Dissenting Report of the Australian Greens

The Australian Greens are committed to equitable access to quality public health care. In considering the impact of this Bill, the Australian Greens have differentiated between the impacts on the public health system and the impact on the private health insurance industry. It is our primary concern to ensure that Australia has a strong, viable, accessible public health system.

Professor Leonie Segal's evidence to the Committee indicated the extent to which the support of the private health insurance industry is draining tax dollars from the public hospital system. The cost of the 30 per cent rebate, for example, which is currently an estimated $3.6 billion, must be contrasted with total federal government expenditure on the public hospital system which in 2007/8 was $9.7 billion.[1]

'Translated another way, if we were not supporting private health insurance and those dollars were available to go into health in other ways, they could be used to increase the commonwealth contribution to public hospitals by one third'.[2]

The Australian Greens share Professor Segal's concern and believe that it is not the role of the taxpayers to subsidise companies providing private health insurance.

The Medicare Levy Surcharge forces people on low to average incomes to contribute at the same rate as those on much higher incomes. The Australian Greens value the principle of equity. This is an unfair burden on households currently struggling with other costs. The failure to index this threshold means it now captures households earning low to average incomes. As Choice argued in their submission to this inquiry, based on average weekly earnings, incomes have increased by approximately 60 per cent since 1997 when this threshold was first introduced.[3]

The Australian Greens argue that people should have a right to choose whether or not to buy health insurance. The Medicare Levy Surcharge penalises people who have chosen not to take out private health insurance. Additionally, it removes the incentive for private health insurance providers to provide the most attractive products.

Modelling the impact of changes to the public health system

The Australian Greens considered in detail the modelling provided to the Committee.

However, rather than providing a convincing argument, the wide variation in the models highlighted the difficulties of making accurate predictions about the impact of this measure.

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1 Australian Government, Budget Paper No. 3, Table B2.

2 Professor Segal, *Proof Committee Hansard*, 22 July 2008.

3 *Submission 11*

In summary, the private health insurance sector argued that the raising of the Medicare Levy Surcharge threshold would lead to a drop in the number of privately insured which would then impact on waiting lists for public hospitals. The sector further argued a second round impact of rising premiums as the number of insured decreased. However, the figures provided to the Committee varied considerably.

For example, the Australian Health Insurance Association estimated a first round loss of 908,000 people or almost 10 per cent of members. The much lower figure of 359,000 people was estimated by Access Economics. The estimations of second and third round effects on private health insurance memberships were similarly varied. This variation indicates the differing assumptions made regarding the decision to purchase private health insurance and undermines the claims of the private health insurance sector of a large impact on public hospitals.

There is clearly some potential for people who drop their private health insurance to add to the elective surgery waiting lists of public hospitals. However, while the private health insurance industry placed considerable weight on the price of insurance as the determining factor in the decision people make to purchase insurance, the more qualitative assessment provided by Professor Elizabeth Savage, Ian McAuley and other submitters to the inquiry included a greater range of reasons why people choose to hold health insurance including peace of mind, planning for the future and a sense of security.[4]

In line with this qualitative assessment, Professor Deeble also argued that factors other than price were greater determinants of the choice to hold private health insurance. His modelling took this position into account. In summary, Professor Deeble calculated an increased demand of approximately two per cent per annum on public hospitals. Out of a total public hospital expenditure of approximately $26 billion, this would be an extra $360 million per year.[5]

The Australian Greens were concerned that the evidence from the Department of Health and Ageing indicated a lack of modelling of the impacts of this measure on the public health system. This is illustrated by the following exchange.

> Senator SIEWERT—Okay. Thank you. You have not done any modelling of the impact on the public health system?
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> Mr Kalisch—No. We have looked at the range of issues and, as I was mentioning to Senator Cameron, talked about and looked at a range of the other factors that would also be impacting on public hospitals in the way that they are managed by states and territories, as well as the additional funding that the Commonwealth government has provided to them, and come to a policy assessment that we would not expect anything more than a modest change.

4 See Submissions 2 and 10.

5 Professor John Deeble, *Submission 3*.

Senator SIEWERT—Part of this comes down to what impact this is going to have on the public health system. I want to be assured that the additional money going into the public health system is going to cover any impact of changing this threshold. None of the information you have just given me assures me that there is enough money in the system to deal with even a modest impact when hospitals are struggling as they are. I would have thought that the increase the government has given in the budget would have been to make up for the fact that the public health system is struggling as it is—without even the modest impact of this change.

Some insurers and some health providers are saying it is not going to modest but rather six per cent, and I will get to the Catholic health service modelling in a minute. How can we be assured that in fact even a modest impact is going to be covered by the increases the government is giving to public hospitals?

Mr Kalisch—There are two aspects. One is what government has already announced. They have already announced at least $1.1 billion of extra funding to public hospitals.

Senator SIEWERT—With all due respect, my question still stands: how do I know that that is actually going to deal with the increase in the public system?

Mr Kalisch—The other aspect which I cannot really give you a number on is what I referred to earlier—that the federal government is talking to the states and territories at the moment about the next healthcare agreement. That is going to be the vehicle for potentially more money going into the public hospital system.

Perhaps I will reframe that. Really, the issue that is being discussed is: how much more money is going to go into the public hospital system? It is really about what the number is going to be at the bottom of the page.

Senator SIEWERT—That is the crux for us. We will be coming to make a decision in the Senate about this. I want to be assured that if this passes there is enough money to deal with the impact on the public health system, and quite frankly nothing you have told me yet reassures me of that.

Mr Kalisch—I suppose I can give you the assurance that on the basis of the numbers that we know are being discussed and our assessment of the impact—

Senator SIEWERT—With all due respect, you have just told the committee that in fact you have not done any modelling on the impact on the public health system.

Mr Kalisch—No, I said we expect that number to be quite modest—

Senator SIEWERT—I understood you as saying you have not modelled.

Mr Kalisch—and I said we cannot do any specific modelling.

Senator SIEWERT—You have not done any modelling, so we do not know whether the figure that, for example, the Catholic health system are saying of around a six per cent increase is correct. I am not here defending the

Catholic system, but I am just saying that they are the figures that are out there publicly, as well the Access Economics figures. They are saying six per cent. How do I know that they are not right?

Mr Kalisch—I think we can certainly point to some of the major difficulties around their assumptions. A number of those assumptions about a very big impact on the public hospital system make some fairly heroic assumptions around a very high proportion of those who drop out of private health insurance requiring public hospital treatment, which is completely out of kilter with what we see even in the broader population. I think the chair talked about some suggestion that younger people may be more likely to drop out of private health insurance as a result of this change. If that is the case, they are not the sort of people that turn up to public hospitals for admitted procedures.

CHAIR—We are short of time.

Senator SIEWERT—I will ask my final question. The issue that has been put is that it is not just the immediate impact now but also the subsequent impact. I take the point that young people dropping out are not going to be turning up in hospital necessarily straight away. But, in subsequent years if they have not then gone into the lifetime process that we have been talking about, have you modelled or looked at what impact it is going to have on the public system in subsequent years?

Mr Kalisch—No, we have not in that level of detail. I would have to say that the modelling is almost impossible to do around that dimension. What you have seen is a number of commentators and submissions suggesting a significant impact within a very short space of time. They are not looking at a change over five or 10 years. They are looking at a change within one or two years. It is hard to quite get to all of the assumptions behind their so-called modelling. I would have to say they are more using assumptions and then driving some numbers through them, but their numbers seem to imply that a very high proportion of people who would be dropping out of private health insurance do turn up at public hospitals.[6]

The question of accurate modelling for the impact of this measure on the public health system is critical. We appreciate the difficulties associated with modelling the second and third round effects, however, a responsible government must have in place monitoring systems that capture and address any increase in demand on public hospitals resulting from this Bill. Waiting lists are already too long. The increased demand on the public health system flowing from this Bill may be as little as two per cent overall, but when added to an existing backlog of patients, it is an additional burden that must be addressed.

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6 *Proof Committee Hansard*, 12 August 2008, pp. 7–8.

The impact on the private health sector

The Australian Greens concur with the Majority Committee Report that the drop out rate from private health insurance as argued by the industry is likely to be exaggerated. On the possible rise in the cost of premiums for private health insurance, we argue it is difficult to make an assessment given that the price of premiums is an outcome of less than transparent commercial decisions. As Professor Deeble noted in evidence to the inquiry, the impact on households of raised premiums may be as little as a dollar a week. Our major concern is that tax payers should not subsidise the private health insurance market. As argued by Choice, consumers will now have a greater capacity to choose whether or not to become members of a fund and greater pressure will be placed on funds to provide appropriate products for consumers (Submission No. 11).

The impact on non government public hospitals

The potential impact on public hospitals operated by the private sector was not discussed in any depth by the Committee's Report. The Australian Greens have some concerns for the impact on non government public hospitals, (including those run by Catholic Health Australia) particularly those in regional areas that offer services not adequately provided by the government and those that use income from hospital activities to cross subsidise community outreach programs such as drug and alcohol rehabilitation.

The impact on individuals

One reason that this Bill is creating so much concern is the failure to index the threshold when it was introduced in 1997. While the Greens in principle oppose the existence of the Medicare Levy surcharge and the rebate, we argue that it should be indexed from this point on to avoid this same problem recurring in the near future.

Conclusion

While the Australian Greens are in agreement with the Majority Report of the committee that lower income households must be protected from being forced to pay the Medicare Levy Surcharge, we do not accept the Committee's recommendation that the Bill be passed in its current form. Rather, we recommend the following:

Recommendations

Recommendation 1

That the savings from this measure are redirected to the public health system.

Recommendation 2

That the Bill be amended to index the Medicare Levy Surcharge threshold from this point on to avoid further lumpiness in future policy changes.

Recommendation 3

That the Bill include a requirement for an ongoing review of the elective surgery waiting lists in the public hospital system to assess the longer term impact of this Bill.

Senator Rachel Siewert

Australian Greens