The Senate

Standing Committee on Economics

Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

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TABLE OF CONTENTS

Chapter 1

Introduction

Background

1.1 The Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008 was introduced into the Senate on 2008. On 18 June 2008 the Senate referred the Bill to the Senate Standing Committee on Economics for inquiry and report by 26 August 2008.

1.2 The bill increases the Medicare levy surcharge threshold for individuals from $50 000 to $100 000 and for couples from $100 000 to $150 000. The increased thresholds will apply from the 2008–09 year of income and later years of income. The inquiry was asked to examine:

(a) the impact of changes to the thresholds on the number of Australians with private health insurance (PHI), including an examination of how many will abandon their policies as a result and how many will not take up PHI in the future;

(b) the modelling underpinning the decision and the veracity of that modelling;

(c) the anticipated impact on PHI premiums and PHI products offered;

(d) the impact of the change on the cost of living and the consumer price index;

(e) including the threshold, PHI rebate and lifetime health cover on increasing PHI membership;

(f) the anticipated impact of changes to the threshold on:

  (i) the public hospital system including waiting lists and the financial requirements of state governments;

  (ii) the ongoing viability of PHI, and

  (iii) private hospitals.

Conduct of the inquiry

1.3 The committee advertised the inquiry in the *Australian* newspaper and on the committee's website, inviting written submissions by Monday 7 July 2008. It received 22 submissions from various organisations including the Treasury, private health funds and peak private health organisations, health insurance consultancies and brokers, consumer groups and private citizens. Appendix 1 lists these submissions: they are also available on the committee's website at: http://www.aph.gov.au/Senate/committee/economics_ctte/tlab_medicare/index.htm.

1.4 The committee held six public hearings: in Perth on 15 July, Brisbane on 17 July, Adelaide on 22 July, Sydney on 31 July, Melbourne on 6 August and Canberra on 12 August. A list of the witnesses who appeared at these hearings is at Appendix 2. The committee did not receive any submissions from organisations or citizens from Tasmania or the Northern Territory. Accordingly, the committee did not hold public hearings in either Hobart or Darwin.

1.5 The committee thanks all those who contributed to the inquiry.

Structure of the report

1.6 Chapter 2 gives an overview of the bill and some detail on the Medicare levy surcharge. Chapter 3 outlines the views that have shaped the debate during the inquiry. Chapter 4 examines the findings of Treasury and various consultancies as to the likely effect of the bill on the Commonwealth's coffers and membership of private health funds. Chapter 5 discusses the main areas of contention in the bill. It canvasses submitters' opinions on various issues.

Chapter 2

The bill and the Medicare Levy Surcharge

2.1 The Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008 increases the Medicare Levy Surcharge (MLS) thresholds from annual taxable incomes of $50 000 to $100 000 for individuals and from $100 000 to $150 000 for families and couples. The increased thresholds will apply from the 2008–09 year of income. For 2008–09 tax returns, therefore, individuals taxpayers earning $100 000 and under will not be liable to pay the MLS.

2.2 To give effect to these changes, the bill amends subsections 6(1), 6(2) and paragraph 12(1)(a) of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999* and subsections 3A, 8B(2) and 8E(2) of the *Medicare Levy Act 1986*.[1]

2.3 Medicare is partially funded through the Medicare levy.[2] It is currently set at 1.5 per cent of taxable income with an exemption for low income earners adjusted regularly to account for changes in the consumer price index (CPI). The MLS is not hypothecated. In 2005–06, revenue from the Medicare levy was $6.1 billion while the surcharge raised $0.3 billion. The overall cost of Medicare in 2005–06 was $16.4 billion.[3]

2.4 Currently, the Medicare levy surcharge is an additional one per cent of taxable income imposed on those who do not have private health insurance (PHI) and who earn over $50 000 per annum (over $100 000 for couples and families). If the bill is passed, a single person without private health insurance on the average annual salary of $58 600 would therefore save $586 a year.[4]

2.5 If the MLS had been indexed to the CPI since it was introduced on 1 July 1997, the threshold would now be $67 000 per annum; if it was indexed to average weekly earnings, it would be now be set at $76 000 per annum.[5] Australian Taxation

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1 Explanatory Memorandum

2 Part of the levy is hypothecated to fund Medicare, although it covers only a small proportion of the Commonwealth's outlays on the scheme.

3 Amanda Biggs, Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008, *Parliamentary Library*, Bills Digest, 4 June 2008, no. 121, p. 3. The Hon. Peter Costello, Treasurer, *Final Budget Outcome 2005–06*, Table B1, p. 3. Australian Taxation Office, *Taxation Statistics 2005–06*, Table 1, p. 3. Australian Tax Office data for 2006–07 has not yet been publicly released.

4 The average salary figure is based on the latest ABS data for the March Quarter 2008 (6302.0).

5 Australian Bureau of Statistics, 6401.0, March 2008 Quarter.

Office figures show that in 2005–06, 465 325 taxpayers incurred the surcharge, up from 436 490 in 2004–05 and only 167 330 in 1997–98.[6]

2.6 The policy intent of the MLS is as follows:

> The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system.[7]

2.7 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.[8]

2.8 Professor John Deeble, the principal architect of the Medicare system in the 1980s, noted in his submission to this inquiry the unusual nature of the surcharge:

> The surcharge is an income-related tax. However unlike almost any other income-based tax, it operates in a reversionary way – that is, it applies to all the taxable income of people earning above the thresholds, not just to the excess. I know of no other tax that works in this way and it is extraordinary that an Australian parliament should have approved it. The result is a very high marginal tax rate for people with incomes at or close to the thresholds.[9]

2.9 As the average income is now $58 600 per year it should be noted that an increasing number of taxpayers close to the threshold are bearing a disproportionate amount of the MLS, and that this is neither equitable nor in keeping with the original intent of the policy.

2.10 The MLS was introduced in 1997 as part of a suite of policies to encourage membership of private health funds. In 1999, the Commonwealth Government implemented a 30 per cent rebate on private health insurance premiums. For people aged between 65 and 69 years, the rebate is 35 per cent; for those aged over aged 70 years, it is 40 per cent.[10] In 2000, legislation was passed limiting any front end deductible (excess) to $500 for singles to qualify for surcharge exemption. In 2001,

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6 Australian Taxation Office, *Taxation Statistics 2005–06*, Table 7: Personal tax, p. 3.

7 Australian Government, privatehealth.gov.au http://www.privatehealth.gov.au/information/surcharges/medicarelevy.htm (accessed 7 July 2008).

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

9 Professor John Deeble, *Submission 3*, p. 2.

10 These changes were effective as of 1 April 2005.

the Commonwealth introduced the Lifetime Health Cover scheme. The scheme imposes a two per cent annual cumulative loading (up to 70 per cent) to the cost of private health premiums for people who only take out health insurance after their 31st birthday. For example, a person who first joined a private health fund at the age of 45 will pay a 28 per cent higher premium (14 years x 2 per cent) than a person who joined at the age of 31.

2.11 The MLS threshold levels have not changed since they were introduced. The Assistant Treasurer, the Hon. Chris Bowen, noted in the Second Reading Speech that when the surcharge was introduced by the Howard government, the policy was targeted at high-income earners. He explained that the bill:

> simply increases the thresholds to an income level around which they originally applied in 1997…around 8 per cent of single taxpayers are estimated to have exceeded the Medicare levy surcharge threshold in 1997-98, when it was introduced…this proportion will be restored to around 8.5 per cent – at the end of the forward estimates – of single taxpayers likely to exceed the new singles threshold in three to four years.[11]

2.12 In explaining the rationale for the bill, Mr Swan described the current $50 000 threshold as a 'tax trap'. He added:

> I think the private health industry should have more confidence in their product. We are a supporter of private health insurance and we have supported the 30 per cent rebate and the variations to it as it runs up the scale and we will continue to do that. But you cannot support it with this sort of compulsory taxation, on a group of people who don't deserve to be hit for six, the way they were hit for six.[12]

2.13 The Medicare levy surcharge, the 30 per cent private health insurance rebate and the Lifetime Health Cover arrangements are a combination of 'carrots' and 'sticks' to encourage PHI membership. The private health insurance industry argues that these three 'pillars' are essential to maintain a 'balance' between public and private health care, and to support Australia's unique system of community rating in private health insurance.

2.14 However, these 'pillars' are expensive to maintain. Those who hold private health insurance currently receive generous tax breaks even before the exemption from the MLS. Table 2.1 shows that in 2006–07, the cost to the taxpayer of the 30 per cent private health insurance refund was higher than the tax concessions given to the total manufacturing sector.[13]

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11 The Hon. Chris Bowen, Second Reading Speech, *House of Representatives Hansard*, 27 May 2008, p. 3349.

12 The Hon. Wayne Swan, *Address to the National Press Club*, Canberra, 14 May 2008.

13 Productivity Commission, 'Trade and Assistance Review 2006–07', *Annual Report Series*, Table 2.5b, p. 2.11.

Table 2.1: Tax concessions 2006–07 (30% PHI rebate & selected industries)

	30 per cent PHI rebate	Manufacturing	Primary production	Mining
Tax concessions 2006–07 ($ million)	980	963	192	131

Source: Tax Expenditures Statement 2007; Trade and Assistance Review 2006–07, Productivity Commission

2.15 Table 2.2 shows that the level of private health insurance increased in all states between 1996 and 2001. Membership levels have remained fairly steady since 2001. Many attribute the jump in PHI membership to the success of the 'Run for Cover' marketing campaign prior to the introduction of Lifetime Health Cover arrangements.[14]

Table 2.2: Percentage of population in private health insurance, 1996–2008

	WA	NSW	SA	Vic	Tas	Qld
March 2008	49.7	46.0	44.5	43.3	43.0	42.1
March 2001	48.2	45.8	45.7	45.1	44.3	42.4
Sept 1996	36.7	33.9	34.0	33.2	36.7	31.1

Source: Private Health Insurance Administration Council, Industry statistics.

14 See Professor John Deeble, *Submission 3*, p. 9.

Chapter 3

Views on the bill

3.1 The committee gathered a range of views on the bill.

3.2 The first is the government's position.[1] The Treasurer argues that Medicare Levy Surcharge (MLS) threshold levels have not changed for a decade and should be increased to restore the proportion of the population who are liable for the surcharge to 1997 levels. An increasing number of average income earners are now falling into this 'tax trap'. In 1997 just 8 per cent of taxpayers incurred the surcharge. This has risen to about 36 per cent of single taxpayers in 2008–09 and up to 45 per cent of single taxpayers by 2011–12.[2]

3.3 This measure will give taxpayers without PHI on typical incomes between $50 000–$100 000 per annum some tax relief. This relief is already given to those with PHI. At the same time the government continues to provide financial incentives to encourage people into private health insurance. Moreover, the government has publicly stated its support for a mixed model of public and private health insurance and the use of a variety of measures to ensure the continuing viability of the public and private health sectors.[3]

3.4 A second view is that of the private health funds (both profit[4] and not-for-profit[5]), private hospitals[6] and private health insurance organisations.[7] They oppose the bill on the grounds that young and healthy fund members who are no longer liable for the MLS will drop their membership, causing premiums to rise, leading to further fallout from the funds and subsequent premium increases. The private health insurance industry expresses concern that these changes will not only affect their

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1 The Hon. Wayne Swan, 'Increasing the Medicare levy thresholds', *Media Release*, 13 May 2008.

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

3 See Mr McCullough, *Proof Committee Hansard*, 31 July 2008, p. 16.

4 The committee took evidence from HBF, HIF, BUPA Australia (MBF), NIB Health Funds Limited, Manchester Unity, Health Partners, iSelect and the Private Health Insurance Intermediaries Association.

5 The committee took evidence from the Health Insurance Restricted Membership Association of Australia and the Queensland Teachers' Union Health Fund.

6 The committee took evidence from St Andrew's Hospital in Adelaide, St John of God Health Care in Perth and Catholic Health Australia in Sydney.

7 The committee took evidence from the Australian Private Hospitals Association, Health Link Consultants, Australian Health Insurance Association, Australian Medical Association National, Western Australian and South Australian branches), *Consulting 1805* and John Small Health Advisory.

profitability, but they claim it will further lengthen public hospital waiting queues. Their argument is pitched in terms of the bill's threat to the delicate 'balance' between public and private provision of health care services and health insurance in Australia. In terms of the bill's principal policy objective, they argue that there are alternate ways to give tax relief than increasing the surcharge thresholds.

3.5 A further group recommend taxpayers' money to be directed to the public health system, and away from the private health funds.[8] They argue that the bill is a welcome policy initiative to encourage a more efficient allocation of resources to the public health system. The committee heard from several witnesses that the federal government should not be subsidising the private health insurance industry, but should redirect its funding to the areas of highest need in the public hospital system. Some witnesses even argued that the bill did not go far enough in increasing the MLS thresholds.[9]

3.6 The following two chapters examine these perspectives on two levels. Chapter 4 examines the evidence from various studies estimating the impact of the proposed higher MLS thresholds on private health insurance coverage, PHI premiums and the public hospital system. Chapter 5 outlines the qualitative arguments sketched above based on the insights of submitters and witnesses. Chapter 5 thereby gives context and perspective to the estimates presented in Chapter 4.

8 The committee took evidence from Associate Professor Louise Savage, Professor Christian Gericke, Professor Leonie Segal, Mr Ian McAuley and Dr Tim Woodruff.

9 For example, Mr Ian McAuley, *Submission 10*, p. 6.

Chapter 4

Modelling the impact of the bill

4.1 An important part of the committee's deliberations on the bill focused on the efforts to model the impact of the increased Medicare levy surcharge (MLS) thresholds, or to contest the scope and accuracy of Treasury's estimates. Treasury has estimated the budgetary impact of the bill's measures due to loss of PHI membership over the period 2008–2012 (see below). The Australian Health Insurance Association (AHIA) and the Australian Medical Association (AMA) commissioned Price Waterhouse Coopers and Access Economics respectively to examine Treasury's figures and the likely effect of the bill on both the private funds and the public hospital system. Separately, iSelect have also commissioned Access Economics to examine the effect of the bill on private health insurance (PHI) dropout, subsequent premium increases and the pressure on the public hospital system. As noted earlier, Professor Deeble has conducted his own analysis. Mr Ian McAuley and Catholic Health Australia also offered insights into the task of modelling the bill's impact, although neither undertook any econometric analysis.

4.2 This chapter presents these findings. It is important to note that the modellers make various caveats about the certainty with which these findings can be made. Not all the necessary information is publicly available and the calculations relate only to the price effect of the MLS threshold changes, not the broader motivations of people for holding private health insurance.[1] Evidence presented to the committee noted that price is not the primary reason why people take out PHI. Security, peace of mind and choice of hospital and doctor rated higher than price.[2] This would imply that private health insurance is relatively price inelastic.

The 'first round' effect: Treasury's position

4.3 Treasury's budget estimates (Table 4.1) measure the 'first round' effect of the bill's measures—the number of people who will leave the private health insurance system purely as a result of the rise in the thresholds and abstracting from any subsequent increase in premiums. It calculates that over the period 2008–2012, there will be a net saving to the public purse from increasing the threshold (excluding any increase in funding for public hospitals). This is based on:

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1 See John Deeble, *Submission 3*, p. 5; Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, p. 5; Ian McAuley, *Submission 10*, p. 1, M. Fitzgibbon, *Proof Committee Hansard*, 31 July 2008, p. 16; NIB Health Fund Ltd, *Submission 7*, p. 3.

2 Mr Ian McAuley, *Proof Committee Hansard*, 12 August 2008, p. 18. Mr John Brogden, *Proof Committee Hansard*, 31 July 2008, p. 24.

- 485 000 adults[3] (644 000 people) leaving private health insurance, resulting in reduced government expenditure on the private health insurance rebate of $960 million;
- an ongoing cost in foregone revenue due to exempting those in the $50 000 to $100 000 income range who are not privately insured from the levy surcharge of $660 million; and
- a resulting estimated net saving of $300 million (see Table 4.1).[4]

Table 4.1: Personal income tax—increasing the Medicare threshold

Revenue ($m)

	2008–09	2009–10	2010–11	2011–12
Foregone tax revenue	-	-195.0	-235.0	-230.0
Private health insurance rebate savings	232.0	236.5	245.6	245.6

Source: *Budget Paper No. 2: Budget Papers 2008–09*, Commonwealth of Australia, Canberra, p. 33.

4.4 Treasury told the committee that Treasury had based its modelling of the foregone tax revenue on its personal tax model.[5] In modelling the effect of the increased threshold on rebate expenses, the Australian Tax Office provided Treasury with a confidentialised sample of data containing comprehensive information on private health insurance coverage.[6] Treasury then provided the Department of Health and Ageing and the Department of Finance and Deregulation with estimates of the 2008–09 income distributions for singles and couples with PHI. From these data were derived an estimate of the number of people with PHI in the less than 65, 65–69 and over 70 age groups.[7]

4.5 Treasury has been criticised for failing to model the effect of the bill in raising premiums (offset by any further drop in membership this causes) and therefore the cost of the rebate, and the impact on the public hospital system—the 'second round effect'. However, in evidence to the committee in June and July, Treasury explained that 'normal costing conventions' do not include costings of second-round effects. It is not a requirement of the Charter of Budget Honesty that has set guidelines for budgeting since 1998. Moreover, these second round effects are difficult to quantify. At the June hearing of Estimates, Mr Ray explained that 'the reason we do not include second round effects is that generally they are highly uncertain…we have not done

3 Treasury's modelling estimates that around 186 000 singles and 149 000 couples and families are expected to drop their private health insurance cover.

4 *Budget Paper No. 2: Budget Papers 2008–09*, Commonwealth of Australia, Canberra, p. 33.

5 Mr Nigel Ray, Treasury, *Senate Estimates Hansard*, 3 June 2008, p. 55.

6 Mr Marty Robinson, Treasury, *Proof Committee Hansard*, 31 July 2008, p. 19.

7 Mr Nigel Ray, Treasury, *Senate Estimates Hansard*, 3 June 2008, p. 55.

that modelling because we do not feel that it is easily quantifiable'.[8] Similarly, in evidence to this inquiry, the Treasury explained:

> Any effects on future premiums are deemed to be second-round effects from the policy, entail a great deal of uncertainty and would be difficult to quantify[9]...there are many other factors, such as the impact of potential marketing campaigns by funds, that might impact on the future growth.[10]

4.6 Notwithstanding the merits of these arguments, there has been criticism that Treasury's 30 per cent rebate savings estimate of $960 million is overstated given they do not measure the possible increase in premiums flowing from the fallout in PHI membership. Treasury did factor into their modelling a premium increase over the forward estimates period from factors *other* than the bill's influence.[11]

Other perspectives on the first-round effect

4.7 Treasury's first round effect—the number of people who will initially drop out of private health insurance—has been challenged by both Pricewaterhouse Coopers (AHIA) and Access Economics (AMA). The approach of both consultancies was to recalculate the number of people who will leave private health insurance based on Treasury's 2008–09 PHI rebate savings estimate of $232 million. The committee notes that this seems a very odd method given it makes no attempt to identify an alternative estimate.

4.8 The AHIA-commissioned Price Waterhouse Coopers report takes Treasury's savings estimate for 2008–09 and calculates the likely 'first round' fallout from PHI. The report argued that the government had significantly underestimated the effect of the increased MLS thresholds on the public health system. It claimed that the government's estimated saving of $232 million in 2008–09 is the equivalent of 908 000 people (assuming the 485 000 adults each have on average 0.87 dependants). This figure seems high, given that the people most likely to drop out of the funds are young and single. This represents 9.7 per cent of the insured population.[12]

4.9 In similar vein, the Access Economics report argued that the Treasury's savings estimates are overstated in 2008–09 and understated in subsequent years. It described the $232 million saving estimate in 2008–09 as 'highly implausible' and possible only if there was a 'sudden and large exodus of PHI members' before 1 July

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8 Mr Nigel Ray, Treasury, *Senate Estimates Hansard*, 4 June 2008, p. 8.

9 Mr Paul McCullough, Treasury, *Proof Committee Hansard*, 31 July 2008, p. 17.

10 Mr Marty Robinson, Treasury, *Proof Committee Hansard*, 31 July 2008, p. 18.

11 Mr Nigel Ray, Treasury, *Senate Estimates Hansard*, 3 June 2008, p. 62; Mr Marty Robinson, *Proof Committee Hansard*, 31 July 2008, p. 18.

12 Australian Health Insurance Association, 'Treasury figures show an additional 900 000 Australians will rely on the public hospital sector', *Media Release*, 17 May 2008, p. 1.

2008. It added, 'we do not expect that to happen'.[13] In this context, the report emphasised that the Medicare levy surcharge is only one factor in the decision to join and remain in a private fund. Access Economics argued that other important considerations may include the perceived 'parlous state' of the public hospitals and the Lifetime Health Cover arrangements which reward early and continuous health fund membership.[14]

4.10 Access Economics noted that, based on an average rebate rate of 32 per cent, Treasury's 2008–09 saving estimate is the equivalent of $720 million in lost private health insurance contributions. For the $232 million savings estimate to be realised in 2008–09, 534 000 people claiming the average rebate rate[15] would have to drop their cover by 1 July 2008. Alternatively, for Treasury's savings estimates—and drop out figure of 485 000 adults—to be consistent, those leaving private insurance must have more expensive premiums than the average. Access Economics argued that this is not likely to be the case:

> …the people who might be expected to drop their cover in the first instance would be younger high income earners who have purchased cheaper PHI products…because that is cheaper than paying the surcharge. These are …the people whose reason for joining a fund is focussed much more on tax saving than on sharing their risk or receiving benefits.[16]

4.11 The report did not forecast the number of people who are likely to drop private health insurance cover as a result of the increased surcharge threshold. It argued that not enough is known about the price elasticity of demand for private health insurance.[17]

4.12 In its August 2008 report for iSelect, however, Access Economics did attempt to make an estimate of the likely dropout from PHI. In terms of the first round effect, it estimated that 202 000 PHI policies (359 000 people) will be dropped and of these, 51 per cent will be by those under the age of 35. This was calculated by multiplying the number of policies affected by the policy change by the proportion of singles and households that hold hospital cover to avoid the MLS. The latter figure was derived from a question in the 2004–05 National Health Survey.[18]

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13 Access Economics, 'Health and the 2008–09 Federal Budget', May 2008, p. 6.

14 Access Economics, 'Health and the 2008–09 Federal Budget', May 2008, p. 5. The same point was made by Access Economics in their report released for iSelect on 8 May 2008 titled 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', p. 4.

15 0.32 times their estimate of the average premium of $1360

16 Access Economics, 'Health and the 2008–09 Federal Budget', May 2008, p. 6.

17 Access Economics, 'Health and the 2008–09 Federal Budget', May 2008, p. 6.

18 Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, p. 9.

4.13 Notably, in its August 2008 report, Access Economics estimated a higher PHI rebate savings figure over the forward estimates than that of the Treasury: $1.2 billion compared to $960 million. The corresponding estimate of MLS tax revenue lost was $693 million (compared with Treasury's estimate of $660 million). Allowing for a first round premium increase of 2.7 per cent (see paragraph 4.20) which would increase the government's rebate liability by around $388 million, Access Economics calculates a net saving to the Commonwealth for the forward estimates period of $113 million.[19]

4.14 Professor Deeble has calculated that 488 000 PHI policies (750 000 people) will leave private health insurance as a result of the higher MLS thresholds.[20] As with most other submitters, he identified the fallout to be concentrated on younger members. He also argued that private health insurance membership is more sensitive to income than price, and younger members with lower incomes are likely to take advantage of the higher MLS thresholds and leave the private system (see chapter 5).

The 'second round' effect

4.15 The 'second round' effect refers to:

- the subsequent increase in premiums to compensate for the initial loss of members from the funds;
- more people dropping out of private health insurance as a consequence of higher premiums; and
- the number of people newly reliant on the public hospital system.

4.16 The committee received evidence from most witnesses that the initial dropout from the funds will result in premium increases and further fallout from the funds, placing greater pressure on the public hospital system. The reason is that those most likely to drop their cover initially—the young and healthy—are those cross-subsidising private health insurance for older people under the system of community rating.[21] However there is disagreement about the quantum of the premium increase and the pressure that will be placed on the public hospital system.

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19 Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, p. 19.

20 Professor John Deeble, *Submission 3*, p. 5.

21 'Community rating' refers to the requirement that insurers are not permitted to discriminate on the basis of risk indicators such as existing health, occupation or dietary habits. Most other insurance markets adopt 'risk rating' whereby a person's personal details can and do affect their premiums. See Mr Ian McAuley, 'More than one health insurer is too many: the case for a single insurer, Centre for Policy Development, July 2008, p. 12. iSelect, *Submission 8*, p. 10. See J. Brogden, *Proof Committee Hansard*, 31 July 2008, pp. 24–25.

The effect on premiums

4.17 The committee received various views on the extent to which premiums are likely to increase as a result of the higher MLS thresholds. In their submission to this inquiry, AHIA argued that the bill's measures may increase premiums by as much as 10 per cent. AHIA interpreted Treasury's estimates as indicating that the fallout from the funds will be between 719 000 and 913 000 people. It assumed an average premium of $1 251 per annum[22] and an average fund policyholder aged under 65. If the higher drop out figure of 913 000 is taken, and it is assumed that those exiting made no claims in the last year, the premium increase could be as high as 10.1 per cent.[23]

4.18 Professor Deeble calculates that per person covered, the average private hospital premium (including the 30 per cent rebate) is about $930. Assuming that those dropping out in the first round (750 000 people) have average premiums, private health insurers' revenue would fall by $697 million. Once the benefit savings ($225 million) are deducted, the $427 million revenue deficit (over a remaining 8.37 million people with PHI) could be covered by a 5.1 per cent increase in premiums.[24] He adds: 'the actual result would probably be less…[and] it is hard to see that as any threat to the viability of private health insurance'.

4.19 In its May 2008 report for the AMA, Access Economics arrived at a similar figure of 5 per cent, albeit with different calculations. Access Economics equated Treasury's 2008–09 savings figure of $232 million to a $700 million loss in fund revenue. It added that the corresponding reduction in benefit payments could 'be as little as $200 million'. The resulting $500 million shortfall in revenue translates into a premium increase of 5 per cent.

4.20 In its August 2008 report for iSelect—based on its own modelling rather than Treasury's estimate—Access Economics found that the initial loss of 202 000 policies will result in, on average, a premium increase of 2.7 per cent in the first full year. This, in turn, will result in a further one per cent loss of membership or nearly 40 000 policies.[25]

4.21 The committee has not received any estimate from the government about the possible impact of the higher MLS thresholds on premiums. The government was not required to measure the second round effects. However, the Deputy Secretary of the Department of Health and Ageing, Mr David Kalisch, did advise the committee that

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22 AHIA notes that this is based on PHIAC's current average hospital contribution.

23 Australian Health Insurance Association, *Submission 12*, p. 6. Dr M. Armitage, *Proof Committee Hansard*, 31 July 2008, p. 3.

24 John Deeble, *Submission 3*, p. 8.

25 Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, p. 14.

the department had done some work into the likely increase in premiums. He suggested that premiums would increase as a consequence of the bill's measures by less than 2½ per cent.[26]

4.22 There was significant variation in the estimate of any increase in premiums as a result of the MS threshold changes. It was generally accepted that there would be an increase in premiums for private health insurance regardless of the changes in the MLS thresholds ('the underlying increase') and this has not been quantified. This confuses estimates of any changes particularly as some estimates totalled the estimated underlying increase and the estimated MLS increase. Other evidence just referred to the MLS related estimate.

4.23 Those estimates that clearly related to the MLS related increase tended to be around the 2.5 per cent mark.[27] Professor Deeble estimated a maximum of 5 per cent but added that the actual result would probably be less.

Committee view

4.24 In this complex area it is not possible to make a meaningful estimate of any premium increase as a result of the increase in MLS thresholds. Health funds do not want to lose membership and will presumably try to minimise premium increases, will compete strongly with each other, and will continue to drive down costs.

Impact on CPI

4.25 The committee does not anticipate that the bill will have much impact on the consumer price index. According to the 2003–04 *Household Expenditure Survey*, 'hospital, residual and dental insurance' was 1.7 per cent of total household expenditure and 'hospital and medical services' (which includes doctors' fees and hospital charges as well as PHI) has a weight of 2.8 per cent in the CPI.[28] Even if the PHI 'weight' alone was as high as two per cent, then the CPI impact of the bill would be around 0.1 per cent (.02 x 5 per cent).

The effect on public hospitals

4.26 Unsurprisingly, AHIA also claims that the higher MLS thresholds will have a significant effect on the public hospital system. Using Treasury's PHI dropout figure of 485 000 adults, AHIA calculates an annual additional cost on public hospitals of $234 million. Using its own 'conservative' dropout estimate of 719 000 people, AHIA

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26 Mr David Kalisch, *Proof Committee Hansard*, 12 August 2008, p. 4.

27 Department of Health and Ageing, *Proof Committee Hansard*, 12 August 2008, p. 4; BUPA Australia, *Proof Committee Hansard*, 6 August 2008, p. 3; Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, p. 14.

28 Australian Bureau of Statistics, *Household Expenditure Survey 2003–04*, 6530.0.

estimates an annual additional cost to public hospitals of $347 million. And with their higher dropout figure of 913 000 people[29], the Association calculates an additional annual cost to public hospitals of $442 million[30] based on an estimated average hospital benefit of $484 per person under the age of 65 paid by private health funds.[31]

4.27 AHIA's submission cites the Tasmanian Government's 2008–09 budget papers, which estimate a seven per cent increase in public hospital waiting lists.[32] AHIA suggests that the state government attributes all of this increase to the fallout from private insurance as a result of the higher MLS thresholds. This is not entirely an accurate assumption. The Budget Paper seems to indicate that the MLS change is just one of *several* possible factors contributing to the projected increase in public hospital waiting lists.[33]

4.28 Professor Deeble has also estimated the impact of the bill on public hospitals. He makes three assumptions:

- that 'private insurance patterns of service utilization and cost are replicated exactly in the public system' (ie: the same annual admission rates per person (0.162) and relative cost index (0.79));[34]
- that the average public hospital cost per admission is $4 079 (2007–08);[35] and
- that 750 000 people under the age of 50 will leave PHI and use the public hospital system.

4.29 He then calculates that the increased cost on public hospitals will be $391 million per annum (750 000 x 0.162 x 0.79 x 4 079).[36] This is an extra 2.1 per cent of all inpatient expenditure. A lower annual admission rate for people under 35 reduces the annual impost on public hospitals to $311 million or 1.6 per cent of all inpatient expenditure. Professor Deeble argued that the most likely figure is about

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29 This figure is deduced from Treasury's 2008–09 savings estimate of $232 million.

30 Australian Health Insurance Association, *Submission 12*, p. 9.

31 In a Media Release dated 17 May 2008, AHIA used a dropout figure of 908 000 (rather than 913 000) on (the same) average hospital benefit of $484 per annum to calculate that '…State Governments would require an additional $439 million in 2008/09 to cover the hospital costs of these newly reliant people'. Australian Health Insurance Association, 'Treasury figures show an additional 900 000 Australians will rely on the public hospital sector', *Media Release*, 17 May 2008, p. 1.

32 Australian Health Insurance Association, *Submission 12*, p. 10.

33 Tasmanian Government, *Budget Paper No. 2, Volume 1, 2008–09*, Table 6.4, p. 6.12 (Footnote 4).

34 These figures relate to insured people under the age of 50.

35 This figure relates to insured people under the age of 50.

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

$367 million annually or 1.97 per cent of inpatient expenditure.[37] He added that the net cost to governments will hardly rise at all:

> …because the Commonwealth now pays significant amounts for medical services and drugs for private patients outside the private health insurance system, and gives at least a 30 per cent rebate on premiums...[38]

4.30 The committee emphasises that calculating the effect of the bill's measures on public hospitals is not as simple as adding the hospital cost of PHI dropouts to the new cost on public hospitals. A rigorous assessment of the impact of the MLS threshold increases on the public hospital system must allow for the large number of people with PHI who concurrently use the public hospital system. Dr Robyn Lawrence, Acting Director of the Western Australian Department of Health, alerted the committee to this fact. She told the committee that the department's preliminary analysis[39]:

> …indicates that in 2007-08 the threshold changes could result in an additional 12 511 public patient weighted separations. This would be mainly the result of people who would otherwise have had procedures done as private patients in private hospitals instead of having them done as public patients. If the department had the capacity to provide for all this additional demand, the estimated additional costs for the public hospital system would be of the order of $53.6 million per annum…One of the key assumptions is that the people who drop out of private health insurance are the people who will have otherwise used their insurance—that is, they are the people who resulted in these hospital separations. If this is not the case, which is possible, the impact on the public hospital system may be minimal.[40]

4.31 Access Economics' report for iSelect also acknowledged the need to take into account the use of public hospitals by those currently in PHI. It noted that 'surcharge dodgers—in addition to being younger and healthier than the average—are also more likely to exercise their rights to access public hospitals'. The effect of the bill, therefore, 'is to shift their caseload only to the extent that they are now accessing private health insurance benefits'.[41]

4.32 That noted, Access Economics did anticipate a substantial shift in procedures from privately insured patients to public patients accessing the public hospital system. It argued that, following an estimated first round fallout of 202 000 policies, there will

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37 He added: 'That is less than the figure of $439 million in 2008-09 cited by the Australian Health Insurance Association on different and much broader parameters, but not by a different order of magnitude.' Professor John Deeble, *Submission 3*, pp. 9–10.

38 Professor John Deeble, *Submission 3*, p. 12.

39 This analysis used Treasury's estimate of 485 000 policyholders leaving the private health funds.

40 Dr Robyn Lawrence, *Proof Committee Hansard*, 15 July 2008, p. 3.

41 Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, p. 18.

be a shift of 82 242 'in-patient episodes of care' to the public system in the first year. The second round effect will shift a further 21 166 annual episodes, while by 2012 there will be an additional 265 000 episodes of care per year shifted to the public system.[42]

4.33 However, those who leave the private health funds will have savings from no longer paying premiums and no longer being liable the MLS. This money will increase the capacity for these people to pay for private hospital care out of their own pocket.

Committee view

4.34 The committee believes there will be some impact on the public hospital system. Private hospitals tend to specialise in elective surgery procedures rather than emergencies. The Commonwealth government has announced $3.2 billion for the *National Health and Hospitals Reform Plan* which includes $600 million to reduce elective surgery waiting lists (see Table 4.2). The recent federal budget also provided $1 billion of immediate funding to relieve pressure on public hospitals.[43]

Table 4.2: Proposed funding for public hospitals ($ million)

	2007–08	2008–09	2009–10	2010–11
Elective surgery waiting list reduction plan	75	155	150	220
Health and Hospital Reform—COAG—Additional funding for public hospitals	500			

Source: Budget Paper No. 2, 2008–09, pp 211 and 223.

Should Treasury model the second round effect?

4.35 The committee believes whilst it would be worthwhile for Treasury to model the second round effects of the bill, the assumptions required to underpin such modelling are inadequate for a rigorous analysis to be undertaken. Treasury has itself noted that 'there is a high degree of uncertainty in the impact on potential premiums in future'.[44] Treasury also indicated that modelling the impact on public hospitals 'would be better directed to the Department of Health and Ageing'.[45] The Department of Health has indicated that while it had done some modelling on the impact of the bill on premiums, it is 'still quite speculative'.[46] The committee also recognises that these

42 Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, p. 18.

43 Department of the Treasury, *Submission 14*, p. 2.

44 Mr Marty Robinson, Treasury, *Proof Committee Hansard*, 31 July 2008, p. 18.

45 Mr Marty Robinson, Treasury, *Proof Committee Hansard*, 31 July 2008, p. 18.

46 Mr David Kalisch, Department of Health and Ageing, *Proof Committee Hansard*, 12 August 2008, p. 4.

estimates may compromise the government in its forthcoming discussions with the funds on premium increases.

The 'third round' effect

4.36 Access Economics defines the 'third round' effect as those people who would have taken up private health insurance as their incomes rose into ranges subject to the MLS but now will not do so as they are no longer liable for the surcharge. It estimates that the number of members dropping out from PHI in the first and second rounds will be a constant number for each of the years 2009–2012. However, the loss of members from the third round effect will increase over the period. In other words, for each year after 2008, there will be a rising number of people who would otherwise have taken up PHI if they were liable for the surcharge.[47]

Committee view

4.37 Access Economics explains this growing rate of 'non PHI uptake' in terms of rising incomes, which would have pushed an increasing proportion of taxpayers over the current thresholds, thereby inducing some to join a fund to avoid the surcharge. The committee argues that the extent of this third round effect really reflects the failure of the previous government to increase the original threshold of $50 000 per annum (leading to a form of 'bracket creep'), rather than any fault in the proposed legislation.

Ignorance, apathy and uncertainty

4.38 Several witnesses have emphasised that the effect of this legislation on the private health funds will depend on people's knowledge of the changes and, thereafter, their personal preferences and motivations. Professor Deeble identified a combination of 'ignorance, apathy and uncertainty' as potentially limiting the immediate fallout from the funds. He told the committee:

> Effects will occur over a longer period because I would not expect people to be totally aware of this—it is not the sort of thing people read every day and happily devour, they learn about a thing like this once in a while—so you could expect that a large proportion of the population, despite all of the publicity, will not even know that the change has taken place. They may know when they go to see their tax accountant and he tells them that they may not have to do this any more, but nevertheless there will be a considerable lag.[48]

4.39 Even if they are aware of the change:

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47 Access Economics, report released for iSelect, 'The impact of the changes to the income thresholds for the Medicare Levy Surcharge', 8 May 2008, pp. 10–11.

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

> …some will defer, or forget to take, the necessary action (at least until tax return time) and others will be held in private insurance by the 'Lifetime Health Cover' rules. If they expect their income to rise in the future, not only will liability for the surcharge come back, but the cost of private insurance will be higher. The rules allow for suspension for limited periods but most contributors would not be aware of that.[49]

4.40 Along similar lines, Professor Savage cautioned:

> …it cannot be assumed that all of the people…[between the old and the new thresholds] will drop their cover. This will depend on the motivation for purchasing insurance and the value that insurance provides to them. In many markets there is considerable evidence of persistence—that is, habit—in behaviour despite changes in incentives, and this is true in health insurance markets all over the world…The Lifetime Health Cover surcharge will also provide a continuing incentive for them to maintain continuous cover. Those who enrolled after 2000 and whose premiums currently include the extra loading—the age-related loading—may also maintain their cover, to take advantage of the Lifetime Health Cover policy change, where after 10 years of continuous cover they no longer have to pay the age loading.[50]

Conclusion

4.41 Estimating the effect of the bill on private health fund membership and the public hospital system is a complex task, involving assumptions about consumers' knowledge, opinions and preferences. Nonetheless, there is broad consensus among private health insurers that the MLS threshold increases will result in an initial fallout from the funds, causing their premiums to increase. To some extent, people earning less than $100 000 per annum who would otherwise have taken out PHI will no longer do so. And throughout this process, privately insured patients will shift to the public hospital system placing added pressure on its resources, particularly for elective surgery procedures. However, this must be placed in some context. Professor Deeble noted:

> …the cost of the shift—which is the main thing I was concerned about—to the public hospitals would be about $360 million a year. In a system which I think last year cost $26 billion—it will be about $27 billion this year—that is trivial.[51]

4.42 This chapter has detailed various estimates of the extent to which the funds may lose members (current and prospective), premiums may increase (immediate and medium-term), and public hospitals may be faced with higher demand. The

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49 Professor John Deeble, *Submission 3*, p. 11.

50 Professor Elizabeth Savage, Centre for Health Economics Research and Evaluation, University of Technology Sydney, *Proof Committee Hansard*, 31 July 2008, p. 44.

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

plausibility of all these estimates can be contested, depending on the underpinning assumptions one makes. Given this, the committee stresses the importance of stakeholders' views and insights into the effect of the bill. The next chapter discusses these views in detail.

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]
>
> …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

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.

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?
>
> 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.

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

APPENDIX 1

Submissions Received

Submission Number	Submitter
1	Dr Greg Taylor
2	Associate Professor Elizabeth Savage
3	Dr John Deeble
4	Australian Private Hospitals Association (APHA)
5	Australian Medical Association (AMA)
6	Private Health Insurance Intermediaries Association Inc. (PHIIA)
7	NIB Health Funds Ltd
8	iSelect
9	Catholic Health Australia (CHA)
10	Mr Ian McAuley
11	CHOICE
12	Australian Health Insurance Association (AHIA)
13	Health Insurance Restricted Membership Association of Australia (HIRMAA)
14	The Treasury [Cth]
15	Health Link Consultants
16	Institute of Actuaries of Australia
17	John Small Health Advisory
18	National Seniors Australia (NSA)
19	1805 Consulting
20	Royal Australasian College of Surgeons
21	Australian Nursing Federation (ANF)
22	Mr Michael Cribbin

Additional Information Received

- Received on 17 July 2008, from Queensland Teachers Union Health. '*Facts about Teachers Union Health*';
- Received on 17 July 2008, Australian Medical Association Queensland. Response to inquiry;
- Received on 6 August 2008, from Mr Rob Bransby, Managing Director, HBF. Answers to Questions on Notice taken on Tuesday, 15 July 2008;
- Received on 12 August 2008, from Australian Medical Association National. '*Sea-change since 1995-96…*' chart;
- Received on 13 August 2008, from the Department of Health, Government of Western Australia, Office of the Director General. Answers to Questions taken on notice on 15 July 2008;
- Received on 20 August 2008, from The Treasury. Answers to Questions taken on notice on 31 July 2008.

TABLED DOCUMENTS

- 31 July 2008, SYDNEY, NSW:
    - Catholic Health Australia, Fact Paper;
    - Catholic Health Australia, '*Potential Impact of Change in Medicare Levy Surcharge on Private Health Insurance Membership, patient Episodes and Benefits paid by jurisdiction*' paper;
    - Dr Michael Armitage, Chief Executive, Australian Health Insurance Association, '*Letter received from Kevin Rudd*'.

- 6 August 2008, MELBOURNE, VIC:
    - Mr Terry Barnes, 1805 Consulting, '*Statement to the Committee*' paper;
    - Dr Tim Woodruff, Doctor's Reform Society, '*Australia's health 2008*' paper.

APPENDIX 2

Public Hearings and Witnesses

PERTH, TUESDAY, 15 JULY 2008

- BRANSBY, Mr Robert, Managing Director
  HBF Health Funds Inc.
- CHENEY, Mrs Carol, Acting Manager,
  Inter-Governmental Relations, Department of Health, Western Australia
- GIBSON, Mr Graeme, Chief Executive,
  Health Insurance Fund of Western Australia
- JENNINGS, Mr Peter, Deputy Executive Director,
  Australian Medical Association (WA)
- KELLY, Dr Shane Patrick, Chief Executive Officer,
  St John of God Hospital, St John of God Health Care Inc
- LAWRENCE, Dr Robyn Ann, Acting Director-General,
  Department of Health, Western Australia
- SOUTH, Ms Jodie, Senior Project Coordinator,
  Health Reform Implementation Taskforce, Department of Health, Western Australia

BRISBANE, THURSDAY, 17 JULY 2008

- GALLAGHER, Mr Kerry, Chief Executive Officer,
  Australian Medical Association, Queensland
- KEARNEY, Ms Ged, Federal Secretary,
  Australian Nursing Federation
- KENDELL, Mrs Kathy, Consumer Representative Member,
  Public Hospitals, Health and Medicare Alliance of Queensland
- RHEINBERGER, Mr Gregory John, Executive Manager,
  Health Fund Strategy, Teachers Union Health Fund Ltd
- SCHRADER, Dr Tracy, Doctors Reform Society (DRS) Representative,
  Public Hospitals, Health and Medicare Alliance of Queensland
- SELJAK, Mr Robert, Chief Executive Officer,
  Queensland Teachers Union Health Fund Ltd; Board Member, Australian Health Insurance Association
- SMALL, Mr John, Managing Director,
  John Small Health Advisory
- THOMAS, Ms Lee, Assistant Federal Secretary,
  Australian Nursing Federation

ADELAIDE, TUESDAY, 22 JULY 2008

- GERICKE, Professor Christian Ansgar Otto,
  Professor of Public Health Policy, and Director, Centre for Health Services Research, University of Adelaide
- GREGORY, Mr Byron John, Chief Executive Officer,
  Health Partners Limited
- SEGAL, Professor Leonie
- WALKER, Mr Stephen Ross, President,
  South Australian Branch, Australian Private Hospitals Association

SYDNEY, THURSDAY, 31 JULY 2008

- ARMITAGE, The Hon. Dr Michael, Chief Executive Officer,
  Australian Health Insurance Association
- BROGDEN, Mr John, Chief Executive Officer,
  Manchester Unity Australia Ltd
- FITZGIBBON, Mr Mark Anthony, Chief Executive Officer,
  NIB Health Funds Ltd
- LAVERTY, Mr Martin John, Chief Executive Officer,
  Catholic Health Australia
- MARONEY, Mr John, Chief Executive,
  Institute of Actuaries of Australia
- McCULLOUGH, Mr Paul, Acting Executive Director,
  Revenue Group, Department of the Treasury
- O'CONNOR, Mr Mark John, Principal Adviser,
  Personal and Retirement Income Division, Department of the Treasury
- PERFECT, Ms Anna Margaret, Senior Policy Officer,
  National Seniors Australia
- ROBINSON, Mr Marty, Unit Manager,
  Household Modelling and Analysis Unit, Tax Analysis Division, Department of the Treasury
- RODGER, Mr Stuart, Convenor,
  Health Practice Committee, Institute of Actuaries of Australia
- ROFF, Mr Michael, Chief Executive Officer,
  Australian Private Hospitals Association
- SAVAGE, Associate Professor Elizabeth
- TOBIN, Mr Patrick Dudley, Director, Policy,
  Catholic Health Australia

MELBOURNE, WEDNESDAY, 6 AUGUST 2008

- BARNES, Mr Terence John
- BOWDEN, Mr Richard, Deputy Managing Director,
  BUPA Australia
- BROWN, Mr Gerald, Chief Operating Officer,
  iSelect
- CARTON, Mr Gerard Patrick, CEO,
  Private Health Insurance Intermediaries Association Inc.
- MARTIN, Mr Rowan, General Manager,
  Corporate Affairs, iSelect
- RASHLEIGH, Mr John, President and Chairman,
  Health Insurance Restricted Membership Association of Australia
- SASSON, Mr Peter, President,
  Private Health Insurance Intermediaries Association Inc.
- SCULLIN, Mr Peter, Managing Director,
  Health Link Consultants
- WALLER, Mr Damien, Chairman and CEO,
  iSelect
- WOODRUFF, Dr Tim, President,
  Doctors Reform Society

CANBERRA, TUESDAY, 12 AUGUST 2008

- DEEBLE, Dr John Stewart
- DUSINK, Ms Pauline, Director,
  Private Health Insurance Branch, Acute Care Division, Department of Health
- FLANAGAN, Ms Kerry, First Assistant Secretary,
  Acute Care Division, Department of Health and Ageing
- HANCOCK, Ms Veronica, Assistant Secretary,
  Medical Indemnity Branch, Acute Care Division, Department of Health and Ageing
- KALISCH, Mr David, Deputy Secretary,
  Department of Health and Ageing
- KINGDON, Ms Anne, Director,
  Private Health Insurance Branch, Acute Care Division, Department of Health and Ageing
- McAULEY, Mr Ian
- O'DEA, Mr John, Assistant Secretary General,
  Policy, National Branch, Australian Medical Association
- SULLIVAN, Mr Francis, Secretary General,
  National Branch, Australian Medical Association