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08/162

Mr John Hawkins
Committee Secretary
Senate Economics Committee
Department of the Senate
PO Box 6100
Parliament House
CANBERRA ACT 2600

Sent by email to economics.sen@aph.gov.au

Dear Mr Hawkins

Please find attached the AMA's submission to the Committee's inquiry into the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008.

The AMA would be pleased to attend the public hearing in Canberra on 30 July 2008 if the Committee wishes to take further evidence.

If you require further information please contact me on (02) 6270 5463.

Yours sincerely

John O'Dea
Deputy Secretary General, Policy

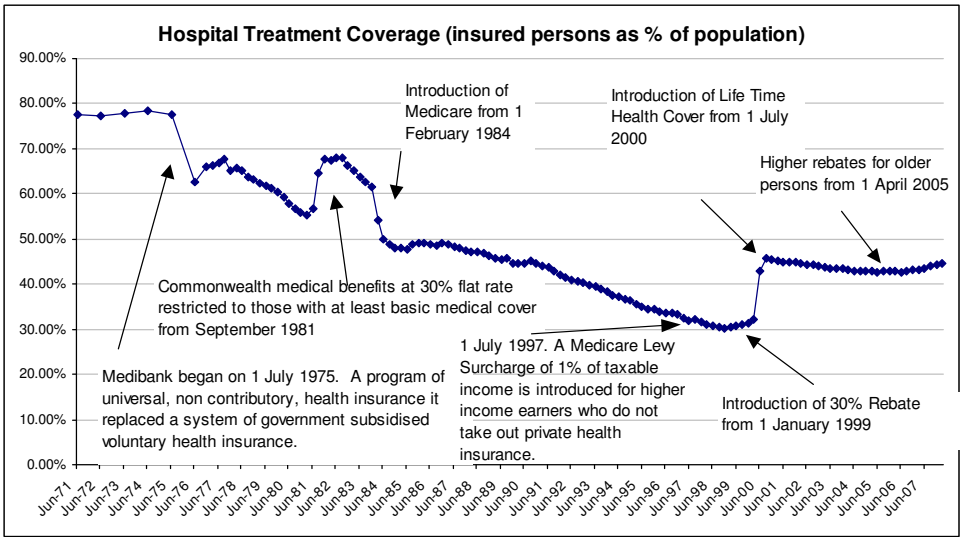
jod:bh D08/5215

AMA Submission to the
Senate Standing Committee on Economics inquiry into the
Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008.

1. Introduction

Australia's health system is a delicate balance between the public and private sectors. The effectiveness and efficiency of the public system relies on a strong private sector. A high rate of private health insurance membership is a key part of the private sector.

After the introduction of Medicare in 1984, private health insurance participation steadily declined as risk profiles of membership, and consequently premiums, increased. By 1998 membership had fallen to close to 30% of the population.



Source: Private Health Insurance Administration Council

Halting more than a decade of decline required Federal Government intervention with three critical support mechanisms: the Medicare Levy Surcharge; the private health insurance rebate; and Lifetime Health Cover. Participation recovered as shown by the graph above and has remained stable for the last eight years. At 31 March 2008, 44.6% of the population was covered for hospital treatment[1].

The AMA recognises that, in increasing the Medicare Levy Surcharge income thresholds, the Government's prime stated objective is to provide tax relief so that working families on average wages have choice about how they spend their money[2].

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

[1] Private Health Insurance Administration Council. Quarterly Statistics. Table 1).
[2] The Hon Chris Bowen MP, Assistant Treasurer. Second Reading Speech. House of Representatives. Hansard, 27 May 2008 pages 3349-50.

premiums. In turn, the public hospital sector will experience increased demand down the track.

The Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008 (the bill) will have an impact on private health insurance membership and, consequently, will also have implications for users of public hospitals. Taking all of this into account, the AMA considers that the bill does not represent good health policy.

This submission examines the impact on private health insurance membership. It also highlights the implications for users of public hospitals.

The AMA concludes that the Senate should not pass the bill.

2. Impact on private health insurance membership

The Australian health financing system relies on intergenerational tax transfers. Similarly, affordable private health insurance premiums require a reasonable balance of health risk in the insured population. In Australia private health insurance is community rated so that the young and the healthy share the cost of the health care needs of the older and the sick. Section 55-1 of the *Private Health Insurance Act 2007* explains the purpose of community rating:

> "To ensure that everybody who chooses has access to health insurance, the principle of community rating prevents private health insurers from discriminating between people on the basis of their health or for any other reason described in this Part."

The impact that the bill will have on private health insurance membership (membership) is directly dependent on whether premiums remain affordable. In turn, whether premiums remain affordable is directly dependent on the risk profile of people with private health insurance. Rigorous modelling is required to fully assess the longer-term impact that the bill will have on membership.

Modelling

The AMA considers that the Treasury modelling is flawed because it does not consider the second round effects[3] which, in this case, are the most important effects.

The Treasury has estimated that in the initial year, there will be 186,000 fewer singles and 149,000 fewer families covered by private health insurance than would otherwise be the case as a result of the new threshold. The loss of these 335,000 memberships is equivalent to the loss of 484,000 adult members. Treasury has not disclosed its estimate of the total reduction in membership. That depends on the number of children covered by family memberships. Nevertheless, the AMA considers the Treasury estimate to be broadly consistent with the estimated reduction in private health insurance rebate expenditure in the first year.

The Treasury has further forecast that the response to the policy occurs in the first year and that there are no further effects in later years. Past experience indicates that

[3] Hansard. Senate Standing Committee on Economics. Estimates. 3 June 2008. Page E58.

there will be substantial second round effects if the initial withdrawal from private health insurance is as large as the Treasury predicts.

The policy, if implemented, can be expected to have the following effects:

- a negative impact on the cash flow of private health insurers as the younger members leaving generally pay more in premiums than they draw in benefits;
- consequential cycles of rising private health insurance premiums because of lower participation rates;
- the shake out of higher claiming members in response to rising premiums leading to:
  - increased demand on public hospitals[4]; and
  - claims by state governments for compensation through the Australian Health Care Agreements (ACHAs).

Cash flows
Access Economics has provided advice to the AMA indicating that the government's estimate of $232m savings in 2008-09 implies a loss of contribution revenue to the health insurers of over $700 million. If the group that drops their membership is the young, low-claiming membership, the corresponding reduction in benefit expenditure is estimated at about $200 million, leaving the health insurers short about $500 million.

Spirals of rising premiums and declining members
Private health insurers are required to meet minimum capital adequacy and solvency standards to ensure that they are financially able to pay future claims of members and they annually assess whether they need to increase premiums to meet these regulatory requirements.

Access Economics has estimated that a cash flow shortfall of $500 million would require a premium increase in the following year of 5% over and above any premium increase that would have been required already to cover increased costs.

A premium increase of that quantum would inevitably lead to a further reduction in members and so a spiralling decline in membership would commence. Instead of a one-off reduction in participation that Treasury has modelled, there will be a long-term cascading effect on membership as premiums increase to compensate for the decline in young membership as more people drop their health insurance as a result of the consequent premium increases. The stability of membership experienced over the last 8 years will be lost.

While the government can theoretically disallow premium increases, in reality it has few degrees of freedom if such a decision would put the health insurers in breach of the prudential regulations.

Diminishing value of private health insurance
There are other possible consequences of a declining membership. For example, insurers may seek to minimise their benefit outlays by interfering in the doctor/patient

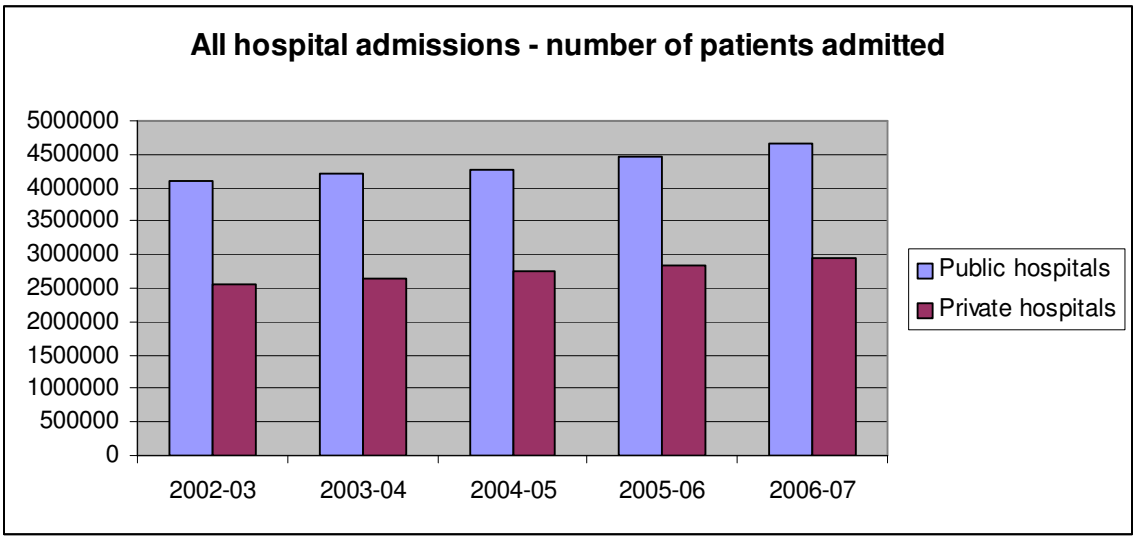
[4] Tasmanian 2008-09 Budget Papers. Page 6.12

relationship and possibly restricting their care choices through managed care-type arrangements. The value proposition will diminish for consumers as higher premiums cover less services, or only certain types of services. The risk profile of membership would change, with a much greater proportion of the membership becoming users of the health care system.

In summary, the bill will adversely impact on membership. People who retain their private health insurance will have to pay higher premiums because of lower participation and a changing risk profile of the privately insured population. In the past when private health insurance subsidies have been pared by governments, the impact has been like a rolling snowball. The initial loss of members, especially if they are low-claiming members, inevitably means premium rises for those retaining their cover in the first instance. These premium increases shake out more members and more premium rises result in time.

3. Implications for users of the public hospital system

In 2006-07 private hospitals provided 38.7% (2.9m) of hospital separations[5] and more than half of all surgery[6]. This reflects the important role not only of private hospitals but also of private health insurance in maintaining a balanced public/private hospital system in Australia. This balance is illustrated by the graph below showing the number of patients admitted to public and private hospitals since 2002-03.



Source: Australian Institute of Health and Welfare. Australian hospital statistics 2006-07.

During the second reading speech debate in the House of Representatives, the Hon Gary Gray MP, Parliamentary Secretary for Regional Development and Northern Australia stated that the younger cohort generally has less need for high-cost healthcare measures and that there will not be a tsunami of people descending into

[5] Australian Institute of Health and Welfare. Australian hospital statistics 2006-07. May 2008.
[6] The State of our public hospitals June 2008 Report. Page 36.

public hospitals[7]. However, the "younger cohort" does use private hospitals, and without private health insurance, will need to use public hospitals instead.

For the purposes of high level analysis, and consistent with the Government's stated objectives of introducing this measure to provide tax relief for working families, we can assume that the people who are more likely to drop their cover are under the age of 40 years (and that their children will also leave). In the 12 months to 31 March 2008, private health insurers paid for a total of 650,285 episodes of hospital treatment for people between the ages of 0 and 39[8]. The "younger cohort" represents 20% of privately insured episodes.

The AMA does not have access to the necessary information in order to make an assessment of how many of these people would retain their health insurance because they earn above the income thresholds proposed by the bill. However, these figures clearly demonstrate that the members of this "younger cohort" are users of acute care services and, if they drop their private health cover, will need to access public hospitals for these services.

The Minister for Health and Ageing has admitted that our public hospitals are under severe strain, with public hospital admissions increasing faster than population growth[9].

In 2006-07 there were 556,770 admissions from public hospital waiting lists with the median waiting time of 32 days, but ranging from 25 days in Queensland to 63 days in the Australian Capital Territory[10]. The situation is worse in respect of the majority of patients. The waiting times for 90th percentile of patients waiting for admission to public hospitals was 226 days[11]. The AMA believes that the current waiting times for elective surgery are not acceptable.

Meanwhile, there are reports that short term funding from Federal Government to address current waiting lists for elective surgery in the public hospital system is having minimal impact in some jurisdictions. An article in the West Australian on 26 June 2008 states that in Western Australia there are more public patients waiting now than six months earlier.

At best, this short term funding of $150 million will provide a one-off reduction of 25,278 people[12] on the current waiting list in 2008 and will not be sustained in future years. It is certainly insufficient to assist state and territory governments to handle the increased demand from patients who drop their health insurance as a result of this bill and still require public hospital treatment.

In short, the impact of this bill is that people who use public hospitals will wait longer for admission than they already do.

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[7] Second reading speech. Hansard. House of Representatives. 29 May 2008. Page 3802.
[8] Private Health Insurance Administration Council. PHIAC A report at www.phiac.gov.au.
[9] Press release on *The State of our Public Hosptals* June 2008 Report. 30 June 2008
[10] Australian Institute of Health and Welfare. Australian hospital statistics 2006-07. May 2008. Page 128
[11] Table 6.1 Page 133
[12] Ministerial Council Meeting Communique. 14 January 2008.

Even with the current public/private mix, the AMA estimates that public hospitals already need at least $3 billion to open an additional 3,750 beds just to cope with current demand and operate at safe occupancy levels (no more than 85% occupancy rates). This estimate was made without any consideration of the possible additional impact on public hospital demand as a result of the bill.

The AMA believes that it would be appropriate for all states and territories to model the potential impact on their public hospital system with a view to formally seeking additional funding to cope with this increased demand over the life of the next Australian Health Care Agreements (AHCAs). The AMA notes that the Tasmanian Government has already flagged in its budget papers that there will be an increased demand on public hospitals from a fall in participation in private health insurance as a result of the change to the Medicare Levy Surcharge thresholds.

In summary, the proposed change will adversely impact on people who currently rely on public hospitals, by increasing demand in an already stretched/overloaded system. The AMA expects that this will not be a one off change in demand: the demand for public hospital services will increase over time as premium increases cause ongoing decline in health insurance membership which in turn causes further premium increases. The net result of this will be that there is an ongoing exponential increase in demand for public hospital services.

The AMA believes that the government should make transparent all of the additional financial consequences of the bill, including amounts required to cover contingent risks such as additional funding required by public hospitals in the future, before asking the Senate to agree to the changes they are proposing.

4. Reducing the impact

While strongly advocating that this bill should not be supported for reasons outlined above, if the Senate does agree to pass the bill, the AMA believes it will be necessary to introduce additional measures to reduce some of the impact that it will cause to the health system.

The next Australian Health Care Agreements (ACHAs) should contain an explicit provision to provide additional public hospital funding to the states and territories for each half a percentage point decrease in private health insurance participation rates over the life of the next agreements.

In addition, the AMA considers that it would be essential to try and stem the flow of younger, healthier fund members from private health cover by providing further financial assistance to low-income private health insurance members to compensate for the inevitable increase in premiums that will arise. This could take the form of increasing the private health insurance rebate or providing some other financial assistance or tax relief to low-income earners to help them retain their private health insurance. Whatever form this assistance takes, it would also need to be reviewed each year in the context of the premium increases allowed by the Minister for Health and Ageing.

Finally, it is essential that the Government take no further action which will erode private health participation in Australia. Private health insurance is a key factor in supporting private acute care in Australia, and in turn ensuring timely access to public acute care for those who cannot afford private health insurance. It is only because 40% of the population pays for their private acute care that the rest of the population can get reasonable access to public hospital services.

5. Conclusion

The AMA considers that the government has overemphasised tax relief and underemphasized the health system impact. As a result, the Government has not properly assessed the full consequences of the bill on the health system.

The AMA fears that, in increasing the income thresholds for the Medicare Levy Surcharge, the Government is upsetting the delicate public/private sector balance in the health system which, despite the pressures within public hospitals, provides Australians with affordable access to high quality medical care and treatment. This bill will make choice in health care more expensive and less accessible for families, low-income earners and older Australians.

As our population ages and health care costs increase, a fully functioning private health insurance system is a necessity for our health system, not an optional extra. The AMA asks the Committee to seriously consider whether a net saving of $299 million over four years is worth the consequences outlined in this submission.