages are nice, but could you tell us how many people that two per cent is?

**Mr Robinson**—Again, I do not have the actual number with me, but I could take that on notice and get back to you with the figure.

**Senator SIEWERT**—That would be appreciated. Thank you.

**Senator CAMERON**—At the last hearing we had on the Medicare levy surcharge, the modelling from the insurance association and Treasury was certainly out a fair bit. The closest we got to anyone indicating that there was not going to be such a significant impact was Professor John Deeble. Do you have any comment about what went wrong last time?

**Mr Robinson**—Sorry, what do you mean by 'what went wrong last time'?

**Senator CAMERON**—In terms of the projections.

**Mr Robinson**—An important part of trying to estimate the impacts of the policy is trying to predict what individuals will do as a result of the policy. Trying to predict individual behaviour is inherently difficult. There are a lot of factors that weigh into people's decisions to keep private health insurance policy, change or potentially to drop their private health insurance policy. We use a variety of sources of information in order to inform the estimates that we undertake, as I am sure others who are trying to estimate the impact of the policy also do. Basically, at the end of the day, there is very little information which gives us hard and fast rules on how people respond to these policies. The main information we relied on in estimating these impacts was from academic literature which estimated a price elasticity of about -0.3. For example, for every one per cent increase in the price of insurance you would expect about a 0.3 drop in the overall membership. That estimate is on the basis of observed behaviour in the past from policies.

Ultimately, people take other factors into account in whether they choose to retain their private health insurance or to drop it. There are things like peace of mind in knowing that they have that private health insurance cover and the additional benefits they get from being able to choose their own doctor. Those sorts of things obviously factor in. Certainly, in relation to the 2008 Medicare levy surcharge measure, we have seen negligible impacts on overall private health insurance membership. In fact, we saw small increases in the overall population of people with private health insurance in both the December and March quarters of the official figures that were released by the Private Health Insurance Advisory Council.

**Senator CAMERON**—I think Professor Deeble spoke about how you take a whole range of issues in before you can properly assess the effects. One of those was the 'incentives' that are there to direct people into private health. He spoke about a number of personal decisions such as whether you favour private health against public health or whether you just were in a health fund and would not make an attempt to come out. There were about five or six different pressure points that he raised. Has Treasury had a look at Professor Deeble's evidence from last time?

**Mr Robinson**—Yes, we have. That was the sort of information that we also took into account this time in undertaking our modelling in relation to this measure. As I said, there are a variety of factors that influence people's decision to retain private health insurance. One of the main factors that we also see is that there is certainly evidence that income effects tend to dominate any impact on price sensitivity. Generally, at higher levels of income people are less sensitive to price changes.

**Senator CAMERON**—Have you had to apply behavioural economics to some extent?

**Mr Robinson**—I guess that is a way to describe it. Behavioural economics looks at a variety of information and makes some judgments as to how people respond as a result of change in price signal.

**Senator CAMERON**—Have you had a chance to look at any of the other submissions that were made by, say, the health industry association who were wildly pessimistic about the situation. Has any analysis been done about these doom-and-gloom scenarios that were being put forward?

**Mr Robinson**—It is difficult to comment directly on some of these other reports, particularly without knowing the in-depth detail of how they arrived at their estimates; although I would say that the Australian Health Insurance Association had some quite high estimates of the number of people they expected to drop their private health insurance compared with the estimates that we had come up with at the time. I think that people take into account various sources of information and may attribute different weight to different factors. But, as I said earlier—

**Senator CAMERON**—You are being polite, aren't you?

**Mr Robinson**—As I said, Senator, it is difficult to comment directly on those estimates without knowing the detail of how those estimates were derived, and I do not have my notes from those submissions in front of me.

**Mr O'Connor**—The government, in the Treasurer's joint press release with Minister Roxon, did raise the issue of why this circumstance is somewhat different from the experience we had last year. These measures have, as referred to by the Treasurer in his press release, a carrot-and-stick approach to them as well. Through the increase in the Medicare levy surcharge, it provides a greater incentive to maintain coverage of private health insurance, because the movement in particularly the tier-3 levels to a 1.5 per cent surcharge has a greater impact on behaviour—and the reduction in the offset for the private health insurance rebate—so there is a balancing there so it is slightly difficult to make comparisons with the modelling last year and the modelling that has been conducted for these measures.

**Senator CAMERON**—The argument from those who opposed the Medicare levy surcharge last time was not simply around people who will drop out. There were the secondary fears that there would be higher premiums. Have you any comments on that?

**Mr Robinson**—Under the Charter of Budget Honesty—at least in the modelling that we do for the budget—we do not take into account second-round impacts, particularly when there is uncertainty in relation to the first round. I think that some of the modelling that had been undertaken by some of the other groups who made submissions in relation to last year's budget measure had estimated second-round impacts—for example, the second-round impact on potential increases in premiums as a result of people dropping their private health insurance and changing the risk pool and also in relation to public hospital utilisation and increased utilisation of public hospitals. The key difficulty, of course, is that if it is difficult to estimate the first-round impacts with any level of certainty, that introduces a much higher level of uncertainty in relation to the second round.

As we have seen to date, where we have estimated a reasonable number of people will drop their private health insurance, that has not actually come to fruition. So any estimates of the second round in that situation would only exacerbate the level of error that is inherent in the modelling.

**CHAIR**—I want to change the topic a bit. I understand that spending on the current private health insurance rebate is growing rapidly and is expected to double as a proportion of health expenditure within the next 40 years. Why is it expected to double? Is that because of a growing proportion of older people or because there is a growing proportion of people taking out private health insurance? Or is that something I should perhaps ask Health and Ageing?

**Mr Montefiore Gardner**—Those projections are based on the methodologies that we use in the *IGR*, the *Intergenerational report*. The way that we model private health insurance in the *IGR* is to look at the benefits paid out by age groups. So there is an effect in there of the ageing of the population. Obviously the benefits paid to people who are privately insured do vary with age and tend to get larger as people age. So there is an ageing impact in there. There is also just the effect of increasing costs in health.

**CHAIR**—But that would not affect the rebate.

**Mr Montefiore Gardner**—It affects rebate expenditure because, as health treatment becomes more expensive, the benefits paid out by the insurer become more expensive. The premiums charged by the insurers become more expensive and, as a result, the rebate increases. So it is based on historical data.

**CHAIR**—So you expect private health insurance premiums to increase steadily over the next 40 years?

**Mr Montefiore Gardner**—That is what the historical data is telling us, yes.

**Senator SIEWERT**—Could we go back to the numbers that you expect to drop out. Could you tell us what you are expecting them to be?

**Mr Robinson**—About 91 per cent of people with private hospital insurance also have ancillary cover. We have taken into account some literature which estimates the price elasticity of demand for private health insurance. That literature indicates, as I mentioned before, an elasticity of about -0.3—that is across the population—with private health insurance. These measures will impact on about the top 23 per cent of people with private hospital insurance. As I mentioned before, people at the higher income levels are less sensitive to price. We have discounted that price elasticity that we have assumed in the modelling and used an elasticity of -0.2. On that basis, we have estimated that about 25,000 people, including dependants, would drop their hospital and ancillary cover. The Department of Health and Ageing, in consultation with us, have undertaken some estimates as well of the number of people who will drop a component of their cover. They have estimated that about a further 10,000 people, again including dependants, will drop the ancillary component of their cover and hence retain the hospital component to avoid paying the Medicare levy surcharge. Health, again in consultation with us, have also undertaken an estimate of people with ancillary only cover. There are currently about 1.4 million people who have ancillary only insurance, which of course also

attracts the private health insurance rebate. The estimate is that about 5,000 people might drop their cover as a result of the means testing.

The one thing I will say in relation to the last estimate is that we do not have information on the distribution of people with ancillary only cover by income level. We would expect that the majority of people with ancillary only cover would actually be underneath the current Medicare levy surcharge thresholds. If someone is going to engage with the private health system and take out insurance and if their income is above the Medicare levy surcharge threshold, it seems counter intuitive for them to take out ancillary insurance but not hospital insurance and be subject to the Medicare levy surcharge. So, while we do not have any hard and fast data on it we would anticipate that the vast majority of that 1.4 million would actually be under Medicare levy surcharge thresholds. So that 5,000 is probably an upper estimate for that group.

**Senator SIEWERT**—Let us go to the threshold of $75,000 for singles: have you done any work on what are the lower bounds of price elasticity? In other words, the higher your income the less sensitive you are likely to be. How many people are in each of those groups?

**Mr Robinson**—In terms of trying to estimate the price elasticity at different levels of income, we have basically just done one estimate for people above the Medicare levy surcharge threshold—above $75,000. The way the changes are structured is such that people in the first tier will have a reduction of 10 percentage points in their rebate and not suffer any higher Medicare levy surcharge should they not have the complying health insurance. People in the second tier have a 20 per cent reduction in their private health insurance rebate and there is a 30 per cent reduction in the top tier. In the second tier there is a quarter of a percentage point increase in the Medicare levy surcharge and one-half a percentage point increase in the third tier. Basically, what is happening is that as the rebate is being withdrawn in the second and third tiers we have commensurate increases in the surcharge. Basically, we are seeing that the overall increases are roughly commensurate in the second and third tiers. So for people under 65 in the second tier we have a 29 per cent increase in out-of-pocket costs. So effectively they go from paying 70c in the dollar currently to 90c in the dollar. That 29 per cent in out-of-pocket costs is roughly met by a commensurate increase in the Medicare levy surcharge—it is about a 25 per cent increase. In the top tier the increase in the surcharge is actually a larger proportion of the out-of-pocket costs for the loss of the rebate. So there is about a 43 per cent increase in out-of-pocket costs from the rebate, going from effectively paying 70c in the dollar to 100c in the dollar yet there is a 50 per cent increase in the Medicare levy surcharge.

So, basically, within the top two tiers we have assumed that in broad terms the number of people in insurance will stay roughly the same. Of course, there is quite likely to be some churn, in that some people may opt to drop their private health insurance, but we are assuming that that is broadly going to be offset by people who are currently paying the Medicare levy surcharge, and we estimate there are about 130,000 people who would be paying the surcharge in 2010-11. So we are assuming that the people dropping out of private health insurance will be rightfully offset by the number of people that come in. The estimates of people dropping their insurance that we have come up with that I mentioned before, the 25,000, are actually from the first tier.

**Senator SIEWERT**—Okay. They are people in the first tier, and you are assuming a status quo, essentially, for the upper two tiers.

**Mr Robinson**—That is right, yes.

**Senator SIEWERT**—I want to pick up on the last point that you made. You said there are about 130,000 people who currently do not have private health insurance who are now going to be picked up with the increase in the surcharge.

**Mr Robinson**—That is right. So, altogether—

**Senator SIEWERT**—I should declare an interest: I am one of them!

**Mr Robinson**—We estimate about 310,000 people in 2010-11 would be above the Medicare levy surcharge thresholds, and about 130,000 of those would be in the income ranges that would put them in the second and third tiers.

**Senator SIEWERT**—Sorry; the 310,000—what is that figure?

**Mr Robinson**—Three hundred and ten thousand people would be above the $75,000 and $150,000 Medicare levy surcharge thresholds, and about 130,000 of those 310,000 are in the top two tiers—so they would have incomes over $90,000 for singles and $180,000 for couples.

**Senator SIEWERT**—I see. Yes.

**Mr Robinson**—So that leaves about 180,000 people who would be in that first tier and would continue to face the one per cent Medicare levy surcharge.

**Senator SIEWERT**—Just the one per cent, yes. Have you looked at the impact of people dropping private health insurance as a result of the global financial crisis?

**Mr Robinson**—No. I guess, as part of estimating the impact of the budget measure, we try to isolate the impact of the means testing of the rebate itself. Obviously, other factors may come into play, and economic circumstances may be one of those factors.

**Senator SIEWERT**—Yes. I expect the private health insurance will be here telling us that they are copping a double whammy—this and the global financial crisis—so I was just wondering if you had done any modelling or projections around that.

**Mr Robinson**—No, Senator.

**Senator SIEWERT**—Okay. Thanks.

**CHAIR**—Any other questions? No. Thank you to Treasury and the ATO for coming in this morning and helping us.

**Mr Robinson**—Sorry, Senator. If I could just make one small correction to something I said earlier.

**CHAIR**—Certainly.

**Mr Robinson**—I think I may have mentioned that about 91 per cent of people with private hospital insurance had ancillary cover as well; I have just been corrected on that. The estimate is actually that 99 per cent of people with private hospital insurance also have ancillary cover. Thank you. Sorry.

**CHAIR**—Right. Thank you.

[9.28 am]

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

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

**CHAIR**—Welcome. I remind you again that we do not have a quorum this morning and therefore we are not covered by parliamentary privilege. Do you have an opening statement?

**Ms Calder**—Yes, I do, Senator, and I apologise for being somewhat late. Senators, the government is rebalancing the suite of policies supporting private health insurance so that those with greater capacity to pay for their own private health insurance do so. Consistent with the government's commitment to maintaining the balance between public and private health systems high-income earners will receive less in government payments for their private health insurance but will face an increase in costs should they opt out of their hospital cover.

Across the tax and payment system the largest benefits are provided to those on lower incomes, except for private health insurance. These changes are consistent with the principle underpinning the tax and transfer systems that the greater support should be provided to those on lower incomes. Following the changes, the government estimates that more than 99 per cent of people who currently have private health insurance will retain that insurance. The most effective component of the existing incentive structure, Lifetime Health Cover, will remain in place. This increases the premiums for hospital cover for people who do not take out insurance until later in life by two per cent for each year they are aged over 30. The government is also increasing the Medicare levy surcharge for higher income earners. For many above average and higher income earners it will be more expensive to drop their health insurance and to keep it even with the lower or nil government rebate. Further, the additional costs to higher income earners with private health insurance as a result of the rebate changes would be more than offset by tax cuts in July 2009 and July 2010.

The government does not anticipate that there will be an impact on private health insurance premiums. As it is expected that more than 99 per cent of people with private health insurance hospital cover will retain their insurance, there would be very little increase in premiums due to people dropping their insurance. Any drop in membership levels would also lead to a drop in claims against the insurer. Similarly, the government does not anticipate significant additional administrative costs to insurers. Australian private health insurers are well managed, with low management expense ratios compared with other types of insurance, and this will continue to be the case. The changes proposed in the Fairer Private Health Insurance Incentives Bill 2009 will ensure that government financial support for private health insurance is more equitably distributed with minimal impact on the industry.

**CHAIR**—You said that this should have no impact on private health insurance premiums despite the estimate that 25,000 people would no longer continue in private health insurance as a result of these changes. I think the basis of that was if there was a drop in membership they

would have a drop in payouts as well, but of course that cannot be continued ad infinitum because you get down to a situation where you have few members but your fixed costs rise. One of the main claims by private health insurance companies as a result of the previous changes was: if that started a drop in membership that would spiral down and they would have fewer people joining over their lifetime, except when people got older then they would join. You do not see that as an issue here?

**Ms Calder**—The modelling indicates that we should anticipate something in the order of 25,000 people dropping their hospital insurance and up to 40,000 modifying their insurance.

**CHAIR**—Do you mean modifying their insurance by taking out cheaper cover?

**Ms Calder**—Yes.

**CHAIR**—That 25,000 would result in 8,000 additional public hospital admissions over two years?

**Ms Calder**—Again, that is modelled on evidence to date.

**CHAIR**—Roughly one-third of those people who drop out will access public—

**Ms Calder**—Survey data that we have indicates that one-third of people with health insurance present to hospital in a two-year period. That is the basis of that.

**Senator PRATT**—What proportion of those present at a private hospital versus a public hospital?

**Ms Shakespeare**—The Ipsos data on which those numbers are based did not distinguish between people with or without hospital insurance. The information from the healthcare and insurance survey 2007 just said that 35 per cent of people were likely to need hospital treatment over a two-year period. Applying that statistic to the dropout rate, you come up with an estimate of potentially 8,000 people who previously had private health insurance but dropped their hospital insurance and, without hospital insurance, would need to go to a public hospital.

**Senator PRATT**—But as I understand it there are significant numbers of people who have private health insurance who still attend at a public hospital because of the gaps or the availability in an emergency situation. What figures do you have that enable us to make that distinction?

**Ms Shakespeare**—We do not have any figures on that at the moment. Every person who is eligible for Medicare is entitled to be treated as a public patient at a public hospital. Hospitals do not collect information on whether the people are insured necessarily when they present for treatment at a public hospital.

**Senator PRATT**—To my mind, it goes to the heart of the issue as to the extent to which middle and low income earners who cannot necessarily afford to use their private health insurance have historically cross-subsidised higher income earners who are quite comfortable in paying the gap. Perhaps under the bill before us some of those issues can start to be addressed,

because that cross-subsidisation is reduced, but from the reports that I have heard from state governments et cetera they perceive that there is a bit of an issue with that. I am not saying that people should not front up at their public hospital—I fully support them in their right to do that, because sometimes the gaps are considerable—but I do think that we need to avoid assuming that because people have private health insurance they are using it.

**Ms Calder**—The modelling suggests that, if all of the 8,000 were to use public hospital access, that would amount to 0.1 per cent of the usual hospital workload over the two-year period.

**Senator PRATT**—Yes, but the question is not the people who are dropping out; it is the people with private health insurance who use a public hospital anyway. That is okay.

**Senator SIEWERT**—The point is that you do not know how many of the 0.1 per cent would have been going to a public hospital anyway, so it could actually be even less than the 0.1 per cent. Is that not a correct assumption?

**Ms Calder**—That is correct.

**CHAIR**—In any case, is there not additional spending on hospitals that would allow them to cope with a small extra increase in numbers?

**Ms Calder**—Yes, the figures I have in front of me are that, with the additional Commonwealth funding through the COAG and national partnership strategies, we have funded an additional 175,000 emergency department presentations and 185,000 public hospital admissions.

**Ms Shakespeare**—That is over the two-year period to which the 8,000 figure applies.

**CHAIR**—I suppose another strand of the argument against this is from private hospitals, who say that the work that they do is essential to the health system as a whole, that they support the public hospital system by taking other cases out of the public hospitals and that anything that puts their continued viability in jeopardy is a problem for the entire health system. Can you comment on that?

**Ms Calder**—There is no expectation that this measure affects the viability of health funds. Indeed, as I said in the opening statement, with the interaction of the Medicare levy surcharge and this measure we expect that there will be very little change.

**CHAIR**—Thank you for coming in. This private briefing of the Senate economics committee is adjourned until 1 pm, when we have the Australian Health Insurance Association and, hopefully, will be quorate. Thank you, everyone.

**Committee adjourned at 9.38 am**