Chapter 5

Interpreting the bill's effects

5.1 The previous chapter presented estimates of the possible impact of the bill on membership of private health funds, subsequent premium increases and the consequent cost to public hospitals as a result of the proposed increase in the Medicare Levy Surcharge (MLS) thresholds. This chapter examines the committee's evidence as to how the various stakeholders in this debate interpret these impacts and the broader merit of the bill. Ultimately, these opinions are based on an assessment as to whether there is an optimal mix of private and public health insurance which the government should be targeting or whether this should be determined in a free market.

5.2 Chapter 3 noted that the debate on this bill has generally split across several lines: the federal government proposing the amendments; the private health funds and health organisations in opposition to the bill; and several academics who support the bill on efficiency and equity grounds. This chapter examines these views across a range of issues:

- the need to preserve 'balance' between the public and private health sectors;
- the price and income elasticity of private health insurance premiums;
- the efficiency of the private health funds and the merit of their subsidies;
- the question of whether to index the MLS thresholds; and
- the interests of the Australian taxpayer.

Upsetting the public–private balance, or simply shifting demand?

5.3 A recurring argument put to the committee by the private health insurance industry is that the bill upsets the delicate balance in the Australian health system between public and private health provision. The crux of this argument is the claim that without a strong private health insurance industry, the provision of private health services will falter and lead to a flood of demand into the public system which it would be unable to meet.

5.4 In this context, the private health insurance industry argued that the MLS, the 30 per cent private health insurance rebate and Lifetime Health Cover are the three crucial pillars which maintain the unique system of community rating, and take pressure off the public hospital system. The Australian Medical Association (AMA) argued in their submission that:

> As one of the three critical support mechanisms for private health insurance participation, the Medicare Levy Surcharge contributes to the public/private balance, and therefore the efficiency of the health system. Adjusting that balance, by excessive increases in the income thresholds for the Medicare Levy Surcharge, risks a return to declining participation in private health

> insurance, fuelled by increasing premiums. In turn, the public hospital sector will experience increased demand down the track.[1]

5.5 A similar argument was put by Dr Michael Armitage, Chief Executive Officer of the Australian Health Insurance Association:

> The AHIA opposes the legislation because it will do much to harm the very delicate and fine balance within our health system which ensures that Australia has a strong private health sector to complement Medicare, our universal public health system…Over the last decade we have seen significant pressure taken off our public system. Since 1997 when the Medicare levy surcharge was introduced, the number of procedures performed in the private hospital system has trebled when compared with those performed in the public system.[2]

5.6 Mr John Brogden, Chief Executive Officer of Manchester Unity, told the committee that the current system has the public–private balance 'about right'. He noted that the current suite of policies supporting PHI is needed to support the principle of community rating, and that the assistance comes with stringent regulations on the funds.[3] Mr Brogden cautioned that:

> …any tweaking at the edges puts the whole system at risk. We run the risk of running back to the spiral we saw particularly in the 1980s where the number of people taking out private health insurance went through the floor.[4]

5.7 Asked at what point (in terms of the population covered) the private health insurance system becomes unsustainable, Mr Brogden replied:

> I do not know what the crisis point is—I am not an expert in this sense—but if we got below 30 or 25 per cent coverage it would be almost unaffordable for anybody, and people would self-insure and walk away. As a consequence, there would be no private health insurance system, which means you would put a massive burden on the remaining public health system.[5]

5.8 The committee doubts whether the balance between the public and private health systems is as 'delicate' as the private health insurance industry insists. Several witnesses questioned whether any diminution of existing government support for

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1 Australian Medical Association, *Submission 5*, pp. 2–3.

2 The Hon. Dr Michael Armitage, *Proof Committee Hansard*, 31 July 2008, p. 2.

3 Mr John Brogden, Chief Executive Officer, Manchester Unity, *Proof Committee Hansard*, 31 July 2008, p. 25.

4 Mr John Brogden, Chief Executive Officer, Manchester Unity, *Proof Committee Hansard*, 31 July 2008, p. 24.

5 Mr John Brogden, Chief Executive Officer, Manchester Unity, *Proof Committee Hansard*, 31 July 2008, p. 26.

private health insurance will upset the broader balance of the health system. One of the reasons is that many people who have private health insurance do not use the private hospital system. The other is that people who fall out of private health insurance do not then place immediate strain on the public hospital system.

5.9 Both these arguments were given in evidence by Professor Elizabeth Savage of the University of Technology Sydney. She told the committee that her research indicated that people who joined a private health fund in response to the financial incentives introduced since 1997 'do not use the private system to anywhere near the same extent as those who joined not motivated by the financial incentives'.[6] She argued that the greater use of private hospital beds since 1997 should not be attributed to the suite of policies encouraging PHI. Rather, the trend of higher private hospital use was present well before 1997 and the influence of these policies on higher private hospital usage was 'minor'.[7] Similarly, the impact of any fallout from the private funds on the public hospital system will not be absolute. As Professor Savage argued:

> It has long been recognised that a person who drops their private health insurance cover does not suddenly join a waiting list for public hospital treatment, especially in the case…of where the people who are most likely to drop it are the young and healthy, those who do not in fact use the hospital system very much. Much of their use of insurance is to do with ancillary cover and is not to do with hospitals.[8]

In Professor Savage's opinion, there is no evidence to conclude that the MLS threshold changes will threaten the ongoing viability of the private health insurance market.[9]

5.10 The committee heard that the proposed changes to the MLS thresholds would help *correct* current imbalances and distortions in Australia's health care system. Professor Christian Gericke of the University of Adelaide told the committee that the bill might 'lead to a change in resource allocation from the private sector to the public sector'. He argued that the current incentives for PHI are serving to siphon money and medical professionals to the private hospital system.[10] Professor Gericke told the committee that the current set of policies encouraging PHI is:

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6 Professor Elizabeth Savage, Centre for Health Economics Research and Evaluation, University of Technology Sydney, *Proof Committee Hansard*, 31 July 2008, p. 47.

7 Professor Elizabeth Savage, Centre for Health Economics Research and Evaluation, University of Technology Sydney, *Proof Committee Hansard*, 31 July 2008, p. 47.

8 Professor Elizabeth Savage, Centre for Health Economics Research and Evaluation, University of Technology Sydney, *Proof Committee Hansard*, 31 July 2008, p. 45.

9 Professor Elizabeth Savage, Centre for Health Economics Research and Evaluation, University of Technology Sydney, *Proof Committee Hansard*, 31 July 2008, p. 45.

10 Professor Christian Gericke, Director of the Centre for Health Services Research at the University of Adelaide, *Proof Committee Hansard*, 22 July 2008, p. 17.

> …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.[11]

5.11 Mr Ian McAuley of the University of Canberra similarly argued that the previous government's initiatives to encourage PHI had moved both patients *and* medical resources to the private hospitals. The incentives did not achieve their claimed benefit of relieving pressure on the public hospitals because more people, with private coverage, used private hospitals and thereby took resources from the public system. Mr McAuley suggested that the bill—and other measures changing the source of hospital funding—will have 'no immediate effect' on the level of resources devoted to providing health care. If demand does shift to public hospitals, skilled medical staff will 'probably move from the private to the public hospitals'.[12]

5.12 Indeed, far from jeopardising the entire balance of the Australian health system, Mr McAuley foresaw little change in the public–private mix of services as a result of the higher MLS thresholds. He argued that high income individuals are generally healthy people of working age with little need of hospitalisation. And if they do need hospitalisation, 'it is likely to result from an illness or accident emergency, with priority access to public hospitals'.[13]

5.13 Neither Professor Gericke nor Mr McAuley opposed the private sector providing medical services. Their objection, rather, is with the idea that there can be no private health *provision* without private health fund *insurance*. Mr McAuley railed against the idea that private hospitals need to 'tie their fortunes' to private insurers.[14] He emphasised that private hospitals can be paid for by governments or by from direct patient payments (see below). Professor Gericke emphasised his objection to 'political discussion' about health systems which (wrongly) equates private financing with private provision. He noted that some countries successfully operate a health system based on private care provision with public financing.[15]

Committee view

5.14 The committee's view is that even if the measures in this bill do result in a drop in private health fund membership, it does not follow that there will be direct and absolute strain on the public hospital system. For example, those leaving the funds

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11 Professor Christian Gericke, Director of the Centre for Health Services Research at the University of Adelaide, *Proof Committee Hansard*, 22 July 2008, p. 18.

12 Mr Ian McAuley, *Submission 10*, p. 4.

13 Mr Ian McAuley, *Submission 10*, p. 4.

14 Mr Ian McAuley, *Submission 10*, p. 4.

15 Professor Christian Gericke, Director of the Centre for Health Services Research at the University of Adelaide, *Proof Committee Hansard*, 22 July 2008, p. 19.

will not suddenly need treatment in a public hospital, particularly if—as is widely expected—these people are young and healthy.

Price sensitivity of private health insurance

5.15 The extent to which people will leave the private health funds if the thresholds are raised depends on how they value PHI and whether they can afford higher premiums. Chapter 4 noted Professor Deeble's observation that private health insurance is more sensitive to income than price. In other words, those on high incomes are more likely to have, and to retain their cover if premiums rise than those on low incomes. And when incomes rise and fall, a person is much more likely to join or leave a fund than if income is fixed and premium levels change.

5.16 The data supports this. A much higher percentage of the wealthy have private health insurance than those on lower incomes.[16] In the Australian experience, premiums have increased by about two per cent more than the general inflation rate in all but one of the last eleven years, but fund membership levels have increased (see Table 2.2).[17] Conversely, the 30 per cent reduction in the price of private health insurance when the rebate was introduced had a 'negligible' impact on the level of cover.[18]

5.17 On the understanding that private health insurance is price insensitive, Professor Deeble anticipated little impact from a $70 a year increase in the family premium.[19] This raises a broader point: the higher the level at which the surcharge is set, the more likely that those earning above the threshold will have PHI and if not, the more likely they are to be self insured.

The funds' efficiency and their need for taxpayer support

5.18 Part of the committee's brief for this inquiry was to assess the ongoing viability of private health insurance if the MLS thresholds are raised. To this end, the committee also received evidence on the current competitiveness of the funds. Unsurprisingly, the evidence from peak private health insurance organisations and the funds themselves was that they currently operate very efficiently. Their administration costs are low—by international comparison—at around 10 per cent.[20] In NIB's case, they lowered administration costs after demutualisation.[21]

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16 Professor Leonie Segal, *Proof Committee Hansard*, 22 July 2008, p. 16.

17 Professor John Deeble, *Submission 3*, p. 9.

18 Associate Professor Elizabeth Savage, *Proof Committee Hansard*, 31 July, p. 45.

19 Professor John Deeble, *Proof Committee Hansard*, 12 August 2008, p. 11 and pp. 13–14.

20 See Mr Robert Bransby, *Proof Committee Hansard*, 15 July 2008, p. 25; Mr Graeme Gibson, *Proof Committee Hansard*, 15 July 2008, p. 32; Mr Byron Gregory, *Proof Committee Hansard*, 22 July 2008, p. 3; Professor John Deeble, *Proof Committee Hansard*, 12 August 2008, p. 17.

21 Mr Mark Fitzgibbon, *Proof Committee Hansard*, 31 July 2008, p. 12.

5.19 The committee was also told that in their negotiations with the private hospitals, the health insurers successfully negotiate lower prices for their members. Dr Michael Armitage of AHIA expanded on this point:

> One of the most surprising things that I have seen in my time in this job…was a letter someone wrote to the editor of the *Canberra Times*. They wrote: 'I had X'…'and it cost me $5,000. Why did my neighbour, who had private health insurance, who had exactly the same operation sometime before, get it for $3,500?'…The administrator of the hospital wrote back, and said, 'That's because the private health insurance system is able to screw us down. They're very good negotiators.'[22]

5.20 Not everyone is so convinced. Professor Savage told the committee that she envisaged a 'far bigger role' for private health insurance with the funds making contracts with the private system in the interests of consumers. She argued that in the past:

> …the insurers have just been passive agents in the healthcare system: they take people's premiums and they pay out. They do some contracting with the private sector but they do not do it in a way which generates efficiency—that is, lower costs for the same level of health care. So I would like to see more action in the private sector but I would like to see more motivation for strategic action in the interests of efficiency in the system.[23]

5.21 Any claim that the funds operate efficiently must also acknowledge the substantial public assistance they currently receive. The committee received evidence questioning whether the funds are deserving of this support. Professor John Deeble argued that funding should have been provided to the private hospitals themselves, rather than the funds:

> …in a perfect world I would have subsidised or paid the providers—that is, the hospitals and the doctors—and allowed people to cover the rest through whatever arrangements they wanted to make…I probably would not have subsidised the insurers. I still have some difficulty in subsidising the insurers' administrative costs and surpluses when all but one of them are now large profit-making businesses. They must be among the few companies in Australia that get a direct subsidy of that kind.[24]

5.22 Mr McAuley offered a solution:

> …it would be useful if the government can come to understand the true nature of the PHI industry, as a part of the financial services sector rather than as part of the health care sector. Any subsidies for PHI, so long as they last, should come through the Treasury portfolio, for Treasury has

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22 *Proof Committee Hansard,* 31 July 2008, p. 9.

23 Professor Elizabeth Savage, Centre for Health Economics Research and Evaluation, University of Technology Sydney, *Proof Committee Hansard,* 31 July 2008, p. 50.

24 Professor John Deeble, *Proof Committee Hansard,* 12 August 2008, p. 15.

> regulatory responsibility for the financial services sector. In that way the government's health care budget can be devoted to health care, rather than being diverted to assistance for the financial sector.[25]

5.23 More broadly, he argued that the idea of a competitive private health insurance market is a misnomer—more private insurers will not produce more market competition. Rather, while it is in the funds' collective interests to sell policies on the basis of 'need', the result is an overuse of 'free' health services (the 'moral hazard' problem). Accordingly, Mr McAuley argued that the funds should be 'weaned off' public subsidies, and if they cannot exist on their own, they should be phased out. In this context, he described the bill's measures as a 'useful first step, but…far too timid'.[26]

The issue of indexation

5.24 When the MLS was introduced in 1997, it was targeted at high income earners. The then Treasurer, the Hon. Peter Costello, told the House in August 1996:

> …higher income earners who can afford to take out private health insurance will also be encouraged to do so…This is the levy which the Government hopes no-one will pay. It is entirely optional. Those who take out health insurance (with the benefits attached) will be exempt.[27]

5.25 Clearly, the $50 000 threshold for singles and $100 000 threshold for couples currently catches many people earning below average yearly earnings ($58 600). It also catches many people over the average wage level who could not be described as 'higher income earners'. This bill redresses this situation. It is squarely targeted at providing tax relief to those in the $50 000 to $100 000 income brackets who may not choose not to take out private health insurance.

5.26 As noted in chapter 2, the basis for setting the singles threshold at $100 000 is to restore the proportion of single taxpayers liable for the MLS to a level comparable to when the surcharge was introduced. In 1997, this proportion was eight per cent of taxpayers. If this bill is passed, it will restore the level to roughly nine per cent by 2012. Treasury told the committee that:

> In the absence of any changes to the threshold, we estimate that in 2008-09 about 36 per cent of single taxpayers would exceed the threshold and that would go up to 45 per cent of single taxpayers by 2011-12.[28]

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25 Mr Ian McAuley, *Submission 10*, p. 6.

26 Mr Ian McAuley, *Submission 10*, p. 6.

27 The Hon. Peter Costello, Appropriation Bill (No. 1) 1996–97, *Second Reading Speech*, 20 August 1996.

28 Mr Marty Robinson, *Proof Committee Hansard*, 31 July 2008, p. 21.

5.27 The committee's concern is that the bill does not propose any basis for adjusting the thresholds after 2012. Several submitters argued that the MLS thresholds should be indexed to either inflation or earnings. The committee believes that the impact of a substantial rise in income threshold levels can result in difficult adjustments for the private health insurers.

5.28 Mr John Small, the director of a health advisory company, proposed that the MLS thresholds be indexed to either inflation or average weekly earnings. He suggested that while the threshold of $150 000 for couples is 'fair', 'the single threshold should not exceed $75 000'.[29]

5.29 The Health Insurance Restricted Membership Association of Australia argued that the thresholds should be set at $75 000 for singles and $125 000 for couples.[30]

5.30 Mr Michael Roff, Chief Executive Officer of the Australian Private Hospitals Association, told the committee:

> …we are told the reason the thresholds are being changed is to make up for the lack of indexation of the original thresholds. If this is the real policy intent it is absolutely nonsensical that the proposals contain no measures for ongoing indexation. Therefore, we are in danger of the same arguments being run and similar excessive adjustments being made a few years down the track.[31]
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> …I think Michael Lee was the shadow minister at the time this legislation was brought in and actually proposed an indexation formula, which we have applied. I think it came out at around $75,000 or $76,000. That was using a wage index; it is probably a bit lower if you use CPI, but it is of that order, whatever index you want to use.[32]

The 1:2 ratio

5.31 Mr Small noted that if the thresholds are increased to $100 000 for singles and $150 000 for couples, there would be a clear incentive for high-earning couples to 'appear to be single'. For example, if both people had yearly earnings of $99 000, both would avoid the MLS. If they are registered as a couple, with a combined income of $198 000, they are liable for the surcharge.[33]

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29 John Small Health Advisory, *Submission 17*, p. 3.

30 Health Insurance Restricted Membership Association of Australia, *Submission 13*, p. 3.

31 *Proof Committee Hansard*, 31 July 2008, p. 58

32 *Proof Committee Hansard*, 31 July 2008, p. 63. See also, Australian Private Hospitals Association, *Submission 4*, pp 2 and 5.

33 John Small Health Advisory, *Submission 17*, p. 3. This argument was also made by the Australian Health Insurance Intermediaries Association, *Submission 6*, p. 3.

5.32 Mr Terry Barnes of *1805 Consulting* noted that had the couples threshold been indexed to AWEs since 1997, it would be similar to the level proposed in the bill ($150 000). The proposed singles threshold, however, is significantly higher than the AWE-indexed figure. Mr Barnes recommended that the government could:

> …simply adopt the Treasury AWE figures and index them annually…More practically, the Government could keep the 1:2 nexus between singles and couples thresholds, but align the singles threshold with the step of the personal income tax scale currently closest to the AWE figure. Currently, this income step is $80,000, which would make the linked couples threshold $160,000.[34]

5.33 The '1:2 ratio' claims to overcome the problem of couples dodging their MLS liability (as a couple) by claiming to be singles. There are still some avoidance issues with this ratio, however. Using the $75 000–$150 000 thresholds, two singles earning $50 000 per annum and (between $75 000 and) $99 000 per annum could avoid one having to pay the MLS if they were recognised by the Tax Office as a couple. It is unclear whether taxpayers would go to these lengths to avoid paying the surcharge and this may indeed occur under the existing thresholds as well.

The taxpayer's interest

5.34 An inquiry such as this tends to attract a large number of vested institutional interests with the time, resources and experience to make their case to the committee. These organisations obviously play an important role in shaping the policy debate, but they can also sideline the voice of ordinary taxpayers. Taxpayers' interests are important to this debate. It is their money that pays for Medicare (partly through the levy and the MLS), the 30 per cent private health insurance rebate, public hospitals and private hospitals. Ultimately, support for both the public and private health insurance systems rests on the opinions and preferences of ordinary taxpayers.

5.35 The committee received only two submissions from citizens with no particular expertise in the area of health insurance. One of these was from Mr Michael Cribbin of Bracken Ridge in Queensland. He offered the following insights:

> I've been writing to the previous administration over the last 11 years since the current level of threshold was introduced but to no avail. So I am particularly pleased to at last see a change proposed. My thoughts about the change cover various grounds including equity. The current thresholds were set in 1997 and the then $50 000 income level for singles and $100 000 for couples should have been increased to $75 000 at least, and $150 000 for couples…The new thresholds should be indexed as most others are to avoid getting out of whack in the future and penalising working families. Even more radical the tax could be abolished and people left free to choose whether they wish to insure or not as they do with other items.

34 Mr Terry Barnes, *Submission 19*, p. 16.

> I've also noticed a false argument that says as I am uninsured I will use the public system. That is incorrect and in fact I self insure and cover my hospital costs myself, so recent eye operations for my wife and a back operation for me were undertaken in private and not public hospital facilities and fully paid for by me.
>
> It is equally false to claim that if people join health insurance schemes they will use private hospitals. Many do not and many insured still use public hospitals.
>
> The other area I would canvas is value for money and suggest that a considerable variation in health fund numbers, via mergers and amalgamations would reduce administration costs and hopefully the premiums which currently seem to rise year on year regardless of the number of members.
>
> So I implore you to pass the Bill through the Senate and give me and my wife some relief from this iniquitous tax impost.[35]

5.36 The committee concurs wholeheartedly with Mr Cribbin's comments. It may well be that if the bill is passed, many other taxpayers like Mr Cribbin will self insure and continue to use the private hospital system.[36] Increasing the MLS thresholds, as the bill proposes, will give taxpayers more choice:

- to remain in a fund for the benefits that that may provide;
- to remain in a fund at a low level of cover (and low premiums) to avoid any Lifetime Health Cover loading and, when needed, be covered as a public patient;
- to leave a fund, benefit from not paying the MLS and, when needed, be covered as a public patient; or
- to leave a fund and, in the absence of any MLS liability, self insure to pay direct for private hospital treatment and avoid public hospital waiting lists.

Committee view

5.37 In the committee's opinion, the overriding consideration is the danger of forcing an ever larger number of low-income people to pay the MLS or to buy low value fund policies for which they have little use. On this basis, the committee strongly supports the bill.

Recommendation 1

5.38 The committee recommends that the bill is passed.

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35 Mr Michael Cribbin, *Submission 22*.

36 Although not stated explicitly, it seems that Mr Cribbin is not in a fund, and incurs the MLS while also self insuring.

Senator Annette Hurley
Chair