23 July 2008

The Secretary
Senate Economics Committee
Parliament House
CANBERRA ACT 2600

Dear Secretary

**INQUIRY INTO TAX LAWS AMENDMENT (MEDICARE LEVY SURCHARGE THRESHOLDS) BILL 2008**

This is my submission to your Committee's Inquiry.

In 1996-97 I was Senior Adviser to the then Minister for Health and Family Services, the Hon Michael Wooldridge MP, and from 2003-07 I had the same role with the then Minister for Health and Ageing, the Hon Tony Abbott MP. With Dr Wooldridge I was closely involved in establishing the original Private Health Insurance Incentives Scheme in 1996-97, and I advised Mr Abbott on private health industry matters, including oversight of the major cover reforms introduced by the Howard government in 2007.

Between those appointments I was a Commonwealth and Victorian public servant, including a period as head of the Department of Health and Ageing branch administering the Australian Health Care Agreements (AHCAs). In 2003 I was part of the Victorian Government negotiating team on the AHCAs.

I also was briefly Government and Regulatory Affairs Manager for Medibank Private. Currently I am a self-employed policy consultant.

The views in this submission are mine and do not necessarily reflect those of any of my former employers.

**KEY POINTS**

Having had the benefit of considering other submissions to this Inquiry, as well as the Government's announcements and such details of the Treasury's modelling as have been released, the raising of the Medicare Levy Surcharge (the Surcharge) thresholds, my conclusions are that:

- The proposed Surcharge thresholds exceed the position put by the Australian Labor Party in Opposition that the thresholds should be adjusted to reflect wage movements since 1999 and subsequently indexed.

- This has been done by the Government with reckless regard for the stability and future of private health insurance and the private healthcare choice generally.
- The privately-insured people who drop this cover as a result of these measures are largely "good risk" people who largely cross-subsidise older and less healthy higher-claiming members, and their departure would significantly increase upwards pressure on private health insurance premiums.
- These people could number one million or more in the short to medium term. Because insurers already operate on very tight margins, and highly-regulated premium setting restricts the scope to buffer against contingencies, significantly higher premium costs will be passed on to remaining members.
- The price-drop-out spiral of private health insurance in the 1980s and 1990s could return.
- The Government's argument that this restores justice to the Surcharge thresholds fails to take into account major tax and family assistance reform since 1997 including increasing household disposable incomes in a relatively low-inflation economy; the introduction of the Goods and Services Tax 1999; the expansion of Family Tax Benefit A and B; and the major reform to personal income tax scales in 2005-07.
- Having commissioned the National Health and Hospitals Reform Commission and other major health policy and governance reviews the Government has effectively undermined a key element of the accepted national health framework before those reviews have got under way, let alone made hard recommendations; and
- If this is a calculated savings measure to reduce outlays on the Private Health Insurance Rebate there are better ways to achieve Rebate savings.

This submission also offers some suggestions about how the Government could proceed from here.

**BACKGROUND**

Australia currently enjoys a healthcare system that involves significant private sector financing and provision. Most recent Australian Institute of Health and Welfare data (2005-06) put the non-government expenditure share at around 32.2 per cent, of which $6.3 billion came from private health insurance benefits[1].

To understand the implications of the Government's intentions it is very important to recap on the private health industry experience since the introduction of Medicare in January 1984.

Many if not most Australians want to have guaranteed quick and timely access to the best medical and hospital care, with their choice of doctor and type of facilities. As the raw cost of this is beyond the immediate means of most people, private health insurance has become the accepted if not a universally popular means of access. The vast majority of the non-public patients in both public and private hospitals are privately-insured patients.

For much of the 1980s and 1990s, however, private health insurance and the private health choice in general went out of fashion. The previous Labor government put most of its eggs into the Medicare basket and, until 1995, its policies almost exclusively targeted at supporting the public sector and public funding of hospital services.

[1] Australian Institute of Health and Welfare, National Health Expenditure, Current and Constant Prices, 2003-04 to 2005-06, AIHW website

As a result private health insurance hospital cover membership plunged between 65.1 per cent in March1983 to 33.9 per cent in March 1996, reaching its nadir of 30.2 per cent as late as December 1998[2]. What was worse, the people dropping out tended to be those who were better health risks, leaving the remaining pool of insured people seriously affected by adverse selection – that is, people maintaining their cover because their age or health status had a high risk of need. Consequently, the industry went into a near-death spiral – members dropping out caused big premium increases, causing more members to drop out, and so on.

Had there not been policy action from 1996 onwards, the industry would have disappeared into itself.

It is not widely remembered now but the Howard government's initial foray into private health insurance support actually failed. The Private Health Insurance Incentives Scheme (PHIIS) gave fixed amount premium assistance to people on taxable incomes up to $35,000 (couples $75,000), with further income allowances for dependants. It was not until after the Government's severe political difficulties in implementing the PHIIS – which led incidentally to the Productivity Commission's 1996-97 inquiry into private health insurance – that it was realised that only structured and systematic support of private health would stop the sector collapsing.

Consequently, between 1998 and 2001 the Howard government introduced the three measures that together have arrested the decline, and restored private health insurance cover to nearly 45 per cent of Australians:

- The non means-tested 30 per cent rebate on private health insurance premiums (supplemented from 2005 by higher rebates for members over the age of 65);
- Lifetime Health Cover and its negative incentive to join before the age of 31 and then to remain in cover; and
- The 1997 one per cent Medicare Levy Surcharge, imposing a penalty on singles earning more than $50,000 and couples and families earning more than $100,000 (with additional income loadings for dependent children) if they don't have private health insurance.

In 2004 the Medicare Safety Net added to this framework by providing added peace of mind around out of pocket health costs not covered by private heath insurance.

Just as importantly, these changes took effect as sweeping reforms of the national taxation system were implemented, particularly the introduction of the GST in 1999 and the later major restructuring of personal tax scales that have given Australians significant reductions in their income tax burdens compared to a decade ago.

As of the March quarter 2008, the latest for which Private Health Insurance Administration Council (PHIAC) figures are available, 44.6 per cent of Australians have private health insurance. This represents 9.5 million fund members, the highest number ever.

*Other current developments*

The Rudd government came to office with a *Health and Hospitals Reform Plan* that was long on rhetoric and short on detail. It's fair to say, however, that the new Government campaigned and

[2] Hospital Treatment Cover (% of persons insured), PHIAC website, July 2008

won a mandate on "fixing public hospitals" and this is core focus of its health policy outlook, coupled with encouraging but equally vaguely-defined messages on investing in prevention.

To implement its mandate, the Government has rolled over for a year the expiring Australian Health Care Agreements with the States and Territories, the main source of Commonwealth funding for public hospital services, and commissioned a number of health policy reviews. The most important of these are:

- The National Health and Hospitals Reform Commission chaired by Dr Christine Bennett, which is due to make its interim report by the end of 2008 and its final recommendations by mid 2009; and
- The National Preventative Health Taskforce chaired by Dr Rob Moodie, which is to provide advice to Commonwealth, State and Territory governments by July 2008 and to develop a National Preventative Health Strategy by July 2009 to coincide with the new AHCAs.

Whatever its political and policy intentions, the Government has set in train a process of deliberation and reform, amid much fanfare and raising of public and stakeholder expectations. Its pre-Budget announcement about the Surcharge thresholds, however, cut right across its own process and questioned its willingness to listen and consult on key policy points.

**HAVE SIMILAR MEASURES BEEN CONSIDERED BEFORE?**

The Howard government considered the possibility of similar measures in its last term, including having effects modelled by the Treasury, but discounted them.

In 2005 the Government decided to proceed with major reforms of the private health insurance regulation with the intention of making the private health insurance choice still more attractive and affordable to consumers. The ensuing large package of measures was incorporated into new *Private Health Insurance Act 2007* that came into effect on 1 April 2007, unopposed by the Australian Labor Party.

In the process of developing its reforms, the Department of Health and Ageing and the Treasury reviewed the operation of the Surcharge and its existing thresholds. This was an internal review to aid with policy development, and included extensive modelling with conclusions similar to those released with this measure. On the basis of the available advice, the concern was that any lifting of the thresholds would lead to a significant cover drop which, once started, could increase precipitously. The option thus was ruled out and not taken further.

There was an opportunity to revisit the issue in January 2007 when the then shadow minister for health, Ms Nicola Roxon, called for a resetting of the Surcharge thresholds to take account of movements in average weekly earnings since the measure was first introduced in 1998. It was her first foray into health issues as shadow minister. Ms Roxon said:

> We (the ALP) think that it is an outrage and that the Government should be looking at the way it can appropriate adjust that threshold, **not leave it not being indexed** (my emphasis)[3].

The then Minister for Health and Ageing, Mr Abbott, made it clear, however, that the Howard government had no intention of changing the thresholds. He said:

[3] Nicola Roxon MP, *PM*, 9 January 2007

> This policy was put in place to try to get more people into private health insurance, along with the private health insurance rebate. Now together, this policy has done exactly what is intended to do[4].

In defending the thresholds, what was not made clear at the time was that although Average Weekly Earnings had increased strongly over the previous decade, there had also been other major government measures that had significantly increased personal and household disposable incomes since 1998. A comparison of personal income marginal tax rates between 1998-99 and 2008-09 highlights the extent of the transformation:

**1998-99**

| *Taxable income* | *Tax on income* |
|---|---|
| $0-$5,400 | Nil |
| $5,401-$20,700 | 20 cents for each dollar over $3,060 |
| $20,701-$38,000 | $3,060 plus 34 cents for each dollar over $20,700 |
| $38,001-$50,000 | $8,942 plus 43 cents for each dollar over $38,000 |
| $50,001 and over | $14,102 plus 47 cents for each dollar over $50,000 |

**2008-09**

| *Taxable income* | *Tax on income* |
|---|---|
| $0-$6,000 | Nil |
| $6,001-$34,000 | 15 cents for each dollar over $6,000 |
| $34,001-$80,000 | $4,200 plus 30 cents for each dollar over $34,000 |
| $80,001-$180,000 | $18,000 plus 40 cents for each dollar over $80,000 |
| $180,001 and over | $58,000 plus 45 cents for each dollar over $180,000 |

*Source: Australian Taxation Office*

These major reductions in personal taxation burdens are exclusive of the big gains in family assistance through Family Tax Benefit A and B over the decade. In addition, the introduction of the Medicare Levy Surcharge predated the introduction of the Goods and Services Tax in 1999 and the New Tax System that accompanied it. The world in which the Surcharge has operated for most of its existence therefore is vastly different from that in which it was conceived and born.

In short, any swings in terms of movements in average weekly earnings over the decade have been strongly offset by taxation relief and other targeted assistance, quite apart from the relatively stable low-inflation environment of the period increasing real buying power of individuals and families. In these circumstances, it was perfectly reasonable for the then Government to encourage people who could afford it to take out private health insurance without adjusting the Surcharge thresholds. This was doubly so given that the participation of more so-called "young and healthy" people in private health insurance spread illness and injury risks and which has helped to keep the lid on premium growth.

This outcome benefits not just those members affected by the Surcharge, but all persons covered – a highly desirable social policy goal that balanced common and individual good.

[4] Abbott rules out changing Medicare levy, *ABC News online*, 9 January 2007

**RESPONSES TO THE TERMS OF REFERENCE**

Instead of responding to each Term of Reference in detail, I will comment on the three key themes that they represent:

- The impact on the number of Australians covered by private health insurance;
- The implications for the future of private health cover and the wider private health sector, especially private hospitals; and
- The flow-on effects to the public hospital system.

Other submissions, particularly that of the Australian Health Insurance Association (AHIA), deal effectively with the issue of the Treasury modelling's adequacy. Indeed, Treasury's admission of its underestimation of actual persons dropping their cover was acknowledged by themselves in recent Estimates hearings[5].

**Impact on the number of Australians covered by private health insurance**

There are two aspects to this issue. The first is the immediate drop-out factor of the Government's measure on private health insurance participation. The second is likely impact on private health insurance premiums.

*Participation effects*

The estimates of drop-outs in the short-term aftermath of the implementation of the Government's decision have been estimated at anywhere between 485,000 and one million Australians, or about 5-10 per cent of those Australians with hospital cover at the time of the Budget announcement.

The PriceWaterhouseCoopers analysis commissioned by the AHIA in May 2008 arrived at a drop-out estimate of 908,000, representing 9.7 per cent of the present insured population. This estimate was based on Budget estimates of the savings from reductions on private health insurance rebate outlays on departed members[6].

Many if not most of the dropping out members will be those who are better risks for insurers, younger people in good health with low claiming profiles, but people who see their private cover as a marginal or even grudge purchase. While its impact cannot and should not be disaggregated from that of the Private Health Insurance Rebates and Lifetime Health Cover, the Surcharge has been a big "stick" factor behind better-risk people joining and remaining in cover.

Removing that stick, especially when it is being marketed by the Government as a de facto tax handback, will make the decision to drop private insurance very attractive to hundreds of thousands of Australians below the new thresholds. This is not just a question of household economics. That many of them see their private cover as marginally relevant to them and their current lives, too often coupled with unsatisfactory experiences as consumers (including the annual painful experience of premium increases) makes the decision to walk away even easier in many cases.

The focus of much of the commentary has been on the loss of young members in terms of their age, particularly those in the prime of their healthy lives and under the age of 30. As the AHIA points out

[5] Senate Economics Committee *Hansard*, 3 June 2008
[6] AHIA press release, 17 May 2008

in its submission to this Inquiry, however, many of those who drop out will be aged over 30[7], notwithstanding the threat of Lifetime Health Cover penalties if they rejoin later in life.

No-one seems to doubt that because of their more fragile health, most older members captured by the Surcharge will choose to hold onto their private health insurance despite the Government's measure. It is also reasonable to assume that many of those in the baby boom generation, who are currently approaching the age of 60 but who are still in very good health, will on balance keep their cover because of "what's around the corner" and the high cost of Lifetime Health Cover rejoining penalties cancelling out the incentive of shorter-term cost relief.

A semantic debate about the ages of people who leave their cover is therefore quite irrelevant. The real issue boils down to the fact that a "young and healthy" person in health insurance terms is someone aged up to 60-65, when claims and costs per insured person start to rise sharply as the natural consequence of ageing set in. Even beyond that age, many people succeed in managing their health and fitness to keep their demands on healthcare services relatively low until their final years.

Even at over 900,000 Australians, the modelled estimates of cover drop-out are probably conservative. They do not take into account the "buzz" or word of mouth factor generated by the Government's policy message, especially when disseminated by the media and personal tax advisers and accountants. What the Government effectively is saying to all insured Australians that it's ok to gamble on their low actuarial risk of needing high-cost health care, and that the public system will look after them in case of unexpected need.

The Government also is saying that if you want to insure against more likely need, come back later if you're prepared to pay the Lifetime Health Cover loading. It certainly is not sending a message that private health insurance membership is a long-fuse investment for most young people, when a long membership history ultimately will pay dividends when one reaches the age of high need – and in turn benefits from succeeding generations of younger members cross-subsidising that need.

It would hardly be surprising, therefore, if the number of leavers in the next 12-18 months is significantly higher than the Government anticipates. If the economy worsens, interest rates remain high, and households generally have to tighten their belts further, the consequent drop-out could be even greater still as singles and families make judgments about their discretionary expenditure.

It therefore is not impossible that by the end of 2009 that there will be at least 1.4 million fewer Australians covered than in the March quarter 2008 – a drop of 15 per cent in the number of insured persons.

The first indication of how steep the trend will be will be in the next quarterly membership statistics released by PHIAC, which will cover the June quarter of 2008. These should be available in August 2008.

The June quarter included the Treasurer's initial reaction and subsequent widespread coverage, the Opposition's decision to oppose the measure and resulting uncertainty about its future, and the referral of the measure to this Committee. If, notwithstanding the widely-known fact that there is as yet no guarantee that the measure will pass in its present form, there is still significant initial

[7] AHIA submission, pages 4-5

downwards movement in the next round of membership data, this will be strong early indication that the loss of members will be great over the short to medium term. Nevertheless, the following two or three quarters, however, will be when the story becomes clearer.

*Premium effects*

The private health insurance industry is in the best shape it has been for many years, but it operates on a fine balance when it comes to premium revenue against claims underwritten. Where the Government measure therefore will be felt hardest will be in the private health insurance premiums paid by those remaining in cover.

Even with government support through the Private Health Insurance Rebates now costing around $3,000 million per year, premiums are not cheap and this is a constant source of great irritation to consumers. Health fund members could be forgiven for believing that Benjamin Franklin was wrong and that there are actually three things certain in this world – death, taxes and private health insurance premiums rising every year.

Since the introduction of Lifetime Health Cover completed the industry support structure in 2000, private health insurance premiums have on average risen between four and eight per cent per year since 2002[8]. Being community-rated rather than risk-rated, this takes into account the claiming profile of funds' total insured population , product mixes, claims costs (including hospital, medical and other professional costs), and government solvency and capital adequacy requirements.

Premium increases are always very unpopular and politically sensitive, but government intervention in the setting process has helped to ensure that they are as low as possible consistent with funds' needs to meet their claims and to stay solvent. The current Minister for Health and Ageing, Ms Roxon, has continued where her predecessors left off in this regard. The effect of ministerial approval is that premiums are the lowest possible to meet projected claims and prudential requirements: there is little capability to buffer for adverse external contingencies such as major policy change. Unexpected policy shocks such as the Government's measure therefore can do great damage to insurers' financial health and their ability to meet their obligations without unavoidable rate rises.

Significant increases are still required year on year (although greatly lower than those in many years in the 1980s and 1990s), notwithstanding the hitherto benign policy environment and the overall better risk profile of the currently insured population[9]. This relates to significant increases in the volume of private health insurance utilisation across the board, the ever-increasing range of services covered, the proliferation of expensive new technology and the high costs of doctors and other professional labour.

Community rating demands that all fund members pay the same premium for their product, regardless of health risk, age, gender and other factors now codified in the *Private Health Insurance Act 2007*. If the pool of insured persons sheds a disproportionate number of good risks, the cost burden will be shared among not just fewer people, but a pool that is commensurately "older and sicker" than before.

[8] Sources: Government press releases.

[9] Indeed, recent quarterly PHIAC data has shown that the fastest growing age group in coverage terms is the 25-30 cohort.

This is compounded by the fact that health funds contribute to a common risk equalisation or reinsurance pool to spread the risk of the high costs of covering older, chronically ill members and, under recent reforms, high-cost claims.

Unless health insurers engage in further fierce cost-cutting, or dip heavily into alternative sources of revenue such as investment income, there will soon be return to pre-1999 annual premium increase levels, which often were well above the levels of recent years. The only question is how severe those increases will be.

The Budget forward estimates for Private Health Insurance Rebate outlays assume a decline of $959.7 million over four years. It is not clear from what has been released, including Treasury evidence to estimates hearings, what assumptions were made about premium changes year on year. This also makes it difficult to assess Treasury's take-up and dropout assumptions beyond 2008-09.

Private health sector groups and analysts have indicated that, as a result of this measure, premiums will increase by 10 per cent of more. Catholic Health Australia, in its submission to this Inquiry, suggested:

> Ongoing cost and increases in utilisation are likely to have resulted in premium increases of the order of around 5 per cent; the loss of income from low users will likely add 3 – 5 per cent to the extent of necessary premium increases in future years. It is not unreasonable to therefore expect a 10 per cent increase in private health insurance premiums in year one[10].

This conclusion is supported by post-Budget comment by health economist Dr Paul Gross, a leading policy expert who is not known for his unequivocal endorsement of private health insurance. Dr Gross concluded that over and above what could be expected on current trends, there would be "a 5-10 per cent lower membership in the first 18 months, 5-10% higher premiums in following years and a smaller reinsurance pool for the chronically ill older members"[11].

If the projections to date of the size of the cover exodus do turn out to be unduly conservative, the initial premium rise in 2009-10 could be still higher, with that trend likely to continue into following years.

While it is inappropriate to be alarmist, this situation could reopen the door to factors that characterised the health insurance version of stagflation that afflicted the whole private health sector under the Hawke-Keating government: regular double-digit increases in premiums making private health insurance unaffordable to many thousands who give up their cover, thereby increasing premium pressure on those remaining.

Ironically, and further questioning the wisdom of the Government's approach, premium increases consequent to this measure would more likely than not absorb and overtake the Rebate savings. Given that the Rebates remain uncapped and are a fixed proportion of premiums paid to health insurers, it cannot be otherwise.

**Impact on private health insurance cover and the private health sector**

Private health insurance is a community-rated market that depends on having a risk pool deep enough to sustain the claiming demands of insured persons affordably. If the projections of fewer

[10] Catholic Health Australia submission, page 5
[11] Expert hits health levy move, *The Age*, 24 May 2008

low-risk members coupled with premium increase well above the current trend do come to pass, then it has to be assumed that there will be severe implications for the operations of the private health insurance industry, individual insurers, providers funded by private health insurance and the product choice available to consumers.

*The private health insurance industry*

The industry itself has been going through a great deal of change in recent years. The most important regulatory changes in more than twenty years came into effect with the new *Private Health Insurance Act* in April 2007.

The most far-reaching of these reforms is the extension of reinsured cover "beyond the hospital gate" for preventive and hospital substitution services, under the Broader Health Cover banner. Broader Health Cover regulation makes it viable for funds to cover preventive care and support for people at risk of greater illness and injury, particularly for chronic conditions such as obesity, diabetes and heart disease. It also makes it possible to cover pre- and post-admission care in such as a way as to remove distortions in best practice occurring simply because hospital cover was just that – covering admitted patient services.

The benefits for consumers of these reforms in terms of better and more appropriate care services and outcomes are obvious. For insurers it is a case of investing in preventive and chronic care management in such as way as to minimise or eliminate downstream high-cost claims associated with expensive acute care episodes. In the early period after the introduction of the reforms, insurers have been slow in their take-up of the opportunities, but this is changing as the opportunities are seen and grasped.

The Howard government developed the 2007 reform package in close consultation with insurers and the private health sector in general. Importantly in respect of the current measure, it was developed on the assumption that there would be no change to the three pillars of government support for private health insurance, including the Medicare Levy Surcharge and its existing thresholds, and that therefore membership levels would remain broadly stable in the low-mid 40s.

By contrast, playing with the Surcharge pillar in isolation has the potential to undermine the stability of the industry as a whole, and the confidence of insurers to proceed with developing and marketing Broader Health Cover products and services.

Another but more benign effect of the changes would be greater pressure on individual insurers to minimise their costs and maximise efficiency. The current trend to industry demutualisation and consolidation, kicked off in earnest by NIB in 2007 and accelerated by the merger of BUPA and MBF in May 2008 and the announced merger of Medibank Private and AHM in July 2008, is already well under way. In a policy and regulatory climate that is becoming overtly hostile to private health insurance, the pressure to consolidate will become even more difficult for insurers to resist.

This, over time, could actually be a good thing if it improves competition on price, product and quality of service, notwithstanding the great break on innovation and enterprise that is the community-rated reinsurance pool.

*Individual insurers*

It seems to be the assumption of the Government that private health insurers are cashed up and able to absorb the effects of its measure. As recently as 16 July 2008, Minister Roxon said:

> I will take a dim view of insurers using these changes to hike up the fees they charge people. If the insurers deliver attractive, effective policies, then people will want to buy them[12].

The Minister does not appear to understand that insurers operate on very tight margins – in 2006-07, management expenses represented 9.6 per cent of contribution income[13]. To highlight how tight this is, Australian Prudential Regulation Authority statistics show that in the year to March 2008, the general insurance industry collected almost $25,000 million in gross premium revenue but incurred $6,200 million in underwriting expenses – in other words, more than one in four premium dollars going on costs[14].

In addition, investment incomes cannot be guaranteed to take up any perceived slack in supporting the future operations and growth of individual insurers, nor are investment returns intended to meet claims costs.

To meet Minister Roxon's expectations with a contracting and worsening risk pool, the industry therefore has two option if it wants to minimise unavoidable premium increases: to cut operating costs still more aggressively or to cut back its products and coverage. While not wanting to overstate the problem, it is possible that some smaller health insurers already operating on very tight margins could be in danger of going to the wall, depending on how the measure played out in practice.

What is more concerning for consumers is that a more perverse environment will lead to more risk-averse behaviour in the market-place. Even with the encouragement of favourable reinsurance treatment, there is far less return for insurers to offer Broader Health Cover services if they do not have the breadth of membership and revenue to support them. Indeed, the commercial short-term risk of Broader Health Cover products is that the range of services offered may give rise to a spike of claims from those who may not need to claim under traditional hospital cover: this could mean a complementary spike of short-term premium pressure, even if it helps reduce exposure to high-cost claims down the track. A deeper risk pool under current policy settings helps to overcome that problem, but the proposed Government measure would somewhat drain that pool of good-risk members and make Broader Health Cover less viable a proposition.

Instead of continually innovating to adapt and thrive, at least some funds would put the wagons in a circle to ensure their survival as a viable business, stick to the tried and tried hospital and ancillary products and not make innovation a priority. But there is at least some upside.

If insurers resist the temptation to form defensive circles, they can turn adversity into opportunity. Firstly, they can ensure that they have products that are more relevant to the health needs of "younger and healthier" lower-claiming members, which is one of the attractions of Broader Health Cover. Secondly, they can improve their image as businesses. While it is not altogether fair, private health insurers as a group have an indifferent reputation for customer service and responsiveness.

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[12] Health cover costs to rise by 15 per cent for families, *Herald-Sun*, 16 July 2008
[13] PHIAC, *Operations of the Private Health Insurers Annual Report 2006-07*, November 2007
[14] APRA, *Quarterly General Insurance Performance*, March 2008

Poor consumer experiences make dissatisfied customers who are more likely to walk given the easy opportunity. If the changes proceed, every member in the affected income group should be prized, pursued and fought for to retain their business.

*Private hospitals*

These changes should not be considered solely in relation to their effects on private health insurers. They also flow on to the services purchased with the assistance of private health insurance.

By far the biggest recipient of private insurance funding is the private hospital sector. In 2006-07 private hospitals received 60.7 per cent of all hospital treatment benefits paid[15], over 12 per cent higher than the previous year.

Private health insurance remains the main gateway for millions of Australians to private hospital treatment. If the pool of insured persons declines, the catchment market for both for-profit and not-for-profit private hospitals declines with it. This discourages investment in the private hospitals industry, and threatens the value of investment decisions taken on the assumption of the stability of the private health insurance structure.

Indeed, the markets have spoken on this point. A very recent paper by Citigroup points out that, since the Budget, hospital stocks have last approximately 22 per cent of their market capitalisation, and that this fall is attributable to the Government's proposed measure[16]. This is consistent with health sector analysts' assessments generally since the Budget.

In respect of not-for-profit hospitals, Catholic Health Australia's submission to this Inquiry highlights its assessment of the disproportionate effect on the Catholic health sectors, particularly those Catholic hospitals with dual public and private status[17].

What have not been highlighted to date are the potential operational viability consequences for private hospitals from fewer privately-insured patients and higher premiums. Even in a benign policy and regulatory environment, insurers often drive hard bargains with private hospital operators in contracting on behalf of their members. Not even the larger hospital chains are immune from such pressures. While it is right for funds to get the best prices they can on behalf of their members, by doing so they can very tightly squeeze the capacity of providers to get reasonable returns on the investments that renew and expand the private hospital sector.

In a more hostile environment, it is likely that the contracting process would get even more aggressive and hospital contract margins still tighter. This would flow through to the operating costs and bottom lines of operators and, in the case of for-profit operators, to their returns to investors and shareholders.

Lastly, health insurers do not have to contract with public hospitals, and in 2006-07 10 per cent of all patients in public hospitals (with a whopping 14 per cent in New South Wales) were private patient admissions[18]. For these patients, insurers can offer the legislatively-mandated "default" benefit

[15] PHIAC, *Operations of the Private Health Insurers Annual Report 2006-07*, page 61
[16] Citigroup Industry Focus Paper, *Healthcare Share Price Triggers*, 22 July 2008
[17] CHA submission to the Inquiry, pages 5-6
[18] Department of Health and Ageing, *State of Our Public Hospitals Report 2008*, page 25

rather than a contract price. This is a definitely better deal for the payer in terms of relative benefits paid.

Encouraging members to be treated as private patients in public hospitals could become increasingly attractive to insurers to reduce costs, as their own underwriting margins get tighter with fewer but proportionately higher-risk members. It also has an obvious attraction to public hospital authorities looking to supplement their public budgets. Without some sort of capping of private patient revenue in public hospitals under the next AHCAs, the incentive for insurers not to discourage private patient elections in public hospitals could well intensify, placing great stress on at least some private hospital operators who struggle to be competitive with public hospitals that are happy to take whatever private revenue they can.

*Medical and other health professionals*

Doctors and other health professionals also are not immune from the effects of these measures. For medical specialists especially, their private patient income makes their lower-return public work feasible. Many other health professionals, such as dentists and physiotherapists, have a high reliance on privately-insured patients for their livelihood.

As with private hospitals, a more hostile private health insurance environment potentially would flow on to both the volume of their private work and the income that they derive from that work. In the case of medical specialists, it is possible that insurers will seek to drive tougher agreements in terms of payments for services above Medicare rebate levels.

In short, the squeeze of these changes would be on the entire private health sector and not just insurers.

**Impact on public hospitals and state governments**

In the world of Australian health policy, there are no greater rent-seekers than State and Territory governments. It was hardly surprising to see, on the day of the original leaked reports of the announcement, the Western Australian Health Minister, Jim McGinty, saying:

> I would expect that if there's anything that would adversely affect the capacity of state hospitals then that (the package) would have compensation included within it[19].

The Treasurer of New South Wales made similar points following the federal Budget[20]. More recently, in the run-up to the 22 July 2008 Health ministers meeting, New South Wales and Queensland all indicated raising their serious concerns with the Commonwealth. Queensland health minister Stephen Robertson said:

> We will be looking at that issue (Commonwealth compensatory funding) very closely, and if we do see spikes in demand as a result of these changes...we certainly will be arguing strongly with the Commonwealth"[21].

Paul Keating's maxim about never standing between a State premier and a bucket of money still holds true.

[19] McGinty calls for compensation for Medicare changes, *The West Australian*, 11 May 2008
[20] Health costs blow the Budget, Daily Telegraph, 30 May 2008
[21] States threaten rebellion over surcharge change, *The Courier-Mail*, 13 July 2008

Even if the drop-out members are all good risks and low- to no-claimers, the States have some justification to their bleating. Without private health cover, each departing member is casting themselves on the public hospital system should they need acute or related care, whether that be essential or discretionary.

While a number of scenarios in terms of increased demand for public hospital services have been floated since the announcement, the truth is that it is very hard to be definitive in what the flow-ons to public hospital demand would be. But indicative judgments can still be made.

The AMA in its submission draws attention to PHIAC data indicating that in the twelve months to March 2008, there were 650,000 privately-insured hospital episodes for patients aged up to 40[22]. Taken further, using PHIAC's March quarter 2008 membership data, 4.6 million people then had hospital cover[23], giving a rough ratio of episodes to members of 1:7. Assuming that one million people overall drop their private cover and one-seventh of them generate a public hospital episode with an average casemix-adjusted public hospital separation cost of $3,700[24], this suggests an annual additional cost to the public system of as much as $528 million, or $2,100 million (before indexation) over four years.

Making such projections necessarily is an inexact science, and the cost may be either over- or understated. If the measure proceeds it will in practice need several years of data to gauge the definitive demand trend on public hospital admissions.

Similarly, it is hard to predict with accuracy what the likely increase of additional demand would be on public hospital elective surgery and outpatients waiting lists. Nevertheless, with perhaps a million or more additional Australians, relying on the public system, and assuming utilisation trends on the lines outlined here (even allowing for regional and State variations), it is highly likely that waiting times for less urgent procedures would lengthen significantly.

*Implications for the Australian Health Care Agreements (AHCAs)*

Knowing that the Commonwealth's measures will have some major but as yet unquantifiable demand flow-ons plays into the hands of the States and Territories as they skirmish for the next round of AHCAs.

There undoubtedly will be strong and exaggerated demands for compensation. A likely approach is reviving a clause in the 1993-98 and 1998-2003 Agreements that initiated a review of Commonwealth funding to the States in for each time private health insurance membership fell by two percentage points, with a compensation formula attached to the triggered review. In those Agreements it worked both ways and provided for Commonwealth clawback of Agreement funds if private health insurance participation increased. Indeed, it is now conveniently forgotten by the States and Territories that the Howard government chose to forego its massive $3 billion AHCA windfall from the huge boost to private health participation in 1999-2000[25] to create a powerful and enduring political myth of Commonwealth AHCA funding cutbacks in 2003.

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[22] AMA submission to the Inquiry, page 6, quoting data from *PHIAC A Report*, March quarter 2008.
[23] PHIAC, *Coverage of Hospital Treatment Tables Offered by Health Benefits Funds by Age and Gender*, March quarter 2008
[24] Source: Australian Institute of Health and Welfare, *Australia's Health 2008*, page 349
[25] *Health Care Appropriation (Amendment) Act 2002*

A triggered review mechanism would not be an automatic funding top-up, but additional Commonwealth funding would be very hard for a federal government to resist practically and politically. But to be fair, it would need to take into account whatever private patient revenue that public hospitals obtain from private health insurance and other sources.

Whatever way that this ultimately is handled, however, the flow-on investment in additional public hospital services through the AHCAs would themselves well and truly cancel out the identified Budget savings from implementing this measure. A Commonwealth commitment to compensate the States and Territories appears to be an outcome of the 22 July 2008 Australian Health Ministers Conference meeting[26].

**POSSIBLE ALTERNATIVES FOR THE GOVERNMENT**

Considering the Surcharge measure as what it basically is – a heavy-handed and ill-thought through bid to curb spending on the Private Health Insurance Rebate, the Government has several broad overlapping possibilities:

- Defer the commencement of this or any replacement measure until the Government's major health policy reviews have reported and decisions have been taken on their recommendations;
- Make the measure defensible in political and policy terms by doing no more than the ALP committed itself in Opposition – adjusting the thresholds to reflect changes to Average Weekly Earnings but no more; and
- Find other ways of managing the growth of Private Health Insurance Rebate outlays and obtaining significant savings to the Budget bottom line.

**Defer the commencement**

Assuming the Surcharge measure passes as is, it will be deemed to already have come into effect as of 1 July 2008.

As highlighted earlier, this runs ahead of major and far-reaching health policy reviews instituted by the Government since it came to office. Most importantly, it pre-decides a key issue for the National Health and Hospitals Reform Commission. Similarly, it cuts across the work of the National Preventive Health Taskforce.

Presumably, one underlying policy reason for such an early announcement is taking a "no surprises" position with the States and Territories in the long and tedious slog that is the negotiation of Australian Health Care Agreement funding deals with the States. If this is true, it must be difficult for the eminent Australians who have taken on the work of the Commission and Taskforce to undertake their consultations and deliberations without looking over their shoulders.

Yet the brief of, particularly, the Commission is to think big and adventurously to shape a blueprint for the future growth and evolution of Australia's healthcare fabric. It may recommend serious, even radical changes, to the way we plan, fund and resource our health services and professionals – changes that will require serious consideration and public debate even if recommendations ultimately are not adopted. It is counterintuitive to make a serious and premature policy change to

[26] Hospital operations on rise, *The Australian*, 23 July 2008 and other media reports

an important structural element of the public-private balance in our health structure without seeing how the various permutations for change are developed and play out in public debate over the next year or so.

Assuming that the Government will persist in its determination to change the Surcharge thresholds, it therefore would arguably be prudent to defer the commencement of this or any compromise measure until 1 July 2009 at the earliest. This could be done by passing the legislation but not proclaiming it until then.

The converse and more persuasive argument, however, is that the perceptional damage already has been done and genie is irretrievably out of the bottle: once the measure passes, proclaimed or not, it is most likely that consumers will start behaving as if it already is in effect. The massive publicity since the Budget already has been too great to prevent a run on private health insurance membership if this measure simply is deferred. Indeed, in Victoria the State government's ambulance fund already is advertising for members[27] with the message that you will still need ambulance cover when you drop your private health insurance.

Therefore, the most responsible approach is for the Government to withdraw the measure altogether and look at alternatives that go at least some way to meet its saving objectives.

**Compromise: making the thresholds conform to movements in Average Weekly Earnings (AWE)**

In evidence to the Committee in Estimates hearings, the Treasury advised that:

> (S)ince the thresholds were introduced in August 1997, average weekly earnings have increased by around 50 per cent. So, if the thresholds had been indexed to average weekly earnings, it would now be $78,000 for singles and $156,000 for couples[28].

The proposed change to the couples threshold of $150,000 broadly conforms to this movement. But raising the singles threshold to $100,000 clearly does not. As discussed earlier, this exaggerated increase calls into question the motives of the Government. In effect it is sending a message that it wants to go further than restoring what it says is an appropriate level commensurate with wage movements. It effectively is showing the door to many thousands of currently-insured Australians with taxable incomes between $78,000 and $100,000 who are basically being told that they don't need to take some responsibility for the cost of their health care.

If the Government is truly serious in believing that a measure along these lines is necessary, it has the choice of withdrawing the current proposals and replacing them with new thresholds. It could simply adopt the Treasury AWE figures and index them annually, which would be consistent with Labor policy as announced in early 2007 by Ms Roxon when the Labor shadow minister.

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. As tax scales are adjusted, so would be the Surcharge thresholds.

[27] As of mid-July 2008

[28] Senate Economics Committee *Hansard*, Mr Ray in response to Senator Cormann, 3 June 2008, page E57

While the arguments that the swings and roundabouts of taxation and family assistance are compelling, and that the status quo is perfectly appropriate and defensible, this would be a logically-justifiable compromise. In submissions to the Inquiry the Health Insurance Restricted Membership Funds Association of Australia has indicated its support for thresholds revised downwards to $75,000 and $125,000 which indicates some measure of acceptance or resignation within the industry of such a possibility[29].

Such a compromise is definitely not the best outcome for the private health insurance industry or the private health sector generally. There would still be a run from health fund membership of better risks, and there would still be adverse premium consequences for those remaining. It would, however, be far preferable to the alternative of the measure as it stands currently.

**Make alternate savings on the Private Health Insurance Rebates**

If the true aim of this measure is to reduce outlays on the Private Health Insurance Rebates, the Government has alternatives to enticing people to drop their cover. A simple way of delivering significant savings would be to abolish the 25 and 40 per cent loadings for privately-insured people aged over 65 and 70 respectively.

The loadings were introduced by the Howard Government in 2005 following an election commitment. The intention was to reward the many thousands of older Australians, many of whom are on low to moderate fixed incomes, for making the effort over many years to contribute to the cost of their own health care, or assisting other family members to pay for their insurance. The measure was targeted to a key constituency, but as policy it is flawed. It was an avoidable mistake.

Essentially, the loadings are counterintuitive. They target the older and generally sicker age groups that are more likely to be affected by large-scale adverse selection. These people do not need additional incentives to keep their health insurance, and the loadings do nothing to increase incentives for younger and better risks to join a health fund and develop a long membership history. This is where the attention should have been focused.

Additionally, when the loadings were implemented insurers were deeply concerned about the administrative costs and red tape of differential rebates for their older members. These concerns arguably remain. The extra administrative costs make older members more generally more costly band less attractive insurance propositions, and the consequences are borne by the whole industry through the reinsurance pool.

Removing the age loadings on the Rebates would, on current health insurance membership numbers, affect about 1.25 million older Australians[30]. Based on the indicative costs of real-life intermediate hospital cover policies marketed though an online health insurance broker (rather than simply using statistical average premiums per person), an indicative estimate of the full-year cost of removal is $156 million in 2008-09 ($78 million if commencing on 1 January 2009). Assuming stable age group membership (although noting that as the wider population ages it will almost certainly increase) and a constant annual average premium increase of 6 per cent, the estimated saving would be $683 million over the four-year forward estimates period.

[29] HIRMAA, submission to the Inquiry, page 5
[30] PHIAC, *Annual Coverage Survey*, 2008

If it were serious about obtaining Rebate savings, the current Government could remove the age loadings with little or no political damage to itself, and thus remove an anomaly in the private health insurance system that actively rewards adverse selection.

While this course would not be welcomed by those whom it is intended to assist, if the choice is between imposing higher Medicare Levy Surcharge thresholds and removing the age loadings on the Private Health Insurance Rebate there is no doubt that losing the loadings would cause far less hurt to older insured Australians. They stand to suffer much greater and ongoing financial pain if their health funds are squeezed dry by higher claims costs on the one hand and a worsening risk pool on the other. The likely spiral in private health insurance premiums would in all likelihood well exceed the cash benefit of the age loading in a more stable and benign membership environment.

In addition, this alternative is a sound strategic policy approach. As it would be ending an anomaly, it would not undercut the pillars of private health insurance as a whole. Implementing it in the short term therefore would not complicate or undermine the policy reform processes now in train, nor should it scare the State and Territory public hospital funding horses as the Australian Health Care Agreement negotiations progress in 2008-09.

A worksheet of assumptions for this proposal is at Attachment A. These estimates are indicative and the measure would need to be subjected to genuine Budget modelling. It may well be that these informal estimates are either over- or under-stated, but there is no doubt that the savings to the Budget would be very significant.

**CONCLUSION**

The proposed Rudd government adjustments to the Medicare Levy Surcharge are ill-advised, premature and confused. They highlight the extent to which sovereign risk from government policy and regulation dominates the whole private health sector. The Government claims to be remedying a policy injustice to middle Australia, but in reality this measure is a savings grab to cut the cost of the Private Health Insurance Rebates.

Ideally, the measure should be abandoned, especially given that there has been more than adequate offsetting income tax and family assistance changes since 1998 to justify leaving the thresholds where they are.

But the Government has two other alternatives: to compromise and reduce the new Surcharge thresholds to levels justifiable in terms of Average Weekly Earnings movements over the last decade, or to find savings elsewhere in Private Health Insurance Rebate outlays. This submission indicates that there is at least one appealing alternative to achieve that latter goal which could avoid tampering with the Surcharge.

But if the measure goes ahead as proposed, it is almost certain to result in a greater then first predicted decline in private health insurance membership, and bring annual premium increases that may be double or more of the those of recent years. An ensuing price-membership loss spiral would be a disaster for not only the private health sector, but for the millions of Australians who would struggle to keep the freedom of access and choice that their private cover affords them.

**A last word**

The Australian Health Ministers Conference meeting of 22 July 2008 discussed demand for public hospital service. The meeting communiqué says this:

> The Ministers also discussed funding under the new Australian Health Care Agreements. It was agreed that as part of the negotiations, all factors driving growth in demand for public health services would be considered. There was general agreement that, due to the complex factors driving growth in public hospitals, work would have to be done to determine the most effective way to monitor this growth. Work also needs to be done on ways to manage any growth in demand.

It would be interesting to know just what Minister Roxon advised her State and Territory counterparts about her Government's proposed changes to the Medicare Levy Surcharge, and their likely impact on the private health sector that complements the public hospital system and eases the demand for public hospital services.

Work does indeed need to be done.

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**ATTACHMENT A**

**REMOVING THE PHI REBATE LOADINGS – INDICATIVE ESTIMATE OF ANNUAL COSTS**

**PHIAC Annual Coverage Survey (2008)**

Persons insured for hospital treatment benefits as at 31 December 2007

Age 65-69 419,644 (round to 420,000)
Age 70 plus 832,024 (round to 830,000)
Total covered 1,251,668 (round to 1,250,000).

**Indicative policy costs**

Broad average costs of a range of intermediate hospital cover policies on i-Select website

Singles $1,500
Couples $3,000

Assume 50 per cent of 65+ age groups covered by singles policies, 50 per cent by couples.

**Ages 65-69 (35 per cent rebate)**

105,000 couples policies @ $3,000/policy = $315,000,000
Cost of 5 per cent rebate loading = $15,750,000
210,000 singles policies @ $1,500/policy = $315,000,000
Cost of 5 per cent rebate loading = $15,750,000

Total policy cost = $630,000,000
Total rebate loading cost (5% of $630 million) = **$31,500,000**.

**Ages 70 plus (40 per cent rebate)**

207,500 couples policies @ $3,000/policy = $622,500,000
Cost of 10 per cent rebate loading = $62,250,000
415,000 singles policies @ $1,500/policy = $622,500,000
Cost of 10 per cent loading = $62,250,000.

Total policy cost = $1,245,000,000
Total rebate loading cost (10% of $1.245 million) = **$124,500,000.**

**Totals – all policies**

**Premiums** $1,875,000,000
**Rebate loadings** **$156,000,000**.

**Over four years:**

Assuming membership stable and average year-on-year constant rate change of 6 per cent

| Year 1 $m | Year 2 $m | Year 3 $m | Year 4 $m | Total $m |
|---|---|---|---|---|
| **156.0** | **165.4** | **175.3** | **185.8** | **682.5** |