Australian
Private Hospitals
Association

Mr John Hawkins
Secretary
Senate Economics Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Hawkins

On behalf of the Australian Private Hospitals Association (APHA), I have attached a submission to the Senate Economics Committee's Inquiry into the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008.

APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute medical surgical hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

Current accreditation is a condition of membership of APHA.

APHA would be pleased to expand on the material in this submission at any of the Public Hearings scheduled by the Committee.

Please contact me if APHA can assist further on this issue.

Yours sincerely

Michael Roff
CHIEF EXECUTIVE OFFICER
7 July 2008

SUMMARY POINTS OF APHA SUBMISSION TO THE SENATE ECONOMICS COMMITTEE INQUIRY INTO THE TAX LAWS AMENDMENT (MEDICARE LEVY SURCHARGE THRESHOLDS) BILL 2008

Neither governments nor the private sector acting alone can deliver a health system that is equitable, efficient and sustainable. While not perfect, Australia's balanced health care system has achieved great success by drawing on the strengths of the private and public sectors.

Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian health system.

Private hospitals:

- treat almost 40% of all hospital patients;
- provide 32% of all hospital beds;
- perform 56% of all surgery;
- provide 69% of sameday mental health treatment and 43% of all hospital-based psychiatric care;
- treat over 1 million patients aged over 65 years; and
- employ over 50,000 staff (FTE).

An indication of the health system's inefficiency is that each year public hospitals treat over 380,000 patients whose treatment is funded by private health insurance and private hospitals treat over 100,000 public patients.

Australian Government's support for private health insurance enabled almost 2.7 million patients to be treated in 2006-07 in private and public hospitals. These patients represented 35% of all patients treated in that year.

In the 2008-09 Federal Budget, the Government announced that it would raise the thresholds at which the Medicare Levy Surcharge applies, to $100,000 for single people and $150,000 for couples and families. Surprisingly, the Government did not propose any form of indexation of the thresholds.

The Federal Treasury expects at least 484,000 adults to either drop out of private health insurance or not take up cover as a direct result of the proposed increases in the thresholds for the Medicare Levy Surcharge, which is likely to be an underestimate.

Regardless of the actual number of people who drop their private health insurance or never take out cover, a direct consequence of the Government's proposal will be an increase in private health insurance premiums which could be as high as 5% over and above any premium increase required to offset increases in costs.

Insured people aged 65 years and older comprise 13% of the insured population but account for 45% of private health insurance benefits paid from hospital tables. The average benefit paid per person aged 65 and older is some 5.4 times the average benefit paid to those aged under 65, who comprise 87% of insured members.

The Government's proposal will impact adversely on public hospitals and their patients, perhaps by as much as $1.76 billion in additional costs per year.

The proposal will also impact adversely on the provision of private hospital services in rural and regional areas and on investment generally in the sector.

If policy change is required in this area, it would appear to be more equitable (and sensible) to increase the thresholds for the Medicare Levy Surcharge by using a transparent measure of changes in earnings or prices over the period since 1997.

Using the total average weekly earnings index, APHA estimates that the threshold would have increased to approximately $76,000 (single income earner) and $152,000 (couples and families) by February 2008. In order to ensure that a similar situation does not arise again in the near future, it would seem sensible to index the thresholds for the Medicare Levy Surcharge from 2009-2010 in line with the total average weekly earnings index.

Should this proposal be adopted, an additional measure for consideration is the rate of Medicare Levy Surcharge itself. The measure has been in place for 11 years, over which time health insurance premiums have increased by more than 50%. In such circumstances, it may be appropriate to increase the Medicare Levy Surcharge by a similar proportion to 1.5% of taxable income at and above the revised threshold levels.

SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE SENATE ECONOMICS COMMITTEE INQUIRY INTO THE TAX LAWS AMENDMENT (MEDICARE LEVY SURCHARGE THRESHOLDS) BILL 2008

Background

Australia has a health system that is largely funded by government (directly or indirectly), supported by private health insurance, that provides access to health services which are delivered predominately by private practitioners in private settings.

History and international experience indicate that neither governments nor the private sector acting alone can deliver a health system that is equitable, efficient and sustainable. While not perfect, Australia's balanced health care system has achieved great success by drawing on the strengths of the private and public sectors, and arguably performs much better overall than countries such as the United Kingdom and the United States.

The Australian Private Hospitals Sector

Private hospitals are a vital and complementary partner to the larger public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian health system.

While some of the large acute medical/surgical private hospitals are virtually undistinguishable from their public sector counterparts in the range and type of services provided, for the most part, private hospitals are quite different from public hospitals in size and types of services offered. This is particularly evident in the mental health sector in which private facilities provide treatment for quite distinct conditions to those treated in the public sector. Indeed, the mental health area is a good example of the complementarity of the private and public sectors.

Contrary to the views expressed by some commentators, the private hospitals sector does provide a comprehensive range of services; does treat older patients; does not merely provide 'profitable' services (whatever these may actually be); does provide training for medical, nursing and allied health staff; does provide safe and quality services; and does contribute significantly to the balance and sustainability of the Australian health system.

The Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the Private Health Insurance Administration Council all report a range of data on aspects of the hospital system, private and public. Selected highlights of the latest data[1] include:

[1] Australian Bureau of Statistics, *Private Hospitals Australia 2006-07*; Australian Institute of Health and Welfare, *Australian Hospital Statistics 2006-07*; Private Health Insurance Administration Council, *Operations of the Private Health Insurers, Annual report* 2006-07.

- Private hospitals treat almost 40% of all hospital patients;
- Private hospitals provide 32% of all hospital beds;
- Private hospitals perform 56% of all surgery;
- Private hospitals provide 69% of sameday mental health treatment and 43% of all hospital-based psychiatric care;
- Of the total 662 different procedures and treatments undertaken in Australian hospitals, private hospitals provide 658;
- Private hospitals treat over 1 million patients aged over 65 years each year;
- Private hospitals employ over 50,000 staff (FTE);
- Private hospitals invest over $35 million of their own funds in the education and training of health professionals;
- An indication of the health system's inefficiency is that each year public hospitals treat over 380,000 patients whose treatment is funded by private health insurance and private hospitals treat over 100,000 public patients.

Why support private health insurance?

Private hospitals are funded by their owners and operators. The services provided to patients treated in private hospitals are partially or fully subsidised from a variety of sources, including private health insurance funds, the Department of Veterans' Affairs, third party insurers, State and Territory governments and out-of-pocket payments by patients.

Privately insured patients account for 77% of patients treated by private hospitals (2.3 million patients in 2006-07). In addition, as noted above, over 380,000 privately insured patients received their treatment in a public hospital in 2006-07.

These patients and other insured consumers elect to provide funding towards their hospital, medical and allied health costs and, in recognition of this personal effort, the Australian Government provides consumers with direct support through the 30%, 40% and 45% rebates which offset part of the cost of private health insurance premiums.

In addition to this direct support for consumers, the Australian Government also provides indirect support for private health insurance through Lifetime Health Cover and the Medicare Levy Surcharge.

This support for private health insurance enabled almost 2.7 million patients to be treated in 2006-07 in private and public hospitals. These patients represented 35% of all patients treated in that year.

Medicare Levy Surcharge Thresholds

Indexation

In the 2008-09 Federal Budget, the Government announced that it would raise the thresholds at which the Medicare Levy Surcharge applies, to $100,000 for single people and $150,000 for couples and families. Somewhat surprisingly, the Government did not propose any form of ongoing indexation of the thresholds.

It has been argued that a penalty tax measure intended to apply above a particular income level requires some form of indexation if it is to continue to be equitable over time. As the Government is justifying these proposals on the basis that the new thresholds make up for the lack of indexation since the introduction of this measure, it appears nonsensical that they have not applied any ongoing indexation to the new thresholds. Therefore, they are simply recalibrating the policy error they claim to be rectifying.

Introducing the legislation to establish the Medicare Levy Surcharge in late 1996, the then Health Minister Dr Wooldridge stated that the measure would provide

"encouragement to high income earners who can afford to take out private health insurance to do so."[2]

The thresholds for the measure were set at $50,000 (single income earner) and $100,000 (couples and families, with a small increase for children) but were not indexed. The then Shadow Minister for Health, Mr Lee sought to amend the legislation to apply indexation to the thresholds, as follows:

"these amendments seek to index the income thresholds at which the new Medicare levy will be applicable, by using the total average weekly earnings index. We think that is most appropriate, given that we are dealing with income limits."[3]

Had the income thresholds at which the surcharge applies been indexed from 1 July 1997 as proposed by the then Shadow Health Minister, the thresholds would have reached approximately $76,000 (singles) and approximately $152,000 (couples and families) by the February quarter 2008[4]. Indeed, Treasury officials have confirmed that indexation of the thresholds from inception would have resulted in current thresholds of this order.[5]

As average incomes have increased significantly since 1997, an increasing number of 'average' income earners have been subject to the application of the Medicare Levy Surcharge as a direct consequence of the thresholds not being indexed.

However, the decision by the Rudd Government to increase the thresholds so far beyond the level at which indexation would have applied will be grossly inequitable

[2] Parliamentary Debates, 12 December 1996 p. 8469
[3] Parliamentary Debates, 26 February 1997, p. 1334
[4] Australian Bureau of Statistics, *Average Weekly Earnings Australia*, February 2008.
[5] Senate Economics Committee, *Budget Estimates 2008-09*, p. E56.

for people who are covered by private health insurance, as community rating gradually becomes eroded.

Community rating essentially means that all individuals pay the same premium for the same health insurance product. In this it differs from all other forms of insurance, which are risk-rated; that is, the premium is set by the insurer on the basis of the level of risk of the insured person. The fundamental problem for community rating caused by the Government's decision to so drastically raise the thresholds is that the 'good' risks (those less likely to make a claim), will drop their private health insurance, thus leading to an imbalance in the composition of the insured population.

Insured people aged 65 years and older comprise 13% of the insured population but account for 45% of private health insurance benefits paid from hospital tables. The average benefit paid per person aged 65 and older is some 5.4 times the average benefit paid to those aged under 65, who comprise 87% of insured members[6]. It can be seen therefore that major changes that undermine the fragile age balance of the insured population (such as the proposed changes to the Medicare Levy Surcharge thresholds), must have correspondingly dramatic implications for the capacity of health insurers to continue to service claims without needing to raise premiums.

The measure will also cause greater inequity for those people trapped on public hospital waiting lists because those lists and accompanying waiting times can only lengthen under the Government's new tax measure.

Impact of the Government's proposals

We know from the Government's Budget announcement and subsequent discussion during the Senate Budget Estimates process, that the Federal Treasury expects at least 484,000 adults to either drop out of private health insurance or not take up cover as a direct result of the proposed increases in the thresholds for the Medicare Levy Surcharge. While APHA has not commissioned its own modelling, the modelling undertaken by a number of other organisations indicates that the Treasury's figures may underestimate the impact of the increased thresholds. Depending on the assumptions underpinning the modelling, this underestimate could be by as much as 100%.

Regardless of the actual number of people who drop their private health insurance or never take out cover, a direct consequence of the Government's proposal will be an increase in private health insurance premiums. It is not possible to be certain exactly how high this increase will be (and therefore how severe the flow-on effects on membership will be) however, it has been estimated that this increase could be as high as 5% over and above any premium increase required to offset increases in costs.[7]

In addition, we also know that the Government's proposal will impact adversely on public hospitals and their patients. Again, it is impossible to be certain of the degree

[6] Private Health Insurance Administration Council, Quarterly Statistics, March Quarter 2008
[7] Access Economics P/L, *Health and the 2008-09 Budget: a report for the Australian Medical Association*, p.7

of the impact, although some estimates indicate that it could be of the order of $1.76 billion per year.[8]

Somewhat surprisingly, neither the Treasury nor the Department of Health and Ageing believed that it would be necessary to include in their modelling the possible impact of the measure on public hospitals. During a recent Senate Estimates Committee hearing, a Deputy Secretary of the Department of Health and Ageing was asked

"Senator Cormann–So you have essentially not conducted any assessment of the impact on public hospitals on the basis it is a second round effect?

Mr Kalisch–Yes, that is correct."[9]

That is, despite Treasury's own modelling indicating that more than 484,000 adults[10] will now be solely reliant on the public hospital system, there has been no attempt to quantify the extra cost to government that will be required. Therefore, any savings identified by the Government must (at best) be highly questionable and, at worst, illusory.

Advice received by APHA indicates that Treasury's modelling assumes that all the drop-out from private health insurance will occur in 2008-09 and that growth in private health insurance membership will revert to the 'long-term' average of around 200,000 extra people insured each year.

We know from experience that the Australian population actually don't react in this way to severe policy shocks such as that proposed by the Government. The far more likely scenario is that there will be a large drop-out of people from private health insurance during 2008-09 and that this will be only the starting point for a downward spiral of increasing health insurance premiums and a falling insured population.

Furthermore, Treasury has explained that an unspecified proportion of the 484,000 reduction in private health insurance membership are people who would have taken up cover (but now won't) had the thresholds remained unchanged. It is therefore not credible to assume that growth rates would return to historical levels if part of the impact is to actually dampen growth.

It is also evident that neither Treasury nor the Department of Health and Ageing have made any attempt to estimate the impact of the Government's proposal on rural and regional areas. During the Senate Estimates Committee hearings, the following exchange took place:

Senator ADAMS-Has the Department estimated the impact on rural areas of the change to private health insurance arrangements? I believe that, if the rate of private

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[8] Australian Health Insurance Association, *Federal Budget 2008/09: Impact of the Federal Government decision to modify the Medicare Levy Surcharge thresholds*, p. 1

[9] Senate Community Affairs Committee, *Budget Estimates 2008-09*, 4 June 2008, p. CA34

[10] Note that the actual number will be higher than 484,000 people as Treasury and the Department of Health and Ageing have conceded that their calculations only include adults and not the dependents also covered by family policies.

health insurance in rural and remote areas were known, it would provide further insight into the disadvantage of people in the bush. Has anything been done on that?

Ms Flanagan-No, it has not.[11]

The latest data from the Australian Bureau of Statistics (ABS) indicates that approximately 26% of all private hospital beds (6,332 beds) are located outside the capital cities.[12] These hospitals provide a vital role in local communities in the provision of health care services, as substantial employers of local residents, as purchasers of goods and materials from local businesses and, together with local public hospitals, as a means of attracting medical practitioners to live and work in the area.

Uncertainty over the proportion of the population who will remain covered by health insurance can only cause disquiet and apprehension in these communities who know only too well how fragile rural infrastructure can be. The loss of a rural or regional private hospital or even the loss of particular specialist services has a ripple effect on the local community.

The latest ABS data also indicates that capital investment by the owners and operators of private hospitals has started to increase as confidence has improved in the sector. However, uncertainty around the insured population and the impact that this will have in next 5 years is very likely to lead to a downturn of investment. This will severely inhibit the ability of private hospitals to maintain existing capacity, let alone expand to meet future demand and continue to assist the public hospital sector to meet the health care needs of the population.

This shoddy and haphazard policy development hardly engenders confidence that either the Treasury or the Health Department (and by inference the Government) have any understanding of the likely total impact of this poorly considered proposal. Obviously, far from a net saving to the Commonwealth, there will be substantial increases in outlays as a result of this measure.

APHA has also been advised that the Treasury has modelled the likely insured population at the end of the forward estimates period. Despite repeated requests, this data is yet to be released to APHA.

Is there another way forward?

If policy change is required in this area, it would appear to be more equitable (and sensible) to increase the thresholds for the Medicare Levy Surcharge by using a transparent measure of changes in earnings or prices over the period since 1997. A variety of indices exist, however, it would seem sensible to adopt then Shadow Health Minister Mr Lee's 1997 proposal to index the Medicare Levy Surcharge thresholds using changes in total average weekly earnings.

[11] Senate Community Affairs Committee, *Budget Estimates 2008-09*, 4 June 2008, p. CA58
[12] Australian Bureau of Statistics, *Private Hospitals Australia 2006-07*; p.19

APHA estimates that this index would have increased the threshold to approximately $76,000 (single income earner) and $152,000 (couples and families) by February 2008. In addition, in order to ensure that a similar situation does not arise again in the near future, it would seem sensible to index the thresholds for the Medicare Levy Surcharge from 2009-2010 in line with the total average weekly earnings index.

Should this proposal be adopted, an additional measure for consideration is the rate of Medicare Levy Surcharge itself. The measure has been in place for 11 years, over which time health insurance premiums have increased by more than 50%. In such circumstances, it may be appropriate to increase the Medicare Levy Surcharge by a similar proportion to 1.5% of taxable income at and above the revised threshold levels.

'Basic' health insurance products

An unfortunate effect of the Medicare Levy Surcharge has been the proliferation of relatively low cost health insurance products with a variety of restrictions and exclusions. Some of these have been priced (and marketed) to attract those people who may have felt forced into private health insurance as a result of the Medicare Levy Surcharge thresholds.

APHA believes that these products do little to add value to private health insurance and are often discriminatory in their impact. For example, of particular concern is that a number of cheaper private health insurance products that are marketed specifically to younger people include some form of restriction or limitation on benefits for private mental health services.

The Private Health Insurance Ombudsman (PHIO) has consistently expressed concerns about such products over a number of years and in 2006, **the PHIO actually recommended that consumers avoid these products**.[13]

APHA recommends that such health insurance products be prohibited. Such a measure will ensure that consumers using their private health insurance will not discover to their cost that their health insurance product does not meet their needs.

APHA recommends:

That the Private Health Insurance (Complying Product) Rules 2008 be amended to prohibit the sale of a health insurance product that includes a restriction, limitation or exclusion of any treatment or service beyond that which is provided for elsewhere in legislation.

It may be that the greatest impact of the Government's measure falls on consumers who hold basic insurance products and receive treatment in public hospitals as a private patient. As noted earlier, there were 380,000 such patients in 2006-07.

[13] Private Health Insurance Ombudsman, *State of the Health Funds Report 2006*, p. 8