Coalition Senators' dissenting report

Introduction

Coalition Senators oppose the Government's proposal to increase the Medicare Levy Surcharge (MLS) thresholds.

At a time when the number of people in private health insurance has never been higher, the Government's proposal to increase MLS thresholds from $50,000 to $100,000 for singles, and from $100,000 to $150,000 for couples and families risks undoing a decade of careful policies that rescued private health from a catastrophic downward membership spiral.

This could ultimately threaten the on-going viability of the entire health system, and in particular could jeopardise Australia's unique system of "Community Rating", under which there is no risk assessment for the provision of health insurance.

By the late 1990s private health insurance membership had collapsed to around 30 per cent of the Australian population; in the June 2008 quarter it was 44.7 per cent. What became clear during this inquiry and the Senate Estimates process was that the Rudd Government has not properly thought through the flow-on implications of this measure.

The Government's assessment was limited to the direct (first round) impact on its revenue and expenditure. Based on the evidence received by the Committee, the Government clearly did not require, neither Treasury nor the Department of Health and Ageing to conduct a proper assessment of the overall impact of this measure on the Australian health system. The consequences for the private health sector – not just private health insurance but the providers they fund – and the public hospital system that will have to deal with the needs of people who leave private health, were completely ignored.

If this measure passes, there is a clear and imminent danger that the gains made over the past decade in securing a better balance in the Australian health system could be wiped away as a result of this measure. Even on the most conservative estimates, health fund membership would plummet and premiums would rise well over the trends of recent years – driving more people out of private health and starting the downward spiral left behind in the 1990s.

What has also been overlooked by the Government is the impact of these measures on private health providers, particularly private hospitals. Fewer privately-insured people mean fewer private hospital episodes; fewer episodes mean the return on private hospital investment is threatened.

There was also universal agreement that this measure would result in additional demand for public hospital services. Those witnesses who had conducted or

commissioned their own modelling or analysis made it clear that they expected significant levels of additional pressure on our public hospitals.

Of greatest concern to Coalition Senators was the clear and compelling evidence presented to the inquiry that working families, low- and fixed-income earners, the elderly and people living in rural and regional Australia would be hardest hit by the consequences which flow from this ill-conceived policy. Community rating, the concept that everyone pays the same premium for their policy irrespective of age, gender and state of health, depends on the good health risk members cross subsidising poorer risk members. If good-risk members leave private health in large numbers, this will push up premiums for those left behind, including many older members on low incomes who struggle to pay for their cover.

If premiums are too high, people will leave on grounds of cost, including many members with poorer health. Those people will have to rely on the public system to meet their needs.

The Government, and the Committee in its majority report, has tried to create an image that the proposal is only opposed by private health funds and private hospital operators seeking to protect their own interests.

The reality is that it is the most vulnerable in our community who will suffer from longer waiting times for surgery. As was outlined very eloquently by Ms Anna Perfect from National Seniors Australia, it will be older Australians on fixed incomes who will be most affected by premium increases caused by this measure:

> "…if premiums were to increase it would have an adverse effect on people on low incomes, pensioners and self-funded retirees on fixed incomes. I think that is an unintended consequence. It also could force them to drop their private health insurance and could place increased pressure on the public hospital system, which would have an adverse effect on a whole range of people." [1]

Coalition Senators believe that the Government has also gravely under-estimated the ongoing impact of the measure, seeking to hide behind an unjustifiable belief that the change would only have a one-off effect on private health membership levels. This error has been compounded by the Government's refusal to ask Treasury to model the second round effects of this measure.

The savings suggested by the Government appear to be illusory at best. The $300 million in supposed savings were exposed as illusive, with the Department of Health and Ageing revealing that the Government had hidden the cost of additional premium increases caused by this measure in its unpublished 'contingency reserve'.[2]

Certainly, there will be a massive cost shift from the Commonwealth and the privately insured to the States through additional demand on public hospitals.

To date there has been no offer of compensation for this additional cost and there are grave doubts whether the public hospital system would be able to cope, even with additional financial resources.

As the Western Australian Minister for Health, Mr Jim McGinty stated;

> The real problem I think for our state hospitals is one of capacity. So even if compensation is paid, will we be able find the extra operating theatres, the surgeons, the anaesthetists, the nurses, the beds in the state hospital system to be able to accommodate a significant increase in the number of people wanting elective surgery?[3]

This measure should be strongly opposed.

Background

In health, the public policy challenge for any government is to ensure timely and affordable access to quality health care for all Australians.

As a nation, we seek to achieve this through a mixed health system with both public and private components. The Australian health system works best when it is well balanced between a strong well funded public system and a strong private system.

By 1996 the system was out of balance. Private health insurance membership was in free fall, with increasing queues at public hospitals while many private hospitals were operating below capacity. Australians choosing to keep their private cover were increasingly from an older demographic making private health insurance rapidly more and more expensive for everyone. Australians could time their private health insurance membership around key lifetime events such as child birth, moving in and out of private cover as required, rather than making a lifetime commitment.

Only after the introduction of a series of policy measures, including the Medicare Levy Surcharge, the 30% Rebate and Lifetime Health Cover was the previous Coalition Government able to turn that trend around and bring our health system back into balance.

Yet, as pointed out by Mr David Kalisch, Deputy Secretary of the Department of Health and Ageing, in his evidence to the Committee, the Medicare Levy Surcharge when it was first introduced in 1997 was not all that successful:

> … the Medicare levy surcharge was the first of the sweep of government policy measures to be introduced, around 1997. Surprisingly, that fairly significant change—of actually introducing the measure, which was pegged at $50,000 for singles and $100,000 for couples at that time — made a relatively small impact on PHI policyholders. It made a very small impact on the participation rate at that time in 1997, when that was the first and only measure that was introduced at that stage. [4]

The obvious reason for that was that as a new measure introduced in 1997 it was pitched too high to be immediately effective, covering only 8% of the population.

Only after the Private Health Insurance Rebate and Lifetime Health Cover were also introduced did private health coverage start to increase again.

What followed was a sharp increase in the number of Australians with private health cover with membership peaking at 45% in March 2001, before slowly starting to slide down again to 42.9% in June 2004.

What happened then is particularly relevant to this inquiry.

Between June 2004 and September 2006 private hospital membership hovered at around 43%. Then, since June 2006 membership has started to increase again.

In that period nearly 700,000 Australians took out private hospital insurance, nearly 400,000 of those in the twelve months to June 2008.

The reason for that is obvious, after a slow start when it was introduced the Medicare Levy Surcharge at its current threshold levels was becoming increasingly effective at achieving the objective that it was introduced to achieve – getting those who can reasonably afford it to take out private health insurance.

With increasing income levels, and more and more Australians aware of the tax implications of not taking out private hospital cover, more and more Australians are choosing to take additional responsibility for their own health care needs.

PHIAC data indicates that particularly younger people have been taking up private health insurance over the past two years. Encouraging young people who can afford to make a long term commitment to private health is good for the overall viability of the health system. The more young people who join private health the more affordable it is for everyone. The more people can afford to take out private health insurance the more private hospitals can help relieve the pressure on public hospital waiting lists.

The Government has deceptively tried to argue the industry is over-reacting because it is leaving the Medicare Surcharge Levy in place, albeit with higher thresholds, and leaving the 30% rebate and Lifetime Health Cover untouched.

But as Stuart Rodger from the Institute of Actuaries of Australia told the Committee:

> There are three pillars of government support—the tax rebate, the Medicare levy surcharge and the Lifetime Health Cover regime—and, a bit like a three-legged stool, if you suddenly shorten one of those legs, the person sitting on it is likely to fall off if they are not properly protected.[5]

This view was also supported by key industry figures such as Mr Mark Fitzgibbon, Chief Executive Officer of NIB Health Funds Ltd, who told the Committee:

> I do not think the MLS is the greatest piece of public policy you will ever come across, but it stands together with some other policy initiatives as a mechanism for encouraging greater contribution to our healthcare costs through a tax, as it were. If you remove that incentive—make no mistake—people will leave.[6]

Confusing health reform with tax reform

In attempting to justify this measure, the Government has mounted a political argument that it is a 'tax relief measure' with the Treasurer, Health Minister and Commonwealth officials all repeating the same line that this would simply remove a tax trap caused by the fact the thresholds had not been indexed after inflation.

A range of submissions pointed out the fatal flaws in this logic:

The measure seeks to double the original threshold for singles ($100,000), not increase it to a level reflecting movements in either the CPI ($67,000) or Average Weekly Earnings ($76,000);

The measure does not include a mechanism for on-going indexation of the new threshold level into the future.

Mr Kerry Gallagher, Chief Executive Officer, Australian Medical Association (Queensland) summed up the commonly-held view among witnesses:

> What we are saying is that you cannot confuse tax relief with health care. If your primary aim is to secure savings and, at some other position, provide tax relief to those who are considered to be no longer earning what is considered to be a reasonable income, that has got to be a consideration of finance and taxation. Do not confuse it with health.[7]

Mr Michael Roff, Chief Executive Officer of the Australian Private Hospitals Association, confirmed that such confusion in policy making could result in the Government hurting more people than its helps:

> The government is entitled to do whatever it wants to do, but the point that we make is that an adjustment of this level, whether or not it is justified on any basis, is a large shock to the system that will have adverse impacts that may leave people worse off than the benefit that the government is trying to deliver.[8]

The Government's faux concern for taxpayers is perhaps best revealed by its own Budget papers, which reveal the Commonwealth expects to save $300 million from this policy measure ($660 million in lost revenue from the surcharge more than covered by $960 million in savings from not having to pay the 30% rebate). As will be noted later, there is a significant question mark over the Government's ability to achieve these savings.

The Government has also raised the phoney argument that the fairness of the measure was reflected in the fact that under the new threshold, 9 per cent of single taxpayers will be liable for the surcharge (by 2011/12), comparable to the 8 per cent of single taxpayers captured by the original measure in 1997. [9]

As previously pointed out, the Medicare Levy Surcharge threshold was pitched too high to be immediately effective when it was first introduced in 1997. Furthermore, the Government is not proposing to index the threshold for singles introduced in 1997,

but rather proposes to double it. Finally, as numerous witnesses pointed out, the overall tax regime has changed dramatically since 1997, making such a comparison meaningless.

This response was best summed up by Mr Terry Barnes who told the Committee:

> When you look at that broader picture, there is the change to GST, the change in personal tax scales, the changes to family tax benefit A and B, and you could also include the Medicare safety net as part of the equation on the health side. The world is different. All I am suggesting is that, just as you have to look at the pillars of private health holistically, you have to look at the family tax situation or the family income situation holistically.[10]

Mr Barnes also told the Committee that the Howard Government has considered the level of the MLS thresholds, but had decided that the risks for private health membership and premiums were much greater than any benefits.[11]

No consultation before or after the election

A major flaw in the Government's new-found concern for those caught in this alleged 'tax-trap' is that this policy was not announced prior to the 2007 election.

It beggars belief that a political party wishing to give taxpayers a break would not publicly promote such a move to its own political advantage.

It is apparent that this move was actually dug up, as one witness put it, from a Finance or Treasury bottom drawer when the newly elected government had to find another 'saving' to cover its significant increases in spending.

Prior to the election, the then Opposition Leader, Mr Rudd, and his shadow minister gave repeated assurances to the private health industry that the Medicare Surcharge Levy would be 'maintained'.

Four days before the election, Mr Rudd wrote to the Australian Health Insurance Association stating;

> Federal Labor will also maintain Lifetime Health Cover and the Medicare Levy Surcharge.

This deception was maintained in government with Mr Roff telling the Committee;

> We had a meeting with Minister Roxon in late December and specifically asked about the Medicare levy surcharge, given that it was something that had been flagged as under review. The response we had was that they were certainly not going to be doing anything to it in the immediate future.

In February 2008, Senator Jan McLucas, representing the Minister for Health, told an Additional Estimates hearing that no change to the Medicare Levy Surcharge was being considered by Government[12]. That evidence was never corrected by the Government, even though the Department of Health and Ageing told Senate Estimates

in June that advice to Government on this had been provided as early as January 2008[13].

The consequences of the failure of the Government to consult with the industry about this change are reflected in the evidence heard by the Committee, which confirms the Government gave no consideration to and had no understanding of the long-term impact of this measure on the health system.

Coalition Senators hold grave concerns that resorting to deception will become the modus operandi of this Government. Already the Committee has heard Commonwealth officials repeatedly refuse to deny whether they have provided or have been asked to provide advice to the Government about the future of the 30% rebate and Lifetime Health Cover.

In light of the Government's deception over the Medicare Levy Surcharge, Australians can have no confidence in any of the Government's assurances of its commitment to the Private Health Insurance Rebate or Lifetime Health Cover.

Treasury Modelling

Treasury modelling was very restricted. It was only focused on the direct 'first round' effect on the Commonwealth Budget bottom line. Treasury assessed how much the measure would cost in terms of lost revenue (an estimated $660 million) and how much it would save (an estimated $959.7 million). The Government did not cost, model or in any way assess the impact on public hospitals, on the future cost of private health insurance, or on health insurance membership levels after premiums increased as a result of this measure.

The only reason Treasury modelled the impact on private health insurance membership was to estimate the saving from not having to pay the private health insurance rebate to those leaving private health.

What we now know of the Treasury's modelling gives us no confidence that the Government has adequately assessed and understood the flow-on effects of this measure. Indeed, the Treasury's modelling was ill-informed and under-researched.

Not having costed the impact on public hospitals itself, it is astounding that in the spirit of the Rudd Government's supposed commitment to Co-operative Federalism in health, they did not ask Treasury to make its modelling available to State and Territory Governments. This would have at least ensured that the States and Territories had the best available information in front of them to conduct their assessments about the impact of this measure on public hospitals.

The Committee was told again and again that the lack of access to Treasury's modelling made it impossible to reliably determine the validity of the Government's claims about the flow-on impact of this change.

The Treasurer originally let people believe that according to Treasury modelling, 485,000 people would drop out of private health cover. Despite industry assessments suggesting the figure could be almost double that, the Government persisted with this original estimate, which was reported in the media for weeks.

Indeed, it was only under questioning in Senate Estimates that Treasury conceded that the figure did not take into account dependent children of policy-holders. A further review by Treasury has since revised the figure up to 644,000 people[14].

Surprisingly, the Government has not made any adjustment to any of its other estimates despite this significant blow-out – because all the Government was interested in was the 'first round effect' on the budget bottom line. This is notwithstanding the fact that much of the savings from the 30 per cent rebate depend on premiums staying at an assumed level that has never been disclosed.

Treasury has steadfastly refused to hand its figures over to the industry, independent modelling organisations or even State government officials.

The reluctance to share this information with the States reveals the Commonwealth's concern that the States will be able to gain a more accurate assessment of the financial costs their public hospitals will incur.

> **Senator CORMANN**—And, of course, you do not have access to the federal government's modelling, so an important piece of the jigsaw is missing, is it not?
>
> **Dr Robyn Lawrence (Acting Director General, WA Department of Health)**—Absolutely—if the federal government's modelling now suggests a much higher figure of people and there is a demographic breakdown that would help to refine our analysis further. But at this time it is very difficult to say. We really do not know what impact changing one variable will have.

It also makes a mockery of the Prime Minister's pre-election rhetoric of 'ending the blame game' in health through 'Co-operative Federalism'. Even worse, it is apparent that none of the States have commissioned their own economic modelling of the impact of this measure on their public hospital systems.

At the Committee's hearings in Perth, two months after the Federal Budget, WA Health officials gave their presentation with a 'very preliminary analysis' based on the original, discredited forecasts of the Commonwealth Treasury. In Brisbane, Queensland Health officials withdrew from their planned appearance on the day of the hearing.

Despite their rhetoric in the media, none of the other State or Territory Governments fronted the inquiry to answer questions about the impact of this measure on public hospitals. This political 'conspiracy of silence' across State and Federal Labor Governments should be of serious concern when it comes to the good governance of Australia's health system.

Coalition Senators call on the Government to release the Treasury modelling to the Senate in time for the debate on this measure.

Modelling of 'Second Round Effects'

The Committee has effectively been told that the Government has been "flying blind" on the impact of its measure on a range of issues such as;

- the increased demand on public hospitals;
- the associated cost of this increased demand;
- the impact on health insurance premiums; and
- the second-round drop-out of members caused by such premium increases.

This has resulted from the Government's refusal to require Treasury to undertake economic modelling of the "second round effects" of this measure.

Treasury, and the Government, have hidden behind the Charter of Budget Honesty which does not require modelling of "second round effects".

However, the Charter of Budget Honesty does not prevent the Government from commissioning such modelling.

Nor does it prevent comprehensive modelling of effects that in fact have direct flow-ons to other areas of Commonwealth expenditure, particularly the implications for the Commonwealth's payments to the States for public hospital treatment of public patients. These compensation payments alone could wipe out the supposed projected savings from the 30 per cent rebate.

It is beyond belief that a government seeking to make such a significant policy change to a measure which has helped to under-pin the viability of the health system would do so, without fully understanding the ramifications of that change.

This is not only poor policy it is a poor policy process.

The Government has simply chosen to assess the short-term revenue and savings impact on its own Budget.

In doing so it has deemed that the future viability of Australia's health system and the people who rely on it are a secondary consideration.

Evidence of second round effects

Mr Peter Jennings, Chief Executive Officer of the AMA,WA, told the committee;

> The system is clearly stressed and it can ill afford to have additional capacity put upon it. Clearly, the federal government's decision was undertaken with no consultation with the states, insurers, private hospitals, or the profession. It cannot be repeated; we have to get things right for the future. As I understand it, it was not an election policy and there was

> seemingly little credible short-term or long-term analysis of the effect before the decision was made. It does not seem to have been made within any overall framework in relation to the level of commitment to a public-private mix, and it is still lacking. Where are we going? Investing in the public system and investing in the private system require certainty and understanding. We have had stability to facilitate that.[15]

On August 22, health insurance advisory group iSelect, released an independent report by respected economic modellers, Access Economics. The report found that there would be 1.15 million Australians who would drop out or decline to take-up private health cover.

Consistent with the evidence heard by the Committee, Access Economics estimated a huge surge of demand for public hospital services – and additional 846,965 episodes of care over four years at a cost of almost $3 billion to the States and Territories.

This would come as no surprise to those who had followed the Committee's proceedings.

In spite of all of this, the Government is clinging to its own unsupported assertion that there will only be a one-off drop in private health insurance numbers before a return to a situation where 200,000 new members join each year.

This flies in the face of all the evidence presented to the Committee.

As Mr Roff (Australian Private Hospitals Association) stated[16]:

> **Mr Roff**—We have also been advised by the Treasurer's office that the modelling anticipates a one-off impact in terms of a reduction in health insurance coverage and then growth in membership returning to some historical average. Suffice it to say we believe such an assumption is heroic.
> ....
>
> **Senator CORMANN**—Are you actually saying that this could be worse than what we experienced between 1983 and 1996? In those 13 years it was a gradual decrease, which bottomed out at 30 per cent. What you are saying now is that this is quite an unprecedented, one-off shock that could actually lead to a muchfaster or worse downward spiral?
>
> **Mr Roff**—Absolutely. I think the one-off shock that we are talking about and the estimates that we have heard of premium increases of five per cent—and that is five per cent over and above what would normally happen, so you are looking at a premium increase of over 10 per cent a year—are going to cause a lot of other people to consider how much the cost of health insurance is. I do not think you are going to get a one-off drop and then a return to the current growth rates, as Treasury is estimating.

This view was supported by the evidence of, among others, Mr Graeme Gibson, Chief Executive of the Health Insurance Fund of WA[17]:

> I take the view that if what is proposed in fact occurs, I am contemplating there will be two waves of change. The first wave will be the immediate

> exit of probably the younger demographic within our database and at a later stage, as we health funds impose increased prices notwithstanding that we are holding all other components fixed, we would then expect that the older demographic will succumb to price and they will represent the second wave of exits out of the health fund. The problem with that from our view is that it is the second wave that will be the major problem in that the second wave of exit will take with them the high acuity claiming patterns into the public system.

The Committee heard consistent evidence that the drop-out rate would place pressure on premiums and there would have to be increases over-and-above the normal annual rate rise.

Specific Impacts

Low and Fixed Income Earners

The effect of this on low- and fixed-income earners, particularly the elderly and pensioners, would be devastating, as evidenced by Ms Anna Perfect, Senior Policy Officer of National Seniors Australia:

> Our members are concerned that whatever the exact departure rate it will have an adverse effect on private health insurance premiums. As you may be aware, National Seniors has for some time been raising concerns with respect to cost of living pressures on older Australians, particularly those on low fixed incomes such as aged pensioners and self-funded retirees, who are struggling with price increases in gas, rates, electricity, water, food and petrol.
>
> We feel these individuals can ill afford to meet the expected premium increases beyond the usual yearly increases. A number of commentators have also raised the issue that, if individuals drop their private health insurance as a result of these proposed changes, it will be older Australians on fixed incomes who will be most affected.[18]

Older Australians

Ms Perfect also summed up the impact this would have on the health choices of older Australians:

> Anecdotally, we have the issue raised a lot that a lot of our members have private health insurance to give them the choice to have surgery such as hip and knee replacements when they need to, without having to wait extended periods. We feel that, if the premiums increased and older Australians were forced to drop their private health insurance, they would seek treatment in the public hospital system and that would lead to lengthy delays. We also think that having to wait would have an adverse effect on their independence and mobility, and they would not be able to carry out important roles in the community such as caring and volunteering. It would also reduce their contribution to the community in terms of economic and social outcomes.[19]

The impact of this measure on older Australians is deemed a secondary consideration by the Government.

Robert Seljak, Chief Executive Officer of the Queensland Teachers Union Health Fund, told the Committee that the prospect of higher premiums as a result of this measure was a major concern for many people struggling to maintain their private health cover;

> Realistically, they are not destitute but they are not millionaires either. They are ordinary people who choose to pay for the options that the private health care system can provide them and they are comforted by the fact that the public health system is there for emergencies and to treat people who may be less fortunate than they are. This member will be worried that the proposed changes to the levy could impact on her health insurance. Why is that? She has read reports in the media that a lot of people could leave private health insurance, making it more expensive for those that stay.[20]

A number of additional, significant concerns relating to the secondary impacts of this measure emerged during the Committee's hearings.

As previously noted, the Commonwealth had done no modelling on the likely additional demand on public hospitals. It flows from this that the Government has no idea how this measure will impact on public and private hospitals in rural and regional Australia.

Rural and Regional Impacts

Australians living in rural, regional or remote locations already face significant disadvantages and difficulties in accessing the range of mainstream health services that urban Australians take for granted.

This measure will reduce the level of choice for rural and regional Australians, particularly where public services are cross-subsidised by private services.

As Mr Martin Laverty, Chief Executive Officer of Catholic Health Australia, told the Committee[21]:

> Almost every Catholic public hospital around Australia—all 21 of them—to a certain extent is subsidised by the operation of other activities. If you think of the St Vincent's Hospital group here in Sydney or in Melbourne, it is true to say that the public hospitals in both Sydney and Melbourne are subsidised to a certain degree by the operations of other healthcare activities of the Catholic Church.

Any decline in activity in our private hospitals has an immediate flow-on effect to the operation of our public hospitals, particularly where they are co-located on the same campus. This impact is even more greatly felt in rural and regional areas where our Catholic hospitals are operating at stretched conditions at the current time.

This view was supported by Dr Shane Kelly, Chief Executive Officer of the St John of God Hospital in Perth[22]:

> This will have a dramatic impact on our hospital group, which includes a number of regional hospitals. It will put pressure on our ability to provide social outreach and advocacy services and force cuts in our equipment replacement and facility capital upgrade program. Ultimately it will impact on the provision of services and affect the number of staff we employ.
>
> Indeed, as has already been alluded to by Mr Jennings of the AMA, if the effect on private health insurance coverage is ultimately as substantial as some groups have identified, we see ourselves revisiting the circumstances that private hospitals faced a decade ago; that is, insufficient operating margins to be able toreplace obsolete capital and equipment, and in some cases a lack of viability to continue operating. Threats to viability are particularly worrying in relation to our regional hospitals, such as Geraldton and Warrnambool—which already struggle to remain viable.

It is apparent that the health care of rural and regional Australians is a secondary consideration for the Government.

Future Capital Investment

As alluded to by Dr Kelly, the future of private capital investment in the health system has also been thrown into doubt by this measure.

Private health funds require a degree of certainty in relation to their incoming membership revenue if they are to make sound, long term investments in both new capital and equipment.

The Committee heard that there had been more than $4 billion of private capital investment in the Australian health system in the past decade.

There is no question that this investment has helped take the pressure off the public system. Therefore, anything that threatens the continued growth of this investment is a danger to the continued strength of the Australian health system.

As Mr Roff (Australian Private Hospitals Association) warned[23]:

> It should be noted that revenue derived by private hospitals from health insurance not only pays for services; it also underpins capital investment, which totalled $4.2 billion in the last decade, as well as education, training, research and quality initiatives. Therefore the ongoing reduction in health fund membership resulting from these changes has the potential to stymie investment in health sector capacity which in turn will reduce our ability to deal with the increasing health service demands of an ageing population.

The Government's actions in introducing this measure have led many to question the future of private investment in the health system, as evidenced by the comments of Mr Jennings (AMA,WA)[24]:

> As John Deeble illustrated earlier, 750,000 people will leave and premiums will increase by an extra five per cent. This all creates a lot of uncertainty for future public sector planning and private sector investment and uncertainties about what the government's policy paradigm really is for the public-private mix in the future.
>
> The federal government states that it supports private health insurance, but its actions without consultation or consideration of the implications of or impact on all private insurers and future have reignited debate.
>
> *"Is this the first cut and is it an endeavour towards redefining the public-private mix?"*

The Government has given no consideration to the negative impact this measure will have on private capital investment to meet our future health needs.

Coalition Senators call on the Government to commission the Treasury to undertake comprehensive modelling of the second round effects of this policy measure and provide it to the Senate before this legislation is debated.

Another heroic assumption: Only Younger Members will leave

The Government has assumed, as evidenced by it public statements and by the views expressed to the Committee by its officials, that the exodus of members from the private health funds will be dominated by younger members.

This argument then allows the Government to set-up a flimsy defence that the change will not see significant additional demand move to the public hospital system as these young members are less likely to use hospital services.

This, of course, appears to confirm the health funds' argument that funds will lose younger members who, because they don't use services, effectively subsidise older members who do, thereby forcing up premiums to cover the cost of an increasingly ageing membership base.

This contradiction seems to be lost on the Government.

Some witnesses, such as Dr Michael Armitage, Chief Executive Officer of the Australian Health Insurance Association argued that the Government's assumption was wrong[25]:

> We can demonstrate that the belief that it is the young and healthy who will be leaving private health insurance is unfounded. Based on research our association conducted in August last year, we expect that eight out of 10 of those Australians who will exit their private cover as a result of this legislation will be aged over 30.
>
> In other words, 80 per cent of people who are likely to drop private insurance will be over 30. In other words, palpably, demonstrably, not the young and healthy.

> So there will be a dramatic effect on the public system. Importantly, such an outcome will result insignificant premium increases of up to 10 per cent in addition to the ordinary premium increases each year due to rising health inflation and ageing. It follows that this expected extraordinary increase in premiums will lead to a further decline in private health membership in the out years and further premium increases, as funds need to cover the loss of premiums because of the need to be capitally adequate.
>
> This is likely to recreate a downward spiral, as was seen in the 1980s and early 1990s. Today private health insurance provides almost 11 million Australians with choice and peace of mind. The AHIA contends that this legislation is bad public policy which places that security at risk.

The majority view, however, appeared to be that young people would make up a large proportion of the first wave of drop-outs.

While the Government may take some heart from this, those same witnesses all confirmed the view that there would be a second and third wave of drop-outs, starting a new downward spiral, which would predominantly be older Australians, particularly pensioners and those on fixed incomes, who could no longer afford increasing premiums.

This is the crux of the failure of the Government's argument: young people dropping out will force funds to charge higher premiums; older Australians, who use hospital services more frequently, will then be forced out and sent toward the public hospital system.

Threat to the Community Rating System

Significant and consistent concerns were expressed throughout the Committee's hearings that this would also strike at the heart of the principle of "Community Rating" which has been the cornerstone of ensuring fairness and equity in private health care costs for all Australians, regardless of their age or physical condition.

Community Rating has also ensured Australia does not go down the path of nations such as the United States, where private health cover, while being a necessity, is beyond the financial reach of many who need it the most.

Mr John Small, Managing Director of John Small Health Advisory, explained the importance of community rating to the debate on this measure[26]:

> Private health insurance is based on the community rating principle which dictates that adults of all ages and states of health are entitled to take up private cover of their choice and to pay the same premium for that cover as anyone else. The bottom line of this is that the young and the healthy are, in effect, subsidising the ageing and those in not so good health. We do not see that as a very bad thing. This, and the enforcing of registration on health funds, has helped develop the Australian private health insurance products to be really among the best and best priced in the developed world.

The clear danger with this measure is that it will encourage young people, who subsidise the elderly and sick, to drop their private health cover; health funds will then be forced to raise premiums for those who remain. Pressure will then increase on health funds to look at those who use or, in other words, need greater access to health services and increase premiums for people of that particular age group or physical condition. Such higher premiums could be aimed at covering the additional cost burden or, more cynically, forcing those people out of the pool to reduce the funds' overall costs.

As Mr Gallagher (AMA, Qld) told the Committee, this measure will have funds examining all their options, including moving away from community rating[27]:

> **Senator EGGLESTON**—The Treasury modelling suggests that mostly it will be younger people on lower incomes who drop out. I think some people have a different view: that there will be a roll-on effect over a longer period. Would you agree with that?
>
> **Mr Gallagher**—From what we are seeing at the moment and from the research that we have done, I would have to say that probably predominantly the dropout will be in younger people—not necessarily those on lower incomes, but certainly in younger people, who would probably begin to question their particular outcomes and values of private health insurance. That clearly will then skew the cost of covering older Australians or more-senior Australians under private health care.
>
> **Senator EGGLESTON**—We have this community rating system in Australia for private health insurance. Does the AMA believe that the impact of this change may be that the private health insurance industry may feel under such pressure financially that consideration could be given to moving away from the community rating system to a risk based premium system?
>
> **Mr Gallagher**—Clearly the AMA feels that this will create pressures on the private health insurers that will make them look at a whole array of ways of changing how they look at their insured clients. It may well be the case that that is one of the options that they look at, but I am not sure that it will be an option that they will choose to follow.

Mr Seljak (Queensland Teachers Union Health Fund) warned the Committee that the Medicare Levy Surcharge, in its current form, had helped insulate Australia's private health system from the need to move away from community rating[28]:

> I suppose it is the only way to keep the system affordable. If people do not join until they are 60 or 70, it is like getting in a car accident and then buying car insurance; it just does not work in terms of insuring the general risk for the general population. Another great feature of Australian health insurance is community rating: that smokers and diabetics et cetera are allowed to pay the same rate as people that are relatively healthy. Without that, it would be completely unaffordable. Again, in the UK and the United States they are risk-rated systems. In other words, older people, unhealthier people, pay more. I think it is the only way to keep the system affordable. It might seem unfair—'Why are these tactics used to force me to pay it?'—

> but from another perspective it is, I suppose, a policy setting that allows the Government to keep its public health expenditure in control and provide a level of service that the community deems acceptable.

Coalition Senators believe that it is imperative that "Community Rating", which is a unique feature of the Australian Health Insurance System, be preserved because it means that all Australians are able to access health insurance regardless of risk factors in their medical history.

False economy

Much has been made by the Government of this measure providing "savings" of around $300 million to the budget ($960 million from not having to pay the private health rebate less $660 million in lost revenue from not collecting the Medicare Levy Surcharge.).

This reveals the measure as being nothing more than a convenient financial sleight of hand to paper over cracks in the Budget caused by the Government's spending binge.

As already noted, it is a false economy.

The Committee heard how the Government's own budget figures indicate that around $3.2 billion will be taken out of the health system as a result of this measure.

The Government says it will save $960 million from not having to pay the Private Health Insurance Rebate to those who drop out of the system. Consistent with the Government's assertion that it will be the young and healthy that will leave, this $960 million represents 30% of revenue lost to the private health system. This means that a total of $3.2 billion will be lost to the system.

Even allowing for the deduction from that funding pool of private health administration costs and net margins, this means that between $2.7 billion and $2.9 billion that would have otherwise been available to fund hospital treatment will no longer be.

Nobody expects overall demand for hospital services, public or private, to reduce over the forward estimates period. So where will that $2.7 billion in lost funding for hospital treatment come from? The Government has not provided a satisfactory response to that question.

As evidenced by private hospital operators, this will not only affect the number of patients they can provide care for, it will also dramatically reduce their ability to invest in new equipment and capital required to keep pace with rapidly developing technological advances in health care.

Further evidence of the hollowness of the Commonwealth's claims comes from the evidence of the States, private health funds and health experts who all confirm a massive shift of patient demand to the public hospital system.

Western Australian health officials told the Committee the additional cost expected from this measure to be in the order of $53.6 million for their State. This, of course, massively understates the financial impact as it was based on the Commonwealth Treasury's flawed assessment of the number of people expected to drop their private cover.

Based on Treasury's revised figure and on the more comprehensive data provided by the Access Economics modelling, the cost to Western Australia's public hospitals would easily be double that figure.

Even using the flawed original estimate, where is the economic sense of the Commonwealth 'saving' $300 million over the forward estimates if the additional bill for just one State is $216 million?

To date, none of the States or Territories have been offered any additional funding from the Commonwealth to cover the massive surge in demand that their public hospitals will face when the full consequences of this measure flow through. Amazingly, according to answers to questions on notice, not one single State Government has submitted a formal or informal request for additional funding to cope with the additional demand flowing from this measure.

The Commonwealth has tried to quell rising community and industry concern about the impact on public hospitals by pointing to its so-called "$600 million elective surgery reduction package" to be paid to the States.

This is elevating spin and deception to an art form.

Firstly, this election commitment package was supposedly designed to help address the existing crisis in public hospitals. This crisis, of course, has been caused by existing levels of demand.

The measure the Committee is considering will generate significant additional demand and will therefore require additional funding.

Even then, as noted earlier by WA Health Minister Jim McGinty, and confirmed by numerous witnesses before the Committee, there is a huge question mark over whether the public system could find the extra capacity required to meet this demand even if the funding was forthcoming.

As Dr Kelly (St John of God Hospital) told the Committee[29]:

> It is well recognised that the public hospital sector has insufficient staffed beds to cope with the existing demand. In Western Australia population growth will continue to outstrip any growth in staffed beds for the foreseeable future, with the hospital reform program having a very long lead time, particularly in relation to constructing new hospitals.

Public elective surgery waiting list trends are clear evidence of the fact that there is no capacity to deal with the transfer of admissions from private hospitals to public hospitals that will occur if the threshold changes are implemented.

It should also be noted that the $600million package was a commitment made before the 2007 election – supposedly well before this measure was even contemplated by the Government. It therefore could not have been intended to compensate the States in any way for the expected additional demand.

A closer examination of the package reveals that it includes only one firm commitment of $150 million (as a one-off) in additional funding for services. As noted earlier, Western Australian health officials expected an additional cost of $53 million a year in their State alone (and even that is a gross under-estimation). The Committee also was told that Catholic Health Australia had undertaken an assessment that "arrived at an impost of about $400 million in operating costs in the first year for public hospitals."

The second allocation of $150 million according to the budget papers - and confirmed by officials - is for improvements to systems and infrastructure. The final $300 million will only be available two years from now to those State Government that will meet certain performance targets.

So far State Governments have not been told what those performance targets are[30]. How they could possibly meet any reasonable targets with the additional demand coming their way is difficult to conceive.

The Government must have realised that talk of the $600 million pre-election commitment was not enough to quell demand – so it started to talk up the $1 billion increase in funding to public hospitals. Lost in the fine print is that this was part of an extension of the Australian Health Care Agreement by a further 12 months and included a routine $500 million adjustment for CPI.

Finally, quite disingenuously, the Government also talks about the $11 billion it will invest in the Health Infrastructure Fund. As the Committee heard repeatedly, capital initiatives do not fund hospital services and treatment.

When is a saving not a saving?

Perhaps of even greater concern is the fact that the Government's $300 million saving is illusory at best.

As noted previously, it is difficult to understand how their savings over the forward estimates from this measure did not change despite Treasury massively revising its estimate of the number of people expected to drop-out of private health from 485,000 to 644,000.

This alone should be ringing alarm bells with Senators who will be asked to vote on this measure without seeing the Government's modelling of its impacts.

The Government's failure to model the second round effects of this measure will come back to haunt it.

As noted, evidence to the Committee from a range of sources indicated this measure would force premiums to rise over-and-above the normal rate of increase.

Estimates of how much that additional impost would be ranged from around 2 per cent up to 10 per cent.

The Government claims it expects to save $960 million from not having to pay the rebate to those who will drop out of private health.

But those who remain in private health will be paying higher premiums, thereby forcing the Government to pay a higher amount in rebates.

This has not even been considered by the Government in compiling its figures published in the Budget.

The most reasonable consensus view is that this measure will result in an additional increase in private health insurance premiums over and above the usual increase of about 5%.[31]

This would represent a staggering $730 million in additional rebate payments over the forward estimates.

Put simply, there are no savings to the Government from this measure over the forward estimates.

This potential $730 million black hole in the Government's figures has been cleverly hidden from proper scrutiny by the Senate.

As Mr David Kalisch, Deputy Secretary of the Department of Health and Ageing, conceded when the figures were put to him[32]:

> If there is this number of people coming out, then, if you have no change to the way in which premiums are constructed by firms, this is potentially the mathematical impact.

Mr Kalsich also told the Committee that the Government had made allocations in the Budget's "contingency reserve" to cover any funding increases required to pay for higher rebate payouts due to increased premiums[33]:

> **Senator CORMANN**—You mentioned in an answer that you provided to me on notice that the financial impact of premium growth on the forward estimates for the private health insurance rebate is currently allocated to the contingency reserve. How much have you allocated to the private health insurance rebate component in the contingency reserve?
>
> **Mr Kalisch**—If it is in the contingency reserve, we are not going to disclose that.
>
> **Senator CORMANN**—You are not going to disclose that?

> **Mr Kalisch**—No.
>
> **Senator CORMANN**—On what basis?
>
> **Mr Kalisch**—It is in the contingency reserve because it really does give an estimate of what we expect the premium increase to be overall. We are not going to disclose that to the market.
>
> **Senator CORMANN**—So you are claiming commercial-in-confidence?
>
> **Mr Kalisch**—No, it is budget-in-confidence. The Treasurer and the government have made a decision that this number will not be disclosed for commercial market reasons, because it is not in the government's interest.

The Government's argument appears to be that it makes a contingency allocation each year for an expected additional call of funds which are required to pay the increased rebate after health funds have their annual premium increases approved.

To disclose this amount, according to the Government's argument, would signal to the funds how much the Government was prepared to allow them to increase their premiums and thereby take the pressure off funds to keep such increases to a minimum.

In normal circumstances, this would not seem unreasonable, but we are not dealing with normal circumstances.

The clear evidence is that private health funds will increase their premiums over-and-above their normal rate of increase, perhaps by as much as 10 per cent, to compensate for the loss of members.

It is not clear that the Government has made any allowance in the contingency reserve for this additional increase, or if so for how much.

If the call for extra funds for the private health insurance rebate is based on the consensus view that premiums will increase by an additional 5% at $730million (or with a 10% increase $1.46 billion over the forward estimates), then there is a serious funding problem

Perhaps the Government has made such an allocation and simply does not want to reveal the amount because of the embarrassment it would cause, or because it would demonstrate that in fact there is no saving to its bottom line?

The Government, through its officials, is trying to argue that any rate increase caused by this measure would be, at worst, minimal. To reveal a larger figure is being held in contingency would be proof that the Government actually expects an increase more in the order of that predicted by the industry, the independent economic modellers and health experts.

Either way, it is unconscionable to ask the Senate to vote on a measure without knowing its full impact on the Budget.

Conclusion

This measure will:

- damage the private health sector and, as a consequence, inflict significant damage on our public health system as a consequence of increased demand causing longer waiting lists and more overcrowding;
- impose massive costs on the public hospital systems of the States and Territories;
- rip away at the fibre of the principle of community rating which has ensured fairness and equity for all Australians seeking private health cover;
- force private health insurance premiums up, hurting those people who most need this cover – working families, low- and fixed income earners, pensioners and the elderly. In many cases it will force these people, many of who have paid their premiums their entire working lives and into retirement, to abandon their cover;
- dramatically reduce the amount of private investment in both capital infrastructure and new health technologies in Australia; and
- threaten the viability of private health services in rural and regional Australia and the public health services, social welfare and outreach services they cross-subsidise.

The Government and its spin machine has gone to great lengths to create an impression that the only people concerned about the impact of this measure are the vested interests in the health insurance industry and private hospitals.

It is disappointing the majority report of this Committee has meekly followed the same path.

But as Mr Robert Bransby, Managing Director of the not-for-profit HBF Health Fund put it[34]:

> Our membership spans the population of Western Australia, representing hundreds of thousands of working families. Our membership extends from the smallest child born today through to families with young children right through to thousands of pensioners, most of whom have maintained membership with HBF for more than 50 years.
>
> These people scrimp and scrape each year to find the money to pay their HBF subscription because they passionately believe in what HBF stands for. These people are not rich; they are not privileged; they are people who deserve to be heard.

Unfortunately for Mr Bransby, his members and hundreds of thousands more like them across Australia, this government is not listening. The Coalition Senators on the Committee are and accordingly believe this measure should be strongly opposed.

Senator Alan Eggleston

(Deputy Chair)

LP

Senator Mathias Cormann

LP

Senator Barnaby Joyce

LNP

25 August 2008

[1] Ms Anna Perfect, Senior Policy Officer, National Seniors Australia, Proof Committee Hansard, 31 July 2008, p. E37.

[2] Answer to Question on Notice, Community Affairs Senate Estimates Committee (E08-005) and Mr David Kalisch, Deputy Secretary, Department of Health and Ageing, Proof Committee Hansard, 12 August 2008, E5

[3] ABC radio, 21/05/08

[4] Mr David Kalisch, Deputy Secretary, Department of Health and Ageing, Proof Committee Hansard, 12 August 2008, p. E2-E3.

[5] Mr Stuart Rodger, Convenor Health Practice Committee, Institute of Actuaries, Proof Committee Hansard, 31 July 2008, p. E32.

[6] Mr Mark Fitzgibbon, Chief Executive Officer, NIB Health Funds Ltd, Proof Committee Hansard, 31 July 2008, p. E10.

[7] Mr Kerry Gallagher, Chief Executive Officer, AMA (Queensland), Proof Committee Hansard, 17 July 2008, p. E12.

[8] Mr Michael Roff, Chief Executive Officer, APHA, Proof Committee Hansard, 31 July 2008, p. E61.

[9] Mr Nigel Ray, Executive Director, Fiscal Group, Treasury, Committee Hansard, 3 June 2008, p. E57.

[10] Mr Terry Barnes, Proof Committee Hansard, 6 August 2008, E9.

[11] Mr Terry Barnes, submission, page 4.

[12] Senator Jan McLucas, Parliamentary Secretary for Health and Ageing, Committee Hansard, 20 February 2008, p. CA125.

[13] Mr David Kalisch, Deputy Secretary, Department of Health and Ageing, Committee Hansard, 4 June 2008; p. CA45.

[14] Mr Marty Robinson, Unit Manager, Household Modelling and Analysis Unit, Tax Analysis Division, Treasury, Proof Committee Hansard, 31 July 2008, p. E17.

[15] Mr Peter Jennings, Deputy Executive Director, AMA (WA), Proof Committee Hansard, 15 July 2008, p. E12.

[16] Mr Michael Roff, Chief Executive, APHA, Proof Committee Hansard, 31 July 2008, p. E58.

[17] Mr Graeme Gibson, Chief Executive, HIF, Proof Committee Hansard, 15 July 2008, p. 34.

[18] Ms Anna Perfect, Senior Policy Officer, National Seniors Australia, Proof Committee Hansard, 31 July 2008, p. E37.

[19] Ms Anna Perfect, Senior Policy Officer, National Seniors Australia, Proof Committee Hansard, 31 July 2008, p. E37.

[20] Mr Robert Seljak, Chief Exeutive Officer, Queensland Teachers Union Health Fund, Proof Committee Hansard, 17 July 2008, p. E25.

[21] Mr Martin Laverty, Chief Executive Officer, Catholic Health Australia, Proof Committee Hansard, 31 July 2008, p. E52.

[22] Dr Shane Kelly, Chief Executive Officer, St John of God Health, Proof Committee Hansard, 15 July 2008, p. E19.

[23] Mr Michael Roff, Chief Executive Officer, APHA, Proof Committee Hansard, 31 July 2008, p. E58.

[24] Mr Peter Jennings, Deputy Executive Director, AMA(WA), Proof Committee Hansard, 15 July 2008, p. E13.

[25] Dr Michael Armitage, Chief Executive Officer, AHIA, Proof Committee Hansard, 31 July 2008, p. E2.

[26] Mr John Small, Proof Committee Hansard, 17 July 2008, p. E17.

[27] Mr Gallagher, Chief Executive, AMA(Qld), Proof Committee Hansard, 17 July 2008, p. E11.

[28] Mr Rob Seljak, Chief Executive Officer, Queensland Teachers Union Health Fund, Proof Committee Hansard, 17 July 2008, p. E29.

[29] Dr Shane Kelly, Chief Executive Officer, St John of God Health Care, Proof Committee Hansard, 15 July 2008, p. E19.

[30] WA evidence – Health Department

[31] Access Economics, Professor John Deeble & evidence by Stuart Rodger from the Institute of Actuaries;

[32] Mr David Kalisch, Deputy Secretary, Department of Health and Ageing, Proof Committee Hansard, 12 August 2008, p. E4.

[33] Mr David Kalisch, Deputy Secretary, Department of Health and Ageing, Proof Committee Hansard, 12 August 2008, p. E5.

[34] Mr Rob Bransby, Managing Director, HBF Health Funds Inc, Proof Committee Hansard, 15 July 2008, p. E5.