Inquiry into the *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008*

Catholic Health Australia

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Summary: Consequences of threshold change

The *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008* is likely to have several adverse consequences which will result in new barriers in access to health care by low and middle income earners.

In summary on the basis of published Treasury commentary, these consequences are likely to include:

- Increases in public hospital surgery waiting times as upwards of 200,000 new episodes of care will need to be carried out in public hospitals
- Specific longer waiting times for older Australians requiring cataract surgery or hip and knee replacements;
- Immediate increased costs on public hospitals of a likely $400million;
- An initial decline in State and Territory public hospital revenue of $35million in direct hospital accommodation benefits and an additional $20m in other services;
- A likely initial increase in private health insurance premiums of up to 10%, which will be felt most by those low and middle income earners with private health insurance;
- Future unpredictable increases in demand on public hospitals as private health insurance becomes more expensive;
- Over $400 million lost from the operational budgets of private hospitals.

The consequences of the proposed threshold changes will disproportionately impact on Catholic not-for-profit hospitals. Catholic private not-for-profit hospitals will be impacted more than smaller for-profit private hospitals. Catholic public not-for-profit hospitals will in turn be impacted as episodes of care that would have been carried out in private settings shift across to public settings.

The Treasury modelling of the impact of the proposed threshold changes has deficiencies. These deficiencies partially shielded the likely consequences of the proposed threshold changes. The likely consequences will be most felt by low and middle income earners, who will bear the brunt of increased cost pressures on public hospitals with longer waiting times for surgery and/or struggle to maintain their private health insurance membership.

In its current form, the *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008* should be opposed as a result of the likely adverse impact it will have on low and middle income earners. In the event of it being passed as law, additional measures to minimise the impact of declining health insurance membership on access to public hospital services will be required.

Catholic Health Australia's role in private and public hospitals

Catholic Health Australia (CHA) is the representative body of public and private hospitals and aged care services operated around Australia by bodies of the Catholic Church. It is driven by principles of equity and social inclusion to ensure all Australian's are able to access quality and compassionate care regardless of income or social status.

The Catholic Church is the second largest provider of hospital services in Australia, with only State and Territory Governments having a greater presence. 21 public hospitals and 54 private hospitals are members of CHA, making CHA the only national advocate representing both public and private hospital consumers and operators.

CHA has as its purpose a role to advocate for the needs of the socially disadvantaged. In Australia, a person's socioeconomic status determines their health status. By way of example, the mortality rate for males aged 25-64 in the most disadvantaged population

quintile was 75% higher than the rate for males in the most advantaged quintile in 2004 (Australian Institute for Health and Welfare: Socioeconomic status and health, 2004).

Driven by a commitment to ensuring Australia's health system is able to meet the needs of those in social disadvantage, CHA has assessed the proposed threshold changes with a view to its system wide impact. The CHA review has found specific impact on low and middle income earners, the group the proposed threshold changes were in fact designed to assist.

Inadequacies in the modelling

The Treasury modelling underpinning the impact of the proposed threshold changes has been shown in various forums to be inadequate. CHA maintains that the Executive Government was not provided with complete detail of the full impact of the proposed threshold changes prior to the policy change being announced. In particular, the modelling did not consider the full impact on the nation's public health system. Nor did it consider the impact on low and middle income earners in their access to both public and private health services.

Other flaws in the modelling include:

- Savings being calculated on the basis that all currently insured members would drop out of private health insurance on 1 July 2008. The dropout rate in subsequent years was estimated as likely to be minimal. This contrasts with past experience, where adverse changes in private health insurance policy have resulted in a more progressive impact building overtime as opposed to a single 'big bang' impact as suggested by Treasury;

- Failure to recognise the large variations in the types of private health insurance policies and their costs when estimating the likely savings of the proposed threshold changes;

- Failure to consider the changes in the composition of the privately insured membership likely to arise from the proposed threshold changes and the subsequent impact on premium levels and rebate. In particular, the modelling has failed to consider the likely early loss of so-called "good risks" leaving an ever concentrating pool of privately insured unwell or aged member resulting in even higher levels of premium increases over and above the initial 10% increase in premium costs.

CHA recognises that in recent years there has been an acceleration of the numbers of people who have been paying for Medicare Levy Surcharge. In the last full financial year there was a 25% increase in the number of surcharge payers. There may be a case for a small increase in the level of the surcharge threshold in order to maintain stability in the numbers eligible to pay the surcharge. However, the increases to $100,000 for individuals and $150,000 for families go beyond what would be needed to maintain stability in the number of surcharge payers.

The proposed $100,000 and $150,000 levels do not appear to have been based on evidence seem arbitrary at best. In seeking to increase the Medicare levy low-income thresholds to $17,309 (from $16,740) for single people and to $29,207 (from $28,247) for those who are members of a family, the Treasurer on 13 May 2008 said *"The increase in (low-income) thresholds takes into account rising living costs for families as reflected in movements in the Consumer Price Index."* If the Consumer Price Index was the basis for the low-income threshold change, consistency would suggest it also be applied to the upper income threshold changes.

An increase in public hospital waiting times

Public debate on the proposed threshold changes has focused on impacts on private health insurance and private hospitals. The public debate has not fully considered the impact on public hospitals and the patients they treat. Patients in both public and private sectors will be adversely impacted by the likely fall in private health insurance membership, but it is low and middle income earners who will most bear the brunt of the new pressure that will be placed on the public health system.

Treasury figures in the 2008 Budget papers indicate that over $700 million in premium income will be lost to health funds each year. If utilisation was evenly spread across the privately insured membership, PHIAC statistics suggest a loss of funding to the private hospital sector of some $400m which would have been spent as private health insurance benefits for hospital treatment for over 200,000 episodes of care.

The 200,000 episodes of care will still be needed, but instead of them being paid for through private health insurance, they will need to be paid for by either State and Territory governments or by individuals themselves - or some people will simply miss out on necessary care.

The 2008 State of the Public Hospitals Report showed 87,000 patients waited an excessive time for their surgery in 2006-07 and that overall waiting times are deteriorating. Public hospitals are not currently well-placed to carry an additional burden at this time. Yet the likely result of the proposed threshold change is that 200,000 episodes of care per year will need to be carried out in public hospitals, without any linked increase in funding to ease this patient shift from private to public care.

Longer waiting time for older Australians

A number of procedures where private hospitals currently undertake the majority of caseload have very long waiting times in the public sector. Cataract surgery, together with hip and knee replacements offer examples of where private hospitals currently undertake the majority of case load. The group with the most utilisation of these types of surgeries are older Australians. These type of operations provide older Australians with treatment to maintain their independence.

With waiting times for hip and knee replacement surgery already lengthy in many public hospitals, it may be that older Australians are forced to wait longer for this type of treatment when the likely increase in general surgery waiting times increases as a result of the changed thresholds.

Any flow-on impact may place additional demand on aged and community care services through lack of mobility, independence etc.

Additionally, as the cost of private health insurance increases by up to 10% in year one and possible more in subsequent years as a result of the proposed threshold changes, it will be aged pensioners least likely to be able to afford private health insurance to cover these treatments for which there will likely be an extended wait in public hospitals.

$400 million in higher costs, and $35 million lost revenue

State and Territory government operated public hospitals would be required in year one to inject at least $400 million into State and Territory health systems to cover the likely costs of the 200,000 episodes of care that will be shifted to them from private hospitals.

Additionally, State and Territory health systems will collectively see a $35 million decline in revenue from privately insured patients being treated as private patients in public hospitals.

Catholic Health Australia does acknowledge and welcome the increased contribution of funding by the Commonwealth to reduce surgical waiting times in public hospitals. For

this reason, we are concerned that the Government, in proceeding with the *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008* may inadvertently be undermining its policy in the Health portfolio.

Cost increases of private health insurance

To the extent that those who drop their private health insurance are not high users of the health system, the loss of revenue to health insurers will have to be made up by premium increases over and above those that would have occurred as a result of ongoing increases in health costs and utilisation. Ongoing cost and increases in utilisation are likely to have resulted in premium increases of the order of around 5%; the loss of income from low users will likely add 3 – 5% to the extent of necessary premium increases in future years. It is not unreasonable to therefore expect a 10% increase in private health insurance premiums in year one.

Combined with the recent acceleration in inflation particularly for essential commodities such as food, petrol and housing interest rates, there is a strong likelihood that high premium increases will prompt private health insurance ongoing membership dropout rates in future years which will increase and become compounding. As premiums rise, the young and healthy are more likely to drop their membership resulting in even bigger increases to pay for the increasingly older and sicker population of the privately insured membership pool. This downward cycle may become self-perpetuating – as it did for long periods during the 1980s and 1990s. This scenario differs from the Treasury forecast of a one-off drop-in membership followed by a period of relative stability.

Disproportionate impact on the Catholic health sector

Catholic not-for-profit private hospitals will be disproportionately impacted by the proposed threshold changes which will see a likely reduction in private health insurance membership and consequent reduction in presentations to their hospitals. The impact on private Catholic hospitals is likely to arise because of their larger size in comparison to other private for-profit hospitals.

Catholic private hospitals provide a more comprehensive range of services than many of the smaller for-profit private hospitals. Comprehensive hospitals face a higher fixed cost structure in the form of expensive plant and equipment as well as maintaining a highly skilled workforce.

With high fixed costs, comprehensive not-for-profit hospitals are reliant on maintaining a large throughput of cases compared to those hospitals, which are smaller and have a greater proportion of variable costs which can be more readily adjusted downwards in order to sustain margins.

Three specific consequences unique to Catholic hospitals will likely arise from the proposed threshold changes:

- Many private Catholic health care services operate both private and public hospitals, very often on the same campus. As the impact of the threshold change is felt and some 200,000 or more care episodes are shifted from private care to public care, some patients will be admitted to beds in Catholic public hospitals instead of the Catholic private hospital on the same campus, taking up a public bed which but for the threshold change would not have been utilised (or will add to the waiting list of the public hospital);

- Catholic private hospitals are not operated to generate profits to shareholders, but they do very often provide a 'social dividend.' By way of social dividend, Catholic private hospitals either dedicate a portion of the operational revenue or the total of any 'profit' made on their operations to a range of social services, capital upgrade, or the purchase of hospital equipment. Any decline in revenues

of Catholic private hospitals will see subsequent declines in funds available for social services, capital upgrade or the purchase of hospital equipment;

- Some Catholic private hospital operations subsidise the operation of Catholic public hospitals. A fact known widely in State and Territory health departments but discussed rarely in wider public debate, many private Catholic hospitals enable Catholic public hospitals to remain viable in circumstances where some State and Territory governments either refuse or are unable to increase operational funding to Catholic healthcare operators in their delivery of public health services on behalf of the state.

Recommendations and alternate options

The *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008* should be opposed.

In the event of it being passed as law, additional measures to minimise the impact of declining health insurance membership on access to public health by low and middle income earners will be required. Such measures might include:

- *Increasing the Medicare Surcharge to 1.5%:* For those earning above the proposed income thresholds of $100,000 and $150,000, the surcharge amount should be increased from 1% to 1.5%. This would provide a stronger incentive for those above the surcharge threshold to take out and maintain private health insurance and better reflect the change in average premium levels since the surcharge was introduced;

- *Remove the artificial incentives for public hospitals to preferentially treat private patients whilst simultaneously retaining long waiting list of public patients*. CHA proposes that public sector funding models be amended to remove the incentive for public hospitals to actively and preferentially seek private patients at the expense of private patients – the objective should be to achieve neutrality (or slight bias that would favour the treatment of public patients by public hospitals);

- *Lifetime Penalties*: The additional penalty payable through health insurance premiums for delayed uptake in private health insurance after the age of 30 years could increase from 2% to 3%;

- *Access to capital:* In the event of a likely decline in private hospital revenues, new government funds will need to be directed to capital projects of non-government not-for-profit hospitals. Catholic and other non-government not-for-profit hospitals should not be overlooked in the allocation of funds from the Health and Hospitals Fund.

- *Additional funding of the Australian Health Agreements:* Catholic public hospitals that are subsidised by Catholic private hospitals will be impacted by declining private hospital revenues and increased demand on public care. The Australian Health Care Agreements should be funded to enable State and Territory Governments to adequately fund Catholic public hospitals.

Catholic Health Australia
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