COMMONWEALTH OF AUSTRALIA

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009; Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009; Fairer Private Health Insurance Incentives Bill 2009; Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

THURSDAY, 9 JULY 2009

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Thursday, 9 July 2009

Members: Senator Moore *(Chair)*, Senator Siewert *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Furner

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Boyce, Furner, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on: Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009; Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009; Fairer Private Health Insurance Incentives Bill 2009; Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

WITNESSES

Committee met at 10.45 am

HAGAN, Ms Amanda, Group Executive, Healthcare, Australian Unity

CHAIR (Senator Moore)—Good morning. This is the Senate Standing Committee on Community Affairs, which is continuing its inquiry into the provisions of the Fairer Private Health Incentives Bill 2009 and related bills. Not all members could attend today, but everything is recorded so all members of the committee have the full story. It is not through lack of interest that the whole table is not full. I welcome Ms Hagan. I know that you have received or can receive on parliamentary privilege and the protection of witnesses, which is standard procedure. I invite you to make an opening statement and then we will move to questions from the committee.

Ms Hagan—Thank you. Apart from my role as group executive I am also the statutory CEO for both of our health funds. On behalf of Australian Unity Ltd I wish to formally thank the committee for an invitation to make a submission to the inquiry into these bills. We are pleased to have the opportunity to present our views on behalf of our health fund members. I will start by giving you a bit of background on us. We operate Victoria's third largest health fund as well as a corporate health fund, preventative health business and dental clinics. The broader Australian Unity group also operates in aged care, retirement living and funds management. Our organisation is a neutral organisation, which means it is owned by our members, most of whom are health insurance policyholders. Our organisation's history dates back almost 170 years. We do not make profits to benefit shareholders; we want to keep private health insurance affordable, particularly for those people for whom it is not a luxury but a necessity—often low-income earners with chronic disease.

It is estimated that one million Australians with private health insurance lived in households with an annual income of less than $26,000. It must be remembered here that we are not in control of the vast majority of our costs: the benefits that we pay out to members. This is because the Australian private health insurance system is based on the principle of community rating. This principle protects the integrity of the clinician-patient relationship and is one of the great attributes of our system. Clinicians can prescribe treatments for patients without reference to us, and we must pay for those treatments regardless of the cost. It is an uncapped liability. Community rating also means that no-one is turned away from health insurance on the basis of their age or health status, nor are the chronically ill charged premiums higher than anyone else. Community rating ensures equity of access to private health care. Community rating requires that we negotiate a fine balance over long periods of time. We must ensure that our health insurance funds have a strong cohort of young, healthy members to keep the fund healthy and costs down for all. Proposed changes to the legislation must be assessed against this long-term requirement.

Australian Unity has invested considerable time and effort into becoming a partner with our members for their health, not just in being a bill payer, by investing in evidence based programs to manage chronic disease but also programs such as Step into Life, the Better Being program and Lift for Life, which are aimed at preventing chronic disease or at least delaying its onset. We have the most extensive range of preventative health benefits on the market today.

We are opposed to this change. We are opposed to it because it tinkers with one of the fundamental fairness premises of this system—that access to private health insurance is equal and, outside of the effect of the different rebate levels, no-one pays more for the same access. The policy settings that have been in place for most of this decade have attempted to support this principle of equal access and to encourage people to take up private health insurance, because it is quite clear that the private health sector reduces the burden on the public sector.

In the 12 months to March 2009, the industry's independent regulator, PHIAC, reported that the total benefits paid by private health funds to the 11 million Australians who hold some form of private health cover was $10.9 billion. If it were not for private health insurance, this $10.9 billion, less the government's premium rebate component, would need to be found in the public purse. The biggest concern we have is that, by taking a series of policy decisions which individually may appear on the surface to be unlikely to have much impact and by not modelling any second-round effects—such as the impact on the ageing of the private health insurance population, the downgrading of policies that is likely to occur, the likely withdrawal of corporate funded health plans and so on—we could be setting ourselves up for a downward spiral in participation rates similar to that which occurred during the 1990s. For every person that drops private health insurance, there are fewer people left to bear the burden of the overall claims pool. Generally it is the healthier people who drop out, which compounds the effect on those left in the system, so private health insurance becomes progressively less affordable for all.

Ageing of the population places relentless pressure on costs. We did, however, have a policy measure, which was the fixed MLS thresholds in the private system that maintained the average age of the private health insurance population steady at about 39.8 years for the 27 months to 30 September 2008. This resulted in lower average premium increases for all policyholders throughout this period. However, by 31 December 2008, less than three months after the change to the MLS thresholds come into effect, the average age started to increase again. While it is far too soon to know if this is a trend that is going to continue, it is of serious concern to us. Sustained future increases in this age over time are reasonably expected to drive increases in claims costs and therefore in the premiums paid by all private health insurance policyholders. It is estimated that every increase of just one year across the private health insurance population requires an increase in premiums of around five per cent before we take into account any growth in hospital or medical costs.

Australian Unity notes with interest that the Department of Health and Ageing submission on the proposed changes to the rebate covers the issue of premium increases in just four lines on page 3 and states:

The Government does not anticipate that this measure will flow on to increased premiums.

The department's submission does not mention the impact of ageing anywhere, and this has not been modelled but it has to be considered. What is the department's opinion on the age profile of the private health insurance population based over the period to 30 June 2012? Because the private health insurance system operates as a whole under community rating, any actions which the government proposes on health insurance need to be analysed over five to 10 years and the impact on the community rating principle.

We submit that this long-term detailed analysis must be undertaken by the government with appropriate review of the results prior to the proposed changes to the rebate being debated in detail; otherwise those who are most likely to be negatively impacted by the subtle but ultimately profound effects of these policy changes will be those who rely on private health care to maintain their health. Often these are pensioners, working families or even young people with chronic diseases and injuries. We also submit that the government looks at other issues that impact on the private health-care sector including safety and quality, informed financial consent and others. Opposing this legislation and taking a more considered approach will help all Australians.

Senator SIEWERT—One of the issues that has come up is the issue around people dropping ancillary cover. People are saying that will have an impact on fees more than costs. My question is: if people are dropping the cover it means that the various organisations will not have to then pay out against claims. Won't that reduce the costs to the funds?

Ms Hagan—It will reduce the costs to some degree, but, if you look at it generally in the industry, the margin that is made on ancillary products is higher than on hospital products. That allows to some degree cross-subsidisation for the hospital products. Generally the people who drop out are going to be the people who are not claiming and so are not seeing as much benefit. The people who are claiming their limits every year probably will keep it because they see there is value in having that—they do a cost-benefit equation and they decide to keep it. The people who will drop it are those who are not utilising it as much and therefore the decrease in the claims cost will not be as great.

Senator SIEWERT—But wouldn't that then be people looking at the benefits they get from their private health insurance and saying, 'Okay, we're not actually getting any benefit from this'? The government has, in effect, through the rebate process been subsidising the private health funds. Because they get the rebate, people have not been questioning the value of their private health insurance and now they are going to turn around and question the value of their private health insurance.

Ms Hagan—The subsidy goes to the member not to the health fund. It is about making private health insurance more affordable for all, and at the end of the day they are getting valuable services in dental that are being done in the private sector. If it is not affordable, those services still have to be performed somewhere. The rebate is not going to the health fund; it is going to the member to make it more affordable.

Senator SIEWERT—Certainly a lot of people are arguing that that money should be paid directly into the public system rather than go into private health insurance funds propped up by people paying for cover they are not even using or see little benefit in.

Ms Hagan—I guess we have to look at the higher level principle here, which is the principle of community rating. If we all agree that fair and equitable access to private health care and to health care in general is a goal of our society, then I think we have to accept that underpinning that you need younger, healthier, non-claiming members to support the older, more chronically ill. That is just a fundamental premise of what we are doing. But I completely agree with you that private health insurers have to display value in their products. At the end

of the day, that is what we do; we are about providing benefits to members and we need to look not just at dental, physio and chiro but at things that are attractive to younger people to keep them in the system.

Senator SIEWERT—By opposing and obviously being unhappy with the changes, in particular when looking at their ancillary cover, are the funds saying, 'We are not prepared to change our products to provide products that actually meet people's needs'?

Ms Hagan—No, that is not true at all. Every year we look closely at that. In the last year we have put in a range of benefits that are targeted at people who will find value outside the hospital setting. In those ancillary products we have looked not just at benefits for cervical cancer to all sorts of things that we have introduced to help prevent chronic disease later on but at some of the programs we have put in place to provide benefits to people now. It is up to the health insurers to have a value equation in the product for everybody.

Senator SIEWERT—If you are providing value in ancillary cover, surely people will keep it.

Ms Hagan—I guess the issue is that when it goes up by 43 per cent people will question it. Anybody who gets a bill that goes up by 43 per cent in one hit is going to question it.

Senator SIEWERT—Where do you get the figure of 43 per cent?

Ms Hagan—That is it. If you are looking at a 30 per cent rebate being reduced, obviously it is a tier in a tiered system.

Senator SIEWERT—Have you looked at some of the figures that have been presented to the committee? For example, Professor Deeble yesterday gave us figures that showed that there is going to be very little increase.

Ms Hagan—I have not seen those figures but, if you look at prices going up by up to that amount and there is no Medicare levy surcharge stick around ancillary, I think you will find people will drop out.

Senator SIEWERT—I would appreciate it if you could get an opportunity to look at the figures. I am a little bit concerned that there is little foundation in the comment 'they all go up by 43 per cent', particularly looking at the figures that Professor Deeble had done yesterday. Even in the other reports that I have seen I have not seen figures around 43 per cent. I have seen no justification for figures around a 43 per cent increase.

Ms Hagan—Our analysis has shown that for some people it will go up by 43 per cent—for those who lose the rebate altogether.

Senator SIEWERT—I do not think we have those figures.

CHAIR—Ms Hagan, is it possible to give figures in amounts as opposed to percentages? That was one of the discussions yesterday. Percentages have been tossed around in a lot of the debates, but we are more interested in the dollar figure. What does a 43 per cent increase mean, if that is what your analysis says? Is that $400 or $500? Certainly Dr Deeble's submission was looking at cutting that across the year. If your private health insurance was to go up by the percentages that they quoted, his argument was that that was four cups of coffee a week. They were the kinds of figures. It would be very useful if we could see that—and we will be asking all the private health folk, not just you.

Ms Hagan—Sure, we can certainly look into that amount.

CHAIR—It would just be amounts, because percentages are sometimes thrown around without us seeing exactly what that will mean. I am a member of a private health insurance fund and I am interested in the amount, not in the percentage.

Ms Hagan—Sure. We will certainly get back to you.

Senator BOYCE—Was Australian Unity health surprised by this move by the government to change the thresholds?

Ms Hagan—Yes, we were surprised. It came without any notice to us or to the industry, as far as I am aware.

Senator BOYCE—It has also been put in evidence that this was in fact the opposite of the election promise made by the government in the area. Had Australian Unity health done any planning on the basis of the comments by the minister in I think February this year and the Prime Minister during the election campaign and subsequently around the fact that there would be no changes to the Medicare rebate?

Ms Hagan—Yes, the last annual price round had no modelling based on this in it. Nothing that we have in our prices to date as taken into account any effect from this change.

Senator BOYCE—We have had some figures from Treasury that really look at first-round effects, not second-round effects. We have also had figures from industry suggesting that half a million or more people might be affected. Have you done any figures within Australian Unity health as to what you think will happen to the number of people covered by insurance?

Ms Hagan—We have not done that modelling yet. We are about to go into the next price round modelling. Modelling takes about six months out from the submission. We are about to undertake that; however, I am aware of the AHIA's research that has been done which is showing that up to 10 times the amount that Treasury has estimated may drop out of the system. Largely that is around the ancillary products that will not have the benefit of the MLS sitting behind them to hold people in.

Senator BOYCE—We also had evidence yesterday suggesting that health insurance was quite a sticky product, for want of a better term—that people might look at how to adjust their budgets to meet changes but that dropping health insurance was a highly unusual thing to do. Is that your experience?

Ms Hagan—Our experience is that people see value in the product and they generally stay in the product. It takes a lot for people to make the choice to drop it. In the 1990s it took a long time to build up the people in the system. And it is the same at the other end; there is a tail on the way down. It takes awhile but once that spiral is going down it is quite difficult to get people back in.

We are concerned that there has been no modelling done on the ageing of the population. We have already started to see—and while it is not a long-term trend by any stretch yet—some alarming things going on in ageing. As I said in my opening statement, one year of change in that population is five per cent in premiums. If that spiral starts and we have to put up premiums because of the ageing, things will change quite rapidly I think. Our concern is that none of that modelling has been done.

Senator BOYCE—What about new contributors? Is there anything different about the profile of new contributors in your view if prices go up?

Ms Hagan—I think there is. As I have said before, the community rating is underpinned by having to have a strong cohort of young, healthy members in the system to lower the claims in the system overall to be able to keep premiums down. We are already starting to see from the changes in the MLS that the growth in that age cohort has gone down and hence the ageing already of the population.

Senator BOYCE—I should have asked you a little earlier: how did your organisation find out about the government's proposed changes in this area?

Ms Hagan—When it was announced in the budget.

Senator BOYCE—What was the company's reaction?

Ms Hagan—Shocked, I guess. We have a corporate health fund. I can tell you that the day after this was announced in the media, we had large blue-chip companies in this country ringing us and saying, 'What are we going to do about this?' Some of these companies fully fund or partially fund their employees' health insurance. They have categorically said to us that they will no longer be able to afford to fund this. We were immediately worried about what this is going to mean.

Senator BOYCE—I do not think anyone has mentioned the change to the corporate area. Has any action happened on that, or is there just a waiting period going on?

Ms Hagan—Without disclosing anything that is confidential, there was immediate action. There were several large tenders in the market at that point that were very well progressed. They were immediately put on hold. Our pipeline has completely dried up in terms of corporates that were interested in taking up and funding, particularly in the mining sector. That had been growing very rapidly over the last five years, and all of that has ground to a halt.

Senator BOYCE—Without revealing anything confidential, can you give us a sense of what you mean by 'very large tenders'?

Ms Hagan—In the thousands—4,000, some of them.

Senator BOYCE—Thousands of people?

Ms Hagan—Yes.

Senator BOYCE—This would generally have been part of someone's package.

Ms Hagan—Yes. I think some of the latest statistics out from Mercer show that employees value private health insurance in the top one or two benefits that employers can be paying in this market.

Senator BOYCE—You said large was 4,000. Are there many around that number?

Ms Hagan—Yes. In the whole market at any one time prior to this announcement there were tenders to cover something in the order of 5,000-plus employees. Now there are hardly any. Our question on that would be: has anybody in government modelled the impact of corporates withdrawing from this market? Obviously there is revenue that comes from corporates attached to this with FBT. Again, we get told second round effects do not get modelled. There are many second round effects that come from this decision that need to be considered, in our opinion.

Senator BOYCE—Not only do you have the loss of FBT revenue, but you presumably also have the fact that these people are now deciding whether to take out their own private health insurance or in some cases not to. Again, they would be going into the public system.

Ms Hagan—We are not talking about the high-income earners here. Some of our clients, which number in the thousands, cover everybody from the gardener through to the CEO. So we are not talking about a population that is skewed towards high-income earners. We are talking about covering the whole gamut of the population in some of these funds.

Senator BOYCE—When you say 'numbering in the thousands', are you talking about thousands of contracts with companies?

Ms Hagan—Thousands of employees in those individual companies.

Senator BOYCE—Are you able to be any more specific on that? Probably not, by the sound of it.

Ms Hagan—I can go back and see whether some of our corporates would be willing to share that information.

Senator BOYCE—It would be good if you could come up with some sort of a total figure of how many people are covered and how many people were involved in the tenders that have now ground to a halt. Following this through, would you anticipate that companies that currently offer corporate private health cover would be less likely to include it in new contracts with new staff?

Ms Hagan—We have been told pretty categorically that some of the larger companies that we have will be ceasing it for current employees as well, not just for new employees. They will not be able to afford the increase in premiums that comes with this announced change.

Senator BOYCE—Obviously you do not want to give us names of companies, but it would be good to get some sort of quantifier around this as to whether we are talking about 5,000, 50,000 or perhaps even more employees. That would be really useful to have. You mentioned in your opening comments safety, quality and informed financial consent as other areas you would like to see the government work on. Can you explain a little bit more what you mean by that?

Ms Hagan—As I said, 82c in every dollar goes out in claims for us. So we are interested in having a dialogue on anything that can help us address the claims going out the door. Informed financial consent helps our policyholders know what it is that they are up for when they go into hospital so that there are no shocks. When they get out-of-pockets that they are not expecting, that devalues the product of private health insurance. We are interested in transparency in what is happening in hospitals in terms of infection rates so that we have best practice on infection rates and we are not funding misadventure in hospital. We think that transparency is good for the consumer, but it also helps the health insurers in terms of negotiating with hospitals.

Senator BOYCE—You mentioned the average age being 39.9 and how very early indications are that that has stretched out. Can you tell us to what at the present time?

Ms Hagan—In that one quarter, from 30 September 2008 to 31 December 2008, it went from 39.8 to 39.9. That might not seem like a huge leap but, as I said, in one year it was five per cent in premiums.

Senator BOYCE—So you are talking about half a per cent rise in that quarter anyway, extrapolating those figures.

Ms Hagan—Yes, and when I say a five per cent increase in premiums, I do not mean five per cent of the premiums; if the premium increase on average was five per cent, it would need to be 10 per cent, to cover the ageing effect. It is too early to call the trend on it. The actuaries will tell you that is way too early to put a trend, but it is a worry.

Senator BOYCE—I realise that but, given that you had mentioned there was a trend, I thought we should have a sense of what that trend was.

Senator FURNER—Thank you, Ms Hagan, for coming along today. Are you are in a position to explain the age demographics of your membership for the funds that you have?

Ms Hagan—I do not have the breakdown here for age demographics. It is spread across all age groups, but Australian Unity is older, on the whole, than the average in the industry. Our average age is 45, as against an industry average of 39.9.

Senator BOYCE—Is that partly because of the corporate cover?

Ms Hagan—No. The corporate cover actually brings the average age down. It is just that our demographics happen to have been that we have gone higher than the industry average. We are largely represented in Victoria, which is 73 per cent of our market, and it is an older demographic in Victoria than in the rest of Australia.

Senator FURNER—Can you explain what sort of modelling you did to draw your conclusions on the exiting of those members out of your funds?

Ms Hagan—We have not done the modelling at a fund level. We are going on what the AHIA has done on market research versus what Treasury has done. We are about to go into the modelling for the next premium round.

Senator FURNER—So you have purely drawn your conclusions based on one submitted to this inquiry.

Ms Hagan—Yes, so we have not made any conclusions yet about premiums, but we come back to the general principle that underpins community rating—that if you have people exiting the system and if they are generally the healthier people then there is going to be pressure on premiums for everybody left in the system.

Senator FURNER—What do you say then to Treasury's modelling of around 25,000 people likely to exit PHI?

Ms Hagan—I cannot really comment on the Treasury figures. I have not seen the models that sit behind them. All I can say is that we are looking at the AHIA figures, which are based on market research that they have done.

Senator FURNER—It probably would be helpful to have a look at the other submissions as well, I think. Like any argument, there are those that have a different story. One of the witnesses we had yesterday in Canberra, Mr Ian McAuley, referred to research on behavioural economics. He referred to 'the endowment effect', where people seem to hang on to what they have. In fact, other submitters indicated that, out of all types of insurance, people tend to hang on to private health insurance as opposed to any other forms of insurance because it is a greater risk to gamble on your life than to decide to withdraw from car insurance or household insurance. What is your view on that type of definition?

Ms Hagan—I guess I look at the statistics that have come through the since the change to the MLS. The industry was growing at four per cent before the change was put in; immediately after that, the growth in rate in the industry halved. So to sit and think this is going to do nothing to the number of people coming into health insurance—I think we have already seen evidence that changes to policy do have a direct and immediate impact on the number of people coming into the industry. And they are the young people, who help to hold the overall claims costs down.

Senator FURNER—Are you referring to the changes to the MLS in 2008?

Ms Hagan—Yes. The industry growth rate halved in the next quarter after that change was made, so that is 200,000 people who would have been in the system and were not in the system.

Senator FURNER—One submitter, the Australian Healthcare and Hospitals Association, indicates that the changes to MLS in 2008 did not result in any massive numbers of people dropping out of the system.

Ms Hagan—It did not result in people dropping out of the fund, but the growth rate of the industry halved. So 200,000 people who would have been in if that change had not been made were not in the system.

Senator FURNER—Conversely, with this proposal it is estimated that approximately 130,000 people may, with the stick approach, decide to join PHI as a result of changes to MLS. Are you aware of that?

Ms Hagan—Sorry, could you repeat that?

Senator FURNER—Around 130,000 people caught up in the new surcharges will probably consider joining PHI as a result of the increases in MLS.

Ms Hagan—I am not aware of that figure. We will certainly go away and have a look at it.

Senator FURNER—You will find that in DoHA's submission. They give a breakdown of the 130,000 as well in the two tiers.

Ms Hagan—We will look at that.

CHAIR—Ms Hagan, I am particularly interested in the corporate stuff because it has not been raised much. It certainly was not raised heavily in either the submissions or the evidence yesterday and I think it is worthwhile following it up. I just want to get an idea of how it works because I do not know. If a company is paying corporately as part of its package of employment for its employees, is it paying just the standard rate? Is there no special rate that it gets?

Ms Hagan—It depends. The fund that we have is quite unique in that we tailor products to individual corporates. So, in that sense, the products are slightly different. If they value some benefits over others we will put them in and model prices based on that. The standard industry practice, though, is that it is basically a retail product with some form of discount for volume that comes into that and efficiencies that come with processing corporates rather than individual retail.

CHAIR—So the process would be based on a company's payroll. The only change this would make when they are doing their budgeting would be to employers who are on $75,000 or above. Is that right?

Ms Hagan—The ones caught in the tiers, yes.

CHAIR—I just wanted to see if I had missed anything. When the company is doing its budgeting, the only difference in what it would have to pay out would be for the percentage of employees who are earning over 75,000?

Ms Hagan—Yes, correct.

CHAIR—I just hoped I was not missing anything.

Ms Hagan—And then they pay FBT on top of that, which basically doubles the cost of it.

CHAIR—Which they already do.

Ms Hagan—Yes.

CHAIR—And the people employed by that company, if that is not offered and they do not take up their own personal coverage, would be subject to the MLS.

Ms Hagan—If they are in the tiers, yes.

CHAIR—So the only difference would be that now they are not subject to the MLS because it has been paid on their behalf by their company.

Ms Hagan—Correct.

CHAIR—The difference would be with the tiers. That makes it clearer. I just had some sense that I may have had it wrong—that they had a special stick over them because every employer, whether they were a gardener or the CEO, was going to be affected. But it only affects the same tier arrangement.

Ms Hagan—The same tier arrangement gets affected. They will have to be funding it themselves, so whether they choose to be in private health insurance or not—

CHAIR—Fine. It is no longer a company decision; it is their own personal decision.

Ms Hagan—Yes.

CHAIR—Yesterday I asked a witness—I forget which—about the philosophical approach to means testing. This has been presented as a means-testing arrangement such that it is not changing access to private health or the availability of private health; it is actually that, from a means testing point of view, people who are earning this much money or above will now have to pay more. Is that how you see it as a company—that is a means-testing imposition?

Ms Hagan—It is coming across as means testing. On the surface probably not that many people would argue with the philosophical position, but it is the flow-on effect in that, if you have the people dropping out of the system as a result of that, you have fewer people left in the system and it drives up the premiums for everyone.

CHAIR—Yesterday, someone used the term, 'It's a matter of long division.' It had been a long time since I had heard that term, but that was the way it was presented to us.

Ms Hagan—And unfortunately it hits low-income earners disproportionately when the premiums go up.

CHAIR—Another issue is young people dropping out. As an organisation, have you given any particular thought to why young people in particular have not been attracted by the continuing advertisements and the approach to lifetime cover? You have noticed the incidence of younger people dropping out before these changes have come in. I am interested to see whether, as a company, there has been a particular evaluation of why young people are not joining. That seems to be the issue. If we are not getting more young people joining, that is pulling the age up. Have you done any work within the organisation to find out why that happens?

Ms Hagan—We have looked in detail at what age groups are claiming what and then we correlate that to people leaving and the slowdown of people in those age groups coming in. On the hospital side that is the whole underpinning of community rating; you are hoping that those people are not claiming on hospital. It certainly shows that people do question the value of it. We can add more value on the ancillary side, but on the hospital side the fact is that the younger age cohorts are just not going to go to hospital in the same patterns as the older cohorts.

CHAIR—And the lifetime health stuff has not, in effect, counterbalanced that?

Ms Hagan—No.

CHAIR—It has had some impact but not enough.

Ms Hagan—It has an impact for the 30-plus age group.

CHAIR—As an organisation, do you have a demographic of your members based on their income?

Ms Hagan—No.

CHAIR—So you do not know how many there are?

Ms Hagan—We do not know. All we can go on is Australian Bureau of Statistics data.

CHAIR—The kind of modelling that you have been doing has been based on best guess as opposed to knowing how many people?

Ms Hagan—That is correct.

Senator SIEWERT—Regarding the data you quoted earlier around the halving of the growth rate, could you provide a reference for that?

Ms Hagan—It is in the PIAC statistics, in the 31 December quarterly report. I think the AHIA also has it in their report.

CHAIR—Ms Hagan, it often happens that people go away and think, 'I wish I'd said that' or we come up with questions. The Hansard record of this will come out within a few days. I cannot tell you exactly when, but it will be on the committee website. You can see when it is available, and you will get a copy directly. You may find something that you just want to add. It is quite a common process that people get back in contact with us.

Ms Hagan—There is one other thing that I would like to say. Regarding ancillary and general treatment and how the margins are higher on those products, what Australian Unity has done with the money is invest in preventative health. We have taken this extremely seriously. Over the last three years, with the introduction of broader health cover, we have invested multi-millions of dollars in chronic disease management programs and all sorts of benefits. They are all evidence based. We do not just pay for gym memberships; we look at what evidence there is that programs in the community can help our members to stay healthy and stay out of hospital. That is what we are using our members' funds to invest in. Some of the programs that we have developed have been running for several years and we look at offering them to the public sector and other private health insurers. We see it as part of a private health insurer's responsibility to look at the age demographics and what is happening with chronic disease and play a part in helping to solve the problem. We have done deep dives into our—

CHAIR—Your company has a very strong reputation in that area.

Ms Hagan—It is absolutely fundamental to what we do.

Senator BOYCE—Could you give us a couple of examples of the preventative health measures that you have taken.

Ms Hagan—About three years ago we had a very detailed look at our data to see what chronic diseases people were suffering from. It showed that coronary artery disease, for example, had been growing at a compound annual growth rate of eight per cent over the last six years. So every year there were eight per cent more benefits than the year before. We started a program for coronary artery disease, which our members have been going through who have been in hospital and diagnosed with that. Since it has been running for two years we have had 77 per cent participation rate in that program. With the people who go in, there is only a two per cent drop-out rate. They are all meeting their respective targets. Our members are meeting the National Heart Foundation targets to reduce their risks. They have a telephonic coach—a dietician on the phone—offering them support and setting targets. We have one for congestive heart failure and osteoporosis. That is at the chronic end. We are also putting in benefits for younger people or people at risk of type 2 diabetes. For those at risk we fund Step into Life and the Better Being program. There are a lot of good programs in Victoria that we are tapping into and funding for our members, and we are working with GPs to look at referrals to those programs and we pay the benefits for them.

Senator BOYCE—It is probably a bit too early to say, but have you had any results?

Ms Hagan—We are about to look at trying to correlate the coronary artery disease program, which has been running for two years, with readmissions into hospital. At the end of the day, while we are looking at better health outcomes we also need to try and moderate claims over time. So we are about to do the analysis to look at whether it has stopped secondary readmissions into hospital. We know already for heart failure that we are stopping people being admitted into hospital. If we have somebody who puts on three kilograms of weight overnight then we direct them to their GP immediately. They have been taught what to do when they put on weight. They go into their GP and are immediately put on antibiotics. Previously they would have been sent to the emergency department and admitted into hospital. That is what is happening now on that program.

CHAIR—Thank you.

[11.26 am]

ENGEL, Mr Mark, Director, Marketing, Product and Corporate Affairs, Bupa Australia

LORD, Ms Brooke, Head of Industry Relations, Bupa Australia

CHAIR—I welcome the witnesses from Bupa Australia. Information on parliamentary privilege and the protection of witnesses is available, and I am sure you have that. Thank you very much for your submission. It is very detailed and we do appreciate that. If either or both of you would like to make some opening comments we will start with those and then go to questions from the senators. Mr Engel, would you like to start?

Mr Engel—First of all, I would like to thank you for the opportunity to appear before you today. I know that this committee has a very full week and Bupa Australia is pleased to be able to contribute to this process. I thought I would start by providing a bit of background about our business. Bupa Australia is the largest privately owned health insurer in Australia, with a significant presence in every state and territory. We support the healthcare needs of more than three million Australians through brands that you would know such as MBF, HBA and Mutual Community. It is in this context of supporting the interests of our customers that we are here today.

Although structured in Australia as a taxpaying, for-profit entity, Bupa Australia is part of the global Bupa Group, a mission driven social enterprise. We are a company limited by guarantee. The Bupa Group has no shareholders so all of its profits are reinvested in the provision of better care facilities and services to customers. In fact our structure is very similar in nature to the mutual structure that you would be familiar with here in Australia. The Bupa Group is also one of the largest private providers of residential aged care in Australia through Bupa Care Services. Since 2002 the Bupa Group has invested over $4 billion in Australia's healthcare sector, acquiring and growing health and aged care businesses in this country.

Bupa Australia has an enviable performance record in the Australian market. With our customers front of mind, we have delivered premium increases that have been below industry average for the past eight years, with a similarly strong record on management expenses. We have always been, and remain, firmly committed to helping our customers access the best possible quality healthcare while keeping costs sustainably affordable for our over three million customers. It is for that reason that we are concerned about the proposed changes to the private health insurance rebate. This proposal will impact directly and indirectly on every one of our customers and on an additional eight million other Australians who hold private health insurance. Furthermore, if these changes threaten participation levels in the sector, which they are expected to do, then they will also increase pressure on Australia's already strained public health sector—which would impact on the entire Australian community.

The rebate means test has been promoted as a targeted measure specifically designed to impact high income earners only. Unfortunately, the reality of the impact of this measure is far different under a community rated system. Community rating requires the entire insured community to share the burden of any cost changes in the overall pool. In short, lower income earners will be forced to fund the cost impact from any decisions made by higher income earners in response to this change. There are many ways that government can effectively target high income earners through policy. However, it is not possible to effectively achieve this aim under a community rated system.

Irrespective of intent, means testing of the private health insurance rebate in a community rated system will result in the cost impact being spread across all insured people. While Treasury has indicated that more than two million Australians will be impacted directly by these changes, their analysis gives no consideration of the potential impact of downgrades or of dropping ancillary cover, neither of which is protected by the Medicare levy surcharge change adjustment. I know this is something that has already been discussed at length as part of this inquiry into these changes, so I will not go into the detail in this brief statement other than to say that research conducted by the AHIA indicates that there could be anywhere up to one million customers who will change their cover as a result of these changes. The vast majority of that impact is expected to be downgrades to hospital cover as well as the dropping of ancillary cover.

The impact of these decisions by customers will be felt in two ways: firstly, those people who downgrade or drop will increasingly rely on the already stretched public sector for their health care needs, which are no longer covered by their health insurance; and, secondly, it has the potential to price choice in health care beyond the reach of low to middle income earners. Those Australians who are forced to drop their health cover for financial reasons will be forced into a public system under greater pressure with even longer waiting lists.

Moreover, for people on the lower income levels directly impacted by these changes the increased cost in the premium is not offset by the increase in the Medicare levy surcharge. Of all people directly impacted, this is the group of people who are likely to have the least amount of financial flexibility during these challenging economic times.

The people most likely to change their cover in response to this proposal are the young and the lower claimers. Should these people leave the sector, or downgrade or simply choose not to join as a result, the subsidy they provide to the overall risk of the insured pool will instead have to be funded by premium growth. This presents an equity and access issue for lower income people in both the private and the public sectors. The majority of people who hold private insurance—more than 80 per cent of our customers—earn incomes below the proposed threshold levels.

Finally, the uncertainty of this proposal comes at a challenging time for the industry. We are already feeling the effect of significant downgrades to cover and a substantial slowing of growth in recent times. We are also concerned that there has not yet been an opportunity for a full assessment of the impact from the changes to the Medicare levy surcharge. Although the PHIAC figures show a significant slowing of growth across the industry since the changes were announced, we have yet to experience the first end of tax year, and Treasury recently confirmed that it still anticipates private health insurance participation rates to fall by almost 500,000 people as a result of the MLS changes. We believe that we should have time to fully assess the impact of the MLS changes before considering any further changes that are likely to place cost pressures on the insured community and additional pressure on the public system.

The policies that have supported private health insurance in this country, the rebate, the Medicare levy surcharge and lifetime health cover, have improved the age mix of the insured population, keeping premiums lower and affordable for lower income earners. The wealthiest Australians may always be able to afford private health insurance. Any extra pressure on premiums will hit low to middle income earners and fixed income seniors the hardest. This includes some of the people who are the greatest consumers of health services in this country. As I have already identified, this has both immediate flow-on impacts for the public sector. For these reasons, and those outlined in our submission, we believe that the private health insurance rebate should be retained for the benefit of all Australians.

CHAIR—Did you have anything to add at this stage, Ms Lord?

Ms Lord—Not at this stage.

Senator SIEWERT—The previous witness and you and a lot of other witnesses have said that they are worried about younger people dropping out as a result of these changes. I do not think that anybody who collects this data, certainly any of the witnesses from the various private health insurance funds, has been able to give us the make-up of the income demographic. Regarding the claims that younger people will drop out, what information do you have to link younger people to the income bracket that is going to be affected by the rebate and what figures are you using for that? I would have thought that a lot of the younger people would in fact be in the 80 per cent you are talking about.

Mr Engel—We have done some modelling of our database. We keep detailed demographics and we have overlaid our database with Roy Morgan income data. Based on the Roy Morgan data, about 82 per cent of our membership is below the threshold levels; they are on low to middle incomes. Also, about 30 per cent of our membership is over the age of 60, and many of those are people on pensions and low incomes. The interesting thing with the younger age band is that whenever we see a shift in premiums—and this is a historical record—those most likely to be affected and to re-evaluate the extra costs that come to them will be the younger or those who are likely to be claiming less. That does not mean they are not seeing value; it means they will be more likely to reassess their capacity to pay.

Senator SIEWERT—We have a loop here, don't we? The assumption is that premiums are going to go up because younger people will drop out.

Mr Engel—It is not just the dropout factor. In fact, the two big things that are not included in the Treasury modelling are that in AHIA research significant numbers of customers will choose to downgrade their hospital cover. The first thing they will look at doing is downgrading their level of premium hospital cover. By and large, that will occur without a significant decrease in benefits paid, so that will mean less premium for a similar claims risk in the pool. The second thing they have said they will do in significant numbers is potentially look at dropping their ancillary cover. The research is telling us that this is to balance their budget in tough economic times.

Senator SIEWERT—So you are saying they are going to do this anyway—despite these changes.

Mr Engel—No, especially in tier 1 and tier 2 of the proposed changes, they are telling us that if the rebate were to be withdrawn they would look at making adjustments to the overall cost of their health insurance to accommodate these reductions in rebate, and therefore the net premium cost to them, by either lowering their hospital cover or by dropping their ancilliary cover. And some, I think a quarter of a million in the AHIA numbers, suggest that they would drop out altogether. So those three elements combined would compound the premium effect on the entire insured pool.

Senator SIEWERT—Is it possible to get a copy of the survey that was undertaken?

CHAIR—Is that the Ipsos survey?

Mr Engel—It is the Ipsos survey overlaid—

Senator SIEWERT—So it is the same survey that everyone has been talking about?

Mr Engel—It is Ipsos overlaid with Roy Morgan data.

Ms Lord—Can I add that when we talk about younger people it is not necessarily 21-year-old people. Often we are talking about 40- or 45-year-old people, who are healthier in general than the population—

Senator SIEWERT—I am glad I am counted as young.

Ms Lord—In terms of the claims profile, we are talking about people who are less likely to claim enormous amounts, particularly in hospital, as the previous witness said. In that sense, the working community is a very strong demographic in that area, and when you look at the higher income levels it tends to be the working population.

Senator SIEWERT—Who do you see as 'young people'?

CHAIR—I have to admit, when you kept saying 'young people' I was thinking people under 30.

Senator SIEWERT—In most surveys I do not count as a young person, unfortunately.

Mr Engel—Like the previous witness, Australian Unity Health, we have a similar actuarial rule of thumb that for every one year of ageing of the membership, or the insured pool, there will be a premium impact of about five per cent added to premiums. We look at the average age of our insured pool, our membership, across the funds. All the funds would do this.

Senator BOYCE—What is the average age of your membership?

Mr Engel—I did not bring the average age with me. I will have to take that notice and come back to you with it. Let us say, for example, it is 48. We would classify people who join below the average age as younger than the average; therefore, they would on average provide extra support to the insured pool.

CHAIR—Has Lifetime Health Cover been bringing that down?

Mr Engel—Lifetime Health Cover has done a terrific thing, as well as the rebate and the surcharge, to stimulate membership from below average age—what we call younger age—into the pool. Our concern is that as growth has now declined, and may decline significantly further, that will bring in fewer younger, healthier people into the pool and therefore drive up the average age.

Ms Lord—To clarify that, healthier and younger is the reference. We talk about people who are younger and therefore less likely to have price flexibility in relation to their PHI choices and then we talk about some of the healthier people in the middle-aged brackets who are part of the working community. As claimers, they will see value in the products; however, they are less likely than others to claim a level of benefit, in which case they are more likely to consider, under financial pressure, downgrading that cover.

Senator SIEWERT—Senator Furner referred earlier to the 130,000 people that Treasury calculates will come under the increased surcharge. Treasury is suggesting that the stick will encourage them to take up private health insurance.

Mr Engel—First of all, those people are already subject to a one per cent Medicare levy surcharge. For the tier 1 change that we are talking about, we are talking about no change at all to the surcharge. So there will be no further encouragement of those people into the sector.

Senator SIEWERT—I presume the 130,000 people that will be encouraged under the changes are taken into account by Treasury's calculations.

Mr Engel—I imagine they are talking about everyone in tier 1, tier 2 and tier 3.

Senator FURNER—No, they are actually talking about tier 2 and tier 3.

Mr Engel—Tier 2 is going up by 0.25 of one per cent and tier 3 by 0.5, so the question remains: will that be enough of an incentive to encourage those people, if they have not been encouraged in at one per cent? Our initial view is that it may encourage some but not all of the tier 2 people. In tier 3 there will be more encouragement, clearly. But the questions remain: will that be enough incentive, how many more will come in and will that offset the numbers of people that we are hearing will potentially downgrade, drop ancillary cover or choose to drop out completely?

Senator SIEWERT—Have you had a chance to look at the report by Access Economics for Catholic Health Australia?

Mr Engel—Yes.

Senator SIEWERT—The conclusion is that they agree with Treasury modelling. My reading of the report is that the main issue is around ancillary coverage and whether people are going to drop that or not.

Mr Engel—Ancillary cover has not been considered in the Treasury modelling and neither has the significant potential downgrading of hospital cover, which is an equal if not bigger issue—that people will look at taking on funding deductibles, exclusions to their cover and these sorts of things to lower the overall cost of their premium, considering the removal of the rebate. So it is equally as big an issue as the potential dropping of ancillary cover.

Senator SIEWERT—I interpreted from your comments earlier that the funds will still have to pay out as much money. Did I interpret what you said correctly?

Mr Engel—The principle of insurance is you are insuring for the unforeseen. What customers are forced to do when balancing a budget is to say, 'If this is all I can afford, what trade-offs am I prepared to make to still be able to remain insured but take on some of the risk myself?' Of course, that means customers will be able to choose from products in the market which enable them to take a larger front-end deductible and larger excess or to choose products that exclude services like hip operations, cataract surgery or those for heart conditions—things that, depending on your age and your health profile, you may wish to take a risk in doing. Some customers that make those choices still get caught up in the unforeseen and then end up having to bear those costs themselves or end up needing to get that treatment in the public system because they are unable to afford an exclusion or an excess that they have chosen to take with their private cover. So an unforeseen event comes, which is the principle of insurance, and they then need to either pay for it themselves or go into the public system. Herein lies the risk—as big a risk, if not bigger, than the dropping of ancillary cover. We probably have not mentioned that the dropping of ancillary cover will drive, one would imagine, more people into the public dental arena as well, if that was to occur.

CHAIR—In your statement you said the funds would still be paying out as much. If someone has gone from premium coverage to middle coverage, is still covered for heart conditions and goes into hospital for heart surgery, why would the funds be paying out as much? That is the point we are trying to clarify.

Senator SIEWERT—That is what I meant.

Mr Engel—That is a very good question. We would not pay as much, but the actual base insurance cost does not diminish that much, because people will still claim for a lot of things and they will choose the things that they think they are least likely to get, so there will be some antiselection.

Ms Lord—If I could add to that as well. As we have indicated, for people who are likely to downgrade their cover even if there were an unforeseen incident in the future the chances are, if they are making that value judgment, that they do not have a history of claiming in that area in the past. So the money that they were funding in their premium revenue for the overall revenue of the industry will decrease but the benefits that were being paid to the overall insured community are very unlikely to change.

Mr Engel—They will decrease, but they will not decrease in the same proportion.

Senator BOYCE—So it is incremental.

Ms Lord—That is how that difference works insofar as if you have a very strong claims history, for example in hip operations, you are less likely to take a front-end deductible or drop your cover for an injury like that than somebody who has not had problems in the past and is unlikely to. So in that example the revenue for the fund has gone down but the benefits probably have not reduced by the same level.

Mr Engel—I could point to a terrific example. Our three funds have been operating in this market for over 70 years. There is an amazing history of evidence of this through the eighties, from the introduction of Medicare in 1983-84 right through to the mid-90s where we had this vicious cycle of premiums rising by in excess of 10 per cent per annum. By definition what happens is that the people who dropped out are on average much healthier risks which puts this exponential impact on the remaining insured pool and you have this cycle of ever-growing rate increases year on year and the pressure that puts on people to re-evaluate. It is the better risk on average who drop out. We have that historical data; we have that experience. That is the cycle of concern we have here if the rebate is means tested and the community rated support is removed then we could end up moving back into that sort of cycle.

Ms Lord—What you might find in this situation is where people's income levels see them in the tiers and they are affected but they consider themselves reasonably healthy and low risk and they do downgrade. Essentially in that scenario for the one million people who are on private health insurance in households with incomes under $26,000 a year, the chances are those people are fairly high claimers, they see a very strong value in that product and it is important for them to keep it. The decision made by somebody on $100,000 to downgrade their cover will actually essentially be impacted down the line in premium cost for a much lower income earner who desperately needs their cover.

Senator SIEWERT—Could you tell me, when you are talking about people downgrading their hospital cover or downgrading or dropping their ancillary cover, what dollar value we are talking about?

Mr Engel—In terms of the potential premium that could be dropped?

Senator SIEWERT—For an individual.

CHAIR—You have a really good statement that says that for a person earning $75,000 the current rebate is $554 and the premium cost is $1,269. I would imagine the $1,269 over a year would be one of the higher covers.

Mr Engel—For a single? It is at least a good mid-range cover, yes.

CHAIR—That would be hospital and ancillaries. If they are paying $1,269 now and they wanted to downgrade and went to one that was just hospital, would that be about $800 a year or less? Could we get that on notice? That would be very useful; we have not asked that question before.

Mr Engel—We could supply you with the range of premiums. There is quite a large range in premiums and policies.

CHAIR—There is such a range across all areas and I know we have asked BUPA, but you are the second largest in the country, so we will use you as an example.

Mr Engel—We would have premiums ranging from $500 a year right through to $5,000 a year depending on whether they were single or family and the level of cover.

CHAIR—I see that Ms Hagan is still in the room, so could you provide us with those figures from your group as well? Senator Boyce has said that example is not a high premium, so it would be like a mid-range one, you would have general hospital and some ancillaries.

Ms Lord—I believe that the table was provided by the AHIA and I am fairly sure they used an average industry wide premium.

CHAIR—That was my understanding as well. Sorry, Senator Siewert, but I was trying to get those figures myself.

Senator SIEWERT—I am having trouble understanding how much we actually mean. It makes it sound like a lot of money but, when it gets down to the cost per week, Dr Deeble was saying it is the equivalent of three cups of coffee or something like that. I want to get a handle on the real effects.

Mr Engel—In our submission, we have examples of average premiums. We have included in our submission the average single premium of $1,800 and the average family premium of $3,600, and we have another example of a family premium of $5,000, so you can see the potential rebate adjusted impacts across a range of different policies and a range of different incomes in our submission.

Senator SIEWERT—It still does not give me a clear idea. Maybe I will do my own sums.

Ms Lord—I am happy to have a look at that and see what we can find and provide it back to the committee. Obviously the degree by which somebody can downgrade a product will depend on the product that they start from, so there is a little bit of assumption required in that space anyway.

Senator SIEWERT—I will finish here, but the work that Treasury have done—and we have had a lot of discussion about it and it is in the Access Economics report—says that price elasticity for health insurance is very different to what it is for general insurance, and they are using minus two or minus three. Your contention is that auxiliary cover is not subject to the same price elasticity. That is your contention, isn't it?

Mr Engel—The price elasticity on?

Senator SIEWERT—The price elasticity on health insurance. The assumptions are that it is very, very low compared to for general insurance.

Senator BOYCE—Not price elasticity, but the reaction to—

Senator SIEWERT—Sorry; the response to price elasticity is very small for health insurance.

Ms Lord—I think we have seen in recent times, certainly with our fund over the last six months, a concept we have talked about in terms of a flight to security during difficult economic times—certainly to insurance and to things people know. PHI is no different to the rest of insurance. We have seen people holding during difficult economic times and, in that sense, sticking. However, we have seen a really strong trend to downgrade products in our own fund in the last six months. So, in that sense, the question about downgrading—we are already seeing that now. Additional pressure—we can only assume we will see that trend escalate or continue.

Mr Engel—I would just like to add two comments. One is that we believe that price elasticity would vary, or does vary, by income band. I think the Treasury papers suggest the same price elasticity.

Senator SIEWERT—Basically they are saying it does vary but overall they have done their calculations assuming it is fairly low, and Access Economics agree with Treasury on that.

Mr Engel—The other history I guess we have got is from the early eighties, when we had over 70 per cent privately insured and we saw price increases across the membership in excess of 10 per cent year on year. That vicious circle, that downward spiral, ended up with an insured industry of about 30 per cent, so we saw over 40 per cent of people drop their insurance over 13 years. I think we have got pretty good evidence that we do not need a huge lift in premium increases to see that affordability is impacted and people will drop out or downgrade and it will impact on the total numbers of privately insured and therefore those that are relying on the public system. We would be concerned if there were any view that the flow-on impacts to the entire membership of this proposed rebate change would not have an effect on people's view of their overall price and therefore propensity to drop out or downgrade—when we see a history of that having happened.

Senator BOYCE—I am going to ask you, as I have asked most witnesses: were you surprised by this budget measure? Were Bupa surprised?

Mr Engel—We were certainly unaware of the measure and, yes, we were surprised.

Senator BOYCE—How did you find out about it?

Mr Engel—Officially when it was announced in the budget.

Senator BOYCE—Why were you surprised?

Mr Engel—As is on record, there was a commitment made by the government that the rebate would be retained, so our planning expectation, as per the previous presenter, was that the rebate would remain in place, and we set our business and modelling and rate review assumptions on that basis.

Senator BOYCE—How have you had to change your planning as a result of this move?

Mr Engel—I guess our No. 1 priority is to attempt to convince this Senate committee that the legislation change should not go ahead. That is very much our focus at the moment.

CHAIR—And your fallback position when you get through that process? There must be more planning in terms of what changes you are looking ahead for.

Ms Lord—I think it is fair to say that we are looking at potential impacts internally. Like the previous witness, we have not done any formal internal modelling. Pretty much the extent of what we have looked at is overlaying income data to get an idea about what proportion of our membership base is likely to be affected. Beyond that, in terms of likely downgrade and dropout impacts, we have not done that modelling, but an internal team started work almost immediately post budget to have a look at how we can best minimise any impact for our customers and staff.

Senator BOYCE—My question was directed at getting a sense of the level of turmoil or concern that this change in direction caused when it suddenly arrived.

Mr Engel—We are certainly very concerned, in the interests of our customers first and foremost. Another area of concern that we have not mentioned is the administrative complexity that this change will bring—complexity not just for the funds and the taxation office but also for our customers in understanding what their incomes are at any point in time and therefore the level of rebate that they should be claiming.

Senator BOYCE—I had been going to ask you about that. Would you like to talk through for us what the complexities are from your perspective and what might be done about it.

Mr Engel—At the highest level, no funds currently collect or are aware of income data. So the first thing we will need to do if this is passed is to warn our customers—

Senator BOYCE—Your 3 million customers.

Mr Engel—our 3 million-odd customers—and continuously remind them that they need to be aware of their income and their potential entitlement to an appropriate rebate.

Ms Lord—Also, in an administration sense, whilst we believe our systems will be able to cope with the varying levels of the rebate, the number of times that can change is perhaps far more significant than the number of times you turn 60. As a result, we will see, just in volume, a lot more changes. But perhaps the largest component is the education component. If you compare it to the time when the rebate levels changed for older people, this time around we have a huge number of people potentially affected—as we said, around 20 per cent of our membership base. The difference here is that we cannot automatically assess who is impacted, because we do not collect income data. As a result, it is important from our perspective for our customers to be aware of the change and how it is going to impact on them. So an education campaign is needed there because when the time comes to do taxes people could get a very big surprise as a result of these changes. Last time the rebate changes occurred any default switch was essentially in favour of the customer. This time that will not be the case.

Senator BOYCE—So you might have someone who throughout the year may not be entirely sure whether they are tier 1 or tier 2, for instance.

Ms Lord—At the moment, our understanding of the administration arrangements is that that will be a matter for funds. It is something we are looking at internally. But, as you have pointed out—

Senator BOYCE—It would be a matter that you would have to be aware of.

Ms Lord—Not that we would be aware of directly, but if customers of ours want to nominate their level repeatedly, two or three times in a year, we as a fund have to make a decision as to whether we can accommodate that in our system. That is part of the investigation we are doing internally.

Senator BOYCE—It has the potential to be extremely complex—

Ms Lord—Certainly; without question.

Senator BOYCE—and involve a lot of individual processes throughout a year.

Ms Lord—Yes.

Mr Engel—Certainly our initial discussions with the Department of Health and Ageing have suggested that it is going to be an extremely complex process, and there are an extraordinary range of things that we and our customers will need to consider when establishing what incomes they calculate and what things should be included or excluded. It is quite complex.

Senator BOYCE—Would you be expected to undertake the administration?

Ms Lord—At this stage the government has indicated that individual funds can choose how they manage customer nominations, if you like. So if we enable our customers—something we are looking at now—to nominate to us the rebate level they would like to see as a discount then we can alter that on our systems, and then the reconciliation will be done through the ATO at the end of the tax year.

Senator BOYCE—But they could either end up owing you money—

Ms Lord—I would imagine that would be a matter they take up with the government during tax time, with the ATO. So that reconciliation will occur during the tax period. We will provide a statement, as we always do.

Senator BOYCE—Because the ATO pays them the rebate.

Ms Lord—That is right.

Senator BOYCE—I am working my way through this one. My other questions went to the Access Economics report that Catholic Health commissioned. It basically says, amongst other things, that in their view the current financial crisis, for want of a better word, is just as likely to cause people to drop out of private health insurance as this government change. Is that your view?

Mr Engel—Certainly we have the view that, given the challenging economic times and the changes that were already made to the Medicare levy surcharge last year, there are already enough variables at play that we are dealing with and that our customers are dealing with. The compounding risk of overlaying another change, which will add cost to members and cost to the funds and will therefore affect all premiums for all customers, concerns us greatly. What element would drive how much of the drop-out on the downgrade is a debatable point. Our view is that they are all significant factors and now is not the time to be overlaying another change before we fully understand and absorb the impact of the economic times and the Medicare levy surcharge impact on slowing growth and slowing the good risks into the insured pool.

Senator BOYCE— Given your long history, would you, for instance, have any sense of the effect of unemployment levels on private health insurance involvement?

Mr Engel—There is one thing we can draw on here, because we are an international group. Our business in Spain, where they are facing 15 per cent unemployment rates, has seen a big shift down, a big drop out of insurance or a rapid acceleration of discontinuance in that business. So there is a point at which unemployment does start to bite into the privately insured population. We have that evidence from our Spanish business. Obviously Australian unemployment rates are a fair bit lower, but they are on the rise. So that is another risk that we face.

Senator BOYCE—We had evidence yesterday suggesting that the Treasury modelling was in fact substandard and looked at first round only, which may or may not be correct at that level, but did not take into account second and third round effects. I was wondering if you would enumerate the effects for us in order, so to speak?

Mr Engel—The order of magnitude effects?

Senator BOYCE—Yes, please.

Mr Engel—What we are thinking is if this means tested rebate were to be applied, yes, it will directly impact up to 20 per cent of our membership. Some will choose to make no change, obviously. But, from research, significant numbers will choose to downgrade their hospital cover, significant numbers will choose to drop their ancillary cover and some numbers will choose to drop out. This will lower the overall insured pool. The premium impact of that will be felt across the entire membership, because we are operating in a community rated environment where we must charge the same premium for the same level of cover to all customers regardless of income, medical history, age et cetera. That will be the impact. Over time that will put more pressure on low-income families, the elderly, the aged and the chronically ill, in particular, who want to hang on to their insurance. They will give up things to hang on to their health cover, until those increases reach a point where they no longer believe they can afford it, at which time that will tip more of those older and iller customers into the public system. It is therefore going to impact the entire Australian health community, because it will see money coming out of the health system from the discretionary investment that is currently made by Australians. Does that tell the story?

Senator BOYCE—Yes. My next question relates to the community. Is the concept, the philosophy, of community rating under threat?

Mr Engel—BUPA Australia are completely supportive of the community rating principle that has operated in Australia for a long period. We are one of the few countries in the world that operate a community rated system, but our system is also the envy of most health systems in the world. We have terrific participation rates and we have top-tier mortality and morbidity rates. So we have a lot going on in our health system that is the envy of the world. We think that system is worth cherishing, nurturing and improving. Anything that would undermine that system or weaken the workings of that balanced health care system is not a good thing and we think the means testing of the rebate would potentially undermine the community rating system.

Senator BOYCE—Are you suggesting that you have an unacceptable crossover when you start putting a means test into the community rating system?

Mr Engel—Yes, we are saying that, Senator.

Senator BOYCE—Given your international experience, can you perhaps tell us what other countries use the community rating system?

Mr Engel—The main one is Ireland. They have a community rated system.

Senator BOYCE—None of your other countries?

Mr Engel—Not that we operate in. There are no others that operate under community rating.

Senator BOYCE—Thank you.

Senator FURNER—Firstly, you indicated that profits are reinvested back into the greater community for preventative purposes. Like the previous witnesses, can you give us some examples of where that occurs and what sorts of illnesses are complemented by the reinvestment?

Mr Engel—As with the previous witness, we pride ourselves on the investments we are making both in chronic disease management and in preventative health programs. We do this directly through our health insurance funds as well as through our foundation. I can cite a number of programs: our COACH program; our Young At Heart program; and, one that we are particularly proud of, our Interlife program, which runs a health risk assessment in the community to help people assess their health risks and provide alerts to changes they need to make in their lifestyle. We are running those in a number of companies around Australia now. We have a long list of programs that we are proud of, and, as with the previous witness, we are tracking and monitoring the success of those programs. We are measuring them in terms of the health outcomes of our patients, readmission rates and those sorts of metrics.

Senator FURNER—I am interested in this view of having the stats on incomes. I think Roy Morgan did some research on the incomes of some of your membership.

Mr Engel—We took the Roy Morgan data and overlaid that on our own membership data to establish what proportion of our membership would be caught up in the income thresholds. Our analysis suggested that about 18 to 20 per cent of our membership would be caught up in the proposed means testing change.

Senator FURNER—How do you overlay it on your own data?

Mr Engel—That is a good question. Our analytics team did that through our data warehouse. I imagine it is done through analysis right down at the census collector district level, but I am not specifically aware of the technical detail of how that is done.

Senator FURNER—Because you do not hold the data on the income of your membership?

Mr Engel—We do not have it at a particular member level, so these would be estimates run based on, I am imagining—

Senator BOYCE—How many 36-year-old women who live in St Kilda are members and how many 90-year-old men in Doncaster et cetera.

Mr Engel—Yes, right down to very small census collector districts based on the survey data.

Senator FURNER—So it is a guesstimate rather than an accurate analysis of what really occurs in the membership.

Ms Lord—No private health insurance funds collect formal income data from their customers.

Mr Engel—So it is an estimate based on Roy Morgan research data and the income is declared through that survey and then overlaid back against our membership.

Senator SIEWERT—There have been claims that there are that there are a million members under the $26,000 is an estimate, isn't it?

Ms Lord—I believe they are figures from the Australian Institute of Health and Welfare. They are figures that I have seen from the AHIA. They are sourced from the AIHW.

Senator SIEWERT—That is a bit different to the way it is explained in your submission. The way I understood it from the submission was that it was an extrapolation—and I am sorry but I cannot remember what page I read it on—of the data about the age at which members' income was under $48,000. It might have been one of the other submissions, sorry. I think it said there were 1.3 million members with an income level under $48,000. So I interpreted from the submission that in fact it was an interpolation of the charter rather than actually hard data.

Ms Lord—The figures in the submission were taken from directly sourced data. I am happy to go back and check through that. If the source is not in the submission, I will make sure we provide it to the committee.

Senator BOYCE—Do you have a sense that you know who your customers are? Just following on from that, obviously any research, whether it is conducted by Roy Morgan, Access Economics or the private health industry, is going to be based on assumptions. Do you have a sense that you know your customers quite well in terms of their demographics, their lifestyle et cetera?

Mr Engel—Yes, we do. In fact we pride ourselves on having a very close relationship with our customers. We have a large number of staff who have direct contact with our customers every day. So we do believe we have a good knowledge of our customers. We also run analytics on all the customer data that we have around their demographics, their health status and those sorts of things. So we have a very thorough knowledge of our customers, excluding obviously the specific details of their incomes.

Senator FURNER—That would be at the point of making claims though, wouldn't it?

Mr Engel—Yes, it would be at the point of making claims but we also obviously have their address data, their dependent details and all those kinds of details.

Senator FURNER—Yes, you have to have that data.

Mr Engel—Yes, but claims data over time does inform you a lot about your customer base.

Senator FURNER—I might take you back to the assertion about the dropout rate for ancillary cover. How have you done that modelling of people dropping out of ancillary cover?

Mr Engel—Again, this based on the Ipsos data. My understanding of that research is that it asked at what level of increase would people's behaviour change around either lowering their level of hospital cover, dropping their ancillary or dropping out completely. I believe the numbers were run on those that were very likely or definitely likely to take those actions.

Senator FURNER—Do you really think most members would know what they are actually insured for?

Mr Engel—Actually it never ceases to amaze me how much knowledge our customers have today of what they are paying for and what their entitlements are, in particular around ancillary cover. It is where in particular a lot of young people, who are not necessarily making claims on their hospital cover, are seeking value from their health insurance. But, again, the ones who are more likely to evaluate lowering that cover are the ones who are currently not drawing as heavily on those covers. So most of our members have a good knowledge of their cover. Of course some do not; some just insure for peace of mind and do not look at the detail of their policies. So we have a mixture of customers.

Senator FURNER—Would it be fair to say that, like most insurance, you only know what your ancillary insurance covers at the point of making a claim?

Mr Engel—We do have customers like that. But, as I said, it never ceases to amaze me how many of our customers know exactly what they are covered for. They make sure they claim their full entitlements.

Senator FURNER—What percentage would that be, do you think?

Mr Engel—That is a good question. I will take that on notice and come back to you. We will see if we can find that through research.

Senator FURNER—The issue was raised yesterday—and I forget which witness asserted this—that some premiums cover 100 per cent of all possibilities of claims. I think they used the analogy of emergency hospital access. Do any of your premiums cover 100 per cent of all possibilities of claims?

Mr Engel—In fact if we are talking about hospital cover then, yes, we do have a large number of products and customers who purchase full or top hospital cover which covers them completely for in-patient hospital and medical treatment. In particular there is a skew of customers who are older and in poorer health—and am talking about the averages here—on those types of products. So, yes, we have those products. We also have a significant number of products now where people are choosing to take excesses or exclusions to their cover. So we have significant volumes of customers in both camps, and in the middle too.

Senator FURNER—Does it cover emergency though?

Mr Engel—Do you mean emergency hospital treatment?

Senator FURNER—Yes.

Mr Engel—Absolutely.

Senator FURNER—Have you had an opportunity to look at Dr Deeble's submissions at all? He made two submissions actually—one to the previous inquiry, which was done through the economics committee, and one to the community affairs committee.

Mr Engel—Yes, I have read one of those submissions. I am not sure which one it was.

Senator SIEWERT—The second one I think has only just been tabled.

Senator FURNER—His submission to this inquiry indicated:

... the demand for health insurance is very susceptible to income levels but like other items which are regarded as 'essentials', it is not sensitive to price.

I am just wondering what your point of view is on that statement.

Mr Engel—Certainly our experience does not suggest that that is the case. If, as I suggested, you look back into the eighties and nineties then you will see that that is certainly not the case. Price rises are the No. 1 reason why people may choose to drop cover or drop out. In all of our ongoing research, again, fundamentally that is the main reason. People's capacity to pay and the perceived affordability of the product is the No. 1 reason why people will either join or choose to drop out or change their cover. Second to that is gaps or the level of cover. But price is absolutely No. 1 and it is why we as a business are absolutely focused on sustainable affordability of premiums for our customers, because we know it is the biggest driver of coverage.

Senator FURNER—And you have done well in that area competing with your competitors and being, more or less, as I understand it, market leaders.

Mr Engel—We are proud of our performance both at the rate increase level—keeping rate increases affordable—and at the management expense level, yes.

Senator FURNER—Are you able to provide us with data on how you compare with other insurers?

Mr Engel—Absolutely, we are happy to provide that.

CHAIR—It is on your website.

Mr Engel—Yes, we do boast about it on our website.

CHAIR—I think you are quite proud of that.

Senator FURNER—When this matter was dealt with initially at the economics committee a Mr Wells indicated in response to Senator Cameron that the sky was not going to fall and in fact the sky had not fallen in when Medicare came in albeit that there was a decline in percentage terms from the high 70s down to 30 per cent levels of coverage. Isn't that the case now—that the sky is not falling in? This is just a change in policy. There will still be people around who need to and will maintain proper health insurance?

Mr Engel—I am a little concerned confused about this. A drop from 70 per cent of people insured to 30 per cent I would suggest is a huge shift.

Senator FURNER—But the sky has not fallen in, although there have been some significant changes.

Mr Engel—That has not happened. I was in the industry back in the early eighties and I do remember that as bed-day subsidies were withdrawn after the introduction of Medicare it drove double-digit premium increases. That was when we started the slide in the numbers insured. It is that precipice we do not want to tip over with changes to rebate policy at this point, when we have a terrific balance in our healthcare system. Is the sky falling in at the moment? No. Does it have the potential to? Well, potentially, yes. Clearly the numbers show that we have about 50 per cent of the Australian population with some form of private health cover. But we have seen a drop from 70 per cent to 30 per cent and there is no reason why it cannot go racing back to 30 per cent or below.

Ms Lord—I was not in the industry at the time but my understanding of the history is that essentially the reason the support mechanisms for community rating and for private health insurance—the rebate, lifetime health cover and the MLS—were brought into existence was to stem the flow that was happening during that slide. So the very reason they exist is to stop the sky from falling.

Mr Engel—In the United Kingdom, where we have a large health insurance business, participation rates are at about 11 per cent of the population. Again, that system often looks at our system and asks: how could we put in supports to get participation rates like they are in Australia?

Senator BOYCE—How would premiums compare in the UK? I know it is a difficult question.

Mr Engel—It is a difficult question. In the UK, premiums are risk rated, which is part of the problem, we believe. We believe our community rating system is far superior, because the cost of premiums is shared across the entire community—

Senator BOYCE—So if I am a 70-year-old with hip issues I am going to be paying double—

Mr Engel—An extraordinary amount—double or triple, yes.

Senator BOYCE—while a 30-year-old has much less to pay, in the UK.

Mr Engel—Correct—which makes it unaffordable for most.

CHAIR—Senator Siewert?

Senator SIEWERT—I wanted to pick up on the comment you made about the UK. Who is asking, 'How can we get a system like Australia's'?

Mr Engel—I can provide you the specifics of that detail. We have had delegations out from the UK. We have had—

Senator SIEWERT—But is it the government, is it the community, is it the private health insurance sector itself?

Mr Engel—I believe it is a combination. We have had inquiries from all of those sectors, but I am happy to provide specifics if that would help.

Senator SIEWERT—Okay. That would be appreciated. Thanks.

CHAIR—You had one more question, Senator Boyce?

Senator BOYCE—I want to ask you whether you are involved in the corporate private health insurance business; and, if so, what effects you have noted of this particular government move.

Mr Engel—Yes, Senator. As per the previous witness, we are also actively involved in the corporate sector and we have had a similar experience to the previous witness, where a number of large corporates either have suspended tendering for participating in the sector or are looking at or talking to us about cashing out their current plans if a rebate means test were introduced. It is partly to do with affordability and, I understand, it is partly to do with how an employer acts equitably—say, if they want to provide support for all of their staff in an equivalent way and the level of premium is then varied based on an income means test. It adds complexity for them as well. We have had the same signal as the previous witness.

Senator BOYCE—Could you give me a sense of how many people might be covered by your corporate insurance scheme?

Mr Engel—We are certainly happy to take that on notice and come back to you.

Senator BOYCE—If you could. I just wanted a sense of the scale of it—as much information as you can give us without breaching confidentiality.

Mr Engel—Commercial-in-confidence. Yes, we are happy to come back to you on that.

Senator BOYCE—Thank you.

CHAIR—Thank you very much. You heard the information given to the previous witness that you will get a copy of the *Hansard*, so if there is anything you want to add please let us know. You have also taken a few questions on notice—if you can get back to us as quickly as you can with those. Thank you very much.

Mr Engel—Thank you very much.

CHAIR—The committee will take a break.

Proceedings suspended from 12.22 pm to 1.15 pm

RASHLEIGH, Mr John, President, Health Insurance Restricted Membership Association of Australia

WILSON, Mr Ron, Executive Director, Health Insurance Restricted Membership Association of Australia

CHAIR—Welcome. Today we have only Senator Furner, Senator Boyce and me here. But everything will be on *Hansard*, as you know, so all the members of the committee will have full access to all your evidence. It does not represent any reflection on our interest; it is just people getting together at this time. I just wanted to assure you that it is a really important committee as far as we are concerned.

Mr Rashleigh—That is certainly understood.

CHAIR—You have information on parliamentary privilege and the protection of witnesses and evidence. We have your submission. Thank you very much. If either or both of you would like to make a statement, please go ahead, and then we will go to questions. We are scheduled to go until two o'clock with you.

Mr Rashleigh—I do not have anything dramatically different to what is already contained in our submission, so perhaps as an opening statement I will just highlight a couple of the key features of that submission. I just want to reinforce the fact that I represent a total of 17 funds. Thirteen of those are restricted access funds and four of those are regional Australian funds. I think the importance of that group is that they represent a wide range of bodies, including a number of unions, a number of employer groups, a number of professional groups. In total, the membership of HIRMAA is in excess of 430,000 contributors, which represents in excess of one million Australian lives.

It has often been asked—and we made note of this in our submission—how the smaller funds of our membership stay competitive. I think I can answer that fairly adequately. There are three primary reasons. One is that HIRMAA as a group is a very active body working particularly in the political arena on behalf of its member funds, irrespective of political persuasion. We try to represent the best interests of our funds, which in turn represent the best interests of our members. About 12 or 14 years ago, the HIRMAA funds undertook two primary initiatives. One was to found the Australian Health Service Alliance, which represents now, in terms of total membership, just short of 30 per cent of the total industry, which in terms of being able to negotiate competitive and attractive rates with hospitals and the medical profession places us in the same league as Bupa since the takeover of MBF and Medibank Private. It is also noteworthy that, at about the same time, we purchased a software house in Adelaide which represents the majority of our members' interests, which enables us to have a dedicated health insurance platform spread over the 23 participating member funds and enables us to do it both efficiently and highly competitively.

I should also emphasise the fact that all of our 17 member funds are not for profit. I think sometimes the media treats health insurers somewhat unkindly, in that we frequently see terms like 'greedy health insurers' et cetera. I can say without contradiction on behalf of the HIRMAA membership that our only interest is the best interests of our members. Aside from working within the prudential framework prescribed by the legislation, we endeavour to supply the very best benefits at the most competitive prices. We have no stakeholders other than our members to service.

CHAIR—And you are based here? Is your head office in Melbourne?

Mr Rashleigh—Yes, it is. That may vary from time to time because our membership has a national coverage. It just depends on who is the chairman of the day and where they would like the executive director to reside. But for the last 10 years it has been Melbourne based.

CHAIR—So the Queensland teachers health fund could take you over and have you up in Brisbane?

Mr Rashleigh—They might. They are very active members of our—

CHAIR—Yes, I saw them on the list.

Mr Wilson—They would make us most welcome.

CHAIR—Particularly in the winter months?

Mr Wilson—Exactly. It could be a very good place to be.

Mr Rashleigh—One of our primary concerns about the proposed legislation is that it is in defiance of all undertakings that were made to us in the past. As an association we frequently sought reassurance as to the undertaking that the 35 per cent and the 40 per cent rebates as they are currently structured would remain intact without interference. We are disappointed that is potentially not the case. I would be of the view, and I

am sure this has been expressed to you because I have read the BUPA paper, that the people who will feel most disenfranchised will be those who rely least on their health fund, being the younger members. That is a known fact. In fact, the structure of health insurance as it is required to be in Australia under legislation with community rating is that the young healthy members subsidise the older members, who have a greater need for health services. Without being in any way able to verify the wide range of figures that have been put forward by various organisations as to what the loss of membership might be or, alternatively, what the downgrading of the level of cover might be, nevertheless I would put forward the view that it will have an adverse effect on membership, the extent of which I do not think any of us have the capability of being able to pinpoint with any accuracy. I would also put forward the contention which I alluded to before that, that the adverse effect will largely rest with the younger, healthier members. That will in turn be reflected in premium levels in the future.

We would also make the point strongly, as we have made in our submission, that we have concerns that this might be one of a series of planned moves ahead. We would make the point to this committee that we will be seeking from all the political parties some reassurance that this is not the beginning of a trail of further fragmentation of the structure of health insurance in this country. I have some genuine concerns that the administrative costs of this will have a very significant impact. All health insurers have a range of policies. The real effect of this change will be to multiply the number of policies that they already have by 10 in every instance. I think that is concerning in terms of being able to contain administrative costs. There is a benchmark which the industry regulator set by which they expect health insurers to be able to contain their management expense ratio at or less than 10 per cent of contribution income, and 90 per cent of us are able to achieve that. I have some genuine concerns that there will be some blow-out in that ratio if in fact we have a multiplication factor by 10 of all the number of policies.

Having had some discussion with the federal department in respect of the administration of the scheme, I also have some grave concerns that we are a long way from finding an ideal solution as to how it can be effectively administered. It has been suggested to us in several different forums that one of the solutions may well be to in fact leave it to the insured contributor to nominate for themselves which level they should fall under. In other words, if there is a reduction in the level of the rebate or if there is the removal of the rebate, it would be the responsibility of the contributor to advise their health insurer. I think messages from health insurers, no matter how carefully they are crafted and constructed, are largely not given a lot of attention by recipients. I foreshadow the case where the majority of contributors would probably not take a great deal of notice and would continue to take private health insurance with the benefit of the 30 per cent rebate and would then find out, with some shock and probably much stronger emotions than that, with the submission of their annual tax return, that in fact they are facing a substantial penalty. Under a somewhat selfish approach to this, I have a real concern that the contributors who are confronted with that shock will in fact blame the health insurer as opposed to the legislation which is driving this.

The final point that I would like to make to this committee is that health insurance is a complex arrangement at the best of times. We have continually seen in recent years the introduction of new acts with some fairly significant changes. Last year we saw changes as to the surcharge thresholds. Now it is proposed that there be changes as to access to the rebate. I would put forward that the majority of the insured community already have difficulty understanding what their health insurance is about. Having been in this industry for some 30-odd years, I am amazed personally by the blandness of some of the questions that professional friends and colleagues ask me. That clearly indicates to me that they have no understanding and that a further change will increase the complexity of that lack of understanding. I think that is a real concern. I would be happy to try to answer with my colleague any questions that you may have to ask us.

CHAIR—Thank you, Mr Rashleigh. Mr Wilson, are you wanting to add something at this stage?

Mr Wilson—Yes, thank you, Chair. I would add two points as to what my colleague has said in his more than adequate summary of our position on this issue. I will pick up on an earlier point that Mr Rashleigh made and emphasise to the committee that we are a not-for-profit organisation. I think we can truthfully say that we come to this committee—and we do so when we go to government—with clean hands. We do not have shareholders demanding that we return certain profits to them. Our organisation—so all 17 funds within the organisation of HIRMAA—is not for profit and is consumer-centric. I think that makes it a very special organisation. When we speak to you about how these changes are going to impact on our members, we can do so without having to be concerned about side issues. Secondly, to pick up on the final point that Mr Rashleigh made about private health insurance being complicated and becoming more complicated, I want to put before the committee my concern. All of us are aware of how Australians are very confused by superannuation rules. I would hate to think that we are going down the same pathway with private health insurance so that the

average Australian who takes out and purchases his or her private health insurance becomes so confused about the rights and incentives that are attached to private health insurance that they find it easier not to participate or do not participate in a fulsome way and get the best benefit from it. I think that when government are making changes to private health insurance they have got to look at the value of them and look at what benefit the Australian community as a whole derives from private health insurance and keep them as simple as possible.

CHAIR—Thank you.

Senator BOYCE—I want to tease out a little bit more information on what you refer to as yours being a special organisation. As I understand it, contributors would come to you in a way different from the way in which they come to some of the other funds in that it would be a group of contributors who are already in an organisation. Is that so?

Mr Rashleigh—Yes, it is. I will give you an example. My daytime job is Chief Executive of Navy Health, and obviously we relate to the Navy. While we are totally financially independent of the Navy and constitutionally are largely unlinked, other than through the act and our membership eligibility requirements, the Navy itself would regard us very much as a part of the family. I, together with my chairman, as a courtesy, report to the Chief of Navy twice annually just to inform him of whether anything is happening. There would be an expectation from the Chief of Navy that, if there were something out of the ordinary happening within our fund, I would alert him to it immediately. I think that is symptomatic of the relationship that exists between Navy Health members and the Navy Health fund as exists across the total 17 funds.

Let me just make an interesting comment. In a wider fora of the industry, during the consultation process leading to the new Private Health Insurance Act, reference was made as to how contributors would understand what they could claim in relation to hospital episodes. It is common across all of the 17 funds that I represent that, before our contributors go to hospital, 90-plus per cent of them would in fact ring the fund and just ensure that their interpretation of what their entitlement was was correct.

CHAIR—Was that in Navy or across all your associated—

Mr Rashleigh—Across the 17 funds.

Mr Wilson—There is a very close relationship between the consumer and the insurer. The consumer feels a very close bond and has the ability to make that contact to ask what their entitlements are rather than get to the other end of the situation and find out what they are not entitled to.

Senator BOYCE—For instance, Navy Health would be the default insurer for all Navy personnel, for retired personnel or for both?

Mr Rashleigh—Both. With respect, if I could make a correction: 'default' would not be the word I would use. It would, in most cases, be the fund of choice.

Senator BOYCE—I am sorry. I am presuming that people do have a choice.

Mr Rashleigh—Yes, they do. They can join any open fund, but they do not. But, again, that would be universal across—

Senator BOYCE—Because you are so good!

Mr Rashleigh—Yes, Senator.

Senator FURNER—How many people would you have in Navy, as opposed to personnel, who are covered by your fund?

Mr Rashleigh—Actual Navy personnel are not covered at all because they are covered by the Commonwealth, as are all military-serving members. So it is only families. Our total membership is approximately 15,000 contributors, which relates to about 40,000 lives. The population of the Navy itself is just under 12,000.

Senator BOYCE—So it would be Navy personnel with families and prior Navy personnel?

Mr Rashleigh—With families, and they would normally retain their membership after they separated from the Navy.

Senator BOYCE—I am trying to get a sense of how you might be different from other funds. You would market yourselves differently? These funds would all market themselves differently to the likes of BUPA, for instance?

Mr Rashleigh—Yes.

Senator BOYCE—They are, in the main, smaller funds and, as you say, therefore have a closer relationship with their members. Are there any other differences that we should be aware of?

Mr Wilson—You are completely correct on size. We have no fund, for instance, over 100,000 contributors. It ranges from the very small funds of 2,000 members, from the Reserve Bank of Australia, up to the 70,000, 80,000 membership funds. Each one of those funds appeals to a certain market, be it a teacher union, the Navy, Defence Health, which is aimed at Navy, Army and Air Force and at religious groups.

Senator BOYCE—Is the Queensland Teachers Union the only union based fund or is the railway and transport—

Mr Rashleigh—Road and rail transport is fundamentally union based. Transport in Victoria is fundamentally union based and New South Wales Teachers Federation is principally union based. So are South Australian Police. Again, their corridor to the fund is via the police union.

Senator BOYCE—I am trying to draw the distinction. Some are around the place of work or the organisation you work for; others are around which union you are a member of?

Mr Rashleigh—Yes.

Senator BOYCE—Okay. I am just trying to get those distinctions clear. I think, Mr Rashleigh, you have already mentioned this, but I have asked all the witnesses this. Given the guarantees that the government were giving right up until February this year, were you surprised by the moves outlined in this legislation?

Mr Rashleigh—I think disappointed would be more accurate. Canberra is reasonably well recognised for being able to release some fairly early rumours. We had a fair hold of those rumours. So 'disappointment' would probably be a more appropriate word than 'surprised'.

Senator BOYCE—Have you approached the government in any way about your disappointment?

Mr Rashleigh—We have written to all parties, including the government, about our disappointment and about our concern of being given specific undertakings and then those undertakings being changed.

Mr Wilson—Before and at budget time we made contact with the minister and the minister's office to express our disappointment at the proposed changes. I should say that prior to the last election our funds took a degree of comfort out of what was being said of the future of private health insurance incentives. When those assurances were given after the election and up until February this year, we again took a degree of comfort out of that. When the rumour mill started and then when the actual changes were announced in the budget we were not so much surprised but, as Mr Rashleigh has said, disappointed.

Mr Rashleigh—Could I just raise one other issue that I think will be of interest and will hopefully be taken on board by this committee. I have been to a couple of consultations now conducted by the department in conjunction with the ATO in relation to the implementation of the changes. I had a great concern at both of those consultations I attended that they have dropped the word 'rebate' and are now using private health insurance 'incentives' as the terminology. I alerted you before about my concerns about confusing the insured community. If we change the terminology away from the rebate, we will confuse them much, much more.

Senator BOYCE—What do you think might be the motivation for the change in that terminology, Mr Rashleigh?

Mr Rashleigh—I do not think I understand. When I say 'I do not understand', I understand why it is being said, but I do not understand what drives that change.

Senator BOYCE—I wanted to go on to talk about a topic you touched on in your submission and mentioned earlier when you talked about whether there were other government plans ahead to do other things. You have mentioned here a justifiable belief by consumers that private health insurance would be increasingly less attractive and affordable if there were more changes to come. I would have also thought that the matter of trust and ongoing change would be an issue.

Mr Rashleigh—I would certainly agree with that.

Mr Wilson—I think the consumer is looking for certainty. There has now been two federal budgets since the election of the current government and both those budgets brought significant changes to private health insurance. If that were to happen again—and then perhaps again and again—the consumer would start to look at the product, confusion and disappointment will take over, and they will think less of the product.

Senator BOYCE—Nevertheless, what store does one put in a guarantee that no further changes are planned, even if you were to get it?

Mr Wilson—Very qualified now.

Senator BOYCE—You have used far more temperate language here, but do you have concerns that this is actually a move against private health insurance that is being introduced in an incremental way?

Mr Rashleigh—That is an underlying concern, yes.

Senator BOYCE—What would be the effect if that were to be the case?

Mr Rashleigh—If we go to the stark facts, 52 per cent of all procedures are currently performed in the private sector. If we were to transfer that workload to the public sector, which is already struggling, we would completely swamp it. If we turn the clock back to the days before the 30 per cent rebate and Lifetime Health Cover, the actual level of the insured population had fallen to 30.2 per cent and was declining rapidly. One would have to question whether private health insurance, had it kept declining as it was when it got to 25 per cent of the population only, was sustainable in totality in that situation.

Mr Wilson—The stark reality is that every person who drops or modifies their private health insurance will be an actual or potential extra pressure on the public health system. We all understand the pressure that that system is already under. Any further drift from private health insurance and the private sector to the public sector cannot be a good thing for the Australian health system.

Senator BOYCE—We have had evidence from a number of other organisations that the effect as far as they are concerned is that the younger, healthier members will pull out or pull back on their health insurance, leaving the older, less healthy—the 'high-end users', for want of a better term—and therefore push up premiums. Is there going to be any difference in the behaviour of your membership?

Mr Rashleigh—It would be fair to say that there is probably a higher level of loyalty towards the fund. As a group of funds we do not suffer the same churn as you see occurring in the bigger, open funds. That is because of the loyalty and the cultural linkage to the fund. But there is the overriding question of affordability. Most of us came under very close examination in the last rate round, which took effect from 1 April this year, to justify our premium increases. I think the fact that the industry was able to contain itself to an average increase of 6.2 per cent versus an average increase in costs of about 9.5 per cent was a fairly commendable outcome. We are advised that the scrutiny which will be applied in the forthcoming round—which they brought forward by submissions being required by 20 November this year to take effect from 1 April, which leaves an enormous gap in the predictability time scale—will be such that there will be an expectation that premiums be contained to increases of five per cent or less. That is going to be very difficult for the industry to achieve, particularly given the last two sets of circumstances.

Mr Wilson—Adding to that, if there is a consumer risk taker in the world of private health insurance, it is going to be the younger and more healthy person—certainly, young males, who think that at 25 they are—

Mr Rashleigh—Invincible.

Mr Wilson—invincible and that nothing is going to come their way in terms of bad and serious health concerns. If there is a very obvious group who might now reconsider their membership of private health insurance, it is young, healthy males.

Senator BOYCE—Which, of course leaves the higher users.

Mr Wilson—It has flow-on effect for those who remain.

Senator BOYCE—Have you done any modelling on what you would anticipate the effect of this move would have on your contributors if it were to go ahead?

Mr Wilson—We have not yet. We conduct consumer surveys on a regular basis, in which 12 of our 17 funds participate. I think part of that exercise now will be asking those who are already members of our funds what they are thinking about their private health insurance and whether some of the changes that have been mooted by government will have an impact upon their decision to stay, go, or decrease their cover.

Senator BOYCE—Would you have any sense of what percentage of your members would be affected in tier 2 or tier 3?

Mr Rashleigh—We have not done that modelling.

Senator BOYCE—Would you have the data to do it? BUPA did it by looking at Roy Morgan's income levels and applying them. Would you have to do something similar? You would not actually have that income data, would you, for your members?

Mr Rashleigh—No.

Senator BOYCE—Mr Rashleigh, I have a technical question. You mentioned the administrative complexity of this and talked about a multiple of 10.

Mr Rashleigh—Yes.

Senator BOYCE—Can you explain what you meant by that?

Mr Rashleigh—It is just the number of multiples, if you take the three different levels and then multiply them across all aspects of your products.

Senator BOYCE—I see. Sorry, I still do not see where we get a multiple of 10 from. We have three tiers—

Mr Rashleigh—Three tiers, yes, but nine is probably a more correct figure. There are three potential levels in each of those three, so we have nine. I am sorry; I was rounding the figures. I apologise for that

Senator BOYCE—Rounding up is always a good thing. Now I understand what you meant.

Senator FURNER—I think you indicated correctly there is no way of ascertaining income data for your members in the variety of funds you have. What sort of people would the Transport Health Pty Ltd fund cover? I assume it would it be truck drivers—correct me if I am wrong.

Mr Rashleigh—Yes, largely speaking it would be—I do not like the terminology—blue collar workers and probably people at a lower socioeconomic level than that.

Senator FURNER—Are you able to inform us what sorts of companies they might be employed by?

Mr Rashleigh—That could go from the very large Fox organisation down to the small single owner-driver of trucks.

Senator FURNER—You could possible draw down information using that scenario—say, Fox or Toll—through an understanding of certified agreements and what drivers might be on on average. You would possibly be able to ascertain for that group of workers in your fund that people—

Mr Rashleigh—I guess you could do it. Theoretically, you could do it with teachers, but then the mix of each level of teaching grade would be confusing. You could probably do some very rough estimates, but they would be rough and potentially very misleading.

Senator FURNER—Yes, but you would at least be able to produce some sorts of figures.

Mr Rashleigh—Yes.

Senator FURNER—And you would also be able to get some information from some union bodies, in particular, about where their members wages are based, wouldn't you?

Mr Rashleigh—We could, but I would be very concerned on two scores—one, as I said, the accuracy of the final numbers you came up with and, two, I would not like—and I can say that very openly in respect of my own fund—to be seen to be invading people's privacy in any way whatsoever. Again, one of our concerns, which we have put to government and to the department, is that we do not want to be involved in any way in asking people questions which could constitute a violation of their privacy.

Senator FURNER—No, that is understandable. But in general, looking at the range of your funds, most of your holders are, if I can use the terms, middle income earners to professional income earners.

Mr Rashleigh—Yes, although we would have a reasonable mix. As BUPA alluded to in their submission, nearly 40 per cent of the insured population are people earning less than $48,000 a year. As I touched on before, we all need to exercise some caution in categorising private health insurance as belonging to the higher income-earning groups, because that is not necessarily the case.

Senator FURNER—No, that is right. In your submissions you refer to the Treasury's projections of retaining 99.7 per cent of their membership. Are you able to draw any conclusion that your policyholders might possibly be considering exiting the fund as a result of these changes?

Mr Rashleigh—No, I do not think I can at this stage. Let me reassure you, Senator, if I have painted the gravest picture. Our actual performance on a day-to-day basis will be to give people incentives to retain their

private health insurance. We will not be taking a dark Grim Reaper's tale out into the world; in fact we will be selling them very good reasons for retaining their private health insurance.

Mr Wilson—We will not get a really accurate or decent feel for who is going to drop out or what number are going to drop out until the consumer starts to hear about this on a very regular basis. They will then start contacting the fund and asking the fund what it means for them and what impact it is going to have on them. It will be then that we will be able to get a fairly accurate view as to whether it is going to have a diabolical impact upon our funds or whether it is going to be more minor.

Senator BOYCE—It could even be when they start to do next year's tax return.

Mr Wilson—Exactly

Mr Rashleigh—Or it could be the 2011 tax return, in June or July or August 2011 when we will get any real measurement.

Mr Wilson—That will be the time that the tax accountant says to the consumer, 'Do you realise you can now do x, y, and z,' or 'you are not required to do this.' That is when they will start making decisions.

Senator FURNER—In fact a number of submitters have indicated that there is a likelihood of very little exiting out of funds. One particular gentleman refers to it as the 'endowment fund' where people retain the insurance based on it being a necessity. They would not be game to let go their private health insurance, unlike some other forms of insurance. They may consider looking at other forms of insurance such as car insurance or household insurance and making changes or reducing some of the coverage in them. Would you concur with that at all?

Mr Wilson—I think that there is significant evidence that people are more inclined to hang onto their private health insurance than they are to other insurance matters in their lives. The question which we do not know the answer to it is: after you keep applying more and more disincentives how long can they hang on for? When will they reach that stage that they decide that this is no longer affordable for them and they make that decision to leave?

Senator FURNER—How long have you been established in terms of the practice for the range of funds you have here?

Mr Wilson—HIRMAA was formed in 1978, 31 years ago.

Senator FURNER—What has your evidence been over that time in terms of growth in the fund?

Mr Wilson—The restricted and regional funds which we represent have had healthy growth, largely, throughout that period. They were always impacted upon by various government changes until the real incentives came in after the 1996 election. There was an obvious decline in all private health insurance membership across the country and that impacted upon our funds as well. But during the course of the previous government and the introduction of a number of incentives, the overall industry membership rose significantly and our funds rose significantly if not somewhat above—

Mr Rashleigh—Marginally above the industry average, yes.

Senator FURNER—Just going back to your earlier statement about retention and particularly the point about younger people dropping out as a result of them thinking that they are 10 foot tall and bulletproof, what sorts of incentives will you be looking at to retain those types of people? We heard evidence yesterday based on young people getting pacemakers and I would be interested to hear what examples you might be able to alert us to—what sort of activities and claims young people are looking at—as a way of retaining them in private health insurance.

Mr Rashleigh—I am fearful that it may act as an incentive for people to bring in more exclusionary products. The difficulty with an exclusionary product—and we have all seen and read media coverage of unfortunate instances associated with exclusionary products—is that people take an exclusionary product within a certain age group, and it might exclude hip replacements, for example, and until their mid-40s that is probably a fairly reasonable exclusion to rationally look at. But people do not remember to change their product and they get to their mid-40s and all of a sudden it is not until they are hospitalised that they find that they are not covered at all.

Senator FURNER—Is that a case of the funds needing to market their product better in terms of keeping an eye on those sorts of things. I do not know whether you have the database or systems in place to alert people upon reaching that age bracket where they are susceptible to that type of illness or injury.

Mr Rashleigh—I think your point is a valid one. There are two issues: one is that, yes, probably the funds need to pay more attention to that sort of thing. I guess there are three issues. Three is that there are always exceptions to the rule. You are not meant to have a heart attack in your 30s but statistics will support the fact that people do and if you happen to be on an exclusionary product that excludes cardiac care of any description then you are likely to be confronted with a substantial bill. The third is the point that I made earlier in my discussion that people find health insurance difficult to understand anyway. I am not sure how carefully we construct our letters—whether they in fact draw the attention that they should—so we have a real problem with the consumer not absorbing the message that goes out there.

Senator FURNER—I have to agree with you on that point. This probably goes across the board for any type of insurance. You very rarely, certainly from my point of view, examine the fine detail until there is a claim that you are looking at to see whether you have a claimable item to get the insurance back.

Mr Wilson—To add to Mr Rashleigh's answer, since the introduction of the new Private Health Insurance Act 2007, which introduced the concept of broader health cover, all of the HIRMAA funds are constantly looking at taking on new programs to be in addition to what people normally expected of their private health insurance so that they can get extra value, whether it be chronic disease management or some maternity programs. All of our funds are constantly looking for providers who can provide certain programs nationally. That is where the problem has been up until now, because this whole concept of broader cover is somewhat new. Until now there have not really been sufficient national providers of these services and programs, but that is increasing and our funds are looking to employ those programs and services so that our product is more attractive to the consumer.

Senator FURNER—You indicated that you are a non-profit organisation. Previous witnesses indicated that they actually deliver back to their fundholders initiatives on preventative illnesses and those sorts of things. Do you do the same with respect to your clients?

Mr Rashleigh—Yes, we do.

Mr Wilson—Yes.

Senator FURNER—Can you give us some brief examples of what you do.

Mr Rashleigh—Let me give you an example and, again, let me revert to my daytime job at Navy Health. Ten years ago—in fact, a little more than that now—we introduced an early discharge program. That was long before anyone had even dreamt up the term 'broader health cover'. We saw it as being a distinct advantage for our members. But, again, particularly if you look at the younger members—where they have got younger carers at home—there is the ability to take advantage of an early discharge program where they can get home nursing for wound management, dressing changes et cetera to be able to recover in the comfort of their own homes. We have got maternity. The big program that the majority of our member funds are now looking at is mental health management programs. We are also looking at other programs relating to coronary care, diabetes et cetera. As my colleague Mr Wilson intimated, we have no shareholders to satisfy so any funds that we generate are poured back for the benefit of our stakeholders, who are our members.

Senator FURNER—The view has been all along throughout this inquiry about people dropping their ancillary matters. Do you have a position on that at all in terms of your fund holders?

Mr Rashleigh—I suspect that that would be the first cover that people would drop off. Because of affordability reasons, many would say: 'We do not want to drop our hospital cover because there is enough media coverage about the problems being experienced within the public sector and we do not want to be exposed to those. But we will manage without our ancillary cover.'

It is also worth reporting that there was a very strong rumour—and I do not know its origin; I guess it would not be a rumour if I did—that, when the rebate was being reviewed, it was being reviewed particularly in relation to ancillary products rather than hospital products. Whether that was thrown out to test the waters, so to speak, and public reaction was such that they found that a lot more people than anticipated would drop their ancillary cover, I do not know. If somebody needs to downgrade I would suspect that that would be the first area that they would look at.

Senator FURNER—You also indicated an increase in administration matters dealing with particular information as a result of the changes to the funds. What occurred as a result of the Medicare changes—was there a need to increase your administration to deal with those changes?

Mr Rashleigh—No. Again, as I mentioned earlier in my address, because we have, largely speaking, a common software house and a dedicated platform that we work to, we are able to accommodate those changes into that platform. So they are absorbed technically as opposed to being absorbed by manpower.

Senator BOYCE—Would this be more complex, though?

Mr Rashleigh—I am sure it is going to be more complex. If you could rely on all your contributors nominating at which tier they stood, it would be somewhat less complex and you could probably accommodate a great deal of it within an IT platform.

Senator FURNER—But it has not been tested yet, has it?

Mr Rashleigh—No, it has not been tested. I guess most of my assertion is on the basis that getting people to communicate that sort of detail—

Senator BOYCE—But they need to know it to communicate it, too, Mr Rashleigh and, in fact, your income might vary through the year.

Senator FURNER—Exactly.

Mr Rashleigh—It might, or you might lose your job, be promoted or get an unexpected incentive. There are enormous complications which in our discussions with the department and the ATO to date have not been as broadly acknowledged as their impact will be.

Senator FURNER—Lastly, DoHA indicates that there is a likelihood of growth as a result of the Medicare levy surcharge—that about 130,000 people, as a result of the change to the surcharge, will consider taking up private health insurance. Do you have any position on that at all?

Mr Rashleigh—I know we had a combination of carrot initiatives and stick initiatives—that was the stick initiative. It has clearly had some impact; I do not think it has had a big impact. I am not sure how you could, by any scientific method, establish what sort of impact it would have. We have tried very hard since 1998, when that component of the legislation was introduced, to alert our members to the penalties that may exist if their income level is X and they do not have private health insurance. Again, I do not know—and I am not trying to apportion fault here—whether that message has been clearly received.

CHAIR—Mr Wilson and Mr Rashleigh, you will receive a copy of the *Hansard*. If there is anything you think you should have said or would like to add please be in contact with the committee. Thank you very much.

[2.04 pm]

KERESTES, Mr Peter Francis, Chief Executive Officer, Private Health Insurance Intermediaries Association

CHAIR—Good afternoon. Have you done this before?

Mr Kerestes—No.

CHAIR—It is very straightforward. Information on parliamentary privilege and the protection of witnesses is available for you. If you would like to make an opening statement, please do so. Then, as you saw with the last witnesses, we will go into questions. Do you have an opening statement for us, Mr Kerestes?

Mr Kerestes—Yes, just a brief one. You are in receipt of our submission. I just want to highlight a couple of points. Our primary argument is about the enduring confusion amongst the private health insurance market, who have had, over a little more than the last two years, three premium increases and two Medicare levy surcharge amendments. The latest Medicare levy surcharge change was in October 2008. We have had less than a full year of that, and, as you have indicated in previous discussions, it is not until people sit down and do their tax return that they even realise there have been changes, no matter how widely publicised they have been. We do not expect to see the full impact of that until next year. It vitally important to realise that there is that lag in reaction in private health insurance. And we now have the change in the tax rebate as well. Our key argument is that these things should stop for the time being. There have just been so many changes. The product itself is confusing to begin with and then, if you add the nine choices for each product range, it becomes incredibly complicated.

The implementation and management of changes is unclear. I know that the department of health is seeking to redress that, and that may well solve those problems. The key problem, apart from minor details, is how you handle increases or decreases in people's wages during the tax year, because many of them, until they sit down and do their tax return, will not realise that that has flowed through to their health insurance and that their health insurance rebate and adjustments will be quite substantial.

The other point is that we believe that the first category that people will drop as a result of increasing cost is the ancillary cover. It is not as vitally important to people as the hospital cover. Most people like to have both, but if they are economising they will drop the ancillary.

Fourthly, and finally, company-paid schemes, which are a market for some of our intermediaries, are a small part of the market but still significant to the individual intermediary. They will see a flow-through to their fringe benefits tax—that is payed for by the company—and that will further exacerbate the problem. It may even motivate some to drop the whole scheme.

CHAIR—Thank you.

Senator BOYCE—Mr Kerestes, you talked about the difficulties there are going to be in knowing where you sit, because of variations in income. Do you have any sense of the volatility of income?

Mr Kerestes—No, we do not. We have not seen or heard any comments about the volatility of the income. It is a real risk, but, as to how many people would end up in a given year in that category, we do not know.

Senator BOYCE—You talked also about the fact that, when we get to the end of tax year 2010-11, there will in some cases—and we do not know whether we are talking about a lot of cases or a small number of cases—be a need for substantial adjustments. Have you done any work at all on what sort of adjustments you might be talking about there?

Mr Kerestes—No, we have not.

Senator BOYCE—Do you have a sense of the size of corporate health insurance, which you mentioned as being a small part of the market?

Mr Kerestes—No; I would be guessing. In terms of membership, that could be around 100,000 or maybe 150,000—

Senator BOYCE—People.

Mr Kerestes—Members.

Senator BOYCE—Contributors?

Mr Kerestes—Yes. For people, you can roughly double that—

Senator BOYCE—And that is nationally?

Mr Kerestes—Yes.

Senator BOYCE—We had evidence this morning that some companies had chosen not to go ahead with tenders and others had said, 'If this goes through, we'll be dropping the scheme.'

Mr Kerestes—Yes, that is right.

Senator BOYCE—Have you heard that?

Mr Kerestes—We have, yes.

Senator BOYCE—Not necessarily naming names, unless it is reasonable to do so, can you just tell me what people have been saying?

Mr Kerestes—Our members are agents and intermediaries and they deal with the corporates all the time. They are hearing that people are suggesting that they may not go ahead with it next year when it comes up for renewal or that they will significantly have to review it. Those sorts of things they are hearing, without sourcing them to specific corporates.

Senator BOYCE—It is, intuitively, probably true. Who are the other customers of your members? Can you give me a quick customer profile, please?

Mr Kerestes—There are the corporate schemes which are paid for by the corporates and there are the corporate schemes which are not paid for by the corporates but voluntarily paid for by the employee.

Senator BOYCE—Is HIRMAA a—

Mr Kerestes—No, it is totally different from HIRMAA. For instance, bank XYZ might say, 'Okay, for working for us we can give you a very attractive deal on health insurance.' That would involve a broker setting up two or three private health insurance schemes for that particular bank of employees. It would also involve an intermediary, who would go around and present the schemes to various employee groups, and they might voluntarily say, 'Yeah, I want them to deduct my wage; I'll sign up with HBA,' or whoever it is. The third category deals just with just the retail public. They are smaller agents who act for and on behalf of one health insurer, or three or four health insurers.

Senator BOYCE—So I can pay there and claim there.

Mr Kerestes—Yes.

Senator BOYCE—So it might be someone who is running a retail business doing other things?

Mr Kerestes—No, they are dedicated private health insurance agents. They specialise in that area. They connect you up with the health insurer and, whilst they do not process the claims—the health insurer processes all the claims—they are your protection, I guess, to ensure that you are properly dealt with and attended to. Then there are people like iSelect—they are a member of ours—who deal over the web and over the phone with the public.

Senator BOYCE—In a broker sort of role, really.

Mr Kerestes—Yes—'Ring us to get the best private health insurance.' You either ring or go onto their website and give the profile that you want and—boom!—they give you a quote, sign you up and so on. So there are all those combinations, from large players, like iSelect, to small agents that have maybe two or three people working for them in their office.

Senator BOYCE—Would they also perform a type of brokerage role?

Mr Kerestes—The smaller ones perform more of an agent's role than a brokerage role.

Senator BOYCE—I think we are told nine million people have coverage—how many contributors would be represented by your members? I am trying to get a sense of the percentage of the market.

Mr Kerestes—There is no definitive survey of these things, but our members estimate that they account for about 10 per cent of the market—all the combined types.

Senator BOYCE—You have spoken about what you think would happen with the actual premiums and the like, but what effect would it have on your members if this legislation were to be passed?

Mr Kerestes—The effect on them is more indirect, because they are the intermediary between the insurer and the insured. The major contribution would be a decline in business, really. You must understand they spend day in, day out talking to private health insurance consumers, so they are very close to them in that

marketplace. The concern is that it would price the insurance out of the market in some cases, so they would lose members.

Senator BOYCE—Are you basing what you are saying about what will happen on the survey information that we have—for example, the Roy Morgan and Ipsos poll—or on what your members are telling you their customers are telling them?

Mr Kerestes—I am basing it more on what our members are saying their customers are saying to them. It not only intuitively does not make sense but has been reinforced by the murmurs and comments that people are making. Not all consumers are really across this issue, as you have heard. Many of them are indifferent to it, but the ones that are connected and switched on are making those sorts of negative comments. For someone who is successful as an intermediary in the corporate market, to lose one or two customers is quite a substantial proportion of their income.

Senator BOYCE—One of our witnesses yesterday suggested that there is a certain degree of stickiness about health insurance—that people will maintain it long after they give up other things. Is that what your members are being told? If not, why not?

Mr Kerestes—It is very hard to say whether there is that level of stickiness. There must come a point where they detach themselves, to continue the analogy. They have been 'sticky' through thick and thin, but you have constant premium increases, you have constant changes to the Medicare levy surcharge and now you are having changes to the rebate. There must come a time where people say enough is enough. I think that their first step will be to drop their ancillary cover, as I said in my introductory remarks. Bear in mind there are a large number of people in private health insurance who are not in the well-off category. Forty per cent are below $48,000 and there will come a time when they can no longer afford it. They will perhaps dispense with other forms of expenditure before private health insurance, but they have probably been doing that for the past couple of years anyway. So we need to be very cautious that we do not price it out of the market.

Senator BOYCE—You mentioned the fact that we have had change on top of change. What effect has that had on your members?

Mr Kerestes—It just adds to the confusion. People say, 'This is such a complicated and confusing product,' and our members are trying to simplify it.

Senator BOYCE—Your members are presumably quite expert in the area.

Mr Kerestes—Yes. Their marketing packages are quite good and impressive. This is just another layer of complexity on complexity on complexity. How simple is it going to be when you have to divide this product category into three because if your income is over this much then your rebate is this much, if your income is over that much then your rebate is that much and so on? It is adding enormous complexity to the product. We, in this room, may think that is quite easy to live with, once you come to terms with what lies behind it, but most people do not take the trouble to come to terms with it. When you try to explain it to them, their eyes glaze over. There is that fear picked up constantly, from my members, that it is a complicated product to begin with and this is just adding more complexity to it.

Senator BOYCE—Can you characterise your members' customers for us? Would they be primarily people who would be in tier 2 and tier 3 levels?

Mr Kerestes—It is hard to say because of the mixed bag of customer bases. In some of these corporate schemes where they pay voluntarily for the insurance, there would be just a normal cross-section of the population. In some of the corporate paid schemes there would be a greater bias towards the tier 2 and tier 3. In the retail market, with the smaller agents, you would say that there was just a broad cross-section of the population. Quantifying that is extremely difficult.

Senator FURNER—In terms of dropping ancillary cover, what range of ancillaries would your members' clients have?

Mr Kerestes—They would work on the package that health insurance products offer. Most insurers have at least two different ancillary tables, some have three or four. It would really depend on the package that the broker or the agent had packaged up to sell to the consumer. They would cover the standard range of things, dental, optical, physio and a whole raft of things. Some have token natural therapies; some have many more natural therapies and so on. It is again difficult to be very definitive about what our members have. They will have the choice of a lot.

Senator FURNER—So it were a plausible argument to suggest that people are going to drop their ancillaries or some of their ancillaries, do you think they would examine what their past usage of those particular ancillaries had been and then say, 'I haven't been using optical, I haven't been using physio, so I'm going to drop them and maintain dental and other types of ancillaries.'

Mr Kerestes—No, I do not think they would have the option. It is all packaged up as one product. You have your hospital coverage and you have your ancillary coverage. Your optical, dental and so on are all part of that ancillary product that you buy; it is one product. If you think that you are only using optical once a year, so you do not need the rest, you will just take out optical coverage—it does not work that way. The concept of insurance is spreading the risk across the pool, so you need a big enough pool and that is why ancillary products are designed that way.

Senator FURNER—Why do you draw the conclusion that they will drop ancillary? Is that through some sort of examination of the other submissions or is it the feedback that you are getting?

Mr Kerestes—It is feedback plus instinct. The hospital cover is the basic desire for having private health insurance. The ancillary is—

Senator BOYCE—An option.

Mr Kerestes—Yes, it is an option, and many people avail themselves of that option, particularly with growing families and so on, orthodontic treatments and you name it. It is quite a handy and useful piece of insurance. If you are confronted with rising costs, you have to start compromising somewhere, and you can drop your ancillary without having any effect on your Medicare levy surcharge. Secondly, it would drop a considerable sum from your total premium. It is not the largest component, the hospital is, but it is still a considerable sum. It varies depending on what it is and who the insurer is; it varies from about $600 a year right up to $1,200 a year depending on what it is, family cover versus single cover and all those sorts of things.

Senator FURNER—One of the submitters yesterday, Dr Deeble, used the example of a family earning $165,000 a year on the private hospital insurance equating to a rise of four dollars a week, and he went further, saying it is a cup of coffee a week. Based on what you have just indicated about dropping the ancillary charges and maintaining the hospital insurance, do you think that is a reasonable suggestion to put, that people would maintain their hospital insurance based on those sorts of results?

Mr Kerestes—They may well at that sort of level because, as you rightly point out, it is an inconsequential rise when you are earning $165,000 per year or something like that.

Senator BOYCE—I do not know that all couples with three children earning $165,000 would share that view, Mr Kerestes.

Senator FURNER—That is difficult and we do not know the answer.

Mr Kerestes—Yes. But when you go to lower levels of salary it does become quite critical and quite sensitive. Most of our families with three kids I would put to you are below the $165,000 level.

CHAIR—So they will be untouched by this legislation in the first action.

Senator BOYCE—No, $165,000.

CHAIR—You said that most of the people with three children are on a lower salary. It cuts in with families at $150,000. Family coverage cuts in at 150 grand. I am struggling to hear the statements about complexity, because the industry in which you are working is one of the most complex industries. Working through private health insurance for anyone is extraordinarily difficult, and the marketing campaigns and the processes around the different optional packages are one of the reasons people use your business, because they are so confused. What is being proposed in the process is a means test. It seems to me that people will have the salary situation worked out. It is certainly another issue to take into account; I do not doubt that at all. But I am interested in the statements about increasing complexity. It is a means test which people cope with in their Centrelink arrangements, with their family tax arrangements—all those things already people are working with. I am interested in why your members are saying that. In answer to Mark's question about the different ways people cut and what they choose to do, can you tell me why a means test in the choice is seen as such a complexity? I do not wish to be difficult but I am struggling a bit.

Mr Kerestes—Because it is not just a simple means test. Sure, it determines what level of rebate you get but there are effectively four levels. There is the 30 per cent, the 20 per cent, the 10 per cent and nothing. And at those various levels when they cut in it adds a layer of complexity. You have to know what your income is, what it is going to be—

CHAIR—Or what you say your income is going to be, the same as in the Centrelink claim.

Mr Kerestes—Yes, but then what happens if you get a wage increase or you lose your job and you fall to the next level? That is a layer of complexity. How do you explain that or answer that?

CHAIR—Certainly that is a level of detail in working with the department about how that is going to work. I totally accept that.

Mr Kerestes—And whatever solution they come up with, it is still adding to the complexity and the confusion around the product. If it is a simple 'You will catch it up—

CHAIR—At the end of the taxation year.

Mr Kerestes—Then, 'Hang on a minute, in good faith I've declared at the start of the year and I'm in this category and then you are telling me that at the end of the taxation year if I've got a wage increase and been successful I'm going to be penalised because my rebate has come down.' The question is, how do you apply that rebate? Is it for the half-year that you had the lower income?

CHAIR—They are the kinds of questions I need to know rather than just, 'It's complex.' The point you are raising now is absolutely critical in terms of working with the department about where it goes. I have to put on record that already the private health insurance area, with the various optional packages that are out there for people, with the marketing campaigns that are going on which are quite direct to encourage people to take up different things, already I think a lot of people are confused. That point has been made by many submitters.

Mr Kerestes—And generally we are saying that this is going to add to the confusion.

CHAIR—It is specifically about how it is going to work.

Mr Kerestes—Yes.

Senator BOYCE—And it comes on top of change that has not yet been bedded down.

Mr Kerestes—That is right.

CHAIR—There was also an income test, straightforward. It applied or it did not. What you are really concerned about is how it is going to work.

Mr Kerestes—Yes. But going back to the earlier point that Senator Boyce made, the Medicare levy surcharge change in October 2008, no-one knows what that effect is.

CHAIR—Until the end of the taxation year.

Mr Kerestes—And that is happening now. Then people are not going to react until the new year, the 2010 year. We are not going to know the full impact of that Medicare levy rate change until 2010.

CHAIR—Can you explain to me why, when they find out now, they will not make changes until 2010?

Mr Kerestes—They will make them when they find out, but that will not flow through until they make their decision, which might be in August or September of this year. Then they will say, 'Okay, I'm going to drop my health insurance' or whatever.

CHAIR—Or orthodontic or whatever.

Mr Kerestes—Yes. So we are not going to see what happens in the whole industry until that year.

CHAIR—Okay, I see the point.

Senator FURNER—Looking at this concept of people being caught up in terms of means-testing, surely it would be the same as people on Centrelink or something like that where they are means-tested based on their earning capacity and therefore their returns are reduced or ceased as a result of their ability to earn an income. It is not directed at you, it is something we need to clarify with the department. Using your examples of wage increase, surely there would be a trigger there to inform the relevant department that that has occurred, so therefore the rebate and those necessities would be changed. As you said, you would not go through a six-month period and then at the end of the taxation year end up with a huge bill to actually pay. It would be the same as other types of insurance. You would not insure a Mini Minor and then six months down the track decide to upgrade to a Calais or something like that and expect the same level of insurance, would you?

Mr Kerestes—No, but it is slightly different insuring yourself from insuring a motor car. You have a wage increase, so your instinct is not to go off and tell the health insurer.

Senator BOYCE—What will I do? I'll ring my health insurer.

Mr Kerestes—And say, 'I've got a wage increase.'

CHAIR—It could be in future, and that was part of the marketing campaign.

Mr Kerestes—It may well be, but how effectively that works remains to be seen. And the longevity of that remains to be seen. If it works, that is fine. Twelve months down the track—

Senator BOYCE—But haven't we just finished simplifying family tax benefit to save families from these sorts of glitches in income as well?

CHAIR—That is possibly not a question for Mr Kerestes. Do you have further questions, Senator Furner?

Senator FURNER—No.

Senator BOYCE—I would like to follow up on that. As Senator Furner points out, people who have regular contact with Centrelink are used to having to notify changes in income and so forth. But, within this area, until recently the only principle that surrounded the private health insurance market has been the community rating concept. How do you see this idea of means-testing working with an industry that is based on everyone paying the same?

Mr Kerestes—Conceptually everyone is supposed to pay the same, but we know in fact they do not. That is why these different products are designed—the exclusionary products and whatnot. So we need to just acknowledge—

Senator BOYCE—Everyone pays the same for the same coverage, whether they are 16 or 75.

Mr Kerestes—Yes. I think that is divorced from whether you can means-test the application of a tax rebate, which is what we are talking about. They are two separate issues. In the consumer's mind, of course, they are part of the one product. So, I think, conceptually they could live with the means-testing, but as a practical measure the consequences of it are such that it will price the product out of the market for a number of people.

Senator BOYCE—Thank you.

CHAIR—If there is anything that you want to add to your evidence—when you go away and think about the questions we have asked you may come across something that would make it clearer—please get in contact with the committee.

Mr Kerestes—Sure.

CHAIR—Thank you very much for your time.

Mr Kerestes—Thank you.

Proceedings suspended from 2.38 pm to 3.00 pm

ILLINGWORTH, Associate Professor Peter, President, Fertility Society of Australia

CHAIR—Welcome. You have been given information on parliamentary privilege and the protection of witnesses, which is standard practice. I am sure you have an opening statement. If you would like to give us your opening statement, we will then go to questions.

Prof. Illingworth—On behalf of the Fertility Society of Australia, I thank you for giving us the opportunity to make a statement on this important matter. The Fertility Society is a multidisciplinary body consisting of health professionals and others involved in the provision of health care to infertile couples. I am the current president of the society but in my day job I am a medical practitioner who works in the western suburbs of Sydney. Next week you will be hearing from the IVF director of the subcommittee of our society. That group normally has responsibility for discussions with government on the area of medical fees.

Infertility is a medical condition. It affects one in six Australian couples. There are safe and effective treatments which have allowed many Australians who would otherwise have been unable to have families to overcome the distress and heartbreak of involuntary childlessness. Thanks to the longstanding support of the Australian government, access for patients to IVF is the fourth highest in the world. Last year, 11,000 IVF babies were born compared to 6½ thousand only five years ago. In other words, three per cent of Australian children are now conceived through IVF, a figure that represents one IVF child in every primary school class. A recent report issued by ICMART, the worldwide review body for infertility, assured that Australian patients enjoy some of the best success rates in the world. The average age of patients in Australia is 36, and this age group's pregnancy rate at 40 per cent is comparable with the best in the world.

IVF in Australia is very tightly regulated. All clinics are required to undergo annual inspections conducted by independent accredited auditors, and all clinics are required to adhere to National Health and Medical Research Council ethical standards. This is a level of regulation and compulsory conformity to community standards that is really unparalleled in Australian medical practice. All of this is achieved while Australia leads the world in transfer of one embryo at a time. This is very important: single embryo transfer minimises the risk of multiple pregnancies. The rate of multiple pregnancy in Australian infertility treatments is the lowest in the world. This has two important effects: one is that it ensures the future health of the child and the other is that it cuts down the cost to society of natal care associated with multiple pregnancies. In the five years from 2002 to 2007 the rate of multiple pregnancies fell from 24 per cent to 12 per cent. It has been estimated by an economic cost analysis that that has saved the Australian taxpayer $14 million in healthcare benefits—enough to fund another 5,000 IVF cycles.

We are very concerned that increased cost burdens for patients will cause increasing pressure to return to days of multiple embryo transfers, with adverse consequences for the health of the children and increased cost of natal care. As fertility doctors we appreciate that these are tough times and fully understand the need for a reasonable review of healthcare spending. In parliament last month, Ms Roxon stated that patients who see specialists who charge $6,000 or less for a typical IVF cycle will not be worse off. This seems eminently reasonable. However, Ms Roxon seems to have the numbers wrong and suggestions that patients charged the average fee of $6,000 will not be worse off are wrong. The minister's suggested caps mean that the average patient's out-of-pocket costs will rise from about $1,000 up to $3,000 for one IVF treatment.

It is important to make the point, we feel, that IVF services in Australia are delivered for about half the cost of prices in the US and about a third less than prices in the UK. Quoted in the *Guardian* in the UK on Thursday 31 May 2007, Professor Lord Winston said, 'It is really rather depressing to consider that some IVF treatments in London are charged at 10 times the fee that is charged in Melbourne, where there is excellent medicine, where IVF is just as successful and where they have comparable salaries.'

It is also important to make the point that the figures that the government has quoted on payments to doctors do not reflect a doctor's personal income. The money that patients pay for IVF pays for the staff to deliver the complex treatments, the scientific equipment, the culture media and the consumables used in the laboratories, as well as the ongoing research that is required to ensure that technology and results remain the best in the world. For every doctor who is involved in IVF, there are at least 10 scientists, nurses and counsellors delivering IVF care to patients. Around Australia, in excess of 2,000 employees work in the provision of IVF patient services.

Our concern is that the proposed changes to the Medicare safety net will make it significantly harder for all Australians to access infertility treatments. I work in the Western Suburbs of Sydney. My patients already

struggle to deal with the emotional and physical burden of IVF. These changes will make the process that little bit harder for them.

Senator XENOPHON—Professor Illingworth, one of the criticisms that has been made is that rate of increase of fees for IVF services for the specialists who perform those services has increased beyond the level of medical inflation. Can you comment as to why that has occurred and why fees have increased faster than fees for other medical services?

Prof. Illingworth—That is a very important and reasonable concern. This has come from the Share report that was conducted on behalf of the government recently. There were a number of aspects that that report did not take into account. The first is the fact that before the introduction of the safety net, patients were previously paying booking fees. The report stated that they could find no evidence of booking fees. However, I previously sat on the independent committee appointed by the last minister, Mr Abbott, to look into this issue. We did find evidence of booking fees that were not considered as part of the cost of IVF to patients as seen by the department. That is part of the rise that was not taken into account by that report.

The second point is that IVF has been an area that has changed significantly in the last five or six years. The technology has developed quite a lot. It is not the same technology that was in place five years. There have been new developments in equipment, particularly in culture media, where advances in freezing methodologies, for example, have led to higher pregnancy rates. The cost of that has had to be passed on to the patients. The equipment has increased beyond the level at which normal medical inflation will have occurred in other areas.

The final concern about that report is that it took no account at all of the change in medical practices resulting in the lower rate of multiple births and the savings that the government has made from that. The issue there is that neo-natal costs are paid out of state government budgets while ART costs are paid out of the Commonwealth budget. Nonetheless, it is a saving to the general public purse as a whole in Australia.

Senator XENOPHON—Firstly, you make references to the technology improving. Could you take on notice providing some more details in relation to the cost increases with respect to the technology. You also made reference to both the UK and the US. I am more interested in the UK system rather than the US system. You said that the costs here are about a third less than those in the UK. Could you provide some further detail on notice in relation to that.

Prof. Illingworth—Of course.

Senator XENOPHON—Thirdly, with respect to the whole issue of neonatal care, there has been a reduction in multiple pregnancies from, I think, 24 to 12 per cent from 2002 to 2007. Have you or has your organisation conducted any research or have any studies been done or consideration been given to, if these changes go through, whether that will mean that patients will seek to have more eggs implanted, to the extent that we will have more multiple pregnancies? Has any consideration been given to that by your organisation?

Prof. Illingworth—There were three questions in that. I accept to take the first two on notice, as you have suggested. I will prepare a written submission for the committee with the information requested in the first two questions. With the third one, there is not really a factual response to that. The evidence that makes us concerned about it is evidence from the United States which shows that the rate of multiple pregnancies, and the rate of multiple embryo transfers leading to those multiple pregnancies, is directly related to the level of insurance rebate that is available to the people doing IVF. So there is clearly evidence that shows that, the higher the level of cost borne by the patient, the greater the pressure there is to transfer more than one embryo at a time. That is clear-cut. Whether that will apply to this specific change I think can only be speculation. But we are concerned about it.

Senator XENOPHON—Finally in relation to this, could you provide, again on notice, details of the United States studies in relation to multiple births? Also, you have mentioned how the state governments pick up the cost of neonatal care for premature births and complications arising out of multiple births. Could you provide some further information in relation to that so that we can draw a direct comparison about unintended consequences or the economics of paying more for neonatal care via the states?

Prof. Illingworth—My comments on that matter come from a report prepared by the National Perinatal Statistics Unit into the effects of multiple pregnancies. They have conducted a cost analysis, from which my estimate of figures has come. I would be very happy to supply the committee with that cost analysis.

Senator XENOPHON—Thank you. Chair, I might reserve the right to chip in at the end of this session.

CHAIR—Sure. Senator Siewert?

Senator SIEWERT—I want to pick up where Senator Xenophon was going with the issue of the evidence around, if costs to the patient go up, that leading to multiple implants. Could you provide that information?

Prof. Illingworth—The study to which I referred to was one carried out in the United States. I would be very happy to supply the manuscript from that to the committee.

Senator SIEWERT—But that is a US experience rather than an Australian experience?

Prof. Illingworth—That is a US experience. There is a worldwide trend—and there is another paper that has been prepared, by a doctor in the UK who has been working with the Australian database comparing practices in the UK and practices in Australia. Australia does lead the way in transfer of one embryo at a time. In speculating on the reasons for that, he suggests that the Australian system of funding a copayment for every cycle contributes enormously to that.

Senator SIEWERT—Pardon my ignorance on these issues—because I am just getting my head around some of the detail now—but I thought one of the reasons in the past for multiple implants was success rate. I would have thought, with improved technology, the success rate of a single implant would have been much better. I am questioning whether it is just cost or whether it is also that improvements in technology have meant that you are likely to have more success. I would suggest that parents would prefer to have a single birth, mostly, than a multiple birth. Has any work been done around that?

Prof. Illingworth—I think that is an important point as well. You are undoubtedly correct that improving success rate is what gives patients the confidence to go ahead with a single embryo transfer. Knowing that they have got a 40 per cent chance of getting a baby from one embryo makes them more confident than in the old days, when they only had a 10 or 12 per cent chance of getting a baby from it. But nonetheless, when people look worldwide at why some countries operate one embryo at a time, while other countries, which have the same success rate, are doing two embryos at a time, the differences that they see between the countries are in the healthcare systems and the funding involved in those healthcare systems.

Senator SIEWERT—Has there been any quantitative work done with parents? Instead of speculating on the issues—and I am not saying that it is not justified to do that as well—has there actually been any talking to parents about the decision-making process?

Prof. Illingworth—There has been. You would probably have to—

Senator SIEWERT—Qualitative, not quantitative—sorry.

Prof. Illingworth—Yes, I understand that question, Senator. You will have to forgive me for not being completely au fait with the details of that. I know that there was a survey carried out in Adelaide. A research group in Adelaide interviewed parents. This was at the time of the introduction of single-embryo transfer. Parents discussed their attitudes towards one versus two embryos and the group found very strongly a high awareness of the serious consequences of twin pregnancies—that it is not all about two little babies and that the serious health risks with twins was an important factor; also that the higher success rate was an important factor. As I recall, that study also found that economic factors played a role.

Senator SIEWERT—I would like to tease out some of the costs. I am interested in the scenario that costs are increasing because technology is developing. Quite often, developing technology actually leads to lower costs rather than higher costs, so I am interested in the whole issue around technology and the significantly increasing costs. As I understand it, out-of-hospital services costs have been increasing significantly whereas in-hospital costs have been reducing. Is that correct?

Prof. Illingworth—When you talk about ART, the distinguishment between in-hospital and out-of-hospital costs is blurred. The reason for that is that, in a typical ART cycle a woman will attend as an outpatient for blood tests and ultrasound scans and she will go into hospital and have a procedure done to have eggs collected in hospital, and then there is the embryology work—the expensive part—which is done in a laboratory. Whether you count the laboratory as part of the in-patient work or as part of the hospital costs is, I think, a little unclear. That creates some of the uncertainty about whether an item number is billed with an in-patient item number, where it is not counted by the safety net, or with an out-patient item number, where it is. It is normal practice for most of the big parts of IVF to be billed as out-patient treatment.

Senator SIEWERT—And that is where you have the significant cost increase?

Prof. Illingworth—Yes, exactly.

Senator SIEWERT—Does the CHERE report detail the issues that you were talking about in terms of increased costs—the culture and all those sorts of costs?

Prof. Illingworth—No, it does not. The CHERE report is quite simply a study that, as far as we can see, was methodically sound—a study of the billing practices for ART in Australia in that five-year period.

Senator SIEWERT—So where do we find the information around the increase—the explanation and the detail around what costs what, where we have seen those significant increases and the reasons?

Prof. Illingworth—When we went back and looked at it we found that a number of our inherent costs had gone up—looking at the laboratory, technology and equipment. As Senator Xenophon suggested, perhaps the best way for me to answer that question would be in a more detailed way.

Senator SIEWERT—That would be extremely useful. Thanks. In terms of funding for these procedures, what happened before the introduction of EMSN?

Prof. Illingworth—The patients paid an out-of-pocket cost, which was quite a lot higher before the safety net came into place. The uptake of IVF was a lot lower at that time; now the uptake of IVF is a lot higher.

Senator SIEWERT—I suspect that is not totally due to the safety net, though. Do you think it is solely as a result of the safety net or are there other cultural factors?

Mr Illingworth—No, I do not think so. I think your comment is probably quite valid that it may not just be the safety net. It may be that, as success rates have got higher, couples have turned to it more quickly. There may well have been a rise in access to IVF without a safety net coming into play as well. I do not know the answer to that question.

Senator SIEWERT—So, in countries that do not have the same funding support that we do in Australia, has there been a corresponding rise?

Mr Illingworth—There has, but not to the same extent.

Senator SIEWERT—Okay. Right—because now we are the fourth highest.

Mr Illingworth—Fourth country in the world.

Senator SIEWERT—And what where we before we had the safety net?

Mr Illingworth—We were down at about 10 to 15, in that sort of area.

Senator SIEWERT—Okay. The other thing is that Australia was one of the leading countries in terms of the development of the technology. Is that correct?

Mr Illingworth—I think that is correct. It is also a hard question to answer. What makes a country a 'leading country'? Undoubtedly, Australia was the first to do this on a large-scale basis. Modern IVF involves giving women medications to stimulate the ovaries, having eggs collected and having embryos frozen. All of those things were first done in Australia, before they were done anywhere else; many Australian IVF babies had been born before a single IVF baby had been born in the United States, for example. Now, what makes our country a 'leading country' nowadays? Our success rates are as high as any other country's, but they are not necessarily the highest in the world. There is no real league table in that respect. We have the lowest rate of multiple pregnancies, the biggest complication of IVF. We have the lowest rate of that because we put back. At the last estimate, 78 per cent of IVF cycles were one embryo at a time in Australia, which is an extraordinary figure compared with the rest of the world. Apart from that, every other aspect of what is good IVF is a subjective thing: are the patients well cared for; are they happy with the experience that they have had? It is very hard to make comparisons between those things.

Senator SIEWERT—Thanks.

CHAIR—Senator Boyce?

Senator BOYCE—Just following up on that: what drives the decision, Professor Illingworth, to have a single or multiple embryo transfer?

Mr Illingworth—A lot of it is about the practice in the clinic and the practice in the country or the city involved.

Senator BOYCE—So it is the clinician or—

Mr Illingworth—It is mainly the clinician that drives it. Most clinics will take the view that they would nowadays never, ever put back three embryos at a time. We would not allow a patient to put back three, even if they wanted to, because of the very high risk of triplets with putting back three. That would be an unacceptable

practice. But the decision between one and two often boils down to the discussion between a patient and her doctor. Almost every doctor in Australia will advise patients to have one put back, but they will give a little leeway for someone, for example, who has been through a number of IVF cycles without success and give that patient the option of having two back if they choose to do so. But, in general, it is really on the advice of the doctor. If a doctor advises a patient to have one then most of the time they will follow that doctor's advice.

Senator BOYCE—So you would anticipate that, should the changes to the safety net go through, clinicians would be saying, 'But this will cost you more'?

Mr Illingworth—Exactly, and I think—

Senator BOYCE—or, 'It would be cheaper if you did two,' not as the advice but as part of the advice.

Mr Illingworth—It is not quite that. It is that if you have a scenario where you have two embryos sitting in a dish, both beautiful quality, you can do one of two things: either you can put one back and freeze the other one for a transfer in a couple of months time—

Senator BOYCE—Subsequently.

Mr Illingworth—or you can put them both back. If the patient looks at the cost of it, undoubtedly the first approach is one that is more expensive for her—to have to pay for two cycles rather than one. At the moment, in the current setting, that change in cost is not that high and so there is not much pressure. Patients understand the fact that their chance of having a baby, which is what they clearly want, is exactly the same whether they put them both back at once or they put them back as two separate events. As doctors we can see that it is far safer for them to put them back one at a time, as two separate events, so they do have a twin pregnancy—or, at least, there will only be a low risk of a twin pregnancy that way. So we always advise them to do it that way. But if the patient says, 'Hang on; the difference to me now is a big difference in cost,' then there will be more pressure over what is ultimately the patient's decision to make.

Senator BOYCE—Just one other question. You said that the health minister, Nicola Roxon, was wrong in the figures that she used based on a cycle costing $6,000 or less. Could you talk us through in detail what was wrong and what the correct figures are, in your view?

Prof. Illingworth—Let me preface any comment on that by saying that the IVF directors group, who are appearing before you next week, are the people who have done the detailed analysis on that. What I might do is defer on that question and ask them to present the detailed analysis. I think detailed analysis on that is important because it really is the crux of the matter. The general principle is that it is reasonable to change the process by which this costing is sorted out—everybody accepts that. It is a question of the details of the actual numbers involved. To work, as Ms Roxon suggests, to a principle whereby patients who are paying the median level of costs are no worse off would, in our view, be a very reasonable approach, but our concern is that it is not quite that. The IVF directors group, who will be speaking to you next week, will provide you with the detail on that.

Senator BOYCE—You may be going to cover this in answer to the questions you took on notice from Senator Xenophon, but you spoke about the increase in costs around the technology, the media culture and the ancillary staff—the scientists and nurses et cetera—for IVF. Will the figures you intend to provide to give us a breakdown of those costs?

Prof. Illingworth—If that is what the committee would like to see, we will do our best to provide that to you.

Senator BOYCE—That would be good. Thank you.

Senator SIEWERT—What is the percentage success of the first cycle of IVF? What is the success rate of somebody the first time they try?

Prof. Illingworth—It depends entirely on how old the person is. It is also affected by whether that person has ever been pregnant before and it is affected by the cause. For example, if it is a clearly remediable cause, as opposed to someone who has just been trying for a long time with no apparent cause, the success rate is higher. But I think what you are asking is: what is the difference between the first cycle and the second cycle.

Senator SIEWERT—Yes, sorry, I am not familiar with the lingo!

Prof. Illingworth—Let me, in my rather rambling reply, get around to that point. If you, say, take a typical woman aged around 35 who has been trying to get pregnant for about two to three years and has never been pregnant before, her typical success rate from an IVF cycle the first time around would be a 35 per cent chance

of having a baby. In a second cycle for that same woman, her chance of having a baby, assuming the first cycle was unsuccessful, would be around 32 to 33 per cent. When I sat on the Abbott committee four years ago, we looked very closely at the effects of different factors on success rates from ART and the success rate seems to drop by about a 10th with each successive cycle. In other words, someone who has a success rate of 35 per cent in the first cycle would have a success rate a 10th less than that in the second cycle and a 10th less again in the third cycle. But the number of cycles that women do is not a huge factor compared to, for example, whether they have ever been pregnant before. A woman who has had a baby from IVF has twice the success rate of somebody who has never had a baby from IVF. There are a lot of factors involved.

Senator FURNER—No doubt there is a deferment of decision making to give birth these days. I take it that is relevant at present?

Prof. Illingworth—Yes, it is. Those of us in our middle ages have grown up in an environment where we look at our parents and realise with horror that, at the time our parents were the same age as we are, we were at university, while our kids are on their way to primary school and high school. There has been this massive demographic change across the whole of the Western world in this. The mean birth age in Australia has gone up from 24, 20 years ago, to just over 30 now. The effect of that is that many more women are now running into their late 30s and beyond, when fertility becomes a much harder thing to achieve.

Senator FURNER—Is that a cause of costs and complications?

Prof. Illingworth—It is a cause of cost, because it means that the same women take more cycles to get pregnant if they are older than they do if they are younger. But it is also one of the factors that you referred to, Senator, with regard to why the uptake might have increased in the last few years.

Senator SIEWERT—The other issue I wanted to follow up on is why the costings are wrong. You made a comment when you were responding to Senator Boyce that in the medium cost range it sounds like it is okay but it is an issue if it is not. Are you able to provide us—and you can take it on notice—what you think is the solution? It sounded as if you were saying that you are not necessarily opposing the fact that we need to look at costs; what you are concerned about is the approach that is being proposed at the moment. Would that be a fair assessment?

Prof. Illingworth—Exactly. That is it exactly.

CHAIR—Are you opposed to the concept of the cap, or just the amount of the cap?

Prof. Illingworth—The amount of the cap.

CHAIR—That was the issue then?

Prof. Illingworth—Yes.

Senator SIEWERT—Thank you for clarifying that. That is what I assumed that you meant. Have you put proposals to government about an alternative approach?

Prof. Illingworth—Yes. This is the area in which the IVF Directors Group will be talking through the detail. They have been working through the details of all of that, and you will be able to ask them about next week.

Senator SIEWERT—So you would be supportive of anything they propose as a way forward?

Prof. Illingworth—Exactly.

Senator SIEWERT—Do you consult with consumer organisations about your proposals?

Prof. Illingworth—Yes, we do. The principal consumer organisation in Australia is Access, and we have had discussions with them about how they feel about things and their concerns about the issues.

Senator SIEWERT—So, when we get that information next week, we can be fairly confident that it has broad support. Is that the point that you make?

Prof. Illingworth—Yes, exactly, and I do hope that these requests for information have been minuted. I do not want to forget—

Senator SIEWERT—Oh, yes. It is all on the *Hansard*.

Prof. Illingworth—Thank you.

CHAIR—Do you have any further questions, Senator Xenophon?

Senator XENOPHON—No. I look forward to getting the answers to those questions on notice.

CHAIR—Professor, in terms of interaction with the government, I know that the report came down, and I take it the CHERA report is the one that looked at all aspects of cost across the whole—

Prof. Illingworth—That is the principle one—

CHAIR—I thought it was. I had not heard it called 'CHERA' before, so I understand—

Prof. Illingworth—CHERA is the body which carried out the report.

CHAIR—Yes. In terms of the interaction, I imagine that your part of the industry would have been fairly concerned immediately that came out because it was quite direct in terms of those figures.

Prof. Illingworth—Yes.

CHAIR—Were there approaches to government in the early stages?

Prof. Illingworth—Yes, there were. The IVF Directors Group has been liaising with department about that.

CHAIR—So the interactions have been going on over a period of time?

Prof. Illingworth—We were particularly concerned by the fact that this was all presented as individual doctors overbilling when in fact the costs of IVF cover such a wide range of costs. There are equipment, consumables and large numbers of staff. The fact that it was so publicly presented by off the record briefings to journalists as being greedy doctors caused us a lot of concern.

CHAIR—Is there wide variation in billing practice in the industry?

Prof. Illingworth—That is a good question. To be honest, I do not know the answer. The department does, because the department sees all the bills. I know what we charge, but I have no idea what my colleagues in other states or departments are charging. It is not something we have ever looked into in detail, so I cannot give you the answer to that question.

CHAIR—So that would probably be an important piece of the puzzle, because that comes down to the kinds of issues you have raised about what has been taken into account. If those things are there for everyone and there is still a great variation, that is a point that we will be following up on as well.

Prof. Illingworth—I agree. I think that is a reasonable question to ask and I have to say, quite honestly, that I do not know the answer to it.

CHAIR—Okay. Thank you very much, Professor. We do appreciate your evidence. Is there anything that we have not asked you that you would like to add?

Prof. Illingworth—I do not think so. I think that our major concerns have been covered in the questioning and I thank you very much for the opportunity to attend.

CHAIR—It is our pleasure. Thank you very much.

[3.35 pm]

HILL, Mrs Anne, Member, Access Australia's National Infertility Network Ltd.

CHAIR—Welcome. I invite you to make an opening statement.

Mrs Hill—Thank you for the opportunity to bring the perspectives of Access Australia to your deliberations. Access CEO Sandra Dill sends her apologies owing to ill health. I am a member of Access, my husband is an Access director and my sister is currently going through an IVF cycle. Access Australia is a consumer-led, independent, not-for-profit charity committed to providing whole-of-life support for women and men who experience difficulties conceiving their families. Access strives to raise community awareness about infertility by being a national voice to bring the social, psychological and financial concerns of couples to governments and medical and scientific communities. Our patrons are Olympic gold medallist Glynis Nunn-Cearns OAM and Candice Reed, Australia's first born IVF child.

Access serves as a lifetime resource for support and information on reproductive health needs. Infertility is not a choice. The one in six people who need medical help have no control over this condition. IVF is a standard, proven and highly successful treatment for infertility. In some cases it is almost twice as successful as natural conception. The main concern of Access in relation to this bill is that, if passed, it will deny many hardworking Australian families their last chance to have a child. The Medicare safety net has ensured that every Australian has had that opportunity. In explanatory notes, the minister says that the reason for introducing a cap is that some doctors are overcharging. If the minister believes this to be true, we do not understand why she is not dealing with those doctors directly, rather the penalising all families who need IVF to have a family.

It is not surprising to us that government expenditure increased when the safety net was introduced. Prior to the safety net, the out-of-pocket costs of patients were paid directly to the clinic. When these costs were directed through the safety net, of course government spending would have increased, without any increase in clinic fees. More than 40,000 individuals were able to access IVF services with the support of the Medicare safety net in 2008 and nearly 11,000 babies are born each year as a result of IVF. Based on estimates reported in the *Australian* newspaper on 2 April 2009, the $42 million spent on IVF in the safety net equates to approximately $4,500 for each of these IVF children born last year. IVF is a valuable investment, given the considerable return each of these children as a productive Australian will bring their families and this country of ours. That is not to mention the heartfelt joy they give their parents.

The cruellest blow is to IVF patients trying to manage the expense of treatment on the one hand with the government's token $900 stimulus check on the other. There has also been the news that the government has raised the baby bonus to around $5,000. If you think of an average classroom, around one child in each classroom is an IVF baby. In terms of the future of our nation, the government's decision will remove this child. Many children born through IVF are now adults and asking why the government appears to value their existence less than children whose parents did not need medical help to conceive them. Access asks senators to give every Australian the chance to share in the joy that having a family can bring by providing equity of access to the Medicare safety net.

Senator XENOPHON—In relation to the proposed changes we heard evidence from Professor Illingworth about the likelihood of multiple implants with the increased possibility of multiple births. Have you surveyed your members as to whether, if these changes go through, people would try to maximise the chance of getting pregnant on fewer cycles by having multiple embryos implanted?

Mrs Hill—I am not sure that I have my finger on the pulse of that one exactly but I do know that this will be very tempting, I would think, for those people who are trying to establish their family to pressure doctors into providing the opportunity in this way. Certainly, I suppose, there are more risks involved when there are multiple embryos re-implanted.

Senator XENOPHON—Thank you. One of the reasons that the government has said that it has gone down this path is that it is concerned about the costs involved. I think it is about overcharging or some specialists making extraordinary amounts of money and Professor Illingworth has dealt with that. Amongst your members, have there been concerns in relation to either overcharging or that consumers or patients have not been fully informed before they have consented to treatment as to the likely costs involved?

Mrs Hill—Whether there is overcharging or not is something that we feel the minister needs to take up with the doctors themselves. Our concern is for the penalising of and the equity of access for the people who are

trying to have children and establish their families and homes in this way. What the minister wants to do about that we feel is something she ought to take up with the doctors themselves.

Senator XENOPHON—Your main issue is that if there is an increase in payments for each cycle, that will discourage a lot of prospective families from taking this up?

Mrs Hill—Absolutely.

Senator XENOPHON—Thank you.

Senator SIEWERT—I want to explore that just a little bit and then I want to ask you about any proposals you have for the way forward. If I understand Access's position correctly, it is that government needs to tackle doctors around their fees. Is that not in a way setting a cap as well by saying, 'We will only pay this much.' I apologise if I am not asking this correctly. The government is proposing a cap now which in effect can be a signal to doctors by saying, 'Right, this is how much we will pay, so operate within that scope.' In terms of overcharging—I suppose it is to a certain extent in the eye of the beholder—but what the government is trying to do with this measure is to say, 'We think this service can be provided for this amount of money.' I am at a bit of a loss as to how the government would say to doctors, 'You're only allowed to charge this much' if they did not set a cap. Isn't this in effect what they are doing?

Mrs Hill—The major concern of Access is the availability of this service to the typical working Australian family. A cap may impact the doctors and the medical people in some way, but the main concern of Access is for the people who are trying to establish a family.

Senator SIEWERT—I understand absolutely where you are coming from. If it is acknowledged that there is some overcharging or that some services being provided at the top end are too expensive or the doctors are charging too much, I understood you were saying earlier that the government needs to address those particular doctors. In effect, that is what they are trying to do with this cap. I am trying to look at what is a better way of meeting everyone's needs, by saying, 'We still want to provide this service but we want to provide it within reasonable expense bounds.' Professor Illingworth said that the IVF Directors Group are coming up with a suggestion for a way forward, trying to address very good access but with some sort of control—they did not use the word 'control'—or sensible charging fees. If the doctors could come up with an agreement with the government that limited the top end of the expenses, would Access be happy with that approach?

Mrs Hill—Access is of course very concerned that the couples who are wanting to establish their families have top quality health care and access to medical services that are going to enable them to do that, or at least to step forward in that area. Of course we want the best treatment provision and everybody wants the best—I was going to say, quite crudely, 'bang for buck' but it probably does not fit in this context!

CHAIR—It probably fits very well!

Mrs Hill—Everybody wants the best quality service that they can have for the money that is expected to be paid. But Access feels that the minister must really address that with the medical people and the doctors involved.

Senator SIEWERT—If a proposal were agreed between the doctors and the government for a way forward, you would be happy with that as long as people needing access to the services were able to access those services?

Mrs Hill—If those services are able to be accessed and the working Australian families who need this medical provision are consulted with regard to it, then there needs to be some sort of forum for discussing the way forward.

Senator SIEWERT—I have one other question. In terms of the members, do you get complaints from your members around what people think have been excess costs, costs that they think have been too high? The minister said some doctors are overcharging. Have your members complained about that? Are you aware of any of those issues?

Mrs Hill—There are certain procedures that are just not rebatable. The minister has within her jurisdiction the ability to determine which of those ones are rebatable and which ones are not rebatable. From that point of view, I guess there is a reflection on the part of the membership that, yes, there are many services that are hugely costing the membership but there can be some way of meeting this in some context and addressing that. Which particular items are actually considered rebatable is completely up to the minister to determine, I understand. Certainly the membership would have an understanding and would appreciate and think that there ought to be some rebate for many of these other things that are not rebatable.

Senator SIEWERT—I should have asked Professor Illingworth this question as well. In relation to the legislation that deals with the extended Medicare safety net, are you just concerned with the cap component that relates to IVF? Do you have a problem with the concept of the legislation in itself? This legislation can be applied to other procedures as well.

Mrs Hill—In the same context as Access represents the infertile, there would be other bodies that represent other conditions that would be just as worthy of presenting a case to the minister too, but certainly our concern is for the way that the average Australian working family is penalised in this context and within this legislation.

Senator SIEWERT—So, in principle, you have a concern about the extended safety net legislation in the first place, as well as specifically around—

Mrs Hill—Yes. I would like to clarify that with Sandra, but I would say that would be the consideration.

Senator SIEWERT—Thank you.

Senator FURNER—You might or might not be able to answer this question. Professor Illingworth indicated that new technology has been introduced, naturally, as a result of an increase in the success rate. In turn, he also indicated that comes at a cost. Are you able to comment on the effect that has had on your consumers?

Mrs Hill—I personally experienced infertility many years ago and there have been a number of progressions in the technology and processes involved since then. I am at liberty to talk about my own experience there. My only current experience is that my sister is currently undergoing an IVF cycle, and she is certainly undergoing many procedures involving techniques that are a product of time passing and progress being made in many technical areas. So I guess there would be an understanding that those would be passed on to the families that are going to be assisted by them. Also, the success rate has risen. The amount of cycles that couples might be going through would be reduced to some extent because of these technologies. So the expense that they would have been incurring from trial after trial may be reduced because of those technologies and the availability of them. I guess there is a little bit of ironing out with regard to that expense.

Senator FURNER—So it becomes a neutral playing field, more or less, as a result of cycles being reduced because of the introduction of new technologies.

Mrs Hill—Yes.

Senator FURNER—Thank you.

CHAIR—Do you know whether any private health insurers offer support for people going through IVF?

Mrs Hill—I am not up to date with what that might be.

CHAIR—I was wondering, in terms of the general operation of health in the country, whether any of the private health insurers covered IVF. You do not know?

Mrs Hill—No, I do not know. I could ask that question.

CHAIR—Yes. In terms of your members, is there an acceptance that there will always be out-of-pocket expenses; it is just the size of the out-of-pocket expenses to which you object?

Mrs Hill—That would be correct, yes.

CHAIR—We heard from Professor Illingworth that there were significant charges and we have heard that over the last few years there have been lower charges, so there has been a bit of a wave effect. You object to any increase or just the size of the increase?

Mrs Hill—Any increase is objectionable, because what is currently being outlaid by average working Australian families is quite exorbitant.

CHAIR— Thank you very much for your time. You will get a copy of the transcript of your evidence. If you wish to make any changes or add anything, please contact us. I hope Mrs Dill is feeling better soon. We have met with her in the past.

Mrs Hill—Thank you. She apologises for not being here today.

CHAIR—Yes, I know she enjoys giving evidence! I will adjourn this hearing until tomorrow, when we will be meeting in Perth to look at the issues around private health insurance.

Committee adjourned at 3.56 pm